NURSING FACILITY RATE DISPARITIES

A Report to the Minnesota Legislature

Nursing Facility Rates & Policy PO Box 64973 St. Paul, MN 55164-0973 651-431-2282

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Prepared by the Minnesota Department of Human Services
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I. Introduction

Laws of Minnesota, 2008, Chapter 317, Section 43, directs the Department of Human Services (DHS) to report on nursing facility rate disparities with a recommendation on how to reduce them by January 15, 2009. The requirement states:

The commissioner of human services shall study and make a report to the legislature by January 15, 2009, with recommendations to reduce rate disparities between nursing facilities in various regions of the state. The recommendations shall include cost estimates and may include a phase-in schedule. The study shall be accomplished using existing resources.

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

Cost to Prepare Report

Minnesota Statutes, chapter 3.197 requires disclosure of the cost to prepare this report. Approximately $2,000 of staff salaries were spent to analyze the issue, gather stakeholder input including quotes from specific providers and trade organization representatives, and write the report.

II. Background

The issue of Medicaid payment rate disparities has long been of concern to nursing facilities and legislators. Facilities with relatively low rates claim that they are at a disadvantage in the labor market because they cannot offer competitive compensation for workers, and that they lack comparable resources for other purposes. Many forms of disparity may exist, such as:

- Differences in rates among nursing facilities within a specified area
- Differences in the average, range and distribution of rates between areas, as defined in different ways and for different purposes (e.g. counties, historic geographic groupings and the new geographic peer groupings for Medicaid payment rates, historic Metropolitan Statistical Areas or MSAs and current Core-Based Statistical Areas or CBSAs for Medicare payment rates, state economic development regions, etc.)
- Differences in rates and payment policies across state lines in the region
- Differences between facilities in how well the payment rate enables them to meet unique resident needs
- Differences between individually-operated facilities and multi-facility organizations in terms of the resources available to support priorities
- Differences in resources available to publicly-owned facilities versus others
- Differences in facility operating costs based on their number of beds (though these are not recognized in rate-setting)
- Differences in operating payment rates among different facility types
- Differences in rates based on the effect of field audits
- Differences in the ability to enhance facility revenue through increased Medicare business, subject to local demand
- Differences between nursing facilities and other health care providers, especially hospitals
- Differences between nursing facilities and other employers of similarly skilled employees within communities
- Differences between nursing facility rates and costs, and
- Differences in the degree of change in local economic conditions among facilities.

While all of these forms of disparity may be of concern, this report will focus on the first two as they are the primary issues that have dominated the discussion. Many of the other types of disparity in the list above are challenging to measure and/or difficult to influence through legislative action. Addressing the two primary issues would likely have a positive impact on many of the other forms of disparity, as seen in part in the analyses below.

> "Disparity is in the eye of the beholder."
> --WO
>
> "Every entity would define disparity differently."
> --PC
>
> "Everybody's got a story to tell."
> --WO

What are the consequences of these forms of disparity? It is apparent that nursing facilities, in general, have spending levels and patterns driven by many factors but ultimately limited by revenues. Some of the possible consequences of rate disparities include:

"We staff according to what our operating rate will allow."
--CR

"Is disparity a bad thing? Not always. What kind is permissible and what is not? The cost of living in small towns is lower."
--SS

"The cost of living in small towns is skyrocketing."
--DB

- Wage levels may be disparately low
- Benefits may be disparately low
- Staffing levels may be disparately low
- Facilities may have more open/unfilled staff positions
- Facilities may experience greater difficulty serving residents with specialized needs
- Building maintenance may be deferred
- Limited ability for facility reinvention via reconfiguration, etc., and
- An unintended positive consequence is facility diversification into home- and community-based service (HCBS) options.

Previous Reports Two reports have been written on nursing facility rate disparities in recent years. In January 2000 a report entitled "Variation in Nursing Facility Rates" was written jointly by the Minnesota House Research Department and the Minnesota House Fiscal Analysis Department. This report provides a great deal of detail on how rate disparities came about, the extent of rate disparities, the variables associated with those disparities and possible solutions that may be considered. Rather than repeat the still valid material in that report, we will provide a link to it:

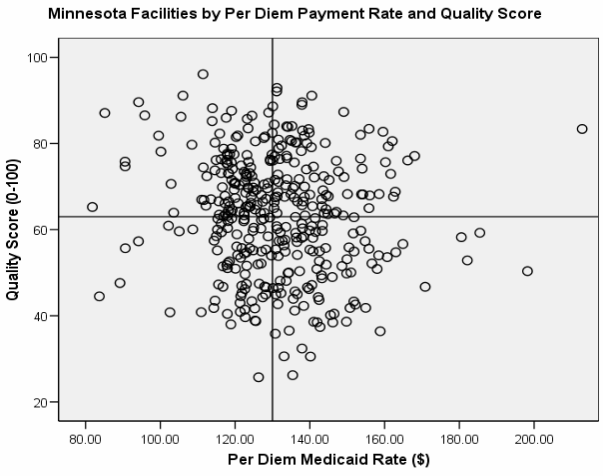
http://www.house.leg.state.mn.us/hrd/pubs/nsgrates.pdf

In February 2000 DHS provided a report to the legislature entitled "Policy Considerations for Nursing Facilities," which included a section (pages 17 to 20) on "Development of criteria and a process under which nursing facilities can request rate adjustments for low base rates, geographic disparities, or other reasons" (see Appendix A). This report lays out a recommendation which will be revisited in the Recommendation section below. This DHS report, in its entirety, may be seen at the Minnesota Legislative Reference Library at RA997.5 M6 P65 2000.

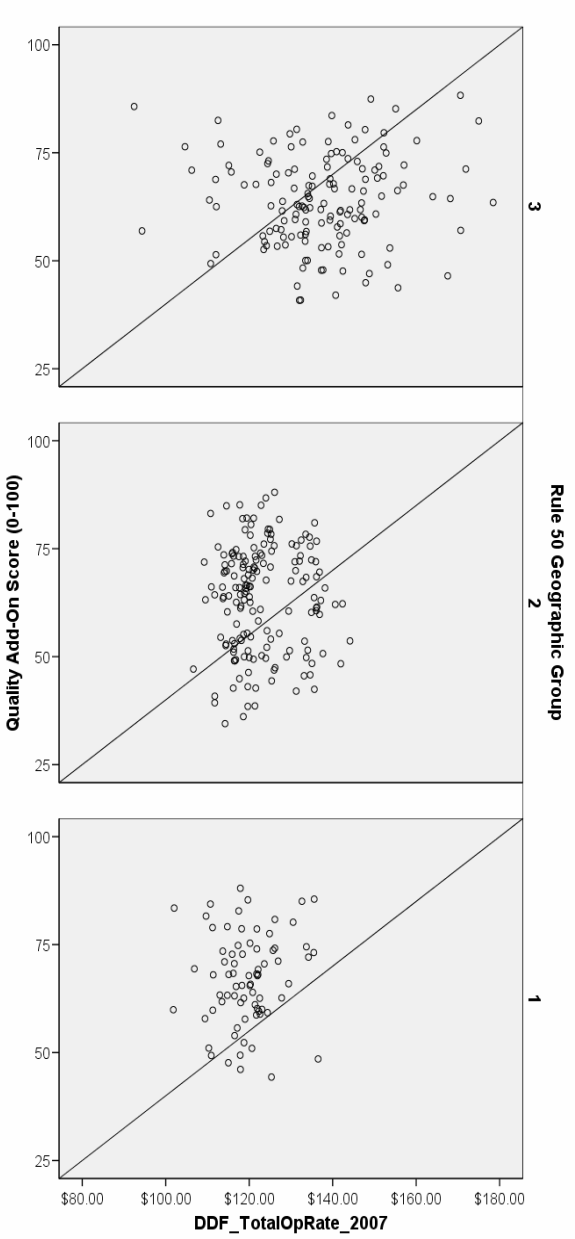
In addition, DHS has examined the relationship between operating payment rates and quality. For purposes of this analysis and for the remainder of this report, operating payment rates for the Resource Utilization Group (RUG) classification DDF are used to prevent confounding acuity differences with care quality differences. Quality is determined using a global score derived from a weighted combination of quality measures provided in the Minnesota Nursing Home Report Card, which may be seen at:

http://www.health.state.mn.us/nhreportcard/

This scattergraph shows the cost/quality relationship for all Minnesota nursing facilities (see sidebar):



The scattergraph has also been prepared for the three historic Geographic Groups used under the Rule 50 cost-based payment system (see sidebar):



If the dots representing Minnesota nursing facilities were grouped along the diagonal lines shown, this would indicate a strong relationship between payment rates and quality. Another way to judge the strength of a relationship between two variables is to calculate their statistical correlation coefficient or "Pearson's R," which can range from -1 (i.e. high levels of one variable are always related to low levels of another variable) to +1 (i.e. high levels of one variable are always related to high levels of another variable and vice versa). Statewide, this correlation equals 0.009, and the values for Rule 50 Geographic Groups 1, 2 and 3 are 0.098, 0.020 and 0.045 respectively. One is forced to conclude from the graphs and low correlations that there is no apparent relationship between rates and quality.

Disparity corrective legislation enacted Several provisions have been enacted to address nursing facility rate disparities. In 2000, the legislature enacted Subd. 28, paragraph (c) of Minnesota Statutes, Section 256B.431, which provided each nursing facility with an operating payment rate adjustment between $1.00 per day and $4.13 per day, referred to here as the "base plus slide" approach. Facilities with the lowest rates received the largest increases. A portion of the funding received under this provision was encumbered for compensation related cost increases.

In 2001 the legislature enacted Subd. 33 of Minnesota Statutes, Section 256B.431, entitled "Staged reduction in rate disparities." Under this provision, referred to here as the "target rate floor" approach, target rate levels were established for metro and for non-metro facilities for July 1, 2001 and for July 1, 2002 (controversy continues to the present day about the definitions of metro and non-metro facilities, both those used in this 2001 provision and those used in other contexts). All nursing facilities with operating payment rates less than the target level were eligible for a rate increase up to the target rate level, but limited to an increase of 7% each year. (This disparity increase was in addition to operating payment rate increases of 3% that were allowed for all nursing facilities, so the actual maximum rate increase was 10%.) A portion of the funding received under this provision was also encumbered for compensation related cost increases.

In 2006 the legislature enacted Subd. 43 of Minnesota Statutes, Section 256B.431, entitled "Rate increase for facilities in Stearns, Sherburne, and Benton Counties," under which all facilities in the St. Cloud area received operating payment rate increases to an amount equal to the rates of the median of facilities in Geographic Group 3. Increases distributed on July 1, 2006 and received by 13 facilities ranged from 3.4% to 21.4%. No requirements for the use of the funding received under this provision were included.

Appendix B includes a table of financial and quality information for the 13 St. Cloud facilities before and after their 2006 rate increase, compared to other facilities statewide. On average, the St. Cloud facilities experienced negative net income prior to the special legislation, though some facilities in the group turned a profit (specific values available upon request). After the legislation, the facilities dramatically increased their net income (832% on average) and spent more on direct-care staff salaries. However, there was little change in direct-care staffing levels or in risk-adjusted quality measures compared to other facilities statewide. These results suggest that funding increases without specific spending requirements may contribute to facilities' financial health and/or benefit staff, but may have little measurable impact on resident care quality. The table also separates other facilities statewide by hospital-attached status to emphasize the particular financial challenges faced by these facilities.

And finally, over the years many provisions were enacted to provide rate increases to specific facilities for a wide variety of reasons.

What was achieved by these actions? The graphs in the analysis section of this report show small reductions in 2000 and 2001 in the variation (standard deviation/average) of the rates of all facilities in the state as well of the variation among counties and differences of average rates between geographic groups. This suggests that the investments made at that time had the intended effect and that the effect persisted into subsequent years.

Bills introduced but not enacted In recent years, many bills have been introduced, but not enacted, to address nursing facility rate disparities. While most of these bills addressed limited geographic areas or specific facilities, some were designed to have a statewide effect:

- HF 55, (2007) provided that all facilities with operating payment rates below the Geographic Group III median would get rate increases up to that level. The state share of the MA cost assigned to this bill was about $32 million per year.

- HF 663, (2007) was a more flexible version of HF 55, under which all facilities with operating payment rates below a specified operating payment rate threshold level (e.g. the 60^{th} percentile of all facilities) would get rate increases up to that level, but limited to a particular percentage (e.g. 4%). The cost of implementing this bill could be controlled by dialing either of those two factors to achieve the desired level of spending. The state share of the MA cost of this bill was estimated to be about $4 million per year.

Why are there disparities? Two forces have interacted over the years to create the rate disparities that we see today: state policies as seen in law and rule, and individual facility spending decisions and actions.

For 30 years, nursing facility rates in Minnesota have been set using either cost-based formulas or a rate-on-rate method, with acuity adjustors, rate equalization and, occasionally, with pay-for-performance (P4P) elements.

Generically there are a limited number of methods that have been devised for setting nursing facility payment rates (any of these methods would be compatible with the use of acuity adjustors, inflation indexing, geographic factors to reflect regional differences and/or P4P features):

- **Pricing method** – a price is determined and applies to all facilities.
    - Advantages
        - May be seen as equitable, as there would be no variation between facilities.
        - May use various methods of categorizing facilities, such as geographic area or facility type, with differing prices for each group, which may allow better targeting of resources, though it will result in some rate disparities.
    - Disadvantages
        - May be inefficient, as some facilities would be paid more than they need in order to operate well.
        - May provide rates that are inadequate for the needs of other providers.
        - The incentive would be for providers to restrain costs in all possible ways if their rates do not consider their costs or quality. Therefore, if prices were adjusted periodically based on overall actual spending, this method might restrain MA program costs.
- **Cost-based method** – a price is determined based on allowable costs, subject to limits, with an efficiency incentive. This is the method used in most states, including Minnesota, prior to 1999. The rebasing law enacted in 2007 at M.S. Section 256B.441 reinstates a cost-based method, subject to an eight-year phase-in.
    - Advantages
        - Ensures that reasonable costs will be supported.
        - Can incorporate pay-for-performance features, as is the case in the rebasing law, though with some delay and tests that may be difficult to satisfy.
    - Disadvantages
        - May be inflationary.
        - Provides for higher payment rates to facilities without considering the quality of the service delivered.
        - As enacted in Minnesota, rebasing has an eight year phase-in, and even this has been partially suspended for the next few years.
        - As enacted in Minnesota, limits on the level of costs that will be recognized in the payment rates, determined using statistical methods, divide the state into three geographic areas – groups of counties – called "peer groups," and apply the statistical method separately for each group. This feature was seen in earlier cost-based methods and is one of the forces contributing to the disparities. See Appendix C for maps showing both the Rule 50 Geographic Groups and the Rebasing Peer Groups; also

see Appendix D for a state map showing each county's median operating payment rate.

- **Rate-on-Rate method** – a price is determined by applying an adjustment factor to a prior rate.
    - Advantages
        - Simplicity
    - Disadvantages
        - Fails to recognize environmental changes such as a locally changing labor market.
        - The automatic inflation for operating payment rates provided in law has been suspended for every rate year from 1999 to 2012, causing providers to be concerned about the reliability and predictability of the system.

> "We inherit [spending pattern] problems from previous owners."
> --CR
>
> "Other states have a framework that is intelligible. From year to year it makes sense. Geographic definitions don't matter without a system you can move forward with. We have a disparity of piecemeal approaches."
> --TB

Wide differences are seen among nursing facilities in their spending patterns, presumably driven by the interaction between local labor markets and other costs of doing business, business decisions and differences in payment rates. These differences, which have tended to have geographic patterns, led to geographic differences in spending limits which then reinforced the spending differences. This, followed by the adoption of a voluntary rate-on-rate method in 1996 and its application to all facilities in 1999 locked those disparities in place. The rate-on-rate method, intended to be used temporarily while a new reimbursement system was being developed, has been in place for over ten years, and under current law will continue to be used on a decreasing basis for another seven years until the full phase-in of rebasing. If a facility chose, under the cost-based method, to provide a generous health insurance benefit for employees, and was able to fund it, the costs were most likely built into their rates, and stayed there when the facility went into the rate-on-rate method. The reverse is also true: If a facility did not choose, or was not able to provide a health insurance benefit during the years when rates were cost based, then the costs of health insurance would not be built into their rates, would not carry forward, and would be very difficult, if not impossible to begin to incur under the rate-on-rate method or the phase-in to rebasing. (A persistent feature of all payment methods used in Minnesota has been a particular rigidity. Flexibility to adapt to changing circumstances has not been adopted.)

So, while Minnesota policy makers seem to have favored a cost-based method – see Rule 49 (1979 – 1985), Rule 50 (1985 – 1999) and rebasing (enacted in 2007 and the phase-in beginning in 2008) – it has consistently been altered, delayed or unadopted because of its costs. It is the tension between the appealing features of a cost-based system and the apparent fairness features of a pricing system that continue to raise concerns about persistent rate disparities.

III. Analysis

Total Operating Rate Disparity among Nursing Facilities Statewide (1999-2009)

The statewide standard deviation in total operating rates declined from 1999 - 2001, held constant for 2002, and has climbed steadily from 2003 – 2008 with a slight downturn in 2009 (Figure 1). The ratio of the standard deviation to the average lets us see rate variability between years independent of average rate values. This ratio peaked in 1999, declined steadily through 2000 – 2002, climbed again from 2002 – 2004, and has remained relatively steady from 2004 – 2009 (Figure 2).

Taken together, it appears that the rate legislation activities (base plus slide in 2000 and target rate floor in 2001-2) were effective in targeting increases to facilities with rates furthest below the norm.

Rate Year	Lowest Facility Per Diem Rate	Highest Facility Per Diem Rate	Statewide Median Per Diem Rate	Statewide Average Per Diem Rate	Standard Deviation between Facilities	Std Dev /Average between Facilities
1999	$71.27	$155.90	$93.88	$96.99	$13.17	13.6%
2000	$78.00	$161.91	$99.68	$102.88	$12.73	12.4%
2001	$87.45	$196.24	$107.11	$110.36	$12.48	11.3%
2002	$96.20	$202.13	$111.14	$114.78	$12.48	10.9%
2003	$85.41	$200.10	$113.39	$117.32	$13.89	11.8%
2004	$85.41	$200.10	$113.33	$117.59	$14.63	12.4%
2005	$87.71	$204.61	$117.93	$121.50	$14.81	12.2%
2006	$90.09	$212.75	$121.02	$125.10	$15.54	12.4%
2007	$94.10	$216.61	$125.38	$129.15	$15.66	12.1%
2008	$96.91	$223.15	$128.55	$132.55	$16.16	12.2%
2009	$95.96	$220.96	$127.28	$131.30	$16.03	12.2%

Total operating rate = Total payment rate per resident day, less Property and Other components
1999-2002 = Minnesota case-mix class "G"; 2003-2009 = RUG-III case-mix group DDF (default)
One outlier facility excluded from analysis due to uniquely high rates and different population served

Figure 1

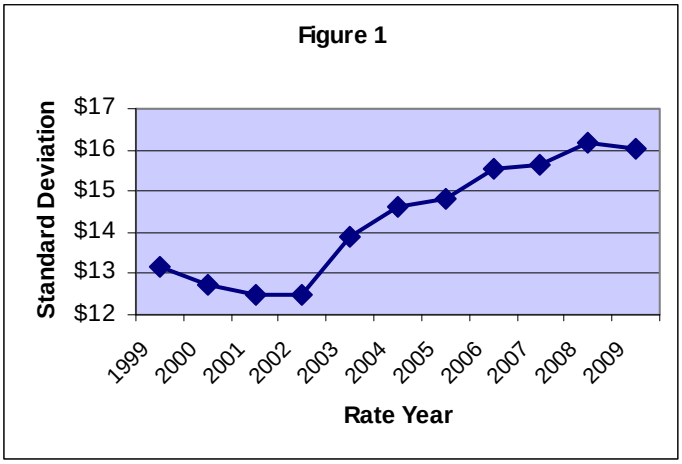
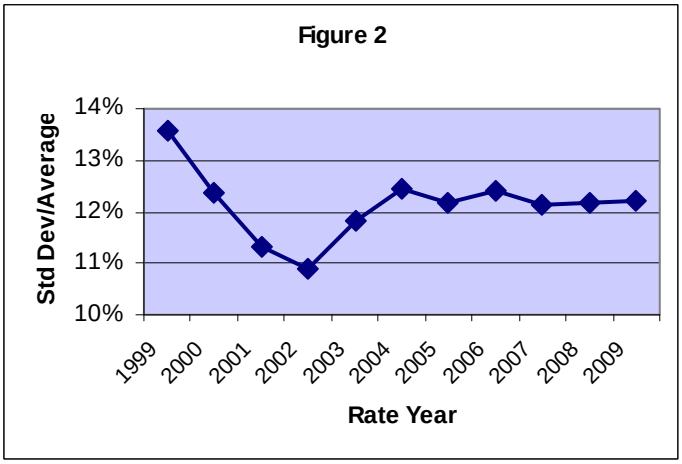


Figure 2



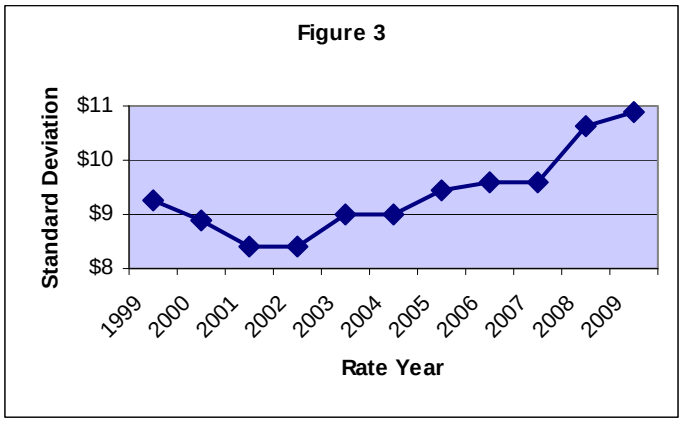
Total Nursing Facility Operating Rate Disparity between Counties (1999-2009)

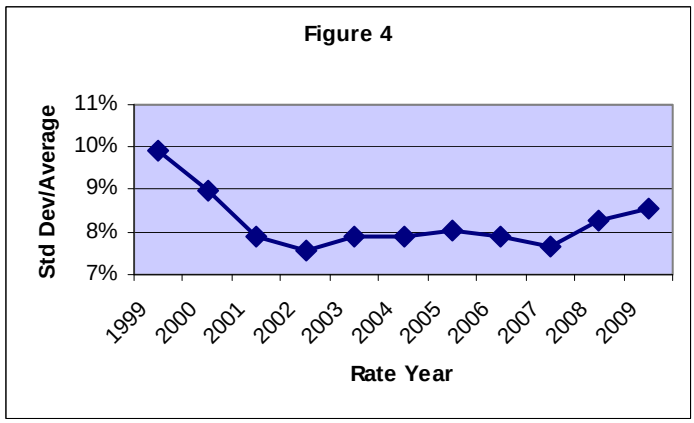
Similar to statewide results, the standard deviation between average county operating rates declined from 1999 - 2001, was steady in 2002, and has increased from 2003 – 2009 (Figure 3). In 2008 alone, the standard deviation increased by $1.00. The standard deviation ratio also drops between 1999 and 2002; for the remaining years, it is basically unchanged until it spikes again beginning in 2008 (Figure 4). These changes in 2008 are likely due to the combined effects of the expansion of the performance incentive payment program, which adds up to 5% to the per diem rates of participating facilities, and the first year of the phase-in of payment-rate rebasing for all facilities (when costs represented 13% of the blended rate).

Taken together, it appears that the rate legislation activities brought counties with lower average rates closer to the norm and had a lasting effect for several years. However, it is impossible with this approach to see in what regions rate changes occurred, which is addressed on the next page.

Rate Year	Lowest County Average Per Diem Rate (Geo Group)	Highest County Average Per Diem Rate (Geo Group)	Average of County Average Per Diem Rates	Standard Deviation between Counties	Std Dev /Average between Counties
1999	$78.41 (2)	$131.78 (3)	$93.23	$9.25	9.9%
2000	$85.00 (2)	$137.26 (3)	$99.26	$8.91	9.0%
2001	$95.13 (2)	$140.29 (3)	$106.85	$8.42	7.9%
2002	$102.63 (1)	$144.50 (3)	$111.35	$8.40	7.5%
2003	$102.24 (1)	$146.45 (3)	$113.99	$8.99	7.9%
2004	$102.04 (1)	$146.45 (3)	$113.99	$9.01	7.9%
2005	$104.64 (1)	$149.76 (3)	$117.92	$9.45	8.0%
2006	$108.18 (1)	$151.90 (3)	$121.43	$9.61	7.9%
2007	$111.39 (1)	$155.09 (3)	$125.48	$9.61	7.7%
2008	$114.31 (2)	$163.24 (3)	$128.49	$10.62	8.3%
2009	$113.19 (2)	$161.64 (3)	$127.40	$10.89	8.5%

Total operating rate = Total payment rate per resident day, less Property and Other components
1999-2002 = Minnesota case-mix class "G"; 2003-2009 = RUG-III case-mix group DDF (default)
One outlier facility excluded from analysis due to uniquely high rates and different population served



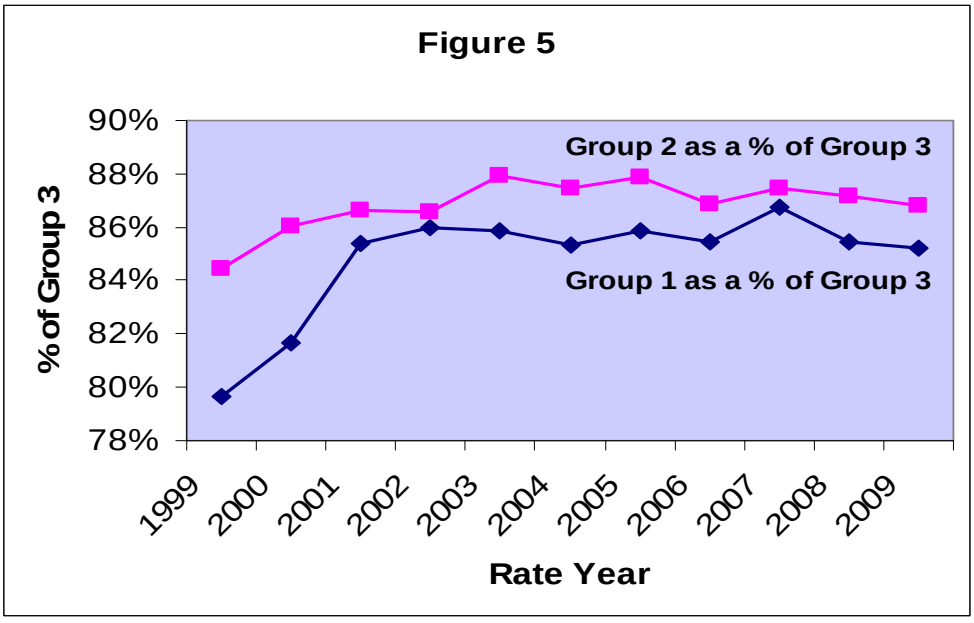


Total Nursing Facility Operating Rate Disparity between Geographic Groups (1999-2009)

Standard deviation cannot be used to look at rates between geographic groups, as there are only three to compare. Instead, this analysis considers Groups 1 and 2 as a percentage of Group 3 (comprising the seven-county metro and the Arrowhead) over time (Figure 5). From 1999 to 2002, the median rates for Groups 1 and 2 approached Group 3, with Group 1 showing especially dramatic growth. The disparity increases of 2001 and 2002 appear to have drawn Groups 1 and 2 closer together. While Groups 1 and 2 have diverged and converged in recent years, they have never reached 90% of Group 3. Also, Group 1 lost ground in 2008, suggesting that it includes counties seeing relatively less benefit from that year's rate initiatives (described above).

Rate Year	Median Per Diem Rates by Geographic Group			Geographic Group as Percentage of Group 3	
	1	2	3	1 as % of 3	2 as % of 3
1999	$85.52	$90.62	$107.33	79.7%	84.4%
2000	$91.96	$96.88	$112.59	81.7%	86.1%
2001	$100.98	$102.44	$118.28	85.4%	86.6%
2002	$104.77	$105.53	$121.87	86.0%	86.6%
2003	$107.96	$110.55	$125.74	85.9%	87.9%
2004	$107.93	$110.62	$126.52	85.3%	87.4%
2005	$111.75	$114.35	$130.10	85.9%	87.9%
2006	$115.51	$117.43	$135.21	85.4%	86.9%
2007	$120.19	$121.19	$138.53	86.8%	87.5%
2008	$121.81	$124.25	$142.55	85.5%	87.2%
2009	$120.62	$122.85	$141.52	85.2%	86.8%

Total operating rate = Total payment rate per resident day, less Property and Other components
1999-2002 = Minnesota case-mix class "G"; 2003-2009 = RUG-III case-mix group DDF (default)
One outlier facility excluded from analysis due to uniquely high rates and different population served



IV. Options

> "In looking at rate disparities, are we trying to correct the most egregious problems – just trying to create a new floor?"
>
> --WO

In this section we will describe several options that may be considered, either alone or in various combinations, as responses to the issue of nursing facility rate disparities.

1. **Accept current status/Await effects of rebasing** The current status includes both the disparities described in Section III, above, and the fact that current law provides for movement back to a cost-based system.
   - Advantages
     - Rebasing provides recognition of costs that nursing facilities are currently incurring.
     - Funds that might otherwise be used to reduce nursing facility rate disparities will be available for other priorities.
     - Rebasing law does include P4P features.
   - Disadvantages
     - Estimates by the department are that rebasing will widen disparities among facilities and geographic areas. See supplementary analysis in Appendix E.
     - While facilities will be permitted to increase their rates by increasing their spending, many facilities will be unable to do so because of both the 24 month delay between beginning a higher spending pattern and receiving the higher rate, the lack of resources to make such an investment and the limited benefit of doing so during the phase-in of rebasing. Additionally, in some cases spending increases will not lead to rate increases because of the geographically-based spending limits in the rebasing law.
     - The future of rebasing appears somewhat uncertain, given the eight year phase-in and then the suspension of portions of that phase-in.

2. **Enact law, similar to the bills not enacted that are described above, to reduce or eliminate disparities**
   - Advantages
     - To the degree allowed by the amount appropriated, this approach will reduce or eliminate disparities.
   - Disadvantages
     - Costly
     - Does not tie rates to facility needs or quality.

3. **Allow rate increases, within specified limits, using a process and criteria to ensure that the increased funding is used for intended purposes.**
   - Advantages
     - Enables facilities with low rates to escape from being prisoners of history.
     - Enables the state to ensure that funds are provided only where needed for such purposes as providing more competitive wages, increasing worker access to health

> "There's a cohort of facilities [without resources to spend] that rebasing won't help."
>
> --PC

insurance, increasing staffing levels and so on.
    - Funds that are not used as promised can be recovered, and will be removed from rates over time by the rebasing formula if not used for allowable purposes.
- Disadvantages
    - Assumes that the need for more resources is more acute among low-rate facilities than among others.
    - Costly

V. Recommendation

The department recommends that, within the limits of funding that can be appropriated for this purpose, Option 3, allowing rate increases, within specified limits, using a process and criteria to ensure the increased funding is used for intended purposes, be considered. Inferred, by not mentioning rebasing, is that rebasing law is left intact. Perhaps the most equitable solution is to take steps to correct disparities between facilities, essentially creating a level playing field, while simultaneously correcting disparities between costs and rates. This recommended action consists of two components:

- **Eligibility** Provisions determining which nursing facilities will be eligible for rate increases to reduce disparities. This component will be modeled after HF 663 from 2007, in which all facilities with an operating payment rate below a specified operating payment rate threshold level would get rate increases up to that level, but limited to a particular percentage. The two factors can be adjusted in order to limit costs to whatever amount the legislature would choose to appropriate and to determine how the new funding will be distributed. A higher threshold level will make increases available to more facilities, resulting in smaller increases to those facilities that are eligible. For example:

Using a threshold level at the:	And a maxi-mum rate increase of:	The number of facilities with an increase would be:	The annual state share of MA costs would be:
40 %ile	3%	152	$3,069,949.78
40 %ile	5%	152	$4,239,306.56
40 %ile	7%	152	$4,880,894.07
----------	----------	----------	----------
50 %ile	3%	190	$4,398,859.47
50 %ile	5%	190	$6,746,864.93
50 %ile	7%	190	$8,372,201.51
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60 %ile	3%	228	$5,595,323.54
60 %ile	5%	228	$8,906,384.68
60 %ile	7%	228	$11,880,008.69

Note: 10/1/2009 DDF total operating rates; 381 total nursing facilities

- **Process** Provisions describing how eligible facilities may receive the operating payment rate increases, what the funding must be used for, and how accountability will be established. For example, the legislature may choose to allow the funds only if a portion of them will be used for increased costs resulting from changes to employee compensation (i.e. wage increases, adding or improving health insurance benefits, pensions), or increased levels of staffing, or other specified improvements to the operation of the facility. Process provisions will not affect the total cost of this recommendation.

Appendices

A. Excerpt of *Policy Considerations for Nursing Facilities: A Report to the Minnesota Legislature* (February 2000; pages 17 - 20)
B. St. Cloud 7/1/2006 rate increase-related spending averages compared to other facilities statewide
C. Geographic grouping maps
D. **Median county DDF total operating rates per diem (10/1/2009 rate year)**
E. Effects of full rebasing on nursing facility rate disparities

Appendix A
Excerpt of *Policy Considerations for Nursing Facilities: A Report to the Minnesota Legislature* (February 2000; pages 17 - 20)

4. Development of criteria and a process under which nursing facilities can request rate adjustments for low base rates, geographic disparities, or other reasons

Rule 50 reimburses a nursing facility its reported allowable costs, up to certain limits. However, facilities with historically low base rates are now locked into those rates. Because of recent changes in cost-based rate setting that limit a nursing facility's "spend up," the rate system has no way to substantially adjust operating cost rates for substantial increases in costs. The only options have been for facilities to seek:

- a moratorium exception (for building renovation or replacement projects only); or
- special legislation.

About 70 percent of the facilities have opted for the greater flexibility available in the Alternative Payment System demonstration. However, industry representatives are saying the "rate-on-rate" approach (granting straight inflation without an ability to adjust to cost) cannot go on indefinitely. The Legislature asked the Department to develop criteria and a process under which nursing facilities can request rate adjustments.

The Department believes that broader changes are needed for long term stability in the nursing facility service system. Rate adjustments alone cannot provide the long term solution for adequate and equitable payment rates. However, the rate adjustment methods discussed below can be applied in a targeted manner to correct certain inequities.

Criteria for rate adjustment requests. There are a number of criteria that could be used for determining which nursing facilities should receive a rate adjustment. Some examples are:

- **Low rates.** Rates are below a specific threshold.
- **Quality.** Rate adjustments could be targeted to facilities with low rates to improve quality or to fund new initiatives that enhance quality and innovation.
- **Financial performance.** The facility needs more money as evidenced by having lost money in the previous year or as measured by some other financial indicator.
- **Employee benefits.** The facility will provide an employee benefit, such as health insurance, for its workers.
- **Wages.** The facility will increase average hourly rates of pay.

- **Spend-up.** The facility has expenditures that exceed its payment rate but because of limits, the extra expenditures cannot be built into its rate. A facility spending beyond their reimbursement rate is strong evidence that the money is needed. The use of this criteria would rely upon a cost report.

- **Downsizing.** The facility is reducing its number of beds (primarily by converting multi-bed rooms to single bed rooms).

Suggested Models for Rate Adjustment

By their nature, rate adjustments that benefit only certain nursing facilities will be controversial. Whatever approach is selected, the Department recommends that it be simple and administratively feasible. We must avoid processes where decisions are subjective and could be open to dispute. Clear rationale for awarding rate adjustments is essential.

When designing a model for providing rate adjustments, key factors are:

- How much additional funding does the Legislature want to appropriate for rate adjustments?

- How broadly or narrowly should the funds be targeted?

- Should there be methods to ensure that funds are spent for the purpose intended?

Below are two models for selecting nursing facilities to receive rate adjustments.

When evaluating these models, it is important not to confuse the concept of a targeted rate adjustment with an across-the-board rate adjustment. In comparing the targeted models below, assume that all nursing facilities also receive a cost-of-living adjustment (COLA) to account for inflation and that the adjustment described below would be in addition to a COLA, not a replacement for a COLA.

A. The Threshold Model

In this model, an eligibility threshold and rate floor are established. (For example, the 100 nursing facilities with the lowest operating payment rates would be eligible, with the operating payment rate of the facility with the 100th lowest rate becoming the floor.) A rate increase is provided for all eligible nursing facilities to bring them up to the established floor.

Pros

- Provides adjustments for nursing facilities with the lowest rates.
- Easy for nursing facilities and the State to implement.

- The rate adjustment is based on factors specified in law, so there would be little or no basis for dispute.
- Allows facilities to determine how to best use the additional funds, without interference from the State.

Cons

- The rate adjustment would be based only on factor(s) specified in law. Nursing facilities that fall outside the eligibility parameters could not receive a rate adjustment, regardless of their need or circumstance.
- No accountability for how the money will be used.
- No assurance that a nursing facility really needs the money.
- Nursing facilities with equal or greater need may not be eligible.

B. The Application Model

This model builds upon the threshold model (above), by requiring that eligible and interested facilities submit a short application specifying how funds will be used, and limiting increases to the costs specified in the facility's application. Funding applications could be limited to requests for purposes specified by the Legislature. The model could also require that the approved application be posted so that employees and consumers can be informed about how the facility plans to spend the new funds.

Pros

- Corrects largest disparity at low end.
- Establishes some accountability for how the money will be used.
- The administrative burden to nursing facilities would be small because the application would be simple. A nursing facility would need to identify the need for a rate adjustment and plan its use anyway. The application could serve as a part of the nursing facility's planning process.
- Enables the Department to analyze the use of the funds and report this to the Legislature.

Cons

- The rate adjustment would be based only on factor(s) specified in law. Nursing facilities that fall outside the eligibility parameters could not receive a rate adjustment, regardless of their need or circumstance.
- Nursing facilities with equal or greater need may not be eligible.
- May be viewed as the State micro-managing the industry, particularly if the legislation specifies uses for the funds.

Recommendation

The Department recommends Model B, where eligibility is established by having a low rate, in combination with an application specifying how funds will be used. This method provides a simple method for identifying facilities that are eligible for a rate adjustment while providing accountability for the facility to identify its needs and to inform stakeholders (including workers and residents) how the rate adjustment will be used. *The Department recommends that facilities with low rates be targeted for rate adjustments.*

Appendix B: St. Cloud 7/1/2006 Rate Increase-Related Spending Averages Compared to Other Facilities Statewide

	St. Cloud Facility Averages			Other Facilities, Non-Hospital Attached			Other Facilities, Hospital-Attached		
	2005	2007	% Change	2005	2007	% Change	2005	2007	% Change
Total Resident Days	34,078	34,587	1%	31,243	30,509	-2%	25,122	24,977	-1%
Average Case Mix Index	1.01	1.03	2%	0.99	1.01	2%	0.99	0.98	-1%
Salary Expense per Compensated Hour									
Nursing Administration	$32.54	$29.29	-10%	$24.09	$28.24	17%			
Registered Nurses	$22.83	$25.27	11%	$22.97	$24.36	6%			
Licensed Practical Nurses	$15.81	$17.69	12%	$17.77	$18.55	4%			
Certified Nursing Assistants	$11.13	$11.77	6%	$11.93	$12.34	3%			
Trained Medication Aides	$12.20	$12.82	5%	$13.17	$13.74	4%			
Social Services	$15.83	$18.04	14%	$18.06	$18.62	3%			
Activities	$11.86	$12.51	6%	$13.06	$13.63	4%			
Other Direct Care	$16.36	$19.70	20%	$18.44	$16.52	-10%			
Net Direct Care Expense per Resident Day	$77.71	$75.79	-2%	$72.21	$74.52	3%	$89.30	$93.72	5%
Net Other Expense per Resident Day									
Dietary Services	$14.47	$16.64	15%	$14.71	$15.75	7%	$19.42	$20.95	8%
Laundry Services	$2.26	$2.39	6%	$2.63	$2.70	3%	$3.28	$3.53	8%
Housekeeping Services	$4.27	$4.43	4%	$4.64	$5.01	8%	$5.18	$5.72	10%
Maintenance Services	$7.89	$8.93	13%	$8.37	$9.29	11%	$11.26	$13.48	20%
Total	$28.90	$32.38	12%	$30.33	$32.06	6%	$39.05	$43.68	12%
Net Income	$18,589	$173,293	832%	$192,370	$75,469	-61%	($983,238)	($1,036,484)	-5%
Net Income per Resident Day	($9.45)	$1.48	116%	$5.79	$2.27	-61%	($43.05)	($48.37)	-12%
Direct Care Hours per Resident Day									
Nursing Administration	0.12	0.15	28%	0.22	0.21	-5%	0.20	0.19	-6%
Registered Nurses	0.30	0.28	-7%	0.32	0.32	-1%	0.47	0.44	-7%
Licensed Practical Nurses	0.84	0.89	6%	0.70	0.73	5%	0.73	0.75	3%
Certified Nursing Assistants	2.17	2.25	4%	2.03	2.05	1%	2.35	2.39	2%
Trained Medication Aides	0.12	0.11	-2%	0.18	0.21	18%	0.14	0.15	10%
Social Services	0.10	0.11	6%	0.10	0.11	3%	0.10	0.10	2%
Activities	0.27	0.28	3%	0.21	0.23	6%	0.24	0.25	4%
Other Direct Care	0.02	0.01	-31%	0.04	0.04	-9%	0.08	0.06	-27%
Total / Facility Average Case Mix Index	3.93	3.99	2%	3.83	3.84	0%	4.35	4.41	1%
Risk-Adjusted Quality Measures									
Resident Quality of Life (0 - 100%)	83.26%	83.08%	0%	82.13%	82.20%	0%	82.14%	82.44%	0%
Clinical Outcomes (0 - 100 points)	62.86	68.99	10%	60.19	68.60	14%	62.30	70.20	13%

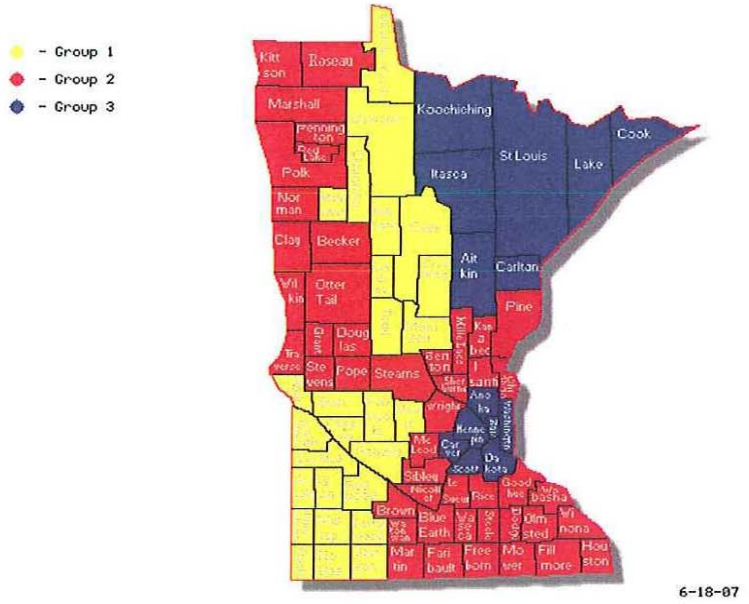
Hospital-attached facilities were first required to report salary expense for specific staff types in 2007.

Notes: Data from Medicaid NF cost report and MN NF Report Card databases; St. Cloud figures include three hospital-attached facilities (specific values provided on request).

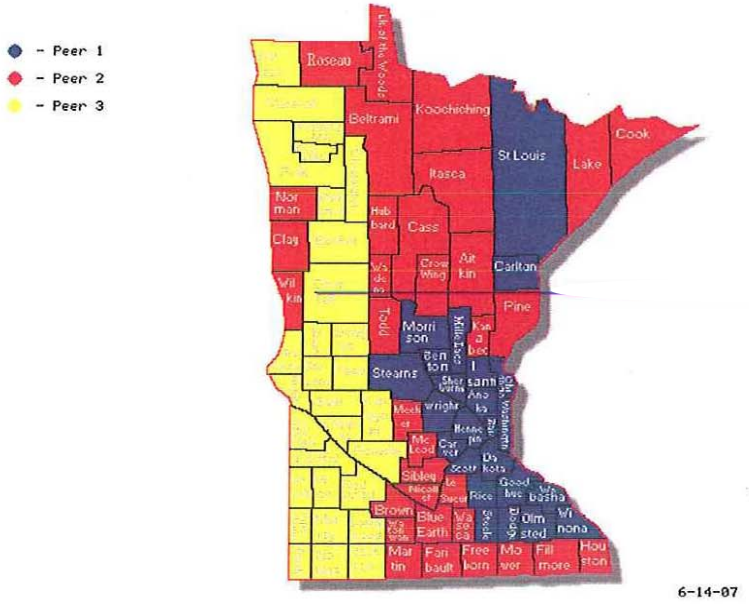
Appendix C

Rule 50 Groups vs. Rebasing Groups

Rule 50

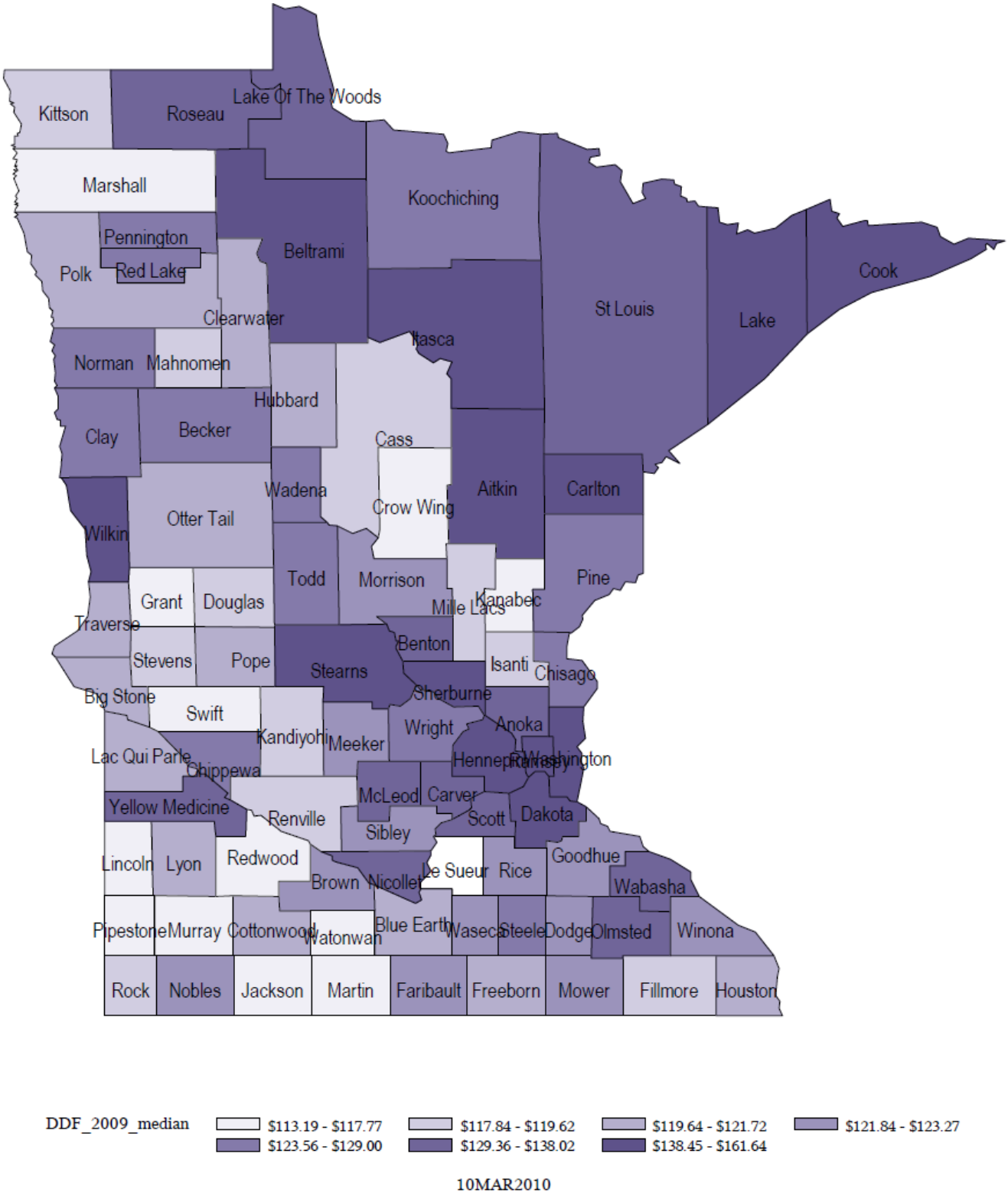


Rebasing Groups



Prepared by Long-Term Care Imperative staff

Appendix D
Median County DDF Total Operating Rates per Diem (10/1/2009 Rate Year)



Appendix E
Effects of Full Rebasing on Nursing Facility Rate Disparities

Under full rebasing, nursing facility rate disparities would increase for the state as a whole (Section 1), decrease between geographic groups but increase within Groups 1 and 2 (Section 2), and show mixed results between and within rebasing peer groups (Section 3). These changes are modest and it is not possible to judge their significance. However, the trends suggest that rebasing will have mixed effects on disparities across the state. It could be asserted that rebasing was never intended to reduce geographic disparities, only the disparity between costs and rates, but the testimony was not entirely clear on this distinction.

Section 1: Under rebasing, statewide rate disparities would *increase*.
The statewide standard deviation in total operating rates would increase $2.24 from 2007 to 2008, if rebasing were fully phased in at that time (Column 6). The ratio of the standard deviation to the mean lets us see rate variability between these two years independent of average rate values; larger ratios indicate more variability. This ratio would increase 0.4 percentage points from 2007 to a fully-rebased 2008 (Column 7).

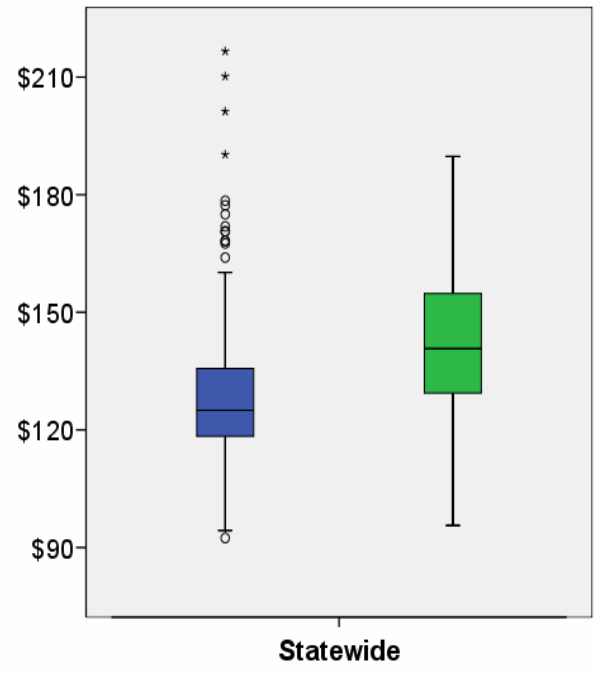
Column 1: Rate Year	Column 2: Lowest Facility	Column 3: Highest Facility	Column 4: Statewide Median	Column 5: Statewide Average	Column 6: Statewide Standard Deviation	Column 7: Statewide Std Dev / Average
2007	$92.43	$216.61	$125.08	$128.77	$15.66	12.2%
2008 with 100% rebasing	$95.63	$189.78	$140.76	$142.25	$17.90	12.6%

Notes:
Total operating rate (Total payment rate per resident day, less Property and Other components) used
RUG-III case-mix group DDF (default) used
One outlier facility excluded due to uniquely high 10/1/2007 rates and different population served

This greater statewide variability under rebasing can be seen in Figure 1 (see sidebar), which shows the statewide total operating rates for 2007 and fully-rebased 2008. Full rebasing would eliminate extreme cases, shown as stars and dots, and would spread statewide rates apart, shown as a larger box and longer whiskers.

Figure 1. Statewide NF Rates: 2007 vs. Fully-Rebased 2008

Blue:
2007 DDF total operating rate
Green:
2008 DDF total operating rate under 100% rebasing



Section 2: Under rebasing, rate disparities between Rule 50 geographic groups would *decrease*, while disparities within Groups 1 and 2 would *increase*.

Standard deviation cannot be used to look at rates between geographic groups, as there are only three to compare. Instead, the approach below considers Groups 1 and 2 as a percentage of Group 3 (Column 3); percentages closer to 100% indicate less rate disparity between these groups. Under full rebasing, Geographic Group 1 would move 0.8 percentage points closer to 100%; Group 2 would move 2.4 points closer.

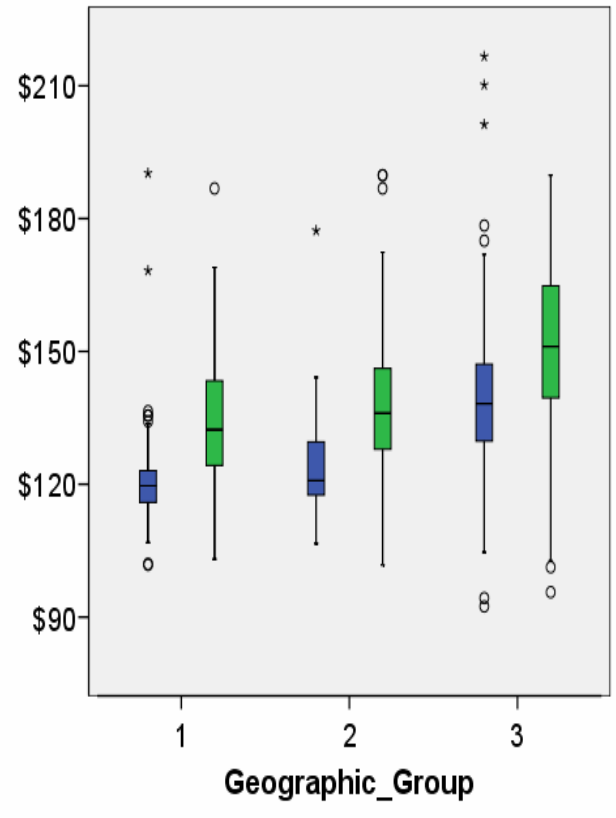
Column 1: Rate Year	Column 2: Median Rates by Geographic Group			Column 3: Geographic Group Median as % of Group 3	
	1	2	3	1 as % of 3	2 as % of 3
2007	$119.68	$120.85	$137.89	86.8%	87.6%
2008 with 100% rebasing	$132.31	$136.06	$151.10	87.6%	90.0%

Notes:
Total operating rate (Total payment rate per resident day, less Property and Other components) used
RUG-III case-mix group DDF (default) used
One outlier facility excluded due to uniquely high 10/1/2007 rates and different population served

This reduced variability between Rule 50 geographic groups under rebasing can be seen in Figure 2 (see sidebar), which shows the geographic groups' total operating rates for 2007 and fully-rebased 2008. Full rebasing would largely eliminate extreme cases, shown as stars and dots, and would move the medians of Group 1 and especially 2 closer to Group 3, shown as horizontal black lines within each colored box. However, rebasing would increase rate disparities *within* Groups 1 and 2, while essentially not affecting disparity within Group 3, as shown by the larger boxes and longer whiskers for Groups 1 and 2 (figures available upon request).

Figure 2. Geographic Group NF Rates: 2007 vs. Fully-Rebased 2008

Blue:
2007 DDF total operating rate
Green:
2008 DDF total operating rate under 100% rebasing



Section 3: Under rebasing, rate disparities between and within rebasing peer groups would be *mixed*.

Comparing the peer groups created under the rebasing legislation (Column 3) shows that disparity between Groups 1 and 2 would decrease (0.5 percentage points closer to a 100% ratio). However, disparity between Groups 1 and 3 would increase (1.7 percentage points further from 100%).

Column 1: Rate Year	Column 2: Median Rates by Peer Group			Column 3: Peer Group Median as % of Group 1	
	3	2	1	2 as % of 1	3 as % of 1
2007	$118.73	$121.80	$133.70	91.1%	88.8%
2008 with 100% rebasing	$129.69	$136.43	$148.86	91.6%	87.1%

Notes:
Total operating rate (Total payment rate per resident day, less Property and Other components) used
RUG-III case-mix group DDF (default) used
One outlier facility excluded due to uniquely high 10/1/2007 rates and different population served

This mixed effect on variability between peer groups under rebasing can be seen in Figure 3 (see sidebar), which shows the peer groups' total operating rates for 2007 and fully-rebased 2008. Again, full rebasing would largely eliminate extreme cases, shown as stars and dots. However, the effect on group medians – shown as horizontal black lines within each colored box – would be mixed. While the Group 2 median would move closer to Group 1, Group 3 would move away. Also, rebasing would increase rate disparities *within* Groups 2 and especially 3, while essentially not affecting disparity within Group 1, as shown by the larger boxes and longer whiskers for Groups 2 and 3 (analysis available upon request).

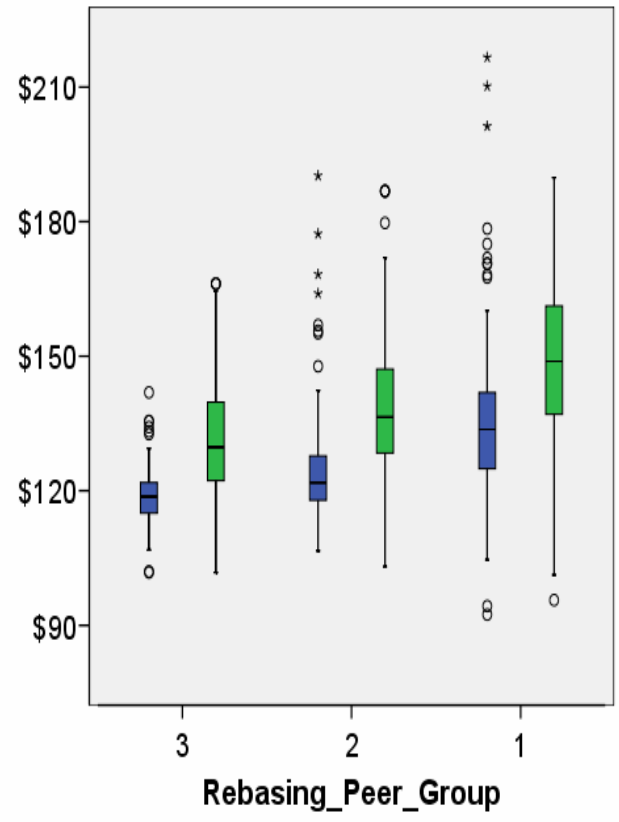


Figure 3. Rebasing Peer Group NF Rates: 2007 vs. Fully-Rebased 2008

Blue:
2007 DDF total operating rate
Green:
2008 DDF total operating rate under 100% rebasing

Minnesota Department of Human Services
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