DEPARTMENT OF HUMAN SERVICES

Nursing Facility Payment Reform

Nursing Facility Rates and Policy Division

March 6, 2017

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Contents

Background

In 2015, the Minnesota legislature enacted major reforms to Medicaid nursing facility reimbursement This new system is commonly referred to as "Value-Based Reimbursement" (VBR). Nursing facility (NF) services are bundled into a comprehensive package of room, board and nursing services. The Department of Human Services (DHS) establishes charges for this package of services as a daily per diem rate. The daily per diem rate can be further broken down into several rate components including the care-related payment rate; operating payment rate; external fixed costs payment rate; and a property rate.

Under VBR, care related costs such as nurse wages and supplies, activities and social services are reimbursed at actual cost subject to a quality based limit. Other operating costs such as housekeeping, laundry and property insurance are reimbursed using a pricing model, meaning the rate for these costs will be the same for all NFs in the state. The external fixed rate component is also established based on actual costs but is not subject to a limit. Examples of external fixed costs include employee health insurance costs, license fees, real estate taxes and employee scholarship costs. The VBR law did not reform property rate setting at this time but directed DHS to conduct a property study for rate reform considerations in the future.

VBR includes a hold harmless feature which protects facilities from rates lower than the rate they had for the year prior to implementation of the new system. Facilities are also protected from large rate reductions in a single year due to a decrease in their care related cost limit. Two NFs are currently designated as specialized care facilities and are allowed care related limits 50% higher than other facilities.

The legislature appropriated $427 million over the first four years of VBR for implementation of the changes noted above. Approximately $51 million of this was for increasing Elderly Waiver and Alternative Care individual limits which are associated with NF rates.

Given the magnitude of the policy changes and the associated investment, the legislature required a report from DHS examining several aspects of the new rate setting system (Laws of Minnesota, 2015, Chapter 71, Article 6, sec. 41):

> **Sec. 41.** DIRECTION TO COMMISSIONER; NURSING FACILITY PAYMENT REFORM REPORT.
>
> By January 1, 2017, the commissioner of human services shall evaluate and report to the house of representatives and senate committees and divisions with jurisdiction over nursing facility payment rates on:
>
> (1) the impact of using cost report data to set rates without accounting for cost report to rate year inflation;
>
> (2) the impact of the quality adjusted care limits;
>
> (3) the ability of nursing facilities to attract and retain employees, including how rate increases are being passed through to employees, under the new payment system;
>
> (4) the efficacy of the critical access nursing facility program under Minnesota Statutes, section 256B.441, subdivision 63, given the new nursing facility payment system;
>
> (5) creating a process for the commissioner to designate certain facilities as specialized care facilities for difficult-to-serve populations; and

(6) limiting the hold harmless in Minnesota Statutes, section 256B.441, subdivision 56.

Payment Reform Evaluation Questions

What is the impact of using cost report data to set rates without an inflation adjustment to account for the time elapsed between the cost reporting period and the rate year?

Previous Minnesota Payment Systems

Previous NF payment systems including both the Alternate Payment System, referred to as APS, and the preceding system, a cost based system referred to as Rule 50, did provide for annual automatic inflation. In APS, the inflation index used for all rate components was the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the Commissioner of Management and Budget's national economic consultant. The inflation adjustment was based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate was being determined. While the legislature decided not to include inflation at the time VBR was enacted, it did require an analysis of the effects of not including inflation.

Inflation Adjustment Methods

The VBR system includes a 27 month gap or lag between when facilities report their costs and the subsequent associated payment rate year. This gap or lag supports the need to examine the possible future role of inflation in VBR. The cost of providing the same level of service should increase by some amount if there is inflation in the general economy.

While it is too early in VBR's implementation to evaluate the impact of the absence of inflation in rate setting, the section presents information and assumptions based on a review of the NF payment literature. Most other states incorporate an inflation factor in their NF rate setting. According to analysis of national data by the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission, between March and May 2014, 44 states (94%) of the 47 for which policy information on inflation could be found provided some form of inflation adjustment to their NF payment rates under Medicaid. There are two primary methods for addressing inflation in setting payment rates for NFs:

- Inflate allowable reported costs by the change in the consumer price index or some other measure of general inflation.
- Inflate allowable reported costs by an inflationary index that is more specific in nature and reflective of NF-related cost increases, such as the Nursing Facility Market Basket Index.

Within these two primary approaches there are a variety of nuances. The category of costs that are inflated vary somewhat across Medicaid programs; some only inflating care-related costs, many inflate all operating costs. Under both methods it is common to see allowable costs inflated from the mid-point of the cost reporting

period to the mid-point of the rate year, but there are some exceptions. Select examples of the variances in both primary methods follows.

- California uses an inflation index, based on a labor study, developed from the most recently available industry specific historical wage data applied to labor per diem costs. Each facility's labor costs are inflated from the mid-point of the cost reporting period to the mid-point of the rate year. The California Consumer Price Index (CPI) for All-Urban Consumers is applied to non-labor per diem costs.

- Ohio includes inflation for each cost center rate for the eighteen month period beginning on the first day of July in the base year and ending on the last day of December in the following calendar year. Inflation is measured using the consumer price index.

- Wisconsin applies inflation in two ways, one applies to costs and the other to an established price. An inflation adjustment is applied to allowable care related costs to adjust them for the time elapsed between the cost report year and the rate year, using change in CPI. The payment rate for support services, based on a historic price applicable to all facilities, is inflated annually, using change in CPI.

- Indiana's policy is typical among the states reviewed: All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest are adjusted for inflation using the Centers for Medicare and Medicaid Services (CMS) Nursing Home without Capital Market Basket index as published by Data Resources Inc./Wharton Econometric Forecasting Associates (DRI/WEFA).

The most common approach used by states for addressing inflation in rate setting is to use an inflationary index that is specific to NFs, such as the Nursing Facility Market Basket Index referenced above. This specific index is also used by the Centers for Medicare and Medicaid Services in setting Medicare rate increases for NFs. While the most recent Eljay Report (2015) noted that historically, the allowable costs of NFs have increased annually by a percentage even greater than the Nursing Facility Market Basket, this index has kept pace in more recent years.[1]

The application of a general inflation index is another rate setting strategy employed by some states. The utilization of this method appears less frequent. The key reason noted for this is that general inflation was not seen as being reflective of the inflationary trends experienced by NFs. The use of a general inflation index may result in payment rates that are insufficient to cover the actual costs of providing care because health care costs typically increase at a rate that outpaces general inflation.

If VBR were to be modified to account for inflation for payment rates effective 1/1/2018 and assuming inflation of 1.51% (July 2016 CPI-U), the approximate state share of this cost would be:

[1] Eljay, LLC & Hansen Hunter & Company, PC. *A Report on Shortfalls in Medicaid Funding for Nursing Center Care*. American Health Care Association: March 2015.

Calendar Year	Estimated Cost (In Millions)
2018	$13.5
2019	$13.7
2020	$15.6
2021	$15.8
2022	$17.7
2023	$18.0

Providers have noted that the lack of an inflation adjustment limits their ability to make investments in expanding staff, raising staff wages, and making capital improvements.

Recommendation

Given the fact that most states recognize inflation, we recommend on-going analysis of the relationship between rate changes and actual costs while the VBR system matures to see if the absence of an inflation factor is causing a problem.

What is the impact of the quality adjusted care limits?

Quality Limit Design

Minnesota has implemented several pay for performance strategies in NFs since 2006, including additional payments for high quality and for the successful achievement of quality improvement goals. VBR incorporates pay for performance by setting facilities' care-related payment rate limits based on their quality. In doing so, the state policy pays for higher costs if the services provided are of higher quality. VBR sets direct care-related spending limits at the median of care related costs of NFs in the seven-county metropolitan area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties), multiplied by a factor representative of their composite quality score.

The quality score is computed using the most recent available data on three quality measures from the Minnesota Nursing Home Report Card (http://nhreportcard.dhs.mn.gov/). Of the total possible quality score,

- Resident Quality of Life interviews account for 50%,
- Minnesota Clinical Quality Indicators account for 40%, and
- State Inspection Findings account for 10%.

Quality Limit Impact

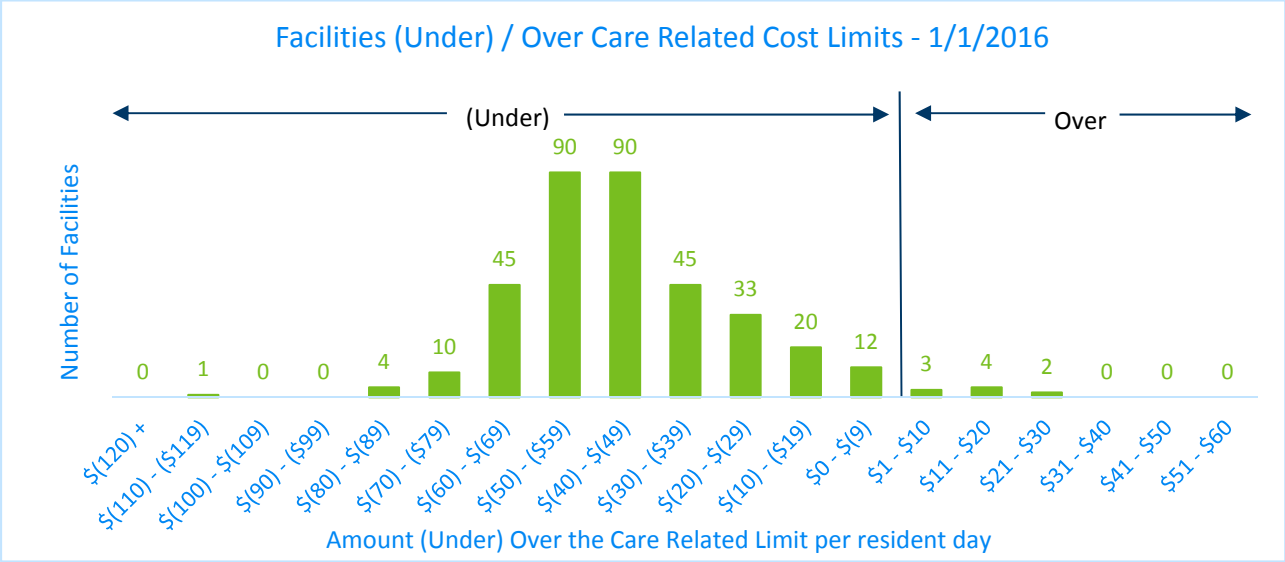
To determine the impact of the VBR quality limits, this section analyzes the spending patterns of 359 Minnesota NFs[2] that were in the Medicaid program on January 1, 2016. Facilities that were excluded were either too new as of the date of this analysis or closed prior to this analysis. It is also important to note that the tables below reflect facility costs that were incurred pre-VBR. Earlier in this report we described how the system provides a 27 month gap from the start (or midpoint) of a cost reporting period to the start (or midpoint) of the associated rate period.

Of these 359 NFs, nine (2.5%) reported allowable care related costs that were greater than their care related limits while twelve (3.3%) had costs within $10 of their limit. All nine facilities spending over their limit are attached to hospitals; in prior analysis[3], DHS has found that many hospital-attached facilities face unique financial challenges. Many hospitals are classified for purposes of Medicare reimbursement, as Critical Access Hospitals. This classification allows the hospital to receive higher payment rates from Medicare, but also requires it to allocate some costs to an attached nursing facility that the nursing facility might otherwise not incur. Many hospital attached facilities set wage scales at the same level as in the hospital to which they are attached and these wage levels may be higher than in free-standing nursing facilities.

A number of facilities were significantly under their care related limits. Of the 359 facilities analyzed, 240 (66.9%) were under the care limit by $40 per day or more. Most NFs would need to increase their spending significantly to reach the limits as currently defined.

[2] Due to its outlier status, Fairview University Transitional Services is excluded from analysis. Courage Kenny Rehabilitation Center, a specialized care facility in Hennepin County is also excluded as per legislation they are not subject to limits. Four other specialized facilities are included, but it should be noted they are allowed 150% of the Quality Based Care Limit.

[3] Held, R., Lewis, T., and Johnson, G.C. *2012 Long-Term Services and Supports: Nursing Facilities.* Department of Human Services, Continuing Care Administration, October 2013. Available at http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs16_179963.pdf



To better understand the characteristics that may be associated with spending above the care related limits, the following section presents graphs of facility spending by facility type (Figure 1.1), location (Figure 1.2) and ownership type (Figure 1.3). Characteristics with different spending patterns across facilities will show bell curves that have different shapes and/or placements on the graph.

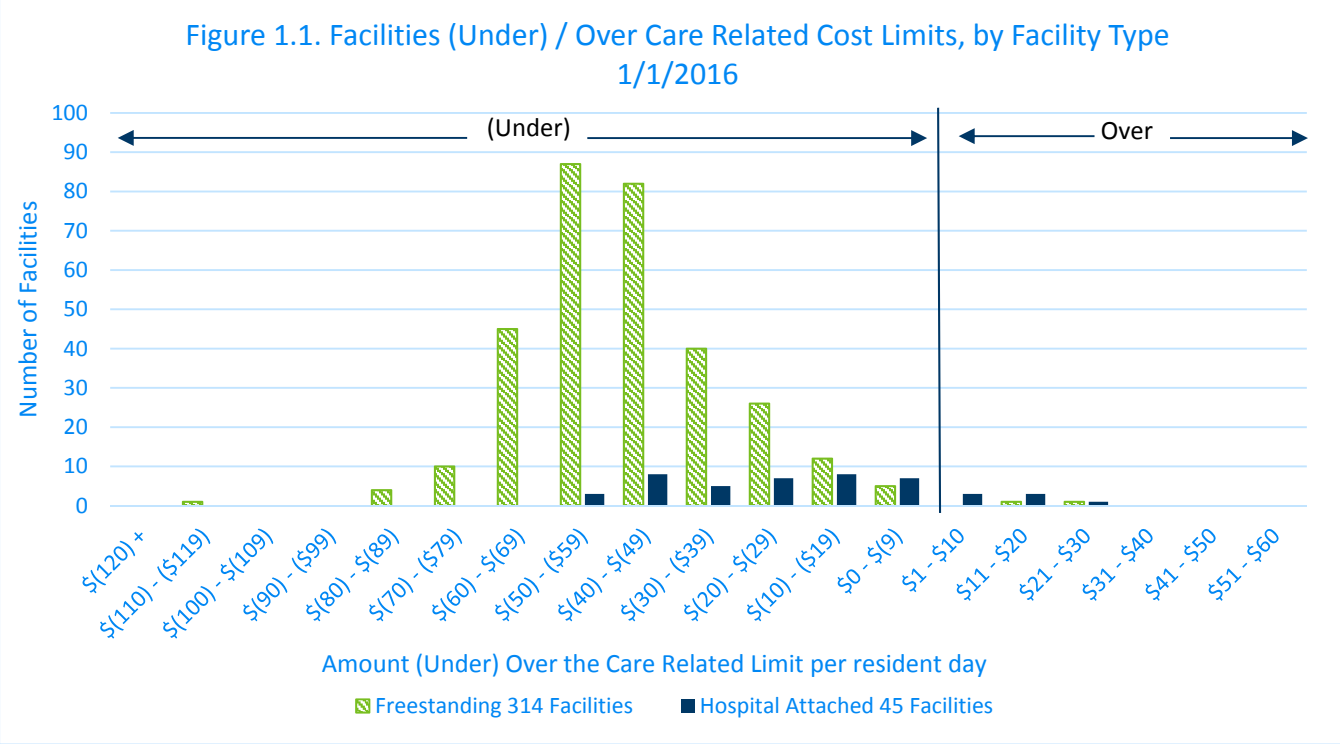
Facility Type

NFs may be classified as hospital attached or freestanding. 12.7% of NFs in Minnesota are hospital attached. While this classification is not used under VBR for purposes of rate setting, it may still be of interest in trying to understand the relationship between care-related costs and limits.

Hospital attached facilities are not required to directly identify all costs on the Minnesota Statistical Cost report, but are allowed to use Medicare approved allocation methods to report cost for shared cost centers. Due to sharing costs with the hospital, hospital attached facilities report higher costs than most freestanding facilities.

Hospital attached facilities were far more likely to report costs over their care related cost limits. Seven of the 45 hospital attached facilities (15.6%) had care related costs exceeding their care related limits versus just two of the 314 freestanding facilities (0.64%). Both of the freestanding facilities that are over their care related limits have been classified as hospital attached in the past as they were both physically attached to the hospital and were owned and operated by the hospital. The facilities are still physically attached to their respective hospitals and still share many cost centers.

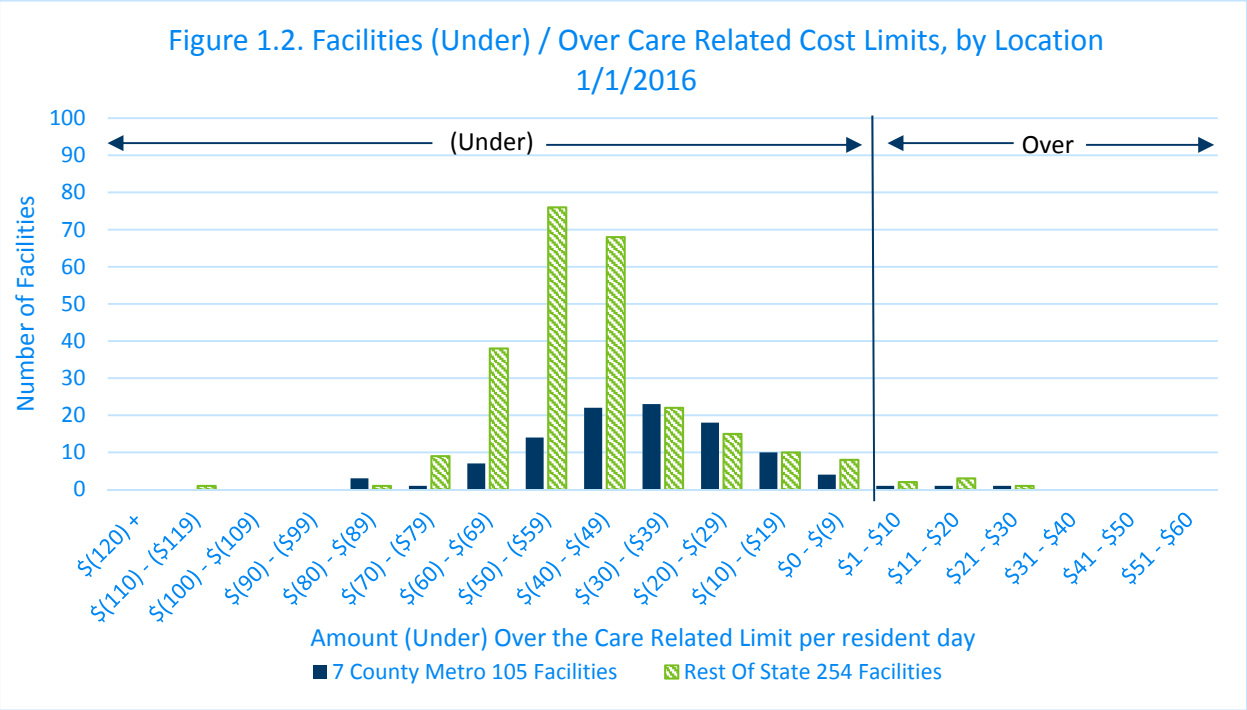
Eleven (24.4%) hospital attached facilities had care related costs at least $40 under their care related limits. In contrast, 229 (72.9%) freestanding facilities had care related costs of $40 per day or more under their care related limits.



Facility Location

Under VBR, care related limits are not related to geography. As noted above, the limits are a quality-based factor multiplied by the median of allowable costs of facilities in the seven-county metro area. While the limiting statistic is based on the metro area, it applies equally to the remainder of the state. Metro and non-metro facilities overspent the care limits at a similar rate. Of the 105 facilities in the seven-county metro area, three (2.9%) had care related costs exceeding their care related limits. This is comparable to the six (2.4%) of the remaining 254 facilities that had care related costs exceeding their care related limits.

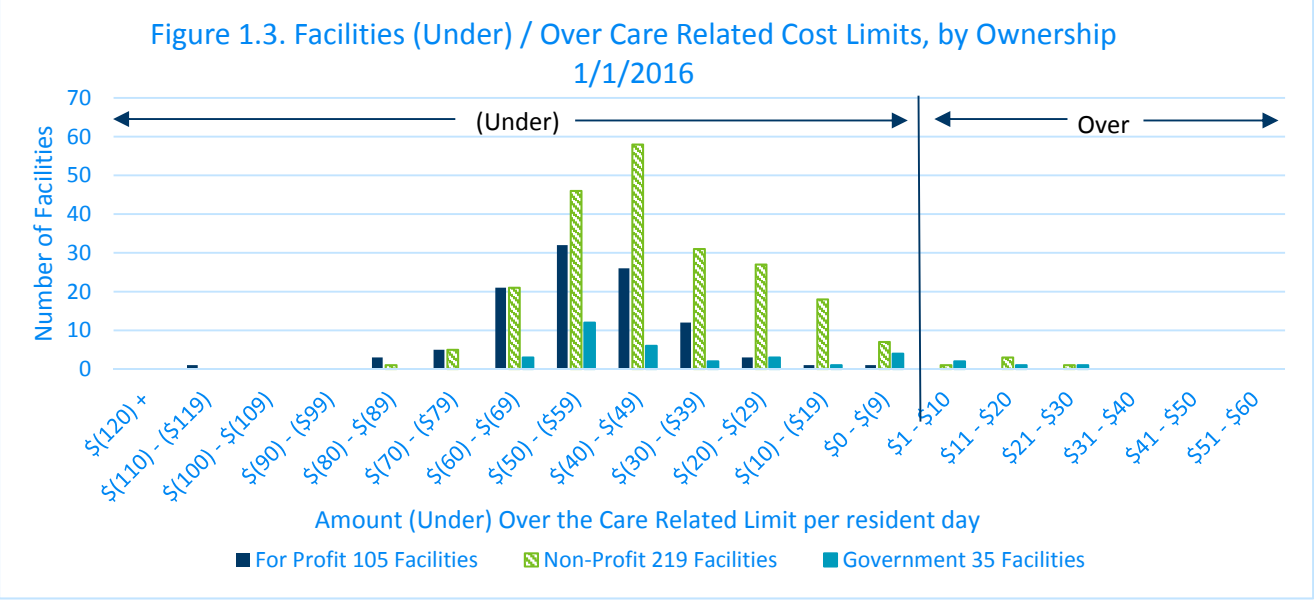
However, non-metro facilities were much more likely to report costs under the care related limit. 47 NFs (44.7%) had care related costs of $40 per day or more under their care related limits, compared with 193 (76.0%) non-metro facilities.



Ownership Type

NFs may also be distinguished by ownership type. In Minnesota, 105 facilities are for-profit, 219 facilities are not-for-profit and 35 facilities are operated by governmental entities. For-profit facilities were least likely to overspend their limits while government facilities were much more likely. None of the for-profit facilities, five (2.3%) not-for-profit facilities and four (11.4%) governmentally operated facilities were over their care related limits.

For-profit facilities were much more likely than other provider types to underspend. 88 (83.8%) were under their care related limits by $40 per day or more, versus 220 (59.8%) not-for-profit facilities and 21 (60.0%) governmental facilities.

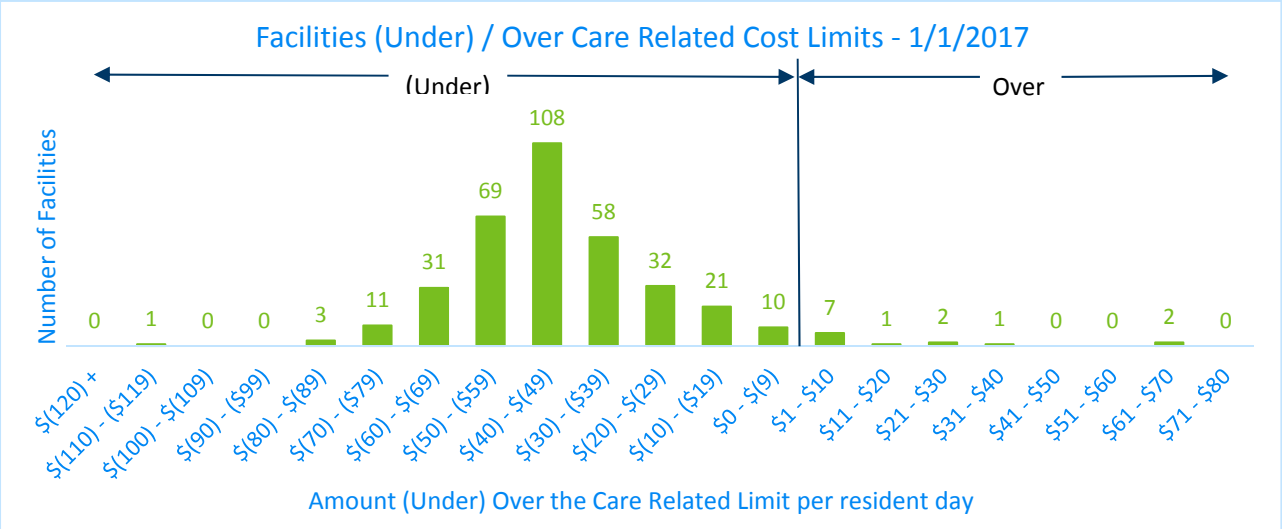


Preliminary Analysis for 1/1/2017

Finally, this section gives preliminary data for the 358 facilities operating during the 01/01/2017 rate year.[4]

Thirteen (3.6%) facilities reported allowable care related costs that were greater than their care related limits and ten (2.8%) had costs within $10 of their limit. This is slightly higher than the 01/01/2016 rate year where ten (2.8%) facilities reported allowable care related costs that were greater than their care related limits and 12 (3.3%) had costs within $10 of their limit.

More facilities reported costs closer to their limits in 2017. 223 (62.3%) facilities were under the limits by $40.00 per day or more, versus 240 (66.9%) for the 01/01/16 rate year.



[4] Fairview University Transitional Services excluded from analysis due to its outlier status.

Upon implementation of the second rate year of VBR, we find preliminary results similar to the first rate year of VBR. While there is a slight shift of costs in Care Related spending per day closer to Care Related Limits, it is not unexpected to see a minimal effect of the quality based care related limits. This is due to the fact that the cost reporting period which would begin to capture increased investment of resources as a result of the new VBR system is not yet available at the time of this report. The 1-1-2017 rates shown in the chart above are based on costs incurred for the 12 month period ending 9/30/2015, pre-VBR. Initial results seem to indicate the quality adjusted care-related limit is having a minimal effect on facility spending behavior.

Recommendation

A thorough analysis of the relationship between VBR care-related limits and quality performance is not possible at this time, as post-VBR quality trend data is not yet available. Therefore, we recommend ongoing analysis to fully understand the impact of the care related limits on quality.

What is the ability of nursing facilities to attract and retain employees, including how rate increases are passed through to employees, under the new payment system?

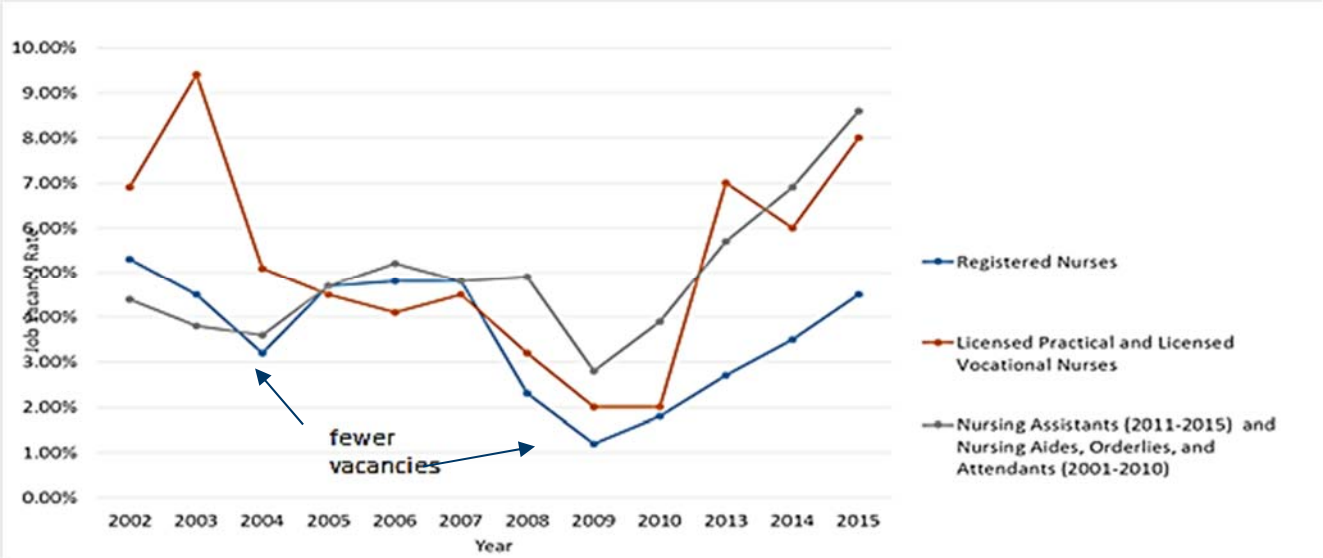
For many years NF administrators and advocacy groups have voiced concerns about difficulty recruiting and retaining staff. They state that the work is challenging, both physically, intellectually and emotionally, and is poorly compensated. NFs compete in the labor market alongside the service and retail industries. Further, NF administrators have expressed frustration with their ability to offer competitive wages under state determined payment rates for both Medicaid and private pay residents that had not been adjusted to reflect changing costs for many years.

A primary driver leading to enactment of VBR was the hope that the new rate setting method and its additional funding would be helpful in building a stronger workforce. This section of the report examines trends in the number of people employed in NFs, the wages and benefits they receive and employee retention. It then examines early trends in how the industry has applied new funding to wages and benefits.

Background

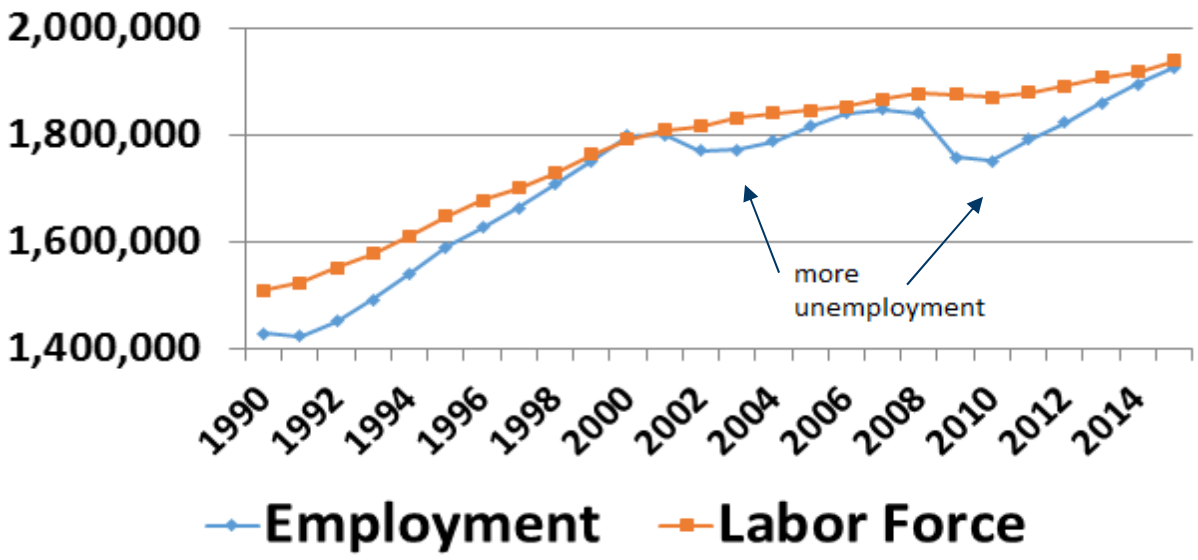
We first present background data on the NF labor market to provide pre-VBR context. All labor force data below was extracted from the Minnesota Department of Employment and Economic Development (DEED) website unless otherwise noted. The graph below displays statewide job vacancy data for the primary direct care categories of workers in NFs. The data reflect the job vacancy rate for all registered nurses, licensed practical nurses, and nursing assistants in Minnesota in all types of workplaces and are not limited to only NFs. The DEED job vacancy data do not provide a breakdown for NFs.

Minnesota Nursing Job Vacancy Rates, 2002-2015



As the vacancy rate above illustrates, over the past ten years workforce challenges in NFs have followed a cyclical pattern. When the economy is weak and unemployment is high, the challenges tend to be lessened. However, when the economy is strong and unemployment is low, the challenges tend to be more acute. The vacancy rate has shown an upswing since 2009, in particular less-skilled job types (nursing assistants, licensed but not registered nurses) that may have more job mobility.

Eligible versus Employed Minnesotans, 1990 to 2014



This pattern in the nursing job market is mirrored in the Minnesota labor market in general. In the graph above, drops in job vacancy rates in 2003-2004 and 2009-2010 coincide with larger gaps between labor force and employment. These represent periods of higher unemployment.

Past payment- and staffing-related legislative actions include:

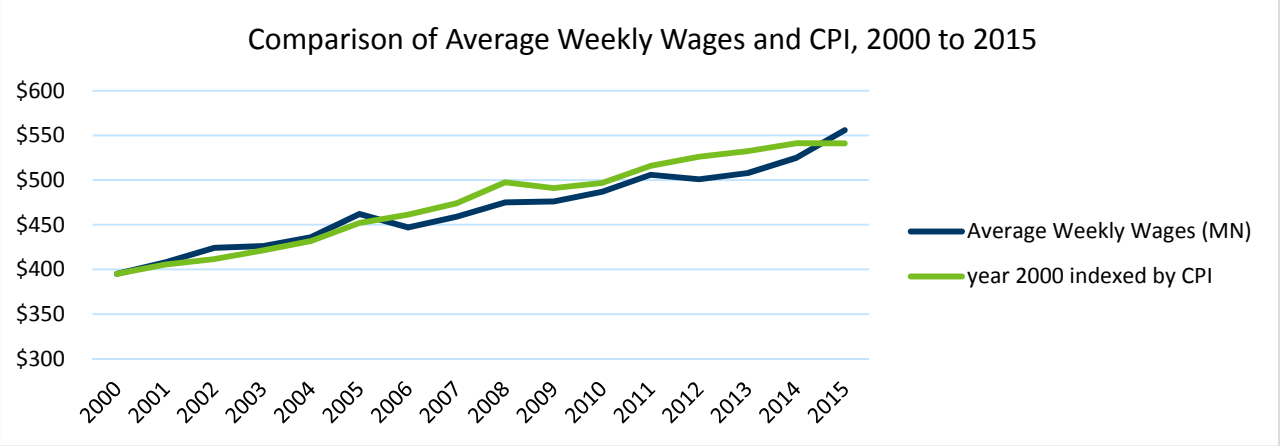
- Providing rate increases with requirements that a portion of the new funding be used for compensation related costs;
- Providing rate increases for NFs with the lowest operating payment rates; and
- Regulating Supplemental Nursing Service Agencies, primarily to prevent them from recruiting temporary workers from NFs, limiting the amounts they could charge and structuring the employment relationship between them and the workers they place in facilities.

Between 2000 and 2015 the number of NF employees decreased by 7.2% (based on DEED data). During this period the number of beds in active service in NFs decreased by 29.5%. As a result, the industry went from employing 1.16 employees per bed in 2000 to 1.53 in 2015, a proportionate increase of 31.6%. This increase does not appear to be attributable to changes in average care needs during this period. Facility-reported direct-care staffing hours for the years 2004 to 2014 show consistent increases across facility types:

- 20% for 234 freestanding facilities
- 21% for 11 boarding care homes often focusing on mental health services
- 23% for 120 hospital attached facilities

Overall, the average number of employees per bed, weighted by job type, for all 365 NFs with available data increased by 21% during this period.[5]

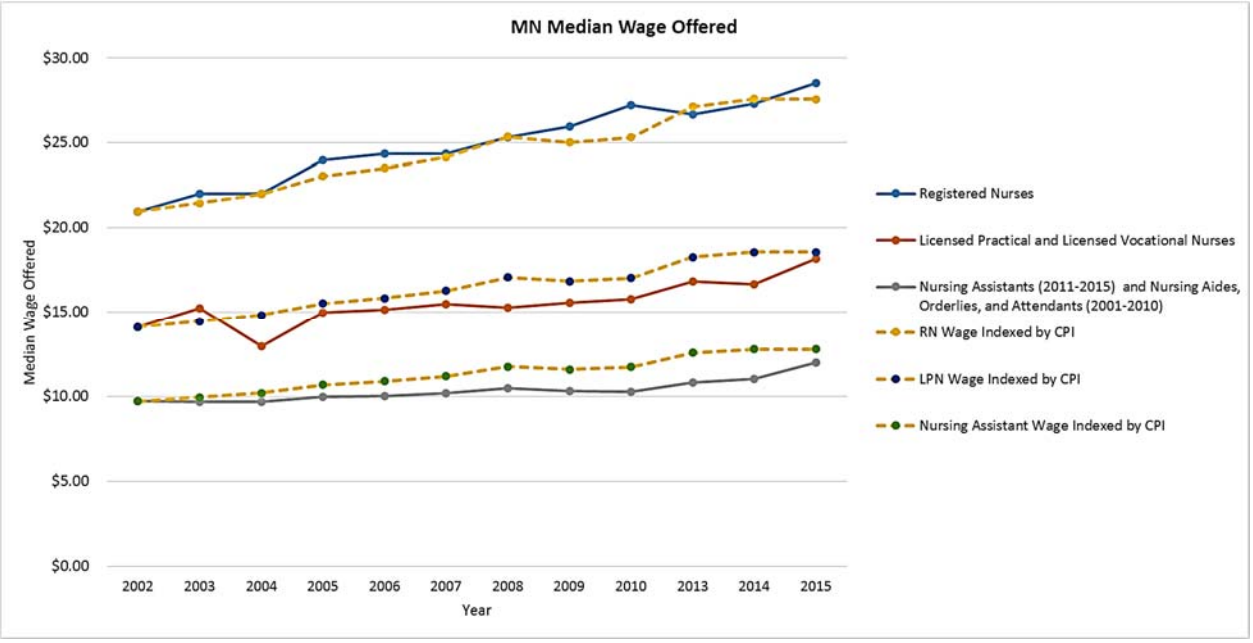
The graph below shows that the average weekly wage has increased from $395 to $556 between 2000 and 2015, or an increase of 40.8%. During this period the US Consumer Price Index (CPI) for NFs and adult day services increased by 37%, meaning that NF workers' wages have grown slightly faster than the CPI, by 2.7% over 16 years.



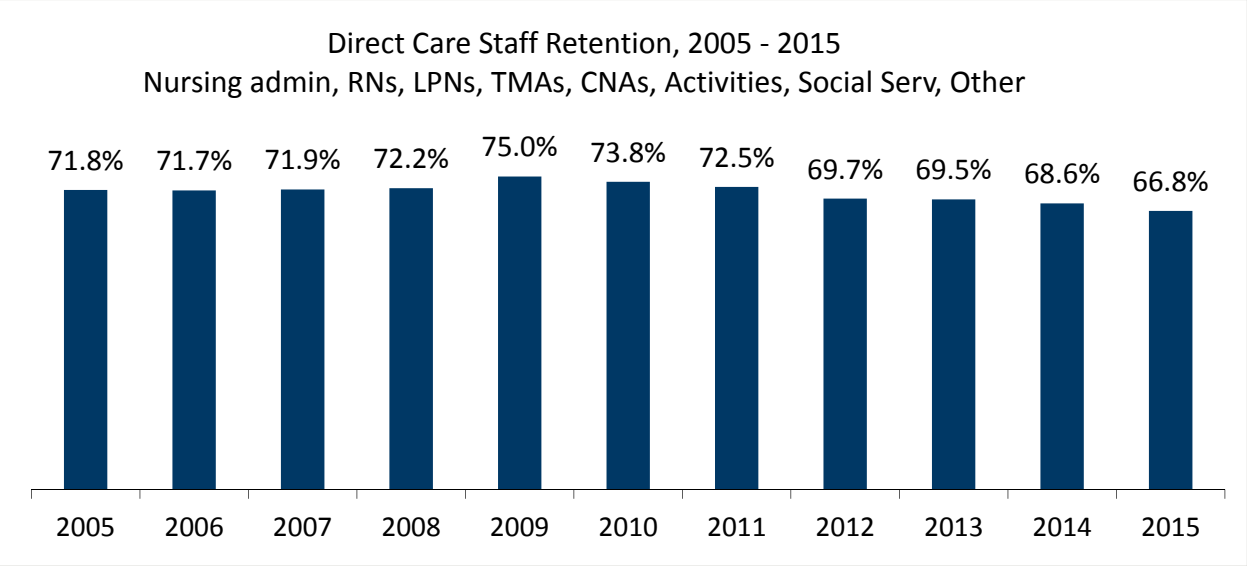
[5] Prorating the 11 years of available DHS facility-reported data to the 16 years of data available from DEED suggests a 30.5% direct care staffing increase, close to the 31.6% derived from DEED.

The next graph shows the close similarity between NF wages and the CPI between 2002 and 2015, and between NF/adult day service wage trends and Minnesota's job market as a whole. However, growth in nursing wages have not been the same for all positions. During this time, registered nurse (RN) wages (measured as median wage offer) increased 35.9%, versus 28.8% for licensed practical nurses (LPNs) and 23.5% for certified nursing assistants (CNAs).

Minnesota Median Hourly Wage Offered and Inflation, 2002 to 2015



Finally, direct care staff retention is defined as the percent of the direct care workforce employed on the first day of the reporting year (October 1) that are still employed in their position on the last day of the reporting period (the following September 30). Direct care staff retention peaked in 2009 at 75%, and has dropped steadily, reaching a low of 67% in 2015.



Key Staff-Related Trends after VBR

The data presented above establish a useful baseline for analyzing the effects of VBR's additional funding on the compensation and stability of the NF workforce. We move now to a discussion of initial post-implementation trends.

For all analyses, we compare data from Medicaid NF cost reports for the year ending September 30, 2015 (i.e. pre-VBR) to Interim Cost Report (ICR) data collected by DHS for the nine-month period covering October 1, 2015 to June 30, 2016 (i.e. post-VBR). The ICR provides the most-current information available for these analyses. In addition to wage and staffing data, the ICR requested facility self-report on a variety of relevant items that we will present below. We removed any outlier data before performing the analyses.

Wages and Benefits

First, we will discuss VBR-related changes in NF staff wages and benefits. The ICR collected salary and compensated hour data from NFs for two pay periods ending June 2016. It included the following employee categories: Nursing Administration, Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants, Trained Medication Aides, Mental Health Workers, Social Workers, Activities Staff, Other Care Related Staff, and Housekeeping.

VBR law did not require spending on worker wages or benefits. However, it is likely that facility management would focus at least in part on this area due to the workforce pressures mentioned above.

The table on the right shows wage increases for 2016 vs. 2015. Per hour wage increases ranged from 3% for Social Workers to 12% for Mental Health Workers.

Facilities were much more likely to use VBR funds to provide increases in wages than in benefits. Of the 356 facilities that submitted an ICR, 325 (91%) reported that they increased employee wages. In contrast, 38 facilities (11%) indicated that benefits such health insurance and Health Savings Accounts were increased. Only 14 facilities (4%) increased retirement benefits.

Wage Increases after VBR by Staff Category

Staff Category	Increase Post-VBR
Nursing Administration	8%
Registered Nurses	10%
Licensed Practical Nurses	9%
Certified Nursing Assistants	11%
Trained Medication Aides	9%
Mental Health Workers	12%
Social Workers	3%
Activities Staff	5%
Other Care Related	4%
Housekeeping	10%

The ICR collected further information on health insurance, summarized in the tables below. Almost all facilities reported offering insurance after VBR. However, the content of insurance plans varies. Fewer than half of reporting facilities improved their offered plan(s) or reduced employee cost-sharing. For those facilities that already offered insurance prior to VBR, a slight majority reported higher employee participation after VBR.

Facility-Reported Changes in Health Insurance after VBR

	Number (%) of facilities
• Did the nursing facility offer employee health insurance on June 30, 2016?	346 (97%)
• On or after 10/1/15, did this facility improve the health insurance benefit for employees? (i.e. select a plan with lower office visit co-pays, etc.)	145 (41%)
• On or after 10/1/15, did this facility reduce the amount of the employee contribution for health insurance? Meaning, did the plan benefits stay essentially the same, but the employer now pays a bigger contribution towards the cost of the premium thereby reducing the employee's portion of the costs?	154 (43%)
• If your facility offers health insurance, is participation greater now than it was in the previous year?	186 (52%)

Post-VBR, fewer than half of all NF employees in Minnesota were enrolled in health insurance. Facilities enrolled as few as two and as many as 245 staff. The median facility enrolled about 30 staff.

How many employees per facility were enrolled in health insurance as of June 30, 2016?

Total (%)	Minimum	Median	Average	Maximum
15,828 (42%)	2	33	46	245

A majority of facilities also reported that they used VBR funds to increase their participation in DHS' NF staff scholarship program. 222 facilities (62%) reported increasing the value of awarded scholarships. More facilities (235, or 66%) reported expanding the program to allow more staff to participate, for instance covering both full and part time employees.

Staffing, Retention, Staffing Pool Usage

Regarding staffing levels, we see a continuing trend of staffing level increases. One-hundred eight facilities (30%) indicated that they increased staffing levels due to the increase in funds from VBR. For the period between 9/30/15 and 6/30/16, total full and part-time NF employees increased by 739 (2%). Full time employees increased by 905 (4%). Part time employees decreased by 166 (1%).

In comparing staff retention rates for the 12 month period ending 9/30/15 (Pre-VBR) and the 9 month period ending 6/30/16, the data indicates an improvement in overall staff retention rate of 9%. For those facilities reporting a staffing level increase, the average staff retention increased by 10% for the ICR period. However, it is important to interpret this data with caution as it is unknown what the effect will be on staff retention when additional data becomes available and a comparison can be made on a full 12 month post-VBR period.

The use of temporary nursing pool staff may be an indicator of challenges with staff retention and the ability to hire new staff. In analyzing nurse pool usage from the 12 month pre-VBR period and the two pay periods ending

6/30/16, overall pool usage increased by 19%. However, approximately 60% of all NFs report using no pool staff. A small number of facilities, primarily non-metro, reported high increases in pool hours. The seven facilities with the highest increase in hours increased their pool usage by 98%. The remaining facilities that reporting using pool hours actually decreased pool usage by 12%. RN pool usage increased the most while LPN usage increased by a less significant amount. CNA and trained medication aide (TMA) pool hours showed no change.

Recommendation

The preliminary data above suggest that NFs are investing additional resources received under VBR in their workforce. They hint at positive trends in higher wages and improved benefits, staff retention and use of available scholarship funds. However, for a more definitive assessment of VBR's success in strengthening the position of the industry in the labor market, we recommend ongoing analysis to fully determine the impact of VBR on the workforce.

What is the efficacy of the critical access nursing facility program under Minnesota Statutes, section 256B.441, subdivision 63, given the new nursing facility payment system?

Legislation enacted in 2012 authorized the creation of the Minnesota Critical Access Nursing Facility (CANF) program. The goal of the program is to preserve access to NF services in isolated areas, rebalance long-term care, and improve quality. The legislation appropriated one-time funding of $500,000. It provided for facilities to be designated as CANFs through a competitive process, with criteria developed by DHS, Minnesota Department of Health (MDH) and stakeholders. The benefits to a facility of designation included:

- Computation of operating payment rates based partially on actual operating costs,
- Enhanced payments for leave days,
- Availability of waivers allowing designated critical access NFs to jointly employ a director of nursing, and
- Easier access to funding for capital projects.

After a lengthy process, in consultation with stakeholders, five selection criteria were adopted:

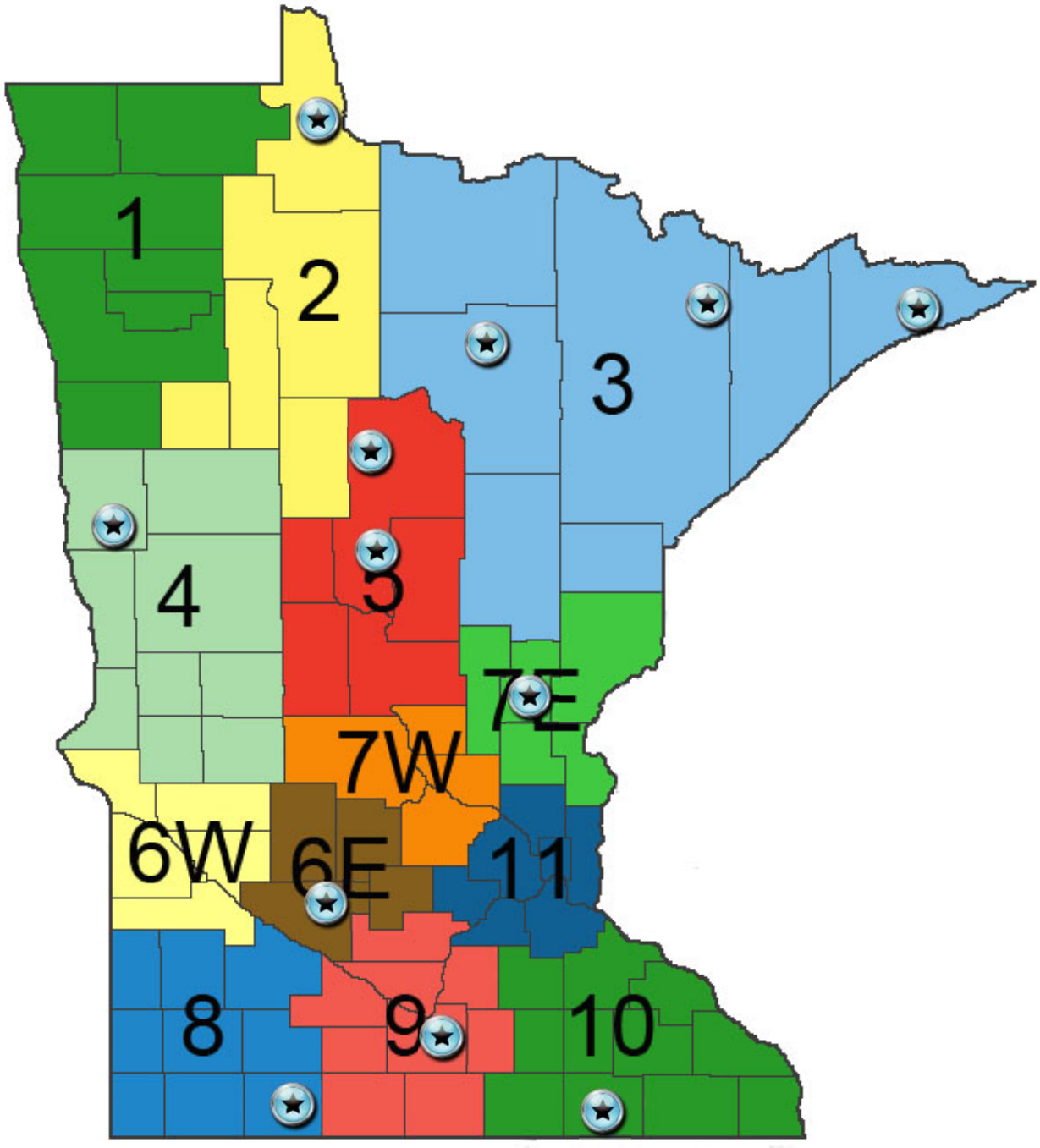
1. Geographic isolation
2. Size and occupancy
3. High outmigration from the county
4. Relatively low beds per age intensity adjusted 1000 elderly in the county, and
5. Relative quality

In addition, applicants were invited to provide an essay of up to 500 words addressing any other issues they felt should be taken into consideration in the CANF selection process.

Fifty nine facilities applied for CANF designation and seven facilities were designated by January 2013. By November 2013 the appropriation was fully used and, since the legislature had not appropriated additional funding in the 2013 session, the program was terminated.

In 2014, the legislature restored and enlarged the CANF program, providing ongoing state funding of $1.5 million per year. Changes to the enabling legislation included maximizing the even distribution of designated CANFs across the state and allowing flexibility in partially setting their payment rates based on their costs. After a new competitive process, using revised criteria, 12 facilities were selected (out of 79 applicants) to participate beginning October 1, 2014. As shown on the following map, the 12 CANFs were disbursed across nine of the 13 economic development regions in Minnesota.

Geographic distribution of 2014 CANFs



In 2015, with the enactment of VBR which implements full rebasing of payment rates to facility costs, the partial rebasing available under the CANF program ceased to be of value. The legislature suspended the program for two years, and required this analysis. All CANF contracts were suspended effective December 31, 2015, and thus

were in effect for only 15 months. Under the suspension, no CANF funds are available between January 1, 2016 and December 31, 2017.

A second feature of the CANF program was intended to make it easier for NFs to make capital improvements by lower the threshold limits on building projects. A lower threshold would allow a facility to obtain a new property rate for smaller projects. Only 2 facilities took advantage of this feature. The CANF program also allowed designated facilities to share Directors of Nursing and no facilities took advantage of this feature.

Recommendation

Given the rate structure under VBR sets rates for direct care based on the metro median and the operating price is established from the metro median, smaller, isolated rural NFs are not likely to be limited and their rates should fully cover their costs. We recommend that the CANF funds be suspended again over the next biennium. We recommend continuing to evaluate the impact of VBR to determine if the CANF program should be reinstated on January 1, 2020, and if so, its goals, benefits and selection criteria or other process for structuring the program.

How should the commissioner designate certain facilities as specialized care facilities for difficult-to-serve populations?

Several populations need NF care and have difficulty accessing that care due to the complexity of their needs, concerns about how well they may fit in with other populations in facilities or the cost of their care. Examples of such populations include people who:

- Need bariatric care,
- Have extreme behavior management needs
- Are under commitment to the commissioner of human services
- Have a history of involvement with corrections
- Are registered sex offenders
- Are members of poorly or under-served ethnic groups

Minnesota first recognized specialized care in nursing homes in 1986 with enactment of a provision allowing higher limits in setting cost-based payment rates for facilities with short lengths of stay and facilities licensed under Minnesota Rules Chapter 9570. Minnesota Rules Ch. 9570 addresses residential programs and services for people who are physically disabled. Four NFs benefited from this provision. Minnesota Statutes, section 256R.46 also recognizes one additional NF that specializes in the treatment of Huntington's Disease and provides for a 50% increase in the total care-related payment rate limit for the facility.

In 2007, Minnesota Statutes section 256B.441 was amended extensively to authorize the adoption of a new cost based formula for setting NF payment rates called rebasing. One of the 2007 amendments addressed specialized care with a provision that would take effect at the end of the eight year phase-in of rebasing, beginning October

1, 2016. This provision authorized state expenditures up to $600,000 per year for the costs of negotiated increases to care-related rate limits of up to 50%, for selected facilities, and specified criteria for the selection of those facilities, considering:

(1) The diagnoses or other circumstances of residents in the specialized program that require care that costs substantially more than the RUG's rates associated with those residents;

(2) The nature of the specialized program or programs offered to meet the needs of these individuals; and

(3) The outcomes achieved by the specialized program.

This provision was never implemented because the phase-in of rebasing was stopped by legislation enacted in 2009.

In 2015, three provisions were enacted related to specialized care:

(1) Four facilities were specified as specialized and allowed care related limits 50% higher than would otherwise apply,

(2) One specialized facility was allowed care-related and other operating rates to be set without application of any limits, and

(3) The analysis provided in this section of this report was required.

Further consideration of specialized care occurred in the 2016 legislative session with the introduction of SF 2708 and its companion bill, HF3055. This bill focused on:

“patients committed to the commissioner of human services and who have complex co-occurring chronic medical conditions and serious mental illness or substance abuse conditions after discharge from a hospital when the commissioners of health and of human services have determined that:

(1) there are inadequate options available within the community or region to provide subacute, transitional care, or residential outpatient options for these patients; and

(2) the lack of available placement options is resulting in poorer treatment outcomes and higher total costs of care for these patients because of higher rates of admission to hospital inpatient and emergency department services, longer lengths of inpatient hospital stays, and increased risks of readmission after a discharge.”

This bill allowed the addition of new beds for this population under the Nursing Home Moratorium Law and provided for higher payment rates, stating that: “The payment rate must be sufficient to cover the additional costs of the program and to create an adequate incentive for NF providers to develop or offer placement options for these patients.”

DHS staff have discussed these issues on numerous occasions with hospital systems, NFs, other state agencies and the Direct Care and Treatment administration of DHS. Common among all of these conversations has been the urgency of the need for improved NF access for one or more of the difficult-to-serve populations and a great

deal of difficulty in quantifying the need. The ability to determine the appropriate amount of resources to allocate for serving persons with specialized care needs is not currently available and further research to collect staff resource time and resident assessment data would be needed. As a result, DHS believes that the issue of specialized care does, in fact, represent an array of needs that are difficult to meet due to limited access and that the need cannot be readily quantified.

Recommendation

Given the difficulty of defining and quantifying the needs, options to address this issue could include:

- Broadening the hardship provision of the moratorium in M.S. 144A.071, subdivision 3, to recognize a situation of statewide lack of access as regards to a specific population.
- Amend M.S. 256R.46 to provide for:
    - Criteria for designating a limited number of specialized programs through a competitive process
    - Benefits of designation, including higher care related limits and a different mechanism for setting a rate for other operating costs
    - Periodic review of all designated programs to ensure they are meeting the criteria for designation, and
    - Periodic analysis by the department and reporting back to the legislature on the effectiveness of this program.

Should there be limits to the hold harmless in Minnesota Statutes, section 256B.441, subdivision 56?

VBR includes a provision called hold harmless. Under this provision: “No nursing facility's operating payment rate, plus its employer health insurance costs portion of the external fixed costs payment rate, will be less than its prior system operating cost payment rate.” The prior system operating cost payment rate is defined as: “the operating cost payment rate in effect on December 31, 2015, under Minnesota Rules and Minnesota Statutes, inclusive of health insurance, plus property insurance costs from external fixed costs, minus any rate increases allowed under Minnesota Statutes 2015 Supplement, section 256B.441, subdivision 55a [the Equitable Cost-sharing for Publicly-owned Nursing Facilities Program (ECPN)].” DHS determined the prior system operating cost payment rate for each NF and ensured that the hold harmless provision was applied on January 1, 2016, when VBR rates first went into effect.

On January 1, 2016, six facilities benefited from the hold harmless. The rate amount by which they benefited ranged from $2.38 to $39.80 per day.

The hold harmless feature creates higher rates for most of these facilities whose reported costs did not support the established payment rate. Four of these facilities have unusually high payment rates because they were set under rarely used interim rate setting provisions.

VBR Payment Rates Relative to Hold Harmless

The proportion of nursing facilities with established rates within $0 to $15 per day of their hold harmless rates included 14 NFs or less than 4% of all facilities. The hold harmless feature is intended to protect against unintended large rate changes and effects relatively few facilities. VBR is a rate setting system that is based on a set of broad principles that, in large part, tie payment new rates to actual costs. Under this new system, the Medicaid program has a sound justification for setting rates at the level at which they are set, and for paying different amounts to different facilities and for different residents. A feature to hold facilities harmless with the implementation of major system change in order to prevent unintended consequences is a practical approach but further analysis of the need for sustaining the hold harmless feature on-going should be considered.

Recommendation

DHS recommends an on-going analysis of the hold harmless feature to determine the benefit to facilities. It is possible that their costs will rise and eventually exceed their hold harmless or that some of the facilities at or near the hold harmless will have unique situations that should be taken into consideration. It is also possible that the hold harmless, in some cases, is providing high rates to a small group of facilities whose allowable costs do not support the higher rate established under the hold harmless provision.

Summary and Recommendations

In 2015, the Minnesota legislature enacted major reforms to Medicaid NF reimbursement effective beginning January 1, 2016. The legislature also directed DHS to evaluate and report on features of this reform by January 1, 2017. A reporting requirement within one year of implementation of a major reform effort introduces a number of constraints in analyzing the impact or effectiveness of the reform. NFs received significant rate increases effective January 1, 2016 but at the time of this writing, actual spending by NFs occurring after the rate increase is not known. In spite of data limitations, preliminary observations can be shared on each of the topics the legislature asked DHS to address.

(1) The initial VBR design does not include an automatic inflation factor. While it is too early in the implementation of the new Minnesota payment system to evaluate the impact of the absence of inflation in rate setting, there is some information and assumptions that can be drawn from a review of the literature. Despite the fact that most states recognize inflation, the department recommends that the rate setting formula not be amended at this time to incorporate inflation. DHS recommends on-going analysis of the relationship between rate changes and actual costs while the VBR system matures to see if the absence of an inflation factor is causing a problem.

(2) The policy innovation in VBR is the incorporation of a pay-for-performance feature in setting the payment rate for care related costs. This feature is the adjustment of care-related rate limits based on quality; the state pays for higher costs if the services provided are of higher quality. Initial comparison of actual costs to quality based care related limits indicates a minimal effect. This preliminary result is not unexpected due to the fact that the cost reporting period which would begin to capture increased investment of resources as a result of the new VBR system is not yet available at the time of this report. A thorough analysis of this issue will require actual trend data of quality measures and actual spending,

looking at the period before implementation of VBR, to create a baseline, and the period after implementation, which is not available at the time of this report. Therefore, follow-up or ongoing analysis to fully understand the impact of the care related limits on quality is recommended.

(3) For many years NFs have voiced concerns about difficulty recruiting and retaining staff. For the initial evaluation of the impact of VBR on the workforce, we compare data from Medicaid NF cost reports for the year ending September 30, 2015 (i.e. pre-VBR) to Interim Cost Report (ICR) data collected by DHS for the nine-month period covering October 1, 2015 to June 30, 2016 (i.e. post-VBR). This preliminary data suggests that NFs are investing additional resources received under VBR in their workforce and hints at positive trends in higher wages and improved benefits, staff retention and use of available scholarship funds.

(4) Legislation enacted in 2012 authorized the creation of the Minnesota Critical Access Nursing Facility (CANF) program. Upon implementation of VBR, this program was suspended for two years. Given the rate structure under VBR sets rates for direct care based on the metro median and the operating price is established from the metro median, smaller, isolated rural NFs are not likely to be limited and their rates should fully cover their costs. We recommended that the CANF funds be suspended again over the next biennium.

(5) Several populations need NF care and have difficulty accessing that care due to the complexity of their needs, concerns about how well they may fit in with other populations in facilities or the cost of their care. It has been determined that defining and quantifying the needs of these special populations is difficult, DHS reported options to consider such as broadening the hardship provision of the moratorium in M.S. 144A.071, subdivision 3, to recognize a situation of statewide lack of access as regards to a specific population. A second option could be to design a competitive process for designating special care facilities with benefits of higher payment rates.

(6) Value-Based Reimbursement includes a provision called hold harmless which protects NFs from a decrease of their operating payment rate from year to year. DHS recommends the continued applicability of the hold harmless be analyzed for the next few years to see if facilities continue to benefit from it. It is possible that their costs will rise and essentially take over the level of their hold harmless or that some of the facilities at or near the hold harmless will have unique situations that should be taken into consideration

DHS recommends an on-going evaluation of VBR to fully understand the impact VBR is having on NF quality of care and life and its effectiveness in addressing workforce issues. It is also important for policy makers over the next few years to understand the sustainability of VBR. Recommended elements of this on-going evaluation include:

- Impact of VBR incentives
  - Effects of VBR on quality
  - Effects of other operating price mechanism
- Effects on workforce

- Projection of long-term cost trend
- Effects on financial status of NFs
- Effect on consumer access
- Effects on industry size / closures of beds and facilities
- Incentives for Change of Ownerships
- NF resident rate of spenddown to MA eligibility
- The interaction between higher VBR rates, private pay and NF utilization
- Occupancy level
- Effects on NF ability to access credit and long-term financing