JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

THE VIRGINIA GENERAL ASSEMBLY

LONG TERM CARE IN VIRGINIA

A report in a series focusing on medical assistance programs in the Commonwealth of Virginia

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LONG TERM CARE IN VIRGINIA

March 28, 1978

Joint Legislative Audit and Review Commission

Most State funding assistance for long term health care is provided by the Virginia medicaid program. The cost of providing that care is the State's largest medicaid expenditure. For example, in 1977, $103 million was spent for care of elderly and disabled persons in nursing homes and mental institutions. This amount is more than the combined medicaid expenditure for hospital and physician care of the poor. Increasing costs and a growing demand for beds could result in long term care expenditures of $175 million by 1980. About $75 million of this amount will be a general fund appropriation.

Two-thirds of all long term care in Virginia is provided in nursing homes that are licensed by the State Department of Health (SDH). Standards for nursing home licensure are generally comprehensive and have contributed to maintaining good quality care.

The Department of Health also administers the medicaid funding program and establishes payment rates. In the past, rates have been adequate to encourage private investment, to stimulate growth in the number of nursing home beds, and to ensure reimbursement of the full costs of care. However, medicaid payments—established retrospectively and based on operating costs—do not encourage efficient management. As a result of current reimbursement practices, medicaid pays nursing homes at widely differing per diem rates for providing generally the same level of care.

Changes in the way the Virginia medicaid program establishes payment rates for nursing home care are needed. There is also a need to strengthen and refine existing reimbursement controls.

A JLARC REPORT SUMMARY

The typical nursing home patient is an 82 year old widow who needs daily assistance in performing such routine activities as eating and dressing. Because patients differ in the amount of medical assistance required, nursing home care is provided on either an intermediate or skilled care level. Most intermediate care is provided by nursing aides who work under the supervision of a licensed nurse. Skilled care requires a more intensive medical component which often is similar to general hospital care. About 90% of the nursing home care provided in Virginia is at the intermediate level.

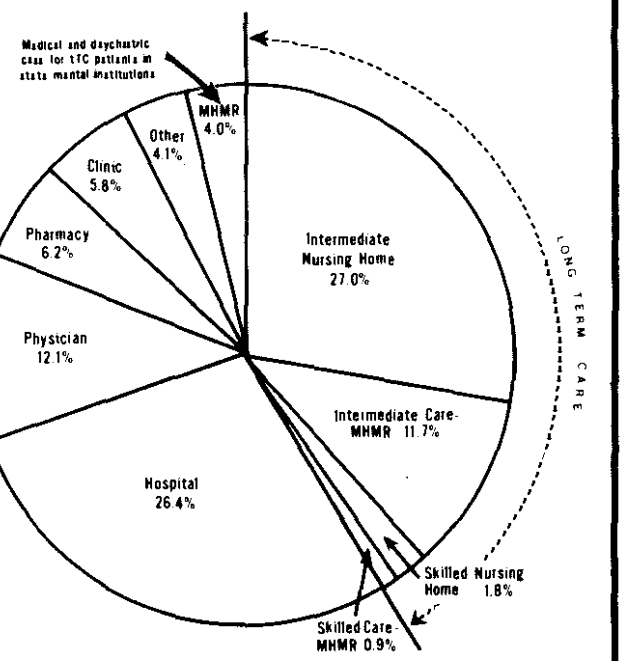
Long term care is also provided for the mentally retarded and the geriatric mentally ill in State mental institutions. Elderly patients in these hospitals are similar in many respects to nursing home patients, but they generally have a longer institutional history and a specifically diagnosed psychological problem.

Need for Nursing Home Care (pp. 7-11)

There has been a 74% increase in the number of licensed nursing home beds in the State since 1970. By August 1977, there were 14,468 beds in 135 homes. Over 4,500 additional beds have been authorized for construction under the Certificate of Public Need Law. Despite this rapid growth there is still an acute shortage of nursing home beds. SDH projects that the shortage is temporary and Virginia should have an adequate number of beds by 1980.

Skilled nursing home care may be an underutilized health resource. The availability of skilled care beds in Virginia (11% of all beds) ranks far below many other states. A number of reasons for the low utilization of skilled care have been offered. One of the most prevalent is that there is an excess of hospital beds which compete with skilled nursing homes for patients. Skilled care is less costly than hospital care (averaging $35 per day *vs* $100 per day for hospitals) and might be viewed as one way to reduce health care expenditures for some patients.

MEDICAID EXPENDITURES BY TYPE OF SERVICE 1977



Medicaid funds a variety of health services. The area bounded by the arrows encompasses the $103 million spent on long term care.

SDH should study the savings that might be available to the medicaid program through expanded use of skilled nursing homes.

Alternatives to Nursing Home Use (pp. 12-14)

While the demand for nursing care is growing, there is a new interest in developing alternatives to institutional care. Caring for the elderly in their home or community rather than in a nursing home is viewed as therapeutically superior and less expensive in some cases. Many studies have shown that some patients in a nursing home could be adequately cared for in the community if necessary services were available. These community-based services include such programs as meals-on-wheels, homemaker assistance, home health and geriatric day care.

Despite the potential benefits of home or community care there is little reliable data on its cost. Providing a variety of alternative services could prove more expensive than institutional care. More information will be necessary before general implementation of an alternative program becomes feasible.

In order to obtain better information, one agency or some combination of agencies should be assigned responsibility for preparing a State plan for the development and use of alternative care programs. The plan should include an estimate of the cost and benefit of community care and identification of appropriate funding sources.

Nursing Home Quality of Care

The quality of nursing home care is a matter of great public concern. Elderly and disabled patients are often isolated and can be subjected to either unintentional or deliberate abuse. The State has established a variety of standards designed to ensure there is an acceptable level of care. Available evidence indicates that the majority of Virginia nursing homes do provide generally good care. Only 21 nursing homes were identified as providing marginal care when assessed by statistical methods and informed observers.

However, clear evidence exists that some standards need to be changed, and improved enforcement and enforcement sanctions are called for. Procedures to implement the patient bill-of-rights legislation need to be established. Furthermore, the State needs to explore the benefits of achieving better quality by relating it to medicaid reimbursement.

Standards Setting and Enforcement (pp. 51-57)

Standards for licensing nursing homes are generally adequate. However, two areas need strengthening—staffing and staff training. Adoption of additional sanctions to enforce licensure standards is also necessary to strengthen the State's oversight role.

Staffing Levels. Under present standards, nursing homes are required to have a sufficient number of staff to provide patient care. Judgements regarding staffing sufficiency are left to Health Department inspectors. There is presently a wide variation in the number of hours of daily nursing

care provided to patients in nursing homes—a variation that cannot be attributed to differences in patient characteristics in most nursing homes.

The 1976 staffing levels for 61 nursing homes are grouped according to nursing hours per patient day in the table below and show the wide variations that exist. An analysis of 19 measures of patient disability found no statistically significant associations which would indicate a relationship between patient nursing needs and staffing in the typical Virginia nursing home.

Nursing Hours Per Patient Day	*Number of Homes*
Less than 2.0	2
2.01-2.5	15
2.51-3.0	14
3.01-3.5	8
3.51-4.0	11
4.01-4.5	7
4.5 or more	4

A JLARC analysis of costs also found that staffing is the primary reason for the wide variation in medicaid payment rates. While a lack of staff might result in poor quality care, staff in excess of those required for adequate patient care would result in unnecessary medicaid expenditures. In light of these findings more specific guidelines on staffing levels in nursing homes may be necessary.

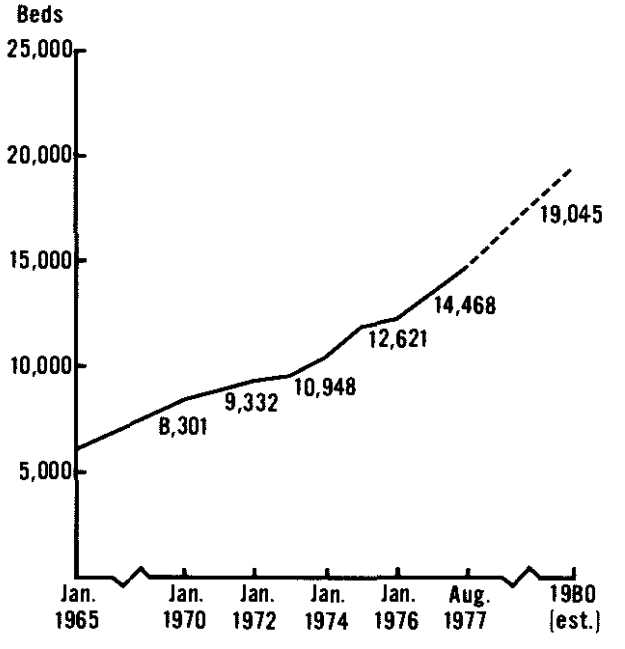
Aide Training. Nursing aides provide about three-quarters of the care in a nursing home. Despite this major role, many nursing aides are not adequately trained. Health inspectors found that training was inadequate in one-quarter of all facilities, and aide training was cited as a major concern by respondents to a JLARC survey of local welfare workers.

Current State standards for training nursing aides do not specify the type, duration or content of training programs. Some states require all aides to complete an approved training course as a condition for employment. There are presently several nursing homes in Virginia with well regarded training programs which could serve as models for a statewide program.

SDH should consider establishing a uniform training requirement for all nursing aides as a part of its licensure standards.

Standards Enforcement. SDH does not have adequate sanctions available to enforce compliance with State licensure standards. Presently, the State has only two possible sanctions: a license revocation or a moratorium on admission of medicaid eligible patients. SDH has never revoked a license, and limiting admissions to a nursing home when there is already a shortage of nursing home beds is detrimental to the patient and rarely used. SDH tries to work with nursing homes to voluntarily correct deficiencies; and while this kind of a cooperative approach may be desirable, there is evidence that it is not always successful. Inspection files, for example, show that even nursing homes that have been cited for serious deficiencies on repeated occasions fail to correct these problems. In one case serious deficiencies went uncorrected for more than a year despite repeated citations.

GROWTH IN THE NUMBER OF NURSING HOME BEDS IN VIRGINIA



Nursing home beds have more than doubled since 1965. Space for at least 4,500 more beds will be built within the next two years.

Several states including California, Florida, New York and Wisconsin link findings of inspection deficiencies to a system of citations and fines. Fines may be assessed depending on the severity of the deficiency or on the willingness of the nursing home to correct deficiencies in a timely manner. A fine for noncompliance would provide an intermediate sanction, short of license revocation, which could greatly strengthen the oversight process.

SDH should seek to establish an intermediate sanction process as soon as possible.

Complaint System (pp. 57-61)

In 1976 the General Assembly passed a nursing home patient bill-of-rights which included a mandate that patients be free to complain to outside sources without hindrance or fear of reprisal. Despite this mandate, the State does not have an

effective way to process complaints. Many complaints do not reach the proper State authorities, and there is evidence to suggest that patients who do not have families or frequent visitors have no effective way to voice a complaint.

For example, in FY 1977, the Health Department received a total of 52 complaints about 77 nursing homes whose files were reviewed by JLARC. During the same period, local welfare offices recorded over 377 complaints. Yet only 10% of local welfare offices routinely refer complaints to SDH. The source of patient complaints indicates that the many patients without outside contacts may be isolated. None of the 52 complaints reviewed in the SDH files appeared to come directly from the patient without the assistance of some third party.

Since most complaints involve a potential violation of standards, SDH has the primary responsibility for complaint resolution. Better coordination between the Departments of Health, and Welfare, and other human service agencies involved with nursing homes is needed to ensure that all complaints made about nursing home care get a fair hearing. Routine referral of all complaints to SDH would also ensure that complete files are maintained as a check on facilities which become the subject of large numbers of complaints.

In order to fulfill the objectives of the patient bill-of-rights, the State should seek to establish specific procedures to implement a complaint reporting and resolution process which ensures all patients equal access.

In addition to posting and referral instructions, greater access could be achieved by strengthening the role of the nursing ombudsman in the Virginia Office on Aging (VOA). Although legal enforcement powers need to remain with the Health Department as the agency responsible for nursing home licensure, the ombudsman could provide an independent channel for nursing home review and patient advocacy.

VOA should consider further developing and clarifying the role of the State ombudsman in this regard. The area agencies on aging could be incorporated as well.

Utilization Control and Medical Review (pp. 62-65)

The medicaid program reviews the care given to medicaid patients for adequacy and appropriateness. Since most of the care provided in Virginia nursing homes is provided to medicaid patients, this represents an important element in the State's quality oversight. Medicaid reviews indicate that many nursing homes have potentially serious deficiences in medical documentation. However, the detail contained in the written inspection summaries is insufficient to indicate how extensive the problem is or whether sanctions need to be applied. More specific documentation of findings would make medical review more effective and useful as an oversight tool.

> ***In Virginia, evidence suggests that the quality of nursing home care is generally good.***

Reviewing the appropriateness of institutional placement is important because inappropriate placement may be both therapeutically unnecessary as well as expensive for the medicaid program. Although studies have shown that many patients in nursing homes do not need such placement, it has proved difficult in practice to return an elderly person to the community once he or she has been placed in a home. For this reason, SDH established a preadmission screening program in 1977 which reviews about one-quarter of all medicaid applications for admission to prevent unnecessary placement before it occurs. According to SDH, the program has been judged an initial success because about one-quarter of all preadmission cases screened are referred to other community services. Admissions from general hospitals and other nursing homes are presently excluded from this review.

Since preadmission screening has the potential to reduce unnecessary nursing home use it should be extended to include all medicaid admissions as soon as feasible.

Quality Analysis and Facility Rating (pp. 65-70)

Two additional steps can be taken to strengthen quality oversight through extension of existing functions.

Quality-Related Analysis. SDH can make better use of the information it presently collects to measure quality. Statistical analysis is useful to raise questions and to assist in the development of guidelines for standards enforcement. Inspectors can also be alerted to potential problems before conducting inspections. For example, there appears to be a wide variation among nursing homes in the use of tranquilizers and sedatives and in raw food expenditures. SDH routinely collects data which could produce a profile of drug use and raw food costs in all medicaid certified homes. This type of analysis is not done.

SDH should review the data it collects and identify quality-related measures which could be used to supplement existing oversight activities.

Facility Rating. Another improvement, admittedly more complex, would be to rate nursing homes. Under present medicaid reimbursement

policies, the payment rate for nursing home care need not be related to the quality of that care. As long as a facility retains its license, payment rates are dependent on the cost of operation rather than the quality of care. This procedure limits the use of medicaid payments as a way to encourage the maintenance or upgrading of quality levels.

Consumers of nursing home services do not have adequate or easy access to information about various facilities. The State employs 29 full-time nursing home inspectors and their inspection reports are public information. However, few persons know of the availability of inspection files or are able to interpret the numerous reports and detailed regulations. Several states such as Florida and Utah are developing rating systems which translate quality-related information into a standard score. These systems are not fully operational and will require additional refinement.

SDH should initiate a review of the potential benefits and problems associated with a rating system. A rating system should have well developed criteria, assurance of validity, and an appropriate appeal process. A rating system might first provide consumer information, and later be used as a part of medicaid rate setting.

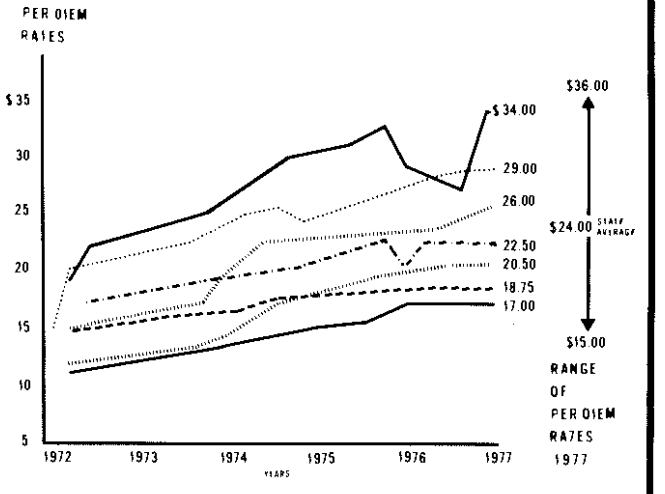
Medicaid Nursing Home Reimbursement

Most elderly and disabled persons cannot afford nursing home care. In 1976, nursing home patients paid an average of $9,000 for intermediate care and $13,000 for skilled care. Medicaid shares in the cost of about three-quarters of all care provided in intermediate level facilities, and one-quarter of all skilled care. The major role of medicaid in funding nursing home care means that few of the State's nursing homes could continue to operate without medicaid participation. This makes medicaid payment rates, and the way they are established, of great importance for both the State and the nursing home industry.

Medicaid Payment Rates (pp. 21-27)

In 1977, the medicaid program paid between $15 and $36 per day for the care of eligible patients in nursing homes. This wide variation in rates is illustrated in the figure below which compares trends in the rates of seven typical facilities since 1972. Based on an extensive analysis, variations in cost do not appear to be related to differences in the needs of patients in the typical nursing home. The analysis found no systematic relationship between cost and the proportion of seriously ill and disabled patients. This suggests that differences in operating costs are generally due to other factors and not to patient needs.

COMPARISON OF SEVEN REPRESENTATIVE PER DIEM RATES (1972-1977)



The graph shows the per diem rate paid to each of seven typical nursing homes. There is no evidence that rates have converged over the last six years.

Under the current retrospective reimbursement system, nearly all operating costs are reimbursed by medicaid regardless of whether the service could have been provided at less cost or more efficiently. Although a small percentage of claimed costs are routinely disallowed, in most cases the disallowed expenditure has been shown to be recoverable through other sources or unrelated to the care of medicaid patients. Thus, under the present system of establishing rates, actual cost reimbursement is virtually guaranteed. While this does provide operators with short term economic benefit, evidence suggests that it does not provide an incentive for efficiency.

The wide variation in rates also shows no evidence of diminishing or converging as the industry matures. And, both industry and State spokesmen confirm that in general, medicaid reimbursement practices neither reward good management nor penalize inefficiency.

Economic Benefits of Reimbursement (pp. 36-39)

Medicaid reimburses nursing homes for the actual cost of providing care plus a fixed annual return for proprietary owners equal to 10% of invested capital. Reimbursement is limited to a rate equal to 150% of the average statewide rate.

The State's medicaid reimbursement system has been criticized by nursing home operators as inequitable and not providing a sufficient return to encourage additional investment. Experience has shown medicaid rates to be adequate to encourage investment as evidenced by the rapid growth of the industry since 1970. The incentive to invest has been provided by a number of economic benefits, including both direct and indirect sources of income available through medicaid reimbursement.

Nursing homes in Virginia currently receive one of the highest per diem rates in the country. Furthermore, to promote expansion, the medicaid program paid a "growth and development" bonus of $1.50 per patient-day to participating facilities between 1973 and 1975.

In addition to the direct profit allowance, proprietary owners are also reimbursed for salaries. A salary for the owner of a single facility can range from $15,700 to $53,400 with an average in 1976 of $25,000. Owners of corporate chains can receive substantially higher medicaid reimbursable salaries. In one case three officers of a corporation were allowed a total of $217,000 in 1976.

Substantial economic benefit is also derived from certain medicaid allowable costs such as depreciation. Finally, medicaid funding support and certificate of need requirements tend to act as a franchise which allows nursing homes to operate and make a profit from the private patients who can afford nursing home care.

Proposed Changes in Rate-Setting (pp. 39-41)

There is general agreement that some changes are needed in the way medicaid rates are established. SDH should take an active leadership role in the development of a system. The Virginia Health Care Association has offered a plan for a prospective reimbursement system which SDH is presently reviewing. The plan would set a prenegotiated rate of reimbursement. Costs in excess of the rate would be absorbed by the provider but savings in operating costs would be retained as profit. The proposal also includes:

- an incentive factor for facilities whose costs are less than 135% of statewide average cost;
- a depreciation limit of $18,000 per bed for new construction;
- a rent limit;
- a cost of living rate adjustment index; and
- a rate renegotiation process.

This proposal could provide nursing homes with an incentive to operate efficiently. However, the proposed system is expected to cost the medicaid program several million additional dollars over current expenditures for the same level and amount of care. Savings if any, would occur over time, and only if the rate of cost increases was reduced.

SDH should conduct a thorough cost analysis of this and all other reimbursement proposals. This analysis should include establishing procedures for evaluating whether efficiency incentives which are established are successful in reducing the rate of overall cost increases.

In addition to promoting efficiency the reimbursement system should promote high quality care. Incentives to increase efficiency without controls on quality would put pressure on administrators to cut corners, possibly at the expense of patient care. The present medicaid reimbursement system is not capable of using medicaid payments as an incentive to upgrade quality. A facility rating system such as described earlier would be one way to tie medicaid reimbursement to changes in the quality of services.

Adjustments to the manner in which rates are established could also affect the profit incentive available to proprietary operators. The growth and development factor described earlier is no longer available. Other benefits, such as allowing owners of several facilities to draw medicaid reimburseable salaries far in excess of those allowed for single proprietorships, are being reviewed. However, elimination of these types of economic benefit could reduce the incentive for continued investment in nursing homes at a time when the State has a shortage of beds. Changes in medicaid reimbursement policy must be sensitive to these concerns.

Among the alternatives which might be considered is more flexibility in the establishment of medicaid's rate of return which has been fixed at 10% since 1972. A return which is in line with

Virginia nursing homes receive one of the highest average per day rates in the country. The JLARC review found that in general:

- *providers are reimbursed for the true cost of nursing care;*
- *a number of economic benefits available to the nursing home operator from medicaid make private investment attractive; and*
- *the present reimbursement system has provided sufficient development capital to support a rapid growth of the industry.*

The development of an efficient and effective reimbursement system is of great importance to the nursing home industry and the State. Such a system must be cognizant of two factors: (1) the unique relationship that exists between the public and private sectors in providing long term care services; and, (2) the need to maintain a balance between economic benefits, quality care and operational efficiency.

regional or national rates, coupled with a profit incentive to encourage efficient management, could ensure that the provision of quality nursing care remains an attractive investment. Direct benefits would also reduce the potential for fraudulent and abusive practices.

Cost Controls (pp. 41-47)

The way in which rates are established can do much to control excessive costs. However, medicaid also has a variety of existing controls to ensure that medicaid only pays for services which are reasonable and necessary for patient care. Controls such as property valuation, auditing and cost analysis could be strengthened in several areas.

Property Valuation. Placing a value on a nursing home at resale is one of the most often abused aspects of medicaid reimbursement nationally. Inflated property values lead to excessive expenditures for rent, depreciation and interest, all of which can be passed on to the medicaid program. SDH's present policy for establishing property values may not be adequately developed.

Several states have adopted a system whereby property values are based on assessed replacement value rather than historical costs. This method removes some of the incentive to manipulate property values and should be considered by SDH as part of any revision in the reimbursement system.

Cost Auditing. The JLARC review found that SDH conducts a reasonably thorough desk audit of cost reports submitted by providers prior to final settlement on medicaid reimbursement. Auditing of nursing home records is less well developed and should receive greater attention.

Some problems in the SDH desk audits were noted. Several providers failed to submit complete and accurate reports, and SDH has not insisted on compliance with established reporting requirements. Failure to provide adequate cost data greatly reduces the effectiveness of the desk audit efforts.

Other reporting weaknesses were found in the areas of interest and depreciation costs. Adequate documentation is not obtained of the reason loans were acquired. Depreciation schedules should be submitted with all cost reports.

Cost Analysis. SDH could better utilize the cost data it receives to identify possible reimbursement problems. There is a wide variation in per-day expenditures among facilities for standard cost categories such as dietary and housekeeping services. Using one simple statistical measure, JLARC estimated that as much as $1.6 million in potentially excessive costs were allowed by medicaid in 1976.

Cost data should be used to identify facilities where costs are out of line with the majority of nursing homes. These facilities should undergo particularly close review, and expenditures that cannot be fully justified should be disallowed for medicaid reimbursement.

Long Term Care in Mental Institutions

Medicaid funds are available to pay for the care of the mentally retarded and geriatric mentally ill in State institutions. Medicaid payments to the Department of Mental Health and Mental Retardation (MHMR) totaled $115 million for the last four years. In FY 1977 medicaid payments were $42 million, fully 40% of the operating cost of the institutions. Medicaid is clearly a major source of revenue for MHMR.

Despite medicaid funding, a number of eligible patients, specifically the geriatric mentally ill, are transferred from mental institutions to nursing homes each year. These transfers take place under MHMR's continuing policy of deinstitutionalization. In 1976 there were 200 such transfers. Concern has been expressed in the past that some of these transfers were not adequately planned. Of particular concern was the transfer of large numbers of patients into a few ill-prepared nursing homes.

Statistics for 1976 show that most transfers were not concentrated in a few nursing homes. This indicates that large scale movement of patients from institutions to nursing homes is not common today, although it may have occurred in the past. Additional study is necessary to adequately compare the benefits of geriatric care in the institutions as opposed to nursing home care. However, in light of the potential savings to the State, MHMR might reexamine its policies regarding the transfer of the geriatric mentally ill to nursing homes.

Conclusion

State funding and oversight are critically important in the provision of long term health care to Virginia's elderly and disabled citizens. In order to ensure an adequate supply of nursing home beds, a delicate balance must be maintained between SDH licensure and rate setting regulations, and the interests of the predominately private nursing home industry.

Since 1972 the Health Department has played an active and generally competent role in promoting the growth of the nursing home industry. It should be commended for encouraging growth in a needed health care area while maintaining the State's quality oversight activities. Most nursing homes appear to provide generally good care which is especially important in view of the multiple needs of the disabled elderly.

There is, however, evidence that growth has been fostered at the expense of efficiency in many cases. The State now pays nursing homes at widely differing rates which cannot be attributed to differences in patient needs. There is little evidence that increased efficiency and a convergence in rates will occur without changes in the medicaid reimbursement system.

Rapid growth, coupled with rising costs, make nursing homes the single largest category of State medicaid expenditure. The development of an efficient and effective reimbursement and oversight system is of great importance to the State and to the nursing home industry. The reimbursement system needs to recognize (1) the unique relationship that exists between the public and private sector in this area, and (2) the need to maintain a balance between economic benefit, operational efficiency, and quality care.

TABLE OF CONTENTS

Preface

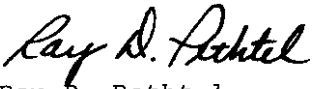
The Joint Legislative Audit and Review Commission has been assigned statutory responsibility to carry out operational and performance reviews of State agencies and programs. Each review is designed to report on the extent to which legislative intent is being met as well as to assess the efficiency and effectiveness of program activity. This review of long term care is the first in a series of evaluations that will focus on medical assistance programs in the Commonwealth.

Long term health care is a major State activity. Although most long term health care is provided in nursing homes that are privately owned and operated, about three-quarters of all care is provided to medicaid patients. Thus, this report looks closely at both the cost and the quality of nursing home care. Medicaid is also an important source of funding for the Department of Mental Health and Mental Retardation. Accordingly, the report deals with funding for the geriatric mentally ill and the mentally retarded.

The Commonwealth is fortunate that the quality of care received by most nursing home patients is good. Good quality is likely a result of the combined influence of licensure standards and the high rates of payment allowed in Virginia. Recently, however, growing demand for nursing home placement coupled with rapidly increasing costs have placed considerable pressure on the medicaid reimbursement system. Some change in the way rates are established is needed. Some improvements can also be made in State oversight and control functions.

Each agency involved in an evaluation is provided an opportunity to review the preliminary report. The Departments of Health, Welfare, Mental Health and Mental Retardation, the Virginia Office on Aging, and the Virginia Health Care Association were invited to comment on this report. A number of helpful suggestions were made, and appropriate revisions have been incorporated.

On behalf of the Commission staff, I wish to acknowledge the cooperation and assistance provided during the study by each State agency and the Virginia Health Care Association.



Ray D. Pethtel
Director

March 28, 1978

I. Long Term Care in Virginia

The rising number of elderly and disabled persons has created an urgent need for long term care services. In FY 1977 the Virginia medicaid program spent $103 million for care provided in nursing homes and State mental hospitals. Of this amount, about $43 million was from the general fund. There are indications that expenditures for long term care will continue to grow at a rapid rate.

Higher costs of health care coupled with the lower incomes of the elderly will increase the number of persons eligible for public assistance. In addition, there will be a general increase in the demand for new facilities and services to meet the health care needs of the elderly. Based on these trends it is estimated that long term care could cost the medicaid program $175 million by as early as 1980--about $75 million will be from the general fund.

Long term care could cost the medicaid program $175 million by as early as 1980—about $75 million will be from the general fund.

The growing demand for long term care services and the fiscal implications of this demand should be of concern to the State. Appropriate institutional and noninstitutional alternatives will have to be developed to accommodate the health care needs of the elderly. Better ways must also be found to manage the quality and cost of services provided in nursing homes.

Types of Care

Long term care generally includes: (1) services which assist the patient in performing routine daily activities such as eating, bathing, and personal care; and (2) physician, nursing, rehabilitation, and pharmaceutical services. Although any person may need long term care for a chronic illness or disability, the great majority of patients are elderly. A national study of nursing homes found that the typical patient is an 82 year old widow who needs assistance in one or more activities of daily life, shows some signs of mental deterioration, and will spend the last two years of her life in the nursing home.

Long term care can be provided in nursing homes, the patient's home or community, and State mental hospitals.

Nursing Homes. There are two levels of nursing home care: intermediate and skilled. The primary difference between the two levels is the intensity of medical care provided the patient. Intermediate level patients need some medical attention by physicians, therapists, and licensed nurses. Most intermediate care, however, is provided by nursing aides who assist the patient in performing routine activities such as eating and bathing. The great majority of nursing home care in Virginia is provided at the intermediate level.

Skilled care patients, on the other hand, require 24 hour attention by licensed nursing personnel and a wider range of medical services and equipment. There are few skilled care facilities in Virginia.

Community-Based Care. Recently there has been growing interest in providing long term care in a noninstitutional setting rather than nursing homes. This type of care encourages elderly persons to stay at home and rely on community-based services. These services could include home health visits, meal preparation and delivery, homemaker assistance, day care, and transportation. Community-based services are generally not well developed in Virginia.

State Mental Hospitals. The mentally retarded and elderly persons who are mentally ill are provided nursing home-like care in State hospitals. Both intermediate and skilled care services are available in these institutions.

Expenditures for Long Term Care

Table 1 shows medicaid expenditures for long term care in FY 1977. Medicaid is a federal/State program with about 43% of all funds coming from the State. Nearly two-thirds of all long term care funds are spent for intermediate nursing home care. The table also shows that medicaid funds for long term care are a major source of patient revenue for the Department of Mental Health and Mental Retardation.

The State Role--Oversight of Nursing Homes

In addition to operating institutions which provide long term care of the mentally ill and retarded, the State has a major role with regard to nursing homes. Since nursing homes are primarily owned and operated by private investors or nonprofit organizations

Table 1

MEDICAID EXPENDITURES FOR LONG TERM CARE
(FY 1977)

Level of Care	Expenditures
Nursing Homes	
Intermediate Care	$ 67,026,079
Skilled Care	4,364,428
Subtotal	$ 71,390,507
Mental Hospitals	
Nursing Home-Like Care	$ 31,430,184
Total	$102,820,691

Source: Virginia Medical Assistance Program.

the role of the State involves oversight rather than direct administration. This role is justified on two grounds:

- the State pays directly for over half of all nursing home care; and
- nursing home patients, due to age and disability, are the least able of all health care consumers to protect their own interests.

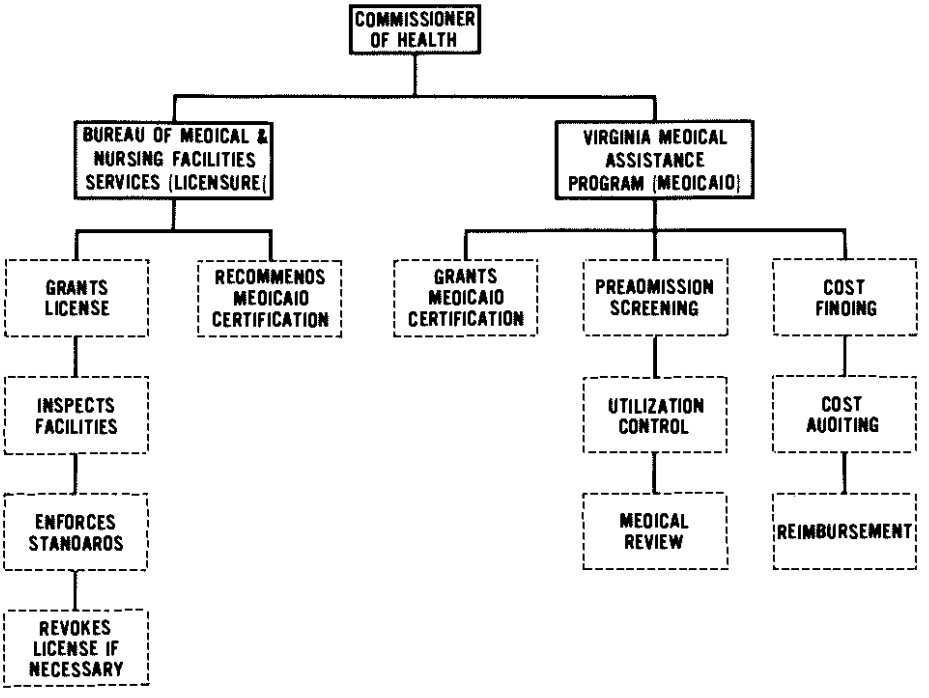
The deteriorating mental and physical capabilities of the patient, and the fact that many elderly patients have no families to look after their interests, increases the need for State involvement.

As shown in Figure 1 the State Department of Health (SDH) performs several major oversight functions. All nursing homes must be licensed by the Bureau of Medical and Nursing Facilities Services in order to operate in Virginia. The bureau is also responsible for developing and enforcing standards, inspecting facilities, and revoking licenses, if necessary.

A nursing home may also elect to participate in the Virginia Medical Assistance Program (VMAP or the medicaid program) in which case the facility must meet additional medicaid certification requirements. Once a nursing home is certified, the facility is subject to another set of regulations and requirements. VMAP conducts periodic inspections and reviews of participating homes to ensure that medicaid patients actually need institutional care and that

Figure 1

STATE NURSING HOME OVERSIGHT FUNCTIONS



Source: JLARC.

they are receiving adequate care. VMAP also requires that homes document their costs, subject to audit, as part of the medicaid reimbursement process.

Purpose and Scope of This Evaluation

This evaluation of long term care in Virginia is part of a comprehensive JLARC review of State programs which provide medical care for the indigent. The objectives, scope, and organization of the report are presented below.

Objectives. The evaluation of long term care in Virginia has the following objectives:

- to evaluate the effectiveness of State oversight functions;
- to assess the overall quality of nursing homes in Virginia;

- to assess the role of medicaid reimbursement in funding nursing home care; and

- to describe the impact of medicaid payments to the State mental hospitals.

Scope. The report is primarily concerned with the provision of long term care in nursing homes. It reviews, among other things, the growth and development of the nursing home industry, the demand for nursing home care, the cost of services, and the quality of care. The State Department of Health and the Department of Mental Health and Mental Retardation were examined insofar as their activities had a bearing on long term care programs in nursing homes and State mental hospitals.

In order to carry out the evaluation, JLARC obtained data from a number of sources. JLARC staff conducted interviews with personnel involved in nursing home oversight and the administration of the medicaid program at both the State and federal level. Field work included visits to eleven nursing homes and three State mental hospitals. JLARC also conducted an extensive review of reports and publications of other states pertaining to long term care programs. Statistical data were gathered from the following sources:

- a representative selection of nursing home cost reports;

- a review of licensure and certification files maintained by the State Department of Health;

- a random sample of patient files;

- a review of computerized medicaid reports; and

- a survey of local welfare agencies and representatives of the State Office on Aging.

A technical appendix has been prepared to explain, in detail, the methodology and research techniques used for this report.

Organization. Most of the report deals with intermediate level nursing home care because it is the predominant level of long term care in Virginia. The remainder of Chapter I presents an overview of the history and growth of the nursing home industry, the need for nursing home care, and the potential benefits of using community-based services. Chapters II and III look more closely at the cost and quality of intermediate nursing home care. Chapter IV describes the type of long term care provided in State mental hospitals and the impact of medicaid payments on the Department of Mental Health and Mental Retardation.

NURSING HOME CARE

Nursing homes are a relatively recent development in health care. Today, however, they are a major and growing segment of the health care industry and of the State's public assistance programs such as medicaid. In FY 1977 the Virginia medicaid program spent more for nursing home care than for general hospital services for the poor. Furthermore, medicaid nursing home expenditures were two and one-half times greater than payments to physicians.

In most cases medicaid pays for medical care for persons who are already poor. However, the high cost and long duration of nursing home care often impoverishes otherwise independent elderly persons and makes them eligible for public assistance. The Virginia Office on Aging estimates that 30% of the State's elderly population is poor, yet approximately three-quarters of all intermediate nursing home care is provided to patients receiving medicaid. This indicates that once elderly persons suffer a chronic illness or disability, they often become dependent on public programs for medical care. As the number of elderly in Virginia increases, this phenomenon can be expected to intensify, resulting in a greater demand for nursing home services.

Care of the Chronically Ill - A Brief History

Historically, care of the chronically ill and disabled was a function of the church. Gradually, much of the responsibility was assumed by municipal governments with the almshouse being the most common alternative for the indigent ill. In the United States the county poor farm provided shelter for disabled and elderly indigents. The extended family was also more common than it is today, and the greater availability of care by family members allowed many of the elderly to be maintained in the home. However, as better health care became available and life expectancy increased there was an increase in the number of elderly who needed nursing home care. In response to growing demand, State and local governments began to develop old age assistance programs in the early part of the 20th century. By 1931, 18 states had some form of an old age assistance program.

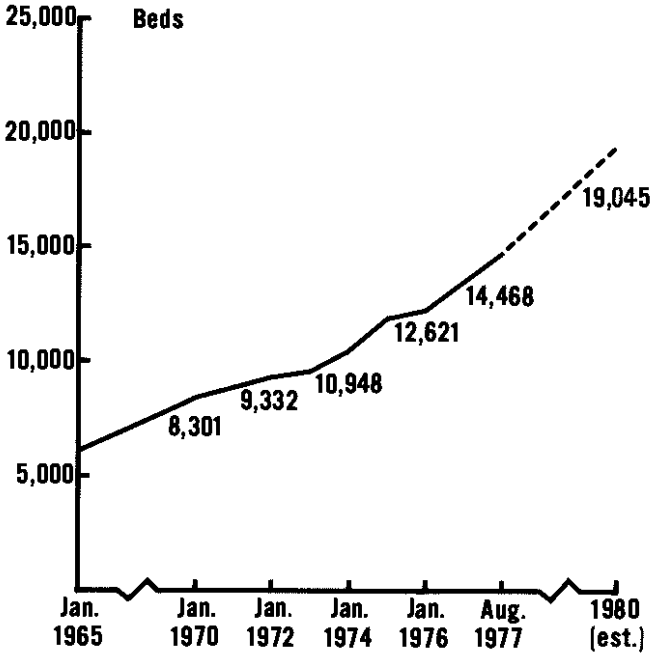
Federal participation in funding elderly care dates primarily from the passage of the Social Security Act in 1935. Social Security and other public assistance programs established in the 1930's provided a funding source for care of the elderly, and initiated the first significant growth of a for-profit nursing home industry. However, even with social security, nursing home care was too expensive for most elderly persons and the industry grew at a modest rate. Then medicare and medicaid were implemented by the federal government in 1965 and the resulting availability of funds, specifically for health care, triggered accelerated expansion of the industry. Nationally, nursing home beds more than tripled between 1960 and 1970 while expenditures for care increased 13 times.

Growth of the Nursing Home Industry in Virginia

Since Virginia did not establish its medicaid program until 1969, the growth of the State's nursing home industry did not mirror national trends. However, with the adoption of medicaid in 1969, and particularly with the 1972 inclusion of intermediate care coverage for the medically needy, the nursing home industry grew quickly. Figure 2 shows the growth in nursing homes since 1965 and the number of beds that will be available by 1980 if only those nursing home beds which are already authorized by SDH are constructed.

Figure 2

GROWTH IN THE NUMBER OF NURSING HOME BEDS IN VIRGINIA 1965-1980



Source: SDH and JLARC.

The number of beds increased by 74% between 1970 and 1977 with over 1,800 new beds being licensed in the last 18 months. In August, 1977, there were 14,468 licensed beds in 135 nursing homes. Over three-quarters of these homes are operated for profit by private investors. There are also 38 nonprofit homes, including nine that are operated by local governments.

Demand for Nursing Home Care Today

At the present time there is an acute shortage of intermediate care beds in nursing homes. But the potential of skilled care has yet to be fully realized.

Intermediate Care. There is a need for additional intermediate care beds in all parts of Virginia. A JLARC survey of 124 local welfare offices found that virtually all nursing homes have waiting lists. Moreover, in the three mental hospitals visited by JLARC staff, there were over 160 patients on nursing home waiting lists and a wait of one year or more is common.

Although there are indications that some nursing homes place limits on the number of medicaid admissions they will accept, this practice does not appear to be widespread. The survey of welfare personnel, who are involved in placing many persons in nursing homes, found that only 5% of the respondents indicated nursing home care was available only to private paying patients. However, access to nursing homes is more of a problem for mental patients awaiting transfer from a State hospital. There appears to be a general unwillingness to accept a mental patient if another, less disabled, patient is available.

In FY 1977 the Virginia medicaid program spent more for nursing home care than for general hospital services for the poor. Furthermore, medicaid nursing home expenditures were two and one-half times greater than payments to physicians.

Skilled Care. Available evidence suggests that skilled care may be an underutilized health resource in the Commonwealth. This is of concern since skilled nursing care could substitute, in some cases, for hospitalization during extended convalescence. This could provide substantial savings to the health care consumer when the $35 per day average cost of skilled care is compared to over $100 a day average for hospital care. Despite these potential savings, skilled care services are not readily available in the State. Nor does there appear to be a rapidly increasing demand, based on the existing definition and use policies, for this level of care.

Only about 1,600 of the 14,468 nursing home beds are classified as skilled care. When compared to other states, Virginia ranks 35th in the number of skilled care facilities receiving medicaid funds. And, as shown in Table 2, the proportion of medicaid funds spent for skilled care is low in relation to the rest of the nation.

Table 2

PROPORTION OF MEDICAID FUNDS USED FOR
NURSING HOMES BY LEVEL OF CARE (1975)

Level of Care	U.S.	Virginia
Skilled	20%	3%
Intermediate	18%	34%
Total	38%	37%

Source: HEW.

During the course of the evaluation JLARC contacted a number of administrators to identify some of the reasons for the low use of skilled care. Some of the most often cited factors include definition of care, hospital occupancy rates, patient prejudice and insurance coverage.

Definition. Virginia has adopted a narrow definition of skilled care that limits the number of persons who could qualify for medicaid assistance. As a result, nursing homes are reluctant to operate expensive skilled care units since patients seldom qualify for medicaid reimbursement at the higher skilled care rates.

Low Hospital Occupancy Rates. Virginia is generally considered to have more hospital beds than can be justified by demand.[1] This condition is more serious in some parts of the State, particularly Richmond, Northern Virginia, and Tidewater. Since skilled care is similar in many respects to acute hospital care there can be substantial overlap in determining which level of care is most suitable. Therefore, hospitals with lower occupancy rates are less willing to refer patients to a skilled nursing home even though the transfer might be justified by the patient's condition. JLARC was told of one instance in which a hospital administrator imposed an occupancy threshold below which no patient could be transferred to a skilled nursing facility regardless of whether skilled nursing would be adequate.

Patient Prejudice or Physician Attitudes. Many persons, particularly the elderly, are fearful of nursing homes. Poor publicity in recent years has increased prejudice in the minds of potential patients. Some physicians share this prejudice, and many others are unwilling to transfer a patient if it means additional travel time for a medical visit.

Insurance Coverage. Although some private insurance plans cover skilled nursing care, many limit coverage to acute care hospitals only. Without insurance coverage, patients will resist placement in a skilled nursing home.

Skilled care provides a less costly alternative to expensive hospital care. However, the low use of skilled care in Virginia suggests that hospitals are sometimes used when a skilled nursing home could provide adequate care. Unnecessary use of hospitals is costly to the consumer and to third party payment sources such as medicaid. Furthermore, the federal medicare program, which covers some skilled care, can be used only if skilled care beds are available. State agencies involved in health care planning should be aware of the potential for increased use of skilled nursing care. In order to facilitate planning SDH should conduct a study to identify the potential for reducing medicaid expenditures through expanded use of skilled nursing care. This study should include an estimate of the number of patients currently in hospitals who could benefit from skilled nursing care.

SDH Projections of Future Needs

As a part of its statewide health planning duties, SDH is responsible for projecting future nursing home needs. These projections serve as a valuable source of information in reviewing requests for a Certificate of Public Need. Any person desiring to construct or expand a nursing home must first obtain a certificate from SDH. In essence, the Certificate of Need program is designed to prevent overbuilding of medical facilities, including nursing homes. Based on the SDH projections of need, the current shortage is temporary and Virginia should have an adequate supply of beds by 1980.

The present method used by SDH to project nursing home needs was adapted from the 1973-1974 State Plan for Construction and Modernization of Medical Facilities. Projections are made through 1980 and are based on the higher of two factors:

- the actual 1975 nursing home use rate for persons age 65 and over, applied to the estimated 1980 population; or

- an estimate that between 3% and 5% of all persons 65 or older will need nursing care at any given time.

SDH recognizes that the 1975 use rates may be too low and has adopted the 3% to 5% estimates to compensate for this fact. Major urban areas generally use a 5% estimate, small urban and suburban areas use is estimated at 4%, and rural areas use at 3%. These percentages are applied to the projected 1980 population for each locality to obtain an estimate of need in all areas of the State. Based on this projection method, SDH estimates that there will be a need for 20,548 nursing home beds by 1980. The 1980 need and the number of beds licensed as of August, 1977 are broken down by Health Service Area (HSA's)[2] and shown in Table 3. A map showing the geographic service area for each HSA is contained in the Appendix.

Table 3

1980 SDH PROJECTED NEED AND LICENSED BEDS AS OF AUGUST, 1977

Health Service Area	1980 Projected Need	Licensed Beds, 8/77	Existing Gap
I	2,718	2,319	399
II	3,200	2,219	981
III	5,421	4,160	1,261
IV	4,287	2,920	1,367
V	4,922	3,675	1,247
State	20,548	15,293[1]	5,255

[1] In nursing homes and general hospitals.

Source: SDH Interim Medical Facilities Plan and Bureau of Medical and Nursing Facilities Services.

The existing gap of 5,255 beds is mostly offset by the fact that 4,577 beds have already been approved for construction through the Certificate of Need program. As a result, the difference between the 1980 projected need and the number of beds currently approved is only 678. Since the typical nursing home consists of 120 beds, there could be a need for as few as six additional nursing homes through 1980. At least partially as a result of these estimates, SDH denied applications for almost 700 additional nursing home beds in FY 1977 which amounted to one-third of all applications filed during the fiscal year.

Recently SDH introduced an additional refinement into its projection methodology. In October, 1977, a consultant employed by SDH proposed that the needs projection methodology for general hospitals, long term care facilities and ambulatory care services be revised. In place of a fixed 3%-5% correction factor for nursing homes, the proposal would use a formula to establish a range of need based on actual use rates for each area of the State. The HSA's could then determine a projection of need within this range which considers local demographic conditions and the availability of alternative services.

The proposed revision received tentative approval in December, 1977, and will be incorporated in SDH's projection methodology during 1978, subject to final approval following public hearings. This revision will do much to strengthen the ability of SDH to equitably control the growth of nursing homes in Virginia.

ALTERNATIVES

The demand for nursing home care will continue to increase in the foreseeable future. Changes in health care technology have extended the average lifespan and increased the number of elderly persons in the population. However, medical technology has not been as successful in controlling the infirmity and disability which often accompany advanced age. The result is a steadily increasing number of elderly and disabled persons who need nursing home care.

In addition, the cost of better health care has risen at a rate above that of most consumer services. Medicaid's expenditures for nursing home care in FY 1977 increased by 30% over the previous year. At the present rates of cost inflation and medicaid participation, nursing home care in 1980 could cost the medicaid program $175 million. With the State medicaid share increasing to 43% in 1977, this could mean a general fund expenditure of $75 million for nursing home care by 1980.

In light of the growing need for nursing home care, the State will have to assume an active leadership role in seeking ways to reduce patient use of institutions and to manage the cost and quality of services.

Alternatives to Nursing Home Care

Services which could prevent or delay institutionalization in a nursing home are collectively referred to as alternative care programs. Although alternatives to institutional care may reduce the utilization of nursing homes, they cannot be looked upon as an easy way to reduce costs. Community-based services are themselves often expensive and most nursing home-type patients would need a variety of services in order to avoid institutionalization. Therefore, careful planning and development of alternative programs will be necessary if the State is to make best use of its health care resources.

Potential for Alternative Use. Numerous studies have found that some patients, perhaps 10% to 30% of those presently in a nursing home, do not need institutional care provided other long term services are available.[3] Home health, homemaker services, meal delivery programs, and geriatric day care are examples of community-based services which can provide the same kind of medical and health-related care that the nursing home offers.

SDH did a study in 1976 prior to the implementation of the medicaid prescreening program and found that as many as 25% of the applicants for medicaid covered nursing home care in Richmond could be cared for using community-based services. All estimates

of inappropriate placement assume that alternative programs will be available. However, without a comprehensive range of community-based services the estimates are less meaningful.

Using alternative services rather than nursing home care could have two advantages: cost savings and therapeutic benefits. Cost savings could be realized because community services are more flexible and can be tailored to the specific needs of each individual patient. Not all patients need all services, but if the patient is placed in a nursing home the charge would be a standard per diem regardless of actual need.

In addition, geriatric experts generally agree that community care is therapeutically better for the patient and should be continued as long as possible. Therefore, the development and use of alternatives to institutionalization offers the advantages of both better care and potentially lower costs for many patients who do not need the full range of services available in a nursing home.

Despite the potential advantages of alternative care there is little data available on how best to develop alternative programs. Several states such as Wisconsin are currently operating pilot and demonstration projects to assess the costs and benefits of various programs. Some information based on the operating experience of local programs is also available. However, pilot and demonstration programs benefit from what may be a unique mix of federal, state, community, and philanthropic support. More experience and reliable cost data will be necessary before general implementation of similar programs in Virginia becomes feasible.

Planning for Alternative Development. The need for some central direction in alternative development was recognized when the Secretary of Human Resources appointed a Task Force on Alternatives in 1974. The Task Force was made up of representatives of the Departments of Health and Welfare and the State Office on Aging, and was to develop a State policy on alternatives to institutionalization. However, the Task Force made no findings or recommendations and is no longer active.

The General Assembly also has been interested in the question of alternative use. The Commission on the Needs of Elderly Virginians, established by the General Assembly in 1973, has studied several areas affecting the elderly including the use and benefits of community care. The Commission made an interim report in 1976 and will make its final report during the 1978 session. Despite the recognition of a need for policy development in this area by both the Executive and Legislature, no lead responsibility for alternative planning, coordination and research has been established.

The Virginia Office on Aging (VOA), SDH, and the Department of Mental Health and Mental Retardation are already involved in planning and coordination of programs for the elderly. VOA operates several programs aimed specifically at the elderly. In order to provide a clear policy focus some agency, or possibly a combination of agencies, should be given the responsibility of preparing a comprehensive State plan for alternative program development and funding coordination. This plan should include at a minimum:

- reliable cost estimates for providing alternative care in Virginia, and an estimate of the difference between alternative use and use of nursing home care;
- identification of all possible funding sources and the relative merits of each; and
- a recommended implementation program which identifies the role of State, local, private and public nonprofit organizations.

The plan should include input from legislative groups such as the Commission on the Needs of Elderly Virginians and should be reviewed by appropriate standing committees of the General Assembly prior to implementation.

Managing Costs and Quality of Care

Of more immediate concern to the State is managing the cost and quality of care provided in nursing homes receiving medicaid funds. SDH has done a creditable job of providing nursing home oversight. But, changes in the nursing home industry and the rising costs of medicaid are placing additional pressure on the State's limited financial resources. As a result, SDH faces a major challenge in ensuring that adequate oversight is maintained. In the following two chapters several alternatives are presented to improve the efficiency of the medicaid reimbursement process and strengthen controls on the quality of nursing home care.

II. Medicaid Reimbursement

The Virginia medicaid program (VMAP) has been criticized by the nursing home industry for not recognizing the true cost of nursing home care. Nursing home spokesmen also claim that medicaid has created a crisis in the industry by not providing enough profit incentive to encourage investment and growth. Despite industry claims, available evidence indicates that medicaid has stimulated the rapid growth of nursing homes since 1970. However, the present medicaid reimbursement system can be better utilized to foster efficiency and quality of care, and some cost controls need to be strengthened. These changes are necessary to ensure that the best use is made of medicaid funds.

Despite industry claims, available evidence indicates that medicaid has stimulated the rapid growth of nursing homes since 1970. However, the present medicaid reimbursement system can be better utilized to foster efficiency and quality of care, and some cost controls need to be strengthened.

This chapter reviews intermediate level nursing home costs and the medicaid reimbursement system. Medicaid reimbursement is directly related to the cost of providing care. Since three-quarters of all nursing homes are proprietary, they receive the greatest attention. JLARC analyzed the 1976 cost reports and financial statements of 67 nursing homes, of which 52 were proprietary. A detailed description of the cost analysis methodology is included in the Appendix.

INTERMEDIATE NURSING HOME COST

Nursing home care is expensive--about $9,000 annually. It is not surprising then that many patients face financial hardship because they cannot afford the high cost of care. This section profiles the cost of operating a nursing home and examines the extent to which certain factors contribute to variations in owner cost.

Description of Costs

There are considerable differences in operating cost among the nursing homes examined by JLARC. The 1976 daily cost of care--most of which is reimbursed by VMAP--ranged from $15 to $45. This is a variation of almost 200% between the highest and the lowest cost homes. The average cost for the 67 facilities was almost $24 per day. This average daily cost can be distributed among nine major categories of expenditure which are shown in Table 4. Salary-related costs make up about 51% of total expenditures and are included in all but the interest and depreciation categories shown in the table.

Table 4

AVERAGE PER DAY COSTS BY CATEGORY
FOR INTERMEDIATE NURSING CARE, 1976

Cost Category	Per Day Cost	Percent
Nursing services	$ 8.54	36%
Dietary	3.84	16
Administration	3.76	16
Plant maintenance	1.57	7
Housekeeping	1.33	5
Interest	1.13	5
Depreciation	.96	4
Laundry	.78	3
Other[1]	1.98	8
Total	$23.89	100%

[1] Includes medical supplies, drugs, therapies, social services, educational and patient activities.

Source: JLARC Cost Analysis.

Based on the $24 per day average, a nursing home patient would have paid $8,760 a year for his care in 1976. Preliminary 1977 data indicate that the average cost has increased to over $26 per day, or $9,500 annually. This exceeds the median Income for Virginia's elderly families and far exceeds the $3,000 annual income of the widowed social security pensioner who is the most likely nursing home patient.

Factors Affecting Cost Variations

Since medicaid reimbursement is based on operating cost, factors which account for cost variations among nursing homes are important to State oversight. However, VMAP has not performed a

systematic analysis of cost variation. As a part of its review, JLARC examined the most commonly cited factors which could affect per day cost differences among nursing homes. These factors include such components as the type of ownership (profit versus nonprofit), facility size and organization, patient characteristics, staffing, geographic location, occupancy rates, and proportion of medicaid patients.

The analysis found that staffing levels and labor costs account for approximately two-thirds of the variations in daily costs among proprietary nursing homes. Profit status accounts for some differences in the pattern of expenditures between proprietary and nonprofit facilities, but not for the wide variation in daily cost. None of the other components appear to have a substantial affect on cost variations.

Type of Ownership. Profit status was found to have an affect on the distribution of nursing home expenditures but not on overall costs. Most nonprofit facilities have per day costs which are similar to proprietary homes. Table 5 shows the distribution and average daily costs for both proprietar and nonprofit facilities. If one extreme case is deleted, the average nonprofit home costs almost the same per day as the proprietary facilities. There does not appear to be an appreciable difference in the overall cost between proprietary and nonprofit nursing homes.

Table 5

PER DAY COSTS FOR PROPRIETARY AND
NONPROFIT INTERMEDIATE NURSING HOMES, 1976

Cost Per Day	Proprietary Facilities	Nonprofit Facilities	Total (%)
Under $20	13	3	16 (24%)
$20-$25	19	7	26 (39%)
$26-$30	17	2	19 (28%)
Over $30	3	3	6 (9%)
Total	52	15	67 (100%)
(Average)	($23.54)	($23.69)[1]	($23.57)[1]

[1]One case had a per diem rate which was much higher than any other nursing home in the State. It was deleted due to a disproportionate affect on the average.

Source: JLARC Cost Analysis.

There is, however, a significant difference in the distribution of expenditures between proprietary and nonprofit facilities. Nonprofit facilities have lower facility costs (interest, rent and depreciation) and lower administrative expenses but spend more for nursing care and dietary services. Table 6 compares the two types of facilities on the basis of several cost measures. Both types of facilities averaged the same number of patient days of care in 1976 so size and occupancy rates would not appear to be a factor in explaining the difference.

Table 6

COST MEASURES FOR PROPRIETARY AND NONPROFIT INTERMEDIATE NURSING HOMES, 1976

Measure	Proprietary	Nonprofit
Facility Cost Per Patient-Day[1]	$ 3.09	$ 1.70
Administration Per Patient-Day	$ 3.97	$ 3.00
Nursing Cost Per Patient-Day	$ 7.98	$ 10.65
Dietary Cost Per Patient-Day	$ 3.58	$ 4.51

[1]Facility cost is equal to the sum of depreciation, interest and rent.

Source: JLARC Cost Analysis.

The higher expenditures for nursing and dietary services could indicate that nonprofit nursing homes provide better patient care. Recently the AFL-CIO recommended that because proprietary nursing homes showed widespread "patterns of abuse" they should be replaced by nonprofit facilities.[1] This conclusion was partially based on different expenditure patterns between the two groups. However, some of the data in Table 6 could be misleading. For example, several municipal nursing homes do not include depreciation as an expense in their accounting system which understates their real cost of operation. Despite this, it is apparent that nonprofit nursing homes have a different pattern of expenditure with more of their costs concentrated in direct patient care categories.

Facility Size and Organization. Larger nursing homes should be able to realize certain cost savings through more efficient provision of standardized services such as dietary, laundry, and housekeeping activities. Also, homes which are subsidiarles of multifacility corporate chains should benefit from centralized administration. The presence of such economies could be considered a test of the efficiency of nursing home management.

Facility size, as measured both in the number of beds and the number of patient days of care provided, had no statistical relationship with the per day cost differences among proprietary

nursing homes. Patient-days is the preferred measure of comparative facility size because it controls for occupancy rate. However, since Virginia intermediate care facilities have uniformly high occupancy rates (averaging 97%) the two measures are essentially the same.

The analysis also tested each of the eight cost categories shown in Table 4 for a relationship to facility size. Of the cost categories, only housekeeping showed a weak relationship to the size of the nursing home. Since the facilities in the cost analysis ranged from 25 to over 240 beds, the lack of any substantial association with per day costs is surprising.[2] The finding suggests that there may be room for additional cost savings in large proprietary homes receiving medicaid funds.

VMAP might want to consider facility size and the potential for cost savings in larger homes in the development of any future medicaid reimbursement proposals. For example, California reimburses nursing homes on the basis of bed size with the larger facilities receiving less per patient-day than smaller ones. This approach asserts there are potential savings available in nursing home operation. Although this type of reimbursement is not widely used, it has the advantage of providing an incentive for the more efficient operation of larger nursing homes.

Proprietary nursing homes which are subsidiaries of a multifacility corporate chain generally pay the central office a management fee which is equal to the central office costs, allocated among the subsidiaries on the basis of bed size. This management fee averaged $50,266 per facility in 1976 and added about $400 a year to the cost of a bed.

It would be reasonable to assume that centralized administration would save money for the multifacility chains and, indirectly, for the medicaid program. However, as is shown in Table 7, facilities which are subsidiaries and pay a management fee have virtually the same administrative cost as single facilities. Nor are corporate

Table 7

ADMINISTRATIVE COSTS FOR MULTIFACILITY
CHAIN AND SINGLE FACILITY INTERMEDIATE NURSING HOMES

Type of Proprietary Facility	Administrative Cost Per Bed	Number of Facilities
Multifacility Subsidiary	$1,384	27
Single Facility	$1,340	23

Source: JLARC Cost Analysis.

chains more likely to realize savings in other cost categories. Therefore, it appears that chain ownership offers no substantial cost savings to either the patient or the medicaid program.

Patient Characteristics. Another factor which could be used to explain cost variations between nursing homes is a difference in patient needs. It would be logical to expect that more ill and disabled patients would require more expensive care. If a difference existed in the concentration of seriously ill and disabled patients between two homes, this could account for variations in cost.

Data were collected on the functional status of 653 nursing home patients from 30 proprietary nursing homes. These facilities had operating costs in 1976 which varied from $16 to $35 per day. There was not sufficient data to conduct the analysis for nonprofit homes. Functional status is the most suitable type of profile for intermediate care because it includes a wide range of characteristics which describe the patient's abllity to perform routine daily activities. The measures used and a detailed description of the analysis are included in the Appendix. The analysis was designed to:

- determine whether differences in the type of patient actually exist between nursing homes; and,
- determine if significant differences could account for cost variations.

The analysis found that differences in patient needs are not related in any systemmatic way to the cost of facility operation. The concentration of patients with various functional characteristics, such as incontinence, varied little among the patient populations In the sampled nursing homes. Where variation did exist it did not appear to be related to operating costs. Based on this analysis it appears that the functional status of patients, and, therefore, the type and intensity of care required does not account for variations in cost among the typical privately operated nursing homes in the State.[3]

Staffing. The key staffing factors which determine cost variation in proprietary nursing homes include:

- the number of nursing staff provided in relation to the number of patients;
- the number of nonnursing staff employed; and
- the salary costs per employee.

These factors in combination account for about two-thirds of the total variation in average per day costs.

The importance of staffing in determining cost variation is not surprising since over half of all nursing home expenditures are for salaries. Costs are higher as more nursing hours of care and nonnursing staff are added, and as the average salary per employee increases. Salary costs per employee, which is an approximate measure of labor costs, does not appear to be affected by geographical location except in Richmond and Northern Virginia where prevailing wage rates tend to be higher. Otherwise, the salaries paid to employees of proprietary nursing homes seem to be based predominately on management attitude since some chains have higher wage rates than others although they employ the same number of staff. (Staffing levels and their relation to quality care and cost are more fully explored in the next chapter.)

MEDICAID REIMBURSEMENT SYSTEM

The medicaid reimbursement system has been criticized by the Virginia Health Care Association (VHCA) which represents the majority of the State's nursing home operators. Operators generally have two concerns about medicaid: inequitable payment rates will retard upgrading of the quality of care; and, inadequate funding will discourage the development of additional facilities to meet growing demands.

These concerns have been viewed sympathetically by SDH. Through its medicaid rate setting and cost settlement process, SDH has taken a number of steps since 1970 to ensure that providers are reimbursed equitably. These steps include early implementation of a retrospective cost reimbursement system, a guaranteed return on investment, a bonus payment for growth and development and a relatively liberal rate adjustment policy. As a result of these actions, Virginia nursing homes receive one of the highest average per day rates in the country. Furthermore, the JLARC review found that in general:

- providers are reimbursed for the true cost of nursing care;
- a number of economic benefits available to the nursing home operator from medicaid make private investment attractive; and
- the present reimbursement system has provided sufficient development capital to support a rapid growth of the industry.

The medicaid reimbursement system has been an effective catalyst in stimulating growth of the nursing home industry. At the same time, however, the system has not been fully utilized to promote efficiency of nursing home operation or to control overall costs.

Reimbursement For Operating Costs

The core of the medicaid payment function is the cost-related, retrospective reimbursement system. At the end of the fiscal year, VMAP reimburses nursing home operators for the actual cost of providing care to medicaid patients, provided that expenditures are not excessively high and are necessary for patient care.

Virginia became one of the first states to adopt a cost-related reimbursement system for intermediate care homes in July, 1972. Many other states chose to adopt a reimbursement sytem which paid a single flat rate for each day of care regardless of the actual cost. These flat rate systems tended to freeze nursing home payments at artificially low levels and discouraged both the establishment of new facilities and the provision of quality care.

As a result of the problems associated with flat rate reimbursement methods, the Congress and HEW mandated that all states reimburse nursing homes on a reasonable cost-related basis by January, 1978. Each state may develop its own reimbursement system provided that it remains cost-related and is approved by HEW. Since the State's reimbursement system was already cost-related, it was approved by HEW in 1976 with little substantive modification.

Table 8 shows that Virginia intermediate care facilities are reimbursed at an average rate which is substantially higher than those in most other states. The lower rates in other states are at least partially the result of flat rate systems.

Table 8

NATIONAL COMPARISON OF REIMBURSEMENT
FOR INTERMEDIATE NURSING CARE (1977)

Average Rate Per Day	Number of States
Less than $18	11
$18 - $22	10
$22 - $24	4[1]
More than $24	2
Total	27

[1]Virginia average was $23.33 per day.

Source: JLARC telephone survey of State medicaid agencies. Rates as of July, 1977. States were contacted if they had a sufficient number of intermediate homes for a comparison with Virginia.

The JLARC review of operating cost reimbursement also found that:

- nursing homes are heavily dependent on medicaid-related payments as a source of operating revenue;
- VMAP reimburses nursing homes at greatly different rates for providing essentially the same type of service; and
- most operating costs claimed by owners are reimbursed by medicaid.

Medicaid Payments for Operating Cost. Although medicaid will reimburse nursing homes for the full cost of care, in practice, most payments are shared between the patient and medicaid. Medicaid is a last-pay option which is used only after all nonexempt patient assets are exhausted. For most patients the only nonexempt asset is a $25 per month personal allowance which is provided by the patient's social security, pension benefits or other income. If the nursing home patient has dependents the amount of exempted income is established by the State Department of Welfare. The medicaid program then makes up the difference between what the patient can pay and the actual cost of care.

Based on the JLARC cost analysis, it was estimated that the medicaid program pays nursing homes directly for about 56% of the total operating cost of intermediate nursing home care in Virginia. Table 9 uses this estimate to show the amount and source of cost reimbursement payments in 1976. Medicaid patients contributed about 19% of the total while private patients paid for the remaining 25% of operating cost.

Table 9

ESTIMATED PAYMENTS FOR OPERATING COSTS, 1976[1]

Source of Payment	Amount	Percent
Medicaid Program	$50,700,000	56%
Medicaid Patients	17,940,000	19
Private Patients	22,880,000	25
Total	$91,520,000	100%

[1] Excluding mental institutions and nursing homes not participating in medicaid.

Source: JLARC Cost Analysis and VMAP Quarterly Provider Utilization Report (C-302) for the 4th quarter, 1976.

Variations in Rate of Payment. There was a wide distribution of daily operating costs among the 67 representative facilities included in the cost analysis (Table 10). These costs are approximately equal to the medicaid payment rate for each nursing home in 1976, although VMAP has not finalized some rates and some adjustments are likely. A difference in rates between two facilities of $10 per patient day amounts to about $300,000 annually for the typical nursing home.

Table 10

APPROXIMATE MEDICAID PAYMENT RATES
FOR INTERMEDIATE NURSING HOMES, 1976[1]

Per Day Rate	Number of Homes[2]	Percent
Over $30	6	10%
$27 to $30	9	14
$23 to $26	11	18
$20 to $22	21	34
Under $20	15	24
Total	62	100%

Average: $23.17
Range: $14.53 to $41.63

[1]Excludes payments for physician, therapy and pharmacy services.
[2]Five of the 67 facilities had inadequate data for use in the table.

Source: JLARC Cost Analysis.

While the average daily cost of intermediate care has increased by 36% since 1974 (Table 11), the increase in medicaid payment rates for each facility has shown much greater variation. The change in interim rates for seven representative nursing homes compared to the Statewide average is shown in Figure 3. Individual facilities experienced increases over the 1972-1977 period of anywhere from 10% to 90%. It would be reasonable to expect that rates would converge as the industry matures and the most efficient ways of operating are identified. Instead, there seems to be no standard rate of payment for intermediate nursing care in Virginia, nor is there a tendency for rates to converge.[4] Each facility has a unique rate history based on differing costs. This is a predictable response in a retrospective cost reimbursement system which provides little incentive for efficiency or economy and which passes on almost all operating costs to the medicaid program. As noted earlier, federal regulations allow states to implement a wide variety of cost controls within the requirements of a cost-related reimbursement

Table 11

INCREASE IN THE COST OF INTERMEDIATE CARE
(FY 1974-FY 1977)

Fiscal Year	Average Per Day Cost	Total Medicaid Payment
1974	$17.10	$30,575,261
1975	19.37	44,984,100
1976	21.75	53,389,768
1977	23.33	67,026,080
(Percent Increase)	(36.4%)	(119.2%)

Source: VMAP, Cost Settlement and Audit Section.

system. It is apparent from Figure 3 that such controls need to be introduced or upgraded in Virginia.

Reimbursement for True Cost. A JLARC review of the 1976 cost reports revealed that VMAP disallows approximately 4% of nursing home claimed costs. Despite this disallowance evidence suggests that medicaid reimbursement policies fully cover the true cost of nursing care in Virginia.

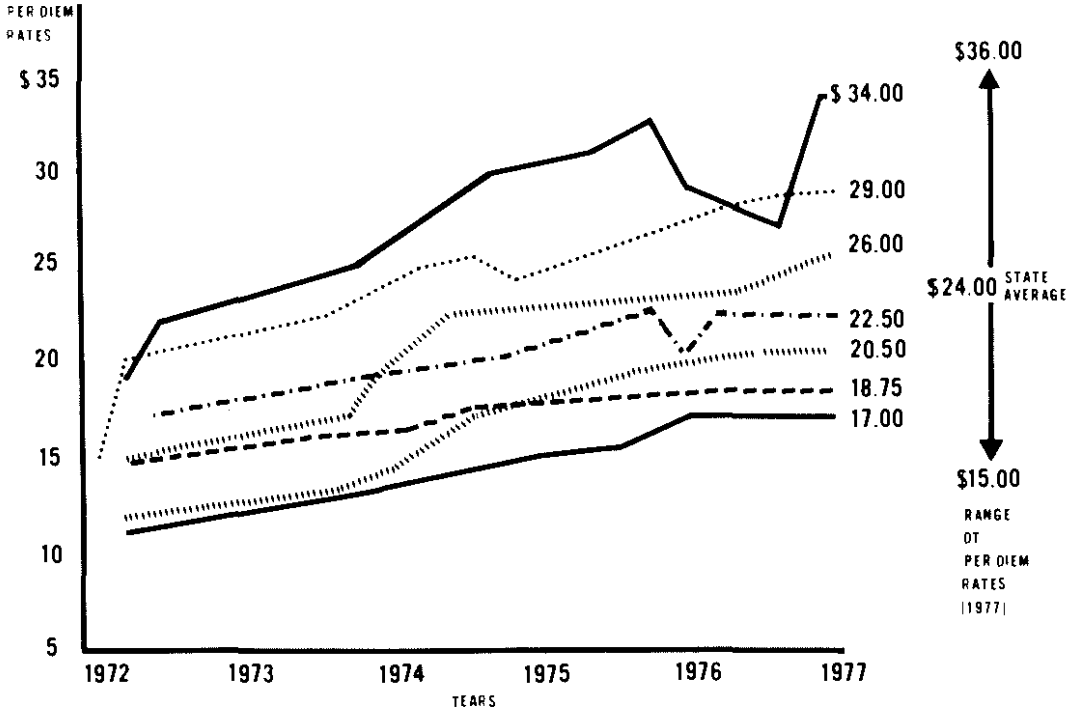
Costs which are generally disallowed by VMAP fall into four principle categories:

- costs which are eventually recoverable through other sources or through user charges;
- costs which are offset through non-operating income;
- costs which are in excess of reasonable levels; and,
- costs which are unrelated to the care of medicaid patients.

An average of $35,850 was disallowed for each of the 67 facilities reviewed by JLARC. The reasons for these disallowances were analyzed and a total of 95% of the disallowance was clearly proper. The remaining 5% are potentially unreasonable disallowances, such as the cost of telephone service for medicaid patients, but these represent only a fraction of one percent of total claimed costs. The four major categories of medicaid disallowances, and the justifications for each category, are included in Table 12. The table shows that the disallowed costs should not be considered part of medicaid patient care or, in the case of drugs and therapies, are billed separately for medicaid eligible patients.

Figure 3

COMPARISON OF SEVEN REPRESENTATIVE
PER DIEM RATES (1972-1977)



Source: JLARC.

There are only two exceptions to total reimbursement of true cost. First there is a ceiling on per diem payment equal to 150% of the Statewide average for all facilities. However, VMAP indicates that only a few facilities exceed the ceiling, generally during the first year of operation when start-up expenses and lower occupancy combine to drive up costs. Only one of the 67 facilities reviewed in the cost analysis exceeded the ceiling and then only by 7%.

The second exception is a requirement that medicaid reimbursed costs be equal to or lower than charges applied to private patients. If costs exceed charges medicaid will pay only the lower charge regardless of true cost. The review found that about 10% of the facilities in the cost analysis were receiving less than their allowable cost for 1976 due to having their costs above charges. However, medicaid guidelines allow nursing homes to recover this loss over a two to five year period. In one case reviewed by JLARC, this recovery allowance totaled $65,000 for 1976. It is evident that neither of the two exceptions to full cost reimbursement is a significant problem for nursing homes, and that reimbursement of most costs related to medicaid patient care is virtually guaranteed.

Table 12

MEDICAID COST DISALLOWANCES
BY TYPE AND PERCENT OF TOTAL

Category of Claim	Justification for Disallowance	Percent of Total
Drugs, physical and other therapies, medical services, employee and guest meals, laundry services.	The cost of these services may be billed separately through medicaid or user charges.	45%
Costs for other related facilities such as a home for adults, bad debts, penalties, income taxes and owner's life insurance premiums.	These costs are not related to the care of medicaid patients.	22%
Owner's compensation and rentals paid to related parties.	These costs are only allowable up to a reasonable limit specified in the medicaid guidelines.	18%
Discounts, rebates commissions, rental and interest income.	Income earned from other than patient care reduces the real cost of operation and must be deducted from cost.	10%
Total		95%

The average disallowance per facility was $35,850.

Source: JLARC Cost Analysis.

Economic Benefits of Medicaid Reimbursement

In addition to reimbursement for operating costs, providers receive both direct and indirect economic benefits from medicaid. These benefits, in combination, account for the rapid growth of the nursing home industry in Virginia. However, direct profits, particularly from medicaid reimbursement, are small. Instead, most of the economic benefits are indirect, less visible, and difficult to control.

Proprietary facilities receive a direct profit from private patients and medicaid. The typical proprietary nursing home charges private patients from $2 to $5 per day more than the cost of providing care. Medicaid includes a direct profit allowance in its reimbursement which is equivalent to a 10% return on the owner's investment (computed as 10% of the average equity capital held during the year).

Overall, JLARC estimates that intermediate care nursing homes which participate in the medicaid program realized a direct operating profit of about $3 million in 1976 from both private and medicaid patients. Of this amount, Medicaid's allowance for a return on equity totaled about $1.2 million, or about $15,300 for each proprietary facility. This amounts to a direct profit of $.50 per day for medicaid patients compared to several dollars per day for private patients.

Virginia nursing homes receive one of the highest average per day rates in the country. The JLARC review found that in general:

- *providers are reimbursed for the true cost of nursing care;*
- *a number of economic benefits available to the nursing home operator from medicaid make private investment attractive; and*
- *the present reimbursement system has provided sufficient development capital to support a rapid growth of the industry.*

It might be expected that proprietary homes would limit their participation in medicaid, since private patients are the source of greater profits. However, as indicated by Table 13, both proprietary and nonprofit homes are equally dependent on medicaid patients. The high proportion of medicaid patients in proprietary facilities suggests that there are other economic benefits available to the private owner from the medicaid program which encourage participation.

Four indirect benefits were identified during the review--nursing home franchising, owner compensation, growth and development payments, and depreciation allowance. These benefits substantially outweigh the return available from medicaid's direct profit allowance and account in large part for the high rate of participation in medicaid.

Table 13

MEDICAID PATIENT-DAYS OF CARE AS A PERCENT OF ALL INTERMEDIATE CARE IN CERTIFIED FACILITIES (1976)

Percent of All Care Provided to Medicaid Patients	Proprietary Homes	Nonprofit Homes	Total
Under 40%	5	0	5
40% to 64%	9	3	12
65% to 90%	26	9	35
Over 90%	11	3	14
Total	51	15	66[1]
(Average)	(81%)	(74%)	(75%)

[1] One nursing home had incomplete data.

Source: JLARC Cost Analysis.

Franchising of LTC. The State provides nursing homes with a large steady cash flow and protection from excessive competition through the certificate of need requirement. Medicaid provides a stable funding source which in effect guarantees that the operator's costs will be reimbursed for three-quarters of his patients. An estimated 56% of the owner's costs will be reimbursed directly by VMAP and an additional 19% will come from patients who require medicaid assistance in order to remain in a nursing home. These costs are generally covered in full regardless of management efficiency, inflation or other economic trends. The guarantee that 75% of cost will be reimbursed amounted to an average income in 1976 of $700,000 per facility for medicaid patients, of which approximately $520,000 is paid directly from the medicaid program.

The value of medicaid's reimbursement of operating costs lies in the fact that without medicaid few nursing homes could operate at all due to the limited number of patients who could afford the high cost of nursing care. Essentially, medicaid subsidizes facility operation and allows the nursing home to make a profit of up to $5 per day from the relatively few private patients who can afford nursing home care.

In addition to guaranteed cost reimbursement, the State, through its certificate of need legislation, prohibits excessive competition between providers. Nursing home owners require a certificate of need prior to construction. The certificate of need program is designed to control health care costs by preventing the oversupply of health care services in excess of actual need. However, certificate of need legislation also makes it likely that a provider will not face local competition in excess of demand. Intermediate

facilities in Virginia presently operate at an average of 97% occupancy which can be expected to continue under certificate of need requirements. The combined effect of medicaid payments and certificate of need requirements amounts to a State franchise of nursing homes with guaranteed cost reimbursement and limited competition.

Owner Compensation. Salaries drawn by owners for administrative services are a substantial part of medicaid reimbursed cost for many nursing homes. Medicaid allows owners to claim compensation for necessary activities such as administrative and legal services which are performed by the owner. This compensation is allowable within limits set by the federal Bureau of Health Insurance and adopted by VMAP. Medicaid allowed an average of $25,000 per facility in 1976 for those owners who claimed compensation as a reimbursable cost. This income is available to the proprietary provider regardless of whether the business is showing a profit or loss.

A second source of direct income for some facility owners is compensation drawn by officers of multifacility corporations. Corporate officer salaries are passed on to medicaid through home office costs which are allocated to subsidiaries. These salaries are allowed by medicaid at levels well above those applied to single facility owners. As a result, corporate officer salaries allowed by medicaid may be much higher than the direct compensation paid to owners. In one case the president and principal stockholder of a multifacility Virginia corporation claimed $182,000 in medicaid reimbursable salary in 1976. Two other officers of the corporation claimed another $94,000 in salary. Under the current guidelines $219,000 of this total was allowed for medicaid reimbursement.

Medicaid Growth and Development Payments. In April, 1973, VMAP initiated a system of bonus payments to nursing homes as an incentive for growth. This "growth and development" bonus was recommended by an ad-hoc committee which reviewed proposals submitted by the nursing home industry. The bonus payments were initiated without consideration of the development capital which is available through standard cost reimbursement. A federal audit of Virginia nursing home costs conducted for the period June, 1972-June, 1974 found that the growth and development payment of $1.50 per patient day had been instituted without consideration of need or reasonableness.

The federal audit did not question the State's right to include such a bonus payment, but did find that the increase was made without sufficient analysis and without demonstrating that the bonus was justified.[5] The bonus payment of $1.50 per patient day was continued from April, 1973 until April, 1975 when it was suspended due to a lack of medicaid funds. The SDH appropriation for FY 1977 included $1,048,000 to fund a $1.00 per patient day growth and development bonus. However, an HEW ruling in July, 1976, declared that such payments did not constitute a reasonable cost under medicaid. The FY 1977 appropriation was not released for payment and was eventually reappropriated by the General Assembly to cover a projected

deficit in the medicaid program which would have resulted from a decrease in federal matching funds during FY 1978.

SDH justified its original use of a growth and development payment by citing the lack of nursing facilities available in 1973. Virginia was and remains short of nursing home beds by even the most conservative estimates of need. However, the same factors encouraging private investment that were cited in the previous section were present in 1973, therefore, it is questionable whether growth and development payments were necessary to encourage development. VMAP should not consider the inclusion of any future growth payments in its medicaid reimbursement system.

Depreciation. The fourth indirect economic benefit for nursing home operators is net income available from medicaid payments for property costs, particularly for depreciation. Depreciation is considered a business cost in recognition of the declining value of property or equipment due to age or obsolescence. It is important to emphasize that in most cases depreciation is a write-off against income. However, in the nursing home industry depreciation payments add to working capital and can be used for expansion, development and for a return on investment. Reimbursement for claimed depreciation expenses cost the medicaid program over $2.5 million in 1976 and averaged $41,644 per facility for the 67 nursing homes included in the cost analysis.

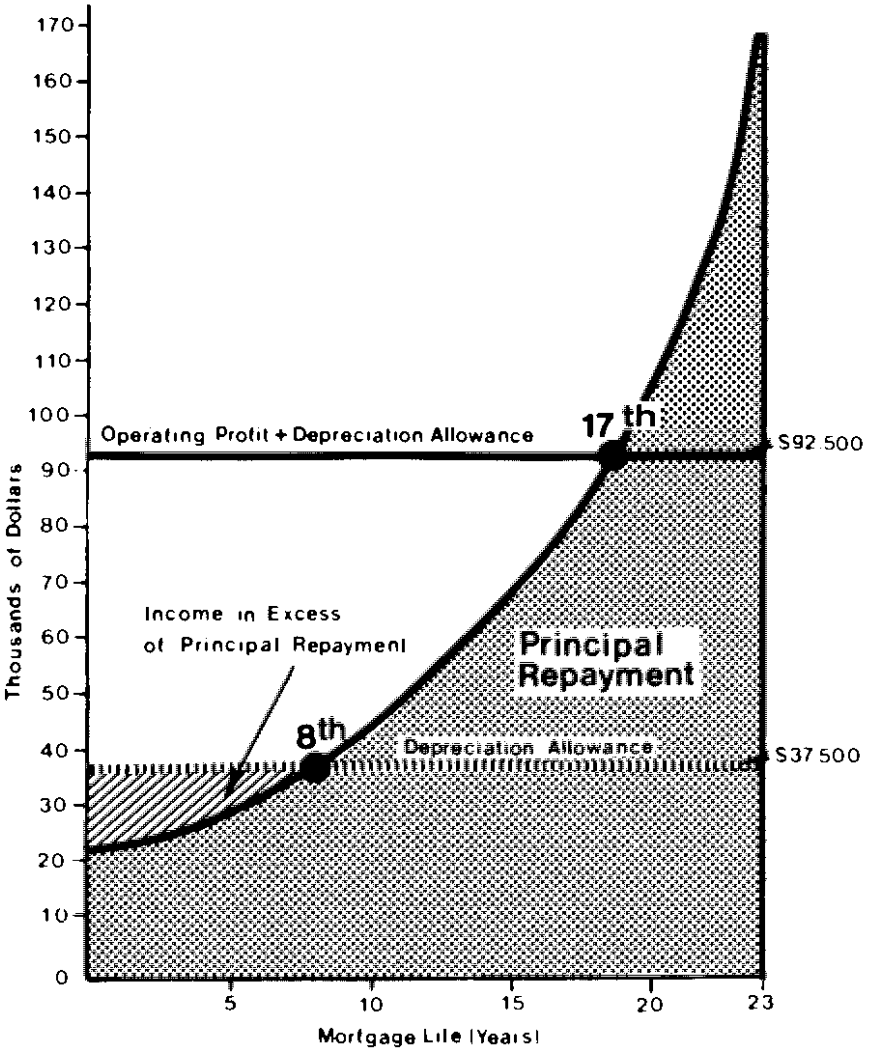
The most comprehensive evaluation of medicaid property reimbursement practices was done by New York State's Moreland Act Commission. The commission used a computer model to assess the expected rate of return on nursing home investment as a result of medicaid reimbursement for depreciation, taxes, and interest. The commission's report documented that a substantial cash inflow is available from sophisticated manipulation of medicaid reimbursement regulations. Key findings of the report were:

- since interest and taxes are fully reimbursable under the medicaid program, they are of little concern to the owner of a predominately medicaid supported facility;
- the owner's principal repayment through the early years of a nursing home mortgage is small, while depreciation can be straight-line (spread out equally over the life of the mortgage) or accelerated (concentrated in the first few years);
- the only real concern for the owner is the ratio of the principal repayment to the depreciation allowance available from medicaid; and
- the difference between principal repayment and the medicaid depreciation allowance represents a net cash inflow for the nursing home owner.

Figure 4 represents these relationships graphically. The graph is adapted from a principal repayment schedule used in the New York report. This hypothetical example shows a standard principal

Figure 4

COMPARISON OF MORTGAGE PRINCIPAL REPAYMENT
WITH DEPRECIATION ALLOWANCE AND OPERATING PROFIT*



*Based on 75% medicaid occupancy

Source: JLARC

repayment schedule for a nursing home valued at $2 million over a 23-year, 80% mortgage. The curved line represents the repayment schedule. The shaded area under the curved line is the total amount of the mortgage--$1.6 million. Each month for 23 years the owner must make a mortgage payment. In the beginning, almost all of the monthly payment goes toward paying the interest, the price the owner must pay to use the money. Gradually, an increasing amount of the monthly payment goes toward the principal. Thus, each month the owner reduces the amount owed the lender until, after 23 years, the owner owes nothing on the principal.

Also, it is assumed that the nursing home owner is depreciating the total value of his property and equipment ($2 million) on a straight-line basis over the expected life of the nursing home--40-years. This amounts to $50,000 per year. However, medicaid only reimburses an owner in proportion to the amount of total patient care provided to medicaid patients. Therefore, the owner's depreciation allowance depends on the medicaid occupancy rate. Assuming that 75% of the home's patients are receiving medicaid assistance, the owner could claim a depreciation allowance of $37,500 per year during the entire life of the 23-year mortgage. This allowance is represented by the dashed line in Figure 4.

The New York study found that the nursing home owner is concerned about the ratio of the principal repayment to the depreciation allowance available from medicaid. As illustrated in Figure 4, during the first few years the owner receives more from the medicaid depreciation allowance than is necessary to repay the annual installment on the principal. This represents a net cash inflow to the nursing homes. However, between the 5th and 10th year the principal payment would begin to exceed the medicaid depreciation allowance. At this point, the owner would no longer enjoy a cash inflow.

Thus far, only the cash income available from medicaid's depreciation allowance has been considered. However, a more realistic situation is to add operating profits from private patient charges and medicaid's return on the owner's equity to the depreciation allowance. By including operating profits in the analysis the owner experiences a cash inflow over a longer period of time. For example, the typical proprietary facility reviewed by JLARC had an operating profit of about $55,000 (from private and medicaid patients and other sources). When this amount is added to the claimed depreciation allowance of $37,500, the total annual cash income available to the owner becomes $92,500. As shown in Figure 4, sometime during the 17th year of the mortgage schedule the principal payment exceeds total income from the depreciation allowance and operating profits.

Assuming that the principal payment exceeds cash inflow during the 8th and 17th year the owner is faced with several possible business options:

- he can refinance to obtain a new principal repayment schedule;
- he can draw on other assets to meet principal repayment requirements; or
- he can sell the facility (in which case the new owner establishes a new depreciation schedule and begins the cycle again).

Virginia's medicaid program prohibits refinancing so this is not an available option. Selling the facility will mean that a new depreciation schedule will be established which will put the facility back in a net cash inflow situation. Since drawing on other assets is not desirable the owner will be under great pressure to sell the facility. This pressure, probably more than any other factor in nursing home administration, accounts for the frequent turnover in facilities which has characterized the industry in other states.

Since Virginia's stock of nursing homes is newer than other states, this turnover has not yet occurred. However, under current medicaid regulations, and with rising costs reducing the number of elderly who can afford private care, it is likely that the State's nursing home owners will reach a point at which property transfer becomes a virtual necessity.

Since Figure 4 is based on overall averages, the owner's decision point will vary by facility and may occur substantially sooner than the 8th and 17th year. Also, the graph shows operating income as a constant when it will vary with the profit available from private patients, the proportion of private patients and the medicaid computation of owner's equity. However, the figure illustrates that medicaid's depreciation allowance will exceed principal repayment during the first part of a standard mortgage and that the difference can be a substantial source of additional income for proprietary owners. In the example case the value of this income would be over $62,000 in seven years.

The Moreland Act Commission estimated that an owner who took full advantage of the medicaid reimbursement system, including the depreciation allowance, could receive an after-tax profit of up to 30% annually providing he sold the facility at the most advantageous time. Since these computations were based on New York regulations and laws, they are not directly applicable to Virginia. However, several case studies developed by JLARC indicate that the same benefits identified by the Moreland Act Commission are available in Virginia, and that these benefits can exceed the direct profit incentives built into the medicaid reimbursement system.

Case A

...A 120-bed two-owner facility operating at 99% capacity with 79% of all care covered by medicaid. The facility reported net after tax earnings from operation of $74,365 (6%) on total revenues of $1,237,570. Interest of $91,355 and depreciation of $60,345 were allowed by medicaid. Since 79% of all care was provided to medicaid eligible patients, the portion of total depreciation reimbursed by medicaid was $47,673.

During the year the owners paid only $8,367 toward the principal. Since mortgage interest is fully reimbursable under medicaid, the $8,367 represents the total real outlay for the facility's long-term debt. If this outlay is subtracted from the medicaid depreciation allowance, the owners realized a cash inflow of $39,306. This money represents an increase in working capital that can be used by the owners for investment, personal drawings, or to reduce other liabilities.

Case B

...A four-facility partnership owned by three individuals. The four facilities operated at 96% capacity with 86% of all care provided to medicaid patients. The facilities reported income from operations of $161,790 (2.6%) on total revenues of $6,166,303. However, the four facilities also reported an increase to working capital of $749,392 which included $166,703 which was withdrawn by the partners during 1976.

The majority of this increase - $414,318 - was from depreciation on the facility and fixtures. The medicaid program reimbursed the owners for 86% of the depreciation or $356,313. The owners paid only $80,429 toward the principal. When the principal is subtracted from the depreciation reimbursement the owners derived a cash inflow of $275,884. This figure should be compared with the total payment received by the four facilities under the owner's equity rule described earlier. The equity capital payment, designed as the primary incentive for proprietary participation in the medicaid program, totaled only $54,400 for the four facilities. In other words, medicaid reimbursement for depreciation provided five times as much income as the direct profit payment allowed by medicaid.

Case B also illustrates a benefit of medicaid depreciation which is available to multifacility corporations. Working capital received through medicaid depreciation reimbursement can be used to reinvest in other facilities through intercompany transfers of funds. This practice, commonly known as "pyramiding", is similar to

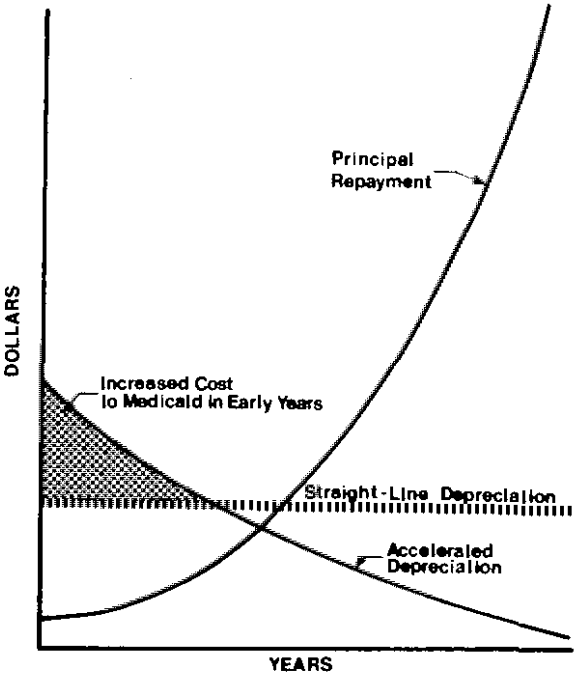
any business expansion except that the necessary cash flow comes from depreciation reimbursement rather than operating profits.

By using a straight-line method of depreciation, owners of nursing homes have a steady source of income over a number of years. However, according to VMAP, one nursing home recently began claiming depreciation expenses on an accelerated basis which concentrates most of the depreciable amount in the first few years of a nursing home's life. Accelerated depreciation is used by business to account for the fact that some assets, primarily machinery and vehicles, are more productive when they are new because mechanical efficiency declines with age, and because of an increased chance for more rapid obsolesence.

Nursing home assets are primarily buildings and fixtures so there is little reason for claiming accelerated depreciation. Accelerated depreciation will result in a shift of the depreciation allowance and greatly increase the size of the net cash inflow in the early years (Figure 5). As a result, the cost of medicaid reimbursed nursing care will increase. This increased cost is not justified given the nature of nursing home fixed assets.

Figure 5

DEPRECIATION PAYMENTS UNDER
STRAIGHT-LINE AND ACCELERATED METHODS



Source: JLARC

VMAP should not allow accelerated depreciation as a reimburseable expense but instead should continue straight line depreciation for medicaid reimbursement purposes. Mandating straight line depreciation may require HEW approval but is clearly in keeping with the most recent federal guidelines on medicaid cost control.

Property Valuation

The economic benefits of property cost calculations, including depreciation, can result in this aspect of medicaid reimbursement being one of the most commonly abused areas in the nursing home industry.[6] Although the manner in which depreciation is allowed can control some of the potential abuse, the underlying issue is the way in which property is valued because depreciation, rent and interest are all based on the established value of the asset.

Virginia currently establishes property values based on construction costs for new facilities and requires an independent appraisal for nursing homes which are sold. The latter part of the VMAP policy has not yet been tested because medicaid participation in funding intermediate nursing care, and the resulting rapid growth of the industry, has occurred only over the last four years. Since the majority of Virginia nursing homes are still operated by the original owners, most property valuation is based on original construction costs. According to VMAP they have not yet had a property appraisal due to a transfer of ownership, although several facilities have recently been transferred and an appraisal will be required.

Virginia's current property valuation system is adequate only as long as most facilities are relatively new and recent construction costs are available. As the existing stock of nursing homes ages and facilities reach the decision points illustrated previously in Figure 4, property valuation could become an increasing problem. Already some of the State's older nursing homes have gone through several ownership transfers which raise questions about the validity of property valuation. One such case is described in the following case study.

Case C

> *...A Virginia facility was purchased in 1963 for $475,000 and opened for business as a nursing home. It was sold in 1967 for $600,000 and again in 1968 for $1.9 million despite the need for an additional $400,000 in renovations. All of the transactions involved related parties, and the mortgages on the property were held by related corporations. The facility was then leased and subleased--again to related individuals. The records indicate that these transactions were probably not arms-length and were designed to artificially increase the value of the nursing home property.*

Although these transactions occurred before VMAP assumed responsibility for intermediate nursing care reimbursement, they highlight the dangers implicit in medicaid property valuation.

Several alternatives to the present method of valuing property have been proposed for use in other states. Two such alternatives are described below.

IMPUTED RENTAL METHOD. Depreciation, interest, rent and other related costs are deleted from the cost analysis. In their place a rental factor is used to establish annual reimbursement.

New York sets this rental factor equal to 80% of the maximum observed arms-length rentals paid in each region of the state. This approach has the weakness of depending on an arbitrary maximum rental, and is subject to abuse if it becomes difficult to establish the arms-length nature of a transaction.

Washington State is presently developing an imputed rental formula which would use a statewide panel to set a value on facility space based on what it would cost to reproduce the asset at current prices. This reproduction cost is then decreased by the observed depreciation of the facility as calculated by an appraiser.

The use of appraised depreciation has the major advantage of encouraging proper maintenance since higher appraised depreciation would lower property cost reimbursement under medicaid. This method has the disadvantage of depending on a panel to establish reproduction costs, although current construction costs for new facilities would serve as a benchmark.

FAIR RENTAL METHOD. The fair rental system was developed by New York's Moreland Act Commission on Nursing Homes. This system is also used in New York and was recommended, with some reservations, by Connecticut's Blue Ribbon Committee which investigated the nursing home industry in that state.

This system would establish a fixed return on property costs based on the equivalent of what would be necessary to fully amortize the cost of the facility over a 40-year usable life. The fair rental system differs from the imputed rental method in its emphasis on the stability of property cost.

Under the fair rental system, adjustments to the fixed return could occur only every ten years, and the asset could not be revalued over the entire 40-year usable life. This control would effectively prevent abuse through property transfer or sale but could discourage a legitimate buyer from investing in a property which was locked into a fixed depreciation schedule. Despite its potential drawbacks, the fair rental system has been endorsed by HEW as one acceptable method of property valuation.

These alternatives have weaknesses which would have to be addressed by VMAP before implementation would be feasible. However, both have the major advantage of standardizing property cost reimbursement and thereby removing the incentive for manipulating property values. VMAP should study the feasibility of various property valuation alternatives with the expressed intention of adopting a standardized property value allowance based on independent appraisal and some measure of replacement cost.

Rate Setting Options

The State has substantial flexibility in establishing its reimbursement rates under medicaid. Presently VMAP uses a retrospective system of reimbursement. But interest in a prospective approach is growing, and one such proposal has been submitted by the Virginia Health Care Association to VMAP for review.

Retrospective Versus Prospective Rate Setting. A retrospective reimbursement system settles on a final payment rate for each provider at the end of the provider's fiscal year and following a VMAP audit. However, the retrospective system has several weaknesses: (1) neither the provider nor VMAP knows what the final payment rate will be which makes budgeting difficult, (2) it is more difficult to control questionable nursing home expenditures after-the-fact, and (3) there is a general lack of efficiency incentives.

The only efficiency control currently in use is the payment ceiling equal to 150% of the Statewide average cost. This ceiling is rarely reached and serves only to prevent grossly disproportionate expenditures. Otherwise, the retrospective cost reimbursement system compensates owners for all costs regardless of whether the same level of care could have been purchased more cheaply. Since the return on equity capital is also fixed and bears little direct relation to cost, there are few efficiency incentives under the existing system.

The recognized weaknesses of retrospective systems have led to various proposals for change which involve setting rates in advance based on prior costs. Such a prospective system would determine what rate will be paid to each provider at the beginning of the fiscal year. Costs in excess of the set rate would be absorbed by the provider, but lower than projected expenditures would generate additional profit for the nursing home.

VHCA Proposal. The Virginia Health Care Association has developed a proposed prospective reimbursement system which is under study by VMAP. The proposed system has several major points:

- an incentive factor, based on operating costs other than property-related expenditures, would be available for all facilities which kept costs at less than 135% of the Statewide average;

- depreciation would be limited to $18,000 per bed for new construction;

- rents would be limited to 14% of appraised value;

- a cost-of-living index would be used to account for inflationary trends; and

- rates would be subject to renegotiation if "substantial" changes took place which would effect provider cost.

The incentive factor proposed by the VHCA would have meant an estimated $2.1 million in additional 1976 medicaid payments to the 67 facilities reviewed by JLARC. Incentive payments would have ranged from $0.23 per patient day to $1.85 per day, and only 5 of the facilities would not have received some sort of an incentive payment. This indicates that the bonus ceiling of 135% of the Statewide average would affect only a few facilities.

The adoption of a prospective rate system with an incentive factor would substantially increase the profit opportunity available to nursing homes. A typical proprietary nursing home which operated at $1.50 to $2.99 below the Statewide average would receive an incentive payment of $55,500 from medicaid in addition to the average $15,300 from medicaid's direct profit allowance. Income would also be available from the medicaid depreciation allowance, as was described earlier, and from any difference between actual costs and the prospective rate. All income from medicaid is in addition to any profits realized from private patients. The reimbursement system proposed by VHCA would not penalize inefficient operators other than to deny them an incentive bonus.

In order for the proposed system to benefit VMAP the incentive factor would have to cause nursing homes to hold down cost increases below what they would have been under the existing system. VMAP conducted a small pilot study based on 20 facilities which suggested that there would be cost savings after the first year of the new system. However, only actual experience will determine whether overall cost savings are available. A 3% annual reduction in the overall rate of cost increase could offset the $2.1 million additional medicaid payment for an incentive bonus; any greater reduction would amount to a savings for VMAP. If a proposal similar to the one now under consideration is adopted, VMAP should conduct annual analyses to determine whether cost increases are being slowed as a result of the incentive payment. Failure to keep cost increases down would be justification for eliminating the efficiency bonus.

A major weakness in the proposed VHCA system is the lack of any relation to incentives for quality of patient care. The proposed incentive factor is based exclusively on cutting costs below that of other nursing homes, although homes which cut costs more than $3.00 per day below the Statewide average do not receive as large an incentive as those ranging from $1.50 to $2.99 below the average.

Other states and HEW have stressed that payment incentives are best used when linked to quality of care measures and/or the expansion of available services in the facility. The VHCA proposal would be a disincentive to expand or upgrade care beyond what is necessary to meet minimum licensure and certification requirements. Adoption of the system would place additional responsibilities on SDH licensure and medical review inspectors who would be called upon to ensure that cost cutting was not done at the expense of the nursing home patient.

A second weakness in the proposed system is a clause which allows renegotiation of rates if substantial changes occur which could effect provider costs. While some flexibility should always be maintained in a rate setting system, the type of situation which would justify renegotiation should be clearly defined. Any prospective rate setting system involves a risk to the nursing home. VMAP should not be expected to guarantee nursing home costs in the event costs exceed rates except in cases where an unforeseen development would clearly affect a major segment of the industry.

Overall, prospective rate setting and efficiency incentives are preferable to the present rate setting policies of VMAP. However, any system which does not relate incentives to quality of care as well as efficiency of operation is inadequate for permanent use. Measuring quality of care in a standardized manner has not been perfected nationally, and those states which do use some kind of quality incentive in reimbursement acknowledge that their systems are still in the developmental stage. VMAP should explore alternatives for measuring quality of care in a standardized manner with the goal of adopting an incentive system based on both quality of care and efficiency of operation as soon at it becomes feasible. This might include a system of rating facilities such as is described in the following chapter.

COST REPORTING, AUDITING AND ANALYSIS

VMAP is responsible for ensuring that payments made to nursing homes are in accordance with a reasonable cost-related reimbursement system, including policies and procedures for controlling costs. JLARC found that several areas need strengthening to ensure that expenditures are controlled as required by VMAP reimbursement guidelines.

Cost Reporting

Nursing homes which participate in the medicaid program are required to submit an annual report of costs incurred and enough supporting information for a desk audit to be performed. This cost report serves as a basis for final settlement of medicaid payments. In the past, VMAP has contracted with auditing firms to perform field audits. However, recent changes in federal regulations have encouraged states to assume the field auditing function. VMAP began field auditing in the fall of 1976 although the program has retained contracts with two private accounting firms to provide some auditing support through March, 1978.

The cost report, and the desk and field auditing based on it, are essential to cost control. However, the cost reports received by VMAP do not always provide adequate information for cost control and, in some cases, cost reports are incomplete or misleading.

Cost Reporting System. A major problem with the cost reports reviewed by JLARC was the lack of a uniform chart of accounts which standardizes cost reporting by category of expenditure. Many reported costs were not comparable among facilities. For example, utility expenses were included alternatively in the administration and plant operation categories. One 230 bed facility failed to report salary expenses by category as required in the report, while another included salaries for all patient services except nursing under the general category of administration.

In an extreme example, four facilities reported virtually all of their expenses including nursing, maintenance, and other patient services under general administration. As a result of inadequate cost reporting, 7 of the 74 facility reports reviewed by JLARC were unusable for a cost analysis. These facilities claimed over $2.1 million in medicaid reimbursement in 1976, and it is questionable whether even extensive desk audits could validate their claimed costs as required for the VMAP reimbursement system.

VMAP recognized the need for a uniform chart of accounts and designed a system for implementation effective July 1, 1977. The first cost reports to be submitted under this new system will not be available for review until 1978. The uniform accounts standardize cost reporting and include a new supplemental schedule which will expand the detail required for reporting under the administrative and general cost category. VMAP should ensure that all providers adopt the uniform chart of accounts in order to provide comparative cost data for an adequate desk audit.

A second related problem with the cost reporting system is the failure of facilities to report costs or other data for all required categories. Reporting costs by category allows desk auditors to compare costs for the current and prior year as well as provide for comparison between facilities. Several cost categories

and data items were not reported as required. Table 14 shows those data items most often not reported.

Table 14

DATA NOT REPORTED ON COST REPORTS

Category	Number of Facilities Not Reporting
Plant maintenance	31
Plant operation	24
Raw food	20
Number of RN's	8
Most prevalent rate	7
Number of LPN's	7
Number of employees	7
Number of nursing aides	6
Depreciation	3
Administrative salaries	2
Laundry and linen	2

Source: JLARC Cost Analysis.

The cost of raw food per patient day can be used as a measure of the quality of patient care. Another statistic not uniformly reported is the number of licensed nurses (RN and LPN). This statistic is necessary to compute the amount of nursing care available per patient which is also used as a quality-related measure. Failure to report these data weakens the oversight capability of VMAP to control costs and ensure acceptable levels of care.

Financial Reporting. VMAP requires that each provider submit a facility balance sheet and a copy of a statement of income and expenses. Despite this requirement, 20 of the 67 facilities in the review provided only an unsummarized computer printout of a trial balance as financial documentation. Many of the providers which submitted only a trial balance were subsidiaries of multi-facility corporations which undoubtedly produce more complete financial documents for their own use.

VMAP should clarify and expand the requirement that adequate financial documentation be submitted. Each provider should submit (1) a balance sheet, (2) a statement of revenues and expenses, and (3) a statement analyzing changes in fund balance, along with all necessary supporting schedules. Computerized trial balances are inadequate without summary data of this kind. In addition, all providers which claim medicaid reimbursement in excess of some

specific amount, for example $250,000, should probably be required to submit a financial statement which is certified by an independent accountant.

Disclosure of Ownership. Nursing homes are required to disclose the identity of all persons who own 5% or more of the facility. Ownership disclosure is necessary to ensure that business transactions--specifically property sales, leasing and the purchase of goods and services--are arms-length transactions which do not provide improper benefits to related parties. Disclosure is required both by licensure regulations and for medicaid cost reporting. The review found that ownership disclosure requirements are not enforced. In one-third of the licensure applications reviewed by JLARC the required disclosure information was missing or incomplete. Disclosure information was also not adequately provided in cost reports and in many cases the information on the cost report conflicted with that on the licensure application.

Transactions Between Related Parties. Transactions between related parties are allowable for medicaid reimbursement provided the cost does not exceed the price of comparable services purchased elsewhere. This is generally referred to as the "prudent buyer" concept and is used in both medicare and medicaid cost control. Two of the cost reports reviewed by JLARC failed to disclose a transaction between related organizations. In one case, the value of the transaction was $97,500. There was no evidence that VMAP took punitive action in either case, and there are no standard sanctions available to enforce the disclosure requirement.

The review also found several cases in which transactions with related organizations were disclosed but no analysis was done to test the purchase against the cost of comparable services purchased elsewhere. In one case three nursing homes with common ownership purchased over $100,000 in nursing supplies from a firm which was entirely controlled by the nursing home owners. This fact was properly disclosed but no analysis was performed. Without such a test, the value of the disclosure requirement as a method of cost control is minimal. VMAP should routinely test all purchases from related organizations against a standard derived either from the cost reports or from a sample of prices for common items such as medical supplies.

Fifteen nursing homes included in the review leased their facilities and paid an average of $192,000 in annual rental costs. Reimbursement for rental costs paid to a related organization must also meet the prudent buyer test. In 12 of the 15 cases, rent was paid to a parent corporation while in two other cases the two parties appeared to be related. In addition, the owners of 8 of the rented facilities are known to have had common business interests in the past. In only two of the 15 cases was the lessor identified in the cost report as a related organization, and VMAP provider representatives expressed concern about whether the cost report adequately documented the relationship between lessor and lessee.

Although rentals allowed by medicaid are now in line with facility costs of provider-owned facilities, the medicaid program nationally has experienced widespread abuse in this area through excessive lease payments between related parties. VMAP should require all lessor organizations along with their primary stockholders to be identified on the cost report. In addition, desk audits should continue to closely review the facility cost of renters compared to provider-owned facilities to ensure the reasonableness of rental costs.

Owners Compensation. Compensation paid to proprietary owners for administrative or other services is controlled through the use of standard guidelines based on facility size. These guidelines range from $15,700 annually for a 50 bed facility to $53,400 for 250 beds. Owner compensation claimed in excess of the guidelines is not a reimbursable expense. Ceilings on owner compensation are a key means of cost control, with disallowances in 1976 ranging up to $40,000 for a single facility.

Providers who own more than one facility can claim salaries which are well above the guidelines for single facility owners. These costs are passed on to the medicaid program through separate corporations which sell management services to subsidiary facilities, or which allocate the cost of a "home office" among subsidiaries. Although medicaid recently established guidelines for these claimed costs, they are liberal. For example, the guidelines would allow corporate officers to claim salary costs through each subsidiary which are about equal to the amount medicaid allows in total for the owner of a single facility. Corporate officer salary costs are allowable in many cases in addition to the salaries paid to administrators employed by each facility.

VMAP's establishment of some guidelines for corporate officer salary costs is a positive step. However, continued review is necessary to ensure that the less visible salary costs of multi-facility corporate chains are not subject to abuse.

Depreciation Schedules. As discussed earlier depreciation costs allowable under medicaid are generally computed on a straight-line basis. However, the provider is not required to submit a depreciation schedule with the cost report. As a result, the desk audit cannot adequately assess whether depreciation is properly calculated and whether the facility is adhering to the schedule. A depreciation schedule for the building, fixtures and major items of equipment should be required for the cost report.

Interest. Medicaid allows reimbursement for interest expenses which are necessary for patient care and in line with the prevailing cost of borrowing. Facilities with high unexplained interest costs are requested to submit a list of creditors so that the desk audit can confirm the total. However, the provider is not required to submit written evidence that the interest was paid on

loans related to patient care. Such evidence is particularly important because of the potential for abuse in interest cost reimbursement. Without controls, an owner could borrow for investment and pass the interest cost on to medicaid. VMAP should require that all interest cost be thoroughly documented as to what the loan is for, what interest rates are charged, the duration of the loan and the creditor.

Cost Analysis

VMAP does not make full use of financial data as a cost control. Additional analysis and some standard decision guidelines are necessary to strengthen control over nursing home expenditures.

The desk audit compares the current year's operating costs for each facility with those of the prior reporting year. Costs are compared on the basis of 19 categories of expenditure in order to identify large unexplained changes within each category. However, the analysis is done independently for each facility with no routine comparison of cost variation by category among all facilities of similar characteristics. Cost analysis can be strengthened by combining a categorical analysis with the present desk audit approach used by VMAP. This dual approach to analysis would be more effective at identifying exceptional cost patterns.

Analysis of nursing home costs by category can provide greater insight into the reasonableness of costs claimed by the provider for reimbursement. JLARC analyzed the costs by category for 67 facilities and found substantially greater variation within categories than between overall per diem costs. Using one standard statistical measure, as much as $1.5 million in costs claimed by the 67 facilities could be excessive. Table 15 shows the range of per diem costs for each of eight standard categories, and the amount claimed which exceeds one standard deviation above the average for all facilities. The total of $1.5 million only suggests the magnitude of the potentially excessive costs and the need for additional analysis.

Under federal law VMAP could impose ceilings on per diem expenditures within each category in addition to the overall ceiling of 150% of the Statewide average which is now in use. However, automatic denial of claimed costs in this manner could limit VMAP's flexibility in determining reasonable reimbursement rates. Instead, VMAP should use a standard measure--for example, one standard deviation above or below the Statewide mean--as a threshold which would single out the facility for special review. Costs which are not fully justified can be disallowed for medicaid reimbursement.

Table 15

COST PER PATIENT-DAY BY CATEGORY OF EXPENSE

Category	Range Low	Range High	Average	Potentially[1] Excess Costs
Administration	$0.94	$ 7.52	$3.76	$ 107,640
Interest	0	5.48	1.13	494,911
Depreciation	0	3.33	0.96	128,310
Dietary	2.54	7.02	3.84	212,940
Housekeeping	0.43	2.44	1.33	147,030
Laundry	0.33	1.45	0.78	84,630
Nursing	6.25	16.07	8.54	241,020
Plant Operation	0.30	4.57	1.57	141,510
Total				$1,558,051

[1] Costs for each category in excess of one standard deviation above the mean.

Source: JLARC Cost Analysis.

CONCLUSION

Medicaid is the primary source of payment for intermediate nursing home care in Virginia. Without medicaid, few nursing homes could continue to operate, resulting in an acute shortage of long term care facilities for the elderly. Therefore, the development of an efficient and effective reimbursement system is of great importance to the nursing home industry and the State. Such a system must be cognizant of two factors: (1) the unique relationship that exists between the public and private sectors in providing long term care services; and, (2) the need to maintain a balance between economic benefits, quality care and operational efficiency.

The rapid expansion of nursing home beds since 1970 is clear evidence that medicaid reimbursement has been sufficient to encourage investment and growth. Private investment has come about through a combination of attractive economic benefits, both direct and indirect, which have been available from medicaid. Although these benefits have provided a stimulus to nursing home development, they have done little to foster operational efficiency. VMAP must now concentrate on developing incentives to encourage efficiency and overall cost control.

In order to ensure an adequate supply of nursing care at reasonable cost, the State should look to a revision of the medicaid reimbursement system. Of greatest importance for a revised system

is an efficiency incentive which links profits, good management and quality care. The wide variation in cost which characterizes nursing homes in Virginia is itself evidence of the need for greater public attention, and the need to fully explore ways to realize cost savings. Presently, efficiency is not encouraged because profit for nursing home operators is not related to management. For example, both the medicaid direct profit allowance and the "growth" bonus paid from 1973 to 1975 are computed on a fixed basis and are essentially unrelated to operating costs. Substantial economic benefits are also available through manipulation of costs for depreciation, owner's compensation and property valuation regardless of management efficiency. In no case is good management rewarded or poor management penalized.

The development of an efficient and effective reimbursement system is of great importance to the nursing home industry and the State. Such a system must be cognizant of two factors: (1) the unique relationship that exists between the public and private sectors in providing long term care services; and, (2) the need to maintain a balance between economic benefits, quality care and operational efficiency.

SDH should take a much more active role in developing a revised medicaid reimbursement system for nursing home care. The VHCA proposal presently under consideration has merit but also has several weaknesses including inadequate controls to ensure that efficiency is not achieved at the expense of the quality of patient care. Some improvements, such as prohibiting accelerated depreciation and tightening existing controls, can be undertaken immediately. Other changes, such as the method of establishing property values, will require study by SDH prior to making any permanent change in the existing reimbursement system.

III. Nursing Home Quality of Care

The quality of nursing home care has been a matter of tremendous public concern at the national level. Congressional hearings, newspaper articles and books written by employees and others associated with nursing homes have often portrayed the quality of patient care as inadequate, and nursing home administration as insensitive to the needs of the disabled elderly. In Virginia, evidence suggests that the quality of nursing home care is generally good. However, there may be as many as 21 facilities which are providing only marginally adequate care.

The combination of licensure and medicaid certification requirements provide generally comprehensive guidelines for quality oversight. A need exists, however, for more specific standards and additional enforcement sanctions. Also, the system for processing and resolving patient complaints must be better defined and organized.

In Virginia, evidence suggests that the quality of nursing home care is generally good.

This chapter examines several key aspects of nursing home oversight including quality of care, standards setting and enforcement, patient complaint resolution, review of medicaid patients, and facility rating.

Quality of Care

A comprehensive evaluation of nursing home quality has never been done in Virginia. Therefore, JLARC had to rely primarily on surrogate measures to carry out its assessment of nursing home quality.

Measures of Quality. Seven measures were used to develop an overall assessment of quality of care in Virginia nursing homes. They include:

- number and type of licensure deficiencies;
- medical review deficiencies;
- nursing hours per patient day;
- raw food expenditures per patient day;
- complaints made to the State Department of Health;
- facility rating by local welfare office staff; and
- interviews with State personnel familiar with nursing homes.

These measures were derived from four principal data sources: SDH files, statistical data, survey responses, and interviews. Data from files and statistical measures of quality, such as raw food expenditures and nursing hours, were useful in determining averages and extremes, and in raising questions about the adequacy of care.

The observations of persons who are familiar with nursing homes in the State were then used to refine the file data, and to balance the statistical measures with more intangible elements of quality such as the overall condition of the facility or attitude of the staff. Observations were obtained through the JLARC survey of all local welfare offices and area offices on aging, interviews of State inspection and medical review personnel, and the nursing home ombudsman of the Virginia Office on Aging. In all, information was obtained from about 150 persons.

This information was then tabulated, focusing on the amount of agreement among observers regarding each facility and the agreement between observers and file data. Since the observations of even trained individuals are somewhat subjective, and file data is subject to interpretation, a high level of agreement is important in validating a finding based on these kinds of data. A more detailed description of the methodology for this analysis is included in the Appendix.

Assessment of Quality. The analysis found a high level of agreement among survey and interview respondents, SDH file data and statistical measures which indicates that, overall, the quality of care in Virginia nursing homes is good. This means that a nursing home patient can expect adequate care and reasonably pleasant surroundings. Unfortunately, it does not mean that individual cases of poor care do not occur, that all patients are satisfied with their care, or that additional attention to quantitative standards is not essential.

The analysis also found general agreement that between 12 and 21 of the 135 nursing homes are marginal. A marginal facility may meet the requirements for licensure but has numerous deficiencies which raise questions about the quality of care. Nevertheless, Virginia appears to be better off than many states in the quality of patient care provided in nursing facilities. This finding is especially important to the Commonwealth in view of the nature of the relationship between the public and private sectors in this sensitive human service program.

STANDARDS SETTING AND ENFORCEMENT

The high level of quality in Virginia nursing homes is due, in large part, to the standards which must be met for State licensure and for medicaid participation. The establishment and enforcement of licensure standards is the most important part of quality oversight. Licensure standards apply to all nursing homes and protect all nursing home patients. Therefore, adequate standards and effective enforcement are necessary if SDH is to successfully fulfill its oversight role.

Staffing Standards

Standards regulating the number of nursing staff required in nursing homes state only that a "sufficient" number of nursing personnel be employed to ensure complete, safe and efficient care of patients. There is no guidance in the regulations as to what constitutes a sufficient number of nursing staff.

The lack of specific standards has resulted in substantial variations in staffing patterns among Virginia's nursing homes (Table 16). A review of the 1976 cost reports found that nursing staff coverage per patient varied by as much as 273% among intermediate care facilities. Moreover, staffing levels ranged from a low of 1.78 hours per day to a high of 6.64 hours per day. This wide variation raises serious questions about the SDH decision to not develop some standard guidelines for assessing the adequacy of staffing.

Staffing and Patient Mix. According to State licensure personnel the principal purpose for having open-ended staffing requirements is administrative flexibility. The licensure bureau wants a certain amount of freedom to determine appropriate staffing on the basis of patient characteristics and nursing needs in each facility. Licensure personnel contend that patient characteristics vary substantially among nursing homes. Therefore, it would be a difficult task to standardize staffing levels, even as general guidelines for inspectors.

Table 16

STAFFING LEVELS IN INTERMEDIATE CARE NURSING HOMES, 1976

Nursing Hours Per Patient-Day[1]	Number of Nursing Homes	Percent
Less than 2.0	2	3%
2.01 to 2.5	15	24
2.51 to 3.0	14	23
3.01 to 3.5	8	13
3.51 to 4.0	11	18
4.01 to 4.5	7	12
More than 4.5	4	7
Total	61	100%

[1]Nursing hours per patient-day is a standard measure of staffing levels in nursing homes. It can be interpreted as the average number of hours of direct contact between a patient and all nursing personnel per day.

Range: 1.78 to 6.64 nursing hours per day.

Source: JLARC Cost Analysis.

In order to test this contention, the patient profiles (described on page 20) were used to establish the patient mix in each nursing home. A difference in patient mix, i.e., a concentration of more seriously disabled patients in one facility compared to another, could justify different staffing levels. The patient data were compared to three levels of daily nursing care--high, medium, and low care in relation to the Statewide average (Table 17).

If the type of patient determined the number of hours of nursing care provided, there would be a statistical association between patient type and the average number of hours of care. For example, a facility with a large population of severely disabled patients could be expected to have a high number of nursing hours. However, the analysis found no systematic association between nursing hours and the characteristics of patients in the nursing home.

For most measures of patient functional level there was no statistically significant variation among the facilities with high, medium, and low levels of nursing coverage. Where there was variation it did not appear to be related to staffing. The evidence

Table 17

NURSING HOURS PER PATIENT-DAY FOR SAMPLED FACILITIES

Category of Nursing Hours	Average of All Facilities	Average of Sampled Facilities	Sample Range	Number of Cases[1]
Low	2.22	2.22	2.02-2.47	9
Medium	3.02	2.83	2.52-3.09	10
High	4.31	3.72	3.16-4.36	9

[1]Thirty facilities were sampled but nursing hour data were not available for two facilities.

Source: JLARC Cost Analysis.

suggests that nursing coverage is not determined by the type of patient in the facility. The findings bring into question the VMAP contention that flexible standards are necessary in order to allow facilities to tailor their staffing levels to patient needs.

Need for Standards. It is clear that having insufficient staff could adversely affect the quality of care. But, as pointed out in Chapter II, staffing is also the key factor which accounts for the wide cost variation among nursing homes. Therefore, unnecessary staff are costly and result in needless expenditures for both the patient and medicaid. Without some standards it is impossible to determine whether 1.78 hours of nursing care per day is inadequate or 6.64 hours per day is grossly inefficient.

SDH should develop some standard level of staffing for intermediate and skilled nursing homes. Obviously, guidelines based on statistical norms are subject to error and should be judiciously applied. However, the wide variation in nursing hours per patient-day, and the fact that patient type does not appear to explain this variation, raise serious questions about the adequacy of staffing on the one hand, and the potentially inefficient and costly use of manpower resources on the other. SDH is in the best position to resolve these questions as part of its oversight responsibility.

Training of Nursing Aides

Nursing aides provide most direct care to patients, but they are often not well-trained. Nursing home administrators and registered and professional nurses must satisfy minimum State educational and experience requirements. However, standards are much less specific on the minimum training required for nursing

aides and orderlies. This is of particular concern because nursing aides provide about three-quarters of all patient care in intermediate nursing homes.

Inservice training programs for nursing aides are mandated by both federal and State regulations but there is only very general guidance as to the content of these programs. For example, there are no specifics on the number of hours required, the qualifications of the instructors or the nature of the training materials.

Standards for aide training are of concern because this area is often found deficient by SDH inspectors. As part of the evaluation, JLARC reviewed 77 SDH facility files which are representative of the inspection records for all intermediate nursing homes. Twenty-one of the 77 facilities had been cited as being deficient in inservice training by inspection personnel during 1976.

The qualifications of nursing aides were also cited as a problem by social service personnel. Thirty percent of all respondents to the JLARC survey of local welfare offices felt that nursing aides were not well trained. Moreover, nine localities cited specific problems with the morale, attitude and competence of nursing aides. In one instance poor attitude was said to have led to physical abuse of a patient.

Inadequate training may also be one cause of the very high turnover which is common among nonprofessional employees of nursing homes. According to the VOA nursing home ombudsman, annual turnover ranges as high as 75% in Virginia nursing homes. The provision of patient care in a nursing home setting can be difficult and unpleasant work. Any training program which does not stress the psychological and emotional needs of the elderly patient can create apathy among the nonprofessional staff and lead to unintentional neglect and abuse.

SDH should consider developing more specific standards for training programs and minimum qualifications for nursing aides. Minnesota currently requires all aides to complete a state-approved training program. There are already several good training programs in use in some Virginia nursing homes which could serve as models for a Statewide program. The cost of additional training is a medicaid allowable expense which could be passed on to the State. However, the key role that nursing aides play in providing quality care justifies an additional expenditure for their training.

Enforcement of Standards

State licensure standards are enforced through at least four inspections of each nursing home annually. SDH requires correction of deficiencies found during these inspections and may

impose a time limit for compliance. If necessary, SDH can revoke a facility's license but it has not done so to date.[1] SDH can also recommend that medicaid patients not be admitted to nursing homes which are out of compliance with federal medicaid certification requirements. This amounts to a moratorium on medicaid admissions. Other than license revocation or a moratorium on admitting medicaid patients, SDH does not have any intermediate sanctions to enforce compliance with State standards. Instead, SDH relies on a cooperative approach to standards enforcement and attempts to work with the facility in order to get deficiencies corrected.

Nature of the Deficiencies. All of the nursing homes examined in the review had at least one deficiency during the review period (January, 1976 to June, 1977). Table 18 shows the major types of deficiency and the average number per facility. There were an average of 23 deficiencies cited per facility during the 18 month period, with deficiencies of the physical plant and dietary operation accounting for about half of the total.

Table 18

INSPECTION DEFICIENCIES
(January, 1976 to June, 1977)

Type of Deficiency	Average Number Per Facility	Percent
Dietary	7.3	27%
Physical Plant	5.0	21
Housekeeping	3.0	13
Patient Records	2.0	9
Nursing Services	1.8	8
Drug Administration	1.7	7
All Other	3.5	15
All Areas	23.3	100%

Based on 77 representative facility files.

Source: SDH Licensure Files.

A shortcoming of the SDH inspection process is the failure to make a distinction regarding the seriousness of the deficiency. A deficiency in the administration of drugs and medication, for example, would certainly be more serious than chipped paint or a leaking faucet. Inspectors employed by the Florida Health Department routinely differentiate whether a deficiency is life-threatening, potentially life-threatening or minor. Although there was evidence in the SDH files that inspectors

recognize differences in the severity of a deficiency, there is no standard method of identifying various levels of severity. SDH also lacks guidelines for deciding which deficiencies warrant a follow-up inspection.

Timeliness of Correction. Facilities are usually required to submit a plan of correction to SDH for major deficiencies. Time limits are not always placed on the correction of deficiencies and, if imposed, are based on the judgment of licensure officials. The review found that half of all nursing homes had the same major deficiency reported in two or more inspections and, in several cases, the same deficiencies remained uncorrected for up to a year after they were first cited. The following case study illustrates that SDH can have major difficulty in obtaining correction of serious deficiencies over an extended period of time.

A large facility was inspected five times during the period May, 1976 to May, 1977. The inspections found the following serious deficiencies:

May, 1976: *Deficiencies were found in staffing, drug control, unsanitary tube feed ing equipment, excessive water temperatures at patient faucets and improper dietary control.*

July, 1976: *Deficiencies were again found with staffing, dietary sanitation and drug control.*

September, 1976: *Deficiencies were found in staffing, sanitation, fire safety, and care of incontinent patients. A plan of correction was submitted.*

February, 1977: *Deficiencies in staffing, sanitation and excessive water temperatures were again found. A second plan of correction was submitted.*

May, 1977: *A fifth inspection found that staffing, sanitation, preparation of therapeutic diets, and drug control were still deficient. A third plan of correction was submitted.*

The case study indicates that potentially life-threatening deficiencies went uncorrected for over a year despite five inspections and three plans of correction. The long delay in correction raises some serious questions about the cooperative approach of SDH toward standards enforcement.

Need for Intermediate Sanctions. The only two sanctions available to SDH are license revocation and placing a moratorium on medicaid admissions. These penalties are extreme because loss of a license or medicaid funds will generally force the nursing home to close or change its status to a home for adults. Also, closing a nursing home will surface the problem of where to house the displaced patients when there are already long waiting lists at almost all other facilities. SDH needs to have some intermediate sanctions which can force compliance with standards without the threat of closure.

Several states including California, Wisconsin, New York and Florida have developed a system of fines which are tied to the severity and duration of deficiencies noted in an inspection. Fining a facility for deficiencies might gain compliance without necessitating revocation of licenses or limiting admissions. Fines and penalty payments are not medicaid reimbursable and would have to be paid from the facility's operating profits.

Informal persuasion and cooperation with facility administrators is the most desirable means for ensuring that standards are met. However, revoking licenses or placing a moratorium on medicaid admissions are not realistic sanctions. SDH needs a better intermediate enforcement tool, and a fine and citation system linked to the severity of the deficiency appears to be a suitable alternative.

COMPLAINT RESOLUTION

Although licensure inspections are frequent, they are of short duration and generally occur during the day. As a result, problems with the care given to individual patients can be overlooked. Therefore, a workable and effective complaint resolution system is essential to ensure that nursing home care is adequate and appropriate. The nursing home patient "bill of rights", passed by the General Assembly in 1976, mandates that patients be able to make complaints openly and without fear of reprisal. Despite this legislative mandate a complaint resolution system does not exist in Virginia. Instead, there is widespread confusion about how complaints should be handled and which agency has primary authority for complaint resolution.

Existing Procedures

In 1976, the Virginia General Assembly enacted a Nursing Home Patients' Bill of Rights which specified the responsibilities and rights of patients in nursing homes. One of the rights is the prerogative of patients to voice grievances to staff or outside persons free from restraint, coercion or reprisals. Although State licensure regulations do not specifically include complaint procedures,

federal medicaid certification standards require that facilities must provide for the registration and disposition of complaints. Therefore, both State and federal policies recognize the need for an open complaint resolution system.

SDH has primary responsibility for complaint resolution because most complaints involve possible violations of regulations and, therefore, come under the jurisdiction of the State licensure bureau. The bureau investigates the complaints it receives. If the complaint is substantiated, SDH attempts to resolve the problem with the nursing home and correction is required if the home is found to be out of compliance with State standards.

Despite SDH's primary role in complaint resolution, many complaints are never received by the licensure bureau. The review found that local welfare offices receive a large number of complaints which are not referred to SDH. In 1976-1977 SDH received a total

The nursing home patient "bill of rights", passed by the General Assembly in 1976, mandates that patients be able to make complaints openly and without fear of reprisal. Despite this legislative mandate a complaint resolution system does not exist in Virginia.

of 52 complaints about the 77 nursing homes whose files were reviewed by JLARC. During about the same time period, local welfare offices received over 377 complaints about nursing home care. Even if complete duplication is assumed, it is clear that many persons are complaining to welfare but not to SDH.

Of even greater concern is the fact that welfare personnel have no set procedure for handling nursing home complaints. Some welfare offices refer complaints to the nursing home administrator, others investigate and try to resolve complaints themselves. Of the local welfare agencies receiving complaints only 10% indicated that they routinely referred complaints to SDH. The apparent lack of established procedures for handling complaints is also reflected in the local agencies' perception of the effectiveness of the existing complaint system. The welfare survey indicated that only

17% of local social service workers believe that an effective complaint system exists.

It is evident that procedures for handling complaints from nursing home patients or their families are weak or unclear. Although SDH has primary responsibility for standards enforcement, welfare offices, which receive most of the complaints, do not routinely refer them to SDH. As a result, SDH does not know about all nursing home complaints and, SDH files, which should be as complete as possible, do not accurately reflect the number of complaints which have been made about a facility.

Access to the Complaint System

A second problem is a possible lack of patient access to the complaint system. Most complaints come from the patient's family rather than the patient. Table 19 shows that of the 52 complaints received by SDH, only one came from the patient and that one reached SDH through the patient's attorney. The fact that almost all of the complaints come from third parties rather than the patients themselves may indicate that those individuals who do not have families or regular visitors are effectively isolated from the complaint process.

The mental and physical disabilities of nursing home patients makes it difficult for them to be able to register complaints, and complaints made by elderly and disabled patients may lack credibility with those who receive them. Also, there is still an apparent problem with patients being afraid to complain. Over one-third of the welfare survey respondents agreed that at least some nursing home patients continue to be afraid to complain for fear of reprisals. Patients without families or other outside contacts would be more vulnerable to this type of abuse.

Table 19

SOURCE OF NURSING HOME COMPLAINTS

Source of Complaints	Number of Complaints
Families	33
Employees	5
Patients	1
Others	13
Total	52

Based on 77 representative facility files.

Source: SDH Licensure Files.

Improving Complaint Resolution

There are at least three actions that could be taken to improve the complaint process. These actions would result in better information and a more structured system for receiving and resolving patient complaints.

Posting Instructions. Knowledge of how to complain is one of the major obstacles to complaint resolution. Making the process more visible to nursing home patients is an initial improvement that could be made. SDH should require that nursing homes post instructions for making complaints, including the phone numbers of responsible officials, in both public areas and patient areas of the facility.

Referral of All Complaints to SDH. SDH should receive and maintain on file all complaints made to State personnel regardless of whether the agency or individual who received the complaint was able to resolve it. Complaints are filed by facility and a large number of complaints, even if apparently minor or unsubstantiated, would be an indication of a potential problem. The Department of Welfare in particular should adopt a policy of referring all complaints to SDH on a routine basis.

Nursing Home Ombudsman. Another possible improvement that has been implemented in several states to enhance complaint processing and resolution is the nursing home ombudsman. An ombudsman operates independently of both the nursing home industry and the responsible State agency, in this case SDH. VOA operates an ombudsman office for nursing homes which is supported by a federal grant under the 1973 amendments to the federal Older Americans Act. However, only one person is employed and VOA has chosen to emphasize the role of the ombudsman in generating interest in volunteer work, fire safety and information collection rather than complaint resolution. Although the ombudsman's office receives some complaints, they are referred to SDH.

In contrast to Virginia's approach, other states have developed the ombudsman's office as a strong patient advocate. Wisconsin and Idaho, for example, have developed centralized ombudsman agencies which have taken the lead role in providing nursing home oversight. Nursing home ombudsmen in other states have the power to investigate and resolve complaints and to ensure that patients are receiving adequate and appropriate nursing care. Although these offices generally have limited enforcement powers, they usually work through the State and local inspection and enforcement agencies. The Wisconsin ombudsman is a good example of this kind of oversight.

The Wisconsin Nursing Home Ombudsman Program was established in 1972 in the office of the Lieutenant Governor with the power to investigate and resolve complaints about nursing homes. In its five years of operation, the office has handled over 3,400 complaints regarding all aspects of nursing home operation and quality of care, from neglect and abuse to administration of facilities.

Although the ombudsman has no legal enforcement powers, complaints are resolved through moral persuasion, and the enforcement powers of other regulatory agencies. The Nursing Home Ombudsman Program has an annual budget of approximately $215,000 financed primarily through State funds. The program employs ten investigators working from three regional offices.

Program officials indicated that the office had significantly improved accessibility to the complaint process for nursing home patients and their families by establishing a central agency to handle problems. Media coverage was described as extensive and very helpful in informing the public about the program.

Most complaints are resolved, although not always to the satisfaction of the complaintant. Program officials felt that the ombudsman program has raised public consciousness about nursing home care and, along with new state legislation, stricter federal regulations and cooperation of the nursing home industry, helped to improve the quality of care in Wisconsin nursing homes.

An ombudsman with a strong advocacy role would be of particular value to those patients who have no families or other frequent contacts outside the nursing home. The fact that almost all complaints come through third parties, and that there still appears to be a problem with some patients being afraid to complain, suggests that more needs to be done to ensure that the legislative mandate regarding complaint resolution is met.

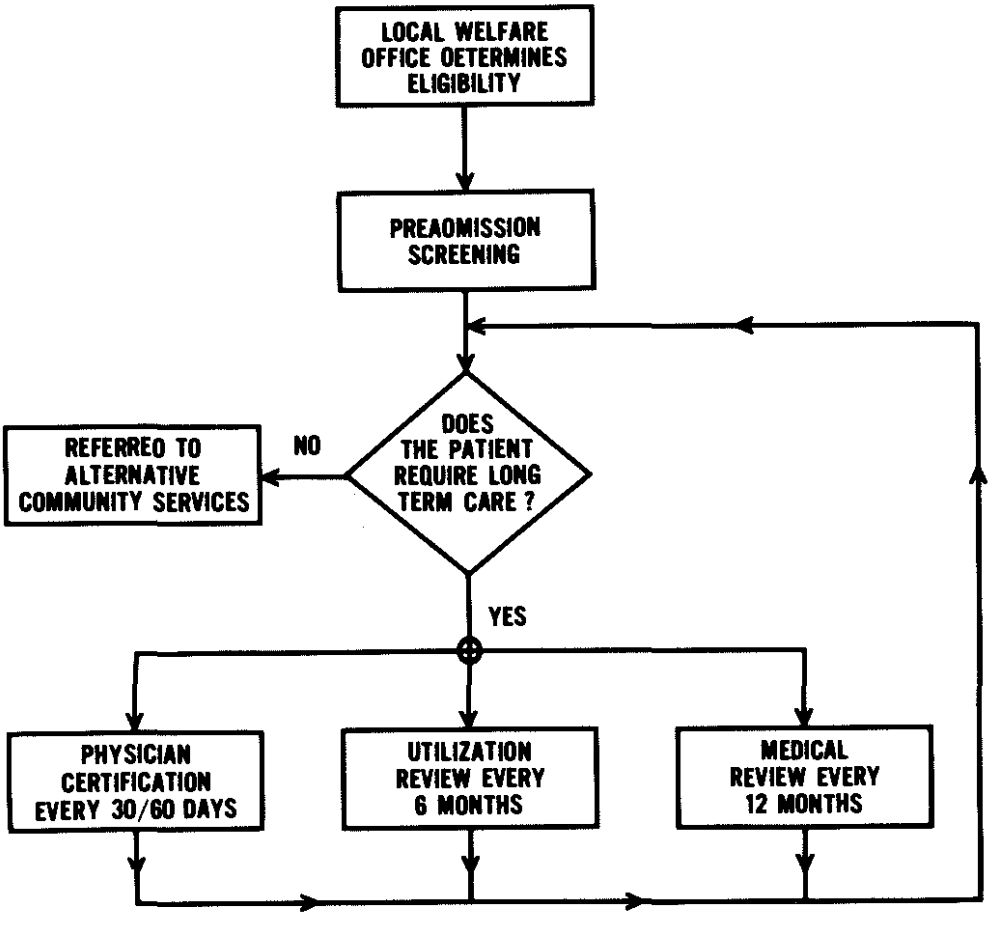
Because complaint channels for nursing home patients are presently diffused and uncoordinated in Virginia, some strengthening of the State role in receiving, investigating and resolving complaints appears necessary. VOA is presently performing a Statewide nursing home ombudsman function which could be expanded to include a complaint resolution role. The State licensure bureau would still be responsible for standards enforcement but some complaint processing responsibilities, such as developing equal access for all patients, could be assumed by VOA.

UTILIZATION CONTROL AND MEDICAL REVIEW

State licensure standards and a complaint resolution process protect all nursing home patients. However, the medicaid program provides additional oversight to ensure that medicaid patients actually need institutional care and that the medical care they receive is adequate. Utilization control and medical review are mandated by federal regulation, and the process used in Virginia is shown in Figure 6. Although not federally mandated, preadmission screening was adopted by VMAP as an additional control which has the potential to decrease unnecessary use of nursing homes.

Figure 6

MEDICAID UTILIZATION AND REVIEW PROCESS



Source: JLARC.

The review process developed by VMAP satisfies federal requirements and provides some quality oversight. However, many facilities are deficient in some aspect of medical documentation. Also, there are indications that utilization review after admission is not a significant control, making the new preadmission screening program particularly important.

Utilization and Medical Review

Medical reviews conducted by VMAP focus primarily on the documentation contained in patient records. As Table 20 shows, over half of all facilities had at least one deficiency in the recertification of the need for nursing home care by a physician and over 40% were deficient in progress notes and charting of medication. Homes with no deficiencies during 1976 totaled only 11%.

Table 20

FINDINGS OF VMAP MEDICAL REVIEWS IN 1976

Type of Deficiency	Number of Facilities Found Deficient	Percent of All Facilities
Physician Recertification	75	56%
Physician Progress Notes	62	46
Medication Charting	54	40
Treatment Charting	23	17
Renewal of Orders by Physician	17	13
Monthly Review of Medications by R.N.	11	8
Homes With No Deficiencies	15	11

Source: VMAP.

The table indicates that many nursing homes are out of compliance with medicaid requirements. However, since one incomplete file renders the entire facility out of compliance, it is difficult to determine the actual extent of the problem. There is also little detail in the inspection summaries about the seriousness of the deficiency. Deficiencies in medication charting, for example, could be a threat to the patient's health if it results in missed or duplicated administration of drugs. Better inspection summary information could help in determining whether immediate action needs to be taken on deficiencies.

Utilization review consists of two steps: physician certification in writing that a need exists for nursing home care, and semiannual review of each patient by VMAP to determine whether nursing home care continues to be appropriate. In practice neither step offers a substantial amount of control. As Table 20 shows, physician certification is a major weakness in the review process. VMAP records also indicate that utilization reviews rarely conclude nursing home care is unnecessary except in a few obvious cases of inappropriate placement.

Despite national studies which indicate that many nursing home patients could be cared for outside an institution, the impact of utilization review continues to be minimal. VMAP has confirmed that much nursing home care in Virginia is unnecessary. The acknowledgement by VMAP that a number of patients receive unnecessary nursing home care raises questions about the effectiveness of utilization control as it has been practiced in the past. In order to strengthen control VMAP implemented a preadmission screening program in 1977.

Based on the first three months of experience with preadmission screening, VMAP estimates that one-fourth of all applicants for medicaid nursing home coverage have been referred to other community services.

Preadmission Screening

There is general agreement that once elderly persons are admitted to a nursing home it is difficult to return them to the community. Therefore, preadmission screening offers a greater opportunity for preventing or delaying unnecessary use of a nursing home. VMAP initiated preadmission screening for some admissions on a Statewide basis in May, 1977.

Based on the first three months of experience with preadmission screening, VMAP estimates that one-fourth of all applicants have been referred to other community services instead of a nursing home. Although there has not been enough experience to conduct a systematic evaluation of the preadmission screening program, a reduction in use of up to 25%, if validated, would indicate that preadmission screening has great potential as a utilization control device.

Despite its potential, VMAP currently exempts from its screening program almost three-fourths of all admissions (Table 21). Under the current program, admissions from both general hospitals and other nursing homes are exempted from screening. According to VMAP the decision to exempt these two sources of admissions was made in order to not overwhelm a new program with work. However, given the program's potential and VMAP's estimates, it should be expanded to include all medicaid eligible admissions as soon as it is feasible.

Table 21

SOURCE OF 1976 NURSING HOME ADMISSIONS

Source of Admission	Percent
General Hospitals	60%
Private Residences	23
Other Nursing Homes	12
Homes for Adults	3
Mental Facilities	2
Total	100%

Source: SDH Licensure Files.

FACILITY RATING AND ANALYSIS

Despite the benefits of the quality controls discussed in the previous sections, there remain two areas in which oversight could be strengthened. First, much of the data which are routinely collected by SDH are not fully utilized as measures of nursing home quality. Second, despite the fact that Virginia employs 29 full-time nursing home inspection and review personnel, there is no single systematic assessment--or rating--of each nursing home. From SDH's perspective all nursing homes which meet minimum licensure requirements are considered equal, despite generally acknowledged variations in quality. As a result, consumers would have to interpret numerous inspection reports in order to evaluate a facility, and the medicaid reimbursement process is unable to implement any kind of a quality-related incentive program.

Some Indicators of Facility Quality

The importance of statistical measures of staffing, including nursing hours per patient-day, has been described previously in this report. Statistical measures can be used to raise questions, serve as guidelines for standards enforcement, and

identify unusual cases which need additional review and analysis. SDH routinely collects a number of statistics which can be used in evaluating the quality of facilities. Two of these measures are the cost of raw food products and the use of drugs in nursing homes.

Raw Food Costs. The quality of food used in a facility is an important aspect of overall quality. As a general measure raw food costs per patient day can be used to detect those facilities which may be using low quality food products. The analysis found that raw food costs per patient-day in 1976 ranged from a low of $1.02 to a high of $3.93--a 285% difference. While the quality of meals cannot be determined exclusively by raw food costs, they can serve as an important indicator of which facilities may be cutting corners on food purchases.

There are facilities which provide excellent care and others which are only marginal. Despite this, each nursing home which participates in medicaid is reimbursed on the same basis, and consumers do not have a primary source of information about nursing home quality of care. The State has 29 full-time nursing home inspectors who could actively participate in a nursing home rating system.

In order to test the value of raw food costs as a measure of quality, JLARC identified those facilities which were found deficient by State inspection personnel in meal menus, adequate food portions or the quality of meals, and also those facilities which had complaints about food. Seventeen nursing homes were found which either had deficiencies in meal quality or received a food-related complaint. Nine of these facilities also had raw food data available. (Raw food cost is a major data item often not reported in the cost reports submitted to VMAP.) In all nine cases the per day expenditure was below the State average. This supports the belief that low raw food costs and poor meal quality are related, and that food costs could serve as a measure of dietary adequacy.

Drug Use. The use of drugs in nursing homes has been criticized nationally because of abuse and overuse which could affect the quality of patient care. Of special concern is the use of tranquilizers and sedatives in nursing homes. JLARC analyzed the drugs taken by a randomly-selected sample of medicaid patients to determine the types and number of different drugs taken by nursing home patients. The results are shown in Table 22 and

Table 22

USE OF SELECTED DRUGS IN VIRGINIA NURSING HOMES

Drug Category	Percent of Patients Receiving Drug
Major Tranquilizers	19%
Some Types of Tranquilizer	31
Hypnotics (Sedatives)	26
Antidepressants/ Stimulants	3
Other Drugs	95
No Drugs Taken	4

Source: SDH Utilization Review Files.

indicate that although less than one patient in five was receiving a major tranquilizer (e.g., Thorazine or Mellaril), almost one-third were receiving some kind of tranquilizer and one-fourth were receiving sedatives.

When drug utilization data are compared on a facility basis, differences in the use of tranquilizers and sedatives become more apparent. Drug usage in six randomly selected nursing homes was compared and the proportion of patients receiving tranquilizers and sedatives was found to range from 17% to 62%.[2] There is no evidence to indicate that such a wide disparity is the result of the type of patient in the facility. Instead it appears that there are significant differences in the drug use policies among Virginia nursing homes. Although SDH reviews drug administration on an individual patient basis as part of medical reviews, it does not develop facility profiles of drug use. Such profiles could be a useful check of drug administration among all nursing homes.

Rating of Facilities

Available data indicate that there are facilities which provide excellent care and others which are only marginal. Despite this, each nursing home which participates in medicaid is reimbursed on the same basis, and consumers do not have a primary source of information about nursing home quality of care. The State has 29 full-time nursing home inspectors who could actively participate in a nursing home rating system.

Development of a System. Evaluating overall quality of care in a nursing home is obviously a complex undertaking. The physical plant, staff competence and attitude and the availability of social and recreational activities are just a few of the quality-related elements which need to be considered.

Presently, State licensure inspectors concentrate on specific deficiency areas and do not develop an overall facility assessment. Medicaid reviewers focus primarily on checking medical documentation, although they are also called upon to make a general determination whether "the nursing home milieu supports wellness, selfness and a sense of identity".[3] There is no doubt that inspectors and reviewers perceive differences between facilities, but these differences are not translated into a rating. This results in a loss of information and lessens the value of the frequent inspections which are a part of nursing home quality oversight.

There are valid concerns about the design of a workable rating system. Among these are:

- the amount of subjectivity necessary to make overall assessments;
- the reliability of ratings given by different inspectors;
- the potential for bribes; and
- the lack of clear, generally quantifiable standards.

Although these concerns are valid, they are not insurmountable. For example, Minnesota tested a patient care rating system to determine whether ratings could be validated despite being made by different individuals. The test found that with training and a properly developed format, raters could reach 90% agreement on ratings, and the areas of disagreement were minor and not critical to the overall assessment. Also, ratings made by teams of inspectors instead of single individuals could help ensure that ratings are a good reflection of actual conditions.

A number of states such as Florida and Utah have developed nursing home rating systems. Florida's rating system was recently declared unconstitutional because the criteria were not specific in the statute. However, revised legislation will be reintroduced in the next legislative session. Utah's system is now operational.

Florida

Florida developed a nursing home evaluation and rating system based on inspection deficiencies and areas of important care-related performance. Six rating categories were established, AA, A, B, C, E, and F, the lowest. A facility is rated upon the most recent state inspection and the rating must be included in all advertising by the home as well as being conspicuously displayed within the facility.

Nursing homes are allowed to appeal the ratings if they feel it is an unfair assessment of their operation. The state medicaid agency is in the process of developing a reimbursement mechanism based on the ratings in which those facilities with higher ratings will receive higher payment levels than those which have lower ratings.

Utah

An incentive reimbursement system based on a rating mechanism has been developed by the Utah medicaid program. The system has two primary benefits: (1) it shows nursing home administrators the weak areas in their operation and provides financial inducements to correct these deficiencies, and (2) it provides state officials with a facility-by-facility measure of quality of care. The heart of the system is a rating mechanism that evaluates nine critical areas affecting service delivery in the facility from physician coverage to control of drugs.

Each nursing home receives a numerical score ranging up to 250 points based on compliance with state licensure standards. The rating is then applied to four incentive areas to determine the amount of incentive payments. The four incentive areas are:

- *capital investment,*
- *specific special services,*
- *occupancy, and*
- *management efficiency.*

The rating applies only to the incentive payment areas and does not affect regular reimbursement. Utah officials feel that the incentive system encourages facilities to improve their quality of care.

Potential for Use. The primary reason for developing a facility rating system is for use in medicaid reimbursement. Under the present reimbursement system a marginal facility can receive over double the daily rate of payment that is paid by medicaid to an excellent facility. Also, as was described in the last chapter, proposals currently under consideration for changing the medicaid payment system could emphasize efficiency at the expense of quality of care.

A rating system would be necessary if medicaid funds are to be used as an incentive to upgrade the marginal facilities in Virginia. Furthermore, the system could serve as a "maintenance of effort" check to ensure that efficiency incentives do not result in an overall lowering of quality in nursing homes.

Ratings could also be used to provide consumer information. Licensure files are public information and are available to consumers. However, few people know of their availability or could make use of the numerous inspection reports and detailed regulations. A single systematic rating would provide better information for consumers of nursing home care.

CONCLUSION

Based on available measures, most Virginia nursing homes appear to provide generally good care to their patients. However, a limited number of nursing homes may be providing only marginally acceptable care. The State can initiate several actions to upgrade the quality of care provided in these homes. Foremost among these actions could be the development of intermediate sanctions to ensure timely compliance with standards, and the establishment of a better system of processing patient complaints. Furthermore, medicaid reimbursement rates could be more closely linked to the quality of care to ensure that a high level of quality is maintained.

A need also exists for more specific State standards dealing with the qualifications and size of nursing home staff. The number of staff is the most important factor in explaining the high cost of some nursing home care. At the same time, however, too few or poorly trained staff can result in inadequate patient services. There are wide variations among nursing homes in the number of staff employed, and these variations cannot be reasonably attributed to patient needs. Staff training, particularly for nursing aides who provide most of the care, needs greater attention. SDH should take steps to develop standards which would ensure that enough trained staff are employed without expensive use of unnecessary manpower.

IV. Long Term Care in Mental Institutions

Although nursing homes provide the greatest share of long term care services in Virginia, State-supported mental institutions also play a prominent role. The Department of Mental Health and Mental Retardation (MHMR) receives about one-third of all medicaid funds spent for long term care services. Medicaid coverage in the State mental institutions is available for two groups: the mentally retarded of all ages and the geriatric mentally ill over 65. In 1977 over 6,000 patients qualified for medicaid assistance.

The medicaid program has had a positive impact on the operations of the Department of Mental Health and Mental Retardation. Medicaid certification requirements have led to a general upgrading of facilities and patient care, and a reduction in general fund appropriations over what might otherwise be expected.

Impact of Medicaid Payments

Medicaid coverage for institutional patients has been a valuable source of operating revenue for MHMR (Table 23). Of the total medicaid payment, about $65 million was provided by the federal government. The $50 million appropriated by the State is essentially a transfer of general fund revenue from the medicaid program to MHMR.

According to MHMR officials, the drop in medicaid payments in 1976 was primarily due to a decision to carry forward over $2 million in medicaid payments from FY 1976 to FY 1977 as a result of a budgetary shortfall in the medicaid program. The substantial increase in medicaid payments in FY 1977 reflects the $2 million carry over and the certification of additional facilities for medicaid participation following a major renovation of several hospital buildings.

Table 23

MEDICAID AND TOTAL PATIENT PAYMENTS TO MHMR
(FY 1974 - FY 1977)

Fiscal Year	Medicaid	Total Patient Revenues	Medicaid Percent
1974	$ 15,341,207	$ 25,269,970	61%
1975	30,233,216	40,734,864	74
1976	28,331,717	40,467,541	70
1977	41,676,777	55,037,002	76
Total	$115,582,917	$161,509,377	72%

Source: MHMR Reimbursement Division Collection

Intermediate care in the mental institutions costs about $31 per day, which is substantially more than the $24 per day average in nursing homes. However, as is detailed in the following section, the type of patient and the level of care provided in the mental institution make a direct cost comparison difficult.

Historically, care of the mentally ill and mentally retarded has been a State responsibility and patients in institutions were not charged for the cost of their care. Statutory changes in the 1940's allowed MHMR to require payment for the cost of institutional care from the patient, his estate or a responsible parent, relative, or guardian.[1] The patient is liable for payment for the full institutional stay. However, a parent or relative is not required to pay for institutional care beyond five years, and payment is not required if it would create a hardship for the patient's family.

Table 24 shows the FY 1977 collections by payment source and indicates that collections for patient care would be reduced by three-fourths if medicaid funds were not available.

Patient revenue, from medicaid and other sources, is primarily used to offset the cost of operation of the institutions. Table 25 compares medicaid payments, total patient revenues, and operating costs for FY 1974 through FY 1977. Revenues in FY 1977 offset 53% of total operating costs. In several cases, notably the two geriatric institutions (Piedmont and Catawba) which are 100% certified for medicaid participation, the cost of institutional operation is almost fully reimbursed by medicaid.

Table 24

SOURCE OF INSTITUTIONAL PATIENT COLLECTIONS
(FY 1977)

Source	Payment	Percent
Medicaid	$41,676,777	76%
Pensions-Social Sec.	5,146,383	19
Commercial Insurance	3,441,335	6
Patient	3,066,011	5
Medicare	2,035,407	3
Subtotal	$55,365,913	
Less Refunds	*(228,910)*	
Net Collections	$55,037,002	100%

Source: MHMR Reimbursement Division Collection Summary, FY 1977.

Table 25

INSTITUTIONAL REVENUE COMPARED TO OPERATING COSTS
(MILLIONS)
(FY 1974 - FY 1977)

Fiscal Year	Medicaid	Total Patient Revenue	Operating Cost	Medicaid as a Percent of Cost	Patient Revenue as a Percent of Cost
1974	$ 15.4	$ 25.3	$ 74.8	21%	34%
1975	30.2	40.7	87.7	35	46
1976	28.3	40.5	95.8	30	42
1977	41.7	55.0	104.4	40	53
Total	$115.6	$161.6	$362.7	32%	45%

Source: MHMR.

The increase in medicaid payments has also resulted in an increase in special fund appropriations, particularly for the major institutions which house most of the medicaid patients. Table 26 shows that a $19.1 million increase in appropriations for the eight principal institutions between FY 1976 and FY 1977 was totally from special funds. Without increased medicaid reimbursement, it is likely that most of the additional appropriation would have been made up from the general fund.

Table 26

APPROPRIATIONS FOR EIGHT MHMR INSTITUTIONS*
(IN MILLIONS)
(FY 1975 - FY 1977)

Funding Source	FY 1975 Appropriation	FY 1976 Appropriation	FY 1977 Appropriation
General Fund	$52.6	$53.0	$53.0
Special Fund	23.7	25.2	44.3
Total	$76.3	$78.2	$97.3

*Includes: Central State, Western State, Eastern State, Southwestern State, Lynchburg Training School and Hospital, Southside Training Center, Piedmont, and Catawba.

Source: Commonwealth of Virginia, 1974-1976 and 1976-1978 Appropriation Acts.

Medicaid Patients in the Mental Institutions

The availability of medicaid funds for institutional care has served as a catalyst for change in the State mental facilities. Over 6,000 patients, or 65% of the institutional population, were eligible for medicaid as of July, 1977. Medicaid coverage of certain mental patients is generally considered to be a reflection of two trends: (1) a change in philosophy about inpatient mental treatment which seeks to separate the geriatric and retarded patient from other mentally ill persons, and (2) a decision at the federal level to use funds as an incentive to upgrade the quality of state mental facilities. Both objectives have been met to a substantial degree in Virginia.

A 1974 amendment to the *Code of Virginia* required the Board of MHMR to provide separate facilities for geriatric patients who previously had been housed with other patients in the mental hospitals.[2] MHMR has also received almost $20 million in capital

and operating appropriations since 1973 for the specific purpose of upgrading institutional facilities in order to meet medicaid certification requirements.

In addition to the mentally retarded and geriatric mentally ill, federal regulations allow medicaid coverage of the mentally ill under the age of 21 in State institutions. However, Virginia has not elected this option, although there are about 200 individuals under 21 in State institutions. By including the under 21 age group, medicaid payments to State institutions would increase by approximately $2 million annually, including an additional $1.2 million in federal funds. However, patients under 21 in private psychiatric facilities accredited by the Joint Commission on the Accreditation of Hospitals would also be eligible for medicaid assistance if this option were elected.

It is difficult to estimate with any precision the number of additional persons that would be eligible for medicaid under

Institutional operating costs to the Department of Mental Health and Mental Retardation were $104.4 million in 1977. Medicaid reimbursed $41.7 million—40% of these costs.

this option, but the overall public expenditure could be significantly higher than the $2 million for State institutions. Additional study would be necessary before the medicaid program was expanded to include the under 21 mentally ill.

Patient Profile. There are significant differences between the MHMR patient and the typical nursing home patient. In order to clarify this distinction, JLARC staff conducted interviews and visited three mental institutions and 11 nursing homes. The review found that there are three basic characteristics which distinguish most institutionalized mental patients from the nursing home patient:

- a diagnosis of psychosis/psychoneurosis or moderate to severe mental retardation;
- a long history of institutionalization; and
- generally better physical health than the nursing home patient.

Although nursing home patients usually show signs of mental deterioration and senility, few show psychotic symptoms. In contrast, patients in the MHMR geriatric centers have usually experienced one or more psychotic episodes which require professional psychiatric care. Also, most nursing home patients have been institutionalized less than two years while mental patients have long histories of institutionalization--averaging over 20 years in many cases--which affect their ability to cope with a less structured living arrangement. Finally the medicaid patient in the mental institution is in reasonably good health considering his age or disability. In comparison, nursing home patients who are institutionalized from their homes are much more likely to be physically ill at admission.

Patient Transfers. Despite these differences, both patient groups share the need for some type of long term care. As a result of this shared need, and of the ongoing MHMR policy of reducing the institutional population in favor of community-based care, there are a number of transfers of mental patients to nursing homes annually. In 1976, there were over 200 such transfers.

Generally, a transfer is indicated when the mental patient has deteriorated physically to the point where the need for routine medical and health-related care outweighs the need for continuing psychiatric treatment in the institution. The large number of transfers in the past has led to charges that a transfer to a nursing home from a mental hospital is just a change in institutional setting with minimal therapeutic benefit, that nursing homes are ill-prepared to deal with mental patients, and that many transfers are made without adequate planning.

JLARC reviewed 1976 facility files to collect data on the number of transfers. Table 27 indicates that, although

Table 27

TRANSFERS FROM MENTAL INSTITUTIONS
TO MEDICAID CERTIFIED NURSING HOMES IN 1976

Number of Transfers	Number of Nursing Homes
35	1
14	1
13	1
5 to 9	3
2 to 4	14
1 or 0	58
Total	78

Source: SDH, 1977 Licensure Renewal Applications.

one facility had a large number of transfers in 1976 and several others had from 5 to 14, there was not a large-scale movement of patients from mental hospitals to a few nursing homes. This would seem to indicate that unplanned transfers, if they occur, are not concentrated in a few nursing homes. It does not necessarily indicate that this problem has not occurred in the past. An additional control over transfers is the preadmission screening program described earlier. Admission of institutional patients to nursing homes is subject to prescreening, and MHMR reports that about 90% of all transfers have been approved since the program was initiated.

CONCLUSION

The medicaid program has had a positive impact on the operations of the Department of Mental Health and Mental Retardation. Medicaid certification requirements have led to a general upgrading of facilities and patient care, and a reduction in general fund appropriations over what might otherwise be expected.

Although patients in mental institutions are more expensive to maintain than nursing home patients, the cost of their care is heavily supported by federal funds. Medicaid funds have been an important source of operating revenue for State hospitals. Nevertheless, a large number of institutional patients have either been transferred to nursing homes or are on waiting lists. Additional study may be needed to determine whether these transfers are therapeutically justified in light of the benefits and potential savings available to the State. If the quality of patient care in State institutions is equal to that provided in the typical nursing home setting, MHMR might want to review its policies regarding the transfer of the geriatric mentally ill to nursing homes.

APPENDICES

END NOTES

Chapter I LONG TERM CARE IN VIRGINIA

1. Virginia, State Department of Health, Division of Health Planning and Resources Development, *Interim Virginia Medical Facilities Plan*, September, 1976.

2. Health Service Areas (HSA) are multicounty geographic areas that were established in Virginia in response to federal regulations (PL 93-641). HSA's are responsible for areawide health planning and control of some federal categorical grant programs.

3. Congressional Budget Office, Congress of the United States, *Budget Issue Paper: Long-Term Care for the Elderly and Disabled*, February, 1977, Appendix B.

Chapter II MEDICAID REIMBURSEMENT

1. AFL-CIO Executive Council, *Profit in Human Misery*, Washington, D.C., 1976.

2. The New York State Moreland Act Commission found that larger nursing homes appear to actually be more expensive per patient-day to operate than small facilities. This indicates that the failure of large nursing homes to experience economies is not an isolated phenomenon.

3. This finding applies to the typical nursing home in Virginia, i.e., a privately-owned intermediate care facility. There are several nursing homes in Virginia which have special patient populations, e.g., infants. There are also several facilities which specialize in some aspect of long term care, e.g., rehabilitation therapy. These facilities may have significantly different patient populations which account for both cost and staffing variations.

4. Further evidence that rates are not converging is provided by an analysis of standard deviations for facilities operating from 1973 through 1977. The standard deviation (SD) is a statistical measure of dispersion around the average. If rates were converging the SD for 1977 would tend to be smaller than in 1973 because the distribution of rates would be "tighter" around the average. Instead, the SD for 1973 was $3.35 on an average of $16.76 per day, and the SD for 1977 was $3.72 on an average of $23.53 per day. The fact that the SD for 1977 is virtually the same as for 1973 is evidence that payment rates remain as widely dispersed as they were four years ago.

5. HEW Audit Agency. *Report on Review of Medicaid Nursing Home Costs: Commonwealth of Virginia.* Audit Control Number 60153-03, July, 1975.

6. Speech delivered by Daniel R. Humphrey, C.P.A., at the Welfare Finance Officers Convention, Dallas, Texas, September 21, 1976.

Chapter III NURSING HOME QUALITY OF CARE

1. Although SDH has not revoked a license, over 20 facilities have voluntarily given up their license to operate as a nursing home since 1973. Most of these have done so under pressure from SDH to meet licensure standards.

2. Using sampled data introduces some margin of statistical error. The actual proportion of drug use in the six facilities could be expected to vary from $\pm 6\%$ to $\pm 14\%$ from the observed proportion (at the .05 confidence level). The variation among the six facilities was significant at the .02 level.

3. Virginia Medical Assistance Program, Medical Review Form (MAP 201).

Chapter IV LONG TERM CARE IN THE MENTAL INSTITUTIONS

1. *Code of Virginia* (1950), Section 37.1-105.

2. *Code of Virginia* (1950), Section 37.1-24.2.

TECHNICAL APPENDIX
(Available on Request)

JLARC policy and sound research practice require a technical explanation of research methodology. A technical appendix was prepared for this report and was part of the exposure draft. The technical appendix is available on request from JLARC, 823 East Main Street, Richmond, Virginia 23219.

The technical appendix includes an explanation of analytical procedures and relevant statistics for five special studies:

1. Cost Report Analysis. The analysis involved a detailed examination of a data base drawn from the cost reports submitted to SDH by selected nursing homes. Sixty-seven reports were selected and tested to ensure the homes were representative of all nursing homes in the State. No size, ownership, or regional biases were found. The major factors accounting for per diem cost variation were identified by use of a stepwise multiple regression. This section also describes several methodological limitations to the analysis. (7 pages)

2. National Comparison of Intermediate Care Rates. This section documents the method used to support the JLARC finding that per diem payment rates in Virginia are among the highest in the U. S. (1 page)

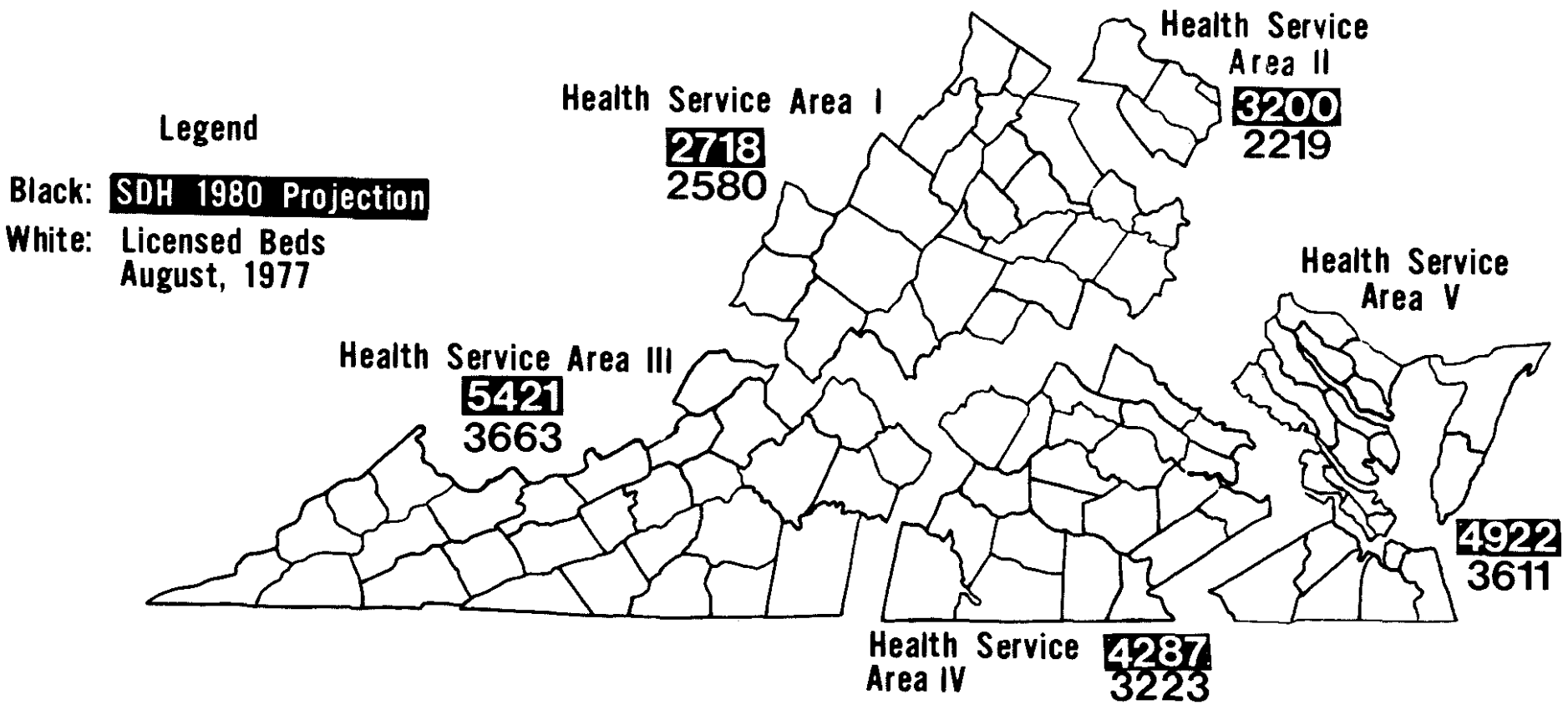
3. Patient Characteristic Profile. The JLARC staff developed profiles of the patients found in Virginia nursing homes. A random sample of 653 patient files was drawn from a random sample of 30 nursing homes. The homes were stratified by high, medium, and low cost. The profile was necessary to determine whether concentrations of more ill and disabled patients could account for variations in the daily cost of care or in staffing levels. Nineteen measures of patient functional capability were analyzed separately and in combination using analysis of variance (two-way nested design) to determine statistical significance. The appendix includes a discussion of checks made for data validity and reliability. (9 pages)

4. Survey of Local Staff. This section describes a survey research effort to provide data on nursing home availability and quality of care. Analysis was made of returns from 93% of all State welfare offices and 78% of area agencies on aging. The appendix includes the survey instrument and aggregated responses to attitudinal questions about the availability and quality of care in Virginia nursing homes. (5 pages)

5. Identification of Marginal Facilities. This section explains the criteria JLARC used to determine the approximate number of marginal nursing homes operating in Virginia. A marginal facility is licensed but is poorly regarded by experienced observers and has numerous deficiencies. (1 page)

Appendix 2

Licensed Nursing Home Beds by Health Service Area, August 1977



HEALTH SERVICE AREA I

Counties: Frederick, Clarke, Warren, Shenandoah, Page, Rappahannock, Fauquier, Rockingham, Greene, Madison, Culpeper, Stafford, King George, Highland, Augusta, Albemarle, Orange, Louise, Spotsylvania, Caroline, Bath, Rockbridge, Nelson, Fluvanna.

Cities: Winchester, Harrisonburg, Fredericksburg, Staunton, Waynesboro, Charlottesville, Buena Vista, Lexington.

HEALTH SERVICE AREA II

Counties: Loudoun, Prince William, Fairfax, Arlington.

Cities: Alexandria, Fairfax, Falls Church, Manassas, Manassas Park.

HEALTH SERVICE AREA III

Counties: Alleghany, Craig, Botetourt, Bedford, Amherst, Appomattox, Campbell, Roanoke, Giles, Montgomery, Floyd, Franklin, Pittsylvania, Pulaski, Carroll, Patrick, Henry, Bland, Wythe, Grayson, Tazewell, Smyth, Buchanan, Russell, Washington, Dickenson, Wise, Scott, Lee.

Cities: Clifton Forge, Covington, Lynchburg, Bedford, Roanoke, Radford, Norton, Bristol, Salem, Galax, Martinsville, Danville.

HEALTH SERVICE AREA IV

Counties: Buckingham, Cumberland, Goochland, Powhatan, Hanover, Henrico, New Kent, Charles City, Prince Edward, Amelia, Chesterfield, Prince George, Surry, Nottoway, Dinwiddie, Sussex, Charlotte, Lunenburg, Brunswick, Greensville, Halifax, Mecklenburg.

Cities: Richmond, Colonial Heights, Hopewell, Petersburg, South Boston, Emporia.

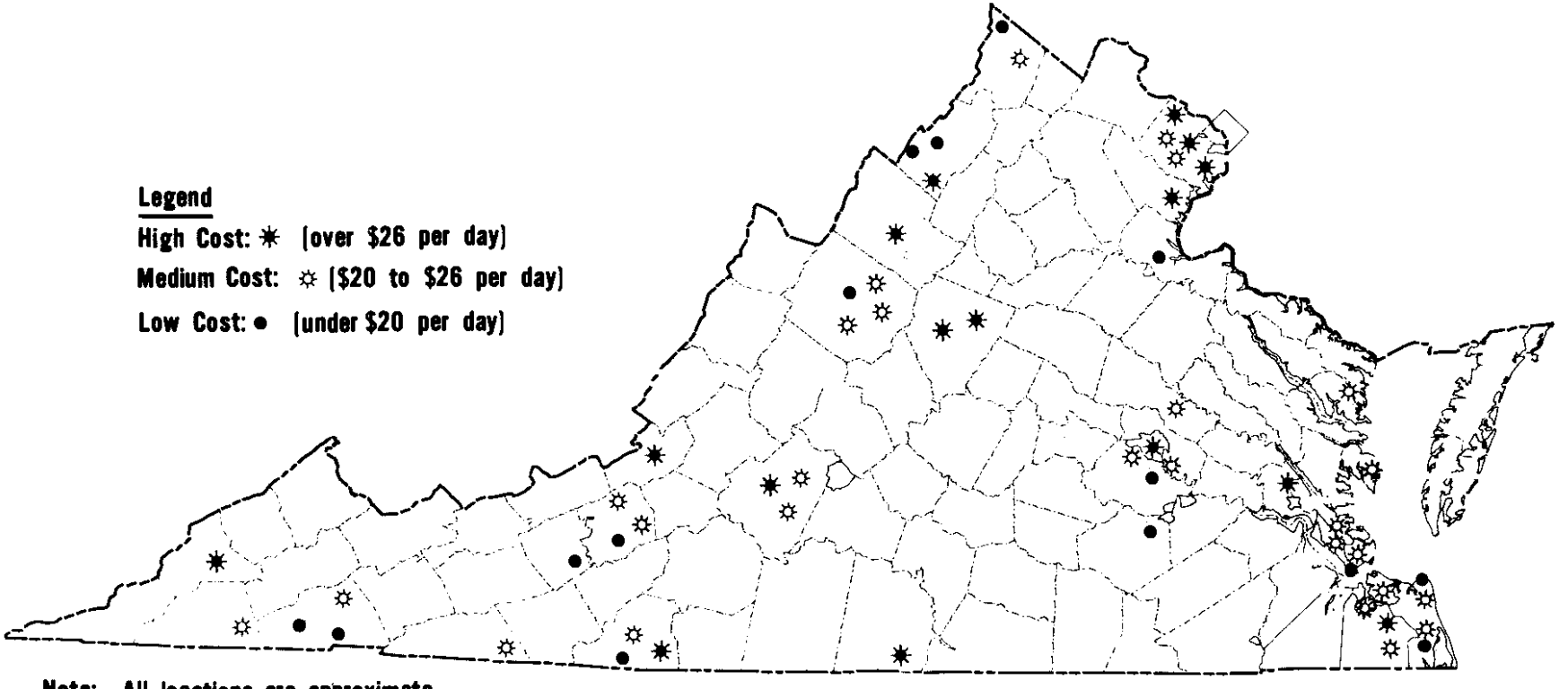
HEALTH SERVICE AREA V

Counties: Westmoreland, Northumberland, Accomack, Richmond, Lancaster, Northampton, Essex, Middlesex, Matthews, King & Queen, Gloucester, King William, James City, York, Southampton, Isle of Wright.

Cities: Williamsburg, Newport News, Hampton, Franklin, Suffolk, Portsmouth, Norfolk, Chesapeake, Virginia Beach, Poquoson.

Appendix 3

Regional Distribution of High, Medium and Low Cost Nursing Homes in Virginia (Proprietary Facilities, 1976)



Note: All locations are approximate

COMMONWEALTH of VIRGINIA

AMES B. KENLEY, M.D.
OMMISSIONER

Department of Health
Richmond, Va. 23219

January 13, 1978

Mr. Ray D. Pethtel, Director
Joint Legislative Audit and Review Commission
Suite 200, 823 East Main Street
Richmond, Virginia 23219

Dear Mr. Pethtel:

This letter and its attachment represent the State Health Department's response to the draft report of the Commission entitled "Long Term Care in Virginia."

Before presenting the Health Department's comments, I want to express my appreciation for the manner in which the data and staff views were obtained. Our thanks especially to Bill Landsidle.

The report is comprehensive, well written, and will serve as a bench mark and provide assistance for progress in carrying out the Department's planning and oversight responsibilities in the area of long-term care.

In the attached discussion and listing of comments, the order of the draft report is maintained. I hope that you will carefully consider these comments and concerns, especially our belief in the adequacy of the current method for determining nursing home bed needs.

Sincerely,

James B. Kenley, M.D.
State Health Commissioner

bn

Enclosure

..COPY..

STATE HEALTH DEPARTMENT COMMENTS ON THE DRAFT JLARC REPORT: LONG TERM CARE IN VIRGINIA

Growth of the Nursing Home Industry in Virginia

It should be also recorded in this report that the intermediate care program for low income Virginians began in 1969 under the direction of the State Welfare Department. Each locality participated in the payment for such care. The 1972 transfer to the Medicaid Program was the result of action by Congress. This transfer into Medicaid meant that the localities no longer contributed and that Medicaid rules on family financial responsibilities became applicable to the intermediate care program, e.g., children, even when financially feasible, were no longer required to participate in paying for the care of their parents. These changes in regards to financing intermediate care resulted in increased admissions to nursing homes.

Current Demand for Nursing Home Care

The report has omitted the important fact that the current definition of "skilled care" under the Medicaid Program is also the definition for skilled care under Medicare, as required by Public Law 92-603 (1972). Virginia's patients are properly classified according to this definition. Prior to P. L. 92-603, each state could define skilled care for Medicaid purposes in its own way--there was no single HEW-approved definition. That fact, coupled with the fact that many states did not have an intermediate care program, meant that federal funds for nursing home care could only be obtained under "skilled care" and most definitions were therefore broad. Virginia was one of the few states with a common Medicare-Medicaid definition for skilled care. Where we are today relative to other states in the distribution of skilled and intermediate patients is an expression of these aspects of our past. Many states have not completed the reclassification of their nursing home patients according to the common definition. We agree with the draft report that there is potential for greater use of the skilled care level of care through early discharge of hospitalized patients. Unlike Medicare, Virginia's Medicaid Program does not require a period of prior hospitalization before becoming eligible for skilled nursing home benefits.

Also of note is the fact that Virginia is among those few states which have maximized intermediate care coverage in our State institutions, thus contributing to the preponderance of long term care funds for this level of care (reference Table 2, page 12).

Future Needs

The methodology used by the State Health Department to project future nursing home bed needs in the Interim Medical Facilities Plan is pragmatic and realistic. Although the formula is

a direct carry-over of the methodology used in the 1973-74 Construction and Modernization Plan (Hill-Burton Plan), these projections were substantiated by a statewide survey on February 15, 1975, of nursing home patients and candidates for placement in nursing homes. This survey was undertaken as a direct result of the same concern expressed in the audit report, i.e., the methodology in use may produce too low an estimate of future nursing home bed needs. At that time there were 11,757 licensed nursing home beds in 133 facilities.

One hundred and thirty (130) nursing homes operating 97.4% of all nursing home beds in Virginia responded to the 1975 survey. Additionally, all general hospitals, local health departments, welfare departments, and state mental hospitals participated. These facilities and agencies were asked to report the numbers of persons who were candidates for acceptance in a nursing home. Response rates ranged from 96% to 100%. The nursing home census was 10,892 patients (92.6% occupancy) and 5,205 persons were reported to be waiting for nursing home beds (unduplicated count).

In addition, the state mental hospitals reported 2,419 patients as being able to be placed in a nursing home setting. In evaluating the survey data to determine whether the methodology used to project future nursing home needs was adequate, these patients were excluded as it was assumed that patients with mental health problems would be better served by long term care programs operated by the Department of Mental Health and Mental Retardation either in the hospitals or local mental health aftercare programs.

In summary, 16,097 persons were identified in 1975 as patients and potential patients for nursing homes. This demand would require 17,900 beds at 90% occupancy as compared with the projected 1975 nursing home bed need of 17,600 produced by the methodology. It should be noted that the estimates of need based on the survey were done without taking into account the probability that many of the persons on waiting lists were deceased or could be served as well or better by alternative services.

Further, the alleged weakness that the Department's current projections do not cover persons under 65 years of age is inaccurate. In making nursing home bed projections, the total population of nursing homes is taken into account. By including persons under age 65 in the base and projecting forward from changes in the population over age 65, those under age 65 continue to be accounted for in the method. Currently, there are more than 15,000 beds in facilities in operation in Virginia and an additional 4,000 beds will be constructed under Certificates of Need which have been granted by the Commissioner of Health.

The states of California and New York have devoted considerable time, effort, and resources in studying various predictive methods for projecting future nursing home bed needs. Each employs a method similar to Virginia's based upon current utilization applied to the projected population aged 65 and older.

Subsequently, an independent consultant was employed by the Department to evaluate current methodologies for projecting future medical facility needs in Virginia and to recommend necessary changes. The consultant evaluation considered that the Health Department formula for projecting nursing home needs may be too liberal. However, the formula projects only a planning objective relative to the rate of building new facilities. Local conditions and area factors are applied before decisions are rendered on nursing home Certificate of Need applications.

Alternatives to Nursing Home Care

The statement regarding the findings of a Departmental study in Richmond is not correct. The study was not focused on nursing home residents, but on candidates for such placement. Patients currently in nursing homes have had their needs regularly reviewed by Medicaid nurses and social workers. All are correctly classified as to level of care, which is not to infer, however, that none could receive the same mix of services from alternate sources in the community.

The State Health Department agrees that emphasis should be placed on home care. The Medicaid Program's recent actions to pre-screen candidates for nursing home admission has shown that 20%-25% of such persons can stay home if the patient's needs and available alternate services match.

It is agreed that a comprehensive state plan for alternatives to long term institutional care is desirable. Planning under P. L. 93-641 requirements will address this need in the preparation of a State Health Plan and a State Medical Facilities Plan. Drafting of these plans is now proceeding in accordance with new federal guidelines.

Medicaid Reimbursement

We are in agreement with the audit report regarding the need to make changes in the payment method which insure quality care and promote efficiency in nursing home operations. As indicated, discussions with the Virginia Health Care Association currently are in progress toward such an end. Clearly, there are many variations in the fifty states' approaches to the purchase of nursing home care. When the Virginia Medicaid Program started in 1969, the Medicare methodology for reimbursement was adopted, and this method is in use today with minor variations. Few states have done as well as Virginia through their Medicaid Programs in meeting long term care needs of recipients, largely because of the departure from flat rates and low payment ceilings.

Reimbursement for Operating Costs

On January 11, 1978, we determined for several of Virginia's neighboring states (telephone survey) the average payment rates for reimbursement to intermediate care facilities in 1977.

Virginia	$23.33	
North Carolina	23.00	
West Virginia	21.50	
Maryland	23.09	(an average of the rates for the two levels of ICF care)

It is difficult to believe that Virginia's payment level is one of the highest in the nation in view of the closeness of these average values. There is great variation in the ceilings imposed in each state; also, some could be reporting average state payment levels not counting patient pay amounts. The averages shown here represent the average total payments received by the facilities.

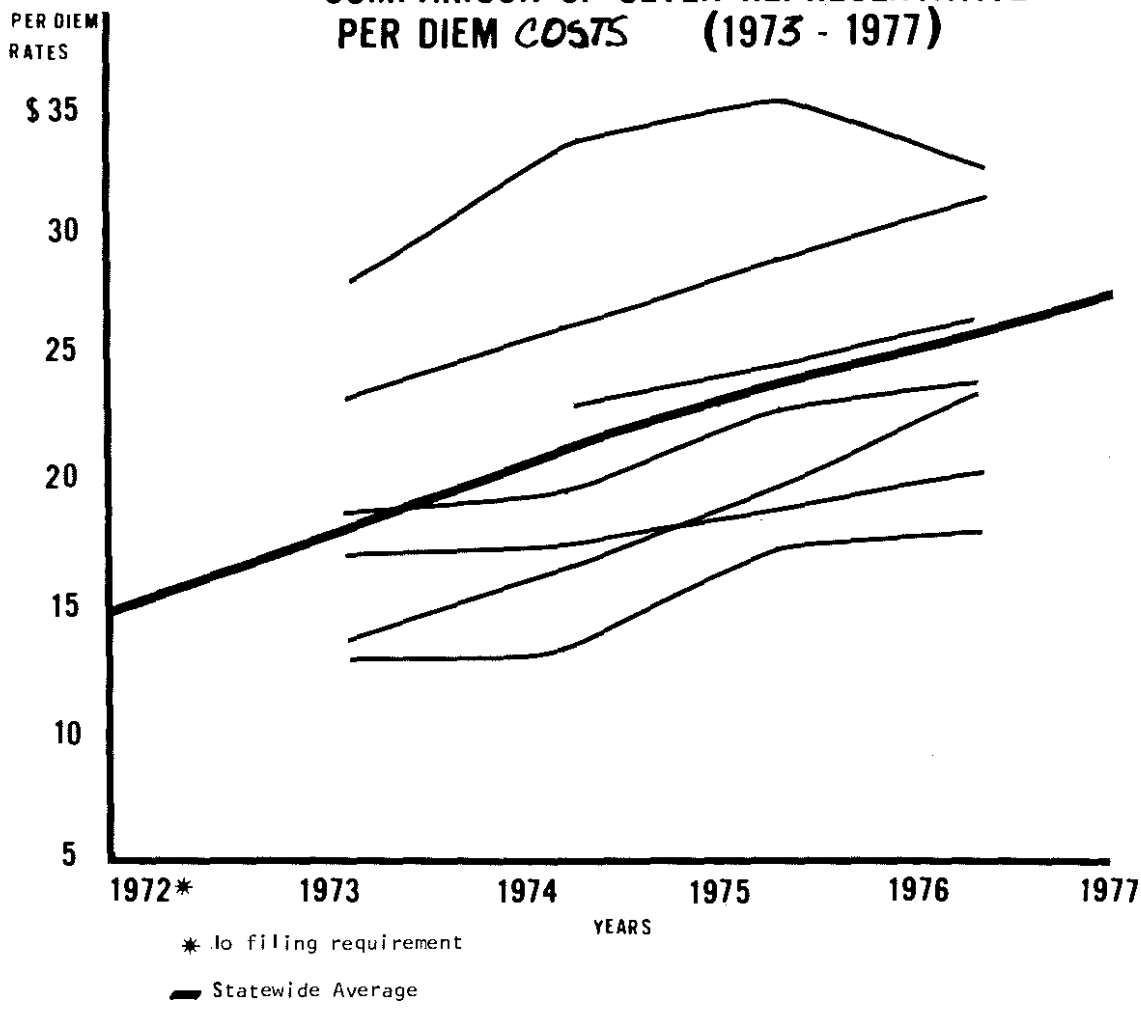
The report should clarify that the difference in the percentage increases in Table 13 is the result of increased number of patients in 1977 over 1974. Surely the report narrative should also point out in any discussion of increasing costs, not only bed count changes, but also the variable costs associated with meeting life safety standards during this period as required by federal regulations. During the years 1974-77, twenty substandard facilities ceased operations, and invariably their "costs" were among the lowest because they were usually older facilities and carried less debt.

We take issue with Figure 3, page 39, and submit the attached alternative using costs rather than "per diem" rates. The cost figures represent the amounts actually paid for care in these seven facilities for the years 1973-76, omitting 1977 as final costs are not available and omitting 1972 because Medicaid rates of payment for that year were determined by the State Welfare Department. These 1972 rates were subsequently shown to be below actual facility costs in most instances. Using cost data over a four-year period, costs increased for the period from 17% to 77%, with a trend toward convergence of rates. The amount of change in a facility's rate over time can often be explained from a knowledge of other changes. The uppermost rate line in alternative Figure 3 represents a facility closely associated with a general hospital and actually functioning as a chronic disease hospital in 1973. Subsequently, the beds became recertified for intermediate and skilled nursing home care and a reduction in staff occurred. The nursing home with a 77% increase in allowable costs experienced many difficulties in meeting standards in this period with resultant staff increases and facility expenses to meet life safety code requirements. Nevertheless, this facility currently operates below average cost. The current reimbursement rate for a facility is largely related to its past history. It is too simplistic to pass off such differences as the "predictable response to retrospective cost reimbursement system".

ALTERNATIVE

Figure 3

COMPARISON OF SEVEN REPRESENTATIVE PER DIEM COSTS (1973 - 1977)



Related to "reimbursement for true cost", the example of telephone services for patient use in the 5% potentially unreasonable disallowance section is clearly documented in Medicare reimbursement guidelines as a nonreimbursable item. Since this is a federal mandate for hospital and skilled care, Medicaid has followed the same concept for application.

On page 41 of the report, the statement regarding a three-year carryover period based on the "lower of cost or charges" principle is incorrect. For ongoing facilities, two years is the maximum carryforward period; for new facilities, the period is extended to five years.

Economic Benefits of Medicaid Reimbursement

In discussion of the allowable 10% return on owner's equity capital, the referenced $.50 per patient day return is correct as an average, however, on a statewide basis 40% of the facilities have a return of less than $.30 per patient day. No such return is received by eighteen proprietary facilities.

Owner compensation has been under review for some time and we continue to examine the application of limitations in this area. Recently, criteria for reasonableness have been developed to limit officer salaries of multifacility corporations. In the example on page 45, the three officers of the referenced corporation had a significant reduction in the amount paid at year-end settlement, below those values shown in the audit.

Cost Reporting

A general comment regarding all statements presented throughout this report is that the facts reviewed by the JLARC staff were those presented in the provider's cost reports, and that such facts and claimed amounts have not been or will not necessarily be included in the final reimbursement computation.

The recently implemented chart of accounts will give standardization of cost categories, adding significantly to internal analysis through the provision of comparative statistics, both between years and facilities.

While sanctions are not now imposed for failure to disclose related-party transactions, usually such transactions are uncovered by field audit activity and documented in our files. They are reviewed for appropriateness with field audit procedures providing indepth analysis of such costs.

Individual attention is given to rental situations and the staff is aware of such agreements and related-party possibilities. Pertinent facts are considered and all leases are reviewed against internal guidelines. Several lease amounts have been disallowed and ownership costs used in their place.

Staffing Standards

On several occasions, this Department has joined with the nursing home industry to consider the desirability of establishing minimum staffing standards for inclusion in nursing home licensure regulations. Each time the conclusion has been that the judgment of adequacy of nursing services by inspectors is satisfactory. Note has been made that Medicare and Medicaid certification standards do not prescribe a minimum number of nursing staff hours per patient day. Where such minimum requirements exist, it is difficult for an

inspector to effect increases in staff above the minimum when the situation in a nursing home requires this. In other words, the minimum requirements tend to become "maximum".

Current nursing home licensure standards in Virginia specify a requirement for nursing services supervision. Each facility with more than 25 beds is required to provide supervision by a licensed nurse at all times.

Training of Nursing Aids

The Virginia Health Care Association is now working toward improvements in this area and the Department will continue to assist to the fullest extent possible. A teaching program and training materials for nursing aids have been developed by the American Nurses Association.

Enforcement of Standards

The Department agrees that the matter of intermediate sanctions is deserving of further study. While it is true that the Health Department has never officially revoked a nursing home license, the 20 closures in the last four years were the result of actions by the Department. A moratorium on Medicaid admissions was judiciously and effectively used four times in 1977.

In regards to inspection deficiencies, it is noted in Table 20 that only 21.4% were related to the physical plant. With the great improvements in physical plants over the last few years, some of the remaining physical plant "deficiencies" are judged not detrimental to health and safety, and even though carried as "deficiencies", in fact represent plant design features which have waiver status, meaning they are not required to be changed. Most nonplant-related deficiencies are mainly "people" problems and are more likely to recur.

Complaint Resolution

The Department concurs that there is a lack of externally formalized and published procedures for handling complaints. Internally, however, it is established that the Bureau of Medical and Nursing Facilities Services handles all complaints concerning licensing and certification violations and the Bureau of Medical Assistance handles most complaints of a financial nature. The State Health Department should receive and handle all complaints.

Utilization and Medical Review

The report indicates that the Virginia Medical Assistance Program records indicate that utilization reviews rarely conclude

that nursing home care is unnecessary, except in a few obvious cases of inappropriate placement. However, because the review processes upon admission are working, Medicaid does not have to recommend a change in level of care except in a minimum number of cases. There are very few patients in nursing homes who do not meet the defined criteria for skilled or intermediate care. When a good system of community-based services is available, however, more patients might be diverted from admission. Also, return to the community from nursing homes would be less difficult to accomplish.

It is agreed that there is need to develop a system to record and analyze the data on file in the medical review reports.

Facility Rating

Every patient should be able to expect the same high level of care in any facility licensed by the Department of Health and certified for Medicaid. The present system is designed to promote such a uniformly high level of care.

We do agree, however, that reimbursement by Medicaid must systematically be related to the maintenance of quality care.

Regarding the use of tranquilizers in Virginia nursing homes, the report indicates almost one-third of the patients were receiving some kind of tranquilizer. In a national study published in 1976 by the Department of Health, Education, and Welfare, 74.2% of nursing home patients received one or more tranquilizers, with such usage being greater in patients with mental illness and neurological disorders. Reviews of nursing home patients in Virginia indicate that tranquilizers are used judiciously and where medically appropriate for the well being of the patient.

January 13, 1978

COMMONWEALTH of VIRGINIA

OMMISSIONER'S OFFICE
09 GOVERNOR STREET
RICHMOND

Department of
Mental Health and Mental Retardation

MAILING ADDRESS
P. O. BOX 1797
RICHMOND, VA. 23214

January 12, 1978

Mr. Ray D. Pethtel, Director
Joint Legislative Audit and Review Commission
Suite 200
823 East Main Street
Richmond, Virginia 23219

Dear Mr. Pethtel:

As requested we have reviewed the Commission's exposure draft on Long Term Care and appreciate the opportunity to offer our comments. We have no objections or comments regarding the information relating to the Department of Health's operations in this area.

With respect to the section on "Long Term Care in Mental Institutions", we offer the following comments. A statement should be included explaining that the term mental institutions as used in the report includes both mental health and mentally retarded facilities. This would better explain the cost of $30.50 per day reflected in paragraph 2 on page 106 since the staffing requirements are more stringent for intermediate care facilities for the mentally retarded than general ICF care.

Additional comments could be included within the patient transfer section regarding the Medicaid Screening Program which was implemented in May, 1977 and its effect on mental health and mental retardation transfers. Approximately 89% of the transfers processed through the screening program have been approved for nursing home placement. This would indicate placements are being appropriately made by mental health and mental retardation facilities.

Under the conclusion, we suggest amending the first sentence of paragraph 2 by substituting the word "funded" or the actual percentage of Federal dollars for Medicaid rather than using the word "subsidized". It should be noted that the budget for the Department of Mental Health and Mental Retardation has become dependent upon these funds for institutional care and therefore the operations of our facilities must be in accordance with Federal legislation and/or standards for participation in Medicaid programs.

Finally, we believe the Health Department should be commended for the support and cooperation it has provided to this Department in achieving the current number of certified beds for Medicaid within the institutions. Also, it should be noted that the General Assembly and the Governor has been very supportive of all budgetary requests for meeting Medicare and Medicaid standards and Life Safety Code requirements.

If I can provide any additional assistance, please do not hesitate to contact me.

Sincerely,

Allen E. Wolfe
Assistant Commissioner, Administration

AEW/RHSjr/bj/41

EDWIN L. WOOD
DIRECTOR

Commonwealth of Virginia

Office on Aging

830 E. MAIN STREET
SUITE 950
RICHMOND, VIRGINIA 23219
TELEPHONE (804) 786-7894
TTY (804) 786-7894

January 23, 1978

Mr. Ray D. Pethtel, Director
Joint Legislative Audit and Review Commission
Suite 200
823 East Main Street
Richmond, Virginia 23219

Dear Mr. Pethtel:

We appreciate the opportunity to comment on the exposure draft of the Commission's report, Long-Term Care in Virginia. As you know, the topic of the report is of great interest to our agency since the elderly make up the preponderance of nursing home residents.

Our comments about the report are arranged according to what we determine to be recommendations spotted throughout the report. The enclosure summarizes each recommendation, reference pages in the exposure draft, and presents our response to each recommendation.

You also ask that we discuss factual material or "technical comments". We have several such comments to make and will make them via a separate letter.

In general, we want to commend you on preparing such a careful and useful analysis of intermediate care nursing homes and related aspects of long-term care. The overview you provide of the nursing home industry and of the Medicaid program which contributes so heavily to the industry, will provide the public, as well as government officials, with a summary which would otherwise be lost in a maze of financial reports and program statistics.

The concerns of our Office parallel yours in many ways: concern for the quality of care received by residents in nursing homes, concern about the ability of long-term care facilities to absorb expected growth and demand, concern about the need for alternatives to placement in nursing homes, and concern that the large amounts of public monies being paid to nursing home operators are being well spent.

Our agency's work with nursing homes has been relatively recent in nature and represents a much smaller investment of agency resources than we have placed with community services. This has been primarily a result of our own orientation towards building a good community service system for the elderly as well as the nature of the funding received by our agency. This orientation, however, does not mean that we do not have increasing interest in this portion of the elderly population and in long-term residential care.

From our limited perspective, we believe that the quality of care in nursing homes in Virginia is relatively good. We have, however, found instances where the quality of care could be improved, where State processes for handling problems within the homes could be improved, and where the placement and patient certification system has shortcomings.

I believe our responses to your recommendations and the exposure draft will summarize our feelings, based on our experience, about the issues which you have raised.

We would be happy to discuss our responses with you further, and look forward to receiving the final draft of the report. Should you have any questions, please feel free to give us a call.

Sincerely,

Edwin L. Wood

ELW/am
Enclosure
cc: Mr. Joel Barr

..COPY..

VIRGINIA OFFICE ON AGING RESPONSES TO RECOMMENDATIONS IN
LONG-TERM CARE IN VIRGINIA:
AN EXPOSURE DRAFT PREPARED
BY
THE JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

1. Recommendation 1 (p. 13) - Study the possible increased use of skill beds.

VOA supports such a study since it may lead to reduced hospitalization and, therefore, reduced costs. We are interested, however, in the reasoning behind Virginia's "narrow definition" for skilled nursing facilities.

2. Recommendation 2 (p. 19) - Projection techniques used by SDH should be reviewed.

The Office on Aging agrees with this suggestion. We are not necessarily in agreement with the 5% figure which you propose as a "demand figure" since we believe many people with functional disabilities do not need nursing care. However, a review of projection techniques has merit. We would also suggest that the experience from the new screening program be built into future projections since they are apparently having a profound impact in reducing the number of persons defined as needing nursing home care.

3. Recommendation 3 (p. 22) - A comprehensive plan for alternatives to institutionalization and money to support such a plan is needed.

Our Office has always supported alternatives to institutionalization. In fact, we believe that most of our funds are now supporting services which act as alternatives to institutionalization. We have prepared a six-year plan for a wide range of aging services. This plan, Virginia's Direction in Aging...A Timely Matter, has, as its first philosophical premise the concept that whenever possible, community and home services should be provided to persons so that they need not enter institutions. We have consistently supported budget recommendations from State agencies which are offering alternatives. At the same time it is also true that Virginia does not have a comprehensive plan for alternatives, and we would support the development of such a plan. It would seem to us that, given the variety of services which should be involved in comprehensive alternatives program, sufficient lead time should be allowed to permit joint planning by departments such as VOA, the Department of Welfare, SDH, Highways and Transportation.

4. Recommendation 4 (p. 29) - VMAP may want to pay less for larger homes in order to encourage them to take advantage of potential cost savings.

From our perspective, the issue regarding payments should be one of levels and quality of services, and not necessarily one of facility size. It may be feasible, for example, to have a full-time recreation worker in a large facility rather than a small

one. Hiring such a worker might, in turn, raise the costs in a larger home so that per diem costs are the same as in a smaller home. Certainly economies of scale should be sought after by VMAP and home operators. However, homes which are large and which also wish to provide a full range of high quality services should not be penalized.

5. Recommendation 5 (p. 38) - VMAP needs to upgrade or introduce cost controls since no efficiency inducements exists, and costs vary widely for the same services.

The Office on Aging concurs with this recommendation.

6. Recommendation 6 (p. 47) - VMAP should not consider growth and development monies for nursing home operators.

7. Recommendation 7 (p. 54) - VMAP should not allow accelerated depreciation.

The issue of profit levels permitted to nursing home operators is appropriately dealt with in the General Assembly. Therefore, the Office on Aging would not concur or disagree with either of these two recommendations. The data you provided in your report should greatly assist the Assembly as it attempts to deal with whether or not current profit levels afforded to nursing home operators has been, and continues to be sufficient to permit continued growth in the industry.

It is conceivable that the Assembly could view the nursing home industry as a franchised industry because of the Certificate of Need program. It may wish to set a profit ceiling on home operators, much as it does utilities. On the other hand, it may wish to control only "excessive profits" with a definition of "excessive" developed by VMAP. Whatever the viewpoint about profits, or other monetary incentives in the nursing home industry, we believe that these are matters for the General Assembly to consider.

8. Recommendation 8 (p. 61) - If the VHCA proposal for incentive money is adopted, it should be reviewed annually, and if cost increases were not kept down, it should be eliminated.

The Office on Aging has not reviewed the VHCA proposal in depth. In general, we are not opposed to incentive measures, although we share the same reservations about rising costs as are noted in JLARC in the exposure draft.

9. Recommendation 9 (p. 66) - VMAP needs to require better financial documentation.

10. Recommendation 10 (p. 67) - VMAP should routinely check all purchases from "related organizations" to test costs comparability.

11. Recommendation 11 (p. 68) - VMAP should require all leasing organizations and their primary stockholders to be identified and rental costs closely reviewed.

The Office on Aging concurs with all three recommendations. The enormous expenditures in the Medicaid program for nursing home care call for careful cost analysis. The concerns about "related organizations" are valid and should be checked as a matter of routine. We might also point out, however, that such analysis is time consuming and that SDH should be provided with staff support to conduct such an analysis.

12. Recommendation 12 (p. 69) - There is a need for owner compensation guidelines.

In our opinion, this issue is related to the accelerated depreciation and the growth and development recommendations above. While the examples cited in the report certainly indicate to us that some nursing home owners or corporation officers are receiving excessive compensation, the desire to limit compensation should be voiced by the General Assembly. Suitable guidelines can be developed by VMAP in this area.

13. Recommendation 13 (p. 69) - Depreciation schedules should be in the cost report.

14. Recommendation 14 (p. 70) - All interest costs and loans should be thoroughly documented.

15. Recommendation 15 (p. 71) - VMAP should have a threshold (e.g., one standard deviation) to single out facilities for review.

16. Recommendation 16 (p. 71) - Categories of costs between homes should be analyzed.

The Office on Aging supports comparisons of costs between homes as well as careful review of financial reports from facilities which appear to have excessive costs. We wish to point out, however, that costs alone are not measures of quality of care. It is also conceivable to us that costs in the industry as a whole might be high so the comparisons between homes will only pick out the "highest of the high". Therefore, unit cost comparisons between the nursing home industry in Virginia as a whole, and other industries which purchase the same services, might be of value.

Singling out facilities for review on the basis of a given threshold, may not speak to the quality of a given service. For example, one nursing home may feel that saving money in the area of nursing care will allow it to operate more profitably, while a second one feels that nursing care is of primary importance in that high salary incentives for nursing staff should be a high priority. Which home should be singled out for review?

17. Recommendation 17 (p. 80) - SDH should develop some standard level of staffing for ICF and SCF facilities.

In our opinion, a standard level of staffing will not assure quality care. Minimum staffing levels may be set so low as to be meaningless. The highest staffing standards may eliminate the

ability of nursing home administrators to design staffing patterns suitable to the rehabilitative purposes of their nursing homes. We would recommend that staffing levels be carefully reviewed and analyzed to see if they are clearly related to service quality. If they prove to be related to service quality then positive consideration should be given to requiring a standard level. If they are shown to be related to service quality then such standards would seem to be of little value.

18. Recommendation 18 (p. 81) - SDH should consider more specific standards for training nursing aides.

From our experience, the problems with nursing aides are not necessarily training problems. We have found that the turnover rate for nurses aides is probably related to the low pay received by these aides and by the nature of the work itself. Training for nurses aides may be one way to improve motivation in the working environment. It will not solve the salary problem.

We would also note that training for nurses aides might include the substance abuse area.

19. Recommendation 19 (p. 85-86) - SDH needs intermediate sanctions such as fines.

20. Recommendation 20 (p. 85-86) - SDH needs to differentiate between minor and severe deficiencies.

The Office on Aging agrees with both of these recommendations.

21. Recommendation 21 (p. 89) - Instructions concerning the registering of complaints should be posted; all complaints should be referred to SDH; the State role in complaint handling should be strengthened, perhaps through expansion of VOA's Nursing Home Ombudsman Program.

We should note that the VOA Nursing Home Ombudsman Program is not "mandated" as indicated on page 90 of the report. The program is operated through a model projects grant applied for by this Office and Virginia need not accept the grant should it feel that it is not in the interest of older Virginians to do so. The expansion of VOA's role in the complaint handling area is made difficult for us at present for several reasons. First, Federal restrictions on the small grant which we received for the Ombudsman Program virtually prohibit such a strong direct complaint handling role by our Office. Second, authority for handling complaints is clearly lodged with the State Department of Health. Third, resources available in the Office to resolve complaints are simply too small.

Should the General Assembly wish to transfer complaint handling responsibilities to the Office, therefore, it seems to us that two basic steps must be taken. First, formal authority should be given the Office to receive and investigate complaints (with a corresponding change in the role of SDH). Second, sufficient resources should be provided to do an adequate job. The Wisconsin program noted that it has a $215,000 budget. Our Program receives no State funds and has a $18,000 annual budget.

Like the Commission, we are concerned that the complaint handling process is currently not a smooth one. However, the fact is that SDH has responsibility for complaint handling, and unless the Assembly wishes to transfer this responsibility, we should be working to enhance the complaint handling procedures already in place. Should a decision to transfer responsibilities to our Office be made, we would, of course, design an appropriate program response and present a needed budget.

22. Recommendation 22 (p. 95) - Pre-screening should be expanded to cover all admissions.

The Office on Aging agrees with this recommendation although extension of screening to private pay patients may present legal problems if the screening process is not undertaken voluntarily.

23. Recommendation 23 (p. 98) - Food costs could serve as a measure of dietary adequacy.

Food cost, per se, may not be a good measure of dietary adequacy. For example, the USDA "thrifty food plan" shows that $10.50 per person per week in 1976 might provide an adequate diet. Clearly, cost is not the only variable of importance. The quality of food service personnel is also important. A better measure of dietary adequacy might be to use the nutrient standard method to actually determine the quality of food given to residents in nursing homes.

24. Recommendation 24 (p. 98) - SDH should do a drug use profile of various facilities.

The Office on Aging concurs with this recommendation. However, we feel that development of the profile should not be done in a punitive manner. That is to say, homes in which residents appear to be receiving an inordinate number of various drugs should be assisted in looking at options to such drug use.

Miscellaneous Notes

1. Table 6 on page 25 contains a cost category called "Other". This colunm seems quite low to us given what is included in the cost category. Our basic concern is that cost for social services, educational, and patient activities are minuscule. As these are the only costs listed which we might call life enrichment costs as opposed to rehabilitative service costs, we believe they deserve some comment in your report.

2. On page 62 you indicate your preference for prospective rate setting and efficiency incentives. We agree with your preference.

3. In the draft you refer to the compilation of quality of care statistics as well as financial data. As you know, we are in agreement with collection of such data. We would, however, take your recommendation one step further. We would recommend that ratings of some kind, particularly as they concern quality of care, should

be distributed or published and should be made easily available to consumers who are "shopping" for nursing homes.

4. In general, we believe that payments to nursing homes must somehow be linked with quality of care.

5. The discussion of long-term care in mental institutions does not deal with the transfer of mental health patients to homes for adults. However, many mental health patients are transferred to such homes, and we believe the problems associated with such transfer deserves attention.

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January 11, 1977

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Joint Legislative Audit and Review Commission
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Richmond, VA, 23219

Dear Mr. Pethtel:

We appreciate this opportunity to comment on the exposure draft of your report on long term care in Virginia. Although your report is lengthy and covers many areas, we will try to limit our comments.

The Association represents over 80% of the licensed nursing home beds in the Commonwealth; we are proud of our members who have worked long and hard to provide high levels of care for the sick and elderly of our state. As providers, we are subject to a continuous barrage of federal, State and local laws and regulations which are often contradictory and aimed more at paper compliance than concern for patient care. We welcome your conclusion that: "Most Virginia nursing homes appear to provide generally good care to their patients." (p. 103)

We applaud your conclusion that: "The State should look to a revision of the Medicaid reimbursement system. Of greatest importance for a revised system is an efficiency incentive which links profits, good management and quality care." (pp. 72-73) It has been a stated aim of the Association for over 2-1/2 years to seek a revised reimbursement system which would assure quality care, cost containment based on good management, and reasonable profits. In an effort to carry out this aim, Association representatives have met with VMAP personnel almost monthly in an effort to work out a new system.

Some areas of your report, however, need clarification and expansion. The short section dealing with long term care in mental institutions is a good example. We believe that it is not possible to fully understand the long term care picture in Virginia without a complete discussion of the long term patient in the mental hospital and Homes for Adults as well. We note your statement that costs in the mental institutions run about $6.50 more per day than in community-

based nursing homes. In light of this, there obviously is a need to take a good look at the institutionalization of these patients to see if appropriate care is being given or whether a less costly alternative is warranted. Attention also needs to be given to the recent ruling of a U. S. District Court Judge in Philadelphia who interpreted a provision of the 1973 Rehabilitation Act to mean that residents of institutions for the mentally retarded must be housed in small, community-based facilities. This judge maintained that "large scale institutions render individual attention impossible."

You refer to Virginia's Homes for Adults only in passing, yet they now provide care for over 9,500 elderly citizens. Only about 18% of these elderly persons receive auxiliary grants through the welfare system. At present, 69 Homes for Adults (23% of those licensed by the Department of Welfare) caring for these people have provisional licenses to operate, which means that they cannot meet the state's minimum standards. The present level of funding for Homes for Adults results in this marginal level of care and provides no incentive for the development of new beds. This is an issue directly related to the cost of nursing home care, as a small percentage of those now certified for nursing home care would be placed in Homes for Adults if the Commonwealth would provide adequate funding for this area of long term care.

As far as Certificates of Need, further study is clearly indicated to determine future bed needs. While an acute shortage may still exist in some areas of the state, the need appears to be slackening elsewhere. Waiting lists tend to be deceptive, as much duplication exists. The existence of the Certificate of Need Law also tends to encourage persons to seek certificates before the "need" is exhausted.

In the area of skilled care, we agree that a number of patients in acute care hospitals could well be cared for in nursing homes. The Health Department should study the use of "swing beds," now in effect in at least 22 states. "Swing beds" allow facilities to provide either skilled or intermediate care for patients, regardless of prior designation of the beds for a particular level of care. This is one factor which would encourage more nursing homes to open skilled care beds.

We believe that the proper level of care should be available for all citizens, be it in their own home or in any number of alternative settings, including a nursing home. Yet alternative programs should be supported for the right reason--to provide for the social needs of the individuals and not necessarily as cost saving devices.

Family commitment is essential to making the concept of home health and other non-institutional services workable and useful. We agree with your statement on page 20: "Although alternatives to institutional care reduce the utilization of nursing home beds, they cannot be looked upon as an easy way to reduce costs." Indeed, new types of alternative services will, along with keeping some people out of the nursing home setting, create a new demand among people who are not now considering institutional care. In this way, the new programs will actually increase expenditures for health care.

Your detailed section on reimbursement makes a number of comparisons and assumptions which need clarification. Cost increases cannot be discussed in a meaningful way without separating increases due to utilization and increases due to the rise in average daily operating costs. As noted on page 38, average per day costs rose 36.4% between FY 1974 and FY 1977. No mention was made of the following factors that affected these increases:

(1) the minimum wage rose 30% in the same period;

(2) new state licensure rules and regulations became effective January 1, 1973, and required Virginia facilities to adhere to some of the highest and most costly standards in the country;

(3) new federal regulations for intermediate care were published in the Federal Register on January 17, 1974, putting in motion a whole series of structural changes (Life Safety Code, ANSI, etc.) and staff changes as well as requiring the use of outside consultants; and

(4) wide-spread general inflation, fed by a 63% increase in insurance rates, a 45% advance in utility rates, a 34% hike in medical supply costs, and a 29% increase in nursing service expenses. (Virginia's long term care providers were able to blunt the impact of these enormous increases only by employing rigid cost containment procedures.)

National cost comparisons (p. 35) cannot be meaningful unless it is realized that even though Virginia's Medicaid reimbursement level is one of the highest in the nation, the level and quality of care being provided ranks at the top nationally, as well. Also, costs cannot be compared meaningfully without a careful look at state licensure rules and regulations, building requirements which are interpreted differently among the states, and the widely disparate levels of care required under state Medicaid plans and survey programs.

For your staff comparisons (p. 32), two other factors should be taken into consideration:

(1) physical layout of the building, resulting in different staffing requirements;

(2) the availability or lack of availability of Registered Nurses or Licensed Practical Nurses in certain areas of the state dictating staffing patterns and thereby affecting costs.

In comparing costs between homes in the state, other individual factors should be taken into consideration. Just as state-operated geriatric units in the mental health system as well as public schools and state-supported colleges do not have identical costs, nursing home costs are different across the state. Costs are often related to prevailing community standards in health care.

We recognize the need for greater attention to the training of nurses aides to which you refer. (p. 104) Our "Train the Trainer" education programs, reaching nearly 100 staff members representing as many nursing homes, have concentrated on training those in nursing homes who are responsible for in-service training. In addition, individual training programs have been held for nurses aides.

It must be recognized that the only way to stabilize the nursing aide work force is through upgrading salaries and fringe benefits, which will have a major impact on nursing home costs in Virginia.

Utilization, the demand for nursing home beds (and therefore for new beds), has also had a major impact on total costs. The elderly population in Virginia has been increasing rapidly and this is complicated by the change in family structure and the increased lifespan of the elderly, as well as their complicated illnesses which usually require detailed nursing care. As noted in our accompanying report, "Providing Long Term Care in Virginia: 1978", between FY 1973 and FY 1975, demand increased 49% (from 1.8 million patient days to 2.8 million patient days) and between FY 1975 and FY 1977, demand rose another 23% (from 2.8 million patient days to 3.44 million patient days.

We have repeatedly stressed the quality and dedication of nursing home staff in providing high quality care to nursing home patients. Reference to deficiencies in VMAP Medical Reviews (p. 94) indicated that 55.6% are related to physician recertification; 49.9% are related to physician progress notes, and 12.6% are due to lack of proper renewal of physician orders. All of these major deficiencies indicated the difficulty of obtaining cooperation from the medical community which has the legal responsibility for the patient's medical care. Nursing homes have the responsibility to notify the physician when his services are needed, but the physician alone can certify the patient's need for continued care and prescribe medication and treatment plans.

The Association developed a Peer Review Program in 1975. To date, over 30% of our members have benefited from this educational and evaluative approach which assists facilities in upgrading care.

The Virginia Health Care Association was one of three associations in the nation to receive grants from the Department of Health, Education and Welfare to develop state-wide training programs for long term care personnel. This program has focused on many major aspects of patient care. Our current schedule is attached.

Your report raises some questions about our reimbursement proposal. A copy of the August 1977 draft is attached. The proposal is still being discussed with state Health Department officials and is being further modified. It should be understood that this proposal was developed during a period when nursing homes have been undergoing drastic changes due to a whole series of new federal laws and regulations, new state licensure rules and a constant upgrading of state surveys.

The VHCA proposal for reimbursement intended no loophole to allow renegotiation of rates (p. 61) Rather, it clearly states that rates can only be adjusted if provider cost is affected by substantial changes in federal or state laws or regulations.

Your report also overlooks our proposal for separation of operating and capital costs before calculating a rate and determining an incentive factor. (p. 59) This concept is essential, as the Certificate of Need process has failed to control construction costs.

In reference to your lengthy section on depreciation and property valuation, we feel that reference should be made to the general principles of HEW reimbursement regulations (HIM 15, Chapter 1) as they apply to health care providers as well as VMAP regulations on this issue. VMAP holds that there is a depreciation recalculation for the seller even though no affiliated depreciation was taken in the past. It may well be that, due to real estate appreciation in the last few years, it would be detrimental for an owner to sell a facility since all past depreciation taken might be recaptured under the above-mentioned regulations. In addition, sale of property is subject to the Certificate of Need process which might possibly result in a denial.

It would appear from the above that the issue of property valuation and depreciation is more complex than stated in your report.

Your report is long, and complete comment is not feasible in this forum. Many issues are discussed and we agree with your conclusion that a number of them warrant further study.

Our goal is to have a healthy business climate so that, working in partnership with the government, we can continue to provide quality care to the sick and elderly citizens of Virginia. Our comments are made in this spirit and we hope they are constructive for your effort to inform the Legislature about long term care in Virginia.

Sincerely,

James K. Meharg, Jr.

James K. Meharg, Jr.
President

JKM:rs
encl:

(1) Providing Long Term Care in Virginia: 1978
(2) A Medicaid Payment System, August 17, 1977
(3) The VHCA Education Program schedule (Sept. 77-June 78)

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ADDENDUM:

Rating of facilities:

More study should be given to this complex issue.

The section on Florida (page 101) should be entirely deleted, as a Florida court has declared invalid the law establishing this rating system. It is therefore not in use.

The Utah plan is operational, but it includes less than 5,000 beds. The cost of setting up such a plan in Virginia for a projected 20,000 to 25,000 beds should be given serious consideration.

JKM

JKM:rs

JLARC NOTES TO AGENCY RESPONSES

State Department of Health

(pp. 86-88). Due to additional information provided by SDH substantial revisions were made in this section of the draft report.

(p. 89, 1st paragraph). JLARC contacted two of the three states referenced by SDH as well as 24 other states to determine comparative payment rates. The report technical appendix describes the criteria used to control for the differences in definition noted by SDH. JLARC concludes the finding that Virginia rates are among the highest in the country is accurate.

(p. 89, last paragraph). It should be noted that using SDH's proposed graph cost increases ranged from 17% to 77% which differs little from JLARC's 10% to 90% range. Furthermore, statistical analysis (End Note 4, Chapter II, p. 79) confirms that there is no evidence of convergence for rates among facilities in operation since 1973. JLARC concludes that Figure 3 is an accurate representation of the widely ranging medicaid payment rates for nursing home care in Virginia.

(p. 93, last paragraph). Although the evidence may suggest that overall, Virginia nursing homes may use drugs judiciously, there appear to be some facilities with drug usage at levels well above the norm. SDH could develop drug usage profiles of nursing homes at additional little cost to monitor this important quality-related area.

Virginia Office On Aging

(Recommendation 4, p. 98). Operational economies are generally available in the major standardized expenditure categories such as dietary and housekeeping services. They would not necessarily apply to specialized services such as supervised recreation. It is unlikely that the cost of specialized services would offset the overall cost savings available through large scale operational economies.

(Recommendation 17, p. 100). No standard can assure quality care. Nor should any standard prevent the exercise of professional judgement on the part of nursing home inspectors. Standards could serve as valuable guidelines for inspectors and should be developed for that purpose.

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