Joint Legislative Audit and Review Commission

The Virginia General Assembly

Medicaid-Financed Long-Term Care Services In Virginia

A Report in a Series on the Virginia Medicaid Program

REPORT OF THE
JOINT LEGISLATIVE
AUDIT AND REVIEW COMMISSION

Medicaid-Financed Long-Term Care Services in Virginia

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Preface

Senate Joint Resolution 180, passed during the 1991 legislative session, requested the Joint Legislative Audit and Review Commission (JLARC) to conduct a comprehensive study of Virginia's Medicaid program. Medicaid is a program designed to provide health benefits to persons who are poor.

This study mandate was passed in response to the escalating costs of Medicaid in Virginia, which have more than tripled since 1980. Currently, the State spends more than $1.2 billion, annually on the program, which extends benefits to more than 400,000 recipients.

Medicaid-financed long-term care services are reviewed in this report. Over the last ten years, the management of these services has improved considerably. Problems with the lack of adequate cost controls in the State's reimbursement system have been addressed through policies which encourage a more efficient delivery of health care. However, the State now faces problems with expanded eligibility policies, the rising cost of institutional care for the mentally retarded, and an underutilization and sometimes inappropriate targeting of community care services.

Given the changing composition of the State's population, it is critical that policies which have the potential to contain the cost of the program be given serious consideration by the General Assembly. Recipients of long-term services constitute just 10 percent of the Medicaid population, but they are already responsible for more than 56 percent of its costs. With projected increases in Virginia's elderly population, the demand for many of the services funded through Medicaid is expected to increase.

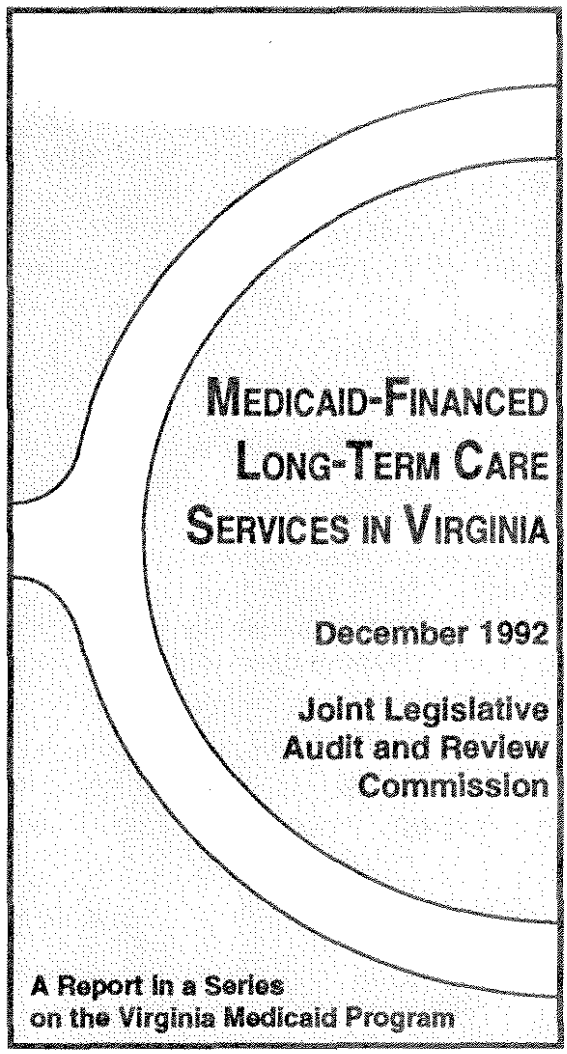
However, even if some of the cost containment measures recommended in this report are adopted, difficult decisions will have to be made to significantly control long-term care costs. While federal law does give the State the necessary discretion to reduce the size and scope of its long-term care program, implementation of these options will create hardships for many elderly citizens who live at the economic margin.

On behalf of the Commission staff, I wish to acknowledge the support and cooperation by staff at the Department of Medical Assistance Services and the various long-term care service providers in the preparation of this report.

Philip A. Leone
Director

December 17, 1992

JLARC Report Summary



Senate Joint Resolution 180 (1991) directed the Joint Legislative Audit and Review Commission (JLARC) to conduct a comprehensive study of the State's Medicaid program. The study resolution was passed in response to legislative concern about the rapidly increasing costs of Medicaid in Virginia. For example, in 1980, total expenditures under Medicaid were just over $374 million. By 1991, although the number of recipients increased by 46 percent, the cost of the program had more than tripled to $1.2 billion.

This report presents an analysis of the implementation of Medicaid long-term care services in Virginia. These services, which are primarily targeted to persons who are elderly and disabled, include nursing home care, institutional care for persons who are mentally retarded, and a diverse array of community-based services.

JLARC previously reported on the status of long-term care in Virginia in 1978. At that time, there were serious concerns about the quality of care in nursing facilities, the Medicaid payment rates were found to need revision, and there was a lack of adequate cost controls. In addition, the 1978 study found that rapid growth in the nursing home industry had been fostered at the expense of efficiency in many cases.

Since 1978, the growth has continued, with the number of licensed beds increasing from about 14,500 to more than 30,000 in 1991. However, the issues in long-term care now are not the same as those in 1978. The creation of the Department of Medical Assistance Services (DMAS) to administer the Medicaid program has promoted a stronger focus on improved management of the program. The issues facing the Commonwealth today relate to problems with expanded Medicaid eligibility policies, the increasing costs of care for persons who are mentally retarded, effective use of community care, and the reimbursement system for community-based care.

Concerns about these issues are heightened because of the changing demographics of the State's population. With projected increases in the Virginia's elderly population, the demand for many of the long-term care services financed through Medicaid is expected to increase.

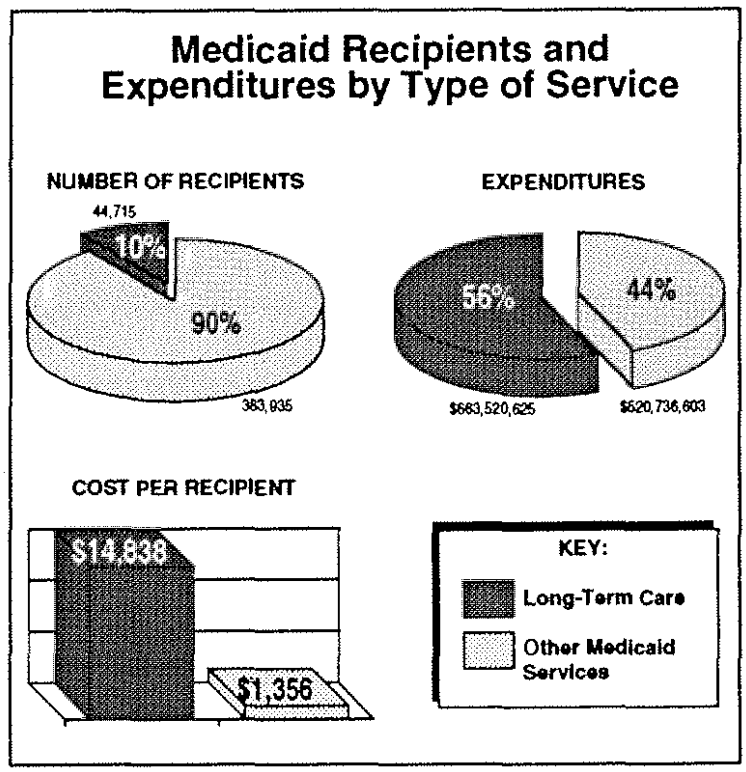
This study explores a number of options for reducing the overall costs of Medicaid funded long-term care services. As a result, the study focuses on five areas: (1) an assessment of the factors influencing trends in the State's Medicaid long-term care costs; (2) an analysis of the impact of the program's eligibility policies on Medicaid costs; (3) an assessment of Virginia's reimbursement policies; (4) a review of the Medicaid-supported community care services; and (5) an assessment of DMAS' cost audit and utilization review procedures. Within these areas, the following issues were addressed:

- What are the major factors that appear to be associated with the rising costs of Medicaid long-term care services?
- What particular cost avoidance strategies can the State pursue through altering current eligibility criteria and service options for Medicaid?
- Are the current reimbursement methodologies used to pay for institutional and community-based services appropriately designed to provide access to quality care at the lowest possible cost?
- Is community-based care adequately and appropriately used to reduce reliance on institutional services?
- Are DMAS' utilization review and cost audit processes adequate to ensure that the long-term care services supported through Medicaid are both necessary and appropriate?

Long-Term Care Services Account for Half of All Medicaid Expenditures

Expenditures on services that can be characterized as long-term care have always been a major component of Medicaid's total budget. Payments to providers of long-term care services have generally accounted for approximately one-half of the medical care expenditures for the program. In FY 1980, 51 percent of the $374 million spent for Medicaid was used to pay for long-term care services. By FY 1991, this percentage had decreased, but this type of care still represented 47 percent of total program spending.

When all of the Medicaid expenditures for long-term care recipients are considered (i.e., pharmacy expenses, inpatient hospital care), the data show that this population represents only 10 percent of the total number of Medicaid recipients, but they account for 56 percent of program costs. This means that the costs of serving this group is almost 11 time greater than for other Medicaid recipients (see figure below).



Institutional Care Dominates Medicaid Long-Term Care Expenditures

Despite changes to federal statutes which are designed to encourage greater use of community-based care, almost nine out of every 10 dollars spent by Medicaid on long-term care in Virginia is still used to support institutional-based services (see figure below). Payments for nursing home care constitute the largest proportion of expenditures on long-term care. In FY 1991, DMAS paid nursing homes more than $312 million — 55 percent of the total expenditures on long-term care. Another 25 percent of the payments ($145 million) can be attributed to the services that were provided persons in State and privately operated intermediate care facilities for the mentally retarded (ICFs/MR).

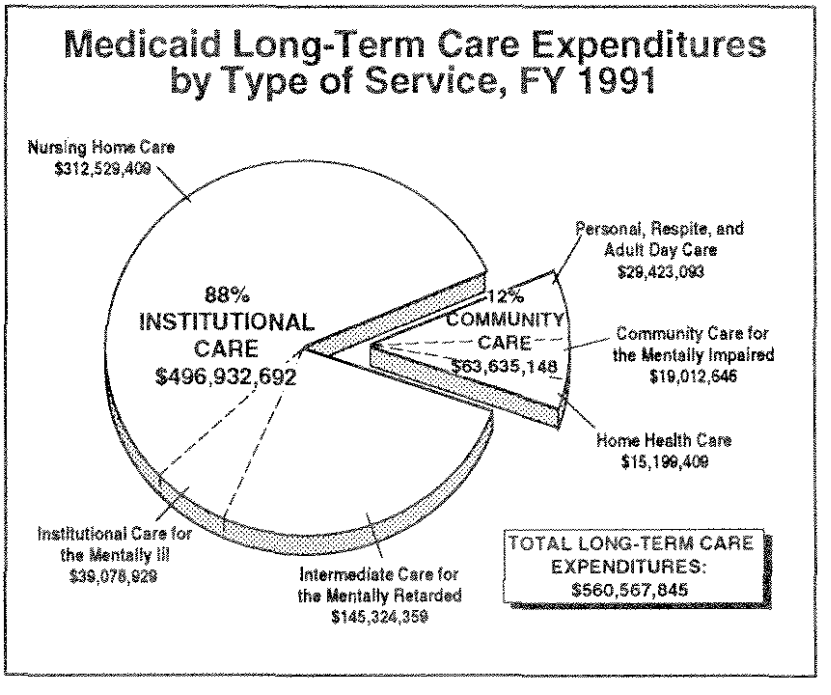
Conversely, just over $29 million was used to provide non-medical, personal care services to infirm and disabled Medicaid recipients in FY 1991. More than $15 million was spent on home health care services. Finally, just over $19 million was used to provide community-based care for the mentally impaired.

Reasons for Medicaid Long-Term Cost Increases Vary by Service Type

Since 1983, the average growth in overall expenditures for long-term care has averaged slightly more than 11 percent. Among the institutional services funded by Medicaid, expenditures for State-operated facilities for the mentally retarded have grown at the fastest rate (approximately 13 percent.) These increases are due almost entirely to sharp rises in the cost of providing a day of institutional care, due primarily to increased federal regulations.

For nursing homes, average annual spending growth has been slightly more than nine percent. More importantly, this increase appears to be partly related to the fact that Medicaid is paying for a greater number of days of nursing home care due to growth in the number of recipients.

The fastest growing long-term care services are those provided in the community. Both personal care and home health expenditures have experienced substantial increases. In these programs, increases in the number of recipients have significantly outpaced the amount of spending per recipient. Still, the impact of these increases on total Medicaid spending is not as great because the services are delivered at a much lower cost than those provided in institutions.



Difficult Decisions Will Be Necessary to Control Long-Term Care Costs

The federal laws which are the basis for Medicaid's eligibility guidelines give the states considerable discretion in deciding who is served by the Medicaid program

and what benefits they receive. As a result, the most effective methods for cost avoidance in Medicaid are to restrict the number of persons who have access to the program or limit the range of benefits that will be provided.

In Virginia, a substantial portion of the long-term care cost in the State is due to the extension of benefits to persons for whom Medicaid coverage is optional. In FY 1991, more than half of the 44,000 Medicaid long-term care recipients established eligibility for program benefits through provisions which were implemented at the option of the State. The total medical care expenditures for this group of recipients exceeded $370 million.

Similarly, more than half of Virginia's Medicaid expenditures for long-term care were for services which the State is not required to provide. The total cost of these optional services in FY 1991 was more than $366 million. This equals almost one-third of the total amount spent on Medicaid services in the State.

These data clearly demonstrate that the State has the discretionary authority to reduce the size and cost of its Medicaid program. However, the outcome would be a reduction in services to many elderly citizens who either live at the economic margin or rely almost exclusively on Medicaid for support of their basic health care needs.

The Reimbursement System Used for Nursing Homes Has Been Improved

When JLARC conducted a review of the Medicaid program in 1978, the State was using a retrospective cost-based reimbursement system for nursing homes. This system was criticized as inflationary because nursing homes were reimbursed 100 percent of their allowable costs. As a result, recommendations were made to establish a reimbursement system which encouraged efficiency in the delivery of nursing services.

Since that time, DMAS has made a number of improvements to the reimbursement system. Nursing home rates are now established prospectively with payment ceilings to limit the amount of reimbursement a facility can receive from the program. In addition, to enhance access for those Medicaid recipients who have substantial care needs, an adjustment is made to each nursing home's Medicaid reimbursement rate based on the intensity of the facility's case mix.

This study found that the current reimbursement system is well designed and appropriately considers most of the key factors which influence cost. Moreover, one effect of establishing payment ceilings has been to slow the growth of nursing home expenditures. Presently, Virginia's Medicaid nursing home expenditures per elderly resident rank among the lowest in the country.

Still, three problems were found with the current system. First, the payment ceilings are not based on measures of efficiency in the nursing home industry. Second, the system does not adequately account for the higher operating costs faced by smaller nursing homes. And third, the reimbursement rates do not reflect the costs nursing homes face due to legislation requiring criminal record checks and protection of employees from bloodborne pathogens.

Recommendations to improve the reimbursement system follow:

- *The Department of Medical Assistance Services should make adjustments to its reimbursement system to account for the higher indirect costs that smaller nursing facilities experience. The Secretary of Health and Human Resources should report the details of the adjustment methodology and its impact on Medicaid nursing home expenditures to the Joint Commission on Health Care prior to the 1994 session of the General Assembly.*

- *The Joint Commission on Health Care may wish to consider ensuring that current efforts to develop efficiency standards for the nursing home industry are coordinated so that the work of the Department of Medical Assistance Services is not duplicative or at odds with the findings being developed by the Virginia Health Services Cost Review Council.*

- *The Department of Medical Assistance Services should develop a methodology for determining the costs of Virginia's requirements regarding the use of criminal records checks and protection of nursing home employees from bloodborne pathogens. This methodology should be used to determine the amount of any rate adjustments required. These findings should be reported to the Secretary of Health and Human Resources by March of 1993.*

No Cost Containment Incentives in Reimbursement System for ICFs/MR

Unlike for nursing homes, the reimbursement system for State-operated institutions for the mentally retarded contains no cost containment incentives. As a result, Medicaid pays virtually 100 percent of the cost for what has become the most expensive form of long-term care in the State. In FY 1991, Medicaid paid the five State facilities an average reimbursement of $169. At this rate, the annual cost of care for a Medicaid recipient with no resources to pay for these services could be more than $61,000.

Still, if DMAS were to lower the rates for these facilities, the State would either have to ignore national trends and consolidate these operations, or use general fund dollars to replace the revenues lost due to the reduction in Medicaid payments.

Personal Care Services Could Be Better Targeted

Medicaid provides states with a number of options for developing community care programs through Section 2176 of the Omnibus Budget Reconciliation Act of 1981. One requirement of this provision is that the costs of services provided in the community do not exceed the cost of institutional care. Specifically, states are required to target services provided under the 2176 waiver program to only those people who are at-risk of institutional placement.

This study found that, in almost all circumstances, the waiver services are less expensive than costly nursing home care. However, the local screening committees which are responsible for recommending personal care services, have not successfully restricted these placements to persons who are at imminent risk of institutionalization. Specifically, personal care services for 57 percent of the current recipients appear to be mistargeted. This has increased Medicaid spending by more than $16 million annually.

Another way in which targeting can affect the overall cost to the State is when people who should be offered personal care are instead steered into a nursing home. Because personal care is a more cost-effective form of care than nursing homes, these services should be offered as an alternative whenever possible.

It appears from this study that hospital-based screening committees have an inherent bias towards placing people in nursing homes rather than in personal care. After accounting for the availability of social support and the individual's functional status, hospital screening committees are still 25 percent more likely than community-based committees to place long-term care applicants in a nursing home.

The following recommendations are made:

- *The Department of Medical Assistance Services should evaluate the feasibility of contracting with community-based screening committees to conduct either all or part of the hospital screening functions. If the agency determines that some screening functions should remain with the hospitals, it should also conduct a study to ensure that there are not other potential inconsistencies in the way in which hospitals conduct screenings.*

- *The General Assembly may wish to reduce general fund appropriations for personal care. This reduction should be between $2 million and $8 million depending on whether changes are made to personal care rates and the ability of hospital-based screening committees to divert more people to personal care. The General Assembly may wish to direct the Department of Medical Assistance Services to prepare a full analysis of alternative levels of reduction for the personal care program, including the potential impact on recipients.*

Community Programs for the Mentally Retarded Have Developed Slowly

While the federal waiver authority has been used to divert the aged and disabled from nursing homes to a less expensive form of care over the past decade, the same has not been true for the mentally retarded. Although the 1981 federal legislation that authorizes waivers for the elderly and disabled also allows similar services to be targeted towards the mentally retarded, the State's use of this authority has lagged. Not until 1991 was the State able to obtain approval for the waiver and begin implementing a program that is designed to divert people from care in institutions to community programs.

Yet it is difficult to determine what impact the State's lack of participation in the waiver has had on overall Medicaid expenditures for the mentally retarded. Available data does not suggest that a more timely development of a waiver program would have led to further reductions in the number of recipients in need of institutional care. Since the early 1980s, the census in State-operated ICFs/MR has declined steadily as most residents who are moderately retarded were placed in community programs.

Further, it is current State policy to limit all non-emergency admissions in these facilities to persons who are severely or profoundly retarded. As a result, the majority of residents in these facilities have complex problems which cannot be easily met in the community. Presently, there is no evidence to indicate that the range of services that would be needed by these individuals can be provided more cost-effectively in the community.

Recommendation: *The Department of Mental Health, Mental Retardation, and Substance Abuse Services should conduct a pilot study to determine whether community-based waiver services could be cost-effectively used to meet the needs of persons who are severely or profoundly mentally retarded.*

Reimbursement System for Community Care Needs to be Reexamined

Although Medicaid expenditures for community-based care represent a relatively small portion of total program expenditures, spending on these services has been growing at a rapid rate of more than 70 percent since 1983. Partly as a result of this increasing trend, there is a heightened interest in the policies used by DMAS to establish reimbursement rates for both home health and personal care services.

A primary concern is whether these policies ensure patient access to community-based care while encouraging a cost-effective delivery of services. Currently, the State reimburses providers of home health care based on a fee for service system. However, the methodology used by DMAS to establish the prospective rates does not appropriately consider the key factors which influence home health costs. Also, fees may have been set too low to ensure patient access to these services in the future. In addition, the decision to pay hospital-based agencies higher rates for providing the same service as other operators does not appear justifiable.

The following recommendations are made:

- *The Department of Medical Assistance Services should eliminate the distinctions made for hospitals when establishing fees for the delivery of home health services. In addition, the Department should only authorize payment of a higher fee to hospitals if there are no freestanding agencies which will agree to accept the home health care referral.*

- *The Department of Medical Assistance Services should use a revised statistical approach for setting the fees in each peer group.*

The Department Has Strengthened Its Utilization Review Activities

As part of its overall efforts to contain Medicaid long-term care spending, DMAS conducts utilization review activities. Utilization review serves as a control mechanism for the amount and type of long-term care that is provided. Control of utilization is necessary to ensure that the Commonwealth pays only for those long-term care services that are necessary and appropriate.

Over the last several years certain aspects of utilization review have been strengthened. Home health agencies are, for the first time, receiving scrutiny. Nursing home and personal care admissions continue to be evaluated to ensure that only persons who meet non-financial as well as financial eligibility criteria receive the services. Still, some improvements are needed.

For example, utilization review activities for personal care recipients need to be improved to ensure that these continue to be individuals who are at imminent risk of nursing home placement. Also, utilization review activities in the ICFs/MR rely on procedures which are not adequate for evaluating the existence of active treatment. The defects in the process raise questions about the validity of the findings produced by the inspections of care.

The Cost Settlement and Audit Process is Not Timely or Comprehensive

Cost settlement and audit serves as a financial control mechanism for Medicaid reimbursement. Financial control is necessary to ensure that the Commonwealth pays only for those costs explicitly allowed under the established principles of reimbursement. Financial controls are also necessary to ensure the reliability of a provider's reported cost information.

In 1991, the Auditor of Public Accounts found that cost reports were not settled in a timely manner. DMAS recently enacted emergency regulations to lengthen the timeframe for setting interim reimbursement rates from 90 days to 180 days after receipt of a nursing home's cost report. Still, due to an increased workload, it often takes DMAS longer than 180 days to establish a new reimbursement rate and settle a cost report. This can adversely affect a provider's cash flow.

Regarding the actual audits, more than 80 nursing homes, or about a third of all

those participating in the Medicaid program, have not had a field audit since at least FY 1986. This raises questions concerning the extent to which DMAS is able verify the accuracy of cost reports.

DMAS recently began to conduct additional field audits. Nursing homes are selected based on length of time since last field audit, amount of Medicaid utilization, and whether the provider's costs are below the payment ceiling. Despite this, 43 nursing homes which have not been field audited since FY 1986 have costs which are below the ceiling. However, only two of these providers were selected for audit by DMAS during FY 1992. These 43 nursing homes received, on average, $2.3 million in Medicaid reimbursement during FY 1990

Two recommendations are made to strengthen the audit process:

- *The Department of Medical Assistance Services should take the necessary steps to expedite the cost settlement process. In addition, the Department should reconsider the regulatory change that lengthens the timeframe for setting interim nursing home reimbursement rates.*

- *The Department of Medical Assistance Services should analyze its most recent field audit and payment data in order to select additional nursing homes for discretionary field audits. The Department of Medical Assistance Services should ensure that nursing homes selected for discretionary field audits meet, to the greatest extent possible, established selection criteria.*

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I. Introduction

Senate Joint Resolution 180 (1991) directs the Joint Legislative Audit and Review Commission (JLARC) to study the Medicaid program. Established in 1965, Medicaid is a health care program jointly financed by the federal government and the states to provide a range of medical care services for the poor.

The impetus for the study resolution stems from concerns by the General Assembly regarding the rapidly increasing cost of Medicaid. For example, in 1980, total expenditures under Medicaid were just over $374 million. By 1991, though the number of recipients increased by 46 percent, the cost of the program had more than tripled to $1.2 billion.

JLARC previously reported on the status of long-term care in Virginia in 1978. At that time, there were serious concerns about the quality of care in nursing facilities, the Medicaid payment rates were found to need revision, and there was a lack of adequate cost controls. In addition, the 1978 study found that rapid growth in the nursing home industry had been fostered at the expense of efficiency in many cases.

Since 1978, the growth has continued, with the number of licensed beds increasing from about 14,500 to more than 30,000 in 1991. With projected increases in Virginia's elderly population, this growth can be expected to continue (Figure 1). However, the issues in long-term care now are not the same as those in 1978. The creation of a separate agency to administer the Medicaid program has promoted a stronger focus on improved management of the program. The reimbursement system for institutional care is greatly improved and the necessary cost controls have been implemented. More importantly, quality of care issues now receive considerable attention.

The issues facing the Commonwealth today relate to problems with expanded Medicaid eligibility policies, the increasing costs of care for persons who are mentally retarded, effective use of community care, and the reimbursement system for community-based services. These and other issues are addressed in this report.

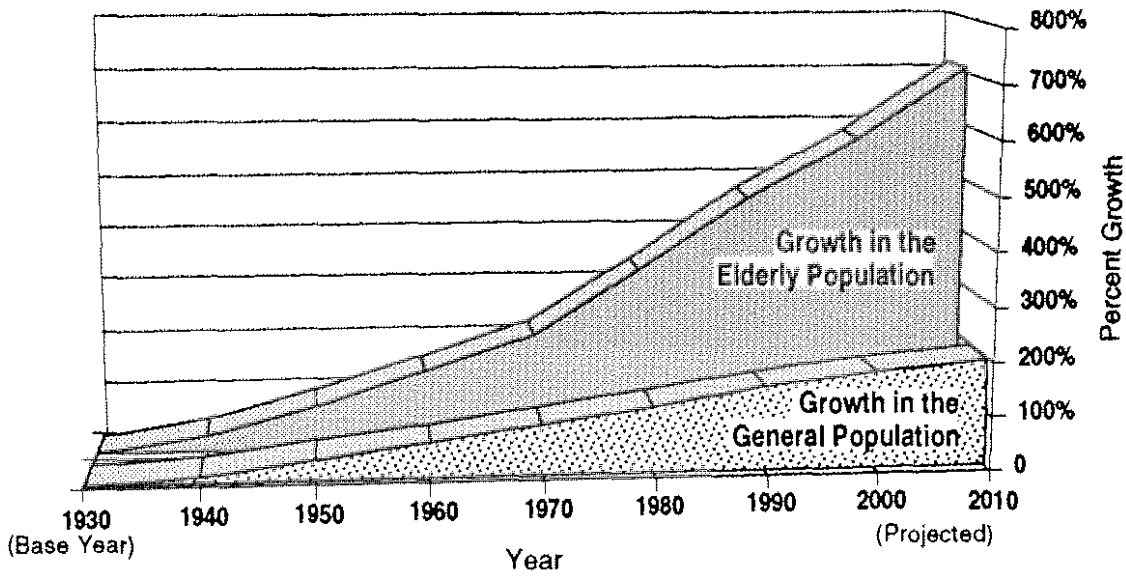
The system of long-term care in Virginia today is comprised of a diverse array of basic health, medical, and professional therapy services which are typically provided to persons who are either elderly, disabled, or mentally impaired.

Some of the major providers of this type of care include nursing homes, professional home care agencies, and State-operated institutions for the mentally retarded and mentally ill. In 1991, these providers delivered Medicaid-funded long-term care services to more than 44,000 persons at a cost of over $550 million.

This report presents an analysis of the organization and implementation of Medicaid long-term care services in Virginia for the purpose of evaluating program

Figure 1

Projected Growth of Virginia's Elderly Population (65 and Over)



Source: University of Virginia, Center for Public Service Statistical Abstract.

implementation and specific cost containment policy options available to the State. Included in this review is an assessment of the State's eligibility policies for long-term care, reimbursement strategies for different service providers, and an evaluation of Virginia's use of the community care system for Medicaid recipients.

OVERVIEW OF THE MEDICAID PROGRAM

In 1965, federal legislation authorized the Medicaid program under Title XIX of the Social Security Act. The Health Care Financing Administration (HCFA), which is part of the U.S. Department of Health and Human Services, has oversight responsibility for the program.

Federal law does not require states to participate in the program. For those that do, however, the federal government shares in the costs by matching state general fund expenditures at a rate that varies based on each state's per-capita income. Virginia, which began implementing the Medicaid program in 1969, currently receives a 50 percent match of the total general fund dollars it spends on approved health care services.

The State agency responsible for the implementation of the Medicaid program in Virginia is the Department of Medical Assistance Services (DMAS). As with other services paid for by Medicaid, DMAS makes payments for a specified range of long-term

care services when this care is delivered by approved providers on behalf of persons who meet the program's eligibility requirements.

Basic Eligibility Requirements

With the exception of certain basic requirements, states have considerable discretion in deciding who will benefit from the program and what services they will receive. In terms of eligibility, three groups of people can be covered by Medicaid: the categorically needy, optional categorically needy and the medically needy.

Categorically Needy. Persons who either receive, or otherwise meet the requirements for eligibility under the Aid to Families with Dependent Children (AFDC) or the Supplemental Security Income (SSI) Programs are considered categorically needy. As such, these individuals are automatically eligible for Medicaid.

Optional Categorically Needy. Medicaid eligibility also allows states to extended benefits to persons considered optional categorically needy. In Virginia, this group of recipients include persons who establish eligibility through the State's use of a special income standard for persons who are institutionalized.

Medically Needy. The medically needy are persons whose income meets a higher established limit for program eligibility either before or after their medical expenses are deducted from their income. Unlike the categorically needy, coverage for this group is not required.

Medicaid provisions for the medically needy are particularly important to persons in need of long-term care. Because of the expense associated with some forms of this care (e.g. nursing homes), these individuals may have too much income to establish eligibility for Medicaid, but not enough to pay the monthly cost of nursing home care. The medically needy provisions allow these people to enter a nursing home as private payers ineligible for publicly-financed health care and "spend down" their income thereby requiring Medicaid to pay any remaining nursing home costs based on a lower public rate.

Service Options

While the Medicaid program mandates states to provide certain benefits to recipients based on whether they are categorically or medically needy, federal law considers a substantial number of services to be optional. This flexibility allows states to customize their program benefit plans to reflect the goals they wish to pursue in the provision of health care to the poor.

The best example of this is the mix of mandated versus optional services for the medically needy. Medicaid law requires those states which offer benefits to the medically needy to provide prenatal care and ambulatory services, among other benefits. However, one of the most expensive benefits — nursing facility care — is not required. Whether

a state chooses to provide this care is usually based on funding concerns as well as the policy goals for its system of long-term care.

MEDICAID SPENDING ON LONG-TERM CARE SERVICES IN VIRGINIA

Expenditures on services that can be characterized as long-term care have always been a major component of Medicaid's total spending. As illustrated in Figure 2, payments to providers of long-term care services have generally accounted for approximately one-half of the medical care expenditures for the program. For example, in FY 1980, 51 percent of the $374 million spent for Medicaid was used to pay for long-term care services. By FY 1991, this percentage had decreased but this type of care still represented 47 percent of total program spending.

To better illustrate the cost differences associated with providing Medicaid supported health services to recipients of long-term care, it is important to consider the per recipient cost of health services for this population. Because most long-term care recipients are elderly or disabled, they often experience numerous health care problems or have long-term support needs which require extensive and expensive forms of medical care.

In FY 1991, for example, there were slightly more than 44,000 Medicaid recipients who benefited from the array of services provided under the general category of long-term care (Figure 3). This constitutes just 10 percent of the 428,000 Medicaid recipients who participated in the program that year. However, when total medical care expenditures for long-term care population are considered (i.e. pharmacy services, inpatient hospital care), these recipients accounted for 56 percent of the program's expenditures. On average, this means that the cost of providing Medicaid services to recipients of long-term care ($14,838 per person) is almost 11 times higher than for other recipients ($1,365 per person).

These cost differences have even larger implications when the changing demographics of the State's population are considered. Since 1980, there has been a 31 percent increase in the number of persons in the State who are at least 65 years old. Based on improvements in life expectancy, this age group is expected to grow at an even faster rate in the next 10 years. Because a number of these individuals will likely need publicly-financed health care, Virginia, like other states, will be forced to make a number of difficult policy decisions about the size and scope of the long-term care services it provides through Medicaid.

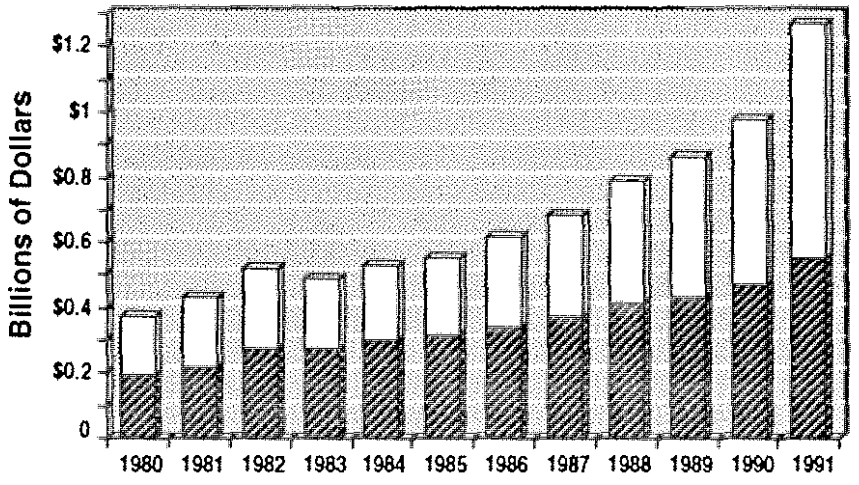
The next sections in this chapter discuss how the State currently distributes its Medicaid funds within the broad category of long-term care, followed by a description of each of these types of services.

Figure 2

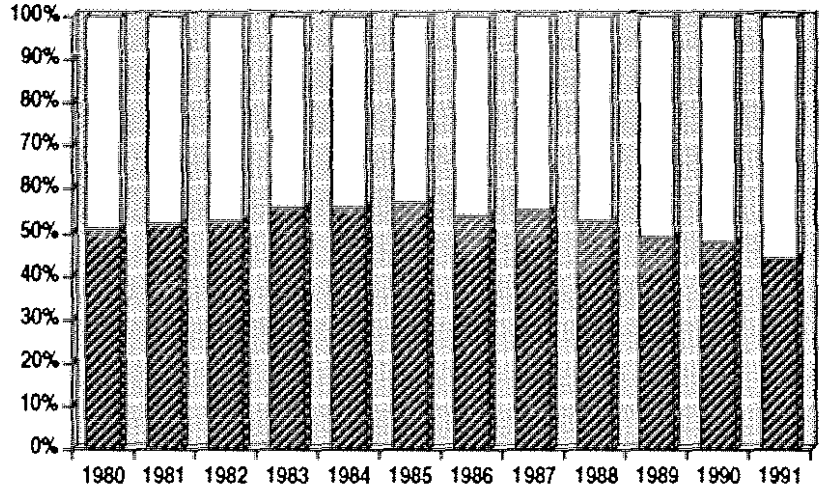
Comparison of Long-Term Care Expenditures and Total Medicaid Budget, 1980-91

KEY: Long-Term Care Expenditures; All Other Medicaid Expenditures

Total Actual Expenditures



Long-Term Care as a Percent of Total Medicaid Budget

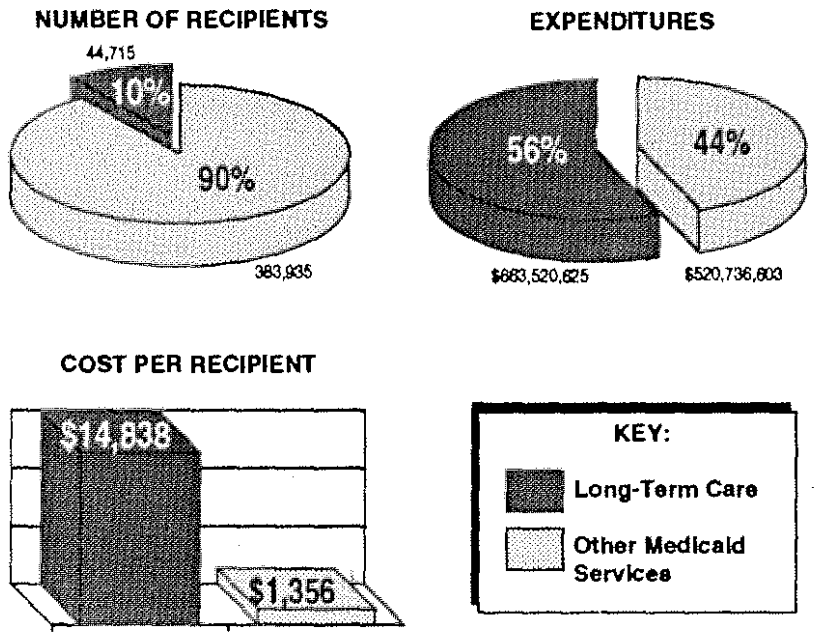


Notes: Long-term care is defined as community care for the disabled, elderly, and persons with mental impairments; nursing home care for the infirm; and public and private institutional care for the mentally impaired.

Source: Department of Medical Assistance Services' internal expenditure report.

Figure 3

Medicaid Recipients and Expenditures by Type of Service



Source: JLARC staff analysis of the Department of Medical Assistance Services' recipient and claims files, FY 1991.

The Focus of Medicaid Funding for Long-Term Care in Virginia

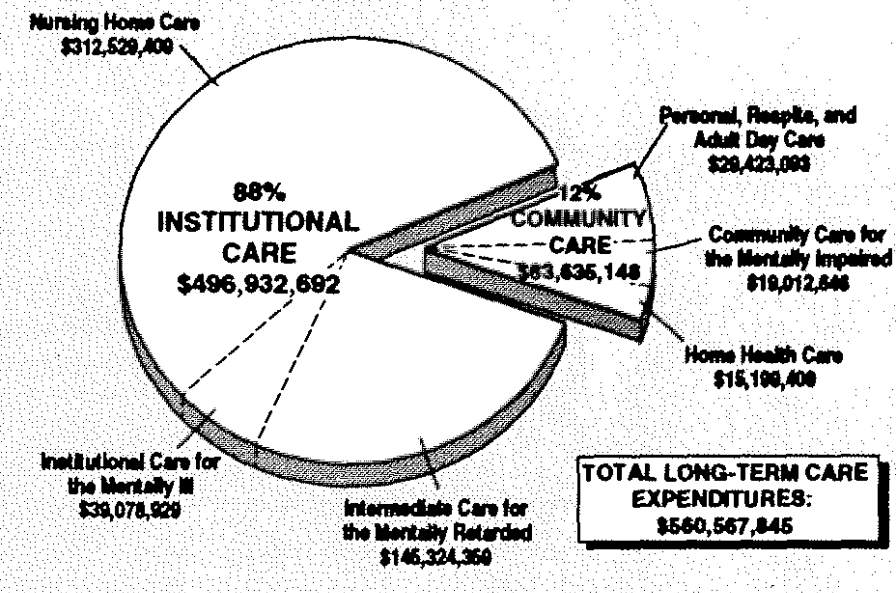
There are several types of providers in Medicaid's system of long-term care in Virginia. In general, these providers can be classified into two distinct groups: (1) those who deliver health and medical care in an institutional setting, and (2) those who provide similar types of care to recipients while they remain in the community. Despite changes to federal statutes which are designed to encourage greater use of community-based care, almost nine out of every 10 dollars spent by Medicaid on long-term care in Virginia is still used to support institutional-based services.

As illustrated by the data presented in Figure 4, payments for nursing home care constitute the largest proportion of expenditures on long-term care. In FY 1991, DMAS paid nursing homes more than $312 million — 55 percent of the total expenditures on long-term care. Another 25 percent of the payments ($145 million) can be attributed to the services that were provided persons in State and privately operated intermediate care facilities for the mentally retarded (ICFs/MR). A much smaller amount ($39 million) was spent on institutional care for persons with mental illnesses.

In terms of community services, although waivers allowing for this type of care have been in place since 1981, the amount of Medicaid funds spent on these activities remain relatively small. Just over $29 million were used to provide non-medical, personal care services to the infirmed and disabled in FY 1991. More than $15 million

Figure 4

Medicaid Long-Term Care Expenditures by Type of Service, FY 1991



Note: Administrative costs are not included in these figures.

Source: Departments of Medical Assistance Services' CARS internal expenditure report.

was spent on home health care services. Finally, just over $19 million was used to provide community-based care for the mentally impaired.

Nature of Institutional Services Supported by Medicaid

As Figure 4 indicates, the institutions which currently receive Medicaid funding in Virginia are licensed private and public nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR), and State-operated hospitals for the mentally ill.

Medicaid-Supported Nursing Home Care in Virginia. Nursing homes are institutions which provide residential services and basic health care to individuals who, because of their diminished mental or physical capacities, need assistance with the basic activities of daily living. The type of care provided can range from services as basic as assisting residents with personal hygiene, teeth and mouth care, and toileting, to more complex invasive therapies such as tube feedings and catheter irrigations.

Before any Medicaid payments can be authorized for nursing home care, a local committee of health and social services staff or hospital staff must conduct a screening of the applicant. The purpose of the pre-admission screening is to evaluate the medical,

nursing, social, psychological, and developmental needs of the individual; to analyze what specific services the individual needs; and to evaluate whether a service is available to meet those needs. If the committee determines that the level of care provided in nursing homes is needed and cannot be provided in the community, approval for an admission is granted.

One of the major factors assessed by the screening committees is the applicant's ability to perform seven basic activities of daily living (ADL). These include bathing, dressing, toileting, and the applicant's ability to control bowel and bladder functions. In each category, the committee determines if the applicant is completely independent or whether some type of assistance is needed.

Characteristics of Nursing Home Residents on Medicaid. At any given time, there are more than 18,000 individuals receiving Medicaid to pay for either a portion or all of their nursing home costs. The data in Table 1 underscore the fragile nature of this population. The typical nursing home resident receiving Medicaid is single (usually due to the death of the spouse), 79 years old, female, and requires assistance with more than five of the basic ADLs. In four of the categories defining activities of daily living — toileting, dressing, bathing, and eating — at least 80 percent of the residents required some type of assistance. Many of the characteristics of present nursing home residents are similar to those identified by JLARC in its 1978 report on long-term care.

Intermediate Care Facilities for the Mentally Retarded (ICFs / MR). In Virginia, long-term care services for the mentally retarded have traditionally been institutionally-based. Currently more than 90 percent of Medicaid funds spent on residential care for the mentally retarded are disbursed to State-operated ICFs/MR. The remaining 10 percent is spent on persons who receive their care from small privately-operated ICFs/MR.

As with nursing homes, ICFs/MR must be federally certified by the Virginia State Department of Health before Medicaid can be billed for the services provided. These facilities can be operated without federal certification but they cannot bill the Medicaid program for services provided to otherwise eligible recipients.

According to federal regulations, residents in the ICFs/MR should require a program of "continuous active treatment" in order to develop the skills necessary to function in the least restrictive environment. In order to better target the services provided in these institutions, each facility resident is classified according to their degree of impairment as measured by their intelligence quotient (I.Q.). The following classification defines the various levels of mental retardation:

- I.Q. of 50-55 to 70 indicates mild retardation.
- I.Q. of 35-40 to 50-55 indicates moderate retardation.
- I.Q. of 20-25 to 35-40 indicates severe retardation.
- I.Q. of below 25 indicates profound retardation.

Table 1

Characteristics of Nursing Home Residents Receiving Medicaid, December 1991

Resident Characteristics	Percent
Sex	
Male	26
Female	74
Average Age	79
Marital Status	
Widow	58
Single	18
Married	14
Divorced	7
Separated	3
Percent Dependent In ADL	
Bathing	99
Bladder	63
Dressing	95
Toileting	82
Transferring	78
Eating	80
Bowel	55
Average Number of Dependencies	5.5
Total Residents	18,781

Notes: Missing data are not reflected in the calculation of the frequencies and mean values reported in this table.

Source: JLARC analysis of data from the Department of Medical Assistance Services' Long-Term Care Information System.

Care in facilities for the mentally retarded requires planned programs to address the habilitative needs and/or health-related services which exceed basic custodial care. Examples of services provided in these facilities include training in the activities of daily living, task-learning skills, socially acceptable behaviors, basic community living programming, or health care and health maintenance.

As a part of the assessment process, a multi-disciplinary team of doctors, nurses, and therapists performs a comprehensive resident evaluation and develops a treatment plan which outlines a strategy for the delivery of care. Depending upon the results of the

resident assessment, these plans could describe strategies for addressing various medical needs as well as any speech, psychological, or physical problems.

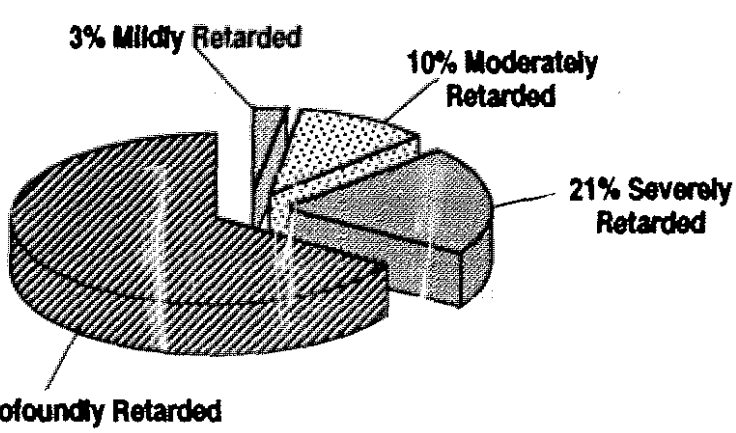
Characteristics of Residents in ICFs/MR. Over the last ten years in Virginia, most of the residents in ICFs/MR with mild or moderate levels of mental retardation have been returned to the community. Moreover, it is the current practice of these facilities to limit most non-emergency admissions to adults who have severe and profound levels of mental retardation. As a result, 86 percent of the residents currently in the five State-operated institutions are either severely or profoundly retarded (Figure 5).

Persons with these types of mental deficits pose a number of challenges to treatment staff. Most are unable to understand simple commands, communicate their basic needs, or independently perform fundamental tasks such as dressing or toileting. Further, a substantial minority of these residents are considered multiply handicapped with complex medical problems ranging from disorders of the central nervous system to severe physical disabilities. These medically fragile persons often require 24-hour care. To effectively serve this population, staff at the ICFs/MR must be equipped to deliver a specific range of therapy and behavior adjustment programs under the general rubric of active treatment.

Institutions for Mental Diseases. The other institutions that receive Medicaid funding are the State institutions for mental diseases (IMD). Medicaid will only reimburse the State for care it provides through IMDs to mentally ill persons who are under the age of 21 or over 65.

Figure 5

Level of Mental Retardation for Residents in Virginia's Five Intermediate Care Facilities, 1991



Source: Department of Mental Health, Mental Retardation, and Substance Abuse Services.

Three criteria are used to determine if a facility qualifies as an IMD. First, the facility must be primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. Second, the institution must contain at least 16 beds. Third, more than 50 percent of the patients in the institution must require inpatient treatment for mental illness according to their medical records.

Nature of Medicaid Community Care Services

The community services which are authorized through Medicaid can be categorized as home health care, personal care, and a variety of rehabilitative or developmental training programs for persons who are mentally retarded. Home health care involves the delivery of medically-related services to persons who are considered homebound. Personal care services are basic maintenance and support activities which should be targeted to persons who are at risk of entering a nursing home. Similarly, the rehabilitative training programs are generally designed to impart a range of independent living skills to help persons at risk of institutionalization develop the capability for community living.

Home Health Care. Almost since its inception, Medicaid legislation has required states to provide home health care as a mandatory service for eligible recipients. The goal of Medicaid's home care program is to provide the medical services necessary to restore the patient to a certain health status. In Virginia, these services are provided by private agencies, hospitals, and local health departments.

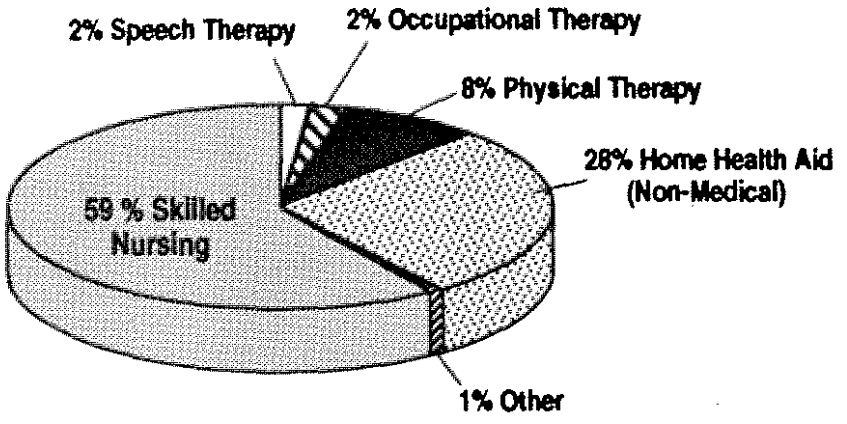
Some of the services that can be provided include skilled nursing, physical therapy, occupational therapy, and speech therapy. These services are provided in the recipient's home by specialists employed by the home health agency. Persons receiving home care can also be approved for non-medical home health aide services (e.g. meal preparation) as long as the basis for the services is a medical condition. For example, a person who is on a puree diet may receive a home health aide to prepare the meal.

Before Medicaid will reimburse home care providers, a physician must certify the patient for the prescribed care by completing a treatment plan. This plan must be reevaluated and signed by the physician every 60 days. Further, if the recipient is not receiving a skilled service, it is the responsibility of the home care provider to send a nurse to the patient's home every two weeks to assess the progress of the treatment plan.

In FY 1991 Medicaid paid for more than 277,000 home health visits (Figure 6). The majority of these visits were made by nurses to provide skilled care (e.g. implementing invasive therapies), supervise the work of home health aides, and monitor the progress of the patient. Nearly one of every three home health visits was made for the purpose of supporting the patient's non-medical needs. As described earlier, this could include preparing meals and assisting the patient with some of the basic activities of daily living.

Figure 6

Medicaid Home Health Visits Made During FY 1991 by Type of Visit



Source: JLARC staff analysis of automated claims data from the Department of Medical Assistance Services.

Personal Care. Prior to 1981, the scope of community care under Medicaid was limited to only those services that could be defined as medically-based. In 1981, the Congress passed legislation waiving this requirement, thereby allowing the expansion of home care to include non-medical or personal care services. The explicit goal of the waiver was to allow states to provide long-term maintenance services in the home of the recipient as an alternative to admission to an institution, like a nursing home or a mental health facility. The federal government has enacted legislation which will make personal care a mandatory service in Virginia in FY 1994.

In Virginia, most of the personal care providers are the same agencies that participate in the home health program. Through the use of aides, these agencies provide a range of services including assisting the patient with dressing, grooming, bathing, and toileting. Before a recipient can be authorized to receive any type of personal care, a screening committee must evaluate the case and approve the service.

Characteristics of Personal Care Recipients. As of December 1991, there were more than 4,400 Medicaid recipients of personal care in Virginia. Assessment data completed for a portion of this group reveal some of their basic characteristics (Table 2). The average age of those receiving personal care was 75. Only 22 percent of these recipients were married.

This population's need for assistance to conduct basic ADLs is similar to those Medicaid recipients in nursing homes. On average, personal care recipients needed assistance in performing about five basic activities of daily living. At least eight out of every ten recipients needed assistance bathing, dressing, and eating.

Table 2

Characteristics of Medicaid Personal Care Recipients, December, 1991

Resident Characteristics	Percent
Sex	
Male	22
Female	78
Average Age	75
Marital Status	
Widow	48
Married	22
Single	19
Divorced	7
Separated	4
Percent Dependent In ADL	
Toileting	84
Bathing	99
Dressing	98
Bladder	50
Transferring	75
Eating	83
Bowel	31
Average Number of Dependencies	5.2
Total Residents	2,953

Notes: There were a total of 4,462 recipients of Medicaid personal care services as of December 31, 1991. At the time the file was created for this analysis, assessments had not been conducted on 1,509 recipients. Missing data are not reflected in the calculation of the frequencies and mean values reported in this table.

Source: JLARC analysis of data from the Department of Medical Assistance Services' Long-Term Care Information System.

Community Programs for the Mentally Retarded. Community care programs for the mentally retarded are organized by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). Presently, Medicaid funds two types of community care programs for persons who are mentally retarded. The first are called State plan option services and they can be provided to any person who is mentally retarded regardless of their actual risk of institutionalization. The thrust of these services are day health and rehabilitation services and case management.

The second group of services are provided under the Medicaid community care waiver authority. Unlike the State plan option services, DMHMRSAS must demonstrate that serving these individuals in the community helps prevent growth in the ICFs/MR.

Because of the complex needs of this population, states have been given considerable discretion in defining the precise nature of the services that can be offered under the waiver. This flexibility was provided in recognition that the services authorized under the 1981 personal care waiver were typically provided to address the physical limitations of the elderly and disabled, not problems stemming from mental impairments.

Nonetheless, in requesting waiver authority for developmental or training services for the mentally retarded, states must plan to structure these services so that they assist this population in acquiring various socialization and adaptive learning skills. Based on these guidelines, DMHMRSAS submitted a service plan to HCFA in 1990. HCFA approved this request in January of 1991.

The service delivery system for both the State plan option and waiver services is coordinated by a network of forty community services board (CSB) agencies. For the services delivered under the State plan option, only the CSBs are considered by DMHMRSAS to be qualified providers. Generally, each CSB acts as a service broker while assuming some case management responsibilities to organize a wide range of programs for the mentally retarded. Included among these services are residential care programs in small group homes, day support services, case management, prevocational training, supported work programs, and therapeutic consultation.

STUDY MANDATE

In 1991, the Virginia General Assembly passed Senate Joint Resolution 180 (Appendix A). This resolution directs JLARC to study Virginia's Medicaid program and other indigent care programs supported through appropriations to State teaching hospitals. The General Assembly's interest in Medicaid is consistent with those of an increasing number of states across the country that are looking for ways to arrest the spiraling growth of the program.

The mandate for this study directs JLARC to assess how cost savings might be achieved in the Medicaid program through the use of policies which limit the scope and duration of optional services. The mandate also requests that JLARC examine the effectiveness of DMAS' reimbursement methodologies in controlling the cost of the program while assuring access to quality care. Finally, through a separate resolution — Senate Joint Resolution 91 — JLARC was directed to support the Joint Commission on Health Care in reviewing Medicaid recipients' use of asset transfers to qualify for the program (Appendix B).

STUDY APPROACH

The framework for this study was designed to explore a number of options for reducing the overall costs of Medicaid funded long-term care services. As a part of building this framework, it was first necessary to determine what factors have the most significant impact on Medicaid costs. Next, based on these factors and an assessment of the options available through Medicaid law, JLARC staff could determine if alternative service strategies exist for long-term care that could produce cost savings for the State.

Based on these objectives, the study focuses on five areas: (1) an assessment of the factors influencing trends in the State's Medicaid long-term care costs; (2) an analysis of the impact of the program's eligibility policies on Medicaid costs; (3) an assessment of Virginia's reimbursement policies; (4) a review of the Medicaid-supported community care services; and (5) an assessment of DMAS' cost audit and utilization review procedures. Within these areas, the following issues were addressed:

- What are the major factors that appear to be associated with the rising costs of Medicaid long-term care services?
- What particular cost avoidance strategies can the State pursue through altering current eligibility criteria and service options for Medicaid?
- Are the current reimbursement methodologies used to pay for institutional and community-based services appropriately designed to provide access to quality care at the lowest possible cost?
- Is community-based care adequately and appropriately used to reduce reliance on institutional services?
- Are DMAS' utilization review and cost audit processes adequate to ensure that the long-term care services supported through Medicaid are both necessary and appropriate?

In addition, a separate review was conducted to evaluate recipients' use of federal asset transfer laws and the potential benefit of establishing an estate recovery program in Virginia.

A number of research activities were conducted to address each study issue. The next section of this chapter provides a brief discussion of some of the activities which were conducted to address several of these issues. Greater detail regarding the methods used for each issue is provided in the remaining chapters of the report.

Examining Factors Associated with Rising Long-Term Care Costs

Before specific cost containment options can be given serious consideration, it was necessary to examine how Virginia's Medicaid long-term care system has grown over the last few years. The general focus of the analysis was on determining whether Medicaid cost increases are due primarily to an expansion of services or an increase in the unit cost of health care. To complete this analysis, summary data were collected on Medicaid recipients and program cost. This information was supplemented with interview data.

Recipient and Cost Data. For each type of long-term care service, JLARC staff collected data on the total medical care expenditures, the number and characteristics of Medicaid recipients who received specific types of long-term care, the amount of care provided (i.e. total days, visits, or hours), and a relevant inflation measure. These data were collected from staff at DMAS and DMHMRSAS.

Structured Interviews. In order to gain additional insight into the factors that are related to the observed expenditure trends for the different categories of long-term care, JLARC staff interviewed key central office staff at DMAS and DMHMRSAS. Further, to get the perspectives of those who deliver the care, structured interviews were conducted with nursing home administrators, professional home care staff, and the administrative staff at Virginia's five ICFs/MR.

Analysis of Recipient Eligibility and Payment Data

A major portion of this study included an analysis of Virginia's eligibility policies for Medicaid long-term care. The purpose of this analysis was to determine how the flexibility in Medicaid eligibility law could be used by DMAS to reduce the cost of long-term care. The research activities conducted for this portion of the study were structured interviews and an analysis of recipient eligibility and payment data.

Structured Interviews. Several structured interviews were conducted with staff at DMAS regarding the agency's eligibility policies for long-term care. The general focus of these interviews was on determining the agency's goals in establishing these policies.

Analysis of Recipient and Payment Data. This analysis involved the use of DMAS' recipient files and claims database. The recipient file contains data on each individual's eligibility status and the types of long-term care services received. The claims files contain information on the total amount that DMAS paid the relevant providers on behalf of each recipient.

By merging these files, JLARC staff were able to determine the total Medicaid costs for serving particular groups of recipients. Moreover, the opportunity for calculating projected savings associated with any proposed changes to Virginia's eligibility criteria was made possible.

Analysis of DMAS Reimbursement Methodologies

There are three different reimbursement methodologies used by DMAS to pay for long-term care services. The study resolution specifically directs JLARC to determine if the resulting reimbursement rates are both adequate to encourage a cost-effective delivery of service and sufficient to promote quality care at the lowest possible cost.

For nursing homes, State-operated ICFs/MR, and home health agencies, JLARC staff conducted structured interviews with DMAS' cost audit staff and the respective providers of the care. Also, quantitative analyses of the factors which impact costs were conducted for each of these service types.

DMAS does not collect cost data on the providers of personal care. These rates are set in the Appropriations Act. Therefore, to develop an understanding of how these rates were established, the appropriate staff at DMAS were interviewed.

Structured Interviews. The initial step in the analysis of reimbursement rates was the implementation of structured interviews with DMAS staff and the various providers of long-term care. These interviews were conducted for two reasons. First, because states have considerable flexibility for establishing reimbursement rates, JLARC staff had to question DMAS to determine what funding and service goals were pursued when the rates were set. Interviews were also conducted with a sample of service providers to listen to their views on the adequacy of the reimbursement rates and the process used to determine these rates.

Second, to facilitate a quantitative analysis of provider costs, JLARC staff had to identify what factors should be considered in an analysis of the costs associated with particular types of long-term care. This involved talking with DMAS staff and providers that were knowledgeable about the costs of delivering certain types of care.

Quantitative Analysis. The objective of the quantitative assessment of provider long-term care cost varied somewhat based on the particular type of care. For nursing homes and home health agencies, the objective of the analysis team was to identify which factors most strongly influenced observed differences in program cost. Based on this descriptive analysis, JLARC staff determined whether all of the key indicators which impact cost were appropriately considered by DMAS when the rate setting methodology was established.

DMAS' rate setting process for State-operated ICFs/MR is completely different from the methodology used for nursing homes. These facilities are reimbursed on a cost basis to maximize the federal match for Medicaid.

Therefore, for this study, JLARC staff examined the methods used by DMHMRSAS staff to allocate costs to the Medicaid program and conducted an analysis of the major factors that affect costs in the ICFs/MR.

The Use of Community Care

A major portion of this study was a review and analysis of how the community care system is used by the State for Medicaid recipients. The general purpose of the analysis was to determine if these services are being targeted to the appropriate groups of recipients. A separate analysis was conducted on the costs of community-based personal care services relative to the care provided in nursing homes. JLARC staff also conducted interviews with several State agencies and local providers concerning the organization of community care for persons who are mentally retarded.

The research activities completed for this part of the study included structured interviews, a telephone survey, and a longitudinal study of the costs of community care versus nursing home care.

Structured Interviews. A number of structured interviews were conducted with DMAS staff who have oversight responsibility for the pre-admission screening process. These interviews were designed to provide the JLARC staff with an understanding of DMAS' policies governing the screening process.

As a part of the field work for this study, JLARC staff interviewed screening committees in 14 different localities. In general, these interviews focused on whether the screening process is consistently implemented across the State.

Telephone Surveys. One requirement of federal law is that personal care services be provided to only those persons who are at imminent risk of institutionalization. This law is designed to prevent the use of personal care as a supplement to, rather than a substitute for, nursing home care. To evaluate whether the screening process adequately makes this distinction, JLARC staff conducted telephone surveys with individuals who receive the assistance of personal care aides in providing support to a family member or friend.

Longitudinal Study of Community Care Costs. A key issue regarding community services is whether this type of care can be provided at a lower cost to the State than institutional care. To evaluate this question, all persons who entered either a nursing home or began receiving personal care in 1986 were identified. Using DMAS claims files, JLARC staff analyzed data on the total amount of medical care expenditures made on these groups behalf from 1986 to 1990. To account for differences in the severity of the patients' care needs, information on each recipient's level of dependency was collected from DMAS' long-term care information system.

Interviews Concerning Services for the Mentally Retarded. In the ten-year period from 1980 to 1990, there was no major initiative to provide community care for the mentally retarded through the Medicaid program in Virginia. JLARC staff interviewed staff at DMAS, DMHMRSAS, and community services boards to obtain their perspectives on this issue. The questions from these interviews focused on why the waiver provisions of Medicaid were not used for community care until 1991.

Adequacy of DMAS' Utilization Review Process

Federal law requires DMAS to establish and coordinate a utilization review process to ensure that the care paid for by Medicaid is appropriate, necessary, and of sufficient quality. One of the final issues examined in this study was a review of how the utilization review process operates. Some of the research activities conducted by JLARC staff included a review of federal utilization review and quality assurance requirements, structured interviews, and observation of utilization review activities.

Review of Utilization Requirements. Evaluation of the utilization review process was complicated somewhat by the fact that the process differs for each type of long-term care service. To develop an understanding of these requirements, JLARC staff reviewed the appropriate documents and examined several reports on the goals and objectives of Medicaid utilization review.

Structured Interviews. During the study, several interviews were held with staff at DMAS, the Department of Health, and providers of each type of long-term care. In these interviews, both the staff and providers were asked to describe the process and assess any inherent strengths and weaknesses. Also, DMAS staff were asked to describe what they found to be the most common problems identified through utilization review.

Observation of Utilization Review Field Visits. JLARC staff accompanied DMAS utilization review analysts and staff from the Department of Health on visits to a nursing home, home health agency, personal care provider, and an ICF/MR. This was done to observe the utilization review process for the different components of long-term care. During these visits, JLARC staff had the opportunity to ask the analysts questions about the objectives and rationale of particular review activities.

REPORT ORGANIZATION

The remaining chapters in this report present the results of an analysis of the organization and implementation of Medicaid long-term care services. Chapter II provides an analysis of service utilization and expenditure trends for Medicaid long-term care. Chapter III discusses the impact of Virginia's eligibility policies for long-term care on total Medicaid costs. Chapter IV presents the results of an analysis of DMAS' reimbursement methodology for institutional service providers. Chapter V examines the appropriateness and adequacy of the community care system for Medicaid recipients, while reimbursement for community care providers is reviewed in Chapter VI. Finally, Chapter VII presents a review of DMAS' utilization review and cost audit procedures.

II. Trends in Medicaid Long-Term Care Expenditures

Because expenditures on long-term care are almost half of the total Medicaid budget, policy discussions concerning ways to contain the cost of the program must give considerable attention to these services. However, before this can be done, it is necessary to examine how Virginia's Medicaid long-term care services have grown in terms of the recipients they serve and the cost associated with funding their care.

Since 1983, the average growth in overall expenditures for long-term care has averaged slightly more than 11 percent. Increases in the number of long-term care recipients is a key factor in the rising cost for these services. However, these figures mask important differences in expenditure and utilization patterns for the different types of long-term care services.

Among the institutional services funded by Medicaid, expenditures for State-operated facilities for the mentally retarded have grown at the fastest rate. These increases are due almost entirely to sharp rises in the cost of providing a day of institutional care. For nursing homes, average annual spending growth has been slightly less than ten percent. More importantly, this increase appears to be partly related to the fact that Medicaid is paying for a greater number of days of nursing home care due to growth in the number of recipients.

The fastest growing long-term care services are those provided in the community. Both personal care and home health expenditures have experienced substantial increases. In these programs, increases in the number of recipients have significantly outpaced the amount of spending per recipient. Still, the impact of these increases on total Medicaid spending is not as great because the services are delivered at a much lower cost than those provided in institutions.

The results from an analysis of utilization and expenditure patterns for most of the long-term care services funded by the Medicaid program are discussed in this chapter. In analyzing these trends, a common line of inquiry was pursued. Specifically, JLARC staff examined the extent to which the observed increases in long-term care expenditures were driven by a growing demand for the services or were the result of the rising costs of health care.

NURSING HOME EXPENDITURES AND UTILIZATION

Medicaid nursing home expenditures are, by far, the largest portion of long-term care spending. DMAS reimburses providers of nursing home care based on a per diem rate. From 1983 to 1990, Medicaid expenditures, net of patient pay, based on these

rates increased appreciably, growing from $159 million to $261 million. During this period, the Medicaid program became the single largest source of payment for nursing home care in Virginia.

In general, the analysis indicates that both increased nursing home utilization and rising costs associated with providing a day of care have played a role in the growth of Medicaid spending for nursing home services. More importantly, the major factor behind the increase in utilization has been a persistent growth in the number of Medicaid recipients who are in nursing homes.

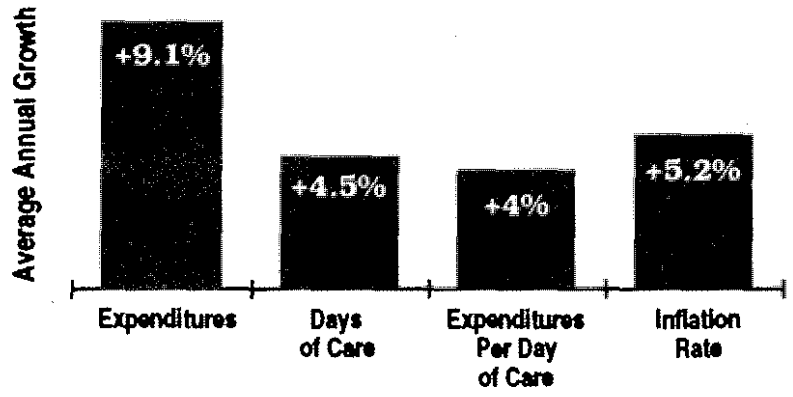
Higher Costs per Day and More Days of Care Increase Spending

Since 1983, Medicaid spending on nursing homes has been driven upward at an average annual rate of nearly ten percent. The key factors behind this increase have been the amount of program spending incurred per day for nursing home care and the number of nursing home days paid for by Medicaid. Both of these factors have increased at an average annual rate of approximately four percent (Figure 7).

Expenditures per Day of Care. An increase in the cost of a day of nursing home care can be caused by a number of factors including general inflation, increased regulation, management inefficiencies, or changes in the health care needs of the facility residents. For example, in the latter case, if a facility's resident population becomes more

Figure 7

Medicaid Nursing Home Expenditure and Utilization Trends, 1983 - 1990



Source: JLARC staff analysis of nursing home payment and utilization data from the Department of Medical Assistance Services, Cost Settlement and Audit Division. Inflation data collected from Data Resources Inc.

debilitated, the amount of staff needed to provide proper care will increase, thereby driving up the marginal costs of the services.

Because Medicaid is the largest payor for the nursing home services that are provided in Virginia, it is important to understand why the costs of a day of care are increasing. If, for example, the increases are due to management inefficiencies or the industry's efforts to increase its operating margin (profits), then the State should take the necessary steps to ensure that Medicaid does not pay a higher reimbursement in support of these practices. The most direct and effective cost containment strategy in this case would be to reduce the amount of the Medicaid reimbursement for nursing homes.

If on the other hand, the increases are beyond the control of the nursing homes (e.g. due to inflation) then it would be expected that changes in Medicaid expenditures for a day of nursing home care would reflect the impact of inflation.

It appears from data in Figure 7 that the increase in the Medicaid expenditures per day of nursing home care is largely attributable to inflationary pressures. As a measure of nursing home inflation in this study, JLARC staff used the Virginia Nursing Home Market Basket (VNHMB) indicator. VNHMB is developed by Data Resources Incorporated (DRI) using national data on key inflationary indicators for the nursing home industry. DRI adjusts this measure to reflect changes in key inputs in Virginia — nurses' wages, food, utilities — which directly impact the cost of a day of care in a nursing home.

As indicated by Figure 7, the average annual increase in VNHMB was slightly higher than the growth in Medicaid spending per day for nursing homes. This suggests that many non-inflationary factors which can increase the daily cost of care in a nursing home have not had an impact on the expenditures made by Medicaid. Moreover, because nursing homes have little control over the impact of inflation on operating costs, this argues against any downward adjustments on the State reimbursement rate as a means of lowering total Medicaid expenditures for nursing home care.

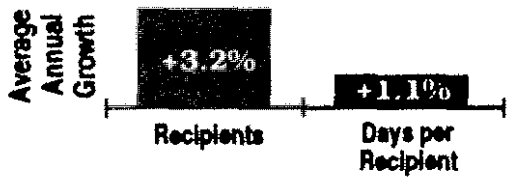
Nursing Home Days. The four percent growth in the number of days of care that Medicaid has paid for can be due to two different factors. One possibility is that this growth simply reflects an increase in the number of individuals who are relying on Medicaid to pay for their nursing home care. Under these circumstances, the State could consider changing its eligibility policies to reduce program costs.

Another possibility is that roughly the same number of people are receiving benefits but, for any number of reasons, Medicaid is paying for increasingly longer periods of their nursing home care. With this scenario, the State has fewer options for reducing costs. If, for example, Medicaid recipients were experiencing longer nursing home stays because they were living longer, the increased cost to the State would be simply unavoidable.

Figure 8 illustrates the average annual growth in these two measures since 1983. This shows the rate of increase in the number of recipients is almost three times

Figure 8

Factors Related to Medicaid Expenditure and Utilization Trends in Nursing Homes, 1983-1900



Source: JLARC staff analysis of HCFA Form 2082 recipient data for nursing homes.

as high as the increase in the days of care per recipient. This means that the average annual increase in the total days of care paid for by Medicaid shown in Figure 7 appears to be due primarily to a growing number of Medicaid recipients in nursing homes.

DMAS staff attribute much of the recipient growth to a temporary lifting of the State's current moratorium on new nursing home beds. Established as a part of the Certificate of Public Need Program, the moratorium was designed to control nursing home costs by limiting the construction of new bedspace.

According to DMAS and the Virginia Department of Health (VDH), lifting the moratorium resulted in an immediate increase in the number of new beds. From 1985 to 1990 alone, the number of new beds increased by almost 28 percent. During this same time period, the number of Medicaid recipients in nursing homes increased by approximately 14 percent.

Most of the nursing home administrators interviewed by JLARC staff for this study felt that the increase in the number of days of care was the result of longer nursing home stays for Medicaid patients. The reason most often cited was Medicare's switch to a Diagnosis-Related Group (DRG) payment system for hospitals.

The DRG system pays hospitals a flat fee for providing care to a recipient. The fee varies depending on the patient's diagnosis but not the length of the hospital stay. Therefore, for any given diagnosis, a hospital receives the same amount of money for ten days of care as it does for one day. Consequently, it is in the hospital's financial interest to treat and discharge patients as quickly as possible.

According to these administrators, many of those hospital patients are being discharged to nursing homes. As a result, Medicaid patients frequently enter nursing homes in poor physical condition requiring longer and more extensive periods of care. While this may indeed be one impact of the DRG system, the relatively minor changes in the number of days of care provided per Medicaid recipient since the system was put in place suggest that it only impacts a minority of those receiving nursing home benefits.

Eligibility Policies Must Be Reexamined to Achieve Cost Reductions

The findings presented in this section do not support policies aimed at lowering nursing home costs through reducing the Medicaid reimbursement rate. Such strategies are appropriate when it appears that the rate paid by Medicaid is supporting non-inflationary growth in the daily cost of this type of care. However, because a key factor behind increased nursing home expenditures is a growing number of recipients, the State will need to reexamine its policies concerning who gets access to these benefits in order to reduce expenditures on nursing home care.

Although Virginia's Medicaid costs are supported with a 50 percent match of federal funds, the program's federal legislation grants states considerable discretion in deciding who will be served by the program. States can generally limit coverage for nursing home benefits to most program participants by establishing more restrictive income guidelines or, using more drastic measures, states can refuse to provide these benefits for large groups of recipients. These options are analyzed and discussed in more detail in Chapter III of this study.

EXPENDITURES AND UTILIZATION IN INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

Virginia's five State-operated intermediate care facilities for the mentally retarded (ICFs/MR) account for the second largest component of Medicaid long-term care spending. As with nursing homes, DMAS pays these facilities for each day of care they provide Medicaid recipients. From 1983 to 1990, the amount of money spent by Medicaid on the services delivered in these institutions grew from $61 million to $115 million — an average annual increase of slightly more than 12 percent. This expenditure rate exceeds the observed increases for all other types of institutional care supported through Medicaid.

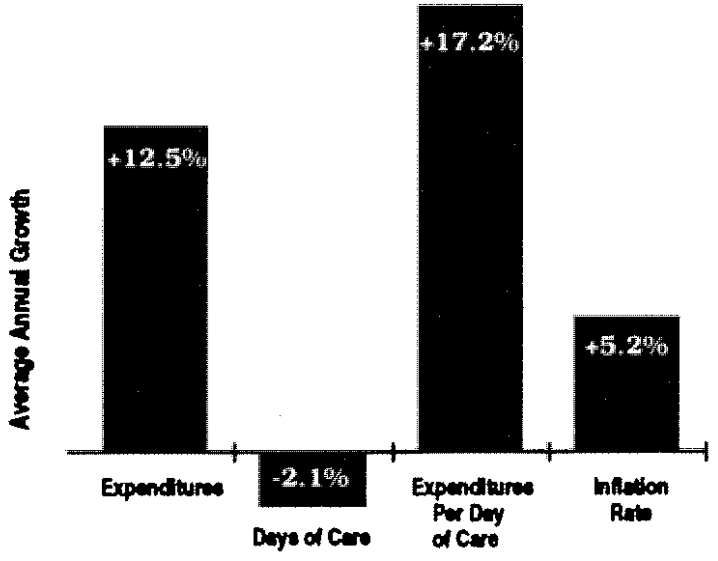
In general, the analysis of these trends indicates that spending increased at these facilities despite a decline in the number of days of care provided to Medicaid recipients. Thus, substantial increases in the cost of providing a day of care was the overriding cause of the growth in Medicaid ICF/MR expenditures. Primary reasons for the increase in Medicaid spending per day are costly federal regulations and fixed overhead costs.

Medicaid Spending per Day in ICFs/MR Has Grown Substantially

Figure 9 indicates that since 1983, the total Medicaid spending in State-operated ICFs/MR increased at an average annual rate of almost 13 percent. While the amount of Medicaid spending climbed, far fewer days of care were provided by these facilities. In fact, the number of days that Medicaid paid for decreased by nearly 15 percent during the same time period that expenditures were increasing — an average

Figure 9

ICF/MR Medicaid Expenditure and Utilization Trends, 1983-1990



Source: JLARC staff analysis of Medicaid expenditure and utilization data from the Department of Mental Health, Mental Retardation, and Substance Abuse Services.

annual drop of slightly more than two percent. The result of this is that the cost for a day of institutional care in the ICFs/MR increased by more than 17 percent.

To determine the impact of inflation on the increased daily cost of ICF/MR care, changes in the VNHMB indicator were compared to the growth in expenditures per day of care. As shown in Figure 9, Medicaid spending per day in ICFs/MR grew, on average, three and half times faster than the rate of inflation.

This finding raised a number of important questions for this study. Namely, why has the daily cost of care provided by ICFs/MR increased at a rate which substantially exceeds inflation? What implications do these reasons have for future Medicaid spending on the type of care provided in these facilities?

To address these questions, JLARC staff interviewed budget and cost accounting staff at the Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS) and the administrative and program staff at each of the State's five ICFs/MR. The general consensus among those interviewed was that high cost of a day of care is driven by stringent federal regulations, the inherent difficulty in reducing fixed overhead costs, and an increase in the proportion of facility residents who are either severely or profoundly retarded.

Federal Regulations. Federal regulations and regulatory enforcement for ICF/MR Medicaid certification have been intensified in recent years. In order for an ICF/MR to receive payment for the services provided to a Medicaid-eligible resident, the facility must first be certified to participate in the program. These requirements are extensive, detailed, and often complex.

Medicaid certification requirements concerning staffing levels and active treatment programs have been particular problems for the ICFs/MR. Prior to 1974, federal regulations for these facilities only required that they provide basic custodial care — a general focus on the housing and feeding of residents. Since that time, the regulations have moved ICFs/MR away from custodial care to more of a treatment-oriented approach to care. In 1988, federal regulations were promulgated which required ICFs/MR to develop and implement programs which ensure that all of the residents' physical, psychological, emotional, and social needs are being addressed through a continuous program of active treatment. It should be noted that Virginia had monitored active treatment long before the 1988 regulations were issued.

To facilitate the implementation of these plans, federal regulations specify minimum ratios for the number of residents per staff member. However, the same regulations require that the ICF/MR provide "sufficient direct care staff to manage and supervise clients in accordance with their individual program plans." This language permits federal regulators to impose staffing standards that actually exceed the minimum ratios specified by the regulations.

During the 1980s, the Health Care Financing Administration (HCFA) conducted "look-behind" inspections to ensure that certification requirements were being met. These federal inspections are made in order to monitor the accuracy and thoroughness of the Medicaid certification inspection conducted by the Virginia Department of Health (VDH). In other words, the HCFA inspection is done in an attempt to verify the findings of the VDH inspection. As the following case examples demonstrate, HCFA found the ICFs/MR to be deficient in many areas despite the facilities' relatively low resident to staff ratios.

> *Southside Virginia Training Center received 80 pages of deficiencies as a result of a 1985 inspection. Problems included an insufficient number of direct care treatment staff, inadequate laundry facilities, and inadequate transportation. However, at the time of the inspection, the facility had 4.3 residents per direct care staff member.*
>
> * * *
>
> *Northern Virginia Training Center was also cited for numerous deficiencies in 1985. Problems included inadequate active treatment programs, inadequate therapy programs, and inadequate staffing in disciplines such as recreation, physical and occupational therapy, psychology, speech, and resident living. At the time of the inspection, the facility had 4.6 residents per direct care staff member.*

* * *

In 1991, this facility was cited for deficiencies by the U.S. Department of Justice. Problems included inadequate medical care and an insufficient number of adequately trained staff.

* * *

HCFA cited the Southwestern Virginia Training Center in 1988 for a continued lack of sufficient numbers of direct care staff to manage and supervise residents during the evening shift. The facility was also cited for failure to properly maintain electrical appliances. At the time of the inspection, the facility had four residents per direct care staff member.

As a result of these federal inspections, the ICFs/MR were required to prepare corrective action plans for HCFA. The plans had to explain the actions that would be taken in order to bring the facilities into compliance with federal regulations. Essentially, the plans called for more staff positions. Additional State funding was provided in order to hire the staff necessary to implement the corrective action plans. For example:

- Northern Virginia Training Center was found to require an additional 47 staff as a result of the 1985 HCFA inspection.
- Southwestern Virginia Training Center was required to hire 21 additional staff as a result of its 1988 inspection.
- Central Virginia Training Center had to hire 60 additional staff as the result of a 1984 inspection.

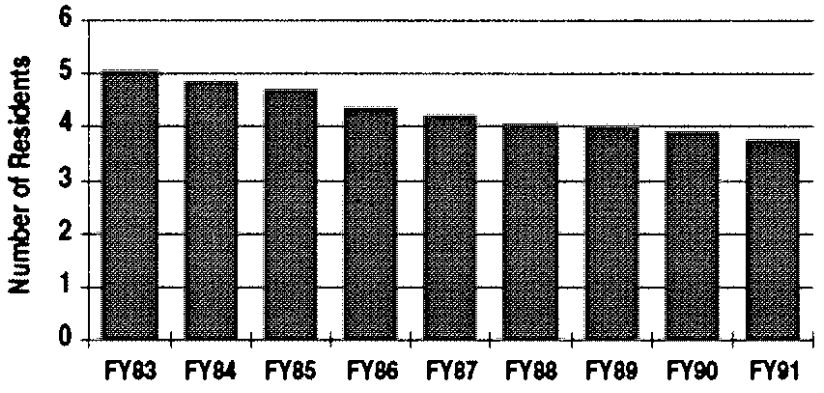
The combination of HCFA look-behind surveys and stricter active treatment requirements has forced administrators at the ICFs/MR to hire additional staff to provide the specialized care for its residents. Consequently, since 1983, the number of direct treatment staff increased by six percent despite a 21 percent decline in total resident population. As illustrated by Figure 10, due to the combined effect of increased staff and a decreased number of residents, these facilities are consistently lowering the ratio of residents to staff.

Fixed Costs in Facilities. One of the major categories of expenses in ICFs/MR are indirect or overhead costs. These non-patient care expenses are incurred for such services as general administration, buildings and grounds work, laundry, and food services, including the salaries of personnel responsible for these institutional functions.

Currently, overhead costs account for almost 40 percent of total Medicaid spending in ICFs/MR. DMHMRSAS accounting staff point out that these facility overhead costs are essentially fixed and therefore not sensitive to periodic decreases in resident levels. For example, if it costs $1 million to manage the building and grounds,

Figure 10

ICF/MR Residents per Direct-Care Staff Member per Shift, FY 1983 - 1991



Note: Direct care staff includes all staff except support services.

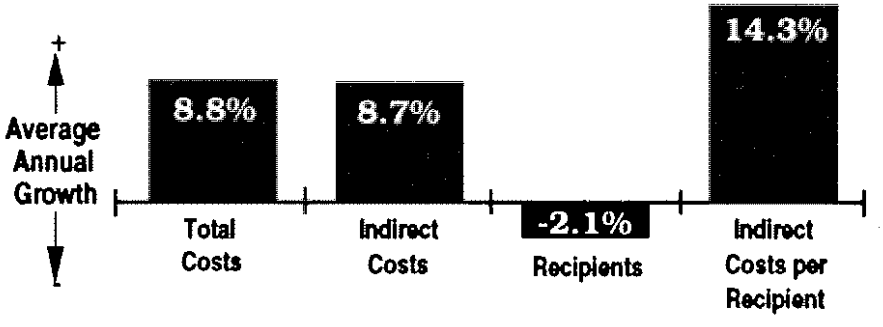
Source: JLARC staff analysis of staffing data for State-operated ICFs/MR.

these costs do not change if the number of residents decline. As one staff person stated, "the same amount of square footage in the building has to be heated, cooled, and cleaned."

However, as the number of residents decrease through death or discharge, there are fewer recipients to whose care the fixed facility costs can be allocated. As Figure 11 indicates, overhead costs in these facilities have increased at an average annual rate of almost nine percent since 1983 despite a decrease in the number of recipients.

Figure 11

Changes in Total and Indirect Costs for State-Operated ICFs/MR (1983-1990)



Source: JLARC staff analysis of cost report data and recipient data collected from the Department of Mental Health, Mental Retardation, and Substance Abuse Services.

This obviously increases the per-patient day expenditures for Medicaid recipients. Specifically, from 1983 to 1990, the indirect costs per patient in these facilities has increased at an average annual rate of more than 14 percent. Until the point is reached at which some portions of the facilities can be closed, overhead costs will continue to grow as a proportion of total spending in the ICFs/MR.

Impact of Caring for Persons with Severe Problems. Somewhat less convincing is DMHMRSAS' contention that the increased severity of its residents are driving costs upward. The five State-operated ICFs/MR have assumed the role of providing care and treatment for persons with severe and profound levels of mental retardation. Moreover, many of these same residents have multiple physical disabilities and sometimes extreme behavioral problems. According to facility staff, this is an especially difficult population to care for. The range of physical and mental deficits suffered by the residents often require extensive professional services, such as occupational, physical, and speech therapy. Many of these recipients require individualized, one-on-one attention in order to perform the basic activities of daily living.

The availability of community-based care for persons with disabilities of this nature has always been limited. These services are provided in Virginia through a network of 40 Community Service Boards (CSBs). One role of CSBs has typically been to support Statewide efforts aimed at reducing the size of its institutions by providing care to those individuals who are mildly or moderately retarded and have the ability to live independently in the community.

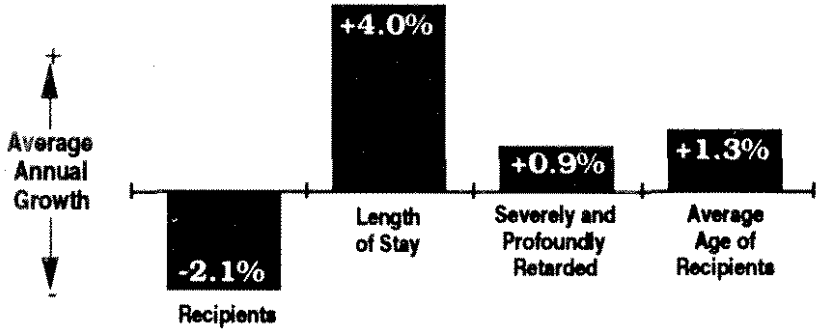
Staff at the ICFs/MR and CSBs stated that the CSBs do not have the resources to provide care for significant numbers of severely and profoundly mentally retarded individuals. As a result, these individuals tend to remain institutionalized, in some cases, for all of their lives. Data on the average length of stay of ICF/MR residents indicates that the length of institutionalization has grown by an average rate of four percent since 1983 (Figure 12). Presently, residents typically remain in these facilities for an average of 17 years.

Over the last 10 years, many mildly and moderately retarded residents were discharged from the State ICFs/MR in order to be cared for in community settings. At the same time, other persons in the community with this same profile who had never been institutionalized were admitted to community-based treatment programs as opposed to entering the State ICFs/MR. This not only reduced the number of individuals in the ICFs/MR but it increased the proportion of residents in these facilities who were either severely or profoundly retarded (Figure 12).

However, the actual number of severely and profoundly retarded residents in the ICFs/MR has decreased. In 1983, there were 2,699 severely and profoundly retarded residents. That number declined to 2,360 by 1990. Although the reduction in the number of these residents occurred at a slower rate than the reduction in the ICF/MR population as a whole, overall there still were fewer residents left for staff to care for in these facilities by 1990.

Figure 12

Changes in Length of Stay and Levels of Mental Retardation for Residents of ICFs/MR (1983-1990)



Source: JLARC staff analysis of resident characteristics and length of stay data collected from the Department of Mental Health, Mental Retardation, and Substance Abuse Services.

This fact weakens the argument that an increase in the proportion of severely impaired residents is a key factor driving the observed cost increases. If overall patient levels had remained constant while the number of severely impaired residents increased, this would undoubtedly increase the expenditures at the margin for a day of care. As it stands, any cost increases due to an increase in the proportion of severely and profoundly retarded residents is likely to be small.

Options for Controlling Medicaid Spending on ICFs/MR Are Limited

As stated earlier, when the rate of Medicaid spending per day for a particular type of service substantially exceeds inflation, the State should consider looking to its reimbursement system as a means of lowering its per diem expenditures for that service. However, in the case of the State-operated ICFs/MR, there are compelling reasons to refrain from this strategy.

First, it appears that much of the increased cost in these facilities, though non-inflationary, is still outside of the control of agency administrators. The stringent federal regulations and persistent overhead are factors which cannot be manipulated by management staff.

In addition, the difficulty associated with restructuring the larger facilities to reduce fixed costs means that these expenses will likely remain even as resident levels are slowly decreased through attrition. Under these circumstances, any reductions in Medicaid reimbursements below the maximum amount allowed by the federal government will effectively be a loss of revenue for the State.

Given these limitations, the State will need to reexamine both the role of the State in providing this form of care and the current structure of ICF/MR services if cost reductions are desired. Two other chapters in this report examine the possibilities for developing cost savings through the reimbursement system and expanding community care services. However, as will be discussed, the disadvantages associated with these strategies raise questions about the potential for generating the desired savings.

HOME HEALTH EXPENDITURES AND UTILIZATION

Although the amount of Medicaid spending for home health care is relatively low in comparison to other types of long-term care, expenditures for this service had the second highest growth rate of all long-term care services. Medicaid home health payments are made to approved providers based on the number of visits they conduct for each recipient of this care. From 1983 to 1990, total Medicaid home health expenditures increased from $3 million to more than $13 million.

Although there has been a slight increase in the amount of Medicaid spending per visit, the primary reason for the observed growth in home health care expenditures appears to be a rise in the number of Medicaid recipients who are receiving this service.

Increased Spending per Visit Has Less Impact than Total Visits

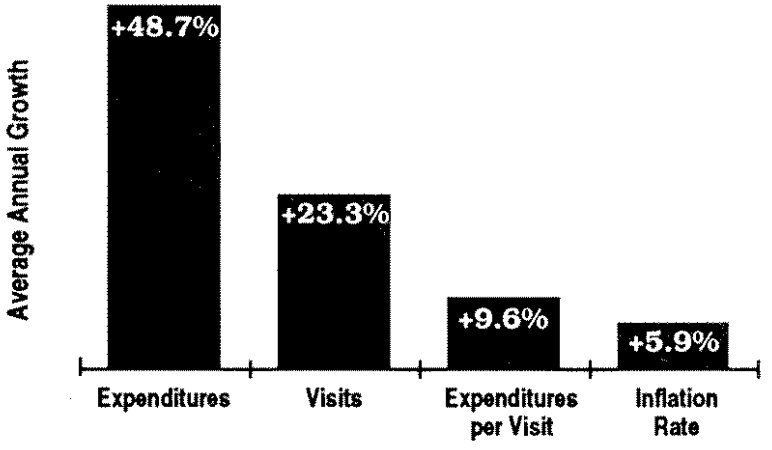
Since 1983, the total Medicaid expenditures for home health care increased at an average annual rate of almost 50 percent (Figure 13). Relative to other factors, it does not appear that increased spending per visit has played a key role in the growth in Medicaid expenditures for home health care. While the average annual increase in Medicaid spending per visit did increase by almost 10 percent, the growth rate for total number of visits approached 25 percent.

Increased Spending Per Visit. Although there are a number of factors which could have influenced the 10 percent increase in Medicaid spending per visit, it appears that inflation was the major reason. As Figure 13 illustrates, the average annual rate of inflation, as measured by the U.S. Home Health Agency Market Basket, was almost six percent. This accounts for more than sixty percent of the average increase in Medicaid spending per visit.

When considering the reasons for the increase not explained by inflation, it is important to understand how home health providers were reimbursed by DMAS during the time period. Prior to 1991, DMAS used a cost-based reimbursement system. Using Medicare principles, DMAS defined what costs would be allowable and providers were required to submit end-of-year cost reports detailing what their expenses were for the visits that were conducted. After reviewing these reports, DMAS reimbursed the providers retrospectively based on their allowable costs.

Figure 13

Medicaid Home Health Expenditure and Utilization Trends (1983-1990)



Note: DMAS cost report data for visits were unaudited and therefore may not be completely accurate.

Source: JLARC staff analysis of data from cost reports of home health agencies.

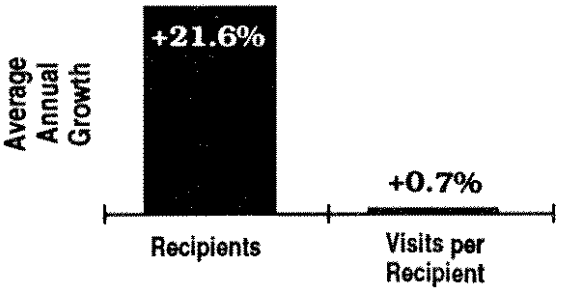
This type of reimbursement system has been criticized as inefficient and lacking in incentives to control costs. As long as the home health agencies worked within the allowable cost categories and stayed below the Medicare upper payment limits, they were reimbursed their reported costs. This creates a number of scenarios too numerous to discuss in this study which could have led to increased Medicaid spending per visit above the levels suggested by normal health care inflation.

Increased Recipients. Clearly the key reason behind the increase in home health expenditures is the growth in number of recipients (Figure 14). From 1983 to 1990, the number of Medicaid recipients receiving home health care increased at an average annual rate of more than 20 percent. However, the number of visits per recipient experienced only minimal growth. Therefore, the entrance of additional Medicaid recipients into the home health program was the major factor behind the increase in total visits and total spending.

There are two general factors that were responsible for the increased number of home health recipients. First, the pool of home health providers has greatly expanded since 1980. This growth was primarily a response to the growing popularity of, and pent-up demand for, home care. During this same time period, the Medicaid program with its generous retrospective, cost-based reimbursement system attracted more providers and became widely known throughout the home care community. In fact, the number of home health agencies in Virginia doubled in the seven years from 1983 to 1990.

Figure 14

Factors Related to Medicaid Expenditure and Utilization Trends for Home Health Care (1983-1990)



Source: JLARC staff analysis of HCFA form 2082 recipient data for home health agencies provided by the Department of Medical Assistance Services.

The second factor was the DRG hospital payment system. As previously discussed, this system creates incentives for the faster release of Medicare hospital patients. In response to these incentives, it is widely believed that many hospitals began to discharge patients before they were fully recovered from their illnesses. Recognizing this, physicians began to use home care to give their patients continued access to the supervised treatment they needed to fully recuperate.

Home health providers realize that they are gaining more and more patients in this manner. One provider said that "the DRGs are pushing the patients out of the hospital quicker and sicker." Home health agencies, as a result, are now having to provide care to patients with chronic medical conditions. Agencies report that they are now providing skilled medical services such as:

- intravenous drug injections,
- feeding tubes,
- catheter irrigations,
- wound care,
- ventilator therapy, and
- chemotherapy.

Controlling Access to Home Health Care Can More Effectively Reduce Costs

The findings presented in this section do not fully support policies aimed at lowering home health costs through restricting the number of visits that a recipient can receive. While such strategies can result in some cost savings, they ignore the major factor responsible for the increase in spending — a rising number of new entrants into the program. The data in this study indicate that while the increase in the number of visits per recipient has been negligible, the number of recipients has increased at an

average annual rate of more than 20 percent. As will be discussed in Chapter VII, DMAS' recent establishment of utilization review activities for home health care is a more effective method for controlling home health cost without creating problems of access and cost shifting.

PERSONAL CARE EXPENDITURES AND UTILIZATION

DMAS offers personal care services for persons who are at-risk of being placed in a nursing home. Agencies that deliver these services are reimbursed at an hourly rate for the total hours of care provided. Personal care expenditures have grown at the fastest rate of all long-term care services. From 1984 to 1990, total expenditures increased from $3 million to more than $25 million.

In general, this increase in expenditures was due entirely to growth in the number of hours of personal care provided. Furthermore, the expansion of services was primarily the result of an increase in the number of persons approved for this type of care.

Medicaid Spending on Personal Care Has Grown Substantially

Figure 15 summarizes the changes that have occurred in Medicaid personal care spending since expenditure data were first collected in Virginia in 1984. As indicated, total Medicaid spending for this type of care has increased by 107 percent annually. The annual rate of growth for the hours of care provided — 108 percent — mirrors the change in spending for these services. Conversely, the rate of change in Medicaid spending per hour of care has experienced no change.

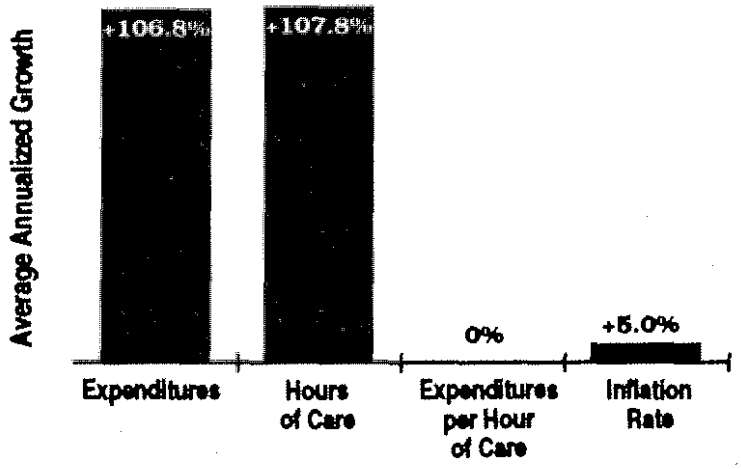
Medicaid Expenditures per Hour. The cost to the Medicaid program for an hour of personal care is essentially the amount of hourly reimbursement paid for the personal care aide. While the number of hours of care delivered by providers of this care since 1984 has increased rapidly, the State has made only minor changes to the reimbursement rate.

For example, from 1984 to 1990, there was only one rate increase for personal care services. For providers in Northern Virginia the rate was increased from $7.00 to $8.50. The rate for personal care providers in the rest of the State was increased from $7.00 to $8.00. These limitations on rate increases have effectively contained Medicaid expenditures per hour of care.

To determine whether the personal care rate increases kept track with inflation, JLARC staff used the U.S. Home Health Agency Market Basket inflation indicator. While this is not a specific measure of inflation for personal care, it was used as a proxy because many of the factors which influence home health costs also affect personal care. As Figure 15 shows, inflation increased at an average annual rate of five percent. This was higher than hourly wage increases that were granted during this time period.

Figure 15

Medicaid Personal Care Expenditure and Utilization Trends (1984-1990)



Source: JLARC staff analysis of expenditure and utilization data provided by the Department of Medical Assistance Services.

In 1992, the State took steps to address this problem by increasing the personal care rate to $11.00 for Northern Virginia and $9.00 for the balance of the State.

Increased Hours. The rapid increase in the number of hours of care being paid for by Medicaid is due almost entirely to growth in the number of persons receiving personal care. As Figure 16 demonstrates, recipients receiving personal care increased substantially from 1984 to 1990, growing at an average annual rate of nearly 60 percent. At the same time, the number of hours of care per recipient grew by less than ten percent.

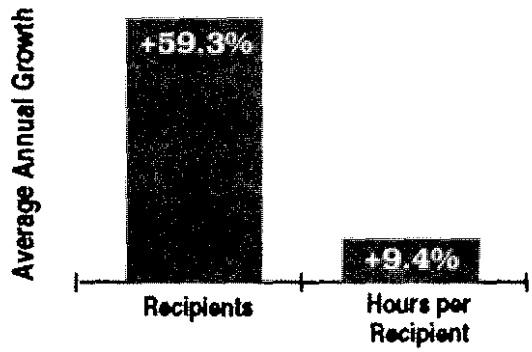
Personal Care Screening Must Be Addressed to Contain Spending

As with home health care, any concern about the growth in personal care services must be tempered by the fact it is less expensive than the form of care — nursing homes — it is designed to replace. However, personal care services are not cost-effective if they are targeted to persons who are not at imminent risk of nursing home placement. In such cases, rather than avoiding future nursing home costs for the State, personal care becomes a supplement to existing long-term care services thereby increasing total aggregate Medicaid spending.

To ensure the cost-effectiveness of these services, it is important that the State's policies governing who gains access to these services are appropriately designed and implemented. This issue will be addressed in Chapter V of this study.

Figure 16

Factors Related to Expenditure and Utilization Trends in Personal Care (1984-1990)



Source: JLARC staff analysis of personal care recipient data provided by the Department of Medical Assistance Services.

CONCLUSIONS

The majority of Medicaid funding for long-term care services is spent on institutional care provided in nursing homes and facilities which offer treatment for persons who are mentally retarded. Medicaid spending on nursing home care has grown primarily due to an increase in the number of recipients who are relying on the program to pay for these services. The expenditure increases observed for the care provided by the ICFs/MR is primarily the result of growing costs associated with providing a day of care in these facilities.

Medicaid spending on community care has grown at the fastest rate of all long-term services. The primary reason for the growth of both home health and personal care services is an increase in the number of people who are receiving care in the community.

The varied nature and purpose of each of these long-term care services have implications for any cost containment strategies that the State may wish to pursue. For these reasons, methods for controlling long-term care expenditures should be carefully considered based on an examination of the State's objective in funding these different types of care through Medicaid. For example, are there cost containment policy changes which can be made to the State's long-term care eligibility guidelines without undermining the basic intent of the program? Does the Medicaid reimbursement process contain sufficient components to contain spending? Is community-based care used efficiently? Are utilization review and cost audit performed effectively? These questions are addressed in the remainder of this report.

III. Medicaid Eligibility and Services for Long-Term Care

The federal laws which are the basis for Medicaid's eligibility guidelines give the states considerable discretion in deciding who is served by the Medicaid program and what benefits they receive. As a result, the most effective methods for cost avoidance in Medicaid are to restrict the number of persons who have access to the program or limit the range of benefits that will be provided. How states use this discretion when designing eligibility and benefits options for long-term care services is particularly important because of the expensive nature of this care.

In Virginia, a substantial portion of the long-term care cost in the State is due to the extension of benefits to persons for whom Medicaid coverage is optional. In FY 1991, more than half of the 44,000 Medicaid long-term care recipients established eligibility for program benefits through provisions which were implemented at the option of the State. The total medical care expenditures for this group of recipients exceeded $370 million.

Similarly, more than half of Virginia's Medicaid expenditures for long-term care were for services which the State is not required to provide. The total cost of these optional services in FY 1991 was more than $366 million. This equals almost one-third of the total amount spent on Medicaid services in the State.

These data clearly demonstrate that the State has the discretionary authority to reduce the size and cost of its Medicaid program. However, the tradeoff would be a reduction in services to many elderly citizens who either live at the economic margin or rely almost exclusively on Medicaid for support of their basic health care needs. Other strategies which can be pursued to slow the growth of long-term expenditures include the implementation of an estate recovery program and tighter federal restrictions on the ability of applicants to gain access to Medicaid eligibility by sheltering assets.

Medicaid eligibility guidelines and service options for long-term care recipients are the subjects of this chapter. Based on these policies, possible strategies for containing costs are presented.

CATEGORIES OF ELIGIBILITY FOR MEDICAID LONG-TERM CARE

The rules governing Medicaid eligibility are extremely complex and even more difficult to understand if all possible variations across states are considered. In general, however, this complexity can be reduced by distinguishing those categories of persons who must be served from those for whom the extension of program benefits is completely optional. Once this is accomplished, the possibilities for reducing the size and cost of the

Medicaid program through altering the State's eligibility policy or service plan can be given serious consideration.

This study found that more than half of the recipients of Medicaid long-term benefits in Virginia receive this care at the option of the State. Most of these individuals are either over the age of 65 and having difficulty performing basic activities of daily living, receiving care through a State-operated ICF/MR, or participating in Medicaid because they are considered disabled according to federal law.

The first section of this chapter describes the eligibility criteria used by Virginia to target the long-term care health benefits it provides and analyzes the costs of these policy decisions. To some extent, the discussion of eligibility requirements has been simplified. Actual eligibility determination for individual recipients can be substantially more complex than represented in this chapter.

Three Categories of Eligibles Receive Medicaid Long-Term Care Benefits

In order to be eligible for Medicaid long-term care services in Virginia, an individual must be classified as either: (1) categorically needy, (2) categorically needy non-money payment, or (3) medically needy. Two other categories of recipients — the medically indigent and refugees — can also receive Medicaid benefits. However, because they are represented in such small numbers among long-term care recipients, these groups were not considered in this analysis.

The Categorically Needy. The early emphasis of the Medicaid program was on providing services to those considered "categorically needy." This term was and is still used to identify those persons whose eligibility in Medicaid is based exclusively on their participation in two other federal public assistance programs — AFDC and SSI. Because these programs are targeted to people who are impoverished, linking participation in Medicaid to these cash assistance programs was seen as a way to expand health care services for the poor.

Categorically Needy Non-Money Payment. A second eligibility classification used for Medicaid in Virginia is often referred to as "categorically needy non-money payment." With this category, Virginia is required to serve certain groups and given the option of extending benefits to others. For example, the State must provide long-term care services to individuals who are deemed to be receiving SSI benefits.

Other mandatory recipients in this group include so called "protected cases." These are individuals who do not meet the program's current eligibility criteria, but because of their special circumstances are considered federally "protected." For long-term care, many of the "protected cases" are individuals who would have been eligible for SSI payments except for increases in their Social Security benefits which pushed their incomes above the SSI income limits.

Another group of persons that the State considers as non-money payment recipients are those who meet a special income limit. Generally called the 300 percent rule, this guideline allows the State to extend Medicaid payments to persons who are either institutionalized or at-risk of institutionalization and have incomes which are greater than the State's limits for SSI but lower than 300 percent of the SSI level. Virginia uses the 300 percent rule to determine eligibility for individuals who are receiving care in the home and community-based care waiver or in state IMDs and ICFs/ MR.

According to DMAS' eligibility specialists, one objective of the State in adopting the 300 percent rule was to encourage families to utilize community care as an alternative to the more expensive services in institutions. Without this standard, all applicants whose income exceeded the Medicaid limit would have to "spend down" by incurring medical expenses in sufficient amounts before the community care could be provided.

"Spending down" in Medicaid can be a complex process that requires applicants to accumulate medical bills, meet with the eligibility workers to have them verified, and then be approved for benefits. These same individuals could, however, be admitted to an institution and actually begin receiving services in anticipation of "spending down" their income based on the large monthly costs of this type of care. Therefore, without the income standard, DMAS felt that more persons who could be served in the community would instead rely on institutional care to avoid service delays and the complexity of the "spend down" process.

The Medically Needy. Many State residents who cannot establish eligibility on the basis of any of the previously mentioned categories can gain access to Medicaid benefits as medically needy. This includes individuals who have too much income to meet the financial eligibility requirements of the SSI and AFDC programs, but not enough resources to pay their medical bills.

Virginia is one of 36 states that have provisions for the medically needy. The State adopted this program in 1972 so that the nursing home benefits that were being paid for with State general fund dollars in the Auxillary Grant Program could be partially replaced with federal Medicaid funds. Unlike the other categories, there is no cap on the amount of income medically needy persons can have, as long as their medical bills exceed their income.

Eligibility Changes for Cost Savings Should Focus on Optional Groups

To examine the State's options for lowering Medicaid cost through changes to the program's eligibility policies, JLARC staff focused its efforts on identifying persons for whom participation in Medicaid is completely optional. This does not mean that Virginia is unable to make Medicaid eligibility more restrictive for mandatory groups. Instead, it is a recognition that the criteria defining which types of recipients are mandatory are already quite restrictive. Further tightening these guidelines would in all likelihood have a greater and more adverse impact on many low-income, non-elderly Medicaid recipients.

For example, the mandatory link between participation in the State's Aid To Dependent Children Program (ADC) and Medicaid can be manipulated by tightening the income restrictions governing access to ADC benefits. However, because this would likely exclude more low-income adults and children from ADC than it would the non-poor elderly from Medicaid, this option was not considered.

With regard to SSI, the other cash assistance program linked to Medicaid, states can deny benefits to certain SSI recipients through the use of more restrictive criteria. However, Virginia already uses this option by applying more stringent guidelines governing how much continguous property an SSI recipient can own and still receive Medicaid. Furthermore, any other option that Virginia uses to make eligibility more restrictive for SSI recipients had to have been a part of the State's medical assistance plan prior to 1972.

To the extent that cost savings can be realized through the implementation of tighter eligibility guidelines for any group of potential recipients, basic principles of equity dictate that this should come at the expense of persons who, relative to others, can most afford it. This requires a focus on persons for whom Medicaid coverage is optional.

Eligibility for Most Long-Term Care Recipients Is Optional

The flexibility in Medicaid eligibility policy provides states with a number of options for designing eligibility guidelines to govern access to long-term care benefits. Examining the distribution of recipients according to these categories is a first step in determining the policy focus of the State's long-term care system for Medicaid.

Figure 17 presents the distribution of Medicaid long-term care recipients across the three major categories of eligibility in the State. As shown, the majority of these recipients are medically needy. This optional group accounts for 44 percent of all Medicaid long-term care recipients.

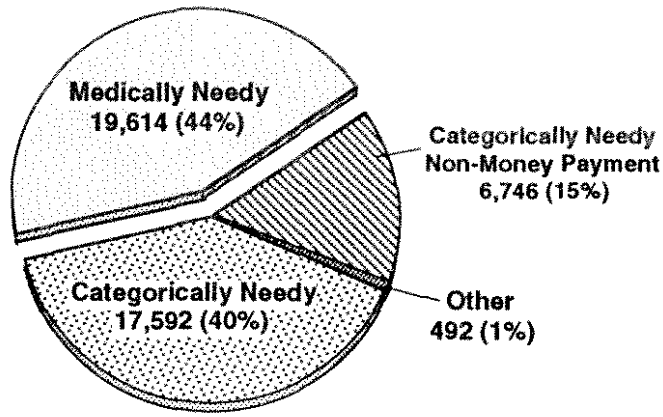
A key factor influencing the prevalence of these recipients is the Medically Needy rule permitting deduction of incurred medical expenses from income. As noted earlier, there is no limit on the amount of income persons can have and still receive Medicaid benefits under this provision as long their income is less than their medical expenses. This is most important to the elderly who need nursing home care.

To determine the medical expenses for this group, the State uses the *private rate* of the facility. Because these rates average more than $2,200 per month, elderly persons with considerable amounts of income can still "spend down" to Medicaid coverage if their income is less than the private rate. The following hypothetical case example illustrates the application of this particular policy.

> *Ms. Jane Doe, who retired in 1990, was living in Northern Virginia on a retirement income of $2,500 per month. This income was composed of $500 in Social Security benefits and a $2,000 pension. Two months after her retirement she was diagnosed as having Parkinson's Disease.*

Figure 17

Virginia Medicaid Recipients of Long-Term Care Services by Eligibility Category, FY 1991



Note: Based on their monthly incomes, a substantial number of persons who are medically needy could also establish eligibility through provisions for the optional categorically needy non-money payment.

Source: JLARC staff analysis of Medicaid eligibility claims files from the Department of Medical Assistance Services.

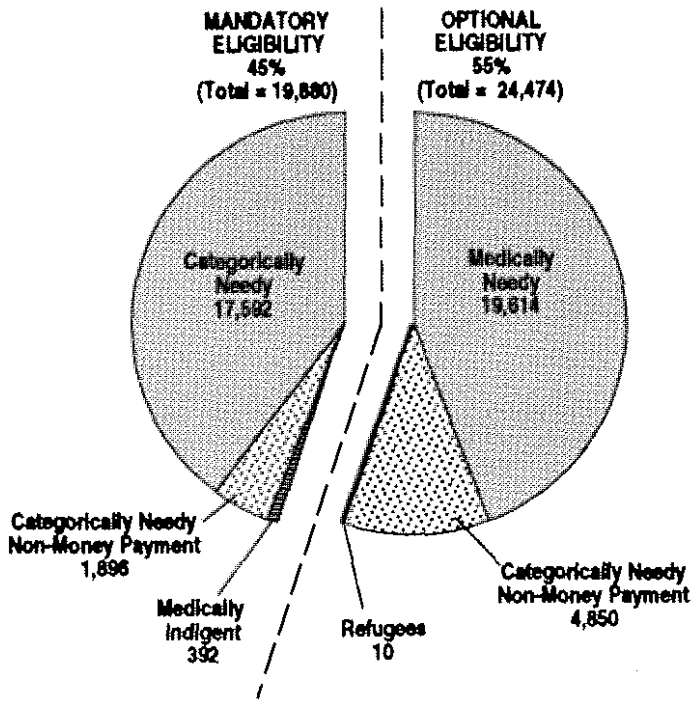
With no one to regularly care for her, Ms. Doe's son sought to place her in a nursing home in Northern Virginia. The daily private rate for this facility was $111.74. This meant the typical monthly cost of her care would be $3,402. Because she only had an income of $2,500, Ms. Doe applied for Medicaid nursing home benefits. After assessing whether she met the level of care criteria, Ms. Doe was approved for Medicaid because the cost of nursing home care exceeded her income by more than $900. Mrs. Doe's income will be applied to her cost of care in the nursing home and Medicaid will pay the difference. Therefore, although Ms. Doe was not considered poor, she was eligible to receive benefits from Medicaid to assist her with the cost of nursing home care.

It is important to emphasize that not all of the recipients who benefit from Virginia's extension of services to optional groups are medically needy persons in nursing homes. To fully assess the impact of the State's use of optional eligibility criteria, it is necessary to consider those non-mandatory recipients who gain access to program benefits through provisions for the categorically needy non-money payment group. This would include all those recipients who are not considered "protected" or deemed to be eligible for SSI or AFDC benefits.

When this is done, eligibility for more than half (55 percent) of the long-term care recipients in the State in FY 1991 was optional (Figure 18). Approximately 80

Figure 18

Virginia's Medicaid Recipients of Long-Term Care by Eligibility Status (Mandatory or Optional), FY 1991



Source: JLARC staff analysis of Medicaid eligibility and claims files from the Department of Medical Assistance Services.

percent of these 24,474 optional recipients established eligibility for Medicaid through provisions for the medically needy. The remaining 20 percent were mostly individuals who established eligibility as "non-money payment recipients."

DMAS staff point out that many of the medically needy also meet the criteria established for the optional categorically needy using the 300 percent rule. Therefore, if an attempt is made to identify the true cost of serving the medically needy, those who are dually eligible would have to be separated. However, because both of these eligibility categories are optional, JLARC staff did not feel this adjustment was necessary for this study.

Characteristics of Optional Recipients. In addition to meeting the financial requirements for Medicaid long-term care services, program beneficiaries must also satisfy a separate set of guidelines which define level of care criteria. In effect, the level of care criteria are an indication of the particular problem that program beneficiaries have which require the services that are paid for by Medicaid.

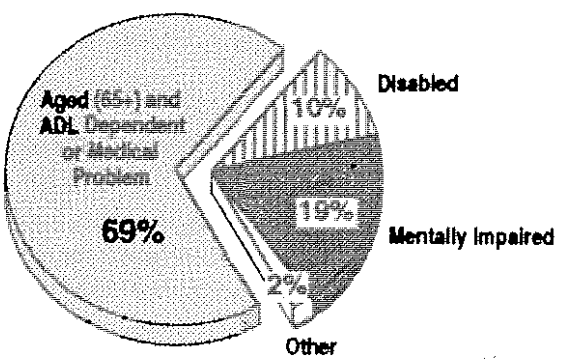
For example, in order to be approved for nursing home or personal care services, otherwise eligible applicants must be sufficiently dependent in many of the basic activities of daily living (ADL). This might include being non-ambulatory, incontinent, or mentally incompetent. Also, before an individual can receive home health services, a physician must indicate that the person has a medical condition which requires supervised treatment. This might include services such as wound care or tube feedings.

The majority (69 percent) of long-term care recipients established eligibility for Medicaid services because they were 65 years old or more, and either needed assistance performing ADLs or had medical problems which required supervised treatment (Figure 19). Eligibility for another 19 percent of these recipients was based on their mental impairments. In most cases, these persons are either severely or profoundly retarded and received treatment in State-operated ICFs/MR. A smaller proportion of these individuals are mentally ill and use Medicaid to pay for the care they receive through state institutions or various mental health clinics.

Only 10 percent of the long-term care recipients established eligibility for Medicaid based on the federal definition of disability. Generally, persons are considered disabled by SSI regulations if they are unable to engage in any substantial activity because of a physical or mental impairment that lasts at least 12 months, or is expected to result in death.

Figure 19

Optional Long-Term Care Recipients According to Non-Financial Eligibility Factors, FY 1991



Notes: The category of "Mentally Impaired" may include a small number of persons whose eligibility is based on unrelated medical problems.

Source: JLARC staff analysis of Department of Medical Assistance Services' Medicaid eligibility and claim files, FY 1991.

MEDICAID COST OF SERVING OPTIONAL RECIPIENT GROUPS

The total Medicaid cost of Virginia's policies which extend benefits to optional groups is substantial. In FY 1991, the State paid providers more than $646 million for Medicaid services (including hospital and pharmacy services) to long-term care recipients. Approximately 57 percent of these expenditures — $370 million — were made on the behalf of persons whose eligibility was optional (Figure 20).

Among those optional recipients, services to the medically needy accounted for 70 percent of the $370 million in Medicaid expenditures. The largest proportion of these resources (83 percent) were used for services provided to individuals who were 65 years or more and met the level of care criteria for the particular long-term care service they received. Undoubtedly a disproportionate amount of these expenditures were made for elderly persons in nursing homes who relied on Medicaid to pay for some or all of the costs of their care.

Optional recipients who were categorized as non-money payment received services that cost the Medicaid program more than $112 million. Most of this money (74 percent) was spent on persons who were mentally retarded. The largest share of the remaining $29 million was used to provide a range of services to persons who were mentally ill.

Cost Savings Solely through Eligibility Changes Would Create Hardships

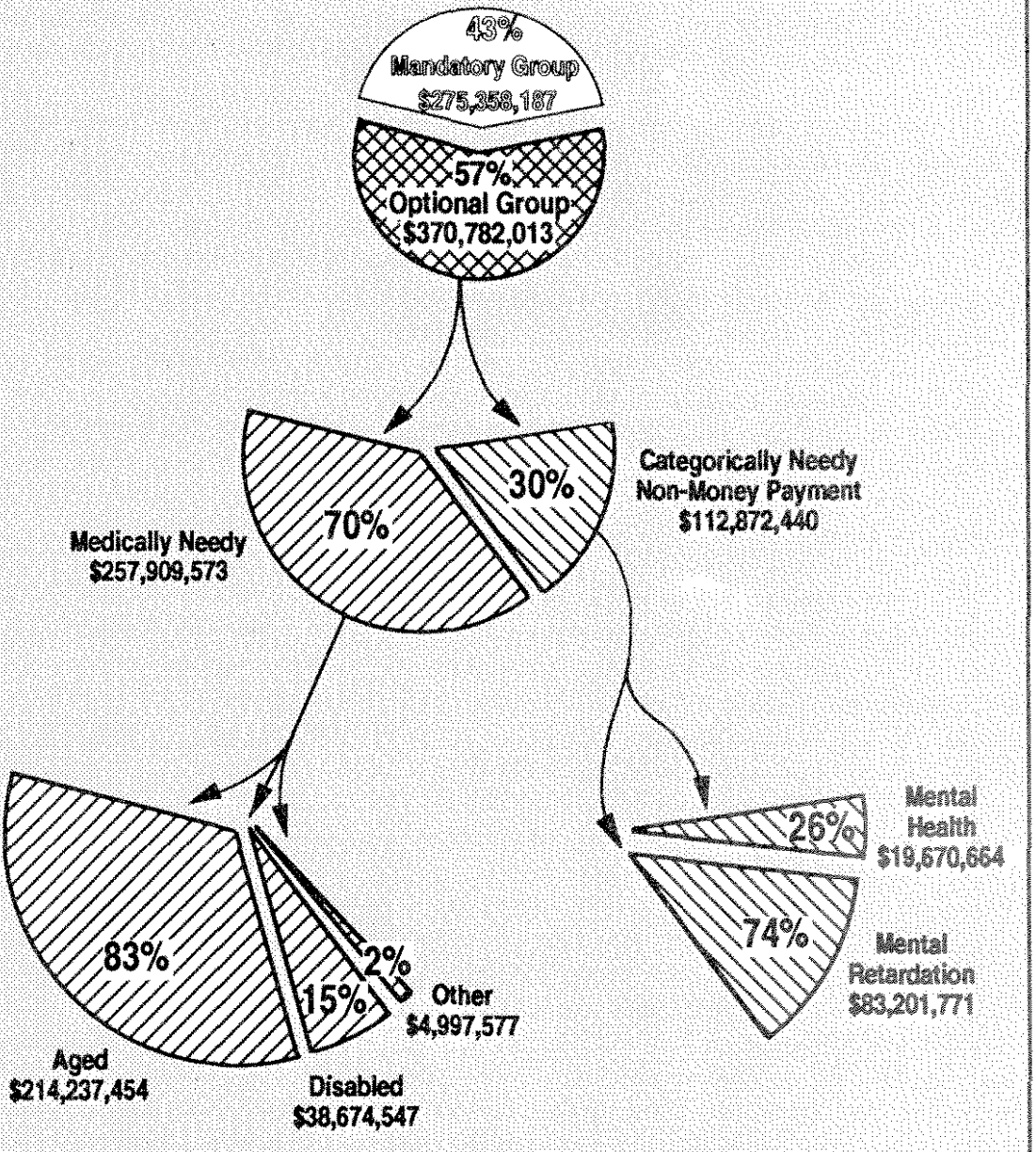
Clearly the State can achieve substantial cost savings by tightening the criteria governing access to Medicaid for optional groups of recipients. Another often-cited criticism of Medicaid is that it provides long-term care benefits to growing numbers of middle-income citizens, perhaps at the expense of low-income residents for whom the program was originally intended.

The most obvious way to address this situation in Virginia would be to change Medicaid eligibility policy by placing caps on the amount of income that a person can have and still receive benefits. However, because Virginia has a medically needy program with more restrictive income guidelines for SSI-related recipients, it must permit persons who are considered medically needy to "spend down" their income to the program's eligibility level by deducting medical expenses. Thus, even if a person is middle- or upper-income, they are entitled to Medicaid long-term care benefits when their medical expenses either exceed their income or reduce it to the medically needy income level.

This requirement leaves the State with two strategies for reducing the number of optional recipients who are eligible for Medicaid: (1) eliminate the medically needy program; or (2) eliminate or reduce the number of recipients who gain access to program benefits as optional categorically needy. If either or both of these strategies are pursued, they will, however, impose severe hardships on those affected by the more restrictive eligibility guidelines.

Figure 20

Total Medicaid Payments for Optional and Mandatory Long-Term Care Recipients, FY 1991



Notes: The figures for mental health may include a small number of persons who were auxiliary grant recipients and did not receive mental health services. Also, the total payments for persons who are medically needy would be substantially less than the reported $257 million if this group of recipients did not include persons who could also establish eligibility as optional categorically needy non-money payment.

Source: JLARC staff analysis of Department of Medical Assistance Servies' recipient eligibility and claims files, FY 1991.

Eliminate Coverage for the Medically Needy. The most effective method to reduce the future cost of the program would be to eliminate coverage for the medically needy. In a presentation to the Senate Finance Committee in 1991, DMAS stated that the elimination of coverage for this group would result in $10 million in savings. This assumes that many of those affected by the elimination of the medically needy program would be able to establish eligibility as optional categorically needy recipients.

However, if in conjunction with eliminating coverage for the medically needy, the income standards for the optional categorically needy were lowered to the SSI level for mandatory recipient groups, all of the medically needy would lose eligibility for Medicaid benefits. Under these circumstances, Medicaid spending would be reduced by more than $257 million — the total medical care expenditures on the medically needy in FY 1991. This amounts to 20 percent of total Medicaid spending.

There are two major disadvantages to this approach for cost savings which could offset the apparent benefits. If the medically needy program is eliminated, it would impact all such recipients, not just those receiving long-term care. This would effectively eliminate access to health care for many individuals who are not eligible for the State's ADC program — the link to Medicaid eligibility for low-income residents — but are still considered poor.

For example, the ADC income limit for a family of two in Virginia is $257 per month. As noted in the JLARC interim report, *Review of The Virginia Medicaid Program*, this is the third lowest income limit in the country. With the medically needy program, persons only marginally above this limit can easily "spend down" to the medically needy income limit of $308 and receive Medicaid-supported health care. Without this choice, many of these individuals would either receive no medical care, including cost-effective preventative health services, or rely on various emergency rooms around the State for their basic health care. Because they do not have the means to pay for these services, the cost would be ultimately paid by the State.

Also, not all persons who receive Medicaid nursing home benefits through this provision have substantial incomes. The actual medically needy income levels for SSI-related recipients are still considerably less than the federal poverty level. Thus it is possible for a person to have too much income to be eligible for Medicaid without "spending down," but not enough income to live above the federal poverty level. As DMAS staff note, if the medically needy program were eliminated, these individuals who live at the economic margin would lose coverage for the long-term care services they need.

Reduce Coverage for the Optional Categorical Needy. The other group of recipients for whom Medicaid coverage is optional are persons who have access to treatment for mental impairments based on the State's use of a higher income standard. If Virginia exercised its discretion by eliminating eligibility for this group, it could reduce Medicaid expenditures by $112 million.

The problem with this approach is that more than $80 million of these savings would come from a reduction of benefits for persons who receive care in the State-

operated ICFs/MR. This would leave the State with two options. First, it could replace the Medicaid funding with State general fund dollars and subsidize the treatment for the affected individuals at a cost of more than $40 million.

Alternatively, it could require the families of these patients to pay the cost of care or be faced with a loss of service. With costs in the State-operated institutions exceeding $150 per day, it is unlikely that these families would be able to pay for this care.

A less drastic cost containment strategy would be to lower the income standard for this group of recipients. The current standard — 300 percent of the SSI benefit — is the maximum level which states are allowed to use. There are no federal restrictions preventing states from lowering this standard to any amount between the SSI monthly benefit and 300 percent of that benefit.

The limitations of this approach are similar to those associated with complete elimination of the optional categorically needy group. More important are the questions this strategy raises about equity in distributing benefits for persons who are mentally impaired. To further restrict the number of mentally impaired who have access to Medicaid benefits while continuing to provide coverage for any medically needy person irrespective of income, undercuts the basic principle of equity which should guide the distribution of program benefits for social welfare programs.

While it is recognized that restricting services through a general tightening of eligibility will create some unavoidable hardships, the potential impact of these options seem especially severe. To avoid this, the State may have to consider some combination of eligibility restrictions and service reductions which will slow the growth of Medicaid while minimizing, as much as possible, the associated hardships. One such strategy is discussed in the next section of this chapter.

MEDICAID LONG-TERM CARE SERVICES

Medicaid legislation authorizes a broad range of long-term care services that states can include as a part its benefit package. As with eligibility, some of these services are required and others are optional depending upon the particular recipient group that is being served. This gives Virginia the flexibility to design a long-term care benefits package that reflects the goals it wishes to pursue in the provision of health care to the elderly, balanced against what can be funded given the limitations of the State's budget.

This study found that the State spends more than $360 million on services that it is not required to provide. The two most important and expensive of these are nursing home benefits for the medically needy and institutional care for persons who are mentally retarded. A significant reduction in the Medicaid spending for long-term care services is not possible unless expenditures on one or both of these services are limited.

Virginia Provides More Long-Term Care Services than Required

To understand the long-term care service requirements under Medicaid, it is important to consider the program relative to its federal counterpart, Medicare. The Medicare program was authorized as an acute care program for the elderly in the 1960s and thus contains only limited provisions for coverage of non-acute long-term care services like nursing home care. For example, Medicare will pay 100 percent of a patient's nursing home costs for only 20 days when the stay is related to an illness for which the patient was hospitalized.

One assumption behind this approach was that all elderly needed to be protected from catastrophic costs that could be related to the onset of problems which required acute care (e.g. heart attacks, strokes, cancer), but that middle- and upper-income elderly would be able to provide for their own long-term care needs.

When Medicaid was authorized, it was designed as the major third party payor for all of the health care needs of the poor including both acute and residential care. The assumption here was that whatever the cost of health care services, persons who are poor simply cannot afford to pay for them. As a result, all states who participate in Medicaid must provide a comprehensive benefit package to program recipients who are automatically eligible — the categorically needy. However, for other groups of recipients who are considered optional, states are not required to provide any of the services that are considered as long-term care in this study.

Virginia's Long-Term Care Benefit Package. Table 3 illustrates the long-term care benefits that the State pays for each of the three major recipient groups in the Medicaid program. Distinctions are made between those services which are required versus those which are mandatory. As shown, the State offers all of the benefits it is required to provide to persons who are categorically needy. This includes nursing facility services and home health care for persons entitled to institutional care. In addition to these, the State pays for personal care services delivered to the categorically needy recipients in their homes and for the treatment this group receives in ICFs/MR.

For both of the optional groups — medically needy and categorically needy non-money payment — Virginia provides a full range of long-term care services even though the services are not required. For example, Medicaid law generally requires that states with medically needy programs provide the following services:

- prenatal and delivery services for pregnant women; and
- ambulatory services for children under 18 and those entitled to institutional services.

According to DMAS staff, the provision of a full range of benefits for persons in need of long-term care reflects a deliberate policy goal of the State. Because of the fragile nature of the elderly and the sometimes severe limitations of persons who are mentally impaired, the State has consistently worked to ensure that these vulnerable populations have access to the care they need.

Table 3

Medicaid Long-Term Care Services Provided in Virginia by Eligibility Group

Eligibility Group	Services Provided	Service Required
Categorically Needy	Nursing Home Care	Yes
	ICF/MR Services	No
	Home Health	Yes
	Personal Care	No
Categorically Needy Non-Money Payment	Nursing Home Care	Yes
	ICF/MR Services	No
	Home Health	Yes
	Personal Care	No
Medically Needy	Nursing Home Care	No
	ICF/MR Services	No
	Home Health	No
	Personal Care	No

Notes: As discussed, the State is not required to extend Medicaid coverage to persons who are optional categorically-needy. However, once eligibility is extended to this group, those services which are mandatory for the categorically needy are also mandated for the optionally categorically needy.

Source: Based on interviews with staff at the Department of Medical Assistance Services and a review of various documents on the Medicaid program.

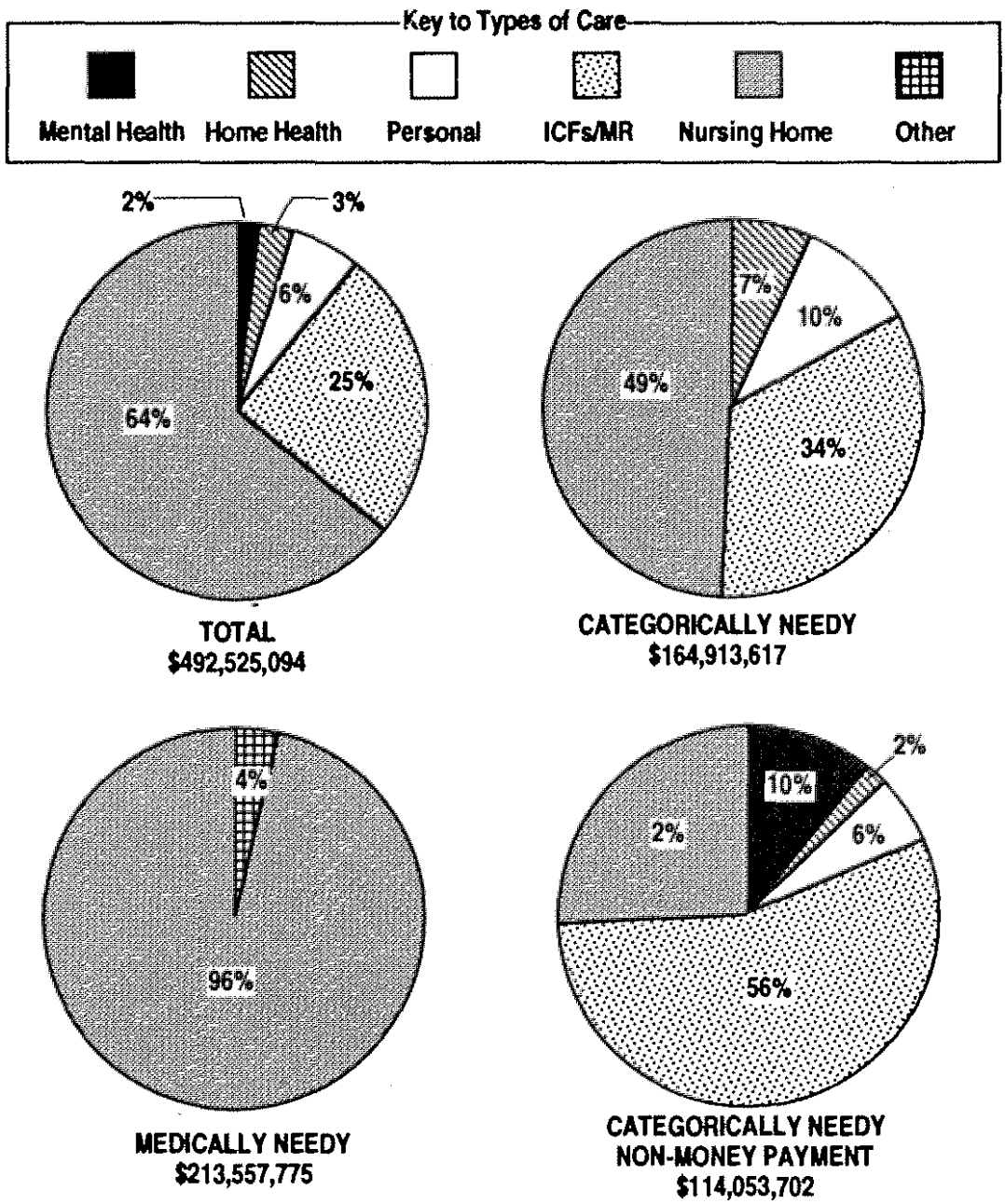
PAYMENTS FOR MEDICAID LONG-TERM CARE SERVICES

Because of the expense of long-term care, any decisions made by the State to provide these benefits as an option will carry substantial implications for the Medicaid program. Figure 21 shows the total Medicaid expenditures made for each type of long-term care service according to the three major categories of recipient eligibility. As shown, of the almost $500 million of Medicaid expenditures for long-term care that could be identified, 64 percent was used to pay for nursing home care. Services provided in ICFs/MR accounted for one-quarter of total spending. About 10 percent of funding for long-term care was spent on community services.

As expected, when these expenditures are separated by categories of recipient eligibility, a different pattern emerges. Virtually all of the $213 million that was spent for persons who were medically needy in FY 1991 was for nursing home care. This substantially exceeds Medicaid nursing home spending for any other group of eligibles.

Figure 21

Total Medicaid Payments for Optional and Mandatory Long-Term Care Services by Eligibility Group, FY 1991



Notes: The figures for total long-term care expenditures were developed from the Department of Medical Assistance Services' claims file. This file does not reflect the payment adjustments made as a result of the cost settlement process. As a result, these figures do not match the expenditure data in Figure 4, which are from the agency's internal management reports.

Source: JLARC staff analysis of Department of Medical Assistance Services' Medicaid recipient and claims files, FY 1991.

Medicaid expenditures for ICF/MR services accounts for over half of all spending on recipients who are considered categorically needy non-money payment. The other large outlay for this service was made for persons in the mandatory eligibility group of categorically needy.

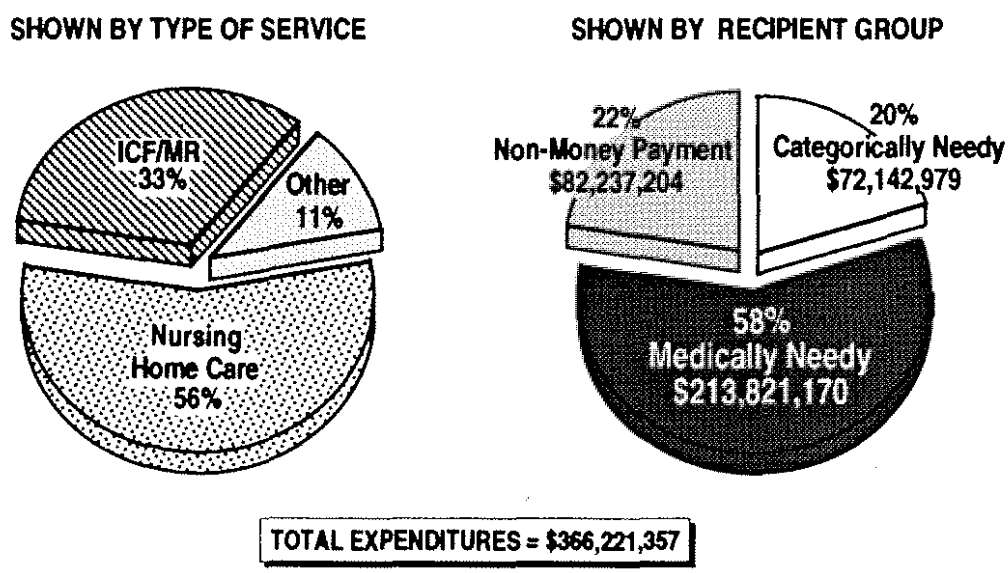
Payments for Optional Services Are Substantial

In order to determine the fiscal impact of those long-term services that are provided at the option of the State, JLARC staff identified the total Medicaid payments made for these services in FY 1991. These figures are reported in Figure 22.

As shown, the total cost to Medicaid for these optional services was more than $360 million. This amounts to almost one-third of the total medical care payments distributed by DMAS. As expected, most of Medicaid funds that were used to support optional services were spent on nursing home care. In FY 1991, 56 percent of Medicaid spending on optional services was made on behalf of recipients who were in nursing homes. Approximately one-third of the spending on optional services was for care provided in the ICFs/MR.

Figure 22

Medicaid Expenditures on Optional Long-Term Care Services, FY 1991



Source: JLARC staff analysis of the Department of Medical Assistance Services' recipient and claims files, FY 1991.

The largest beneficiaries of the State's optional benefit package was the medically needy. Almost 60 percent of Medicaid spending on these services was paid out on behalf of this group. The remaining forty percent was equally split between persons whose eligibility was mandatory (20 percent) and those who were a part of the optional categorically needy (22 percent).

The implications of these findings for Medicaid cost savings should not be understated. These numbers indicate that if the State wants to lower Medicaid spending on long-term care, a decision must be made to reduce expenditures on nursing home care for persons who are medically needy.

Cost Savings Possible through Eligibility and Service Reductions

The most equitable method for reducing nursing home expenditures for the medically needy would be to cap the amount of income that a person can have and still receive Medicaid benefits. Because of the restrictions the State faces by operating a medically needy program, two strategies must be pursued to establish the income standards. These are: (1) eliminate coverage for nursing home benefits for the medically needy; and (2) establish a policy which extends nursing facility care to all persons who have an income below a predetermined level.

If income restrictions are adopted, this policy should not be viewed as a panacea for the rising costs of long-term care. Instead, it represents one strategy that could slow the growth of the program while allowing the majority of program recipients continued access to nursing home benefits.

Eliminating Nursing Home Benefits for the Medically Needy. Under the current Virginia program, DMAS must allow all persons who have income above the program's limit to "spend down" by deducting their medical expenses. This effectively prevents the State from establishing an income standard on which it can base eligibility for nursing home benefits for the medically needy. The State could elect to drop its medically needy program but, as discussed earlier, the adverse effects of this approach would likely outweigh any of the benefits of potential cost savings.

To address this problem, the State could use its discretion to eliminate the nursing home benefit for the medically needy. Thus, persons who were medically needy would still be eligible for all other services that Medicaid covers but they would no longer receive payment for nursing home care. Once this was done, the State would then be able to establish a nursing home benefits package for the optional categorically needy that contained limits on the amount of income a person could have and gain access to these benefits.

Use of Income Standard for Nursing Home Care. In establishing an income standard, federal law for Medicaid nursing home benefits requires that it not exceed 300 percent of the SSI monthly benefit for one person. States are free to set the standard at any level between the 300 percent of the SSI monthly benefit and the actual benefit. In

1991, the monthly benefit for SSI for one person was $407. If the 300 percent rule were used the income standard in Virginia would be $1221.

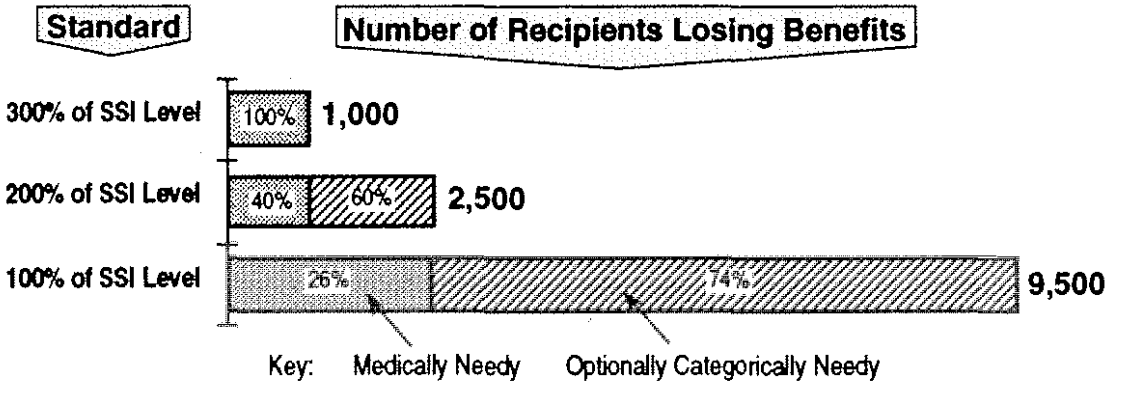
DMAS staff presented this as a possible strategy to contain costs to the Senate Finance Committee in 1991 and estimated that approximately 2,500 individuals would no longer be eligible for Medicaid if the income standard were set at 200 percent of the SSI level (Figure 23). The total reduction in Medicaid spending would be $14 million.

Possible Consequences of Income Standard. The proposed income standard does create problems for those who would lose eligibility under this provision. Specifically, these would be persons whose income is above the Medicaid standard, but not sufficient to pay the monthly private costs of nursing home care. In such cases, these individuals would be forced to rely on family members or friends for support, seek care through nursing homes operated by local governments, or survive on their own. Also, privately run homes with low occupancy rates might be willing to accept a payment from these persons which covers a portion of the care rather than carry an empty bed for an entire month.

Recent studies indicate that 20 states either use an income cap to determine eligibility for nursing home care or do not cover the aged in their medically needy programs. One such study concluded that persons who are ineligible for nursing home care because of the income standard "receive inadequate medical care, and their primary caregivers face tremendous financial and emotional burdens with little hope for relief."

Figure 23

Number of Medicaid Nursing Home Recipients Who Would Lose Benefits at Different Income Standards



Source: JLARC presentation of analysis conducted by staff at the Department of Medical Assistance Services, FY 1991.

This finding indicates the dilemma that Virginia faces as it searches for ways to slow the growth of Medicaid expenditures on long-term care. While many of the persons who will no longer be able to receive Medicaid benefits are middle-income elderly, they will not be able to consistently pay for their long-term care needs. At the same time, if tighter restrictions are not placed on eligibility for program benefits, long-term care costs will continue to grow as a proportion of an expanding Medicaid program.

In summary, two major options for cost containment are available to the General Assembly for curbing the rising expenditures for nursing home care. First, the General Assembly could eliminate coverage for medically needy recipients and lower the income standard for the optional categorically needy to the SSI level. This would save the State more than $200 million. A less drastic alternative would be to eliminate nursing home benefits for the medically needy and lower the income standard for the optional categorically needy to 200 percent of the SSI level. Estimated savings for this approach are $14 million.

MEDICAID ASSET TRANSFERS AND ESTATE RECOVERIES

There is a growing concern that a number of Medicaid recipients in Virginia are using "loopholes" in federal and State laws to gain access to the program's benefits while preserving resources for their heirs. These strategies, while legal, effectively undermine the basic intent of Medicaid — to increase access to health care for persons who are poor.

Unrelated to this are federal Medicaid laws which require states to exempt the real property of applicants at the time they initially apply for nursing home benefits. This allows more than a third of all program applicants to be approved for care even though they may have substantial resources.

In response to this concerns, JLARC was directed by Senate Joint Resolution 91 to determine the extent to which people use asset transfers laws to establish eligibility for Medicaid nursing home benefits in Virginia. In addition, a separate analysis was conducted to determine the potential benefits of developing an estate recovery in Virginia.

The details of the study are presented in a separate JLARC report entitled, *Medicaid Asset Transfers and Estate Recovery*. This study found that about one-quarter of those who apply for Medicaid nursing home benefits transfer assets either prior to or just after enrollment in the program. However, the majority of these transfers are conducted by applicants to pay medical expenses or a portion of their care.

A small number of applicants are using "loopholes" to shift the cost of their care to the taxpayers while preserving assets for their heirs. If this practice is to be stopped, both the State and federal government will have to change the laws and regulations which govern asset transfers.

Regarding estate recovery, the lack of a proactive program has prevented Virginia from achieving the savings reported in other states. The results of JLARC staff's analysis show that 16 percent of the Medicaid recipient's terminated from nursing homes in Virginia own property. It appears that as much as two-thirds of the cost of providing nursing home care to these recipients could be eventually recouped through estate recovery. JLARC staff estimate that the State could recover almost $10 million an effective estate recovery program. According to DMAS staff, approxiamately $2.6 million could be recovered annually.

Some of the recommendations made by JLARC staff based on the findings in the report are listed below:

- To ensure that the property owned by Medicaid applicants will be completely disclosed, the General Assembly may wish to require the Clerks of the Court to conduct property checks for all persons applying for Medicaid benefits.

- The Department of Medical Assistance Services should use the discretion recently provided by HCFA to adopt a State regulation permitting eligibility workers to count multiple transfers as a single transaction.

- Because Medicaid applicants are beginning to purchase high cost term life insurance policies as a means of protecting liquid assets for their heirs, the General Assembly may wish to adopt legislation giving the Department of Medical Assistance Services the authority to count the resources as a part of these recipients available assets.

- In order to defray the cost of nursing home care, the General Assembly may wish to consider requiring the Department of Medical Assistance Services to implement a proactive estate recovery program.

- In order to enhance Virginia's ability to recover benefits paid on behalf of institutionalized Medicaid recipients, the General Assembly may wish to consider revising Section 63.1-133.1 of the *Code of Virginia* to allow liens to be attached to the real property of Medicaid recipients of nursing home benefits.

CONCLUSIONS

The rising Medicaid expenditures for long-term care services in Virginia are directly related to the eligibility guidelines and service policies that the State uses in distributing program benefits. More than one-half of all the persons who have access to Medicaid-funded long-term care services receive these benefits at the option of the State. In addition, the State spends more than $366 million on optional services.

If Medicaid spending for long-term care is to be reduced, the State will have to alter its eligibility and program benefits package for the medically needy who receive nursing home coverage. In FY 1991, more than 56 percent of the optional benefits that were paid by Medicaid were used for nursing home care. At the same time, almost 60 percent of optional program recipients established eligibility through the program's medically needy provisions. The most equitable method for restricting services to this population would be to establish fixed limits on the amount of income a person can receive and still be eligible for Medicaid nursing home benefits.

Limiting certain types of asset transfers and establishing a formal program to recover Medicaid nursing home expenditures from the estates of recipients can also be used to slow the growth in long-term care spending. While Virginia must depend on the federal government to provide the major restrictions on applicant asset transfer, Medicaid laws do permit states to develop estate recovery programs. With a properly implemented program, it is estimated that Virginia could recover almost $10 million dollars. Approximately $2.6 million could be recovered on an annual basis.

IV. The Reimbursement Process for Institutional Care

Federal law gives the states a great deal of flexibility in determining how to reimburse providers for the institutional services covered by the program. While the law requires that states reimburse nursing homes based on the reasonable cost of an efficiently operated facility, it prescribes no particular method for doing so. In light of this, a key concern in Virginia is whether the reimbursement policies established by the Department of Medical Assistance Services (DMAS) for institutional care are sufficient to contain spending while encouraging a cost effective delivery of these services.

The two primary forms of Medicaid-supported institutional care in Virginia are nursing home services and intermediate care for the mentally retarded. In 1990, DMAS substantially modified its payment system for nursing homes. These changes were made to more equitably distribute Medicaid reimbursements and increase nursing home access for recipients with heavy care needs. A review of this new system indicates that it is well designed and appropriately considers most of the key factors which influence the cost of nursing home care.

However, when the actual rates were set under this system, it was assumed that payment ceilings based on the cost experiences of the typical nursing home were adequate measures of nursing home efficiency. Concerns about this assumption have prompted DMAS to conduct research on alternative measures of efficiency. Not until this work is complete can the State be certain what the cost impact of the State's modified reimbursement system for nursing homes will be.

The reimbursement system for State-operated institutions for the mentally retarded contains no cost containment incentives. As a result, Medicaid pays virtually 100 percent of the cost for what has become the most expensive form of long-term care in the State. Still, if the Department were to lower the rates for these facilities, the State would either have to ignore national trends and consolidate these operations, or use general fund dollars to replace the revenues lost due to the reduction in Medicaid payments.

This chapter presents the results from an assessment of the State's reimbursement policies for institutional care, including an analysis of the appropriateness of the reimbursement system. Also, a review of the methods used by the State to determine actual nursing home payment rates is presented.

THE EVOLUTION OF VIRGINIA'S NURSING HOME REIMBURSEMENT SYSTEM

Prior to 1982, nursing homes that participated in Medicaid received payments based on the principles of reasonable cost reimbursement. Under this approach, all providers were required to submit financial reports detailing the cost incurred for serving Medicaid patients. These reports were used by the State to identify those costs which were allowable under Medicaid and the facility was reimbursed 100 percent of these costs.

These principles of reimbursement were changed in 1981 because they were perceived as inflationary with no incentives for promoting the efficient delivery of nursing home care. The catalyst for this change was the 1981 Omnibus Budget Reconciliation Act. One provision of this statute, referred to as the Boren Amendment, changed Medicaid law by requiring states to pay facilities rates "which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities...."

Since the passage of the Boren Amendment, Virginia's Medicaid program has used two different systems for reimbursing nursing homes. From 1982 to 1990, the State used a prospective system of reimbursement. In 1990, the State modified this system to provide incentives for nursing homes to admit a greater number of Medicaid recipients who have heavy care needs.

The data examined for this study indicates that DMAS has been reasonably successful in controlling nursing home spending. The use of alternative reimbursement system appears to have been a key factor in slowing the growth of these services.

Virginia's Prospective System Helped Control Nursing Home Expenditures

One year after the Boren Amendment was passed in 1981, the State developed a prospective system of reimbursement for nursing home providers. With this system, DMAS established four regional peer groups with separate distinctions for nursing homes that provided skilled and intermediate care. During this time period, HCFA differentiated between nursing homes according to the licensed staff requirements. Because they provided a higher level of care, skilled nursing facilities were required to have more licensure hours.

To reflect this requirement in its reimbursement system, DMAS used the following peer groups for categorizing nursing homes:

- Intermediate care facilities in Northern Virginia,
- Intermediate care facilities in the balance of the State,
- Skilled nursing facilities in Northern Virginia, and
- Skilled nursing facilities in the balance of State.

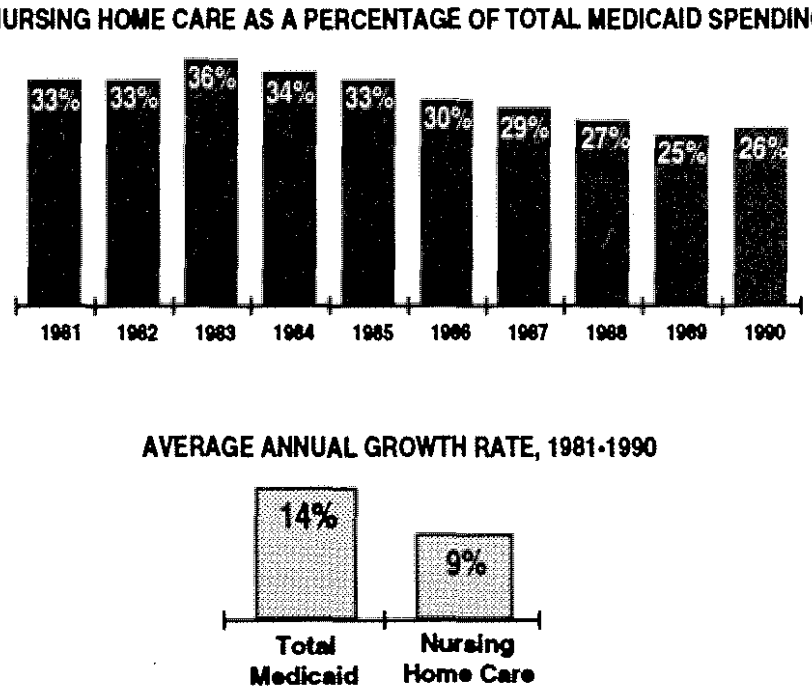
Within each of these peer groups, payment ceilings were established based on the median per diem operating rate for the nursing homes in that group. Once this rate was established, DMAS made annual adjustments to each peer group ceiling using an inflator that was linked to changes in the Consumer Price Index.

Each year, DMAS staff calculated the actual per diem cost of care for all nursing homes and then compared this rate to the respective ceiling for the peer group. Nursing homes were paid the lesser of the facility's actual per diem operating cost or the ceiling.

As Figure 24 indicates, nursing home care as a percentage of total Medicaid spending has on average been decreasing over the last nine years. This suggests that the State's reimbursement policies may have been somewhat effective in containing the growth in Medicaid nursing home expenditures in comparison to other services. For example, in 1981, one year prior to the establishment of the prospective flat-rate system, nursing home expenditures accounted for 33 percent of total Medicaid spending. In 1990, the last year DMAS used the flat-rate system, nursing home expenditures as a percent of total Medicaid spending had dropped to 26 percent.

Figure 24

Trends in Medicaid Nursing Home Spending 1981-1990



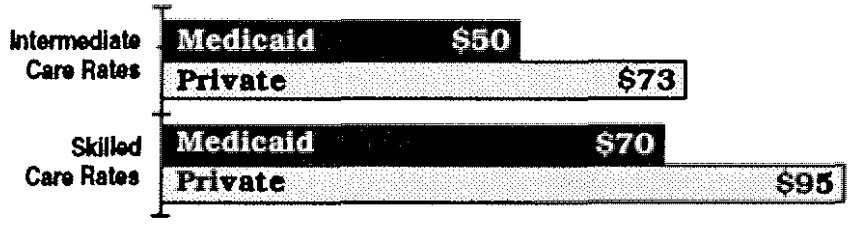
Source: Department of Medical Assistance Services' internal expenditure report.

When the rates of increase for all Medicaid services and nursing home care are averaged over this nine year period a similar pattern is observed. Total Medicaid expenditures grew at a rate of approximately 14 percent. By comparison, the average annual growth in Medicaid nursing home expenditures was less than 10 percent. This indicates that Medicaid payments for other services increased at a faster rate than nursing home expenditures during the time period that DMAS paid providers through a flat rate. Nationally, Virginia's per capita Medicaid expenditures for nursing home care ranks it among the lowest in the country (Table 4).

The rate that DMAS pays nursing homes is also considerably lower than the prices these facilities charge persons who do not have a third party payor (Figure 25). In 1990, DMAS purchased more than six million days of care. For both intermediate and skilled care, the private pay rate was at least $20 higher. If the State had purchased the same number of days based on the private rates at these facilities, Medicaid spending for nursing home care would have been $126 million greater.

Figure 25

Nursing Home Rates Paid by Medicaid in 1990 Compared to Private Rates



Source: Data on private rates collected from the Virginia Health Services Cost Review Council. Medicaid rates collected from the Department of Medical Assistance Services, Cost Settlement and Audit Division.

System Modified In 1990 to Increase Access for Heavy Care Patients

While the prospective flat-rate system successfully provided the State greater control over nursing home expenditures, DMAS staff were concerned that patient access problems were beginning to develop in Northern Virginia. Because the system did not account for the applicant's care needs, it was recognized that nursing homes had no incentive to admit patients that required intensive services. To address this problem, DMAS made three major modifications to the payment system. These three changes are described below:

- First, nursing home operating costs were separated into two components — direct patient care and indirect costs — and per diem rates for each of these two categories were developed.

Table 4

State Medicaid Nursing Home Expenditures Per Elderly Resident

State	Medicaid Nursing Home Expenditures (in millions) 1991	Spending Per Elderly Resident 1991
Alaska	$ 37.4	$ 170
Washington D.C.	121.0	151
Connecticut	643.2	141
New York	3,345.5	140
Massachusetts	1,150.3	138
Maine	206.8	126
Rhode Island	166.2	110
Minnesota	600.5	109
New Hampshire	129.5	100
Ohio	1,241.9	89
North Dakota	77.1	87
Wisconsin	550.5	85
Indiana	574.2	83
New Jersey	836.2	78
Vermont	52.2	78
Louisiana	328.7	68
Hawaii	87.1	68
Maryland	358.8	68
West Virginia	175.0	66
Washington	355.8	64
Georgia	428.5	63
Mississippi	204.6	62
Delaware	50.7	62
Nebraska	135.8	61
South Dakota	60.6	60
Tennessee	373.6	59
Pennsylvania	1,073.8	59
Montana	59.2	59
Colorado	181.7	56
Arkansas	201.2	56
Kentucky	261.1	56
Wyoming	22.6	54
North Carolina	426.5	52
New Mexico	84.7	51
Texas	899.6	51
Oklahoma	214.1	50
California	1,563.2	49
Missouri	346.4	48
Iowa	193.1	47
VIRGINIA	**313.7**	**46**
Idaho	53.7	46
Illinois	666.8	46
Alabama	227.7	43
South Carolina	170.1	43
Kansas	147.4	43
Nevada	45.0	40
Michigan	417.1	38
Oregon	132.7	36
Florida	776.8	32
Utah	19.5	14
Arizona	9.4	2
U.S. Total	$20,798.8	$ 66

Source: Unpublished data from Systemetrics based on 1991 HCFA 64 data.

- Second, for direct operating costs, DMAS reconfigured the State into three peer groups. For indirect costs, two peer groups were established.

- Third, to account for the severity of the patient's needs, an indicator of casemix was developed for each facility and used to adjust direct costs. This system is described as the Patient Intensity Rating System (PIRS).

Direct Versus Indirect Costs. According to DMAS staff, before consideration could be given to rewarding nursing homes for serving heavy care patients, a mechanism had to be in place to identify the costs of direct patient care. To facilitate this, DMAS defined direct care costs to include such expenses as nursing salaries and benefits, expenses for contract nurse services, nursing service supplies, and the salaries and benefits of staff that provide ancillary services (e.g. physical therapy.)

Indirect costs were primarily defined as general administrative overhead and operating expenses. This included such expenses as administrative salaries, telephone charges, office supplies, and liability insurance.

Reconfiguration of Peer Groups. The use of peer groups is based on the principle that a portion of the costs of nursing home care can be attributed to factors that facilities cannot control. In other words, facilities with certain characteristics are thought to face higher average cost curves which could be mistaken for inefficiency if compared to other nursing homes which are not similar. Therefore, to account for any disparities in costs based on these factors, facilities which are similar should be classified in the same peer group.

DMAS modified its peer grouping system based on two factors. First, the Congress passed major nursing home reform legislation in 1987 which eliminated the distinction that had existed between skilled and intermediate care facilities. This allowed DMAS to drop the peer group distinctions which had been made for these types of facilities under the flat-rate system.

Second, using the results from a consultant's study, DMAS decided that three separate peer groups would be needed to account for differences in direct patient costs and two for indirect costs. For the former cost category, DMAS used Northern Virginia, Richmond-Petersburg, and the remainder of the State. For the latter category of indirect costs, distinctions were made only between Northern Virginia and the rest of the State.

Patient Intensity Rating System (PIRS). A key aspect of this new system is the method used by DMAS to account for the severity of each nursing home's casemix. With PIRS, a measure of the patients' care needs was derived based on an assessment of their ability to independently perform the basic activities of daily living (ADL). This evaluation was used to rate the patient's health care needs on a scale ranging from zero (light needs) to 12 (severe or heavy needs). Based on this assessment, patients were grouped into the following three classes of care:

(1) Class A - Routine I. This category is used to describe patients whose level of impairment is considered light due to an ADL score of 0 to 6.

(2) Class B - Routine II. This category is used to describe patients whose level of impairment is considered moderate due to an ADL score of 7 to 12.

(3) Class C - Heavy Care. This category is used to describe patients whose level of impairment is considered high due to an ADL score of 9 or more and the presence of any of five special care needs.

Once these classes were defined, DMAS calculated a relative cost index by determining the average relative cost of care for each class of patient. According to DMAS staff, a time and motion study conducted in Maryland indicated that the cost of care for Class A patients is, on average, equal to 67 percent of the daily nursing costs for the average nursing facility patient. For Class B the rate is 109 percent. The cost of care for Class C patients is 164 percent of typical nursing costs.

Using these resource figures, DMAS created a service intensity index for each provider. Each facility's service intensity index was then normalized by an average resource measure for the entire State. This determined whether the patients in a given facility were more or less costly to care for than the State average. With the normalized index, DMAS staff adjusted the direct care peer group ceilings and the nursing home direct cost operating rate. The facility was then reimbursed at the ceiling or the adjusted operating rate, whichever is lower.

IMPACT OF VIRGINIA'S REIMBURSEMENT POLICIES

Under DMAS' reimbursement system, each facility's actual payment rate is ultimately constrained by the cost experiences of all homes in the peer group. This provides an incentive for nursing homes to keep costs below the ceiling and a retain a portion of the difference as an "efficiency incentive payment." Current State policy is to pay nursing homes that contain costs below the payment ceilings a "bonus payment" of up to 25 percent of the difference between operating costs and the peer groups ceilings.

At the same time, however, a given nursing home can only indirectly affect the payment ceiling for a peer group. Therefore, if the nursing home is unable to keep operating costs at rates that are consistent with most other facilities in the peer group, the ceiling will cap its Medicaid payment below the costs of providing care to program recipients.

One objective of this study was to assess differences in the cost of care for different types of nursing homes and evaluate how providers were affected by the recently established PIRS. The general findings indicate that there are five major types of nursing homes that participate in Medicaid. Many of these facilities are low cost, profit-oriented homes that successfully recover from the State most of the cost incurred by serving Medicaid recipients. A smaller number of facilities are non-profit homes and hospitals that have substantially higher costs. Although these facilities receive adjustments to their Medicaid payment based on the heavy care needs of the residents, the total amount of the reimbursement covers only a portion of reported costs.

For-Profit Nursing Homes Have Lower Costs

In 1990, there were five types of nursing homes that participated in the Medicaid program. Each of these different facility types are described below:

- For-profit chains are private nursing homes that are managed by a corporation. The smallest chain that participated in Virginia's Medicaid program consisted of two homes. The largest contained 28 homes.

- Sole proprietary nursing homes share the same characteristics of for-profit chains — private, profit-oriented — except that they are individually owned.

- Non-profit chains are a group of homes managed by one organization but they are not operated for the purpose of making a profit.

- Individual non-profit homes are similar to non-profit chains in there orientation but they are owned privately by individuals or an organization such as a church.

- Hospital-based nursing homes are owned by a hospital. Whether these facilities are profit-oriented or non-profit usually depends on the status of the affiliated hospital.

As Figure 26 indicates, for-profit chains constitute the largest proportion of nursing homes that participate in the Medicaid program in Virginia (47 percent). Historically, these nursing homes have been able to deliver care at a relatively low average cost. The average costs data in Figure 26 indicate that these facilities had the second lowest costs for a day of care in the State.

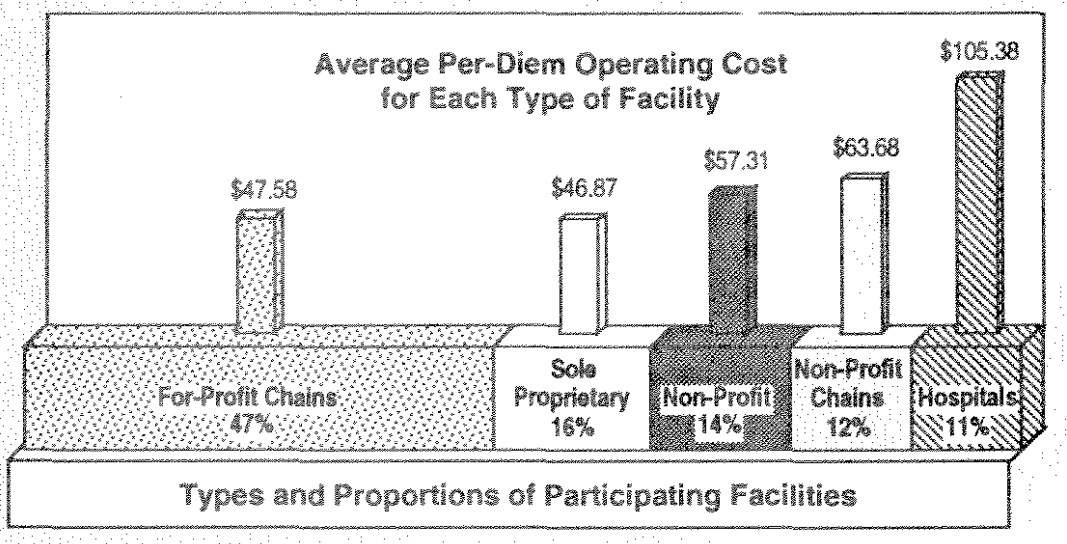
The second largest group of homes in the Medicaid program are sole proprietary facilities (16 percent). The average operating costs of these facilities is actually the lowest in the State.

Approximately 14 percent of the homes that participated in Medicaid were individually operated non-profit facilities. Included among this group are nursing homes operated by local governments. The average per patient day operating costs of these facilities is at least $10 higher than profit-oriented homes.

The two highest cost providers in the State are the non-profit nursing homes which are either managed by a chain or those facilities which are linked to a hospital. In 1990, 12 percent of the nursing homes that participated in Medicaid were non-profit chain facilities and the cost of a day of care at these homes was $63.68. The average cost at the 23 hospital-based nursing homes was even higher — $105.38.

Figure 26

Types and Operating Costs of Nursing Homes Which Participate in Virginia's Medicaid Program, FY 1990



Source: JLARC staff analysis of data collected from the Department of Medical Assistance Services and the Virginia Health Services Cost Review Council.

Nursing Home Costs at Non-Profit Facilities Exceed Medicaid Payments

A key issue in this study was whether certain types of nursing homes are better able to recover the cost of care for serving Medicaid patients under the current reimbursement system. This is an important issue because it has implications for patient access. If a large number of facilities have difficulty delivering nursing home care within the constraints imposed by DMAS' new reimbursement system, future Medicaid recipients may be given the lowest priority in the admissions process.

To examine this issue, JLARC staff calculated two different indicators of the industry's performance within the Medicaid payment system. The first was called a "coverage rate." This variable is defined as the nursing home's total Medicaid payment for operating costs — direct and indirect — as a percent of the facility's total Medicaid operating cost. To account for the impact of PIRS, the data used in the analysis included the actual payment adjustment that nursing homes received in 1990 based on the severity of their casemix.

The second indicator was a measure of the proportion of facilities with direct and indirect operating cost which were above the ceilings established by DMAS. For those

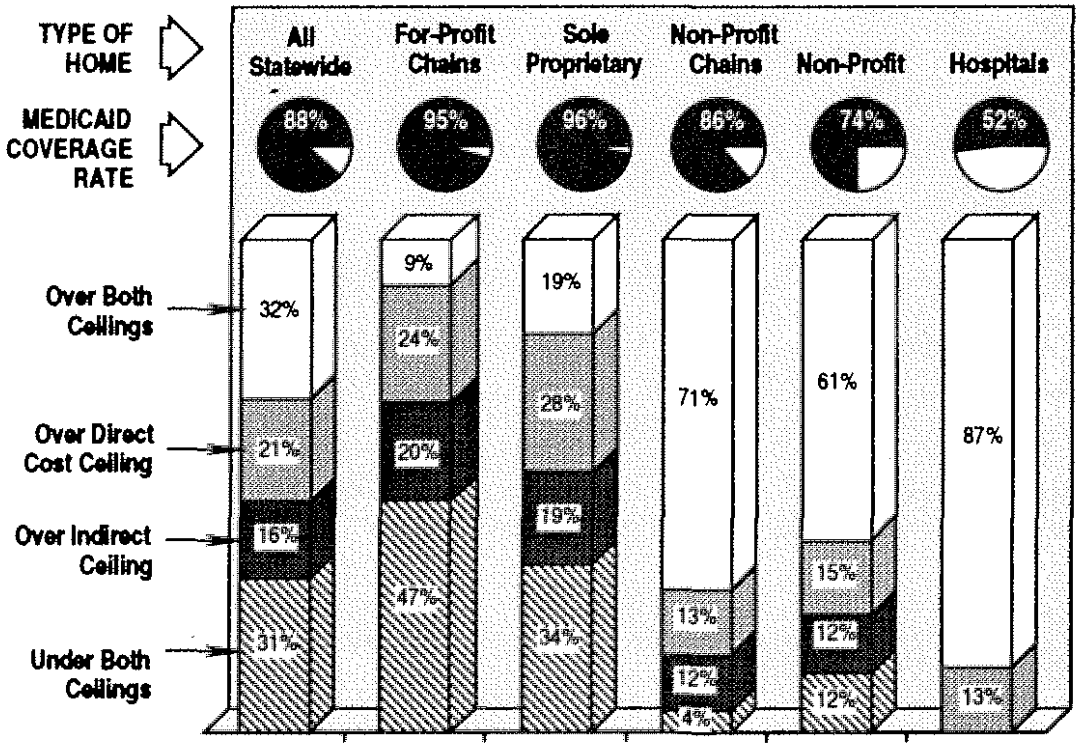
facilities with low coverage rates, this measure pinpoints the particular area of operating costs which is the source of the problem.

According to DMAS staff, nursing homes that are above the direct cost payment ceiling are spending more resources on patient care than Medicaid is responsible for reimbursing. Conversely, those who are above the indirect cost ceilings are viewed as sacrificing patient care by spending too much for administration and overhead. Nursing homes that exceed both ceilings are regarded as generally inefficient.

Coverage Rate. On average, the reimbursement system used by DMAS pays nursing homes at a rate which covers almost 90 percent of allowable Medicaid costs (Figure 27). However, there are sharp differences in the comprehensiveness of these rates based on type of facility. As Figure 27 shows, the reimbursement rate provided to for-profit facilities covers virtually all of the allowable costs associated with providing a

Figure 27

Medicaid Coverage Rates and Impacts of Payment Ceilings



Notes: The coverage rates reported in this figure were determined by dividing the sum of each nursing home's direct and indirect Medicaid per-diem rates by the sum of its direct and indirect per-diem costs. For some facilities, 1990 data were used. For others, 1991 cost figures were used.

Source: Data on Medicaid payments and ceilings provided by the Department of Medical Assistance Services, Cost Settlement and Audit Division.

day of care in these homes. On average, chain-operated nursing homes recover 95 percent of the allowable Medicaid costs. Similarly, sole proprietary facilities are able to cover 96 percent of allowable costs with the reimbursement provided by Medicaid.

The coverage rate begins to decline when examined for non-profit nursing homes. Individual non-profit facilities are more successful than others in this category as they typically recover 86 percent of Medicaid costs. The reimbursement rate established for non-profit chains covers just under three-quarters of their costs. Hospital-based nursing homes experience the most difficulty with the State's reimbursement system. The prospective rate established for these facilities in 1990 covered approximately half of their reported Medicaid costs.

Impact of Direct and Indirect Cost Ceilings. When data on nursing facility costs and the State's separate payment ceilings for direct and indirect costs are examined, for-profit chains (47 percent) were more likely to be below both of these payment ceilings By comparison, only a small number of non-profit or hospital-based nursing homes had costs for Medicaid patient care that were below both ceilings. More important, these facilities typically exceeded the payment thresholds set by DMAS for both categories of operating cost.

For example, 71 percent of non-profit chains and 61 percent of non-profit nursing homes that were individually operated exceeded both the payment ceilings established by DMAS. Almost nine out of every 10 the hospital-based nursing homes (87 percent) reported Medicaid costs for both direct and indirect categories which exceeded the program's limit. Conversely, only 13 percent of these facilities were able to provide nursing home care to Medicaid patients at costs that were below both payment ceilings.

Questions about Reimbursement Policy. These findings raise a number of questions about nursing home costs and the State's policy for reimbursing these facilities. Specifically, what factors explain the observed cost differences by type of facility? Does the reimbursement model appropriately consider the key factors which influence nursing home costs? Are there other cost factors associated with the delivery of nursing home care that should be considered by DMAS when establishing payment rates for providers? These are some of the questions which are addressed in the next section of this chapter.

ANALYSIS OF THE NURSING HOME REIMBURSEMENT SYSTEM

To be considered effective, a reimbursement strategy for nursing homes should control program spending for services while promoting an efficient delivery of care. DMAS has attempted to address these issues with its current reimbursement system by using peer group payment ceilings to control costs and a casemix adjustment factor to increase access for heavy care patients.

The objective of this portion of the study was to identify the key determinants of nursing home costs and assess whether they are appropriately considered in the State's current reimbursement system. It has been suggested by providers that the system is

inequitable because it produces rates that are too low to adequately compensate those nursing homes which provide a higher level of care and serve more residents with intensive service needs.

The results of the JLARC review indicate that the current reimbursement policy does appropriately consider most of the key factors which influence nursing home costs. Further refinements should be made to account for the diseconomies of scale that small nursing facilities experience. However, the higher operating costs faced by non-profit and hospital-based providers appear to be the result of management decisions to provide a higher level of nursing home care. Additional analysis indicated that this level of care exceeds the amount that Medicaid is required to purchase.

Nursing Home Cost Function Developed to Evaluate Reimbursement Policy

There are a number of factors that affect the cost of providing nursing home services to persons in need of long-term care. Because of differences in the geographic location of nursing homes, type of ownership (public versus private), facility size, and patient casemix, developing a methodology to sufficiently reimburse providers for the cost of their services is a complex undertaking.

Since the Boren Amendment requires states to compensate nursing homes for the reasonable cost that an efficiently run facility must incur, Medicaid reimbursement systems should be based on those factors which impact costs.

To address this issue, a cost function analysis was conducted for the nursing homes that participate in Medicaid. This analysis was based on the standard economic theory which holds that a nursing home's operating costs are a function of the price of its inputs. This theory further assumes that nursing homes will produce a certain level of output according to two factors: input prices (e.g., nursing wages) and the revenue which can be generated from each unit of output (patient days). Given this assumption, nursing homes can be expected to choose the combination of inputs to outputs which minimize costs and maximize profit.

However, as noted earlier, not all nursing homes that participate in Medicaid have the same profit maximizing goal. For example, administrators of non-profit facilities may choose to provide a higher level of care at a greater cost to the nursing home. Moreover, these facilities may also be less selective in the type of patients they admit and extend care to a higher proportion of persons who need intensive services. This would also increase facility costs.

Because of this, other nursing home cost factors were considered in this analysis through the use of multiple regression. They included type of ownership, facility size, occupancy rate, patient casemix, and geographic region. In specifying this cost function, models were developed which quantified the relationships between the dependent variable — average costs per day — and these independent cost factors. Using the results of this analysis, the appropriateness of the State's reimbursement system for nursing

homes was evaluated. (A separate technical appendix explains the methods used to conduct this analysis in greater detail and is available from JLARC upon request.)

Separate Peer Groups for Non-Profit Facilities Are Not Needed

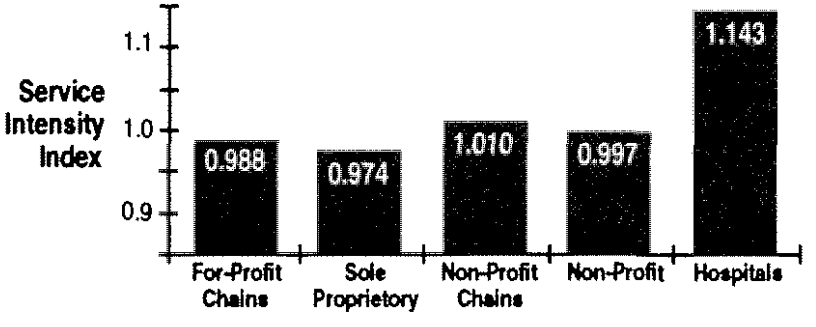
A major question surrounding DMAS' selection of peer groups is whether they should be expanded by establishing separate groups for hospital-based and non-profit nursing homes. Because a number of non-profit facilities are operated by local governments or linked to hospitals, they do not have the same discretion in setting wage levels for nursing and support staff. Thus, while for-profit nursing homes can contain costs by controlling wage levels, many non-profit facilities must pay their personnel according to the usually higher wage structure of the hospital or local government.

Also, non-profit facilities and hospitals traditionally admit a larger proportion of patients who require intensive services. An example of this is illustrated by the State's service intensity index (SII) for the different types of nursing homes. A facility's SII score increases with rises in the proportion of heavy care residents. Data on the average SII scores for 1990 indicate that hospital-based and non-profit nursing homes serve a higher percentage of heavy care patients (Figure 28).

Although the State's reimbursement system adjusts each facility's direct operating cost based on patient intensity, several of the providers interviewed for this study contend that the adjustment does not cover the costs of care these patients need.

Figure 28

Differences in Measures of Service Intensity According to Facility Type



Notes: An index of 1.0 represents the resource needs of patients in the average Virginia nursing home. Thus, the service intensity index of 1.143 for hospital-based nursing homes means that the patients in these facilities are 14.3 percent more costly to care for (1.143 minus 1.0) than those in the average nursing facility.

Source: Data on patient acuity levels collected from the Department of Medical Assistance Services, Cost Settlement and Audit Division.

DMAS staff stated that establishing separate peer groups for non-profit facilities was not considered. They feel the costs differences for these nursing homes are the result of decisions to provide higher levels of care. They further point out that federal law only requires the State to pay the reasonable costs that nursing homes must incur when delivering services to Medicaid recipients.

Basis for Higher Costs in Certain Nursing Homes. The cost differences that exist between facility type were examined through the specification of several regression models. The goal was to determine if the differences associated with facility type could still be observed after other factors were explicitly considered. If these differences persist, this could be an indicator of general inefficiency or management decisions to provide more care than is required by the program. In either case, this should not be rewarded in the reimbursement process.

If, however, the differences by facility type are diminished through the introduction of other cost indicators, then those factors should be examined to determine if they merit formal consideration in the State's reimbursement system.

To conduct this analysis, a series of variables were created to represent the different types of nursing homes. The variables used are listed in Exhibit 1. When the

Exhibit 1

Factors Used In Analysis of Nursing Home Cost

Variables	Variables
Locality Characteristics	Type of Facility
Northern Virginia	For-Profit Chains
Richmond-Petersburg	Sole Proprietary
Southeast Virginia	Non-Profit Chains
Northern Neck Virginia	Sole Non-Profit
Shenandoah Valley	Hospital-Based
Southside Virginia	
Southwest Virginia	
Urban/Rural Indicator	
Facility Characteristics	Patient Factors
Total Beds	Casemix Indicator
Occupancy Rate	Percent Medicaid
Management Factors	
Nursing Hours	

Source: Data for this analysis was collected from the Virginia Health Services Cost Review Council and the Department of Medical Assistance Services' Cost Settlement and Audit Division.

regression model is extended in this manner, it is possible to evaluate the difference in costs for each type of nursing home. To determine whether these cost differences by facility type were independent effects, other variables measuring geographic region, facility size, occupancy rate, patient casemix, and amount of nursing hours provided per patient day were added to the model.

The results of this analysis do not support the use of separate peer groups for facility type. Before other factors were considered, the statistical relationship between average cost per day and type of ownership was strong. The amount of variation in costs per day explained by ownership type alone was 21 percent.

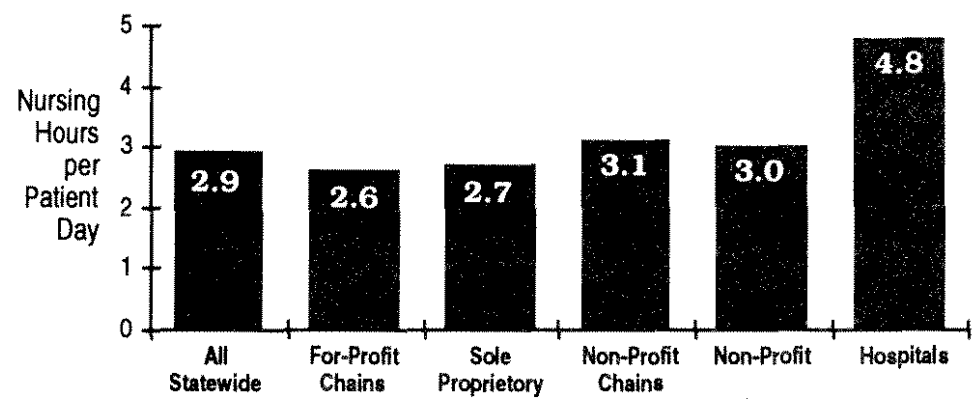
When variables measuring facility size, occupancy rate, patient casemix, and geographic region were added to the model, the amount of variation explained in the dependent cost variable increased to 63 percent. Still, the effect of ownership type was substantial.

However, after the total number of nursing hours per patient day were considered in the model, the R^2 increased to almost 80 percent and the effect of ownership type was substantially diminished. This indicates that previously observed cost differences for type of facility actually reflected decisions by management in hospital-based and non-profit homes to provide more hours of care per patient day.

Figure 29 more clearly illustrates the differences in the amount of care according to ownership type. On average, hospitals provide 4.7 hours of nursing care per patient day. This is 80 percent higher than the amount of care provided by sole proprietary and for-profit chains. The differences between for-profit and non-profit chains, although not as great (20 percent), are still substantial.

Figure 29

Differences in the Number of Nursing Hours According to Facility Type



Source: Data provided by the Virginia Health Services Cost Review Council, FY 1990.

As DMAS staff point out, Medicaid is required to pay for this higher level of care only when it represents the reasonable costs that must be incurred by an efficient and economically-operated facility. JLARC staff examined whether the level of care provided by non-profit facilities and hospitals is necessary by analyzing data from the Virginia Department of Health on nursing violations. If the care provided by the for-profit homes is substandard due to insufficient staff, these facilities should be disproportionately represented among the homes cited for nursing violations.

This analysis revealed that in 1990 none of the for-profit chains in the State were cited by the Virginia Health Department for nursing violations. Further, less than three percent of the sole proprietary homes received this type of violation.

These findings do not provide a basis for making judgments about the adequacy of the State's reimbursement rate for nursing homes. Rather they simply indicate that a separate peer group to recognize the differences in costs for type of nursing home does not appear to be necessary.

Reimbursement System Should be Refined to Account for Facility Size

Another key feature of the State's reimbursement system is the separate peer grouping used for certain geographic areas. To complete the evaluation of the State's reimbursement system, JLARC staff focused its evaluation on two major questions:

(1) Should the reimbursement system be modified to account for facility size?

(2) Are the geographic peer groups used for both direct and indirect cost appropriate?

Impact of Facility Size. One concern that has been expressed by the Virginia Health Care Association (VHCA) regarding DMAS' reimbursement system is that the system does not account for facility size when setting the payment ceilings for indirect operating costs. According to staff at VHCA, smaller nursing homes face a distinct disadvantage when compared with larger facilities because they are unable to achieve similar economies in the operation of the home. Therefore, to provide these facilities some relief for the higher average costs they face, the State should make some adjustment in indirect cost reimbursement rates to account for facility size.

When developing the current reimbursement system, DMAS chose not to make adjustments for facility size based on the recommendations of its consultant. In a report summarizing Virginia's options for establishing reimbursements, the consultant stated that indirect costs were not adjusted for patient days "under the assumption that Medicaid days should not influence costs."

To test this assumption, a model was developed to isolate the impact of facility size on per diem indirect costs. Table 5 shows some of the results of this analysis (for more details see the technical appendix). As indicated, facility size does have a significant

Table 5

Impact of Several Nursing Home Factors On the Indirect Per Diem Cost of Care

Variable	Standardized Coefficient	Impact
Type of Facility		
For Profit Chain	-.348	Strong
Sole Profit	-.262	Strong
Hospital-Based	.229	Strong
Facility-Specific		
Total Beds	-.320	Strong
Occupancy Rate	-.227	Strong
Patient-Specific		
Intensity Index	-.007	Weak
Locality-Specific		
Urban Area	.136	Moderate
Northern Virginia	.292	Strong
Richmond-Petersburg	.037	Weak
Southeast Virginia	.074	Weak
Shenandoah	-.001	Weak
Northern Neck	.098	Weak
Southside Virginia	.001	Weak
R^2	.603	
Total Cases	145	

Notes: The dependent variable for this analysis was total nursing home indirect operating cost per patient day. The standardized coefficients reported for each independent variable represent the impact of these factors on the dependent variable minus the influence of all other factors in the model. Data on indirect costs for 1990 were not available for all nursing homes. However, additional analyses indicated that the characteristics of this subset of nursing homes were not significantly different from those for the universe of all nursing homes in the State's Medicaid program.

Source: Data for this analysis were collected FY 1990 from the Virginia Health Services Cost Review Council and the Department of Medical Assistance Services Cost Audit Division.

effect on indirect costs after other factors are considered in the model, including occupancy rate, geographic location, and facility type.

More importantly, the value of the coefficient for facility size is negative. This means that there is an inverse relationship between facility size and indirect costs. More specifically, smaller nursing homes tend to have higher indirect operating costs than larger facilities after other important factors are considered. Further, because the State

has a moratorium on the construction of new nursing home beds, these facilities do not have the option to expand and benefit from the same economies as larger facilities.

DMAS staff point out that some money was included in the reimbursement system to recognize the higher costs for small homes when the payment ceilings were initially established in 1990. However, they acknowledge that further adjustments are needed.

Recommendation (1). **The Department of Medical Assistance Services should make adjustments to its reimbursement system to account for the higher indirect costs that smaller nursing facilities experience. The Secretary of Health and Human Resources should report the details of the adjustment methodology and its impact on Medicaid nursing home expenditures to the Joint Commission on Health Care prior to the 1994 session of the General Assembly.**

Geographic Peer Groups. The final issue concerns the appropriateness of the State's reimbursement model related to the geographic peer groups that DMAS developed when the system was modified in 1990. As noted earlier, the primary goal of this type of classification system is to place nursing homes with similar characteristics in the same group so that equitable payment ceilings can be established.

In interviews with DMAS staff, it was indicated that some providers were not pleased with the classification system. The general complaint has been that nursing home costs in Southeast Virginia are higher than the other areas which are included in the peer group. Those providers who express this view feel that a separate peer group for this portion of the State should be established for direct and indirect costs.

JLARC staff examined this issue by specifying two different nursing home cost functions. Each of these models was designed to isolate the effect of geographic region on direct and indirect per-diem operating costs for nursing homes that participated in Medicaid (Table 6). In all cases, separate statistical controls were implemented for facility casemix, total beds, occupancy rate, and ownership type.

Based on this analysis, there is little evidence to suggest that the current peer group classification for geographic region should be modified. For direct costs per day, the current system uses three peer groups — Northern Virginia, Richmond-Petersburg, and the rest of the State. As the model indicates, after other factors are accounted for, cost differences for regions outside of Northern and the Richmond-Petersburg area are minimal.

The cost function for indirect costs supports the current peer grouping system as well. DMAS has established one peer group for Northern Virginia and another for the rest of the State. These are precisely the cost differences by geographic region which are observed when indirect costs are regressed on each independent cost factor.

A key factor influencing these findings is the variable measuring ownership type. Before differences in the type of nursing homes were accounted for in both models,

Table 6

Impact of Several Nursing Home Factors On the Per Diem Cost of Care

Variable	Standardized Coefficient For Indirect Costs	Standardized Coefficients For Direct Costs
Type of Facility		
For Profit Chain	-.348	-.309
Sole Profit	-.262	-.153
Hospital-Based	.229	.434
Facility-Specific		
Total Beds	-.320	-.063
Occupancy Rate	-.227	-.161
Patient-Specific		
Intensity Index	-.007	.115
Locality-Specific		
Urban Area	.136	.165
Northern Virginia	.292	.418
Richmond-Petersburg	.037	.212
Southeast Virginia	.074	.022
Shenandoah	-.001	.022
Northern Neck	.098	.106
Southside Virginia	.001	.112
R^2	.603	.766
Total Cases = 145		

Notes: The dependent variables for this analysis were total nursing home direct and indirect operating cost per patient day. The standardized coefficients reported for each independent variable represent the impact of these factors on the dependent variable minus the influence of all other factors in the model. Data on direct and indirect costs for 1990 were not available for all nursing homes. However, additional analyses indicated that the characteristics of this subset of nursing homes were not significantly different from those for the universe of all nursing homes in the State's Medicaid program.

Source: Data for this analysis were collected for FY 1990 from the Virginia Health Services Cost Review Council and the Department of Medical Assistance Services Cost Settlement and Audit Division.

nursing homes in Southeast and Southside Virginia appeared to have significantly higher costs than those in other regions. However, when differences in ownership type were added to the models, these effects diminished.

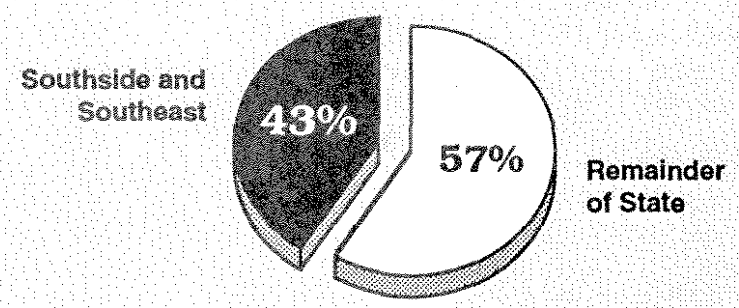
This indicates that a disproportionate number of high cost non-profit facilities are located in Southeast and Southside Virginia (Figure 30). Apparently this has caused some providers in the industry to mistake the high costs which are associated with the operation of non-profit homes as an effect of providing care in a particular region of the State.

FEDERAL REQUIREMENTS FOR NURSING HOME RATES

Apart from the question regarding the factors the State considers in devising its reimbursement system is the issue of the methods which are used to establish the actual payment rates. When setting rates, federal law generally requires the State to ensure that its rates are adequate to reimburse efficient facilities for the cost they must incur in providing reasonable access to health care. Further, the State is expected to adjust these rates to reflect the cost impact of federal regulatory requirements. This section of the chapter reviews the methods used by DMAS to set base payments for nursing homes and adjust these rates to account for changing regulations in the nursing home industry.

Figure 30

Percent of High-Cost Non-Profit Nursing Homes in Southside and Southeast Virginia



Source: Data on Medicaid payments and ceilings provided by the Department of Medical Assistance Services, Cost Settlement and Audit Division.

The results of this review indicate that DMAS used peer group medians as measures of efficiency when the base payment rates for PIRS were established in 1990. However, DMAS is concerned about recent court rulings questioning the validity of using medians as the primary basis for establishing nursing home payment rates. Consequently, the Department has sponsored an initiative to develop efficiency measures for the nursing home industry as a means of validating its payment ceilings, but has not coordinated this effort with similar work being conducted by the Virginia Health Services Cost Review Council.

Also, DMAS has systematically evaluated the impact of federal nursing home reform requirements and adjusted the payment rates to account for the impact of this law. Since that time, however, the State has imposed additional standards which need to be considered when setting future payment rates.

Median Used as Efficiency Measure to Set 1990 Base Payment Rates

When Congress established the requirement that reimbursement rates be tied to the costs of efficiently operated nursing homes, it stopped short of defining efficiency. As a result, since 1981 Virginia has been free to develop its own definitions as a part of the rate-setting process. In implementing this process, federal law requires the State to make findings and assurances that the rates meet the requirements of the Boren Amendment. As noted earlier, the Boren Amendment requires states to establish rates which are sufficient to reimburse nursing homes the reasonable costs that must be incurred by an efficient and economically-operated facility.

In this case, findings represent the work that is conducted to ensure that payment ceilings established by DMAS reflect rates that are sufficient. There are no requirements that these findings be in writing, and they are not submitted to the Health Care Financing Administration (HCFA) for review. When the reimbursement rates are changed, DMAS must submit assurances to HCFA that the new rates are adequate.

Using the discretion granted by federal law, DMAS first adopted payment ceilings for nursing homes in 1982. Later in 1990, the ceilings were recalculated as the State moved to a patient intensity rating system. The payment ceilings for both of these systems were created based on 106 percent of the median allowable direct costs and 105 percent of the median indirect cost.

Payment Ceilings as Efficiency Measures. While the findings previously discussed support the basic structure of the peer group system, there is some uncertainty regarding the adequacy of the approach DMAS has used for setting payment ceilings for each peer group.

As noted earlier, the payment ceilings that were in place in 1989 were actually established in 1982. In each of the following years, these ceilings were inflated to establish the maximum allowable payment for the relevant year. According to DMAS staff, when the system was rebased in 1990 the following steps were implemented:

- First, the payment ceilings were reevaluated using 1989 cost reports adjusted forward to reflect inflation in the industry for 1990. With inflated cost figures, each nursing home was ranked from the lowest to highest cost using separate peer groups for direct and indirect costs. Based on this ranking, the median cost provider was identified.

- Second, an analysis of the effect of the rebasing indicated that a number of providers that were operating below the peer group ceilings which existed

prior to rebasing, were now over the median payment ceilings established for 1990. Therefore, to "preclude this unintended consequence of a change in reimbursement methodology, a budget neutral adjustment of $7.1 million was added to the median-based payment ceilings." This resulted in peer group ceilings for direct costs that were 106 percent of the median and ceilings for indirect costs that was 105 percent of the median. According to DMAS staff, these higher ceilings were established to recognize the management efficiencies that the industry had produced since 1982.

- Third, due to a 1991 mandate by the General Assembly requiring the Secretary of Health and Human Services to achieve $5 million dollars in savings through changes to the reimbursement methodology for nursing homes, each provider's payment rate was reduced by 1.2 percent for FY 1992. This allowed the State to "share in the management efficiencies" of the industry without actually lowering the payment ceilings.

DMAS staff explained that when establishing the payment ceilings, they looked for evidence of patient access problems and examined whether any providers were leaving the program. However, specific indicators of efficiency were not considered. When the median cost (or in this case a percentage of the median) for nursing homes is used as a payment ceiling without comparing them to measures of efficiency, the implicit assumption is that the home operating at this cost level provides the threshold for efficiency.

When states began to establish prospective payment ceilings in 1982 there was widespread use of mathematically determined payment ceilings as a measure of an efficiently operated nursing home. Recently, however, this notion has been challenged by the nursing home industry in several courts. The results of these challenges, while varied, have usually been decided on procedural issues and not the adequacy of the reimbursement rate. However, in a few cases, the rulings have raised questions about the use of a median as the primary measure of efficiency.

For example, in Idaho, the State Medicaid agency uses the 80th percentile in the peer group to cap the costs that it will reimburse unless it can be demonstrated that excess costs were beyond the control of the provider. When one nursing home challenged this system, the case was eventually appealed to the Idaho State Supreme Court.

The Court upheld the State's right to use a percentile cap. However, in doing so, it ruled that the nursing home did successfully prove that it was efficiently operated but was found inefficient by the State solely because its costs exceeded the cap. Because the State's presumption of inefficiency had been rebutted, the Court reversed the decision of the district court and required Idaho's Medicaid agency to prove that the nursing home was inefficient.

In a case involving the State of Alaska, the Supreme Court enjoined the Medicaid agency from applying its payment ceiling because it failed to meet the procedural requirements to support the assurances which Alaska made to HCFA.

Moreover, in making this ruling the Court made the following comments concerning the use of payment ceilings:

> *The findings of the State Medicaid agency must identify and determine ... efficiently and economically operated hospitals.... The findings must be objective. They must be based on empirical evidence of such matters.... Further, the findings must be more than mathematical calculations that appear adequate.... Any reasonably principled analysis will include consideration of the Boren Amendment economic and efficiency standards.*

In other cases, the courts have upheld states' reimbursement methodologies because adequate findings were made to support the payment caps. In the State of Washington, the Court ruled that the reimbursement system was not in violation of the Boren Amendment because the State could demonstrate that adequate findings were made to link the percentile caps it used to the cost of an efficiently operated nursing home. These findings demonstrated that the State had considered measures of efficiency through methods other than the use of mathematically-derived payment ceilings.

Efficiency Measure Being Considered. DMAS staff are aware of the judicial trends pertaining to the validity of payment ceilings as efficiency measures. At the time this concept was pursued in Virginia, DMAS staff stated that the use of a peer group median "seemed logical." It was pointed out that many of the court decisions which "are hurting the states" were recently decided and therefore could not be considered when Virginia was developing its payment ceilings.

As one staff member stated, "it was not envisioned that the courts would interpret Boren as requiring states to specifically identify those nursing homes that are efficiently and economically operated and determine the specific costs that these facilities must incur." However, in light of these recent court rulings, DMAS officials report that they are pursuing the development of efficiency standards.

These issues underscore the importance of the efficiency standards that DMAS is presently having developed. If the resulting measures suggest that the State's payment ceilings are too low, adjustments could be required that would increase Medicaid spending for nursing homes. If, however, the efficiency standards are less than the payment ceilings, the State may be able to reduce Medicaid expenditures for nursing home care.

Coordination of Work on Efficiency Standards. In addition to the efficiency standards DMAS is having developed through a consultant, the Virginia Health Services Cost Review Council (VHSCRC) has been directed by the General Assembly to develop a series of indicators for the nursing home industry. Given the implications of this issue, it is important that DMAS and VHSCRC work together to produce one set of indicators for the industry. According to staff in these agencies, there has been no such coordination to date. While VHSCRC has provided information to DMAS regarding the methods it is considering to measure efficiency in the industry, the agency has not been made aware of specifics of DMAS' work on similar indicators.

Recommendation (2). **The Joint Commission on Health Care may wish to consider ensuring that current efforts to develop efficiency standards for the nursing home industry are coordinated so that the work of the Department of Medical Assistance Services is not duplicative or at odds with the findings being developed by the Virginia Health Services Cost Review Council.**

Nursing Home Reform Adequately Accounted for by DMAS in Rate-Setting

In 1987, based on a report by the Institute of Medicine, the Congress passed the most significant nursing home reform legislation in the history of the industry. This legislation — the Omnibus Budget Reconciliation Act (OBRA 87) — was designed to improve the quality of life for nursing home residents by changing the basic procedures used by facilities for providing custodial care. To ensure that the reforms would be implemented, the law required states to adjust payment rates for nursing homes prior to the October 1, 1990 (the date the law took effect) in anticipation of increased costs that facilities would face.

To comply with this law, DMAS analyzed the changes required by OBRA 87 in light of existing State regulation of the industry. Based on this analysis, DMAS staff worked with the VHCA to develop a payment adjustment for all nursing homes in the Medicaid program.

The Focus of OBRA 87. Prior to the passage of OBRA 87, most nursing homes were oriented towards providing basic custodial care to their residents. After OBRA 87 was enacted, nursing homes were required to shift from focusing on basic maintenance or custodial care to an emphasis on restorative services. In other words, the reform legislation requires a greater focus on patient outcomes. As one nursing home administrator explained:

> Before OBRA, quality of care was defined as: "Did you prevent a decline in your resident's functioning?" After OBRA, quality of care is: "Did the resident improve?"

Under this new system, nursing homes must first conduct a comprehensive assessment of the resident. Then based on this assessment, the nursing home must develop and implement a written plan of care. This plan must describe the activities and services that will be provided to residents to allow them to reach their highest level of functioning in the least restrictive environment.

To accomplish this, nursing homes were forced to reduce the use of drugs which effectively sedated residents for extended periods of time. Moreover, the facilities were required to implement activities that are designed to help residents become independent in as many of the basic activities of daily living as possible.

The Cost of Nursing Home Reform in Virginia. To determine the costs of OBRA 87, HCFA required all states to develop a comparison of the differences between its

certification requirements and the new law. According to DMAS staff, OBRA 87 did increase the cost of nursing home care in Virginia but not as much as in some other states. The reason for this was that the State already had many of the requirements which involved increased costs in place. This view was generally shared by the VHCA.

The actual comparison of existing State requirements with those of OBRA 87 was conducted by the Virginia Health Department. Based on this analysis, those factors that involved increased cost were considered by DMAS and adjustments were made to bring the reimbursement rates in line with the requirements of OBRA 87. (The table in Appendix C shows how OBRA 87 differed from previously existing Federal law. This table was developed by a national research firm for HCFA shortly after the law was passed.)

The State identified three areas in which the new law had a cost impact: the staff requirements for social work; increased staffing requirements for a registered nurse; and requirements that hospital-based facilities hire a licensed nurse administrator. Working with the VHCA, DMAS staff determined that OBRA 87 requirements added 44 cents to the cost of a day of nursing home care in Virginia.

One source of disagreement between the industry and DMAS regarding the impact of OBRA 87 is the effect of the federal Minimum Data Set (MDS) assessment tool. A nursing facility must conduct a comprehensive assessment using a standardized assessment of each patient's functional capacity at various times. At the same time, DMAS has its own assessment form that nursing staff must complete for PIRS. The industry contends that "considerable nursing staff" is required to complete these assessments. The MDS form consists of 16 sections with more than 100 items to be completed. In some cases, these are the same items for which data are requested using the State's assessment form.

One way to reduce some of the burden of the paperwork associated with this process is to eliminate the duplication of effort required to complete the federal form and the State's PIRS assessment. When MDS was being developed, DMAS thought that the agency would be allowed to modify MDS to include some items from PIRS, thus requiring only one assessment. HCFA, however, did not allow this.

According to DMAS staff, the agency has conducted extensive reviews of the two forms and concluded that major changes in the method for calculating PIRS would have to be made if MDS were used. To reduce the burden on the industry, DMAS has eliminated some of the information requested on its PIRS assessment form.

Also, the agency is monitoring the progress of several studies which are examining how a casemix indicator can be calculated from the federal MDS form. Staff acknowledge that other states use indicators which make more distinctions in the level of care, but add that this makes the system more difficult to administer and monitor. One staff person stated, "With three levels of care, there has to be a substantial change in the resident's condition to move to a higher level of care. This reduces the ability of nursing homes to play games with the system."

New State Requirements Could Increase Medicaid Nursing Home Spending

The 1992 Virginia General Assembly passed legislation which may have cost implications for the nursing home industry. One such law relates to federal standards on occupational exposure to bloodborne pathogens such as the Hepatitis B Virus. Included among the requirements of the standards is the mandate that all nursing homes offer Hepatitis B vaccinations to all employees who have occupational exposure. State law also requires all nursing homes to request criminal records checks on all new employees.

According to DMAS, the agency recently discussed these new requirements with the VHCA and the costs could be significant. Staff from VHCA informed DMAS that the cost for each Hepatitis vaccination is $80. In addition, the criminal records checks costs $10 per employee. Presently, the nursing home industry in Virginia has more than 22,000 employees. VHCA staff point that the turnover rate is "thought to be around 50 percent."

Because nursing homes are not free to set their own prices for Medicaid patients, any additional costs imposed on this industry due to State regulation must be considered in the Medicaid reimbursement rate. DMAS indicates that these issues are being discussed. Currently however, neither the VHCA or DMAS has defined a method for quantifying the impact of these regulations.

Recommendation (3). **The Department of Medical Assistance Services should develop a methodology for determining the costs of Virginia's requirements regarding the use of criminal records checks and protection of nursing home employees from bloodborne pathogens. This methodology should be used to determine the amount of any rate adjustments required. These findings should be reported to the Secretary of Health and Human Resources by March of 1993.**

MEDICAID PLANT COST REIMBURSEMENTS

Virginia's nursing home reimbursement system provides a separate payment rate for plant costs. Unlike operating cost rates, all nursing homes in the program are reimbursed for 100 percent of their allowable plant costs subject to limits established by Medicaid. This section briefly analyzes trends in Medicaid plant costs expenditures and reviews the State's policies governing reimbursements for these expenses.

DMAS has implemented a number of policies to limit Medicaid plant costs expenditures. As a result, capital-related expenditures by the program have been reasonably contained. In light of this, there appears to be no reason to develop policies to further limit these expenditures.

Medicaid Expenditures for Physical Plant Costs Are Controlled

Under Medicaid, allowable plant costs include depreciation expenses, interest, rent, lease payments, and certain types of debt financing costs. The Medicare program provides the general guidelines for state agencies to follow when defining allowable plant costs. However, states are free to provide more specific controls when determining how certain expenses will be treated.

The growth in Medicaid plant cost since 1984 has been just under five percent. At the same time, average annual growth in the amount of Medicaid spending per nursing home has been less than six percent.

As a percent of total Medicaid spending on nursing homes, physical plant costs have actually dropped. In 1984, physical plant costs represented 16 percent of total nursing home expenditures. By 1990, this amount had decreased to 14 percent. This is an important finding. During this time period, all other nursing home costs were capped by payment ceilings based on the median costs of nursing home care. However, plant costs faced no such ceilings. Under these circumstances, it might have been expected that these costs would grow as a proportion of total spending on nursing homes. The fact that physical plant costs actually declined can be attributed to the Certificate of Public Need Program and DMAS cost containment policies.

Certificate of Public Need. In 1986, in response to the rising cost of all medical care, a Governor's Commission was established to examine the effectiveness of the Certificate of Public Need (COPN) program in controlling health care costs. Certificate of need requirements had been established in federal law in 1974 as a way to contain health care costs. Most states, including Virginia, used the law to create COPN programs to avoid the loss of federal funding for health care.

When the federal law supporting this program was repealed in 1986, the General Assembly faced pressure from various health care lobbyists to eliminate State laws governing COPN in Virginia. Instead, the aforementioned Governor's commission was created to examine the effectiveness of COPN. This committee advocated for some deregulation of the hospital industry but recommended that COPN be retained for nursing homes.

As a result, the General Assembly approved a 1988 moratorium on the construction of new nursing home beds that was to be in effect until January 1991. With the support of the Commission on Health Care for All Virginians, the General Assembly voted in 1990 to extend the moratorium on nursing home beds until June 30, 1993. Because potentially large physical plant cost expenses for Medicaid are the construction and financing costs associated with the addition of bedspace, the COPN has effectively slowed Medicaid spending in this area.

DMAS Cost Containment Policies. The most significant factor that has helped contain Medicaid plant costs expenditures is the policies implemented by DMAS as a part of its nursing home reimbursement system. Prior to 1983, Virginia, like most other

states, had very few limitations on the plant cost that could be reimbursed under Medicaid. According to a study by the U.S. General Accounting Office, this led to widespread abuse of the program's plant cost reimbursement system.

Some states responded to the problem by changing its system of reimbursement from cost-based to flat rate systems. DMAS chose to retain its cost-based reimbursement system but has developed restrictive policies to curb past abuses.

Interest Caps. Before reforms were implemented, states typically placed no limits on the interest costs for which a nursing home could bill the Medicaid program. As a result, nursing home owners had no incentive to seek financing arrangements which were favorable for Medicaid. DMAS addressed this problem by limiting interest expenses. Currently the limit is based on the average of the rate for 10 and 30 year U.S. Treasury Constant Maturities, plus two percentage points if the debt financing is not exempt from federal income tax. If this is not the case, the limit is based on Baa municipal rated bonds plus one percentage point.

Related-Party Transactions. A number of states had problems with related-party transactions in Medicaid. In these cases, owners would sell the nursing home to a business partner or a relative who would lease the facility back to the original owner. Medicaid would then reimburse the owner for the cost of the lease which was often higher than the actual costs of the home.

Though never considered a serious problem in Virginia, DMAS has taken steps to prevent this practice by establishing provisions which set the reimbursable cost of a related-party transaction based on the costs to the related organization. In other words, the lease cost cannot exceed the annualized costs of Medicaid allowable depreciation, insurance, interest, and legal fees of the facility owner.

Revaluation of Assets. In 1986 Congress passed a law requiring states to place limits on the revaluation of assets for nursing homes that were sold within a five year period. This law was passed to stop the frequent selling of nursing homes for purposes of maximizing Medicaid capital cost reimbursements. Because plant costs in most states are reimbursed on a cost basis, the market value of nursing homes often exceeds the actual cost of the facility to the owner. Consequently, there was an incentive to sell nursing homes to establish a higher cost-basis for purposes of Medicaid reimbursements.

DMAS has adopted the federal law which limits how assets are revaluated if the home is sold within five years. Specifically, the purchaser would be forced to accept a Medicaid reimbursement based on the historical costs of the previous owner. If the facility was owned for a longer period of time, Medicaid reimbursement is based on the purchase price, appraised replacement costs value, or federal limits established in 1985, whichever is less.

Other Limitations. In addition to the aforementioned restrictions, DMAS has the following policies in place as a means of limiting physical plant costs:

- Three competitive bids are required before the initiation of any major capital expenditures greater than $100,000.

- The aggregate of loan costs and other financing expenses are limited to five percent of the total allowable project costs; and

- The aggregate of legal fees, cost certification fees, title and recording fees, printing and engraving costs, and rating agency fees are limited to two percent of the total allowable project costs.

DMAS staff stated that plant costs receive close scrutiny in the audit process. If a new facility is built or there is major renovation, a field audit is mandatory. Also, desk reviews are used to look for any unusual changes in a facility's reported plant costs.

Tighter Controls on Physical Plant Costs Could Pose Problems

In a study of the State's expenditures on physical plant costs in 1987, DMAS was presented with three options for further reducing Medicaid capital expenditures. One was to impose greater restrictions on lease payments. Another involved tightening the current policies on the revaluation of assets. The third was to adopt payment ceilings. However, it appears that these strategies are either not necessary or have associated disadvantages which could outweigh the potential benefits.

Greater Restrictions on Lease Payments. The current restrictions on lease payments are based on a five-year time period. As noted in the study conducted by the Peat Marwick accounting firm, these restrictions can be extended to cover a longer period of up seven to 10 years. However, data on the State's Medicaid payments for leases suggest that this policy would have only a minimal effect. In 1990, facility lease payments accounted for less than five percent of plant costs (Figure 31).

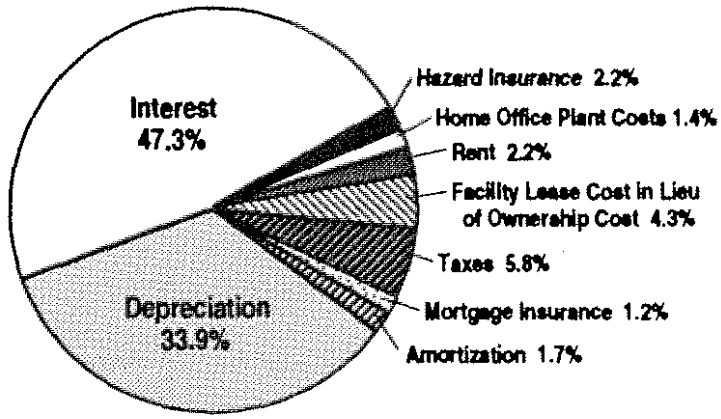
Tighter Restrictions on Asset Revaluation. According to Peat Marwick, Virginia could eliminate the revaluation of assets altogether after a property was sold. This would limit the Medicaid reimbursement to the historical cost of the original owner. The problem with this approach is that it could be interpreted as a violation of the Boren Amendment. If capital reimbursements for any new owners of nursing homes are automatically restricted to the costs of the previous owner regardless of the circumstances of the purchase, questions could be raised about whether the State was adequately recognizing the reasonable costs of an efficiently operated nursing home.

DMAS staff also point out that tightening this policy would have only a minor effect because there have not been many property transfers involving nursing homes in Virginia.

Payment Ceilings. Perhaps the most effective cost containment strategy for plant costs would be a flat payment ceiling based on the typical costs for nursing homes

Figure 31

Major Components of Nursing Home Physical Plant Costs, FY 1990



Source: JLARC staff analysis of plant cost data provided by the Department of Medical Assistance Services Cost Settlement and Audit Division for 47 percent of the nursing homes in the Medicaid program.

of similar characteristics (such as age and size of the facility.) DMAS considered this option based on the 1987 study but concluded that it was not feasible.

Because of differences in the types of capital expenditures — movable versus fixed — the State would have to establish separate ceilings to recognize these distinctions. Moreover, in the process of establishing the ceilings, the State would have to construct measures of efficiency to support the payment ceilings. As one DMAS staff person noted, the failure to do this could result in legal liability based on the Boren Amendment.

In light of these findings and data on the magnitude of plant cost expenditures for Medicaid, there appears to be no need to adopt a completely new system of reimbursement.

THE REIMBURSEMENT SYSTEM FOR STATE INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

The major provider of long-term services for persons who are mentally retarded is the Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS). In reimbursing the five institutions which provided these services, DMAS uses a retrospective cost-based payment system. With this approach, each ICF/MR is reimbursed its total Medicaid costs, subject to Medicare upper payment limits.

One purpose of this study was to evaluate the possibility of containing Medicaid spending on ICFs/MR services through the use of an alternative reimbursement system. The general findings of this analysis indicate that relative to the payment systems used for other providers, the cost containment provisions in DMAS reimbursement policies for ICFs/MR are limited. Partly as a result of this, the average interim Medicaid payment rate for these State facilities is more than $160 per day.

One reason for the high cost of care in these facilities is a federal emphasis on the provision of these services through smaller institutions. While these facilities are considered to provide the most effective and appropriate environment for persons who are mentally retarded, they cannot produce the same economies of larger facilities. Therefore, if the reimbursement rates for these facilities are lowered through specific cost containment policies, the State will have to replace this lost revenue with general fund dollars.

Minimum Cost Containment Provisions Exist with Current Policies

There are five State-operated ICFs/MR in Virginia. For each of these facilities, DMAS uses a retrospective cost-based payment system subject only to the Medicare upper payment limits. As noted earlier, relative to payment systems used for other providers of long-term care, this system has proven to be the least effective in containing Medicaid spending.

Under retrospective cost-based systems, providers receive payments equal to their costs, thus reducing the ability of the payment system to control spending. As long as providers can be certain that their cost will be reimbursed, there is little incentive other than normal state budgeting practices to deliver care more cost effectively.

Payment Rates for ICFs / MR. In order to receive Medicaid payments for the care provided eligible recipients, staff at the DMHMRSAS establish an interim payment rate for each facility. The actual amount of the payment is determined as follows:

- First, the aggregate amount of Medicaid payments that can be reimbursed for all five facilities is determined by multiplying projected patient days for the upcoming fiscal year times the Medicare upper limit. This upper limit was initially established in 1989 based on the Statewide per diem cost of care for ICFs/MR services that year. In each year since 1989, the limit is raised using an inflator developed by Data Resources Incorporated.

- Second, based on the total allowable payments for ICF/MR services, DMHMRSAS staff determine an interim payment rate for each facility. The agency then bills DMAS monthly based on the interim charge rate or the upper payment limit, whichever is less.

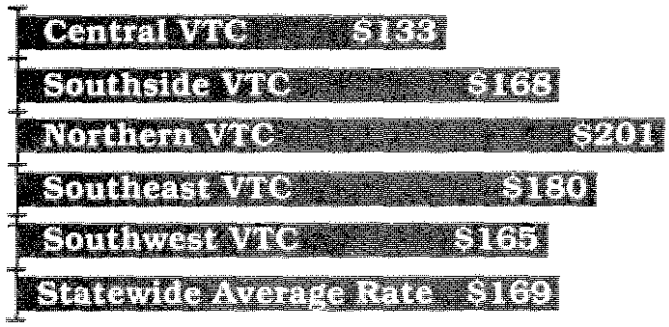
- Third, at the end of the fiscal year, cost reports for each facility are submitted to DMAS for settlement. If the payments exceeded or were less than allowable

costs based on the actual number of days of care provided Medicaid recipients, the appropriate adjustments are made.

While the upper limits do provide a cap on Medicaid expenditures for ICFs/MR, they should not be viewed as a tool for substantially reducing the costs of these services. Even with these limits, interim payment rates for these facilities are significantly higher than $100 per day (Figure 32). At the Northern Virginia Training Center (NVTC), the interim rate exceeded $201 per day. The lowest interim rate was for the Central Virginia Training Center (CVTC) at $133 per day. Statewide, the average rate for the five ICFs/MR in FY 1991 was $169 per day. Based on this rate, the cost of care in these facilities for one Medicaid recipient could exceed $60,000 per year.

Figure 32

Interim Medicaid Payment Rates (per Diem) for State-Operated ICFs/MR, FY 1991



Note: VTC = Virginia Training Center.

Source: Data collected from cost accounting department of DMHMRSAS.

DMHMRSAS staff point out that it is not in the State's interest to use a reimbursement system for ICFs/MR which pays the facilities a lower prospective flat rate. They suggest that fixed costs in ICFs/MR, stringent federal treatment requirements, and a larger proportion of profoundly retarded residents, are the major factors which influence costs in these facilities. Further, because these factors are largely beyond the control of facility administrators, the expensive nature of these services is unavoidable.

Under this scenario, they note that lowering Medicaid payments will result in a reduction of program expenditures for ICF/MR services, but not a decrease in the costs of operating these facilities. Because of this, the State would have to either make up for the loss in revenue through general fund expenditures or close some facilities. As one staff member noted:

DMHMRSAS is constantly being asked to maximize the use of Medicaid funds because they replace State spending. So what is a cost to the Medicaid program is revenue for the State. Over time, because of declining census, the upper limits will cap Medicaid spending in the ICFs/MR. This, however, will not save the State money.

State Options for Cost Containment Have Serious Disadvantages

As noted in Chapter II of this study, Medicaid expenditures for ICFs/MR have continued to increase even though the patient census has dropped sharply in the two facilities and remained constant in the three smaller facilities. The effect of this has been an increase in the daily costs of care for these services which has exceeded the inflation rate.

Under these circumstances there are two ways to contain Medicaid spending: establish a prospective flat-rate payment system or seek greater economies in the delivery of ICF/MR services through consolidation of facilities.

Reduction in Reimbursement Rates. Increases in the cost per day of care can be directly addressed by lowering the amount of reimbursement provided these facilities. However, in the case of State-operated facilities, this is an acceptable strategy only when it is clear that the increased costs represent management inefficiencies, excessive services, or otherwise wasteful spending. The presence of these factors were not observed during this study.

For the ICFs/MR, most of the data examined for this study indicate that the major factors which influence the costs of these services are outside of the control of facility administrators. The most significant of these factors are the federal regulations and "look-behind" surveys which have constantly increased staffing requirements for these facilities despite the downward trend in population.

This means that any reduction in Medicaid reimbursements would not necessarily produce similar reductions in operating cost in the ICFs/MR. If such a policy were pursued, for every one dollar reduction in Medicaid funding, there would be a 50 cent increase in required State funding. Given the more recent budget problems for the State, this strategy has little merit.

Facility Consolidation. One of the key features of the State's system of care for persons who are mentally retarded is its decentralization. Prior to 1970, there were only two ICFs/MR in the State. These facilities — Southside and Central Virginia — were built to provide services to more than 3,000 individuals.

In 1971, through amendments to the Social Security Act, Congress made matching funds available to states for the services they were providing in the ICFs/MR. In order to gain federal financial participation (FFP), States had to meet a number of requirements including increased staff levels and major facility renovations. Virginia

not only enhanced the level of care at the two large facilities, but over the following five years built three smaller facilities in different regions of the State.

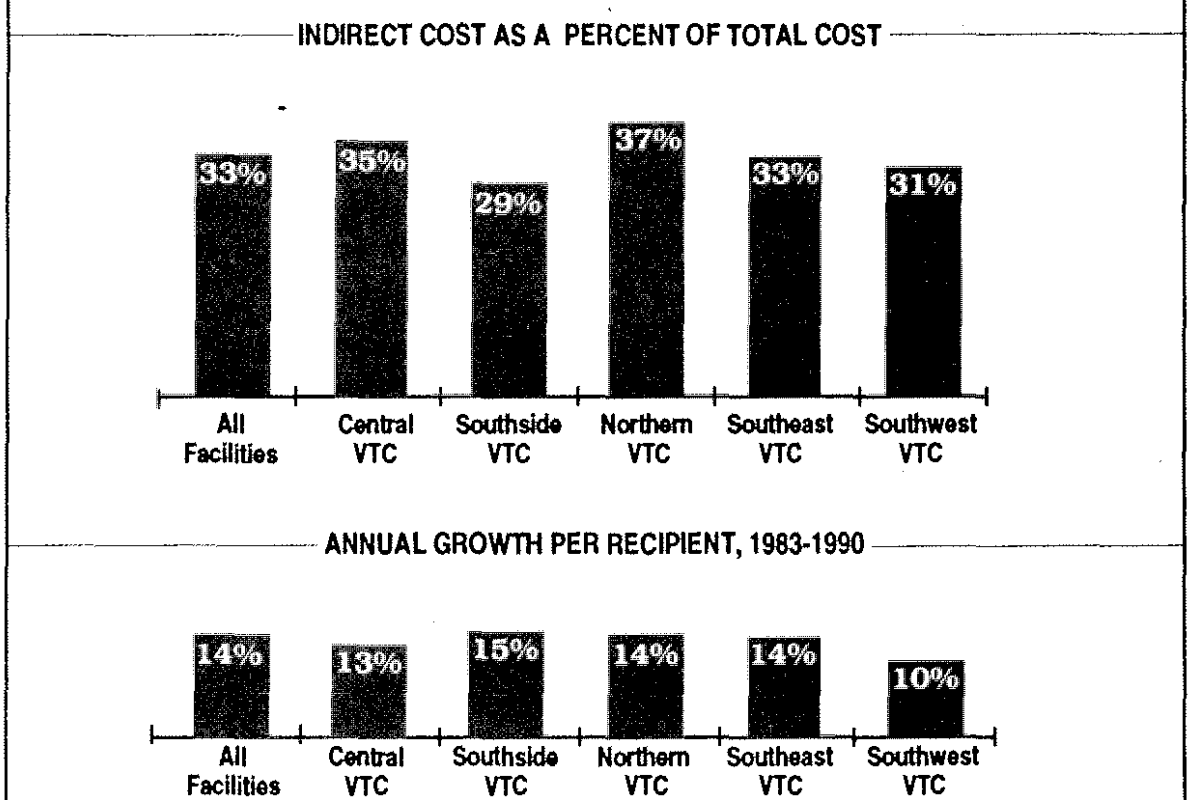
The trend towards the use of smaller facilities continued as both Southside and Central Virginia training centers began to reduce their populations through attrition — restricted admissions, and accelerated community placement initiatives.

In interviews with DMHMRSAS central office staff and program and administrative staff in the five facilities, the retrenchment of large State-operated institutions was described as a part of a national trend to enhance the quality of life of persons who are mentally retarded.

However, an unintended consequence of this policy was the introduction of significant diseconomies in the operation of ICFs/MR. This is most evident when the data on indirect, or non-patient care costs are examined (Figure 33). In 1990, more than three

Figure 33

Indirect Cost in State-Operated ICFs/MR



Source: JLARC staff analysis of data collected from cost reports provided by DMHMRSAS staff.

of every 10 dollars spent on care for the mentally retarded in State-operated institutions were for indirect costs. This includes administration, buildings and ground work, power plant services, housekeeping, laundry, food service and salaries of personnel in these areas.

Differences in the amount of indirect costs by facility indicate that these expenditures range from 29 percent of total costs in Southside Virginia to over 37 percent in Northern Virginia. As a portion of total expenditures, DMHMRSAS staff point out that indirect costs in the ICFs/MR are consistent with national standards. However, the diseconomies which are present in the operation of these facilities are evident when the expenditures for indirect costs are adjusted by the number of residents in the facilities. Since 1990, the average annual growth in indirect costs per recipient has exceeded double digits for all five facilities. In one facility, the increase has averaged 15 percent.

Federal Government Might Oppose Consolidation. DMHMRSAS staff point out that the national trend in care for persons who are mentally retarded is towards smaller facilities and community-based care. Although there are no federal laws that would prevent a state from establishing a larger facility, staff indicated that such an attempt would likely generate strong opposition from HCFA and the Justice Department. One DMHMRSAS staff member indicated that the Justice Department is presently evaluating one of the State's smaller facilities and could require that facility to double the amount of staff. If the State attempted to increase the size of any of its facilities through consolidation, this staff person was certain that it would be opposed by the federal government.

Recommendation (4). **The Joint Commission on Health Care may wish to request DMHMRSAS to conduct a study of whether consolidation or other methods which could contain the cost of ICF/MR services are feasible alternatives for Virginia.**

CONCLUSIONS

The reimbursement policies used by DMAS to fund the institutional services which are supported by Medicaid provide the most effective mechanism for reducing the cost of these services to the State. Using reimbursement policies as a tool to control program spending is usually appropriate when the cost of a day of institutional care has demonstrated rapid increases. Still, attention must be given to the federal law which requires that the reasonable costs of certain long-term care facilities be reimbursed.

For nursing home care, the data examined in this study indicate that DMAS has been reasonably successful in containing the costs of these services. At the same time, the Department has modified its payment system for nursing homes in an attempt to ensure access to care for persons with heavy care needs. This new system appropriately considers most of the key factors which drive the costs of nursing home services.

However, a final analysis of the potential costs of this system to the State cannot be made until DMAS completes its work on efficiency indicators.

When devising a reimbursement system for State-operated ICFs/MR, no attempt was made by DMAS to place payment caps or ceilings on these facilities other than those established by the federal government. As a result of this decision, these facilities are typically reimbursed at rates that are substantially higher than other long-term care providers. Still, if the rates for these facilities were reduced, it is likely that State general fund expenditures for persons who are mentally retarded will have to be increased.

V. Use of the Community Care Alternative

Although institutional services are still the predominant form of long-term care, during the past decade, community care has been widely heralded as a more cost-effective alternative. State implementation of community care programs has shown that this form of care can effectively substitute for the more expensive institutional care. Aside from its monetary advantages, many claim that community care is preferable because it allows individuals to maintain a better quality of life than could be realized in an institution.

Medicaid provides states with a number of options for developing community care programs through Section 2176 of the Omnibus Budget Reconciliation Act of 1981. Section 2176 allows the Health Care Financing Administration (HCFA) to waive certain Medicaid requirements regarding the amount, duration, and scope of services provided. One requirement of this provision is that the costs of services provided in the community do not exceed the cost of institutional care. Specifically, states are required to target services provided under the 2176 waiver program to only those people who are at-risk of institutional placement.

Some questions have surfaced about Virginia's waiver program for elderly and disabled Medicaid recipients. Specifically, concern has been raised that the waiver services are not cost-effective when offered to people who have heavy care needs or require services over extended periods of time. This study found that, in almost all circumstances, the waiver services are less expensive. However, it appears that these services are not properly targeted and therefore may have actually increased Medicaid spending by as much as $16 million.

The waiver services that are provided to the mentally retarded have not been as well developed as those provided to the aged and disabled. While the authority for implementing community services as an alternative to institutional placement for the mentally retarded has existed since 1981, the State did not develop such a program until 1991. However, it is unclear whether earlier participation in the waiver program would have allowed significant reductions in overall Medicaid expenditures on the mentally retarded.

This chapter presents the results from an analysis of cost of personal care and nursing home services. Additionally, findings from an evaluation of the pre-admission screening practices of local assessment teams are also discussed. Finally, an assessment is made of the potential cost-effectiveness of the waiver program for the mentally retarded.

COMMUNITY CARE AS AN ALTERNATIVE TO NURSING HOME PLACEMENT

Virginia's first waiver request for long-term care was submitted to the federal government in 1982. This waiver is targeted towards the elderly and disabled and is intended to be used in lieu of nursing facility placement. The State began providing services under this waiver program in 1983. Since that time, the scope of services that are provided have been expanded. Currently, the elderly and disabled waiver program serves more than 5,000 people. The average length of services provided is 31 weeks.

Because waiver services are intended to serve as an alternative to institutional placement, only those people who are at-risk of institutionalization should receive them. Accordingly, before being approved for waiver services, the applicant's risk for nursing home placement is assessed through a comprehensive pre-admission screening process. The process incorporates the use of a structured assessment instrument which is used to determine whether the individual meets nursing home level of care criteria. The effective implementation of this screening process is a key factor in determining whether individuals are being appropriately placed in community care.

Community Care Program in Virginia Offers a Variety of Services

The primary focus of the elderly and disabled waiver program is on providing personal care services. These services have been covered by the waiver since its inception. In recent years, however, additional services have been included under this program. Currently, the elderly and disabled waiver program offers personal care, adult day health care, and respite care.

Personal Care. Personal care services are defined as long-term maintenance or support services which are necessary in order to enable an individual to return or remain at home rather than enter a nursing home. The service is designed to help people who have functional disabilities perform routine activities of daily living (ADL). This may include assistance with such things as personal hygiene, getting into and out of bed, meal preparation, and shopping. The focus of the personal care program on ADL dependency is predicated on the assumption that it is the decline in an individual's ability to perform these functions that will lead to nursing home placement.

Personal care services are provided by personal care aides who are employed by private companies and local area agencies on aging. The personal care aide goes into the Medicaid recipient's home to assist the individual in performing various ADLs. The amount of time the aide spends in the recipient's home can vary based on an assessment of the recipient's needs.

Adult Day Health Care. Adult day health care, like personal care, is designed to assist the individual with routine activities of daily living. The primary difference between the two types of services is the setting in which they are provided. While

personal care is provided in the recipient's home, adult day health care takes place outside the home in a licensed adult day care center.

The range of services provided to each individual receiving adult day health care varies. However, DMAS requires that, at a minimum, each center must provide: nursing services, rehabilitation services coordination, transportation, nutrition, social services, and recreation and socialization services.

Respite Care. Unlike the other waiver programs, respite care is not targeted directly to the Medicaid recipient. Rather, the service focuses on the recipient's caregiver. The caregiver is generally a family member or friend who lives with and takes care of the recipient. The intent of this waiver is to prevent the caregiver from becoming "burned out" from providing continuous care to the recipient.

Respite care offers the caregiver either episodic or routine relief from the continuous care demands of the patient. Routine relief may include sending an aide to relieve the caregiver once a week. Episodic relief may be provided for one week a year and would enable the caregiver to take a vacation. The service is typically provided by the same agencies that provide personal care services.

Assessment Process is Crucial for Cost-Effectiveness of Program

Because the waiver program is intended to be an alternative to nursing home placement, only those people who are at-risk of institutionalization should receive these services. These are people who meet established nursing home level of care criteria, but who have a support structure in the community that will allow them to remain in their homes with the assistance of the personal care aide. In order to ensure that long-term care applicants meet this criteria, DMAS has established an extensive pre-admission screening process.

The pre-admission screening function was originally developed in the late 1970s for the purpose of ensuring that individuals placed in nursing homes actually require that level of care. In 1982, with the introduction of the waiver programs, pre-admission screening was extended to people seeking waiver services. The assessment process serves as a gatekeeping mechanism designed to ensure that inappropriate placements to long-term care are not made. In this sense, the process is crucial in ensuring the cost-effectiveness of the waiver program.

Pre-admission Screening Committees. The pre-admission screening process is conducted by screening committees using a standardized assessment instrument. The screening committees can be either hospital or community-based. Pre-admission screening is organized at the community level through cooperative agreements with the local health and social services departments. These local screening committees are typically made up of a local social service worker and a health department nurse and physician. Local screenings are initiated when an applicant applies for long-term care services.

Once a request for pre-admission screening is made, the social service worker and the nurse will visit the applicant's home. During this visit, the screeners meet with the applicant and the applicant's caregiver and collect information to complete the assessment instrument. Once all the pertinent information has been collected, the social service worker and the nurse review their findings to determine whether nursing home or community-based care is appropriate. They will then make a recommendation to the physician who is responsible for reviewing and approving the recommendation.

Hospital screening committees are formed when a long-term care applicant is applying for care while in a hospital. DMAS currently contracts with 88 hospitals to perform screenings. The two prescribed members of the hospital screening committees are a discharge planner and a physician. Hospital screening committees utilize the same pre-admission screening instrument as community-based screeners. However, the instrument is completed in the hospital. Hospital screeners do not visit the homes of the applicants. Typically, it is the responsibility of the discharge planner to complete the entire assessment, although they may receive input from nurses or others who have worked with the applicant. The physician is responsible for reviewing and approving the instrument.

Assessment Instrument. The assessment instrument utilized by the screening committees was developed by the Long-Term Care Assessment Training Center at Cornell University. The instrument is designed to assess the applicant's overall medical, social, and functioning status. Accordingly, the instrument is divided into three major components.

The first part of the assessment instrument focuses on demographics. In this section, the screeners collect information on such things as the applicant's age, sex, marital status, employment, and living arrangements. Also in this section, information is collected on whether the applicant's social support is willing and able to provide assistance with certain activities of daily living.

The medical component of the assessment instrument focuses on such things as impairments of speech, hearing, and vision. It also addresses whether the applicant has fractures or dislocations, missing limbs, and paralysis. The screeners must collect information on the onset of the medical problems and whether there are any rehabilitation needs associated with the condition.

The final component of the assessment instrument involves the applicant's functional status. It is this section that plays the most crucial role in determining whether or not someone meets nursing home level of care criteria. In order to assess an individual's functional status, the screeners collect information on the degree of assistance that the applicant requires in performing the following activities of daily living: bathing, dressing, toileting, transferring (i.e., getting in and out of a bed or chair, etc.), bowel function, bladder function, eating and feeding, overall mobility, walking, using a wheel chair, and stairclimbing. In addition, an assessment is made of the individual's behavior patterns, orientation, and ability to communicate.

The information that is collected during the assessment process will ultimately be translated by the screening committee into general service needs in eight primary areas. From this, the screening committee makes a decision as to whether the individual meets nursing home level of care criteria and, if so, what would be the most appropriate placement.

COST-EFFECTIVENESS OF PERSONAL CARE

While community care is generally recognized as a less expensive alternative to nursing home placement, there has been some question about whether it is always cost-effective. There is concern that when the cost of providing ancillary services, such as hospital care and physician services, is added to the cost of providing both waiver and nursing home services, the community alternative may be more expensive for some groups of recipients.

In order to assess whether this occurs in Virginia, an analysis was conducted to compare the total cost of personal care services to the total cost of nursing home services. The results of this analysis suggest that even when ancillary services are considered, community care remains a less expensive form of care. Moreover, the cost of providing personal care services remains less than the cost of nursing home services even after controlling for the recipient's level of functioning and the length of stay in the Medicaid program.

Questions Have Been Raised about Cost-Effectiveness of Personal Care

In the ten years since the waiver programs were first implemented, extensive evidence has accrued illustrating the cost-effectiveness of these services. State participation in the program is conditioned upon demonstration to the federal government that the state's average per capita expenditure for the waiver programs does not exceed the cost of nursing home care. Because average annual per-capita expenditures on personal care are typically about 43 percent less than for nursing homes, this has not been difficult for most states to prove.

Federal policy requires states to demonstrate that personal care services continue to be less costly than nursing facility care when the ancillary costs associated with the two types of care are considered. The formula, which must be approved by HCFA, contains estimates of these ancillary costs and annual reporting must continue to show the combination of both personal care and ancillary costs are less than the combination of nursing facility care and ancillary costs.

Concern has been expressed that personal care recipients may require more ancillary services, such as hospitalization and physician services, than their nursing home counterparts. The cost of these services is believed to drive up the cost of community care. In addition, questions have arisen about whether personal care

remains less expensive when patient characteristics and length of stay are accounted for. The formula used by DMAS is not adequate for addressing these questions as it is based on differences in the average cost of care for the two types of services for one fiscal year.

To address these concerns JLARC staff analyzed automated data from DMAS' long-term care information system (LTCIS), payment files, and recipient eligibility files. Specifically, JLARC staff collected data on patient characteristics, payments, and length of stay for all personal care and nursing home recipients who entered care in 1986 and were discharged from care by 1990. The cost of providing care was tracked along with changes in patient characteristics in order to determine the cost-effectiveness of community care.

Ancillary Services Cost More for Personal Care Recipients

While receiving personal care or nursing home services through Medicaid, recipients will often require other types of services funded by the program. These services include such things as hospitalization, transportation, home health, physician services, outpatient services, dental, and lab services. It has been stated that the cost of providing these ancillary services is greater for personal care recipients because they are not located in a setting that provides around-the-clock professional care. Proponents of this view suggest that nursing home recipients are less likely to require such services because these facilities are better equipped to handle medical needs.

As can be seen in Table 7, JLARC analysis of DMAS data shows that the average cost per day for ancillary services provided to personal care recipients is significantly higher than for nursing home residents. The differences in hospital and physician expenses appear to be the most substantial. The cost per day for hospital expenses is almost four times greater for personal care recipients than for nursing home recipients. Physician expenses are more than five times higher per day. These differences in cost per day appear to support the theory that the cost of ancillary services is greater for personal care recipients.

Key Differences Exist in Use of Ancillary Services

In order to determine what type of ancillary services appear to have the largest impact on total Medicaid spending for these services, the cost of each service as a percent of total ancillary costs was calculated (Figure 34). Several key differences emerge when the data are examined. Most notably, the use of pharmacy services is significantly higher among nursing home residents. Fifty-five percent of total ancillary costs can be attributed to pharmacy expenses for this group of recipients.

This could reflect the absence of restrictions on drug usage in nursing homes at that time. When the cohort used in this analysis began receiving Medicaid in 1986, the nursing home reforms which limited the use of psychotropic drugs had not been implemented. A common nationwide practice in the industry was to sedate the residents so they could be more easily managed.

Table 7

Average Medicaid Cost per Day of Care by Type of Service for Recipients Who Entered Personal Care or a Nursing Home in 1986 and Were Discharged by 1990

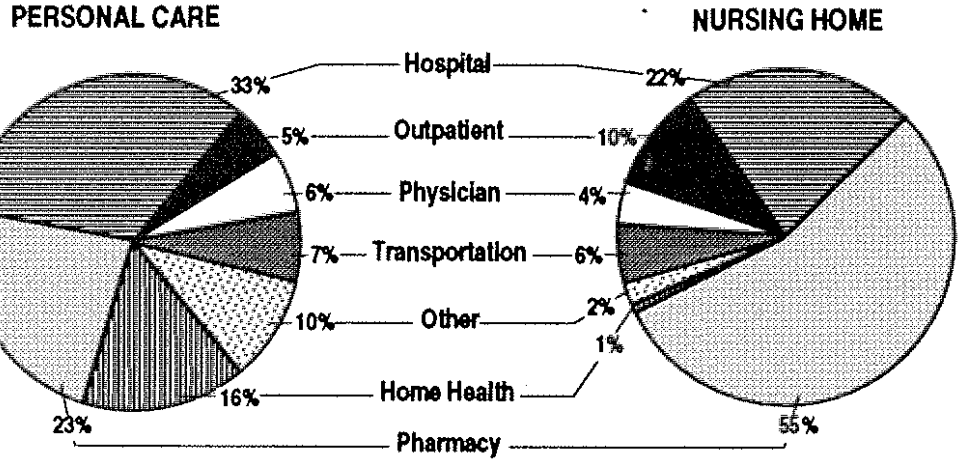
Type of Service	Average Cost Per Day		Difference
	Personal Care	Nursing Home Care	
Pharmacy	$2.86	$2.57	$ .29
Physician	$ .77	$ .16	$ .61
Transportation	$ .87	$ .27	$ .60
Hospital	$3.99	$1.05	$2.94
Outpatient Services	$ .60	$ .45	$ .15
Home Health	$1.93	NA	
Other	$1.19	$ .11	$1.08

Note: This analysis was based on the universe of persons who begin receiving Medicaid payments for personal care or nursing home services for the first time in 1986. To account for differences in utilization, the calculation of average cost per day includes zero values.

Source: JLARC analysis of Department of Medical Assistance Services' claims data for calendar years 1986 through 1990.

Figure 34

Cost per Ancillary Service, as a Percent of Total Cost of Ancillary Services



Source: JLARC analysis of the Department of Medical Assistance Services' claims and eligibility data.

For personal care recipients, analysis indicates that hospital expenses account for the greatest portion of ancillary expenditures. This lends credence to the concern that there is a higher rate of hospitalization among personal care recipients than nursing home residents.

Waiver Remains Cost-Effective After Controlling for Functional Status

While it appears that personal care recipients incur greater expenses for ancillary services than their nursing home counterparts, further analysis was conducted to determine whether these differences caused personal care to be more expensive for some categories of individuals.

The initial step in this analysis was to determine the cost of providing care controlling for the recipient's ADL status. As noted above, ADL status is considered the primary indicator of whether someone will require nursing home level of care. It is also crucial in determining the intensity of the services that the individual may require.

Therefore, differences in ADL status were considered based on concerns that as a recipient's functional needs increase, it may become more costly to provide personal care services than nursing home services. This would be due to the greater need for the personal care recipient — who is not receiving full-time professional care — to utilize ancillary services and to require additional hours of personal care service.

To account for ADL status, an algorithm created by DMAS was used to place long-term care recipients in various ADL categories. These categories are used by DMAS to, among other things, determine the number of personal care hours an individual requires. The first category includes individuals who are dependent in zero to six activities of daily living. These people would be considered the least functionally dependent. The second category is made up of recipients who are dependent in seven to 12 ADLs. The third category includes people who are dependent in nine or more ADLs and who also require some form of specialized care. This could include wound care, specialized feeding, or rehabilitation for conditions such as paralysis, quadriplegia, or multiple sclerosis.

This analysis shows that even when functional status is considered, personal care remains less expensive than nursing home care. As can be seen in Table 8, the total Medicaid costs of nursing home care including payments for ancillary services is more than $11 per day higher than the costs of personal care. Moreover, for all three categories of ADLs, the average cost of personal care is less than for nursing home care.

For example, the Medicaid cost of care for recipients in nursing homes with the most extensive care needs is 45 percent greater than the cost for a similar group of recipients receiving personal care services. This suggests that functional status has no impact on the cost-effectiveness of personal care services.

Table 8

Average Medicaid Cost per Day of Care by Type of Service and Recipients' Functional Status

ADL Dependency Category	Average Cost Per Day Personal Care	Nursing Home Care
Total Cost	$29.77	$40.86
0 to 6	$32.76	$42.45
7 to 12	$26.97	$39.51
9 or more and special Care	$32.34	$47.19

Notes: This analysis was based on the universe of persons who begin receiving Medicaid payments for personal care or nursing home services for the first time in 1986. The calculation of average costs for both nursing home and personal care includes Medicaid payments made for all other ancillary services.

Source: JLARC staff analysis of Department of Medical Assistance Services' long-term care file and claims data, 1986 through 1990.

Waiver Remains Cost-Effective after Accounting for Length of Stay

In order to assess whether personal care becomes more costly than nursing home care over time, the average cost of each type of care was examined controlling for the length of stay of the recipient in the program. As can be seen in Table 9, it does not appear to be more costly over time to serve personal care recipients.

Personal care does, however, appear to be more expensive for people who remain in care for less than a year. This may be due to the nature of the problem that forced them to seek care. If the need for long-term care was precipitated by a sudden illness, for example, the care needs may be greater during the initial periods of illness, before the individual's condition stabilizes. This would increase the recipient's need to utilize ancillary services provided through Medicaid.

In fact, after controlling for length of stay, it appears that ancillary costs have a more significant impact on the total cost of providing care during the first year, than during any other year. This is particularly true for personal care recipients. As can be seen in Figure 35, ancillary costs make up almost three-quarters of the total cost of personal care for people who are in the program for less than one year. However, ancillary costs as a percent of total costs decrease significantly in subsequent years.

Table 9

Average Medicaid Cost per Day of Care by Type of Service, Controlling For Length of Stay

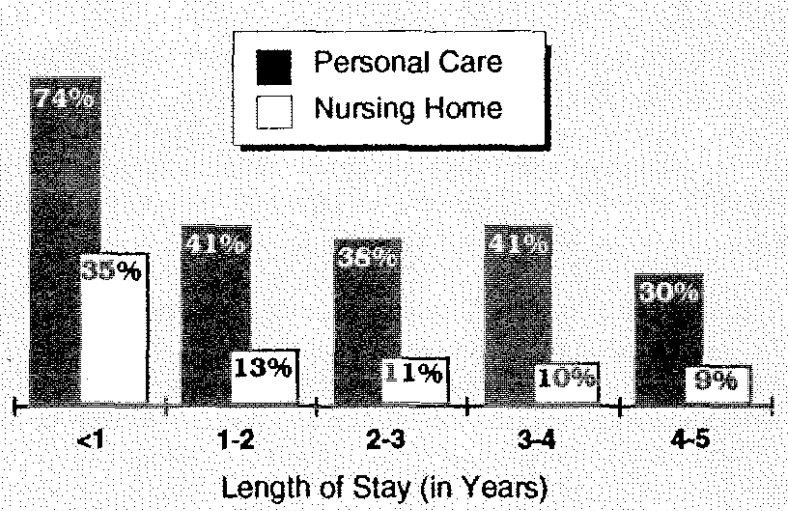
Length of Stay (years)	Average Cost per Day: Personal Care	Average Cost per Day: Nursing Home Care
Total Costs	$29.77	$40.86
Less than 1	$54.57	$51.76
1 - 2	$25.90	$38.45
2 - 3	$28.58	$37.60
3 - 4	$30.01	$39.53
4 - 5	$26.80	$41.11

Notes: This analysis was based on the universe of persons who begin receiving Medicaid payments for personal care or nursing home services for the first time in 1986. The calculation of average costs for both nursing home and personal care includes Medicaid payments made for all other ancillary services.

Source: JLARC staff analysis of Department of Medical Assistance Services' long-term care file and claims data, 1986 through 1990.

Figure 35

Ancillary Services as a Percent of Total Costs, by Length of Stay



Source: JLARC analysis of the Department of Medical Assistance Services' claims and eligibility data.

TARGETING PERSONAL CARE SERVICES

Although personal care is a more cost-effective form of care than nursing home placement, it will remain so only as long as services are appropriately targeted. The cost-effectiveness of personal care is dependent on targeting in two ways. First, the targeting process must ensure that only those people who are at imminent risk of nursing home placement receive personal care. Secondly, for people who are at-risk of institutional placement, personal care must be consistently offered as an alternative.

It appears, however, that in Virginia, some of the savings that can be realized by implementing personal care are lost due to the ineffective targeting of these services. Research for this study indicates that a significant number of people currently receiving personal care services would not have entered a nursing home if the waiver services were not available. Moreover, there is evidence that inconsistencies in the screening process lead many people to nursing homes who could have been less expensively served in the community.

Many Personal Care Recipients Not At-Risk of Nursing Home Placement

The waiver program was established in an effort to contain the cost of Medicaid-provided long-term care. Accordingly, federal regulations stipulate that services provided under the waiver can only be offered to people who would have otherwise entered a nursing home. Without this provision, the increase in the number of people who are served by the waiver program could potentially offset the savings that are achieved by providing a less expensive form of care.

Although the personal care program was established as a more cost-effective alternative to institutional placement, studies conducted in other states suggest that as many as two-thirds of personal care recipients would not have entered a nursing home if personal care had not been offered. Typically, these individuals do met the criteria for nursing home placement but because of the availability of family support, were not at-risk of institutionalization at the time personal care services were offered. What appears to have happened is that the advent of personal care created supply-induced demand. In other words, people who have no intention of entering a nursing home become aware that personal care services are available. As a result, they apply for the services so that they, or their families, can receive some assistance.

Because of the implications this can have for the cost of Medicaid long-term care, JLARC staff conducted a survey to determine whether the same phenonomenon could be observed in Virginia. The results of the survey indicate that Virginia's personal care program does, in fact, serve a substantial number of people who were not at-risk of institutional placement. Specifically, 57 percent of personal care recipients would not have entered a nursing home if personal care were not offered.

Survey of Caregivers. In order to assess the adequacy of DMAS' process for targeting waiver services to only those people who are at-risk of nursing home placement, JLARC staff conducted a telephone survey of the people who were designated as primary caregivers for personal care recipients. The primary caregiver is the person who has agreed to be available to provide care to the recipient when a personal care aide is not in the home. Most often, the primary caregiver is a member of the recipient's family, such as a son or daughter or a niece or nephew.

The survey was designed to determine whether, in the absence of personal care, the recipient would have had to enter a nursing home. JLARC staff surveyed the primary caregivers instead of the recipients themselves because of a concern that although the recipients may indicate that they have no intention of entering a nursing home, they would actually be forced to do so because of a lack of support in the home. By targeting the survey to those persons who would provide the support, JLARC staff were able to determine whether it would be feasible for the personal care recipient to remain at home in the absence of personal care. The universe for the survey of caregivers was all recipients who were receiving personal care services in April 1992.

To achieve a sampling error of five percent, 380 primary caregivers needed to be surveyed. To allow for non-responses, 450 cases were randomly selected from the universe of 5,161 personal care recipients. In order to obtain the names of the caregivers, JLARC staff sent data collection instruments to the 119 personal care agencies that provided services to the recipients in the sample. The agencies were asked to provide the name and phone number of the recipient, as well as information on the types of services provided and the number of hours of personal care provided.

DMAS Policy on Eligibility for Personal Care. DMAS policy is explicit about who should receive personal care services. The DMAS personal care manual states:

> In order to ensure that Virginia's Personal Care Waiver Program services **only** individuals who would otherwise be placed in a nursing home, Personal Care services **can be considered only for individuals who are seeking nursing home admission or for individuals who are at imminent risk of nursing home admission**. Personal care services must be the critical service that enables the individual to remain at home rather than being placed in a nursing home. [Emphasis in DMAS policy manual.]

According to this policy, it is possible for someone to meet the nursing home level of care criteria, but not be considered appropriate for personal care because their social support structure is such that the applicant is not at imminent risk of nursing home placement. While DMAS policy is explicit on this issue, it appears that the agency has been unsuccessful in targeting its personal care services accordingly.

Survey Results. In order to determine whether the recipients in the sample were truly at "imminent risk" of nursing home placement, JLARC staff asked the caregivers what they would do if Medicaid did not offer personal care services. As can be seen in

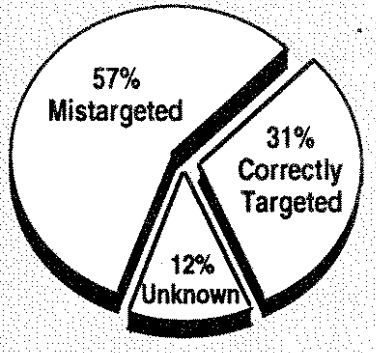
Figure 36, 57 percent of the survey respondents stated that they would not place the recipient for whom they provide support in a nursing home. Only 31 percent of the respondents indicated that they would be forced to place the recipient in a nursing home. The remaining 12 percent did not know what they would do in the absence of personal care.

JLARC staff also attempted to determine the proportion of Medicaid recipients who apply for Medicaid seeking personal care. Thirty-eight percent of the caregivers surveyed said that the person for whom they were providing care was hoping to receive personal care services at the time they applied for Medicaid long-term care. Of those caregivers who stated that they would not place the Medicaid recipient they were caring for in a nursing home, 39 percent said that the recipient was seeking personal care services at the time he or she applied for Medicaid.

Screening Committees Unclear on DMAS Policy. It appears that part of the targeting problem is that the policy of offering personal care to only those people who are seeking nursing home placement has not been made clear to the pre-admission screening committees. Over the course of the study, JLARC staff interviewed members of both local and hospital pre-admission screening committees. During these interviews, most screening committees indicated that they would continue to seek personal care for people who refused nursing home care.

Figure 36

Portion of Personal Care Recipients Who Were Mistargeted



Notes: A total of 300 persons responded to the JLARC telephone survey of primary caregivers.
At a 95 percent level of confidence, the sampling error for the proportion of recipients who received personal care services because of mistargeting is plus or minus 6 percent.

Source: JLARC staff analysis of the results of a telephone survey of primary caregivers for personal care recipients.

Members of eight of the 14 local screening committees interviewed by JLARC staff said that if an applicant indicated to them that they would refuse to enter a nursing home, the screening committee would still attempt to place them in personal care. When one screening committee was asked whether the committee would deny personal care services to an applicant who refused to enter a nursing home, a screening committee member stated:

> We can't do that. If people hear about personal care, we cannot deny them the service if they refuse to go into a nursing home. We look only at whether the person meets the level of care criteria. If they meet the criteria, then we offer the services.

Most of the hospital screening committees that were interviewed expressed the same sentiment. Staff on five of the eight hospital screening teams visited by JLARC staff stated that they would also attempt to place applicants in personal care if they refused to go into a nursing home.

It appears that many screening committees' primary focus in determining whether personal care should be offered is on whether or not the individual meets the nursing home level of care criteria. As long as the applicant meets these criteria and could be safely served in the community, personal care will be offered. Social support is only considered to determine whether the individual's needs will be met when a personal care aide is not in the home. It is not considered from the standpoint of whether the level of support that is available to the individual is sufficient to the extent that the person may not require personal care services at all.

Implications of Survey for Personal Care Expenditures. The results of the survey have a great deal of significance in terms of overall long-term care expenditures. The projected total amount of personal care expenditures for recipients in the sample is $29.5 million (plus or minus $1.4 million due to sampling error). The projected cost of providing personal care to people who were mistargeted is $16.2 million. (This amount could be as high as $19 million or as low as $13.5 million due to sampling error.)

DMAS Attempts to Clarify "Imminent Risk." For the last year DMAS officials have been concerned about the nursing home criteria and whether those people who were receiving personal care services were actually at-risk of nursing home placement. On August 17, 1992, the Secretary of Health and Human Services submitted for the Governor's signature, emergency regulations that clarified DMAS policy regarding who is to be considered at imminent risk of nursing home placement. The Governor signed the emergency regulations on August 27, 1992.

The new policy requires that screening committees document that the individual is at imminent risk of nursing facility placement by finding that one of the following conditions is met:

- application for the individual to a nursing facility has been made and accepted;

- the individual has been cared for in the home prior to the assessment and a deterioration in health care condition or change in available support has occurred which prevents former care arrangements from meeting the individual's need;

- there has been no change in condition or available support but evidence is available that demonstrates that the individual's medical and nursing needs are not being met. Examples of such evidence may be, but shall not necessarily be limited to: (1) recent hospitalization, (2) attending physician documentation, or (3) reported findings from medical or social services agencies.

It appears that the new regulations could have a positive impact on the ability of pre-admission screening committees to effectively target personal care services to only those people who would have otherwise entered a nursing home. It is crucial, however, for DMAS to communicate to the screening committees the importance of their assessment of the extent to which an applicant's needs can be met through existing informal care networks. Because screening committees appear to have misinterpreted DMAS policy on this issue in the past, it would be useful for DMAS to conduct training for all screening committee members on their new policy.

Recommendation (5). **The Department of Medical Assistance Services should conduct training for screening committees responsible for implementing the new policy on documenting who is considered at imminent risk of nursing home placement. Over the course of this training, DMAS should stress to the screening committees that their assessment of the extent to which the recipient's needs can be met through informal care networks is an integral part of the placement decision.**

Personal Care Services Not Utilized as Frequently as Possible

Offering services to people who are not at-risk of nursing home placement can significantly drive up the cost of long-term care services. Another way in which targeting can affect the overall cost to the State of long-term care is when people who should be offered personal care are instead steered into a nursing home.

Because personal care is a more cost-effective form of care than nursing home placement, personal care services should be offered as an alternative to nursing home placement whenever possible. This means that anyone who meets nursing home level of care criteria, has an adequate support structure in the community, and is actually at-risk of nursing home placement, should be given the option of choosing community care as opposed to institutional placement. If personal care is not consistently offered as an alternative, the State could end up incurring greater expenses on long-term care than necessary.

Discussions with screening committee members and DMAS staff suggest, however, that there is some question as to whether people who meet the criteria for

personal care are consistently being offered the service. Specifically, it appears that hospital screening committees make far more recommendations for nursing home placement than are made by community-based screening committees. Both DMAS staff and screening committee members have expressed concern that hospital screening committees are much more reliant on nursing homes than necessary.

Factors Contributing to Inconsistency in Placements. A variety of factors have been mentioned as possible contributors to this apparent bias on the part of hospitals towards nursing home care. During JLARC staff interviews with both hospital and local screening committees, committee members were asked whether they believed that the structure of the screening process is such that two different screening committees, evaluating the same individual, would arrive at the same conclusion as to the most appropriate placement.

Most screening committee members agreed that overall the screening process is sufficiently objective to ensure that two committees of the same type would make similar recommendations. However, concern was expressed that there may be inconsistency in the conclusions reached by hospital- and community-based committees. Specifically, some screening committee members suggested that hospital screening committees are more likely to recommend nursing home care as opposed to community care.

Some committee members stated that this potential inconsistency could be due to the fact that hospital screeners do not visit the homes of potential long-term care recipients. As a result, their assessment of the adequacy of social support is not as thorough as that of the community-based screeners.

Others have suggested that the setting in which the assessment is carried out is such that applicants in hospitals appear to be more functionally dependent than they really are. One screening committee member pointed out that people in the hospital are often told not to attempt to perform routine activities of daily living, such as toileting or transferring, on their own. Rather, they are instructed to wait for help from hospital staff. Although this does not reflect their actual ability to perform these functions once released from the hospital, screeners may only be considering functional status prior to release. This could impact how dependent the people in hospitals appear and could overstate their care needs.

In response to this, emergency nursing home regulations took effect September 9, 1992 requiring that the "rating of functional dependencies be based on the individual's ability to function in a community environment, not including any institutionally induced dependence."

Finally, some screening committee members have concluded that many physicians are predisposed to recommending nursing home placement and cannot be convinced that personal care is a viable alternative. Thus, the screening committees recommendation may be swayed by the bias of the physician who must sign off on the assessment instrument.

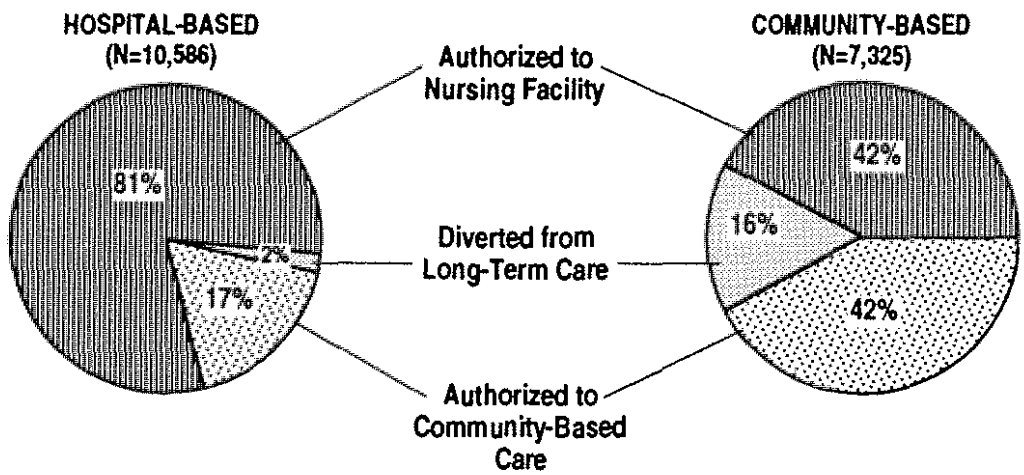
DMAS Examination of Hospital Screening Committees. DMAS staff have also expressed concern about the tendency of hospital screening committees to place persons in nursing homes when personal care services may have been a suitable alternative. Based on statistics collected over past few years, DMAS staff compiled data to compare the percent of recommendations to community care between hospital and community-based screening committees.

As can be seen in Figure 37, DMAS data show that the percent of recommendations to personal care made by hospital screening committees was significantly less than the percent made by community-based screening committees. In FY 1991, hospital screening committees screened a total of 10,856 people for long-term care. Of these, community-based care was recommended for only 17 percent of the cases. Community-based screening committees, on the other hand, recommended personal care for 42 percent of the 7,325 people they screened.

One possible explanation for the discrepancies in placement rates, that was not considered by DMAS, is that there are actual differences in the types of people who are screened by hospital and community-based screening committees. If, for example, the long-term care applicants in hospitals are more functionally dependent and have less social support, then it would be appropriate for hospital screening committees to make more recommendations for nursing home placements than their community-based counterparts.

Figure 37

Placement Recommendations Made by Hospital- and Community-Based Screening Committees



Source: Department of Medical Assistance Services.

Multivariate Analysis of Placement Decisions. In order to examine this issue, JLARC staff attempted to determine the probability of being placed in a nursing home after controlling for such factors as functional status and the willingness and ability of an applicant's caregivers to provide support. To do this, JLARC staff constructed a multiple regression model that simultaneously controlled for the effects of both of these factors, as well as the source of the screening (hospital or community-based screening committee). The analysis included everyone screened for long-term care services for the first time in calendar year 1991.

The results of the analysis show that there does appear to be some inherent bias on the part of hospital screening committees towards placing people in nursing homes as opposed to personal care. Specifically, as can be seen in Table 10, after accounting for the availability of social support and the individual's functional status, hospital screening committees are still 25 percent more likely than community-based committees to place long-term care applicants in a nursing home. This suggests that hospital pre-admission screening committees are predisposed towards making recommendations for nursing home placement.

Implications for Long-Term Care Expenditures. Because approximately 60 percent of pre-admission screenings are conducted by hospital as opposed to community-based screening committees, the implications that mistargeting could have for the cost of long-term care are great. The average annual per capita expenditure on personal care is approximately 43 percent of the cost of nursing home care. Thus, the State could be spending significantly more on long-term care than is necessary.

Table 10

Factors Which Impact The Placement Recommendations Made by Screening Committees

Variable	Standard Coefficient	Impact
Availability of Support	-.45	Strong
Light Care Needs	-.11	Weak
Heavy Care Needs	.02	Weak
Source of Screening	.25	Strong
R^2	.36	

Note: The dependent variable was a dichotomous variable indicating the type of placement recommendation (0 = personal care, 1 = nursing home). If a hospital conducted the screening, the variable "Source of Screening" was given a value of 1, otherwise it was given a value of 0. The standardized coefficients reported for each independent variable represent the marginal probability of nursing home placement. The R^2 value represents the total amount of variation that was explained after all of the independent variables were added to the model. Because the dependent variable was a dichotomous variable, the parameters were recalculated using logit analysis. The findings were consistent with those reported in this table.

Source: Data for this analysis came from the Department of Medical Assistance Services' Long-Term Care Information System.

Alternatives for Eliminating Bias. In response to an analysis, which began subsequent to this study, DMAS is considering two alternatives to eliminate the potential problems created by the apparent bias of hospital screening committees. According to DMAS:

> Hospitals continue to view themselves as self-contained entitites and have little commitment to care of the patient after discharge. Hospital discharge planners do not see themselves as part of the chronic care community service network....Therefore, now is an appropriate time to evaluate other alternatives.

The first alternative that is being considered is taking away the responsibility for pre-admission screening from the hospital screening committees entirely. Under this scenario, DMAS would contract with the community-based screening committees to take over the screenings conducted by hospitals. However, DMAS points out that this may not be feasible given the workload demands of local screening committees. Accordingly, DMAS is also considering having the hospitals continue to assess patients, but have local screening teams develop the post-discharge plan of care.

These issues are important because they impact the amount of money that should be allocated for personal care services. As noted earlier, JLARC's analysis indicates that mistargeting has increased personal care spending by as much as $16 million. Because of the 50 percent federal match for State Medicaid spending, half of this $16 million would be general fund dollars.

However, if DMAS establishes policies which improve targeting by hospital-based screening committees, there would be an appropriate increase in demand for personal care services. This would obviously decrease the amount of money which could be reduced from the program. DMAS staff indicate that the actual savings in personal care expenditures due to improved targeting would be $4 million. Half of this amount would be State general fund dollars.

Recommendation (6). **The Department of Medical Assistance Services should evaluate the feasibility of contracting with community-based screening committees to conduct either all or part of the hospital screening functions. If the agency determines that some screening functions should remain with the hospitals, it should also conduct a study to ensure that there are not other potential inconsistencies in the way in which hospitals conduct screenings.**

Recommendation (7). **The General Assembly may wish to reduce general fund appropriations for personal care. This reduction should be between $2 million and $8 million depending on whether changes are made to personal care rates and the ability of hospital-based screening committees to divert more people to personal care. The General Assembly may wish to direct the Department of Medical Assistance Services to prepare a full analysis of alternartive levels of reduction for the personal care program, including the potential impact on recipients.**

STATE COMMUNITY CARE SERVICES FOR THE MENTALLY RETARDED

While the federal waiver authority has been used to divert the aged and disabled from nursing homes to a less expensive form of care over the past decade, the same has not been true for the mentally retarded. Although the federal legislation that authorizes waivers for the elderly and disabled also allows waiver services targeted towards the mentally retarded, the State's use of this authority has lagged.

The State submitted its first waiver request for services for the mentally retarded to the federal government in 1986. However, according to officials in the Department of Mental Health, Mental Retardation, and Substance Abuse Services, (DMHMRSAS), the request was poorly developed and was denied by HCFA. It was not until more than five years later that the State was able to obtain approval for the waiver and begin implementing a waiver program that is designed to divert people from care in intermediate care facilities for the mentally retarded (ICFs/MR).

It is difficult to determine what impact the State's lack of participation in the waiver has had on overall Medicaid expenditures for the mentally retarded. The scope of this study, combined with the relatively short duration of time during which waiver services have been offered to the mentally retarded, prevented a detailed analysis of the cost-effectiveness of community care for the mentally retarded.

However, it appears that the impact the waiver would have had on further reducing the census in the State-operated ICFs/MR or on preventing new admissions to these facilities is minimal. Moreover, there is no conclusive evidence to suggest that the cost to the State of providing community care to the mentally retarded would always be less than the cost of providing institutional care.

Waiver Services May Not Address Needs of Potential ICF/MR Residents

As with the elderly and disabled waiver, the waiver program for the mentally retarded is intended to serve as an alternative to institutional placement. However, the waiver program for the mentally retarded does not appear to be sufficient in scope to address the total needs of people who are either currently in institutions or who are at-risk of being institutionalized.

The services provided for the mentally retarded are offered under two separate waiver programs. The first waiver is targeted towards individuals who reside in nursing facilities who have been assessed and determined to require the level of care usually provided in an ICF/MR. The second waiver is designed for people who reside in either an ICF/MR or the community at the time of assessment for waiver services. Both waivers were implemented in January 1991 and they have identical program structures.

While the waivers offer a variety of services, the focus of these services is primarily on improving the individual's functional status and does not address either

domiciliary arrangements or medical needs. Four types of services are currently provided under the waivers: (1) residential support, (2) day support, (3) habilitation, and (4) therapeutic consultation. Waiver services are delivered by the 40 Community Services Boards across the State, either directly or through contracts with private agencies.

Residential Support. Residential support is provided in the mentally retarded individual's home or in a licensed residence. It involves providing individualized training, assistance, and supervision to enable the individual to maintain or improve his or her health, development, and physical condition. This includes the monitoring of the the person's health status, medication, and need for medical assistance. In addition, residential support may include training or assistance in routine activities of daily living or training in the use of commuinity resources.

Day Support. Day support encompasses training in intellectual, sensory, motor, and affective social development. Among other things, this includes: self, social, and environmental awareness; learning and problem solving; communication and self-care; and use of community resources. Unlike residential support which provides assistance in independent living skills training within a community integrated environment, day support provides problem solving skills in a training environment such as a licensed center.

Habilitation. Habilitation services are prevocational and supported employment for individuals who have been discharged from a Medicaid certified nursing facility. Prevocational services include training in skills which are necessary to prepare the individual for employment, such as paying attention to a task and maintaining time schedules. Supported employment provides special assistance that will allow a mentally retarded individual to enter and maintain employment in work settings with nondisabled people.

Therapeutic Consultation. Therapeutic consultation involves consultation by specialists in speech, occupational and physical therapy, as well as psychological services.

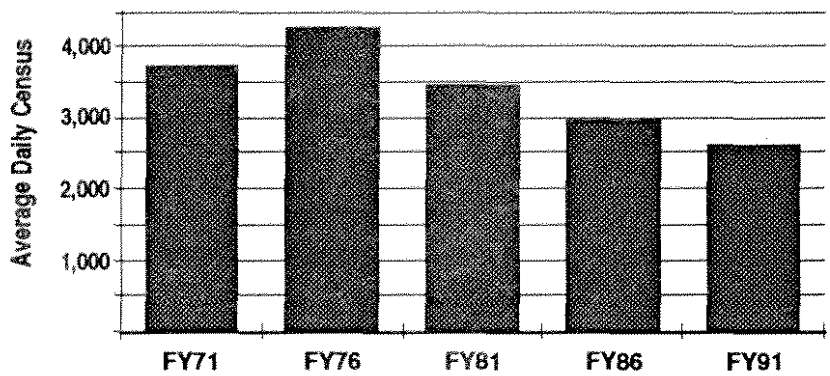
Evidence of Cost-Effectiveness of Services is Lacking

Because of the limited scope of waiver services, it is unclear what ramifications the State's failure to participate in the Medicaid waiver program for the mentally retarded, prior to 1991, has had on overall Medicaid expenditures. The steadily declining census in the State-operated ICFs/MR, as well as the State's policy of limiting new admissions to State facilities, suggest that the number of people who could have been removed or diverted from ICFs/MR had the waiver been in effect sooner, is minimal.

Decline in Training Center Census. Between 1971 and 1991, the number of people served in State-operated training centers declined significantly. The average daily census declined from 3,723 in fiscal year 1971 to 2,626 in FY 1991 (Figure 38). This represents a reduction of almost 30 percent.

Figure 38

Average Daily Census in State-Operated Institutional Care Facilities for the Mentally Retarded (Fiscal Years 1971, 1976, 1981, 1986, and 1991)



Source: JLARC analysis data from the Department of Mental Health, Mental Retardation, and Substance Abuse Services.

A major reason for the decline has been State restrictions on new admissions. Between 1971 and 1991, the number of new admissions to State-operated training centers also declined significantly. In FY 1971, 81 percent of the persons entering training centers were new admissions (Figure 39). By FY 1991, the percentage of new admissions had declined to 32 percent. The reduction in the number of new admissions to State-operated facilities suggests that the waiver program could not have been used to divert a significant number of mentally retarded individuals from ICF/MR placement.

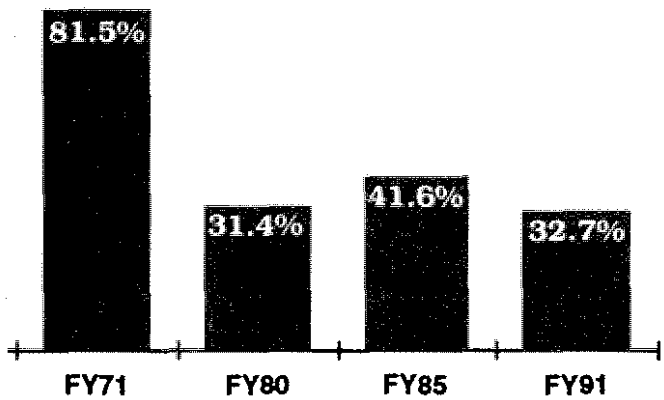
Cost-Effectiveness of Waiver Services Questionable

As with the elderly and disabled waiver program, questions have also arisen regarding whether waiver services are cost-effective for all groups of eligible persons who are mentally retarded. Very little research has been done nationally on the cost-effectiveness of community care for the mentally retarded. However, concern has been raised that the cost to the State of providing waiver services may be higher for individuals with severe or profound retardation or those who lack any informal support structure in the community.

Level of Retardation. According to DMHMRSAS officials, the vast majority of the mentally retarded in the State-operated ICFs/MR could be served in the community if the appropriate mix of services were available. However, these officials maintain that the existing array of community services would not meet the intense needs of the people who are currently in ICFs/MR.

Figure 39

Percentage of Admissions to Virginia Mental Retardation Training Centers Which are First Admissions (Fiscal Years 1971, 1980, 1985, and 1991)



Source: JLARC analysis of data from the Department of Mental Health, Mental Retardation, and Substance Abuse Services.

Due to the State's success in reducing the census in the ICFs/MR, most of the people who remain are considered severely or profoundly retarded. Moreover, as noted in Chapter II, current DMHMRSAS policy is to limit non-emergency admissions to people who fall into these two categories of retardation. The low functioning levels of these individuals mean that many demand continuous, intensive supervision. Many of these people also have medical conditions that warrant continuous monitoring. Thus, the range of services that would be required is great and could not be met by the waiver program alone.

For these reasons, staff in both ICFs/MR and local CSBs question whether the care needs of these individuals are such that the cost of providing services in the community could exceed the cost of providing care in a training center. This is also due, in part, to the fragmented nature of services that would be provided in the community. Because service needs would have to be addressed by a number of different entities, coordination of services could be difficult and the cost of providing them may be excessive.

Lack of Informal Support. Concern has also been expressed that the cost to the State of providing community care may be greater than institutional care for people who do not have families that will provide lodging and informal support. If an individual does not have a primary residence, then the State would be responsible for arranging for the person to live in an adult home, a group home for the mentally retarded, or a foster home. Because Medicaid does not pay for this type of residential care, the cost of providing a residence, combined with the cost of the State's match for the waiver program, could exceed the cost to the State of providing institutional care.

This problem is particularly relevant for Virginia's ICF/MR population. The average age of training center residents is 38 years. Many of these people have been in the institutions for most of their lives and no longer have family members available who could meet their informal care needs.

Recommendation (8). **The Department of Mental Health, Mental Retardation, and Substance Abuse Services should conduct a pilot study to determine whether waiver services for the mentally retarded could be cost-effectively used to meet the needs of the severely or profoundly mentally retarded.**

CONCLUSIONS

Analysis of the cost of providing personal care services to the aged and disabled suggest that, even when ancillary services are considered, personal care is a less expensive alternative to nursing home care. While there is little data available to determine whether the same would be true for the mentally retarded, it appears that waiver programs would not produce similar costs savings.

With regard to the aged and disabled, the cost-effectiveness of waiver services is qualified by the ability of DMAS to correctly target the services. There appear to be two problems with DMAS' current targeting strategy that could impede the ability of the personal care waiver program to reduce long-term care costs. First, DMAS has been unable to ensure that only those people who are at imminent risk of nursing home placement receive waiver services. As a result, over half of the people who have entered the program should not be receiving the services.

In addition, there have been problems with ensuring that all those people who could be effectively served in the community are offered this type of care. Specifically, ineffective targeting may have resulted in a number of people being diverted from community services who should have been offered them. Because of the cost-effectiveness of personal care, this too could have a significant impact on overall long-term care expenditures.

In order to ensure that Medicaid expenditures on community care are effectively used, DMAS needs to improve its targeting in two ways. First DMAS should conduct training for the screening committees to ensure that its policies are correctly implemented. Secondly, DMAS needs to take action to eliminate the bias on the part of hospital screening committees against the use of personal care services.

With regard to waiver programs for the mentally retarded, it is less clear that these programs can be utilized to cut the cost of Medicaid long-term care. Because the range of services authorized under the waivers is limited in scope, it is doubtful that the programs can be used to significantly reduce the cost to Medicaid of providing services to the mentally retarded. The mentally retarded individuals who are the most Medicaid dependent are also those who could benefit least from the waiver services in and of

themselves. These are people whose needs are such that the cost of the range of services that would need to be provided in the community may exceed the cost of institutional care. However, to determine more conclusively whether the waiver services could be used to offset the cost to Medicaid of institutional care for the mentally retarded, DMHMRSAS should conduct a pilot study on this issue.

VI. The Reimbursement Process for Community-Based Care

Although Medicaid expenditures for community-based care represent a relatively small portion of total program expenditures, spending on these services has been growing at a rapid rate of more than 70 percent since 1983. Partly as a result of this increasing trend, there is a heightened interest in the policies used by the Department of Medical Assistance Services (DMAS) to establish reimbursement rates for both home health and personal care services.

A primary concern is whether these policies ensure patient access to community-based care while encouraging a cost-effective delivery of services. Currently, the State reimburses providers of home health care based on a fee for service system. With this system, DMAS pays each provider a predetermined flat fee which varies according to the type of visit that is provided each eligible recipient. To determine the actual rates under this system, home health agencies are organized into different peer groups, and fees are set for the providers in each group.

The methodology used by DMAS to establish the prospective rates does not appropriately consider the key factors which influence home health costs. More importantly, the methodology appears to result in fees that do not accurately represent the cost of home health services. In addition, the decision to pay hospitals higher rates for providing the same service as other operators does not appear justifiable.

Despite spending twice as much on personal care services, DMAS does not collect any data on the costs of these services. This has raised questions about the adequacy of the reimbursement rates for personal care. However, the absence of reliable cost data from personal care providers prevents any systematic study of the cost of these services for the purpose of establishing payment rates.

This chapter presents the results from JLARC's analysis of the rate-setting process for community-based care. Based on the results of this review, recommendations are made to improve the reimbursement systems for some of the Medicaid-funded community-based care services.

FEATURES OF THE HOME HEALTH REIMBURSEMENT SYSTEM

Prior to 1991, home health agencies were reimbursed through a retrospective payment system. In this system, each provider was required to submit a cost report at the end of the fiscal year detailing total expenses for the visits they provided. After reviewing these reports, DMAS reimbursed these providers 100 percent of their allowable costs, subject to upper payment limits which were set by the Medicare program.

This type of payment system has been criticized as promoting inefficiency in the delivery of health care services. Because payments are linked directly to the reported costs of the agencies, there is no incentive for the providers to seek economies in the delivery of health care.

Recognizing this problem, DMAS switched to a prospective, flat-rate system of reimbursement in July of 1991. Through use of a predetermined flat fee, DMAS reasoned that it could establish stronger controls over home health expenditures, encourage providers to be more efficient in the delivery of services, and eliminate the administrative burden of reviewing cost reports. The next part of this chapter describes the key features of the reimbursement system used by DMAS to purchase home health services.

DMAS Prospective System is Based on Several Peer Groupings

Prospective flat rate payment systems are based on the concept that provider reimbursement rates should be set at a level which reflects the costs of the most efficiently operated agency. Without available measures of efficiency, an attempt must be made to classify facilities into peer groups based on factors which influence the cost of operation. One objective in grouping facilities is to ensure that any cost variations which may be due to factors beyond the control of the providers are consistently accounted for.

Once this is done, various methods can be used to identify what is believed to be the most efficiently operated facility in the peer group for purposes of setting the maximum payment rate for all providers in the group. When establishing the prospective payment system for home health providers, DMAS created peer groups based on geographic location and agency type. Within each of these peer groups, varying reimbursement rates were established for different types of services. Table 11 shows the different peer groups that are used to establish home health rates in Virginia.

Table 11

Home Health Agency Peer Groups

Peer Group	Number of Agencies
Northern Virginia Freestanding	8
Northern Virginia Hospital-Based	3
Rural Freestanding	20
Rural Hospital-Based	34
Urban Freestanding	40
Urban Hospital-Based	23
Virginia Department of Health	78

Source: Department of Medical Assistance Services Home Health Manual, May 31, 1991, and Virginia Department of Health.

Geographic Location. A primary factor which impacts the cost of home health service according to DMAS staff is the geographic location of the agency. Based on a consultant's study conducted in 1989 and its own cost analysis, DMAS decided to establish separate peer groups for Northern Virginia and all other urban and rural locations.

To define urban and rural, DMAS relied on the Standard Metropolitan Statistical Areas (SMSA) used by HCFA to establish upper payment limits for Medicare home health providers. The premise underlying this approach was that costs would be systematically different in three basic areas of the State. Therefore, the assumption in this approach is that agencies in high cost areas of the State may be as efficient as other providers but face higher average costs due to factors beyond their control.

Northern Virginia was expected to have the highest operating expenses due to greater wage demands and other input factors (e.g. cost of real estate) which increase the cost of delivering home care. Agencies operating in urban areas outside of Northern Virginia were generally thought to face the second highest operating cost of all home health providers, followed by those delivering services in the rural areas of the State.

Type of Agency. Perhaps the most controversial peer grouping used by DMAS is the distinction between home health agencies which are hospital-based and those considered freestanding. Agencies defined as hospital-based are functionally independent of the hospital but are linked for purposes of identifying expenses. Freestanding agencies are usually privately run, sole proprietary, or chain-operated facilities.

Historically, hospital-based home health agencies have reported higher costs due to the cost allocation system required by Medicare. Specifically, Medicare requires these agencies to report not only their direct cost of delivering services, but their proportionate share of the indirect or overhead costs for the entire hospital as well. National data indicate that this process for allocating expenses to home health agencies raises their reported costs to a level that is 13 percent higher than freestanding facilities. Therefore, by choosing to recognize hospital-based agencies as a separate peer group, DMAS is in effect agreeing to pay these agencies more for the same services provided by freestanding agencies.

In addition to hospital-based and freestanding agencies, home health services are also provided by local health departments. As with hospitals, DMAS recognizes these agencies in a separate peer group for purposes of establishing payment rates.

Varying Rates for Different Services. A key feature of the home health care reimbursement system is the distinction made between the different types of visits. Presently, providers can be reimbursed for five major types of services. These are skilled nursing, physical therapy, occupational therapy, speech therapy, and home health aide. Because the cost of the staff required for these types of visits differs significantly, DMAS incorporated varying fee schedules for each type of visit.

After establishing fees for each of these disciplines, DMAS further adjusted the rates to reflect the different cost associated with visits that are considered assessment, follow-up, and also comprehensive in the case of skilled nursing. During assessment visits, the home health care provider must conduct a thorough analysis of patient needs. Because these visits require more time than follow-ups, DMAS has set a higher rate for assessments (Table 12).

Table 12

Reimbursement Rates for Skilled Nursing Visits

Peer Group	Assessment	Followup	Comprehensive
Northern Virginia Freestanding	$ 92.73	$77.73	$155.46
Northern Virginia Hospital-Based	$100.18	$85.18	$170.36
Urban Freestanding	$ 72.37	$57.37	$114.74
Urban Hospital-Based	$ 90.63	$75.63	$151.26
Rural Freestanding	$ 72.78	$57.78	$115.56
Rural Hospital-Based	$ 91.67	$76.67	$153.34
Virginia Department of Health	$ 92.03	$77.03	$154.06

Source: Department of Medical Assistance Services, Home Health Agency Rates Effective January 1, 1992.

Comprehensive nursing visits are reimbursed at the highest rate because they require even longer stays in the home. For example, a comprehensive skilled nursing visit might involve intravenous administration of drugs, extensive wound care, or extended teaching sessions for family members of the patient.

ANALYSIS OF HOME HEALTH REIMBURSEMENT SYSTEM

To evaluate the appropriateness of the peer groups used by DMAS for its home health reimbursement system, JLARC staff used regression analysis. As noted earlier, this is a statistical technique that quantifies the effect of a set of independent or predictor variables on a dependent variable. The purpose of this analysis for home health was to determine what key factors appear to be associated with the cost of these services for the freestanding and hospital-based agencies that participate in Virginia's Medicaid program.

In general, the study findings suggest that the rate-setting methodology does not appropriately consider key factors which appear to be associated with the cost of home care. Moreover, the rates appear to be unjustifiably high for hospital-based agencies.

Peer Group Distinctions between Agencies is Not Necessary

To conduct this analysis, data were collected from the 1990 cost reports for all home health agencies that received a reimbursement for Medicaid in that year. The dependent variable for this study was the total cost of home care services per visit. This method of standardizing the dependent variable is a recognition that much of the variation in agency cost can be attributed to the number of visits provided. Once this was done, the remainder of the analysis was focused on isolating the impact of key independent variables and evaluating their contribution to the overall model used to assess these relationships. The variables used in the analysis are listed in Exhibit 2.

An underlying assumption of this analysis was that the cost of home care is a function of the price the agencies are willing to pay for various inputs (e.g. labor costs) and additional costs due to external factors over which they have little control, such as their geographic location. Ideally, the peer grouping system should be used to classify similar agencies along factors which impact cost but are outside of their control.

Using results from the regression analysis, JLARC staff could determine whether the key factors which appear to affect the cost of operating a home care agency are appropriately considered in the DMAS peer groups and reimbursement system.

Exhibit 2

Factors used in Analysis of Home Health Costs

Location Specific:

- Northern VA
- Central VA
- Southside VA
- Southeast VA
- Southwest VA
- Shenandoah Valley
- Northern Neck
- Outside of State
- Rural Localities

Service Specific:

- Skilled Nursing
- Physical Therapy
- Speech Therapy
- Occupational Therapy
- Medical Social Service
- Home Health Aide
- Percent Medicaid

Agency Specific:

- Administrative Hours
- Supervisory Hours
- Total Salary
- Service Salary
- Total Visits

Type of Facility:

- Freestanding Agencies
- Hospital-Based Agencies
- Local Health Department Agencies

Geographic Location. A key feature of DMAS' reimbursement system are the distinctions made between providers in Northern Virginia and those located in urban and rural areas. However, the results of the regression analysis do not completely support the use of this peer grouping system. While facilities in Northern Virginia do face higher costs, the difference in operating costs for rural and urban areas is minimal. (A separate technical appendix explains the methods used to conduct this analysis in greater detail and is available from JLARC upon request).

Specifically, home health agencies that are located in urban areas have operating costs which are on average about one percent lower than those in rural areas after accounting for other factors in the regression model. While this may seem counterintuitive, a closer look at the data indicates that a key factor influencing this result was the type of home health visit provided by the agencies.

Before this variable was considered in the model, significant cost differences could be observed between home health agencies in urban and rural localities. Specifically, average costs in urban areas were 12 percent higher than those in rural areas. However, together with geographic region, these two sets of variables explained less than 13 percent of the total variation in costs. After type of visit was added, the model explained almost 30 percent of the variation in the dependent variable and the cost differences between urban and rural localities was substantially diminished.

This suggests that the relationship between being located in an urban area and having higher home health cost is spurious, reflecting a greater tendency for agencies in these areas to provide a higher proportion of skilled visits.

The data on type of visits reported in Figure 40 confirms this finding. In 1990, agencies in urban areas provided almost two-thirds of all home visits in the State. Almost 15 percent of these visits were for the more expensive physical therapy services. Conversely, these type visits accounted for less than eight percent of the total number of visits provided by agencies in rural areas. Together, these findings call into question the peer group distinctions being made for urban versus rural locations.

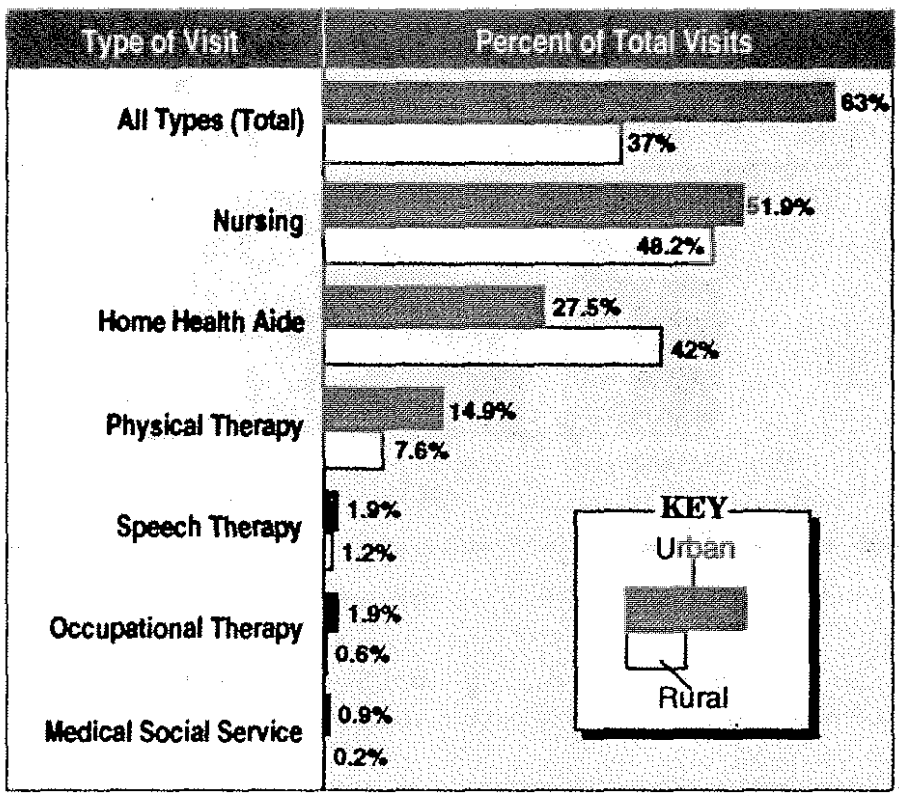
Recommendation (9). **The Department of Medical Assistance Services should eliminate the peer group distinctions between urban and rural localities for the purposes of establishing prospective payment rates for home health agencies.**

Higher Fees for Hospital-Based Agencies Not Justified

As discussed earlier, one aspect of the DMAS peer grouping system which has generated considerable debate is the special treatment granted hospital-based agencies for purposes of setting fees. Due to this distinction, these agencies receive higher fees than their counterparts for providing the same service. As an example, the fee schedule for skilled nursing services pays hospital-based agencies for each assessment, follow-up,

Figure 40

Type of Visit, by Urban/Rural Distinction, FY 1990



Notes: Totals do not include visits made by local health department agencies. Totals include visits made by agencies located outside of Virginia.

Source: JLARC staff analysis of data from cost reports submitted by home health agencies to the Department of Medical Assistance Services for FY 1990.

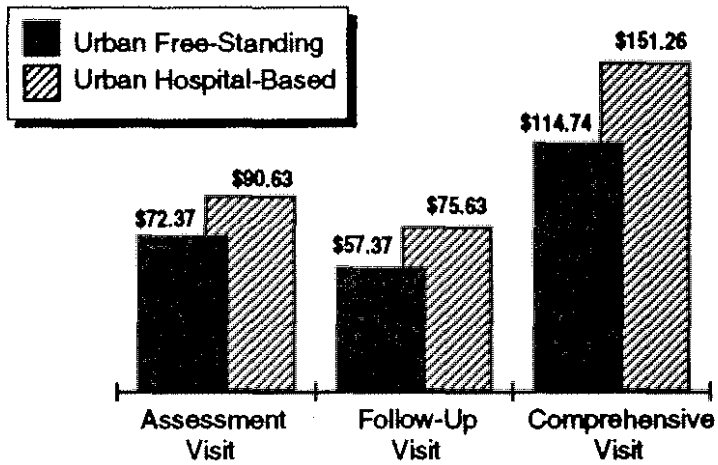
or comprehensive visits at a rate that is in some cases 30 percent higher than similar rates for freestanding agencies (Figure 41).

Administrators from the hospital-based agencies that were visited by JLARC staff for this study defended this practice on two grounds. First, it was stated that the higher fees are necessary because these agencies serve a higher proportion of patients requiring skilled care. This, according to those interviewed, results in a higher average cost per visit. Second, hospital administrators suggested that because these agencies could not afford to operate with lower fees, they would be forced to leave the program which would give rise to access problems, especially in rural areas of the State.

Basis for Higher Costs in Hospital-Based Agencies. The purpose of this analysis was to determine if cost differences exist between hospital-based and freestanding agencies after accounting for other factors such as patient mix, geographic region, agency size, and salary structure. Because these are the major factors related to the costs of

Figure 41

Comparison of Reimbursement Rates for Skilled Nursing



Source: Department of Medical Assistance Services' home health agency rates effective January 1, 1992.

delivering home health care, any remaining cost differences due to agency type would be a possible indicator of inefficiencies or excessive costs.

Variables representing agency type, geographic region, type of service, total visits, hours allocated to administration, and staff salaries accounted for more than 37 percent of the variation in home health costs per visit. When the variable representing agency type was added to the model, the percentage of variation explained increased to 41 percent. More importantly, the cost of operation for freestanding facilities was, on average, 23 percent less expensive than hospital-based agencies.

This raises important questions about the source of these cost differences. Because the effect of facility type is independent of patient mix, agency size, geographic region, and staff salaries, these differences appear to reflect the impact of the "step-down" cost allocation process used by hospital-based agencies. While Medicare requires that this cost allocation process be used to identify agency expenses and revenues, it does not require states which use a fee for service system to recognize these allocated costs in the reimbursement process for home health care.

The Issue of Access. Whether an elimination of higher fees for hospital-based agencies would cause an access problem is a question that can not be fully addressed in this study. However, in a national study of this issue, the United States General Accounting Office (GAO) rejected this notion on three grounds.

First, it was demonstrated that the percentage of freestanding for-profit home health care providers increased in number and share of the home health market from 1979 to 1990. Second, GAO pointed out that one-third of the hospital-based home health

agencies in the country reported costs that were below the federally-established limits for freestanding agencies. Third, no evidence could be found that the availability of an add-on for allocated costs was the deciding factor in the operation of a home health agency.

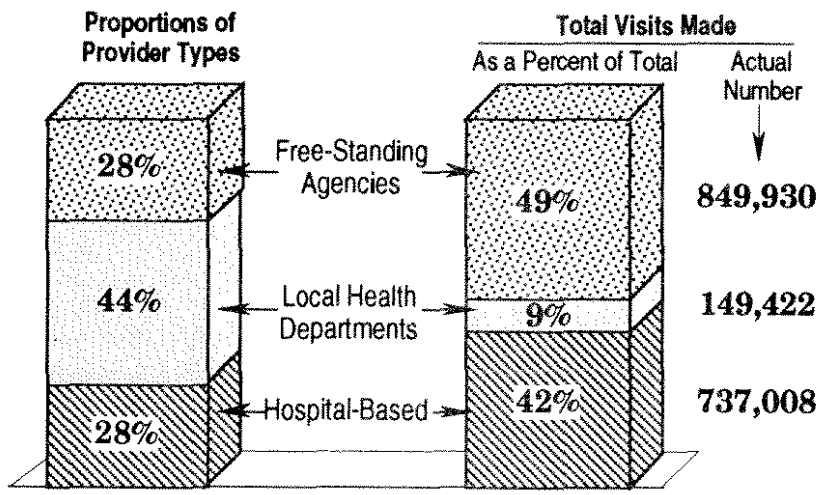
In FY 1990, there were an equal number of freestanding and hospital-based agencies in the State. When the local health departments that provide these services are considered, both freestanding and hospital-based agencies account for 28 percent of all providers (Figure 42). However, freestanding agencies provided 49 percent of the total home health visits in the State in 1990. This compares to 42 percent for hospital-based agencies.

One concern expressed by DMAS staff was whether freestanding agencies would take on the difficult cases in rural areas. They point out that "bottom-line" oriented freestanding providers often can not financially justify traveling long distances to provide care in isolated areas. Further, during interviews with staff at the hospital-based agencies, the claim that freestanding providers refuse to accept cases in rural areas was repeatedly cited.

The general consensus of freestanding providers was that hospital-based agencies get a larger share of cases that are less difficult to care for. This happens, they pointed out, because most referrals for home health care originate from hospitals. As a result, hospital-based agencies can screen their potential clients and select the "cream of the crop."

Figure 42

Types of Home Health Providers and Visits Made by Each Type, FY 1990



Source: JLARC staff analysis of data from cost reports submitted by home health agencies to the Department of Medical Assistance Services for FY 1990.

The central question regarding the issue of higher fees for hospital-based agencies is whether they are necessary to ensure the operation of these facilities. Because the additional costs which are recognized are indirect expenses for the overall administration of the hospital, there is no clear relationship between these costs and the services provided by the home health agencies. Further, when regression analysis is used to account for the key factors thought to be related to the delivery of home care services, substantial cost differences between freestanding and hospital-based agencies remain.

Under a retrospective cost-based reimbursement system which pays providers 100 percent of their reasonable costs, there is room for recognition of expenses allocated from general hospital overhead. However, this approach is not consistent with the goals of the fee-for-service system which are to encourage the efficient delivery of home health services.

According to the Director of DMAS, the agency has recently reconsidered its position on this issue and is presently developing a policy to address the problem. Although the policy has not been finalized, the Director stated that it would involve paying higher fees to only those hospital-based agencies in areas "underdeveloped with freestanding providers."

A variation of this approach could be to use a referral system. With this strategy, DMAS would retain the right to pay higher fees to hospitals if there are no freestanding agencies willing to accept a home health referral regardless of the number of providers in the area. This would require each hospital-based agency to initially refer all persons approved for home care to a specified number of freestanding agencies, unless the hospital-based agency was willing to accept the regular fees. If the freestanding agencies that were contacted turned down the referral, the hospital-based agency could bill DMAS at the higher rate.

Recommendation (10). **The Department of Medical Assistance Services should eliminate the distinctions made for hospitals when establishing fees for the delivery of home health services. In addition, the Department should only authorize payment of a higher fee to hospitals if there are no freestanding agencies which will agree to accept the home health care referral.**

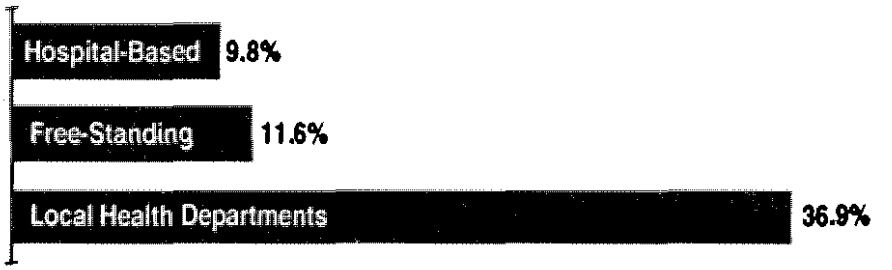
Health Departments Are Treated as Special Cases

Local health departments play a small but significant role in the delivery of home health services. While they account for only nine percent of all the visits provided in the State, they provide a larger proportion of visits to Medicaid recipients (Figure 43).

Reasons for Higher Fees. As noted, DMAS places the local health departments in a separate peer group for the purpose of setting fees for the Medicaid visits they provide. According to a staff member in the Cost Settlement and Audit Division, one reason for this is that local health departments are viewed as the provider of last resort for many patients. As a part of their mission, these agencies will accept cases that other

Figure 43

Medicaid Visits as a Percent of the Total Visits Made by Each Type of Provider, FY 1990



Source: JLARC staff analysis of data from cost reports submitted by home health agencies to the Department of Medical Assistance Services for FY 1990.

providers are unwilling to accept. In many instances, these are patients who live in isolated areas of the State.

A second reason for the higher rates was to maximize the federal revenue for an existing State service. The Virginia Department of Health (VDH) identifies home health costs for all local health departments on one statewide cost report. Prior to FY 1992, VDH used a cost allocation process to determine the total cost of home health visits. As a part of this process, a proportion of the administrative overhead cost for the entire agency was allocated to each revenue producing unit in the local health departments. As indicated by Table 13, this resulted in a statewide cost per visit for health departments that was substantially higher than all other providers, including hospital-based agencies.

Table 13

Agency Characteristics for Home Health Agencies

	All Agencies	Hospital-Based	Free-Standing	Health Department
Total Visits	1,736,360	737,008	849,930	149,422
Average Cost per Visit	$61.10	$65.06	$56.69	$88.53

Source: JLARC staff analysis of data from cost reports submitted to the Department of Medical Assistance Services for FY 1990.

By establishing a separate peer group with a higher rate for home health services, the State effectively used Medicaid funding to subsidize the normal operating costs of its health department. Because the fees established for the State are in many cases higher than those for freestanding providers, the obvious effect is an increase in Medicaid spending.

DMAS had the option to impose a lower fee for these agencies which could have produced some minor savings in Medicaid spending. However, if the health departments were unable to actually reduce the costs of providing these services, the State would have been forced to replace the Medicaid funding losses with general fund dollars. Thus, while the amount of Medicaid spending would have be reduced, the cost to the State would have increased.

Changes in Cost Allocation. In 1991, federal officials reviewed the cost allocation method used by VDH and ruled that the agency could no longer use this approach. Instead of revising the approach, VDH decided against allocating any indirect overhead cost to the home health units. This effectively lowered the reported average home health costs for local health departments in FY 1992 to $66 per visit.

When DMAS staff were asked about the effect of this on VDH's Medicaid reimbursement, they indicated that they were not aware of the agency's decision to discontinue allocating general overhead expenses. However, they point out that if VDH's overhead costs are not reflected in the cost reports for home health agencies when they are reexamined in five years, the agency could receive a lower Medicaid reimbursement at that time. In the interim period, VDH will continue to receive the fees for Medicaid visits which were based on an analysis of its 1989 cost report.

Cost Impact of Recent Legislation Not Considered

Recent legislation requires that home health care providers provide criminal record checks, hepatitis B vaccine, pay for inservice training, orientation, counseling and adhere to the Americans with Disabilities Act hiring procedures. One provider estimated that these new regulatory requirements will cost their agency almost $23,000 per year. Because these regulations became effective this year, the impact of their costs has not been considered in current reimbursement strategies. When updating the rates for home health care, steps should be taken to factor in the impact new regulations will have on the cost of providing services.

Recommendation (11). **The Department of Medical Assistance Services should consider any additional costs incurred by home health agencies due to federal or State regulations when updating reimbursement rates.**

THE ADEQUACY OF HOME HEALTH FEES

While cost containment is a key objective of a prospective flat rate reimbursement system, some attention must also be given to whether existing rates are adequate. If agencies are reimbursed at levels that are below the reasonable costs of an efficient provider, access problems can develop for Medicaid recipients.

The objective of this analysis is to evaluate the adequacy of DMAS' reimbursement fees for home health care. The results of the analysis indicate that the measure of central tendency used by DMAS to establish home health fees are calculated using questionable methods and may not accurately reflect the cost of an efficiently operated home health agency.

Medicaid Home Health Fees May Not Accurately Reflect Provider Cost

As noted in Chapter IV, the most difficult aspect associated with developing a prospective flat rate payment system is determining the amount of the fee which should be used to represent the cost incurred by the typical provider. In creating such a system, the objective is to establish a rate which is high enough to provide an incentive for providers to accept Medicaid patients, but low enough to discourage inefficiencies in the delivery of the services.

In establishing the fees for most of the home health peer groups, DMAS' cost audit staff used a "weighted median." To calculate this statistic, agency staff conducted the following steps:

- First, each home health agency was placed in its appropriate peer group.
- Second, the Medicaid cost per visit by discipline (exclusive of medical supplies cost) was obtained from the 1989 cost reports for each home health agency and inflated to a common point (June 30, 1991).
- Third, all agencies that had extremely high or low cost relative to this average were dropped from the analysis.
- Fourth, using this reduced number of cases, the home health agency's per visit rates were ranked and weighted by the number of Medicaid visits per discipline to determine a median rate per visit for each peer group.

Impact of Dropping Outliers before Calculating Median. When an attempt is made to represent a distribution of data with a single parameter, the two most frequently used measures of central tendency are the mean (or average) and the median. If data are skewed by extreme values or outliers, the mean, which is sensitive to outliers will likely be unrepresentative of most of the cases in the data.

Table 14 illustrates the impact of outliers on the costs data for home health agencies. The skewness statistic reported in Table 14 measures the degree to which the data are normally distributed. As values of skewness depart from zero, this could indicate that outliers are exerting a higher degree of influence on the average calculated from the distribution of data. In most cases, the average cost per visit for each home health peer group used by DMAS was skewed by outliers in the data.

To compensate for this, DMAS calculated a "weighted median." The advantage of using a median with skewed data is that it is not sensitive to outliers. This statistic has this property because it represents the middle point in the data. However, before the median was identified, DMAS staff dropped from each peer group all of the home health agencies with costs that were outside of one standard deviation from the mean.

Table 14

Descriptive Statistics for Key Independent Variables for Analysis of Home Health

Variable	Mean	Median	Skewness	Range
Medicaid Visits as a Percent of Total	12.8%	9.5%	2.096	71.2%
Skilled Nursing Visits as a Percent of Total	50.3%	51.5%	-0.334	67.1%
Physical Therapy Visits as a Percent of Total	11.7%	10.0%	2.058	69.6%
Speech Pathology Visits as a Percent of Total	1.6%	0.9%	1.729	8.7%
Occupational Therapy Visits as a Percent of Total	1.3%	0.3%	2.507	13.3%
Home Health Aide Visits as a Percent of Total	33.7%	31.6%	0.520	70.5%
Supervisory Hours as a Percent of Total	5.8%	0%	4.153	97.5%
Administrative Hours as a Percent of Total	27.8%	25.4%	1.137	100%

Source: JLARC staff analysis of data from cost reports of home health agencies submitted to the Department of Medical Assistance Services for FY 1990.

The problem with this strategy is that it was unnecessary given the decision to use the median as the basis for establishing the peer group fees. More importantly, it artificially lowers the median cost of home health services in each peer group because most of the agencies excluded were high cost providers. When cases are systematically dropped from the upper half of the data, the effect is to move the middle point of the data — the median — further down in each peer group.

To illustrate, Table 15 compares the median cost values for skilled nursing from a list of freestanding providers in Northern Virginia, to the median from the same group of providers in which the outlier cases have been dropped. As shown, the median from the reduced dataset is smaller. This weakens the median as an indicator of the typical costs that these agencies incur in providing home visits.

Table 15

Comparison of Median Values With and Without Outliers

Cost per Visit With Outliers		Cost per Visit Without Outliers	
$149.02			
137.26		$107.01	
107.01		92.51	
92.51	**(Median)**	**84.51**	**(Median)**
84.51		77.25	
77.25		73.37	
73.37			

Source: JLARC staff analysis of data provided by the Department of Medical Assistance Services.

Alternative Methodology Can Improve Rates

Given the problem with this approach, the question is what measure of central tendency should be used to establish the peer group fees for Medicaid home health services. There are numerous parameters which can be used as a measure of central tendency. However, the three most commonly used are the mean, median, and weighted average.

When determining the impact of each of these statistics, JLARC staff used only two peer groups — Northern Virginia and the rest of the State. This decision was based on the previously discussed results of the regression analysis of factors influencing home health costs.

Arithmetic Mean. The mean (or average) is the most common measure used to make inferences about a dataset. The advantages of using the mean include its conceptual simplicity, and its efficiency. Compared to other measures of central tendency, the mean has the lowest variance. In other words, it is influenced by the amount of dispersion in the data. Therefore, as a indicator of the costs of home health services for a particular peer group, each agency's costs will be reflected in this average value.

Unfortunately, the strength of this measure is also its weakness. Because it is influenced by the value of each data point, this measure is more highly influenced by significant outliers in the data, compared to other measures of central tendency.

To project the cost of Medicaid home health services through the use of the mean, JLARC staff first calculated this statistic for the two peer groups. Next, the number of visits provided by each agency in the peer group were multiplied by the mean to determine total projected costs. Table 16 illustrates the difference in costs that result from the use of the mean as the prospective flat fee. It is estimated that using the average as the peer group ceiling would cost the State more than $2 million more than using the DMAS "weighted median."

Apart from the question of the impact of outliers on this measure is its stability. If the mean were selected as the prospective payment fee for each peer group, appropriate adjustments could possibly be needed over time to prevent the ceiling from dropping below desired levels. If home health agencies, in response to the ceiling, worked to push their costs below this level, any future rebasing of the system could result in even lower ceilings. This would in effect be a penalty for those providers who had worked to keep their costs beneath the ceiling.

Table 16

Comparison of Home Health Costs Using the Average

Service	DMAS Weighted Median	Average
Skilled Nursing	$4,797,753	$ 6,314,450
Home Health Aide	1,751,229	2,244,852
Physical Therapy	813,891	934,172
Speech Therapy	259,307	339,867
Occupational Therapy	195,033	249,017
Total	$7,817,213	$10,082,358

Notes: The cost figures calculated by JLARC using the average cost per visit as the fee for each peer group does not account for Medicare upper payment limits which could cap the per visit fee at a lower level.

Source: JLARC staff analysis of data provided by the Department of Medical Assistance Services

Straight Median. As discussed earlier, the median is the best measure to use when there are outlier cases in the data because it is not influenced by these values. Also, because it is simply the middle point in the data it is easily understood by the provider community and would have more stability over time than an average.

The major disadvantage of the median is that its value would not reflect the cost differences between the various providers as much as the mean. Therefore, if there is a tendency for a substantial number of home health operators to provide services at costs which are significantly above or below the median, this type of dispersion would have no impact on the peer group ceiling.

Table 17 compares the costs of providing home health services using the straight median with DMAS' "weighted median." As shown, DMAS' "weighted median" is still a less expensive alternative. However, the difference in effect between the two measures is less than a million dollars.

Weighted Mean. The third option examined in this analysis was a weighted mean. The purpose of using this measure is to give more influence to the costs incurred by large providers. This approach considers the cost per visit of all of the agencies within a peer group and weighs it by the number of visits the agency provided.

One objective for using a weighting scheme is to give more influence to the large providers under the assumption that their costs are more likely to be typical of the provider community than smaller agencies. Thus by giving more weight to large providers, smaller agencies which may have higher costs due to temporary diseconomies of scale, do not exert an equal amount of influence on the average.

Table 17

Comparison of Home Health Costs Using the Median

Service	DMAS Weighted Median	Straight Median
Skilled Nursing	$4,797,753	$5,563,142
Home Health Aide	1,751,229	1,786,015
Physical Therapy	813,891	890,766
Speech Therapy	259,307	281,243
Occupational Therapy	195,033	210,434
Total	$7,817,213	$8,731,600

Notes: The cost figures calculated by JLARC using the median cost per visit as the fee for each peer group does not account for Medicare upper payment limits which could cap the per visit fee at a lower level.

Source: JLARC staff analysis of data provided by the Department of Medical Assistance Services.

Table 18 compares the costs of providing home health services using the weighted mean with the DMAS' current measure. The weighted mean results in cost approximately $540,000 more than those produced by DMAS' "weighted median."

In selecting a measure of central tendency for home health costs, the goal should be to use the measure which will ensure that efficient providers of the service are not penalized. The methods used by DMAS to calculate the "weighted median" appears to have underrepresented the costs of the typical home health agency and cannot be supported by normal statistical practice.

Recommendation (12). **The Department of Medical Assistance Services should use a revised statistical approach for setting the fees in each peer group.**

Table 18

Comparison of Home Health Costs Using the Weighted Mean

Service	DMAS Weighted Median	Weighted Mean
Skilled Nursing	$4,797,753	$5,186,373
Home Health Aide	1,751,229	1,826,148
Physical Therapy	813,891	838,708
Speech Therapy	259,307	287,204
Occupational Therapy	195,033	218,766
Total	$7,817,213	$8,357,199

Notes: The cost figures calculated by JLARC using the weighted mean per visit as the fee for each peer group does not account for Medicare upper payment limits which could cap the per visit fee at a lower level.

Source: JLARC staff analysis of data provided by the Department of Medical Assistance.

THE RATE SETTING PROCESS FOR PERSONAL CARE

Personal care is the oldest of the home and community based care waiver programs. In FY 1991, approximately $30 million in Medicaid funding was used to pay for these services. More recently, the State has funded a number of additional community care programs designed to provide more specialized services that will enable persons with acute health care problems to remain in the community. The objective of this part of the study was to evaluate the rate-setting process for personal care services and determine whether DMAS's policy for setting these rates is appropriate.

Despite the key role these services play in the nexus of long-term care services funded through Medicaid, DMAS has not developed a systematic method for analyzing the cost of these services and establishing fees to promote an efficient delivery of this care. The payment rates for the different types of community care appear to be arbitrarily set and could understate the true cost of these services.

No Methodology for Setting Personal Care Rates

According to DMAS staff, when the personal care program was established through a federal waiver in 1982, the rate structure was designed to fully reimburse providers for the cost of the services. One goal with this approach was to expedite development of the provider community so that some of the costs of the more expensive nursing home services could be avoided.

The initial rate established for the program was $7.00 for each hour of personal care delivered by these agencies. This rate was determined based on minimum wage figures and estimated administrative overhead costs. For the next six years, there was no increase in the rates for these services. Moreover, DMAS did not establish any policies defining what costs it would continue to recognize as allowable, nor were providers required to file cost reports.

In 1988 the rates were increased to $8.50 per hour for agencies located in Northern Virginia and $8.00 per hour for the rest of the State. This rate differential was implemented by the General Assembly after recognizing the higher operating costs associated with that area of the State. In 1990, the Northern Virginia rate was again raised to $9.50.

DMAS Proposed Rate Changes. In a budget amendment submitted in the fall of 1990 to the Department of Planning and Budget (DPB), DMAS proposed an increase in the reimbursement rate from $9.50 to $11.00 in Northern Virginia and from $8.00 to $10.20 for the rest of the State. In addition DMAS proposed the use of a fee inflator which would automatically increase the rates at the beginning of each fiscal year. According to the Director of the agency, the proposal for the higher rates was designed to address what was felt to be a problem of access in key areas of the State.

The basis for DMAS specific rate proposals was data collected during a survey by the Virginia Association of Home Care (VAHC) in October 1990. This survey asked providers to calculate the total cost of providing personal care using a data collection form and methodology developed by the Association.

Although the response rate of the survey was considered too low to make inferences about the entire provider community, VAHC generally found that the reimbursement rate at the time of the survey was lower than the average cost per hour calculated by the agencies.

DMAS' request for a rate increase was reviewed by the General Assembly and a decision was made to set the rates based on what the State could afford to pay. As a result, the reimbursement rate was increased once again in January of 1992. The current rate for Northern Virginia is $11.00 and $9.00 for the rest of the State. An inflation factor was not considered in any of these increases according to DMAS staff.

Assessing the Adequacy of Rates. Without reliable data on the costs of personal care services, there is no objective way to evaluate the adequacy of the rates. Perhaps the best available indicator is the current location of personal care agencies across the State. Despite being the most populated area in the State, only nine percent of the current personal care providers are located in Northern Virginia (Figure 44). Similarly, six percent of the providers are in the Northern Neck portion of the State.

Lack of providers also appears to be a problem in some of the rural areas of the State. Approximately 10 percent of the providers are located in Southwest Virginia. Slightly less than 10 percent are concentrated in the Shenandoah Valley.

Because of the dearth of providers, some agencies must cover larger portions of the State. As a result, the larger the area an agency must cover, the greater the problem of access.

According to DMAS staff, 20 providers cancelled their contracts for the provision of personal care from June 1989 through July 1990. During interviews with staff at various personal care agencies, complaints were consistently made about the inadequacy of the rates. Without rate increases to account for general wage growth in the labor market, providers state that they are finding it difficult to keep their personal care aides.

Like home health, recent legislation requiring criminal record checks on all personal care aides will have an impact on the cost of providing care. When asked if DMAS was considering a rate-setting methodology for personal care services, the Director stated that no such plans were being developed.

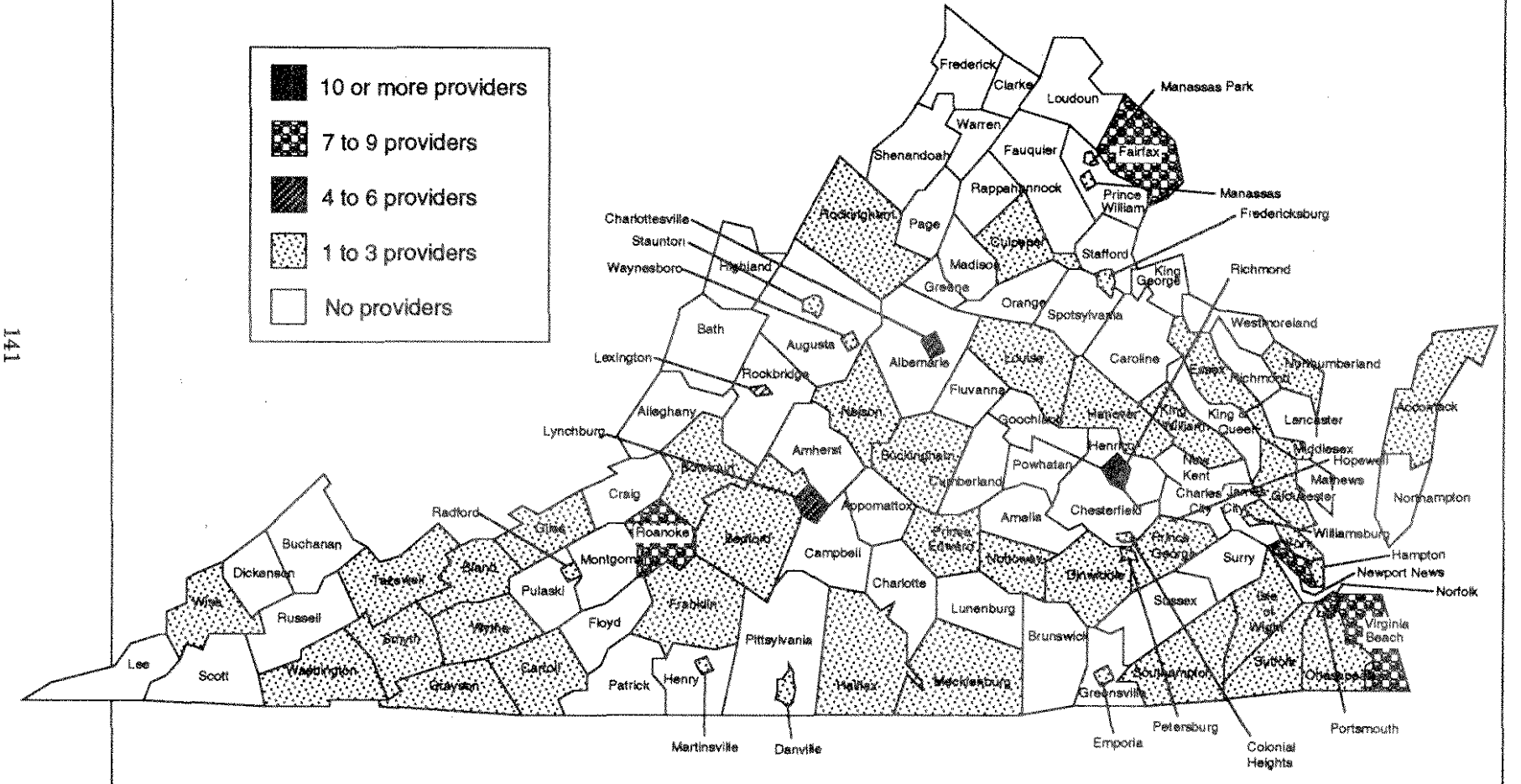
No Methodology Exists for Other Waiver Programs

There are currently five home and community-based waivers that DMAS administers. Each of the service programs within these waivers is designed to provide home-based care as a less expensive alternative to institutionalization. However, like personal care, there is no systematic process in place to set the rates for four of these community services. Table 19 lists all of the service programs provided by DMAS through home and community-based waivers.

As with personal care, the Technology Assisted Waiver (TAW) program is a major concern in the provider community. Providers maintain that participation in the program remains low due to inadequate reimbursement rates. The program was first implemented by DMAS in December 1988 to treat ventilator-dependent children. It was expanded in 1990 to include other children with high-technology needs. The objective

Figure 44

Location of Personal Care Providers



Source: Department of Medical Assistance Services' list of personal care providers.

Table 19

Home- and Community-Based Care Waivers

Service Program	Effective Date	Last Rate Increase	Rate Setting Methodology?
Elderly and Disabled Waiver			
Personal Care	Nov 1982	Jan 1992	No
Adult Day Care	July 1989	July 1989	No
Respite Care	July 1989	July 1989	No
Technology Assisted Waiver			
Private Duty Nursing	Dec 1988	July 1990	Yes
Respite Care	Dec 1989	Dec 1989	Yes
AIDS Waiver			
Private Duty Nursing	Feb 1991	Feb 1991	No
Personal Care	Feb 1991	Feb 1991	No
Respite Care	Feb 1991	Feb 1991	No
Case Management	Feb 1991	Feb 1991	No
Mental Retardation Waivers (2 Waivers)			
Residential Support	Feb 1991	Feb 1991	No
Habilitation	Feb 1991	Feb 1991	No
Day Support	Feb 1991	Feb 1991	No
Therapeutic Consultation	Feb 1991	Feb 1991	No

Source: Department of Medical Assistance Services, Quality Assurance Division.

of the program is to provide the opportunity for children with acute care needs to receive services in their home.

The severity of the problems faced by some of the children in the program and the potential cost-effectiveness of the service is illustrated in the case example for one of the 60 children that were served in TAW in 1991.

> *A one-year-old child with "Hirshsprung Disease" was hospitalized for the first five months of her life. During her hospitalization, the doctors removed a major portion of her intestine. After being admitted to the TAW program, she was able to live at home where she receives continuous gastrostomy tube feedings and 12 hours of supervised care. The cost of one year of home care according to the provider is less than half of the $328,000 that the State would have paid to keep her at the Medical College of Virginia.*

Reimbursement Process. Currently there are thirty-six providers in the State who participate in TAW. In 1991, these agencies provided services to 60 children.

DMAS did apply a formula to establish the initial rate for this program. However, no mechanism has been put in place to regularly evaluate the appropriateness of the rates. Rates were originally set based on the average wage for nursing staff plus 1.5 overhead. When the program was initiated the reimbursement rate was set at $19.00 per hour. Since that time, rates have been adjusted to differentiate between geographic location and the skill of nursing involved. The current rates are $30 per hour for a registered nurse (RN) in Northern Virginia and $26 for a licensed practical nurses (LPN). For the rest of the State, RNs receive $21.60 per hour and LPNs $19.60.

According to providers in the TAW program and case management workers, obtaining qualified nursing staff that is willing to work at current rates is becoming increasingly difficult. Because of the severe health care needs of the children in this program, highly skilled nursing services are needed.

The absence of a formal rate-setting process means that agencies are not reimbursed for costs that occur due to factors beyond their control. The most recent example of this is the previously mentioned legislation mandating criminal record checks and hepatitis B vaccine shots.

Formal Rate-Setting Process is Needed

Without data on the costs of the services provided by personal care agencies across the State, objectively determined rates can not be developed. As the administrative agency responsible for Medicaid, DMAS should develop a system of cost reporting for these services. Appropriately designed, this system could be used to support any proposed rate changes by the Department for the range of personal care services funded by Medicaid. At a minimum, this system of cost reporting should include guidelines defining what costs are allowable, whether certain allowable costs will be capped, and whether an inflation factor will be used to periodically adjust the proposed rates for these services.

Recommendation (13). **The Department of Medical Assistance Services should conduct an analysis of the cost of services in the personal care program. To conduct this analysis, the Department should require all (or a sample) of providers to submit financial reports which identify the cost of the services provided by these agencies. Based on an analysis of these reports, the Department should develop a methodology for setting reimbursement rates for these providers on an annual basis. The first set of rates should be established in time for consideration by the 1994 General Assembly.**

Recommendation (14). **The Department of Medical Assistance Services should assess the cost impact of relevant federal and State regulatory changes on each of its special waiver programs. Based on this analysis, the Department**

should develop a proposal for rate changes for the programs in time for consideration by the 1994 General Assembly.

CONCLUSIONS

Community-based care services are an important part of the array of long-term care benefits provided by Medicaid. If appropriately designed and implemented, these services can play a significant role in reducing the Medicaid expenditures because they are much less expensive than the traditional forms of long-term care.

However, the process used by DMAS for setting home health reimbursement rates does not appropriately consider the factors which influence costs. Some of the distinctions made for geographic region are not necessary. In addition, the higher fees paid to hospital-based agencies are not justifiable.

With the other community-based health care programs, there is no systematic method for identifying the costs of these services. DMAS does not collect cost report data from the agencies that provide these services or regularly evaluate the impact of federal and state regulations on the price of community care. This has raised questions about the adequacy of the current rate structure for these services.

VII. Improving Utilization Review and Cost Audit Operations

As part of its overall efforts to contain Medicaid long-term care spending, the Department of Medical Assistance Services (DMAS) conducts utilization review and cost audit activities. Utilization review serves as a control mechanism for the amount and type of long-term care that is provided. Control of utilization is necessary to ensure that the Commonwealth pays only for those long-term care services that are necessary and appropriate.

Certain aspects of utilization review have been strengthened over the past several years. In addition, payments made for home health services are, for the first time, receiving scrutiny under the Department's recently adopted utilization review program for home health. However, other improvements can still be made, especially in the review of ICF/MR services where the process appears to be ineffective and burdensome.

Cost settlement and audit serves as a financial control mechanism for Medicaid reimbursement. Financial control is necessary to ensure that the Commonwealth pays only for those costs explicitly allowed under the established principles of reimbursement. Financial controls are also necessary to ensure the reliability of a provider's reported cost information. Without these controls, the Commonwealth could spend more general funds than necessary on Medicaid long-term care services.

The Department has also improved its cost settlement and audit efforts. For example, the amount of provider cost data collected and audited by DMAS has increased. However, further improvements are still required. In particular, the amount of time required for settlement needs to be reduced. In addition, the selection of providers for field audits needs to be improved.

This chapter evaluates the utilization review and cost audit activities of DMAS. Based upon an examination of the objectives and procedures for conducting these activities, recommendations for improved operations are made.

OVERVIEW OF LONG-TERM CARE UTILIZATION REVIEW

Under federal regulations, DMAS must provide for the continuing review and evaluation of the care and services covered by the Medicaid program. DMAS must ensure that the care paid for by Medicaid is appropriate, necessary, and of sufficient quality.

This section provides a description of long-term care utilization review in Virginia. Overall, the study found that the applicable federal regulations are rather

general. Within this regulatory framework, DMAS has designed a utilization review program consisting of two general components: utilization control and quality assurance.

Federal Requirements Are Broadly Defined

Federal regulations require states to have on-going utilization review programs in order to participate in Medicaid. The requirements for utilization review are to:

- Safeguard against unnecessary or inappropriate use of services, and against excess payments;
- Assess the quality of services;
- Provide for the control of service utilization;
- Conduct on-going evaluation of the need for services and the quality and timeliness of those services; and
- Perform a post-payment review consisting of the development and review of recipient utilization profiles and provider service profiles.

DMAS Reviews Appropriateness and Quality of Long-Term Care

Long-term care utilization review is conducted primarily by the DMAS Quality Care Assurance Division. This division conducts utilization control and quality assurance programs through a number of research and investigative activities. In addition, the Division of Program Compliance is beginning to play a small role in long-term care utilization review. The Virginia Department of Health (VDH) through its State licensure and Medicaid certification inspections, also conducts quality assurance activities.

Quality Care Assurance Division. This division consists of the long-term care section, the community-based care section, and the medical support section. The long-term care section reviews nursing homes, ICFs/MR, and home health agencies. The community-based care section reviews personal care agencies. The medical support section is not involved in the review of long-term care services. The division's primary objectives are:

- To review the quality of care provided to recipients;
- To determine the adequacy and appropriateness of services available to meet the current health needs of recipients,
- To promote the maximum physical and emotional potential of each recipient;

- To determine the level of care of each recipient;

- To examine the necessity and desirability of continued care or placement of the recipient;

- To determine the feasibility of alternative care plans to meet the needs of the recipient; and

- To verify the existence and appropriateness of all documentation required by Medicaid.

Program Compliance Division. The program compliance division conducts a post-payment review process. This process includes the analysis of trends which might point to problems with certain providers. For example, close attention is given to providers with continued billing irregularities. These providers are investigated to determine if a situation of fraud or abuse exists.

Although this activity can be an effective tool for curbing the misuse of Medicaid funds, long-term care providers constitute only about 30 percent of the program compliance case mix. However, long-term care comprises 47 percent of total Medicaid spending. Program compliance has only recently begun to investigate some home health agencies. It should be noted that characteristics of the reimbursement system limit the ability of DMAS to perform such reviews for some long-term care providers. For example, since nursing homes bill on a per-diem basis, there are few details for program compliance to examine to determine if the billing is appropriate. Most of the emphasis for these post-payment reviews continues to be on hospitals and physicians.

Recommendation (15). **The Department of Medical Assistance Services should examine the post-payment review process conducted by the Division of Program Compliance. The examination should focus on developing procedures by which the number of post-payment reviews of nursing homes, intermediate care facilities for the mentally retarded, home health agencies, and personal care agencies can be increased. All additional reviews should be coordinated with the the Quality Care Assurance Division. The Division of Program Compliance should report the results of its analysis to the director by June 30, 1993.**

EFFECTIVENESS OF LONG-TERM CARE UTILIZATION REVIEW

The utilization review process varies according to the type of long-term care. It includes elements of prospective, concurrent, and retrospective review. Prospective review evaluates the appropriateness and necessity of care before it is delivered and can be used to determine whether care should be provided. Concurrent review is performed during the time that service is being delivered and can be used to assess the quality of the care. Retrospective review is performed after the service has been provided and can be used to determine whether reimbursement was appropriate.

This section examines the effectiveness of long-term care utilization review activities. The effectiveness of utilization review varies according to the type of care for which it is performed. The utilization review process for nursing home care is designed to ensure that only persons who are dependent in the basic activities of daily living are approved for nursing home service. This prevents the expenditure of resources for persons who are financially eligible but whose care needs are not considered to require nursing home placement. Recipients are discharged if it is determined that they no longer require nursing home care.

Personal care utilization review now includes strong control and quality assurance components. However, this process does not adequately evaluate whether persons who are receiving personal care continue to be at imminent risk of nursing home placement. Also, certain improvements should be made to other aspects of long-term care utilization review, particularly for ICF/MR and home health services.

Personal Care Utilization Review Generally Works Well

The primary goal of personal care utilization review is to ensure that services are appropriate for the recipient's needs. The review activities of the JLARC study indicate that personal care utilization review efforts are generally thorough. This process appears to control service use, and provides close monitoring of the quality of care. However, DMAS needs to ensure that it adequately evaluates whether the recipient continues to be at imminent risk of institutionalization.

Utilization Review Objective and Procedures. Personal care utilization review has four general objectives:

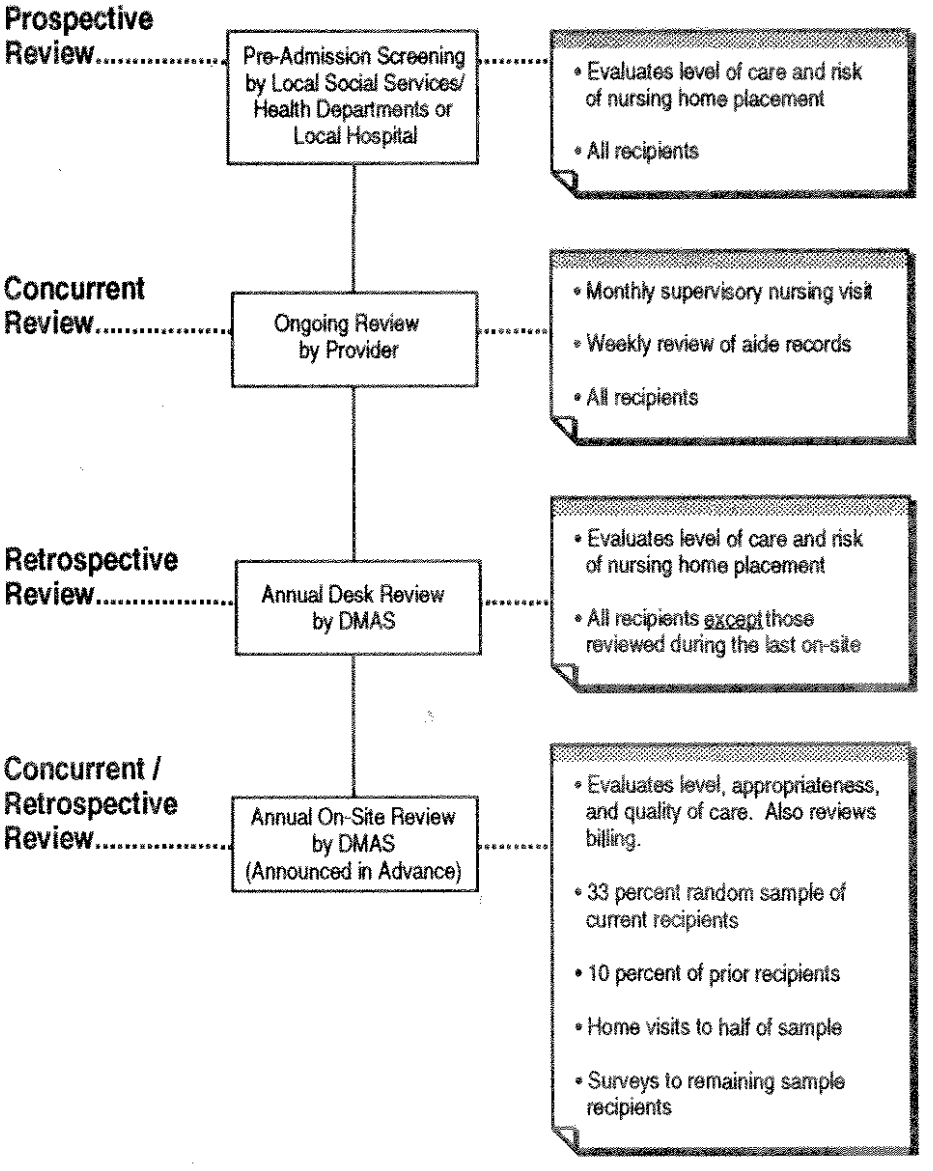
- To ensure that the recipient is at imminent risk of nursing home placement;
- To ensure that the personal care services authorized meet the recipient's identified needs;
- To ensure that the services rendered have been billed appropriately; and
- To ensure that the services are of a quality that meets the health and safety needs, and rights, of the recipient.

The utilization review process is illustrated in Figure 45. Recipients must meet the nursing home level of care criteria, and be at imminent risk of nursing home placement, to receive personal care services. That determination is made through the pre-admission screening program. For DMAS staff, utilization review for personal care recipients begins after the placements have already been made.

Once a placement is made, DMAS staff conduct annual desk reviews of the recipient files. The desk review includes a reassessment of the recipient's ability to perform the Activities of Daily Living, as well as a progress report on the recipient's social support system, home environment, and unmet needs.

Figure 45

Personal Care Utilization Review



Source: JLARC staff analysis of Department of Medical Assistance Services documentation, and interviews with agency and provider staff.

DMAS examines the reassessment to identify any recipient who no longer appears to meet the level of care criteria. Progress reports for those recipients are reviewed to identify any reasons why the criteria are not being met, or to determine whether the agency is proceeding to decrease or terminate the number of hours of care provided.

All providers receive an annual on-site review. During the review, DMAS assesses the level, appropriateness and quality of care provided to each recipient. DMAS also reviews the accuracy of the provider's billing records.

Home Visits Assess Appropriateness and Quality of Care. Home visits are made to selected recipients in order to determine if the recipient's needs can still be met through personal care. In addition, the visits assess the recipient's satisfaction with the services, as well as the overall quality of care. Moreover, DMAS may inform the recipient that, due to changes in functioning status, the number of personal care hours provided will be reduced or terminated altogether.

Utilization Review Controls Future Utilization. At the conclusion of the on-site review, DMAS discusses each recipient's record with the agency. During the exit conference, DMAS can, and often does, inform the provider of the need to reduce hours for certain recipients. This is done in situations in which, in DMAS's judgement, the number of hours provided under the current plan of care is excessive. As a result, DMAS and the agency are able to fine tune both the amount and type of care that is provided to recipients.

Provider Impression of Utilization Review. During interviews with JLARC, 80 percent of the personal care providers generally thought that the process was thorough. Some of the comments made were:

> There are no weaknesses in the utilization review process. The forms that DMAS uses cover all aspects of the patient's needs. In addition, I like that the analysts send surveys to the recipients who are not visited at home.
>
> * * *
>
> DMAS appropriately places greater emphasis on quality of care than on audit of paperwork. Our nurses get a lot of help in resolving problem cases from the DMAS analysts. DMAS will cut the number of personal care hours based on utilization review.
>
> * * *
>
> The utilization review process keeps people honest. DMAS has been very thorough and efficient with utilization review. I don't see any flaws in the process.

Identified Underpayments Exceed Overpayments. DMAS reviews billing records to identify any overpayments which it has made. An overpayment results when the agency bills, and DMAS pays for, a greater number of personal care aide hours than have been provided. Data provided by DMAS indicate that the amount of dollars identified as either an over or underpayment is small (Table 20). Moreover, DMAS has identified a greater amount of underpaid claims than overpaid claims. Underpaid claims generally result from inadequate bookkeeping by providers.

Beginning in FY 1991, DMAS no longer gave providers written notification of underpaid bills identified during utilization review. However, verbal notification is still provided during the exit conference. DMAS explained its decision to no longer provide written notification as follows:

> If they are sloppy and want to get underpaid, that's fine. There is no reason for DMAS to do their work for them. We are out to save DMAS dollars.

Risk of Nursing Home Placement Needs to be Continually Evaluated

As discussed in Chapter V, DMAS policy mandates that personal care may be provided only to those recipients who are at imminent risk of nursing home admission. However, if a person has been placed in personal care although they would not have otherwise entered a nursing home, the ability of utilization review to correct this problem is questionable. According to DMAS management, risk of institutionalization is not really assessed during the utilization review process. DMAS states that the primary focus of utilization review, in terms of the appropriateness of care, is to determine if the recipient continues to meet the nursing home level of care criteria. However, utilization

Table 20

Personal Care Overpayments and Underpayments

Fiscal Year	Overpaid Claims	Underpaid Claims
1989	$ 60,993	$ 39,162
1990	$ 40,460	$145,460
1991	$ 22,600	--
1992	$ 15,381	--
Totals	$139,434	$184,622

Note: Underpaid claims data not available for FY 1991 and FY 1992.

Source: JLARC staff analysis of personal care payment data collected from the Department of Medical Assistance Services.

review forms designed by DMAS require its analysts to evaluate the recipient's risk of institutionalization. It appears that the degree to which such evaluation is actually being performed may be minimal.

The emergency regulations recently enacted by DMAS, as discussed in Chapter V, are an attempt to clarify the types of recipients who are at imminent risk of nursing home admission. The regulations are specific to the nursing home pre-admission screening program, and do not mention personal care utilization review. However, utilization review of personal care services could be strengthened by formally incorporating provisions of those regulations into the utilization review process.

Recommendation (16). **The Department of Medical Assistance Services should ensure that its personal care utilization review analysts evaluate if each recipient continues to be at imminent risk of nursing home placement. This should be done by incorporating relevant provisions of the department's emergency regulations concerning conditions constituting imminent risk into its utilization review policies and procedures. The department should also conduct training for its utilization review analysts concerning implementation of the new policies and procedures.**

Utilization Review of ICFs/MR is Ineffective and Burdensome

Utilization review is performed for recipients in ICFs/MR in order to determine if the recipient still requires the level of care provided in these facilities, and to assess if the recipient is receiving active treatment. However, the utilization review process is not designed to result in valid determinations of whether active treatment is being provided. In addition, utilization review requirements enacted by DMAS conflict with Medicaid ICF/MR certification requirements. This imposes unnecessary regulations on providers.

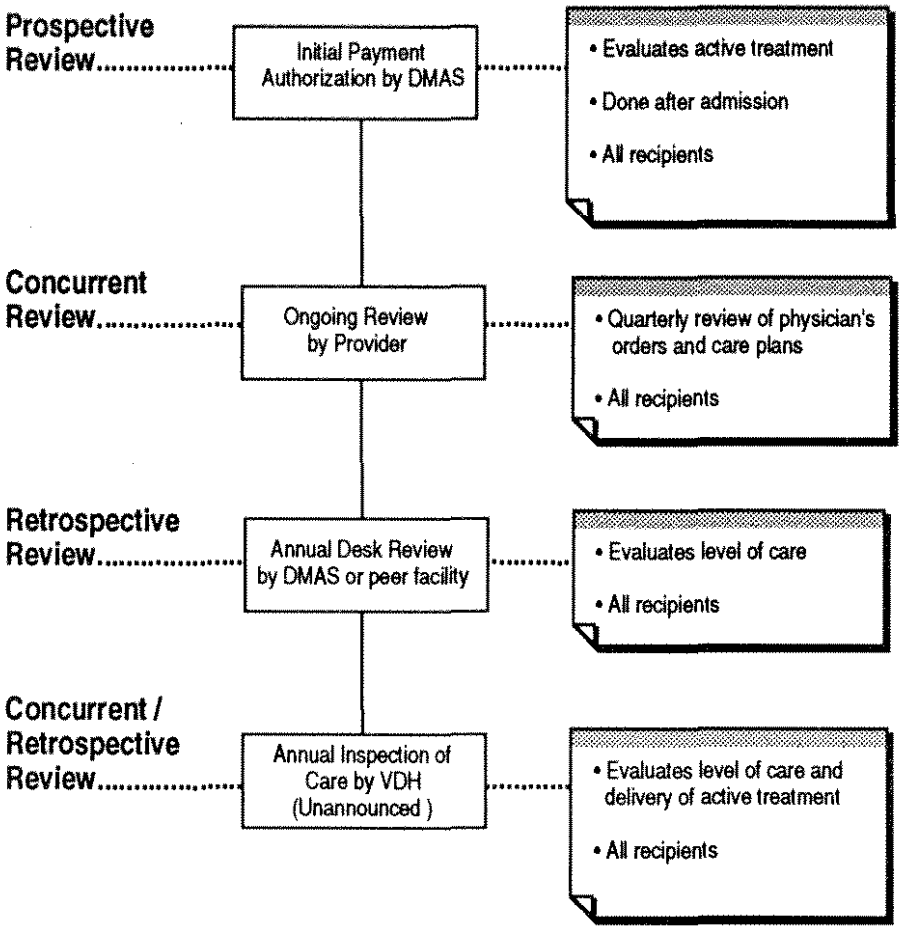
Utilization Review Objectives and Process. Utilization review is conducted to determine if the recipient continues to meet the criteria for nursing facility level of care, and to determine if the recipient is receiving active treatment. DMAS cannot reimburse the provider for services to a recipient if active treatment is not being provided. The utilization review process consists of initial payment authorization, desk review, and an inspection of care (IOC) by VDH (Figure 46).

Federal Inspection of Care Regulations. Virginia is required by federal regulations to annually determine, for each ICF/MR Medicaid recipient, whether active treatment is being provided. While this determination must be made, federal regulations do not mandate that the State use a specific methodology for making the determination. The federal regulations do contain possible items for the State to consider, but nothing is mandatory.

In addition to making an active treatment determination, the inspection of care must also evaluate if the facility's services are adequate to:

Figure 46

ICF/MR Utilization Review



Notes: The Department of Medical Assistance Services conducts desk review for ICFs/MR with 15 or fewer beds. Desk review for all other ICFs/MR is conducted by each facility, on a peer review basis.

Source: JLARC staff analysis of Department of Medical Assistance Services documentation, and interviews with agency and provider staff.

- meet the health, rehabilitative, and social needs of each recipient, and,
- promote the maximum physical, mental, and psychosocial functioning of each recipient.

HCFA is in the process of preparing revised regulations for the inspection of care. One purpose of the revised regulations is to more specifically mandate how the inspection of care should be performed, including the types of items that should be examined. According to HCFA, "we are proposing to make the inspection of care more outcome oriented, just as we have made the certification survey more outcome oriented."

Number of IOC Active Treatment Denials Has Declined. The Virginia Department of Health has performed the IOC since December 1989 as the result of an interagency agreement with DMAS. Almost immediately after VDH assumed this responsibility, the number of recommendations for denial of Medicaid reimbursement on the grounds that active treatment was not being provided dropped sharply.

VDH did not make any recommendations for active treatment denial in either 1991 or 1992 (Table 21). The IOC is conducted using the procedures and protocols that were developed and used by DMAS prior to December 1989. This difference raises questions concerning the validity of IOC findings. Since DMAS can reimburse providers only if active treatment is provided, the validity of IOC findings has important utilization control implications.

Table 21

Recommendations for Denial of Active Treatment Resulting from Inspections of Care

Fiscal Year	Number of Recommendations
1986	56
1987	31
1988	29
1989	37
1990	11
1991	0
1992	0

Source: Department of Medical Assistance Services' memo to the Virginia Department of Health, 2/20/92; JLARC interviews with VDH.

DMAS management considers the drastic decline in the number of active treatment denials to be a serious problem. Upon learning that no active treatment denials had been made in FY 1991, a DMAS division director complained to VDH.

> I am very concerned about the implications of this report. As you can see, there is a dramatic difference in the numbers of recommendations made in 1990 and 1991 as compared to previous years....As one of the main thrusts of IOC is to ensure that recipients are receiving appropriate and necessary services, we need to be sure that is, in fact, what we are doing. DMAS cannot reimburse a facility for care that has not been provided....I am certainly open to any suggestions you may have as to why there is such a difference in figures between the time the IOC function has been with VDH and when it was conducted at DMAS.

Problems with the IOC Process. According to VDH staff, the use of current IOC procedures does not allow them to determine if continuous active treatment is being provided. For example, VDH has identified deficiencies in the IOC data collection instrument which DMAS requires VDH to use. These defects have implications for the entire IOC process and call into question the validity of its findings.

According to VDH, the current IOC form is designed to collect "frequency-based" data, such as:

- number of times a program is planned for a recipient,
- number of times a program is attended by a recipient, and
- reasons for non-attendance and non-implementation as planned or scheduled.

This type of data, while probably necessary, is not sufficient for making an active treatment determination. According to VDH:

> Frequency-based data is good if you want to determine how many times a toothbrushing program has been implemented. But for residents exhibiting severe maladaptive behavior, and acting-out episodes, frequency-based data provides too narrow and limited of an information base on which to make an active treatment determination.

The current IOC form forces VDH to make active treatment determinations based solely on frequency-based data. However, there are other factors which should be considered. Informal programs can also be used to provide active treatment, but such programs cannot always be planned in advance. For example, staff cannot plan how many times a resident will have a violent outburst requiring intervention. As a result, data cannot always be collected concerning the implementation of such programs. The following provides an example of this problem:

> A resident's program calls for toothbrushing to occur from 8:30 to 8:45 a.m. If the IOC inspection does not see toothbrushing taking place at that time, that does not necessarily mean that the resident is not receiving active treatment. The resident may be receiving an informal program...such as compliance training or generalization training. The objective of compliance training is for the recipient to follow instructions. Generalization training entails having the recipient transfer appropriate behavior from one environment to another.

Moreover, federal regulations do not require ICFs/MR to collect this type of data. VDH is concerned that any recommendations it makes for active treatment denial, based solely on frequency based data, could be successfully challenged either on appeal or in court.

DMAS claims that it needs to determine if the individual program plan is appropriate, and that the individual is receiving the program as designed. According to DMAS, this determination must be made before reimbursement can be made. If care is not provided as evidenced by frequency-based data, DMAS states it should not have to pay for services. However in so doing, DMAS seems to be bypassing the need to make a valid active treatment determination, which should serve as the basis for deciding whether reimbursement is appropriate. DMAS and VDH have been working to resolve these problems but, to date, no solution has been reached.

Recommendation (17). **The Department of Medical Assistance Services should work with the Virginia Department of Health to revise the inspection of care form. The objective should be to reduce the reliance on frequency-based data in making active treatment determinations. Revised versions of the IOC form, previously developed by the Virginia Department of Health, should be given additional consideration. The Department of Medical Assistance Services and the Virginia Department of Health should report to the Secretary of Health and Human Resources by June 30, 1993, on their progress in revising the inspection of care form.**

IOC and Certification Requirements. An additional problem with the IOC process is that several DMAS requirements are in conflict with Medicaid ICF/MR certification regulations. Specific conflicts occur in disciplines including social services, psychology, recreation, and rehabilitative services. For these disciplines, the certification requirements and the DMAS *Nursing Home Manual* both require an initial comprehensive evaluation of the recipient. However, DMAS also requires:

- development of a separate services plan with measurable goals and realistic time frames for each discipline,
- annual review of the services plan,
- quarterly updates of the services plan, and
- quarterly progress notes.

Under the IOC requirements, ICFs/MR are required to prepare these plans whether or not the resident actually requires that type of service. The directors of the State-operated ICFs/MR have criticized these IOC regulations as being costly and unnecessary.

> The way it stands now, we need to conduct the interdisciplinary comprehensive assessment, and produce an individual program plan in order to certify for Medicaid. In addition, we need to have annual professional assessments for each resident in order to pass the IOC. This is wasteful and duplicative.

* * *

The IOC in effect requires programs in these disciplines whether the resident needs them or not. Under the certification requirements, on the other hand, the ICF/MR is required to provide such services only if the comprehensive assessment determines that they are needed.

* * *

Conforming the two sets of regulations will improve efficiency and save money by eliminating redundant paperwork.

DMAS claims that its requirements are in the best interests of recipients. In addition, DMAS states that care plans in these disciplines are required by federal regulations. However, the Code of Federal Regulations does not specifically require that the ICF/MR prepare such plans. The federal regulations simply require that the recipient's plan of care include any services which have been ordered by a medical professional. The regulations also state that the IOC may examine documentation concerning any services which have been ordered for the recipient.

Recommendation (18). **The Department of Medical Assistance Services should review its nursing home manual to determine if there are ICF/MR inspection of care requirements which conflict with Medicaid certification regulations. Initial emphasis should be placed on examining those provisions which mandate service plans in social services, psychology, recreation, and rehabilitative services.**

Home Health Utilization Review is Effective, But Started Late

Home health utilization review is conducted to ensure that services provided to recipients are necessary and appropriate. However, despite the fact that home health services have been provided by Medicaid since 1969, DMAS did not perform utilization review until 1991. Since 1991, utilization review has identified many instances of unnecessary and inappropriate utilization. Home health providers have been critical of the review program. Some of that criticism is probably due to lack of familiarity with the new program. However other criticisms concerning the manner in which the review is conducted appear to have some validity.

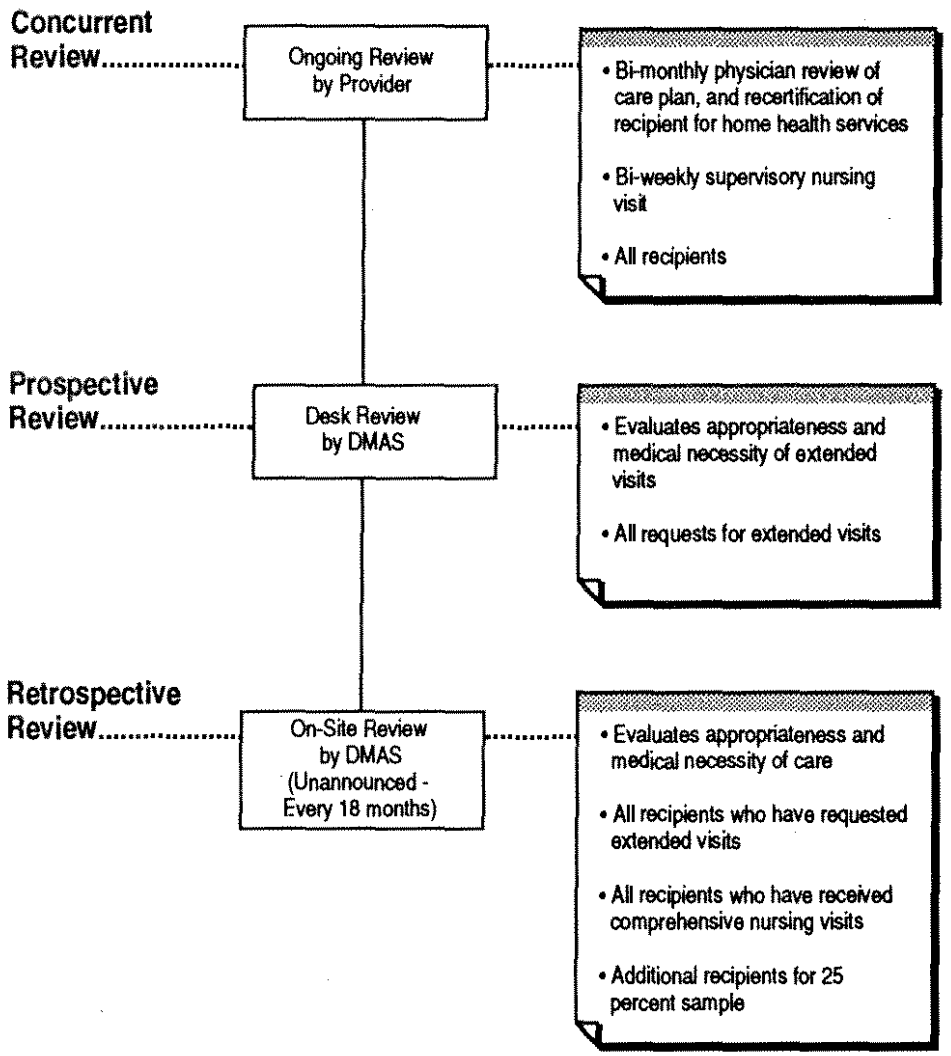
Utilization Review Objectives and Procedures. Utilization review is conducted to ensure that home health services provided to Medicaid recipients are medically necessary and appropriate. The utilization review process consists of two general components: desk review and on-site review (Figure 47). In addition, the provider has responsibilities for on-going review of the recipient's plan of care.

Desk review is performed in order to determine whether to authorize additional visits beyond the annual maximum number of allowed visits. The annual on-site review consists of an examination of a sample of recipient files. DMAS policy is to review each provider every 18 months. The review examines documentation for areas including:

- plan of treatment,
- nursing services,
- rehabilitative services,
- home health aide services,
- durable medical equipment, and
- discharge planning.

Figure 47

Home Health Utilization Review



Note: Effective July 1, 1992, extended visits may be requested only for physical therapy, occupational therapy, and speech therapy services.

Source: JLARC staff analysis of Department of Medical Assistance Services documentation, and interviews with agency and provider staff.

Initial Implementation of Utilization Review. Virginia first offered home health services through the Medicaid program in 1969. However, DMAS did not begin to perform utilization review until January 1991, when the home health unit was established.

DMAS is required to quarterly certify to HCFA that it has performed utilization review for all services, including home health, provided to its recipients. It is not clear, for home health, what activity DMAS used as the basis for its certification to HCFA prior to 1991. While some DMAS staff state that reviews conducted by the Division of Program Compliance satisfied the HCFA requirement, those reviews did not begin until 1991.

Because home health utilization review activities have only recently started, only about 25 percent of providers have had an on-site review. Therefore, DMAS did not come close to meeting its objective of providing each agency with an on-site review by June 1992, eighteen months into the program. DMAS attributes the delay to the fact that many reviews are taking longer than anticipated because it is finding many examples of unnecessary and inappropriate utilization.

Improper Utilization and Expenditures Have Been Identified. Since beginning utilization review, many types of improper utilization and needless DMAS expenditures have been uncovered. These include reimbursement paid for:

- services provided to recipients who were not home bound,
- services not covered under the home health program, and
- unnecessary medical supplies and equipment.

Many of these improper practices are, most likely, longstanding on the part of certain providers. Since there was no utilization review by DMAS prior to 1991, those types of practices went undetected. As a DMAS analyst stated, "DMAS just kept paying and no one worried about it." Examples of these problems as cited by one DMAS analyst are provided below.

> *At least three home health agencies provided home health aide services in licensed homes for adults. Medicaid was billed for these services and reimbursement was paid. However, adult homes are not supposed to accept clients who require hands-on medical care.*
>
> * * *
>
> *Several homes for adults accepted deinstitutionalized psychiatric patients as clients. These individuals were not home bound and therefore were not eligible for home health. Nevertheless, on at least two occasions, home health staff visited the individuals to draw blood. The blood was sent to a laboratory for analysis. Medicaid was billed separately for both services, and reimbursement was paid. Since these individuals were not home bound, the blood should have been drawn and analyzed only by the laboratory.*
>
> * * *

A home health agency nurse did not indicate the number of medical supplies needed by a recipient during the coming month. That information is supposed to be recorded on the recipient's plan of care. Consequently, the medical supply company provided the maximum number of supplies that could be supplied without prior authorization from DMAS. The amount provided was greater than the amount needed. Medicaid was billed for these supplies, and reimbursement was paid.

DMAS paid home health providers more than $50 million from 1983 to 1990. Given the lack of utilization controls by DMAS, a portion of that spending may have been unnecessary. Since 1991, DMAS has identified and recouped nearly $350,000 in reimbursement paid for inappropriate and unnecessary visits and services. These savings are a result of the disallowance of more than 6,000 home health visits (Table 22). These savings have accrued after reviewing just 25 percent of the providers.

DMAS staff expect to uncover additional improper utilization practices as their review is expanded. Therefore, the amount of inappropriate program expenditures recouped from providers will likely increase.

Policy on Visit Limitations is Misdirected. DMAS should continue its efforts to identify unnecessary and inappropriate visits, and to promote proper utilization practices by providers. As was discussed in Chapter II of this report, the major factor responsible for the increase in home health spending has been tremendous growth in the

Table 22

Home Health Utilization Review Cost Savings

Service	Number of Denied Visits
Home Health Aide	3,505
Skilled Nursing	1,501
Physical Therapy	666
Comprehensive Nursing	199
Occupational Therapy	131
Speech Therapy	63
Total Visits Denied	6,065
Total Estimated Cost Savings	$347,420

Note: Denied visits include those identified during the on-site review, and those denied in requests for extended visits. Estimated cost savings are based on the number of visits denied for each service multiplied by the average reimbursement rates for each type of service.

Source: JLARC staff analysis of Department of Medical Assistance Services data.

number of visits due to a rising number of new entrants into the program. Utilization review can help contain spending by reducing the number of unnecessary and inappropriate visits.

On the other hand, a new DMAS policy designed to contain spending by limiting the number of home health visits per recipient is misdirected and arbitrary. This policy limits the number of home health aide and skilled nursing visits to 32 per recipient per year, while limiting therapy visits to 24 per year. While recipients may request additional therapy visits, no additional home health aide or nursing visits are permitted.

While this policy will save the State money, it does not address the major factor underlying the increase in expenditures—a rise in total visits resulting from a growing number of recipients. As described in Chapter II, the increase in the number of visits per recipient, by contrast, has been negligible. Because the recently adopted policy does not address the more important cause of increased spending, its ability to result in major long-term savings for Medicaid is reduced. More importantly, the new policy raises questions of access to care and cost shifting. Recipients affected by the new policy may begin to use more expensive Medicaid services, such as hospitals, emergency rooms, and nursing homes in the absence of home health care.

The Director of DMAS stated that cost containment was only one consideration at the time that the limitations on visits were proposed. Another objective was to simply remove the State's liability for any care beyond the "normal level." The precedent for this, he stated, has been established through policy which limits the state's liability for hospital stays beyond a certain number.

Recommendation (19). **The General Assembly may wish to remove the cap on home health visits as required in the 1992 Appropriation Act. As an alternative, the Department of Medical Assistance Services should reinstate its policy to permit requests for extended visits once the number of allowed visits has been reached.**

Home Visits in Utilization Review Process. While DMAS has made home visits to recipients on an as-needed basis, recipients are not visited as a matter of practice. The lack of home visits contributes to a perception among providers that DMAS utilization review places excessive emphasis on compliance with documentation requirements, and insufficient emphasis on the actual recipient. The following comment made by one provider during field visits typifies those generally expressed:

> The DMAS utilization review process is confusing, paper-driven, and does not focus on patients. Home visits were not made. By looking only at paper and not observing the patients, DMAS does not get a real feel for the patient's situation. Also, DMAS does not get any indication of how the patient feels about the services being provided.

At least one DMAS utilization review analyst would like home visits to be a regular component of utilization review.

> I would like to see if the recipient matches the description contained in the file. Sometimes I will review a file and get a sense, based on my nursing experience, that the recipient probably does not match the description. I would also like to determine how satisfied the recipient is with the service, and assess what the home environment is like. In addition I would like to see what medical equipment is being used in the home.

Home visits to a sample of recipients would enhance the quality assurance component of home health utilization review. In particular, it would enable DMAS to assess the satisfaction of recipients and their family members with the home health services.

Recommendation (20). **The Department of Medical Assistance Services should analyze the costs and benefits associated with making home visits as part of home health utilization review. The analysis should include an examination of how the current method of sample selection for the on-site review could be modified in order to facilitate home visits to current recipients. The Division of Quality Care Assurance should report the results of the analysis to the director by June 30, 1993.**

Nursing Home Utilization Review Appears to Be Effective

Nursing home utilization review is performed in order to ensure that the level and quality of care are appropriate, and that the recipients' patient intensity ratings are accurate. In general, the review process appears to operate effectively.

Utilization Review Objectives and Process. Nursing home utilization review serves three general purposes. It attempts to ensure that:

- the recipients meet the nursing home level of care criteria,
- the recipients' Patient Intensity Rating System (PIRS) assessments are accurate, and
- the recipients are safely and appropriately cared for.

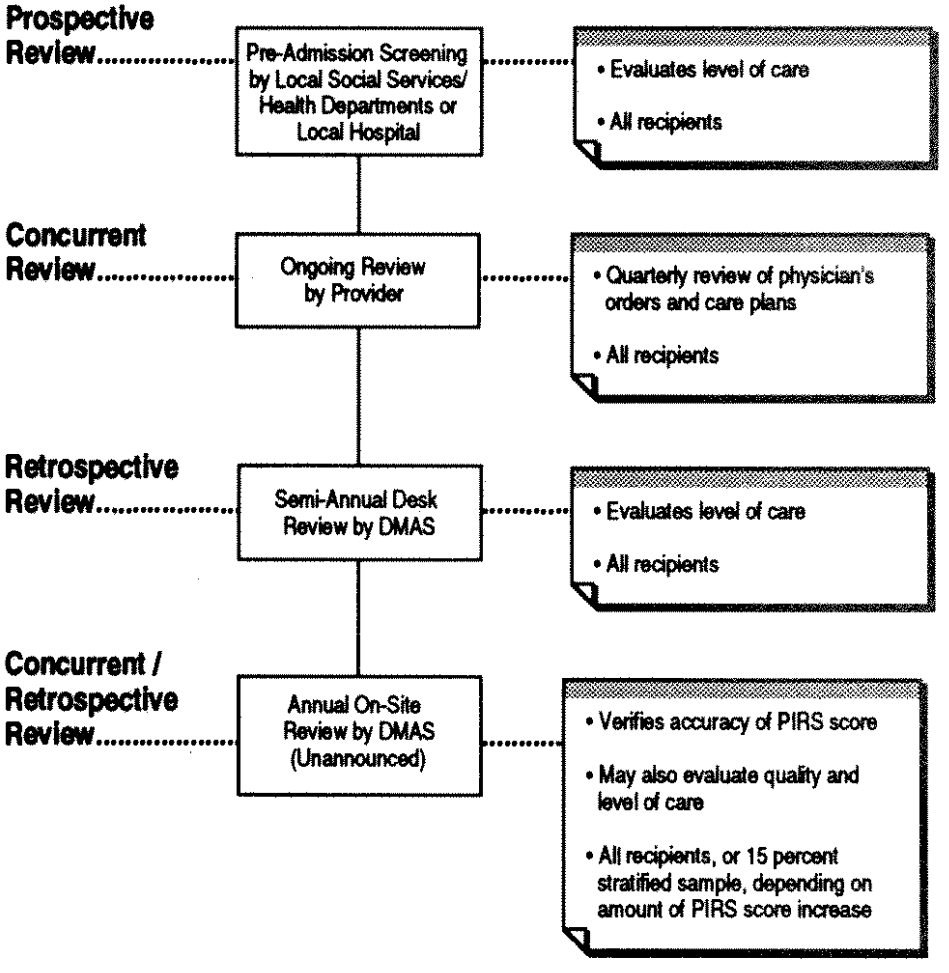
The review process consists of three general steps: pre-admission screening, desk review, and on-site review (Figure 48). Once a recipient begins to receive care, the nursing home is responsible for on-going review of the recipient's plan of care. DMAS performs a semi-annual desk review to assess if the recipient continues to meet the level of care criteria. The assessment covers virtually every aspect of the recipient's condition, including:

- communication and hearing patterns,
- physical functioning and structural problems,
- continence,
- psychosocial well-being, and
- health conditions.

DMAS performs an on-site review for each provider. The primary purpose of the review is to determine whether the nursing home's PIRS score for each recipient is accurate. If a nursing home's PIRS score has increased by at least 15 percent, DMAS will verify the PIRS scores for each of the provider's Medicaid recipients. Otherwise, DMAS

Figure 48

Nursing Home Utilization Review



Source: JLARC staff analysis of Department of Medical Assistance Services documentation, and interviews with agency and provider staff.

reviews a random sample of recipients, stratified across the three patient intensity classes.

While DMAS is not bound to any required schedule for on-site reviews, it would like to review each provider on an annual basis. However, DMAS states that it does not have enough staff to do so. Approximately ten percent of nursing homes have not yet had an on-site review.

During the on-site review, DMAS may also perform utilization review. The purpose of the utilization review is to assess the quality and appropriateness of the care that is being provided. DMAS performs inspections of care on an as-needed basis. For example, DMAS will perform an inspection of care if the nursing home has been cited for an excessive number of deficiencies during a VDH Medicaid certification inspection. VDH performs an annual Medicaid certification inspection in each nursing home.

Desk Review Results. It appears that DMAS usually determines that nursing home recipients continue to meet the level of care criteria. To evaluate the results of the desk review for nursing homes, JLARC staff reviewed a random sample of nursing home utilization review files. These files contained the results of desk reviews for a total of 1,678 Medicaid recipients. Only 13 percent of these recipients did not meet the criteria for continued stay in a nursing home.

DMAS attributes these findings to two general factors. First, the pre-admission screening program prohibits recipients who do not meet the criteria from entering a nursing home. This is the first and most important control in the system. Second, all nursing home providers are trained in administering the level of care criteria. Aware of the financial consequences, providers make few mistakes in this area.

Recipients who do not meet the criteria during desk review do not necessarily receive level of care changes. The decision to change a recipient's level of care is initiated by the utilization review analyst, and approved or disapproved by the DMAS Director of Medical Support. According to DMAS, only about one percent of nursing home recipients actually have their level of care changed. Some recipients who at first appear not to meet the criteria, upon closer review by DMAS, are determined to still need nursing home care. For example, a recipient who functions at a relatively high level will probably appear not to meet the criteria. However, that same recipient may have a medical condition which requires continuous nursing care.

Patient Intensity Rating. The Patient Intensity Rating System (PIRS) is used by DMAS to measure the amount and type of services that a nursing home recipient must receive. Each recipient receives a PIRS score based on his medical and functioning status. Based on the PIRS score of each recipient, a nursing home receives a facility PIRS score which is used to determine its reimbursement rate.

It appears that, in most instances, the recipient's patient intensity rating does not change as a result of the DMAS on-site review. JLARC staff reviewed a random sample of nursing home utilization review files. These files contained the results of PIRS validation surveys for a total of 1,228 Medicaid recipients. The intensity rating did not change at all for 87 percent of the recipients. However, while the patient intensity rating decreased for approximately ten percent of the recipients, it increased for only three percent.

A decrease in a recipient's intensity rating is beneficial to DMAS because it tends to reduce the nursing home's PIRS score, which is directly linked to the facility's per diem reimbursement rate. Therefore, it appears that the PIRS review helps to contain the amount of program spending on nursing home care.

There is some concern among providers that some nursing homes are willfully attempting to manipulate, or "game" the PIRS assessments of their recipients. This could potentially be done by making it appear that the recipients require a more intense level of care than is actually the case. DMAS acknowledges that it has been concerned that PIRS could be manipulated and is monitoring an entire nursing home chain for this reason. The chain told DMAS: "We know that you are not going to change your PIRS system and the criteria that go along with it. Therefore, we are going to try to game our results." DMAS plans on conducting a PIRS validation survey for facilities in this chain regardless of how its PIRS scores change. According to DMAS, the best way to prevent manipulation of PIRS is to perform validation surveys on a regular basis.

OVERVIEW OF THE COST SETTLEMENT AND AUDIT PROCESS

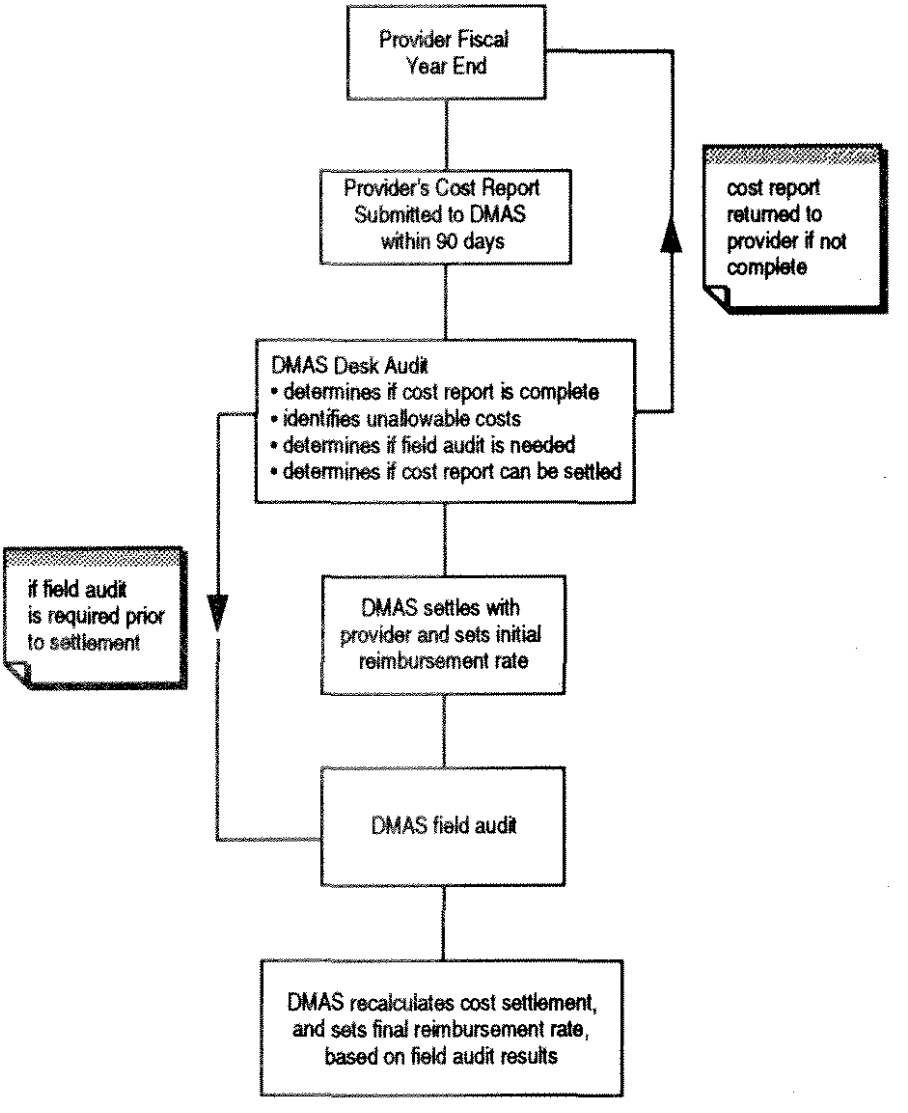
Generally speaking, cost settlement and audit (CSA) is the process used to examine a provider's annual reported costs and to determine those costs which will be considered for reimbursement by the Medicaid program. DMAS uses the process to "settle" or close out the cost report for each provider receiving Medicaid reimbursement. In this process, DMAS staff determine if all of the reported costs are allowable and whether the amount of the Medicaid payment should be adjusted.

For some types of long-term care—nursing home services and institutional care for the mentally retarded—the CSA process is used to determine the next year's reimbursement rate. Home health and personal care providers are not included in the CSA process since they are reimbursed on a fee-for-service basis.

This section provides a description of the CSA process. The CSA process is based on the principles of reimbursement as set out by federal laws and regulations and the *State Plan Under Title XIX of the Social Security Act for Medical Assistance Services*. Two general activities are performed during CSA: desk audit and field audit (Figure 49). While all cost reports receive a desk audit, a field audit is not always performed.

Figure 49

Cost Settlement and Audit Process



Source: JLARC staff analysis of Department of Medical Assistance Services documentation, and interviews with agency and provider staff.

Desk Audits Verify Cost Report Data in Order to Set New Rates

The desk audit and rate setting phase of the CSA process begins when providers submit their cost reports to DMAS for settlement. Nursing homes and ICFs/MR are required to submit their cost reports to DMAS within 90 days after their fiscal year ends. The desk audit is used to test the accuracy of cost report data prior to the establishment of a new reimbursement rate.

Desk Audit Process. Desk audits are performed in order to ensure that the cost report is complete and accurate, to verify the reasonableness of costs claimed for reimbursement, to identify non-allowable costs, and to determine if a field audit is warranted. The desk audit process includes a completeness review, clerical review, professional preview, and professional review.

The completeness review determines if all lines of the cost report have been filled in, and if all required supporting documents have been submitted. The clerical review is used to verify the mathematical accuracy of the cost report and identify any unusual variation in current year costs from prior year costs.

Professional preview and review consists of a series of steps which DMAS takes to determine whether the cost report can be settled with the establishment of a new rate or whether a field audit is necessary. However, the preview/review process does not specify any criteria or materiality thresholds for determining if a field audit is necessary. While DMAS currently leaves such determinations to the professional judgment of its analysts, it is working to develop materiality thresholds.

The purpose of the preview phase is to uncover areas that require more research by the analyst. Desk preview includes the following:

- analysis of provider's financial statements;
- analysis of unusual cost variances from the prior year;
- verification that the prior year's audit findings and adjustments have been incorporated into the current cost report; and
- verification that the amount of patient days and DMAS payments has been correctly incorporated into the cost report.

The desk review phase, on the other hand, is designed to provide detailed answers to questions developed during the preview phase. Desk review is performed by analyzing information that is readily available in the cost report. However, DMAS may request additional information from the provider in order to verify cost report information. A number of topics are examined during this review, including:

- capital-related costs,
- interest expense,
- costs of services purchased from related organizations,
- costs related to patient care, and
- home office costs.

Rate Setting Process. DMAS establishes new reimbursement rates and "cost settles" the reports based on the findings of the desk audit. Prior DMAS policy required that a tentative settlement be made, and a new interim reimbursement rate be set for a provider within 90 days of receipt of the cost report. DMAS also had an internal policy to complete cost settlement within 180 days of receipt of the cost report.

In August 1992, however, DMAS implemented a new emergency regulation which replaced the 90 day rate setting deadline with a 180 day requirement. The emergency regulation applies only to nursing homes. However, some DMAS staff stated that a 180 day cost settlement deadline applies to both nursing homes and ICFs/MR.

If DMAS determines that the cost report is not complete, the provider will be instructed to supply the missing information. The 180 day cycle does not begin until DMAS receives a complete cost report. Furthermore, if the desk review results in findings that call into question the accuracy of the cost report, an immediate field audit may be requested. The 180 day cycle also stops running in this situation. In such cases, DMAS has 90 days in which to complete the field audit.

Field Audits Are Not Always Mandatory

The field audit unit conducts on-site reviews of the operations and financial records of selected providers. These audits are conducted for the primary purpose of identifying unallowable costs. However, in most cases they occur several years after the cost report is settled by the DMAS. A field audit must be performed when a new provider submits its first cost report, if a facility has been sold, or after major renovation or construction.

Other field audits are performed on a discretionary basis. For example, some providers are recommended for field audit by the cost settlement unit. In addition, the field audit unit has recently begun to select certain providers for field audit based on a number of criteria including the length of time since the last field audit and the amount of Medicaid utilization.

IMPROVEMENTS TO THE COST SETTLEMENT AND AUDIT PROCESS

This is not the first review of the CSA process for long-term care services. In 1978, JLARC recommended that DMAS consider collecting additional information on nursing home cost reports such as fixed assets, depreciation schedules and expenses. DMAS has made improvements in terms of the amount of information required to be submitted on nursing home cost reports. Moreover, the cost settlement process is now automated.

On the other hand, the Auditor of Public Accounts recently found that cost settlement was not completed in a timely fashion, that cost report analyses were not appropriately documented, that many providers had not had a recent field audit, and that the number of available field audit staff might not be sufficient. While DMAS is starting to make progress in some of these areas, further action is warranted. This section discusses aspects of the CSA process which could be strengthened.

Some Improvements Have Been Made to the CSA Process

The 1978 JLARC study, *Long Term Care In Virginia*, cited a number of deficiencies in nursing home cost reporting and cost analysis, including:

- lack of a uniform chart of accounts to standardize cost reporting by category of expenditure;
- failure to report costs for all required categories;
- failure to submit balance sheets and statements of income and expenses;
- failure to identity all nursing home owners;
- failure to disclose transactions between related parties;
- failure to adequately review owners' compensation;
- insufficient information on depreciation schedules;
- no documentation on whether loan interest is related to patient care; and
- failure to adequately analyze cost variations.

In general, all of these concerns have been addressed by DMAS. This has been done by developing standard, and extensive, nursing home cost reporting forms, and by developing the preview/review desk audit program. Little, if any, additional action is required in these areas. However, other problems now exist within the process.

Cost Settlement Process is Slow

Due largely to an increased workload, the CSA process often takes longer than six months to complete. At the conclusion of this lengthy process, DMAS usually determines that it owes the provider additional funds. The prevalence of additional payments by DMAS results from the long period of time that passes between receipt of the cost report and settlement.

DMAS Settlement and Rate-Setting Deadlines Not Met. One objective of this analysis was to asses the timeliness of the rate-setting process. To do this, JLARC staff reviewed the cost settlement files of a sample of nursing homes and ICFs/MR for fiscal years 1989, 1990, and 1991. The files of those providers who had been visited by JLARC staff were selected for review.

DMAS policy, until very recently, required that a new interim reimbursement rate be established within 90 days of receipt of the cost report. Cost settlement, along with the establishment of a final rate, was to be completed within 180 days. This objective was frequently not met for nursing homes (Table 23). Also, though DMAS staff stated that most ICF/MR cost reports are settled within 180 days, that does not appear to be the case. In fact, the cost settlement process for ICFs/MR takes even longer to complete than it does for nursing homes, with 80 percent of the settlements requiring more than 180 days. As a result, many providers go through nearly their entire fiscal year receiving the prior year's reimbursement rate. This can adversely affect a provider's cash flow.

Table 23

Time Frame Analysis of Nursing Home and ICF/MR CSA Process

	Percent Settled After 90 Days	Average Days Late	Percent Settled After 180 Days	Average Days Late
Nursing Homes	73%	172	73%	98
ICFs/MR	93%	165	80%	125

Source: JLARC staff analysis of data from a sample of the Department of Medical Assistance Services cost settlement files for ten nursing homes and five ICFs/MR for fiscal years 1989-1991. A total of 22 nursing home cost reports were examined. Six nursing homes had not yet submitted FY 91 cost reports at the time of the JLARC review. One nursing home cost report for FY 89, and another for FY 90, were missing from the DMAS files. A total of 15 ICF/MR cost reports were examined.

Cost Settlement Workload Has Increased. As the number of providers participating in the Medicaid program increases, so does the number of cost reports that must be settled. According to DMAS, 53 nursing homes were added to the program from 1989 to 1991. During that period of time, however, the number of cost settlement staff remained about the same. Consequently, the workload of each analyst increased during that period of time.

The cost settlement unit experiences its peak workload during the Spring. That is because nearly half of all nursing homes in the Medicaid program have fiscal years which end on December 31. Their cost reports are all due to DMAS 90 days later, March 31. The amount of work during this peak period is about to increase even more. One of the State's biggest nursing home chains will adopt a December 31 fiscal year end effective at the end of 1992. As a result, more than half of all nursing homes in the program will have fiscal years which end on December 31.

DMAS Usually Determines Provider is Owed More Money. At the conclusion of the CSA process, DMAS usually determines that additional reimbursement is due to the provider. It is relatively rare, by comparison, for DMAS to determine that the provider

has received excessive reimbursement and owes money back to the Medicaid program. In FY 1991 for example, the State paid approximately $31 million to long-term care providers as a result of cost settlement. Nursing homes and ICFs/MR received $24 million, or 77 percent, of these payments. In contrast, less than $5 million was collected from providers.

The majority of these payments are the result of retroactive adjustments made during the CSA process. A retroactive adjustment is made in order to compensate the provider for the number of days of care which DMAS reimbursed using the prior year's rate.

Under the new emergency regulations, DMAS has up to 180 days after receipt of a nursing home's cost report in which to establish a new prospective reimbursement rate. Since a nursing home has up to 90 days in which to file its cost report, as much as 270 days (nine months) can elapse in the provider's fiscal year before DMAS is required to set the new rate. Consequently, large retroactive adjustments by DMAS are likely to continue to be necessary.

Recommendation (21). **The Department of Medical Assistance Services should take steps to expedite the nursing home cost settlement and audit process. In addition, the department should reconsider the regulatory change that lengthens the timeframe for setting interim nursing home reimbursement rates.**

Many Providers Have Not Been Field Audited in Several Years

Current federal regulations merely require that DMAS demonstrate to HCFA that it conducts field audits. Until 1982, DMAS was required to field audit each provider every three years. That policy was eliminated, in part, due to the recognition that the three year cycle was often excessive and unnecessary. DMAS continued to audit all providers on a three year cycle until 1986. In 1986, DMAS began to adhere to the new, less stringent, federal regulations.

More than 80 nursing homes, or about a third of all those participating in the Medicaid program, have not had a field audit since at least FY 1986. Many nursing homes have gone much longer without a field audit. This raises questions concerning the extent to which DMAS is able to verify the accuracy of information contained in the providers' cost reports. The manager of the field audit unit has acknowledged that "the field audit process could be improved, in part, through more timely audits." DMAS is taking steps to address this situation.

Field Audits Can Examine Greater Detail than Desk Audits. Field audits permit staff to review detailed information that can not be examined in a desk audit. While desk auditors often raise questions concerning certain cost report items, due to the press of time, they are sometimes unable to fully address the questions. It is the role of the field auditor to get to examine the report in greater detail.

Field auditors go to the nursing home in order to inspect all of the provider's financial records, and also to question nursing home staff concerning the contents of the records. In this way, the accuracy and completeness of information in the cost report is more thoroughly verified. Field audits often focus on the following aspects of nursing home operations:

- administrative and general costs,
- owner and administrator compensation,
- travel to seminars and conventions,
- refinancing, and
- plant costs and depreciation.

Discretionary Audit Program. In order to increase the number of field audits that are conducted, DMAS recently began to select certain nursing homes for audit. These audits are being done in addition to those requested after the desk audit. Nursing homes are being selected for field audit based on three criteria:

- length of time since the last field audit,
- amount of Medicaid utilization, and
- difference between the provider's per-diem costs and the peer group ceiling.

According to DMAS, the most cost effective field audits are those of providers whose costs are below their ceiling. In those cases, every dollar of unallowable cost identified by DMAS represents a savings to the Medicaid program. In other words, the provider's reimbursement rate could be reduced even further below its ceiling based on the audit results. On the other hand, DMAS does not feel that it is generally cost effective to audit providers whose costs are above the ceiling. In order to affect the amount of reimbursement, the audit would have to identify enough unallowable items to drive costs below the ceiling. While this is possible, DMAS does not consider it to be a cost effective use of audit resources.

DMAS had planned to begin conducting 26 discretionary audits during FY 1992. As of the end of FY 1992, only eight of the audits had started. Four discretionary field audits have been completed. The audit of one provider identified more than $1 million in overpayments made by DMAS over an eight year period. The audits of three other providers found that no overpayments had been made.

Discretionary Audit Program Should be Expanded. While not all nursing homes are in equal need of a field audit, the State could benefit from efforts to audit a greater number of nursing homes on a more frequent basis. The criteria used by DMAS to select the discretionary audits are sound. However, the application of those criteria could be improved.

For example, only two of the 84 nursing homes which have not had a field audit since at least FY 1986 were selected for a discretionary field audit in FY 1992 (Table 24). However, more than half of those 84 providers had costs which were below the peer group ceiling. Those providers below the ceiling received, on average, more than $2 million in

Table 24

Profile of Potential Nursing Home Discretionary Field Audit Selections

Nursing Homes Not Field Audited since FY 86	Nursing Homes with Costs below the Ceiling
84	43

FY 90 Average Medicaid Payment	FY 90 Total Amount Reimbursed	FY 90 Average Medicaid Days	FY 90 Total Medicaid Days
$2.3 million	$97.3 million	39,945	1,717,651

Source: JLARC staff analysis of Department of Medical Assistance Services' nursing home field audit data and FY 1990 payment data.

Medicaid reimbursement during FY 1990. Therefore, serious consideration should be given to selecting these providers for field audit.

Recommendation (22). **The Department of Medical Assistance Services should analyze its most recent field audit and payment data in order to select additional nursing homes for discretionary field audits. The Department of Medical Assistance Services should ensure that nursing homes selected for discretionary field audits meet, to the greatest extent possible, established selection criteria.**

Use of Outside Audit Firm for Field Audits Is Ineffective

DMAS has a three year contract with an accounting firm for the performance of field audits. This contract enables DMAS to reduce the workload of its field audit staff. The number of DMAS field auditors has decreased during the last few years. During FY 1992, DMAS paid the firm $86,000 for the performance of field audits. DMAS plans to assign the accounting firm approximately 15 field audits during FY 1993.

However, DMAS staff are dissatisfied with the performance of the firm, and outside audit firms in general. The staff's concern centers on the fact that the contract is only for a short-term, and that outside firms assign inexperienced auditors to conduct the audits. The auditors, who normally perform financial audits, are not familiar enough with Medicaid regulations to be effective. Moreover, there is so much turnover among the firms' auditors that they are never able to develop sufficient expertise with Medicaid regulations.

DMAS had used the current firm, along with two other firms, from 1986 to 1988, and was not satisfied with the results. According to a DMAS manager, "We didn't get very good results in terms of dollars." DMAS paid the three firms more than $1.7 million over that three year period.

These concerns raise questions concerning the wisdom of continuing to use any outside accounting firm for Medicaid nursing home field audits. DMAS could improve its likelihood of conducting a successful field audit by eliminating its use of outside audit firms.

According to DMAS, it would require two more field auditors in order to perform the audits that are currently conducted by the firm. Furthermore, DMAS expects its field audit workload to increase over the next three years. Consequently, DMAS estimates that five additional field auditors would be necessary to eliminate its use of outside audit firms over the next three years.

An intensive staffing analysis was beyond the scope of this study. JLARC staff did not identify exactly how many full-time equivalent positions would be necessary for DMAS, given its increasing workload, to have an effective field audit program. On the other hand, DMAS should periodically perform such an analysis as part of its normal agency planning. However, DMAS had not recently performed such an analysis until it did so as part of its response to a JLARC data request. Moreover, DMAS has not recently prepared a formal budget request for additional field audit staff.

Recommendation (23). **For the FY 1995 budget, the Department of Medical Assistance Services should develop an addenda outlining the costs and methodology of conducting additional field audits of nursing home cost reports. This addenda should include an assessment of the costs and benefits of conducting these audits using DMAS staff, private contractors, or a combination of those sources.**

CONCLUSIONS

Utilization review and cost audit are two processes that Virginia uses in its effort to contain the amount of Medicaid long-term care expenditures. Utilization review can best control expenditures by preventing the inappropriate use of Medicaid-funded services and through monitoring the provision of services to eligible recipients.

In general, the effectiveness of DMAS utilization review activities vary for the different components of long-term care. The activities conducted for nursing homes, personal care, and home health services are, for the most part, comprehensive, thorough, and effective. However, similar activities performed for ICFs/MR appear ineffective and overly burdensome.

Over the past several years, as reimbursement systems have changed and the number of Medicaid providers has increased, the cost settlement and audit process has become more difficult to administer. As a result, there are considerable delays in the amount of time required to cost settle with providers and establish payment rates for the next fiscal year. DMAS needs to take steps to reduce the amount of time that the process consumes.

At the same time, the amount of financial information collected during the process has grown. Efforts of desk auditors to verify the accuracy of this information and to use it in identifying unallowable costs, have been hampered by a rising workload. This creates the possibility that some of the long-term care expenditures by the State are unnecessary.

Appendixes

Appendix A

Senate Joint Resolution No. 180

Requesting the Joint Legislative Audit and review Commission to study the Commonwealth's Medicaid program and the indigent care appropriations to the state teaching hospitals and the Medical College of Hampton Roads.

Agreed to by the Senate, February 19, 1991
Agreed to by the House of Delegates, February 15, 1991

WHEREAS, a goal of the Commission on Health Care for All Virginians is to provide access to basic health care for all Virginians; and

WHEREAS, approximately 330,000 persons in Virginia are eligible for the Medicaid program, but an estimated 300,000 additional Virginians in poverty have no health insurance; and

WHEREAS, the number of Virginians eligible for Medicaid has increased by only 10 percent during the last 10 years, but Medicaid expenditures in Virginia have tripled during that period; and

WHEREAS, costs in the 1990-92 biennium are expected to be more than 40 percent greater than the costs in the 1988-90 biennium; and

WHEREAS, the Medicaid program now represents about 12 percent of the Commonwealth's general fund budget, with an estimated $1.4 billion (general fund) cost for the 1990-92 biennium; and

WHEREAS, Medicaid costs will continue to escalate at a rapid rate as inflation in health care costs far surpasses other goods and services; and new federal mandates are likely to continue as Congress expands health insurance for the elderly, disabled, and poor through Medicare and Medicaid; and

WHEREAS, federal mandates establish the core of the Medicaid program, but states can partially shape the benefits and costs through policy adjustments in reimbursement rates for service providers; services offered to recipients; utilization review to ensure appropriate care; and eligibility for groups of persons, and to some extent, how much recipients pay for their own care; and

WHEREAS, University of Virginia Medical Center, Medical College of Virginia Hospitals, and the Medical College of Hampton Roads provide a significant amount of care to low-income persons and receive state support for this care through Medicaid and direct general fund appropriations; now therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Legislative Audit and Review Commission be requested to study the Virginia Medicaid program and the indigent care appropriations to the state teaching hospitals and the Medical College of Hampton Roads.

The study shall include, but not be limited to:

1. Assessment of the cost savings and health policy implications of limiting the scope or duration of optional services, or adjusting recipients' contributions to their care;

2. Examination of the interpretation of federal requirements to determine if they have been implemented in the most effective and least costly manner;

3. Determination of the effectiveness of current utilization review procedures in controlling costs and exploration of additional options;

4. Evaluation of reimbursement methods to determine if they adequately encourage cost effective delivery of services;

5. Determination of the sufficiency of reimbursement rates to provide quality care at the lowest required cost;

6. Review of budget and forecasting methods to ensure that they adequately identify and project the cost of policy changes, service utilization, and new mandates;

7. Determination of how the legislative branch could increase its capacity to more closely monitor Medicaid forecasts and expenditures;

8. Exploration of the costs of alternative administrative methods for implementing program requirements and options;

9. Examination of the relationship with other State programs to promote optimal utilization of State funds;

10. Identification of options for using Medicaid funds for services currently supported with general funds; and

11. Review of eligibility, scope of services, and reimbursement rates for indigent care at University of Virginia Medical Center, Medical College of Virginia Hospitals, and the Medical College of Hampton Roads, and a determination of the appropriateness of general fund and Medicaid allocation methodologies.

All agencies of the Commonwealth shall provide assistance upon request to the study as appropriate.

The Joint Legislative Audit and Review Commission shall complete its work in time to submit its findings and recommendations to the Governor and to the 1993 Session of the General Assembly, and shall provide interim reports to the Commission on Health Care for All Virginians and to the 1992 Session of the General Assembly and at other times as appropriate, using the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix B

Senate Joint Resolution No. 91

Requesting the Commission on Health Care for All Virginians to study the issue of property transfer for purposes of Medicaid eligibility.

Agreed to by the Senate, March 5, 1992
Agreed to by the House of Delegates, March 3, 1992

WHEREAS, health care spending continues to increase at a rapid rate; and

WHEREAS, the cost of Medicaid for the elderly is increasing at a rapid rate due to the aging of the general population; and

WHEREAS, the Medicaid budget is projected to grow by $743 million over the previous biennium; and

WHEREAS, many persons give away assets or otherwise dispose of resources they could use to purchase medical care, especially nursing home care, in order to become Medicaid-eligible; and

WHEREAS, the federal Medicaid eligibility rules regarding transfer of assets have been made more lenient in recent years; and

WHEREAS, it is common practice for persons anticipating the need for medical care for themselves or their relatives to consult attorneys and financial planners familiar with Medicaid law and regulations for advice on ways to circumvent the Medicaid rules so as to transfer assets to establish Medicaid eligibility; and

WHEREAS, the Joint Legislative Audit and Review Commission is examining Medicaid financing of long-term care including the issue of asset transfer and asset recovery, as directed by Senate Joint Resolution No. 180 passed by the 1991 General Assembly; and

WHEREAS, the resources of the Commonwealth should be used to help those most in need who do not have resources with which to purchase health care; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Commission on Health Care for All Virginians be requested to study the current practice of persons transferring or giving away assets without compensation so that they can become eligible for Medicaid, and to recommend to the General Assembly options available to limit the financial impact of such practices on the taxpayers of Virginia.

The Joint Legislative Audit and Review Commission shall, upon request of the Commission, discuss its study plan and report its findings and recommendations to the Commission prior to the 1993 Session of the General Assembly.

The Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1993 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents.

Appendix C

Major Differences Between OBRA 1987 Regulations and Prior Regulations

Pre OBRA 1987	Post OBRA 1987
Separate regulations applied to SNFs and ICFs.	The distinction between SNFs and ICFs was eliminated; all facilities are called nursing facilities with the same regulations.
No specific timeframes regarding completing plans of care were required. No quantifiable goals or objectives for care planning required.	A written plan of care is required which will provide services and activities that allow the resident to attain or maintain their highest level of functioning and well-being.
Patient assessments were not required, nor were requirements spelled out for the content of assessments if performed.	A comprehensive, accurate, standardized, reproducible assessment of each patient's functional capacity, coordinated by a registered nurse is required within four days of admission to the facility, and the resident must be reviewed at a minimum once every three months to assure contining accuracy of the assessment.
Staffing Requirements: SNFs-RN on duty at least 8 hours per day, seven days per week and LPN coverage 24 hours per day. ICFs-RN or LPN on duty 7 days per week during day shift available for prompt action in emergency situations 24 hours per day.	All facilities must have a RN on duty at least 8 hours per day, 7 days per week and an LPN on duty 24 hours per day, 7 days per week. States can waive these stipulations if facilities can prove they are unable to recruit staff, that residents' health and safety is not endangered, and that an RN or physician is on call to the facility.
No requirements for certification, registry, or testing of nurse aides.	The employment of nurse aides who have not completed the required training and competency evaluation programs after four months of starting work is forbidden.
No requirement for a full-time social worker.	Facilities with more than 120 beds must employ a full-time social worker.
Resident's rights were included as a standard, under the Governing Body and Management condition.	Residents' rights have been spelled out, and have been elevated to Condition Level.

Appendix C
(continued)

Pre OBRA 1987	Post OBRA 1987
Utilization review was at a condition level, but emphasis was on appropriateness of utilization, not assessment of quality of care.	A quality assessment and assurance committee that develops and implements appropriate plans of action to correct identified quality deficiencies must be established. The data sets and instruments used to assess residents must be developed.
There was no preadmission screening requirements for persons with mental illness or mental retardation.	Each state must have a preadmission screening program for all persons with a primary or secondary diagnosis of mental illness or mental retardation (excluding a primary diagnosis of dementia). States must review all mentally ill or mentally retarded persons in nursing facilities to determine whether continued placement is appropriate and must arrange for discharge and active treatment of residents when continued admission is inappropriate.
Certification surveys were conducted annually, with no provision for flexible scheduling. Surveys were generally scheduled in advance.	Surveys can be scheduled up to 15 months after the prior survey, with some flexibility as to timing, although the statewide average for surveys must be every 12 months. Surveys are unannounced.
Enforcement options for facilities that violated certification requirements were limited to repeat offenders, i.e. facilities with deficiencies that went uncorrected from year to year. States had to close down facilities and/or transfer residents when facilities were found to place the health or safety of residents in jeopardy.	State enforcement powers were expanded. Intermediate sanctions, previously adopted by some states, are specifically authorized by federal law. Facilities that pose an immediate danger to residents can be placed under temporary management while improvements are made; civil penalties can be assessed, or the state can deny payments for new Medicaid admissions. States may establish programs that provide incentives for high quality care that can include public recognition or incentive payments or both. While final interim sanctions have not been published, any deficiency could result in some type of sanction.

Source: Abt Associates, Inc. - Quality Assurance in Non-PPS Settings

Appendix D

Technical Reports Supporting Study Methodology

The following appendixes to this report are available upon request from the Joint Legislative Audit and Review Commission.

- *Technical Appendix: Nursing Home Cost Functions*
- *Technical Appendix: Home Health Cost Functions*
- *Technical Appendix: Sampling Methodology and Telephone Survey for Personal Care Analysis*

Appendix C

Agency Responses

As part of an extensive data validation process, each State agency involved in a JLARC assessment effort is given the opportunity to comment on an exposure draft of the report. This appendix contains responses by the Department of Medical Assistance Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Appropriate technical corrections resulting from the written comments have been made in this version of the report. Page references in the agency responses relate to an earlier exposure draft and may not correspond to page numbers in this version of the report.

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 14, 1992

Mr. Glen Tittermary
Senior Division Chief
Joint Legislative Audit
and Review Commission
General Assembly Building, Suite 1100
Capitol Square, Virginia 23219

Dear Mr. Tittermary:

It was a pleasure to meet with you on October 7, 1992, to discuss your two recent reports: **Medicaid Asset Transfers and Estate Recovery and Medicaid-Financed Long-Term Care Services in Virginia.**

We appreciate your willingness to accept our input and make modifications as appropriate. There are still some issues and findings that we continue to be uncomfortable with. I am taking this opportunity to summarize and reiterate those key issues we offered.

Medicaid Asset Transfers and Estate Recovery

A redoubled effort at recovering assets is called for, and we agree to continue to increase those efforts now that we have greater authority in this area of estate recovery. Time will tell whether there is as much as $14 million in recoverable assets. We reiterate our earlier observation that increased recoveries, along with the advent of affordable long-term care insurance policies in the Commonwealth, will jointly produce changes in the approaches citizens take when engaging in estate planning. Hopefully, we may look forward to these more dignified alternatives for the spend-down population. The LTC insurance and other options, when and if available, should be more appealing to prospective applicants when our proactive recoveries program is in place.

Medicaid-Financing Long-Term Care Services In Virginia

We are especially concerned about your methodology for arriving at the conclusion that 57% of clients utilizing personal care would receive the same care from existing caregivers if the program were discontinued; and therefore, this percent of clients does not meet the "imminent risk" criteria for participating in the Personal Care program.

This finding is based on a research technique of telephone interviews. Telephone interviews are highly error prone. Family members or caregivers are likely to say what they think the interviewer wants to hear (e.g., I will take care of my parent regardless of personal care availability), or simply acquiesce to what they infer to be the government interviewer's position.

Telephone surveys are not well-suited to speculative questions about what a person might do if a nursing home were not available, they are best used for matter-of-fact questions [Babbie, et al]. There is no way, without a validation study or the use of a focus group before survey start-up, to be confident that threats to the study's validity have been controlled. There is a substantial risk, then, that the findings from this telephone survey are imprecise and misleading.

Cost Audit and Rate Setting

DMAS analysis of the 43 NF's identified by JLARC as having costs below their ceilings indicates that 6 of the NF's had allowable costs of less than $1 Million. These facilities would not normally be high priority candidates for a discretionary audit.

Of the remaining 37 NF's, 30 percent (11 NF's) are currently either undergoing or scheduled for discretionary audits during FY 92 and FY 93. The DMAS will evaluate the remaining 26 NF's under the established selection criteria to determine which should receive discretionary audits during FY 93, if audit resources are available, or during the FY 94 audit cycle.

I should like to thank you again for your willingness to hear our comments on the two studies.

Sincerely,

Bruce U. Kozlowski

BUK/jwp

COMMONWEALTH of VIRGINIA
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October 8, 1992

Mr. Philip A. Leone, Director
Joint Legislative Audit and Review Commission
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Capitol Square
Richmond, Virginia 23219

Dear Phil:

I appreciate the opportunity to comment on the exposure draft of the JLARC report on Medicaid Financial Long Term Care Services. Attached is a list of the comments on those items related to the Department's Mental Retardation facilities.

I would like to commend your staff on the efforts to become familiar with our system. The feedback we have had from the facilities and community services boards has been very positive. It is my understanding that a meeting is being scheduled with our staffs to go over the comments and concerns which I trust will be incorporated in the final report.

Sincerely,

King E. Davis

KED/bm

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Department of Mental Health, Mental Retardation and Substance Abuse Services
Comments on Exposure Draft of JLARC Report on Medicaid Financing of Long Term Care Services in Virginia

Page 33 - Paragraph 3

The statements in paragraph three "expenditures for State-operated facilities have grown at the fastest rate" and paragraph four "the fastest growing long-term services are those provided in the community" appears to be contradictory as well as misleading. First, as reflected in various sections of the report the institutional increases usually refer to the increase in per diem expenditures rather than total expenditures. This is misleading given the efforts of the Department to reduce the census and size of the institutions as part of the National and State public policies over the last thirty years, and concurrently to improve the quality of care for those more severely and profoundly retarded remaining in the facilities. Also, it has been a longstanding budget policy to improve staffing standards whenever possible through census reductions rather than establishing new State jobs.

Furthermore, the community services expenditures are increasing rapidly because of the recent approval of the community based waiver as an effort to provide more appropriate and efficient services. While this is stated on page 34 it should be noted this is in response to public policy and demand for services rather than unchecked rapid cost increases.

Page 40 - Paragraphs 1 & 3

Paragraph one reflects an average annual increase of over 12% in institutional Medicaid expenditures and almost 13% in paragraph three on the same information. The statements should use the same number for consistency.

Page 42 - Paragraph 2

This should also include planned census reduction as a key factor contributing to the increased costs.

The comments on federal regulations on pages 42 - 45 are well done. However, there does seems to be a discrepancy between the 15% decline in residents on page 41 and the 21% on page 45 for the same time period. The 15% applies to Medicaid patients while the 21% applies to <u>all</u> patients.

Page 45 - Paragraph 3

Insert the work "significantly" after "charge" in the third sentence.

Also in relation to overhead or indirect cost, the 40% overhead costs should be defined to show this includes all non direct care costs such as food, laundry, housekeeping, building and grounds, and other support costs as is done on page 146. Since overhead and indirect in non health care systems may primarily be personnel and administration overhead, a distinction for our system should be made. Also since the national medicare health industry standard is 40%, it should be noted that our percentages are below industry standards.

Page 46 - Figure 10 and accompanying narrative relating to direct care staff ratios

The methodology used is questionable. It appears that Figure 10 may not have accounted for relief factors required to provide 7 day - 24 hour coverage along with leave and holiday usage. This factor is usually 1.6 times the staff requirement. For example: 5 staff per 24 hour day, a total of 8 (5 X 1.6) is required. The chart implied a ratio of more than 1 staff to 4 residents. While overall we meet ratios of 1:8, 1:8, 1:16 per 8 hour shift, only in areas showing the most severely handicapped are we approaching ratios of 1:4, 1:4, and 1:8. Further verification on these charts and related detailed is warranted.

Page 49 - Paragraph 1

The statement that the State should consider looking to its reimbursement system as a means of lowering its per diem expenditures when the rate of spending exceeds the Medicaid inflation rate fails to account for two key factors. First the "upper limit caps" imposed by Federal Medicare and Medicaid standards does in fact apply ceilings on reimbursement beyond health care inflation increases. This is noted later on page 141. Secondly, there needs to be a distinction between inflation on total expenditures versus the per diem to account for census declines and acuity of care and increasing standards of quality. There is a difference in the degree of increase and the implication that overall costs are escalating. For example, the total appropriations for the five training centers increased at an average rate of 5.69% for 1983 through 1990 which included salary and selected staff increases as well as major increases in fringe benefits and insurance costs, virtually all of which where external factors to this Department.

Page 94 - Paragraph 1

The second sentence should read "100 percent of cost" rather than "charge" rate, or clarify that charges equal cost.

Page 142 - Paragraph 2, Sentence 2

"As long as providers can be certain that their cost will be reimbursed, there is no incentive to deliver care more effectively." While on the surface this is true, with respect to the State's system, it fails to remotely recognize the tight budget policies the State has been operating under since at least the beginning of Governor Robb's administration when agencies have been "level funded" or base budgeted for eight years before the cuts of the 1990's. The implication that the institutional costs go unchecked and are inconsistent with the State's budget practices is invalid because no increases for non personal services with the exception of workman's compensation, insurance, and special education costs have been appropriated since FY 1982.

Page 147 - Figure 33

This chart is incorrect. Based upon a review of staff work papers there are at least two major flaws in the data. First the comparison at Southwestern Training Center is incorrect due to not including all of the buildings and grounds costs in 1983 as compared to 1990. (In 1983 there were two lines in the cost report as compared to a merged one line in 1990.) Secondly, and more importantly on a system-wide base general administration costs in 1990 included a "one-time accounting adjustment for accumulated annual leave cost". This was done as an revenue enhancement project to recover retroactive annual leave liability costs. This action occurred in 1990 and grossly inflates the rate of increase since this was a one-time action and was not comparable to 1983. Adjusting for this will also reduce the rate of indirect cost increase referred to earlier in the report and reduces the percentage of indirect/overhead costs in Figure 33 and on page 45 even more below the industry average. These corrections will require changes in the narrative. For example, applying these corrections to Southwestern Virginia Training Center the annual growth per recipient from 1983 to 1990 will be 10%.

Page 148 - Recommendation 4

Discussions regarding facility consolidation are contrary to State and Federal direction and would be a major set back for services to the MR population in Virginia; therefore the need for recommendation #4 which requests a study of facility consolidation is seriously questioned. Even requesting such a study would do serious harm in the community among families and coalition groups interested in this population. Further, it would send a dangerous message to those parties, such as the Federal Justice Department, who are already looking closely at services in Virginia and who believe our facilities are already too large, even the smaller ones.

Page 188 - Recommendation 8

The logic for this recommendation seems questionable since the basis for mental retardation waivers is that of cost effectiveness when compared to institutional ICF/MR placements. This was concluded prior to the State requesting a Federal Waiver and a study would be redundant.

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Medicaid-Financed Long-Term Care Services in Virginia, December 1992

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