

Long Term Care Briefing

Virginia Health Care Association
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Virginia Health Care Association

SERVING THE LONG TERM CARE NEEDS OF VIRGINIA

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Critical Issues: Long Term Care in Virginia

The Economic Impact of Virginia Long Term Care Facilities

Key Points:

- LTC facilities represent 2.1 percent of all economic activity in Virginia.
- Medicaid payments to Virginia nursing facilities make up about 2.5 percent of the Commonwealth's total expenditures.
- LTC facilities pay over \$400 million in state and local taxes each year.
- LTC facilities provide employment for 62,800 individuals in Virginia and another 41,700 in support businesses.
- According to projections, Virginia nursing facilities alone employ over 30,000 full time employees with a total payroll in excess of \$1.3 billion annually.

Health care, including long term care, is a significant economic driver in Virginia. In many areas of the Commonwealth, health care providers are the primary employers. In addition, downstream activity – sale of health care supplies and employment with supply companies are significant in both local and state economies.

Critical Issues: Long Term Care in Virginia

Virginia Medicaid Long Term Care Reimbursement

Key Points:

- 62% of all Virginia nursing facility patients are funded by Medicaid.
- The average nursing facility in Virginia is projected to lose \$12.45 per day per Medicaid patient in state fiscal year 2010.
- **Global Insight**, the economic forecasting company under contract with DMAS to develop the annual Medicaid payment rate update factors for nursing facilities, reports in their most current update that **“Nursing home wages and salaries have decelerated as a result of Medicaid cuts by the state as a result of budget deficits”** and that **“Nursing homes will have to cut staff, freeze wages, and decrease overtime payments to contain their operating costs.”**

These critical observations by Global Insight warn of a potentially disastrous scenario for Virginia’s nursing facilities – declining payment rates calculated in response to “survival mode” belt tightening that sets up a downward spiral where ultimately facilities can no longer provide the level of long term care services required by regulation and demanded by the public.

- The disconnect between what regulators require of nursing homes and what policy makers and elected officials are willing to pay for Medicaid long term care services is taking a significant and troubling new course as for the first time in decades, Medicare skilled nursing facility (SNF) payments are being cut. Traditionally, nursing facilities have relied upon positive Medicare margins to offset the losses incurred in providing Medicaid services. Medicare cuts scheduled to take effect beginning October 1, 2009 will exceed \$10 million for Virginia providers in federal fiscal year 2010.
- In addition to known cuts for both Medicare and Medicaid, changes that may result from the current national healthcare reform debate are likely to significantly reduce nursing facility payment over the next ten years. To illustrate, legislation now in the U.S. House of Representatives contains massive cuts to Medicare-funded skilled nursing care that could amount to more than \$32 billion over 10 years. These cuts are in addition to cuts outlined above. The ten-year cut totals \$44 billion nationally and \$1.1 billion for Virginia - a staggering \$29.48 per SNF patient day in the Commonwealth.
- The rapid growth of Medicaid program expenditures is not attributable to the nursing facility program as nursing home funding has been stable over most of the past decade while other Medicaid services have shown significant increases. In addition, the growth in Medicaid funding is impacted by the General Assembly’s fiscally prudent decisions to move other state general fund programs under the Medicaid program to draw down additional federal matching funds.
- Virginia is a 50/50 Medicaid match state. For every dollar Virginia invests in Medicaid, an additional dollar of funding is provided by the federal government.
- Nursing home Medicaid payment is a “bundled” payment with multiple components covered in one per diem rate – nursing care, food, activities and housing.

Critical Issues: Long Term Care in Virginia

Virginia Medicaid Long Term Care Reimbursement – *continued*

Virginia's Medicaid program is a very efficient, low-cost program compared to those in other states. While Virginia's Medicaid funding is rising with additional utilization as Virginia's population grows, nursing facility funding is very stable and grows only slightly each year. Other parts of the Medicaid program are growing at a much greater rate. Nursing facilities, by design, provide efficient and economical care for the most disabled and dependent of our citizens.

Virginia Medicaid Cost, Payment and Shortfall Analysis

	Actual Provider Fiscal Year						Projected	
	2002	2003	2004	2005	2006	2007	2009	2010
Medicaid Cost per Day	\$114.66	\$118.43	\$124.11	\$133.73	\$137.74	\$146.42		
Average Medicaid Payment per Day	103.58	109.23	114.07	123.94	132.52	140.32		
Medicaid Payment Shortfall	\$ (11.08)	\$ (9.20)	\$ (10.04)	\$ (9.79)	\$ (5.22)	\$ (6.10)	\$ (8.99)	\$ (12.45)
Total Medicaid Payment Shortfall (in millions)	\$ (70.1)	\$ (60.1)	\$ (66.1)	\$ (64.3)	\$ (33.6)	\$ (38.9)	\$ (57.5)	\$ (85.9)
Budget Cut for Nursing Facilities (in Millions)							\$ 18.5	\$ 28.4

Virginia Medicaid Compared to Other States

Total Population ¹	Rank 12 th
Per Capita Income ¹	9 th
Total Personal Income ¹	10 th
Number of Medicaid Recipients ²	22 nd
Number of Medicaid Recipients as a % of Population ²	47 th
Expenditures per Medicaid Recipient ²	31 st
Total Medicaid Expenditures per Capita ³	48 th

¹ U.S. Bureau of Economic Analysis State BEARFACTS:2007

² Kaiser Commission estimates, 2005

³ Total Medicaid Expenditure from Kaiser Commission 2006; Population from BEA 2007

Critical Issues: Long Term Care in Virginia

Staffing and Workforce

Key Points:

- Long term care facilities depend on an adequate supply of Certified Nursing Assistants (CNAs) and Licensed Practical Nurses (LPNs) to provide patient care in facilities.
- Long term care providers must compete with other health care providers for CNAs and LPNs. Competitive pay and benefits are essential to attract quality caregivers. In 2007, the average CNA received \$14.03 per hour in wages and benefits and LPNs received \$24.12 per hour.
- CNA wages range from a low of \$9.35 an hour to nearly \$17.00 an hour depending on geographic location. It is critical that increases in wages for these primary caregivers keep pace with increases in the cost of living. Many CNAs are single moms trying to provide for their families on very modest incomes.
- Virginia's support for community college programs for CNAs and LPNs must be expanded to meet the growing demand to care for an aging population. To do this, more nursing faculty must be employed and clinical teaching sites must be expanded.

According to the "2007 AHCA Survey of Nursing Staff Vacancies & Turnover Rates" published July 21, 2008, Virginia facilities reported the following data on staff turnover rates and vacancies on June 30, 2007.

	Virginia Nursing Home Annualized Turnover Rate By Job Category	Virginia Nursing Home Vacancy Rate By Job Category
Director of Nursing	33.3%	2.5%
Administrator	41.2%	11.6%
Staff Registered Nurse (RN)	58.5%	17.1%
Licensed Practical Nurse (LPN)	58.6%	10.3%
Certified Nursing Assistant (CNA)	79.8%	8.7%

Most nursing programs have a waiting list of qualified students because of inadequate teaching capacity in Virginia's community colleges. Many college programs are unable to hire sufficient qualified teaching staff to address waiting lists because of low pay scales in the community college system for masters-prepared nurses. The cost incurred by community colleges to operate nursing programs is high due to the fact that a professor can adequately supervise only a limited number of students in the clinical setting. The cost per nursing graduate, therefore, is higher than for many other programs.

Most of the care provided in nursing homes is provided by CNAs and LPNs. Recently, hospitals have announced their intention to staff hospitals with RNs only and, as a result, many have closed their clinical sites to LPN programs. Nursing homes can serve as clinical sites for LPN programs, but most do not offer training in pediatric and psychiatric care, which are required by the Board of Nursing in preparation for the LPN licensure exam. Virginia should examine requirements for the LPN exam to address the varied realities of today's health care settings, including whether the state should focus LPN training on care for the elderly and disabled.

Critical Issues: Long Term Care in Virginia

Regulatory Oversight of Long Term Care

Key Points:

- Most nursing home regulations are federal and enforced by The Centers for Medicare and Medicaid Services (CMS) which contracts with the Virginia Department of Health to survey nursing homes and investigate complaints. Medicaid payment for nursing facilities is set by the General Assembly at the state level. This sets up a dysfunctional reality – care and facility standards set by the federal government and payment levels established by state government. In times of economic downturn, the state cannot adjust regulatory requirements when payment rates are cut.
- All nursing homes are surveyed annually and upon the filing of a complaint.
- Nursing homes must self-report all “incidents” as defined by CMS or face significant fines. All “incidents” must be reported to at least four different state agencies and in some cases local police. Agencies include the Office of Certification & Licensure of the Department of Health, Department of Health Professions, Adult Protective Services of the Department of Social Services, and the Ombudsman in the Department of Aging.
- Surveyors, by regulation, are not allowed to recognize good or superior quality service and can only recognize less than adequate care in 178 different areas identified in the survey regulations.
- Assisted Living Facilities (ALFs) are regulated by the Commonwealth of Virginia. The Virginia Department of Social Services surveys ALFs on an annual basis for life safety code, staffing, staff training, medication administration and resident assessment.

CMS has recently developed a “five-star rating system” for nursing homes. A facility’s overall five-star rating incorporates ratings in three categories: survey results, quality measures and staffing levels. The new “five-star” nursing home quality rating system is, overall, an inaccurate measuring criteria that fails to provide consumers with the accurate tool necessary to evaluate a given facility’s level of care and quality of care.

The “five-star” rating system is a well-intended initiative that, unfortunately, is premised upon a subjective and flawed nursing home survey system. Quality improvement is a dynamic, ongoing process and its quantification must reflect the many variants that go into the delivery of care. Today’s federal survey system does not specifically measure quality – rather, it assesses compliance with federal and state regulations.

Customer satisfaction – how a patient or family member judges the actual care being provided in a particular Virginia nursing home – is a superior indicator of the quality of care and quality of life experienced by patients. A February 2008 My InnerView. Inc. report on customer satisfaction in Virginia nursing homes indicated 78% of patient respondents rated overall satisfaction with their nursing home as “excellent” or “good”.

Virginia must guarantee that all facilities have the resources necessary to sustain improvement efforts for the long term by ensuring that Virginia’s Medicaid system funds the actual cost of providing quality care. This is not now the case, and staffing is often the biggest casualty.

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Professional Liability Issues

Key Points:

- Virginia law permits long term care facilities to use binding arbitration agreements in their contracts for services so long as withdrawal provisions are included in the agreement.
- Arbitration is more efficient, less adversarial, less costly and results in reduced settlement time with patients receiving a greater portion of the settlement.
- The current medical malpractice cap of \$2 million is more than adequate for long term care liability cases in Virginia.
- Virginia Medicaid pays its portion of long term care liability costs for providers who accept Medicaid patients.

Arbitration saves legal costs to the Medicaid program by efficiently settling issues without expensive legal and court costs.

Virginia's medical malpractice cap also lowers Virginia Medicaid funding expenditures by creating a lower liability insurance environment than exists in states without a medical malpractice cap. Insurance payments are an allowable Medicaid expense and therefore impact the amount the Commonwealth spends on Medicaid reimbursement.

Information from the Virginia Bureau of Insurance shows that between for the years 2002 through 2007, there were 273 claims closed involving long term care facilities in Virginia. Of the total claims closed, 260 claims were for less than \$250,000, ten were closed between \$251,000 and \$500,000, two were closed between \$751,000 and \$1 million and only one claim was closed for more than \$1 million.

No single claim for long term care facilities in Virginia closed for more than \$1,250,000.

During the 2002-2007 reporting period, a total of \$14,704,094 was paid by insurers to claimants while \$7,062,564 was paid in legal costs to defend LTC providers against the claims.

Critical Issues: Long Term Care in Virginia

Home and Community-Based Services (HCBS)

Key Points:

- Medicaid patients should have a choice of care settings when it is appropriate and cost effective. Nursing homes and HCBS programs are appropriate for certain people, at certain times, and for certain periods of time. Patient safety and quality of care can be more problematic in the home care setting. Research shows notable improvements in nursing home quality, however little is known about quality in rapidly growing HCBS programs. The Olmstead Task Force Report in 2003 stated “While people with disabilities assert their rights to live and receive services and support in the settings that are their preference..., they remain more vulnerable to abuse, neglect and mistreatment than do most citizens of the Commonwealth.”
- HCBS payments are not “bundled”—each service is paid separately. HCBS has not stopped or slowed Medicaid LTC expenditure growth. Research shows that HCBS can increase overall LTC costs.
- The increase in HCBS results in higher acuity patients in nursing homes.
- Virginia must fund *both* HCBS *and* nursing homes adequately for the provision of quality care.

Soon more than 26 million “baby boomers” will reach retirement age and begin to place unprecedented demands on Medicaid and Medicare programs. Of particular concern are the needs and expectations these boomers will have for long term health services.

The Centers for Medicare and Medicaid Services (CMS) states that “long term care reforms will be built on successful programs that use consumer direction and home and community-based care to improve satisfaction and lower costs.” The “consumer directed” aspect of this initiative refers to a system of flexible funding for services that allows individuals to choose where and from whom they receive the services they need.

Currently, the need for institutional care is determined through a process that assesses an individual’s functional status in order to determine nursing home eligibility. The assessment tools generally focus on evaluating the individual’s performance in the areas of activities of daily living, cognitive impairment (including hearing and vision), behavior status, nutrition/skin condition, and the need for restorative care and various therapies. The assessment process is always initiated by a physician to determine whether nursing home care is warranted or if care can appropriately be done in the person’s home. Under the standards in place today in Virginia, which has very strict preadmission screening requirements, those currently residing in a nursing home truly need to be there.

Virginia pays nursing homes varying rates based upon patient acuity levels. This means that the more care a patient needs, the more the nursing home is paid to provide that care. Conversely, lower acuity patient care is reimbursed at a lower level than is paid for higher acuity patients. In a nutshell, Medicaid is getting, literally, what it pays for and ensuring fiscal responsibility and accountability of taxpayer’s monies.

Critical Issues: Long Term Care in Virginia

Home and Community-Based Services (HCBS) - *continued*

Are there savings to be derived by providing services in the home or in another community setting compared to the same services provided in a nursing home? It is unlikely, given the economies of scale associated with facility-based care. For example, it is more cost effective to have a nurse provide services to several people in one place than it is to have them provide the same service while traveling from place to place.

The real question that must be answered is whether HCBS actually will be able to provide the care for nursing home eligible patients adequately and prevent them from having to use nursing home services or whether the Commonwealth will simply be expanding Medicaid-funded care to more recipients with no corresponding reduction in the number of individuals needing nursing home care. While it might be the “right thing to do” to assist families in caring for their loved ones at home, expansion of the number of people receiving Medicaid funded care will increase overall Medicaid funding – not lower it.

Trend in State Expenditures for Long Term Care Services

Source: Virginia Department of Medical Assistance Services

