**Health Care Finance Working Group**
**Long Term Care – Draft of June 25, 2001**

## Overview

Last July, the Finance Working Group submitted a report on the financial condition of nursing facilities. This report revisits that issue, presents updated financial and related information, reviews recent changes, and summarizes the Working Group's discussions about the broader long term care continuum, including home and community-based providers. It also considers the relationship between financial condition, quality of care and access to services.

The Working Group acknowledges that long term care has appropriately been an area of increasing focus for the Commonwealth. Through the efforts of the Vision 2020 Task Force,[1] the Executive Order 421 effort undertaken by state agencies,[2] the Health Care Task Force, and other initiatives (such as the Pharmacy Advantage program), the Commonwealth has devoted increased attention and resources to institutional and community-based long term care needs. Long term care needs must be balanced with other health care concerns and with non-health-related public policy goals. The Working Group acknowledges the broader context in presenting this report.

During the last several weeks, the Working Group has heard presentations by and had discussions with representatives of nursing facilities, assisted living facilities, home health care providers, adult day health providers, the Division of Medical Assistance, the Department of Public Health, the Division of Health Care Finance and Policy and the Executive Office of Elder Affairs.

The Group has approached long term care with two major questions: Is there a crisis? And, are we doing as well as we could be doing with the resources we are spending? In summary, the Group has serious concerns but did not identify a crisis. Given likely constraints on future resources and increases in future needs, the Group believes we need to find ways to do better with the resources we devote to long term care in the future. In considering these questions, the Group looked at five main aspects of long term care:

1. Capacity – In general, the overall capacity of the system appears adequate to handle current demand (at least as expressed through patients who come forward to request care), with the caution that in certain parts of the state, access to nursing facility beds could become a problem if more facilities close.

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[1] The Vision 2020 Task Force was created and led by Senator Richard Moore and then-Representative, now Senator Harriette Chandler to examine and plan for the Commonwealth's long term care needs for the future.

[2] Executive Order 421 directed the Executive Office of Health and Human Services, the Executive Office of Elder Affairs and the Office of Consumer Affairs and Business Regulation to study and plan for the next five years of long term care service needs.

2. Quality – Though quality of care is generally good, there are concerns and problems related to staffing difficulties, and quality should be monitored closely. The Working Group is concerned that some nursing homes may not have enough money or staff to provide quality care, but the evidence on this point is not as strong as the Group would like.

3. Financing – The results of the group's examination of financing issues are mixed. Though the situation does not appear to be worse for nursing facilities in the aggregate than it was last year, margins are still negative for many facilities. The bulk of the report focuses on this issue.

4. Oversight – While generally adequate, monitoring and oversight of quality and financial conditions should be increased with respect to nursing facility chains coming out of bankruptcy. Certain additional oversight measures, such as collecting audited financial information from nursing facilities, should be considered, although it is important to weigh their usefulness against the costs they might impose.

5. Administration – Many parties in the state have a role in long term care financing, regulation, monitoring and administration. Greater coordination would improve each of those functions and facilitate planning efforts.

6. Future Needs – The Group is concerned, looking into the future, that public and private resources will not be adequate to support the system as it is now. Although we are managing with the system now, trends point towards increased demand in the future.

**Nursing Facilities**

In its report last year, the Working Group expressed concern about worsening financial conditions among nursing facilities and recommended an approach of targeted assistance and intervention. An important aspect of the original report was a concern that bankruptcies of national nursing facility chains resulted in part from high debt costs caused by the high prices they paid for facilities and investments in high-end care that did not yield anticipated revenue. While we felt those costs should not necessarily be reimbursed by the state, we were concerned that widespread closures could lead to access problems.

The most recent evidence suggests that there has been marginal improvement in financial conditions overall. However, we have not yet seen the full effect of the chain bankruptcies. Although some of the chains are closing facilities in some states, we have not heard of plans to close many Massachusetts facilities. Our hope is that with continued reasonable rate increases and the emergence of chains from bankruptcy in accordance with reorganization plans, the nursing facility industry may be headed for increasing stability in another year or two. Nonetheless, the industry still should be monitored closely, particularly in parts of the state where access could become a problem. We still believe targeted intervention, in addition to reasonable rate increases, may be necessary in the short run.

## Long Term Care in the Long Run

The Working Group is concerned about the financing and structure of delivering long term care services over the long run. The Group foresees increasing demand for long term care services and continued increases in the cost of providing those services. Factors driving these trends include advances in pharmacology, medical technology and treatment that enable people to remain outside institutional care settings longer than they could have in the past. Often, these people need supportive services in the community. As community options expand, lighter care patients leave (or don't enter) nursing homes, and those with the most intensive needs become concentrated in facilities. Consequently, cost per patient day in nursing facilities rises for the patients who remain and require more intensive care. At the same time, the disintegration and geographic dispersion of traditional extended families has decreased the availability of informal family supports for seniors as they require more of that support. Full employment and tighter immigration restrictions have also reduced the supply of workers available to provide that support through paid work.

Unlike other segments of the health care sector, nursing facilities are heavily dependent on the state Medicaid program. This situation is at least in part a result of public policy decisions that have made it difficult for people to qualify for Medicaid services unless they have a high level of clinical need. As a consequence, when people do require institutional care, they generally need a more intensive (and expensive) level of care than in the past and exhaust their private resources quickly. People who require light levels of assistance may exhaust private resources on community care before coming to a facility when their care needs increase. Private resources tend to be used and in some cases exhausted often in private homes, where the private resources never even appear in the state's analysis of long term care resources.

Given the fact that state funds will always be limited, and given the pressures on demand, it is necessary to find ways to promote creative alternatives that will provide more public and private resources to support community-based and institutional long term care. We need, and do not have, an affordable and accessible system of long-term care financing across a continuum of settings. This is not a new challenge, and it remains as difficult as it has been for the many decades public policy-makers have struggled with it. It is also more important than ever. The Working Group supports the creation of a special commission to study the future of long term care in the Commonwealth, as provided for in both the House and Senate budgets.

The report first outlines institutional providers' problems, possible causes and policy options. It then addresses non-institutional providers' problems, possible causes and policy options. Finally, it considers system-wide concerns and policies.

## I. Institutional Providers

### A. Problems.

The financial condition of nursing facilities in Massachusetts continues to be weak. Margins dipped further in 1999, particularly for the least profitable quartile of facilities, but improved in 2000 to 1998 levels[3]. Total profit margins, in the aggregate, have increased very slightly; the percentage of facilities losing money has decreased slightly from 56% in 1999 to 52% in 2000. Approximately 15% of facilities are now owned by parent corporations in bankruptcy, as opposed to 25% when we reported last summer.[4] A number of nursing facilities are at risk of closure. It would take approximately $236 million to bring all facilities to a break-even point, based on the 2000 data included in this report. Profit margins vary greatly: some facilities are doing well, and many others – particularly those owned by companies that are in bankruptcy – are doing poorly. (Figures 1-6.) There are also non-bankrupt homes that are losing money, which deserve scrutiny out of concern that quality problems may arise.

Providers across the board continue to experience difficulty attracting and retaining staff. This may register in a nursing home's financial problems and may cause quality problems. Staffing issues are therefore of the greatest importance and merit continuous monitoring. Nursing facilities rely increasingly on temporary nursing pools to fill vacant positions and shifts necessary to provide adequate care. (Figure 7.) Although state action taken since our last report has helped, including enactment of a wage pass-through for certified nursing assistants and limitations on the rates temporary nursing pools may charge for temporary staff, workforce problems persist.

Quality deficiencies identified by the Department of Public Health investigators have increased over the last several years, although they appear to have leveled off somewhat in recent months. (Figure 8.) Complaints relating to nursing care also remain high, possibly as a result of the staffing problems identified above. (Figures 9 –10.) The Working Group believes that deteriorating quality of care as a result of staffing difficulty continues to be a problem.

The Working Group has not identified a statewide access problem with respect to nursing facility services, although there are a limited number of areas where low numbers of available beds will probably cause access problems in the event of more closures in these areas. (Figures 11-14 - Maps). In general, occupancy rates, which declined from 1992 to 1999, began to increase somewhat in the last year. Overall, the occupancy rate for the state stood at 91% in 2000. (Figures 15-16) The decline in occupancy rates during much of the 1990's resulted from declining census as alternative services such as assisted living

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[3] 2000 data include those cost reports processed by the Division of Health Care Finance and Policy as of June 1 and represent approximately 85-90% of the nursing facilities in the state.

[4] This change is due largely to the emergence of Vencor, Inc., now called Kindred Healthcare, Inc., which owns approximately 35 facilities in Massachusetts, from Chapter 11 earlier this spring. The lasting effects of Vencor/Kindred's restructuring (such as effects on administrative and capital costs and on quality of care) remain to be seen. Of the 65 facilities still in bankruptcy, 28 are owned by Sunbridge. If Sunbridge were to come out of bankruptcy, or to sell all of those facilities, the bankruptcy rate would be down to 8%.

and home based services became more available, coupled with a slow increase (and more recently, slight decrease) in the number of licensed beds. (Figures 17-22.) The closing of a number of facilities in the last few years has helped reduce much of the excess capacity and there is now a growing sense that overall, capacity is closer to an appropriate level for the short term. Nevertheless, the rate-setting formula for the state Medicaid program, which is the dominant payer for nursing facility services, still assumes that 96% occupancy is optimal. Facilities that fall below this level are penalized in their reimbursement rate. The Working Group is concerned that Medicaid's "appropriate occupancy rate" may be too high. Nursing facilities currently treat larger numbers of short-term rehabilitation patients who have higher turnover rates, so the need for slack capacity to handle this greater fluctuation in demand has increased.

## B. Analysis of Possible Causes

### 1. Revenue.

As the Working Group previously reported, many factors contribute to poor financial performance by nursing facilities. The Balanced Budget Act of 1997 (BBA) reduced nursing facilities' Medicare revenue considerably and changed the method by which Medicare reimburses for physical and occupational therapy and other ancillary services. The American Health Care Association estimates that BBA "give-back" measures have returned approximately $81 million in Medicare revenue to Massachusetts nursing facilities, but Medicare reimbursement remains substantially below levels projected prior to the BBA. (Figure 23)

Working Group members disagree with one another about the relative contributions of (a) the low (and decreasing) level of private revenue, (b) lower Medicare reimbursement, and (c) inadequate Medicaid rates in harming nursing facility financial margins. Medicaid payment levels, in the aggregate, may contribute to the financial problems of nursing facilities, although the appropriate level of Medicaid rates is difficult to determine and requires further study. Working Group members agree that Medicaid payment levels should be high enough to provide revenue sufficient to maintain an efficient, well-run facility and that provides safe, adequate and dignified care for Medicaid patients. Working Group members also agree that Medicaid should not pay for additional costs some facilities have (or may have) incurred investing in more expensive services used primarily by Medicare patients (who generally require more intensive care) or in higher-end amenities to attract privately paying residents. Facilities that made those kinds of investments created more expensive cost structures than would be required to serve only Medicaid patients. Because anticipated Medicare and private revenue have failed to materialize, those facilities have been left with high fixed costs, dependent on a Medicaid payment stream that is not designed to pay for many of those costs.

The situation is further complicated by the fact that traditionally at many nursing homes, private payments helped to sustain quality of care when Medicaid payments were lower than average cost. This can be seen as the privately paying patient subsidizing his or her

care over time, because after his or her private resources are exhausted, the care is paid for by Medicaid at a lower level. As fewer privately paying patients enter facilities, opportunities for cross-subsidization decrease.

The Working Group understands that the state is moving toward a standard Medicaid rate system based on statewide average recognized costs rather than on facility-specific reported costs, and the Group supports moving toward this standard pricing approach. It is important that standard prices be set at a level designed to yield revenue sufficient to support an efficiently-run facility that provides safe, adequate and dignified care for Medicaid enrollees. Despite the soundness of the general approach, however, certain aspects of the rate-setting methodology or of the transition in rate systems are or could be creating problems. First, the "occupancy threshold," which imposes a financial penalty on facilities with occupancy rates below 96% harms many homes. Although occupancy rates statewide are starting to rise as more homes close, the 96% level is still only attained by approximately 30% of facilities. The occupancy threshold appears to be a holdover from a cost-based reimbursement system and is less appropriate in a fully implemented standardized prospective payment system. Retaining the threshold and penalty warrants examination.

Second, during the transition to the state's new "standard rate" system, it has imposed a ceiling on the amount by which the rates for historically low-cost facilities could be increased. Ironically, this has resulted in an inability to recognize and compensate for some legitimate increases in operating expenses, such as nursing staff, for facilities that are generally low cost.

Third, the "base year" of costs used to calculate the standard payment levels, coupled with the inflation adjustment factor, may not account for recent significant increases in necessary costs such as staffing. For example, discharges from hospitals to nursing facilities have increased (Figure 28), and industry representatives have said that patients are arriving with higher levels of care needs and therefore may be more costly. (Figure 24)

**2. Cost and Management**

Representatives of the industry have said that they believe a high percentage of Medicaid enrollees in a facility's patient mix is the most significant factor leading to low margins. However, there are facilities that have a high percentage of Medicaid patients that have survived well, provided their occupancy levels have remained high. In fact, a study conducted for the Working Group indicates that the strongest predictor of low total profit margins for a nursing facility is low occupancy. In this analysis, occupancy rate explains 25% of the variation in total profit margin. Other significant predictive factors of low total profit margins include high nursing expenses and high administrative expenses per day, high percentage of Medicaid patients, low percentage of private paying patients and private revenue, and low casemix (a measure of the intensity of illness of the facility's patient population). (See appendix for details of this analysis.)

There is, at least potentially, some tension between maintaining high occupancy by attracting large numbers of patients, particularly private patients, and at the same time maintaining low total costs. It may be necessary for facilities to invest in extra staff or other expenses to attract residents. Obviously, facilities with low occupancy have fewer patients over whom to spread fixed costs. Managing these competing priorities has likely presented problems for many facilities, and the Working Group recognizes the tensions inherent in balancing these competing demands.

There is great variation in costs across nursing facilities. Certainly for some, high administrative costs or high capital costs cause problems. As noted above, some of the cost problems may result from investments made in anticipation of Medicare or private revenue that failed to materialize.

Lack of audited financial data, plus inevitable inability of even the best data to register fully a nursing home's financial circumstances – and the causes of those circumstances – limit our analysis and suggested responses.

## C. Options

Many forces affecting the financial condition of nursing facilities (and other providers) and the accessibility of services are beyond the state's immediate control. Medicare payment policies and general economic conditions such as full employment, worker shortages and interest rates will not change in the short term because of state action. The main tools the state has to improve things are additional state funds (through the Medicaid rate, special loans or grants), technical assistance (which would also cost something to develop); Medicaid rate-setting methods; state-controlled eligibility rules; and state regulatory policy. In its report on the financial condition of nursing facilities last summer, the Working Group outlined three broad policy options: a "hands off" approach, an industry-wide "bail-out" approach, and a strategy of targeted intervention. The Group recommended the last.

During the last year, the Commonwealth has enacted substantial increases in Medicaid funding, a wage increase "pass-through" for certified nursing assistants in nursing facilities, and funding of career development programs for direct care workers. The Department of Public Health brought an additional 25 inspectors on board during fiscal year 2000 and has added another 13 in fiscal year 2001 to investigate possible quality of care problems. A draft report by several state agencies proposes incremental steps toward developing increased community care capacity to enable more people requiring care to remain in the community longer.[5]

In broad terms, the policy options with respect to nursing facilities remain the same as they were last summer. The Commonwealth could decide that it has done enough for

[5] A draft of the report being prepared pursuant to Executive Order 421 recommends a variety of steps to increase community-based care options.

now and that it should not continue large funding increases or other special assistance at this time. Without repeating the observations in last year's report, the Working Group continues to believe this "hands off" option is unacceptable because the risk is too great that too many more facilities will close and that quality of care will be further compromised. If we do nothing, more homes will close, and we will probably reach a point where the system has less capacity than is needed.

On the other hand, the Commonwealth could step in with large funding increases aiming to preserve all facilities and raising them all to break-even levels. Again without repeating all the observations in the previous report, the Group continues to believe that this "bail out" approach would fail to recognize important variations in efficiency, cost and quality and – in some cases – could reward bad management practices and fail to reward good ones. Given that biggest statistical predictor of low margins is low occupancy, it may be ill advised to fund losses due to the inability of a home to attract residents. Although the state should have the goal of reimbursing fairly for care and should adopt reasonable and regular increases in reimbursement, the Group advises against a strategy of raising rates across the board to cover whatever each facility reports as its costs of care.

The Group's recommendation, again, is to pursue reasonable rate increases coupled with targeted and strategic support of long term care providers in the short term, as well as additional planning activities. While recognizing that the Commonwealth has taken action pursuant to the recommendations last year, the Group believes that further action is required. The Working Group has discussed a number of interventions, including short term and longer term strategies, outlined below.

*Revisit Medicaid Rate-Setting Method.* Certain aspects of the rate-setting method identified above may be contributing to the problem that, despite substantial increases in funding over the last two years, Medicaid rates are still not sufficient to sustain many nursing facilities. The level of the occupancy threshold, the ceiling on "total payment adjustment," the base year of costs recognized and the adjustment from base year to rate year costs should be re-examined to determine whether they are appropriate in the current climate. A more comprehensive approach would be to contract for a study of the rate-setting method to determine whether Medicaid rates are adequate to cover the costs incurred by an efficient provider to provide safe, adequate and dignified care to Medicaid patients. The contractor should also be asked to recommend methods for structuring Medicaid rates to include incentives for provision of high quality care and for efficiency. If such a study is pursued, however, it should not delay action to address the specific factors mentioned above, nor should it delay reasonable rate increases.

*Increase Private Resources.* As noted above, members of the Working Group disagree on whether the expansion of private revenue in the long term care industry is necessary or likely to succeed, but some believe it is important to pursue. (Figure 25) One way to bring more revenue to offset higher cost structures would be to allow private revenue (for example, from a family member) to pay for amenities above the level reasonable Medicaid rates would cover – something current federal rules do not allow. Some

Working Group members have suggested that allowing private payment by relatives or others for "extras" would help defray aspects of higher cost structures that are not part of the necessary costs incurred by an efficient provider of Medicaid services. In addition, although long term care insurance has not yet proven to be an effective strategy to bring in much more private financing, mechanisms such as long term care medical savings accounts, reverse mortgages and life insurance policies that allow proceeds to be spent on long term care prior to the insured's death are worth exploring.

Some Working Group members believe that the restrictions on private payments to supplement Medicaid make sense on the grounds that if partial private payments were allowed, facilities would discriminate against those patient who cannot afford to make them, and that if such payments were permitted, Medicaid might cut back on its payment levels and facilities would not wind up with any additional revenue.

Regardless of their views on the merits of increasing private dollars, Working Group members agree that it is important to find ways to add private nonpaid caregivers to the long term care system through expanding family and community volunteer programs, including innovative methods of doing so.

*Increase Monitoring.* As noted above, the effects of chain bankruptcies have not been fully felt. In addition, certain regions in the Commonwealth appear to be at greater risk of nursing home bed shortages than others due to high occupancy rates and low margins among facilities. The Commonwealth should increase monitoring of provider financial conditions, occupancy rates and availability of alternative services in those regions. It should monitor closely the quality of care and financial condition of facilities emerging from bankruptcy. One way to improve monitoring of financial status would be to require nursing facilities to submit audited financial statements to state regulators, just as hospitals, community health centers, and many other providers do. The cost of adding this requirement should be weighed against the potential benefit.

*Provide Technical Assistance*. In light of the wide variation in cost and quality among nursing facilities, the Commonwealth may want to identify specific examples of "model" facilities that are low cost, provide high quality care, and serve a high percentage of Medicaid enrollees. These facilities could be evaluated to determine "best practices" and could be followed over time as "benchmark" facilities. Similarly, it may make sense to identify examples of facilities that have persistent problems with high costs to determine the reasons for difficulty and to offer help in reducing costs. One option could be for the state to develop or purchase the services of a team of expert administrators that could be deployed to assist facilities in reducing administrative costs and improving efficiency. Another option would be to offer rate enhancements to facilities that demonstrate low administrative costs or low costs overall, and high quality; or to facilities that have low costs but also low margins and have quality problems.

*Improve Coordination of Agency Policy.* Representatives of various long term care providers have asserted that policy directives from different state agencies sometimes conflict or compete with each other. For example, some nursing facility representatives

believe that some facility and quality requirements imposed by the Department of Public Health may require investments that are not possible under the Medicaid rate. Regulating and policing are vital to protecting patients, but are a complement to adequate payment and cannot substitute for adequate payment. There can be a role for technical assistance and continuous quality improvement as a complement to inspection and regulation approaches. The Working Group supports the notion that the Commonwealth should pay a Medicaid rate commensurate with an appropriate level of quality, and that regulatory requirements should be coordinated across agencies and streamlined as much as possible.

*Targeted Financial Assistance.* Targeted financial assistance is suggested as a short term option only. Regular rates should be sufficient to sustain each efficiently operated provider of quality care. To the extent possible, appropriate compensation and incentives should be built into rate-setting methodologies. On the other hand, it appears that at this time, there may be circumstances (for example, relating to problems caused by the transition in rate-setting systems) that warrant special intervention to preserve low-cost, high quality facilities, or to preserve access in geographic areas where occupancy rates are high. The state has already provided such targeted assistance to some low-cost providers imperiled by aspects of the rate method transition, in order to preserve access. Any action in this area needs to be balanced with the recognition that intervening to "save" one facility may indirectly "hurt" other facilities because they will not be able to increase their occupancy rates as they might have if the "saved" facility had closed, and because administrators may perceive special assistance as a reward for ineffective management, causing morale problems and possibly creating bad incentives. On balance, it is better to save a *needed* home even at the risk of introducing unfairness, particularly in the short term.

*Lifting Regulatory Restrictions on New Beds.* Because the statewide average occupancy rate in nursing facilities is low, the Commonwealth has instituted a moratorium on new beds in order to preserve existing facilities. To ensure access, the Commonwealth should consider lifting this moratorium in certain geographic areas where the occupancy rate is much higher than this. In order to encourage construction of new beds in such areas, rates would have to be sufficient to permit a return on the investment in the capital structure.

## II. Non-Institutional Providers

### A. Problems

The financial conditions of many or most home health care providers and adult day health providers are tenuous. Home health care provider representatives assert that revenue does not cover the cost of care in general, leaving a gap of $20-25 million statewide. They point to a particular problem with pediatric home care, where they report that the gap between cost and reimbursement is approximately $8 million. They also reported that much of the home health care prescribed by physicians is not actually delivered due to staffing shortages, which are arguably associated with underpayment. Continued

financial viability of home health providers is a concern for those needing long term care in the community, and also for everyone who may need short-term home health care. Moreover, because total margins are generally low, providers have difficulty obtaining funding for capital investments, such as purchase of laptop computers, which could increase the productivity and effectiveness of home health care personnel. (Figures 26-27)

Financial viability of adult day health providers should be monitored while the usefulness and appeal of this type of provider – from both patient satisfaction and cost effectiveness viewpoints – are assessed over time. Industry representatives reported financial difficulty, but systematic data on adult day health providers were not available for this report.

Access to community-based long term care services is hard for most people without private resources, due at least in part to limited public funding and complex eligibility rules for various programs. The Executive Office of Elder Affairs offers many services through its home care programs that help people stay more safely in their homes. Still, because of clinical eligibility rules, it is easier for many people, and certainly for those with more intensive needs, to obtain public support for nursing facility services than for community-based care when some skilled care services – or heavy care – are called for.

## B. Analysis of Possible Causes

For home health agencies, Medicare reimbursement changes resulting from the BBA included an interim payment system that led to large losses, and more recently to a new prospective payment system. Because Medicare covers approximately 50-60% of home health agency patients (according to provider representatives), changes in Medicare payment policy profoundly affect finances. Fortunately, at this time, industry representatives believe that the new PPS system is covering costs of serving Medicare patients.

Low Medicaid reimbursement rates and restrictive service eligibility rules are cited by home health and adult day health providers as contributing to their financial distress and to problems Medicaid enrollees have in accessing services. The Division of Health Care Finance and Policy is in the midst of its biennial review of Medicaid rates for both home health and adult day health providers.

Medicaid eligibility rules often resemble those of Medicare, and Medicare has restricted clinical eligibility for home health services to those with relatively intensive needs. Fears of unaffordable costs if eligibility were broader help explain limitations on program eligibility.

## C. Options

*Medicaid Rates and Rate-Setting Method.* While the Working Group has not discussed in detail the Medicaid rates paid to home health and adult day health providers, it seems appropriate to examine those rates as part of a broader evaluation of the effectiveness of the Commonwealth's policies in encouraging cost-effective long term care along a continuum of service levels and locations.

*Eligibility Rules.* Eligibility rules for various programs administered by different agencies in the Commonwealth and for different benefit levels within those programs should be evaluated to determine whether changes can or should be made to facilitate access to services in a way that promotes the provision of long term care in the most cost-effective and clinically appropriate setting – in the community wherever possible and practical. To the extent federal rules lack flexibility, the state may choose to re-design rules for state programs around the federal rules or seek additional waivers of federal rules.[6]

*Alternative Payment Arrangements and Provider Relationships.* For providers that serve an especially high percentage of Medicaid clients, the state may choose to explore special contractual relationships that allow alternative reimbursement systems. For example, home health agencies that serve a high number of Medicaid clients might enter into a special provider arrangement and be paid under a prospective payment system similar to the one instituted by Medicare. This type of payment system, in which payment is provided for an episode of care rather than on a retrospective fee-for-service basis, could help providers manage cash flow. Whether payment levels would have to be raised could be considered as part, but not a necessary part, of this strategy.

*Developing Community Options and Reducing Reliance on Facility Care.* The Group recommends that the Commonwealth explore options for reducing the share of long term care given in nursing homes over the long term through the development of more and more flexible community-based care options. Different models of care could be pursued through pilot programs and those that work well can then be developed further. The Commonwealth should encourage experimentation and innovation in the development of new models.

# III. Broad Policy Issues

As noted in the Working Group's report last summer, Massachusetts relies more heavily on nursing facilities for long term care than many other states, and more than the national average. (Figures 29-30) Given the stated preference of most people to live in the community, it makes sense to promote the development of cost-effective community care

[6] One effort already underway in this area is the Senior Care Options or "SCO" program being developed by the Division of Medical Assistance and the Executive Office of Elder Affairs in which Medicare and Medicaid funds for people eligible for both programs may be combined to leverage the services available to program participants.

models accessible to those relying on either private or public payment mechanisms. Over time, this strategy should enable more people to stay in the community and decrease the Commonwealth's overall dependence on nursing facilities. At the same time, we recognize that there has been much talk but little success in this effort over the last four decades. This speaks to the difficulty of the problem.

Potential pitfalls in that strategy include the fact that, without family help to supplement professional community supports, home care is often costlier than facility care, particularly for people with moderate to severe disabilities. Also, some Working Group members anticipate that expanding publicly supported community-based care may result in decreased availability of private or family care, and thus may not expand the level of care now being provided but only shift a greater percentage of the burden to the state. Moreover, if more care is available in the community, facilities will become devoid of people with less intensive needs as they are able to stay in or return to the community – with the result that facilities provide increasingly intensive care, at increasingly high cost. Increasing the availability of community-based care, increasing the public and private resources available to support that care, and making sure the entire continuum remains affordable will require unprecedented innovation and creativity.

The Working Group believes that the following principles should guide policy development and intervention strategies for the short term and the long term:

1. People in need of long term care services should be able to obtain those services in the least costly setting appropriate to their needs. Where possible, people should also be able to obtain care in community-based settings, and should be able to obtain services at the level of intensity most appropriate to their needs.
2. To the extent possible, the amount of private (i.e., nongovernmental) resources – of both time and money – for long term care should be increased.
3. If private revenue for long term care is increased, government should not perpetuate or increase cost-shifting, which may mask the true cost of care, and should make efforts to identify the necessary costs of efficiently provided care.
4. Expanding eligibility for services without expanding funding to pay for more services is not helpful and should be avoided.
5. The patchwork of different programs, eligibility rules, and funding streams should be simplified and reformed to further the goal of principle number one.
6. Innovations, pilot projects and multiple solutions are likely to be required; there will not be a "single solution" to making long term care more cost effective and more affordable and available.

## Conclusion

To summarize:

1. The Working Group recommends continued use of a standard pricing method for nursing facility services, and in the short term, some targeted intervention to assist high quality, low-cost providers in need, particularly in areas where access may

become a problem if more facilities close and where facilities have been harmed by transitional payment rules. This targeted intervention would be in addition to reasonable rate increases for the industry as a whole.

2. The Group also recommends review of the Medicaid rate methodology for nursing facilities and other long term care providers.
3. While recognizing competing priorities, the Working Group also recommends increasing concentration on and investment in community-based systems of care, as well as continuous and intensive monitoring of nursing facility financial, quality and access conditions.
4. The Commonwealth should monitor closely the effects of reorganization plans of national chains as they emerge from bankruptcy.

Although we are hopeful about signs of increasing stability, return to a more stable system for long term care will not occur in short order. The Commonwealth, long term care providers, communities and citizens should commit to a longer process to ensure appropriate long term care for the decades ahead.