APPENDIX I

MEDICAID REIMBURSEMENT FOR LONG TERM CARE: PROBLEMS AND OPTIONS

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INTRODUCTION

We shall attempt in this paper to present some of the more important problems associated with Medicaid reimbursement for long term care (LTC) and pose some strategies for attacking those problesm. Since political values are important determinants of the way public policy problems are viewed, we shall begin our analysis by describing the values that have shaped the problem for us.

POLITICAL VALUES

Respect for Individual Rights

In our society, individual rights and freedoms have always been given special attention. Protecting the "inalienable" rights of those who cannot care for themselves is part of this tradition. "Respect for individual rights" requires that long term care be continued in the future and has implications for what can be considered acceptable care. Individual rights to privacy the pursuit of happiness, self-determination, and freedom must be safeguarded.

Private Sector Involvement and Accountability

It is appropriate, often, desirable, for the private sector to become involved in carrying out important public responsiblities. When this occurs, it is important that a chain of accountability be maintained. Providers of long term care must be accountable to elected officials, patients and their families, and local communities. They must be accountable not only for the accountable not only for the appropriate use of public funds but, more important, for the safety and well-being of patients and the protection of their individual rights.

Economy, Efficiency, Effectiveness, and Equity

Funds spent for public purposes should actually accomplish those purposes (effectiveness) in the most direct way (efficiency) with the least burden to the taxpayer (economy). Public programs should be fair (equity) to providers and consumers alike; allowing a reasonable profit for providers, with equal

access and consistent eligibility determination for consumers.

Although it is easy to address problems with respect to a single political value, it is hard to find procedures that yield improvements with respect to all values. For example, using the private sector to accomplish a public purpose is valued. The profit motive, however, tends to divert the providers' attention from serving the public purpose and lengthens the chain of accountability. Efforts to achieve economy and efficiency run headlong into the problem of assuring concern for human dignity. As it is not possible to obtain optional results with respect to a single value without sacrificing other values; stategies, structures and methods must balance gains with respect to one value against losses with respect to others.

PROBLEM - 1: Environmental Factors

The LTC sector of the health industry is a part of that industry; deficiencies in other areas, such as preventive medicine and ambulatory care, effect the resources needed to care for patients at the LTC level. Impoverished individuals without adequate access to lower levels of care will wind up at the higher levels of care. Individuals not receiving needed check ups are more liable to become incapacitated through detection of diseases at later, less treatable stages. At the LTC level, with its high per patient expense, Medicaid pays over 50% of the cost. Efforts, beyond the scope of this paper, are needed at the lower levels of care to effect long term reductions in LTC costs.

Changing demographic characteristics may lead to increased LTC costs. New York State estimates an 8% increase in the age group of 65 years and older and an 11.5% increase in the age group of 75 years and older between 1970 and

1980. Studies indicate that the prevalence of chronic diseases, impairments, and utilization of medical services increases with age. (Select Committees on Aging and Population, 1978: 124). The proportionate number of residents in LTC institutions increases with age (Select Committees on Aging and Population, 1978: 127).

The final environmental constraint mentioned here is the nature of the market as a whole. Cost containment is limited by insulation of consumers and providers from costs through third party reimbursements, patients are not knowledgable consumers of sophisticated care to limit unnecessary use, additional costs entailed by large third party coverage, and gaps in insurance and government coverage encourage inefficient use (Cahill, 1977: 26; CHIPS, 1978: 12; Davis, 1975: 3, 11).

These issues must be addressed at the national level for LTC cost containment and better, more efficient care.

PROBLEM 2: Mechanism for LTC Placement is inefficient, resulting in longer stays than necessary and misplacement in higher levels of care in the LTC system.

Early studies (GAO, 1971: 30; Spiegel, 1979: 16) indicated a 20% misplacement in a higher, more costly level of care than needed. At these higher levels, the patient is more restricted and has less freedom; the inefficient placement costs more as well. Since these early studies, a standardized rating form, the DMS-I, was instituted. Current levels of misplacement are between 5 to 8% for Skilled Nursing Facilities (SNFs) in Monroe County, and 25% for Health Related Facilities (HRF) (Monroe County LTC Program, Inc., 1977b: 2,6). This may be understated, as a 1978 study (CHIPS, 1978: 26) done at a state hospital indicated that of patients discharged to nursing facilities, of those with

similar ailments, 100% of those on public assistance were institutionalized compared with 30% of the remainder.

One reason for this misuse is lack of consideration of alternatives. The Select Committee on Aging (1977; 32) found that in Massachusetts fragmentation in the delivery system for Home Health Care (HHC) made placement easier in SNFs and HRFs. The HSA of NYC found a similar fragmenation in the HHC delivery system (1977: 500). It takes less time to arrange care with one agency than to arrange different services with several.

Multiple access points compound information gathering for planning purposes and placement decisions. In Onondaga county 30 planning, placing, and delivery agencies provide access to the LTC system (CHIPS, 1978: 31). Data was not given for Ames County. Multiple access points may also retard entry into the system by ignorance of available facilities, engendering delay in acute care facilities.

Lack of an organized placement system also hinders changes to other levels as patient conditions change (CHIPS, 1978: 3). Lack of knowledge of openings may result in inadequate or too much care.

PROBLEM 3: Restricted definitions of levels of care and limited reimbursement alternatives results in poorer care at higher cost.

The current defined levels of care uncer Medicaid are SNFs, HRF, Domiciliary Care Facility (DCF), and Home Health Care (HHC). Patients do not fit neatly into those categories. A study done at Upstate Medical Center showed DMS-I form scores above the state median. This was a factor in late discharge from acute care facilities. This indicated that another level of care was feasible (Mascherry, 1978: 9). A study cited by the HSA of NYC (1977: 457) indicated

25% of those surveyed in SNFs needed more care than they were reimbursed for or provided. 40% did not meet the SNF standard for level of care, but were above thelevel of care provided at HRFs.

Another study cited by the Monroe County LTC Program, Inc. (1977: 1) states that a constraint in HHC use is thelack of consistent definitions against which appropriate home care services could be applied.

Gaps in HHC coverage are cited by Senator Tarky Lombardi, Jr. (Lombardi, 1977b). The HSA of NYC projects a need for 50,000 to 70,000 persons to be serviced through HHC (1978: 233).

PROBLEM 4: Lengthy periods in determining eligibility, price ceilings set below the private rates, and reasonable cost reimbursement mechanism tied to a cost basis yields inequitable care disincentives for institutions to take Medicaid patients, and lack of ability to control cost.

The lengthy eligibility process cited in the simulation data hinders transferral of patients between levels of care. This results in unnecessary costs and does not enhance patient care. The SUNY study (Macsherry, 1978) states that 16.9% of those sampled were delayed from discharge from acute care facilities by lengthy eligibility assessment procedures.

The reasonable cost reimbursement formula leads to inflation and inefficiency by allowing more sophisticated equipment and those with higher costs to be paid more. (Cahill, 1977: 28) The Moreland commission found that cost variations in care were not related to the need for care.

Low ceiling rates are cited as detrimental to development of alternative care in two GAO studies (1977c: 41; 1974a: 35). Low rates combined with high admission standards force many of the highest need patients, and therefore the most costly to care for, away from voluntary facilities and into public ones.

This creates higher cost for the public institutions.

PROBLEM 5: There is a need for greater accountability in the reimbursement system. Greater financial accountability needs to be tied to better quality assessment to ensure abuses.

GAO investigation of New York State audits yielded additional undiscovered excess claims (1977a: 10, 34). Specific comments can be found in a 1979 study by GAO (1979b: 26,27).

The Finger Lakes HSA (1977: 106) found that help was not available or known to all. The infirmities of the patients, and that many of them are alone, restrict their ability to bring litigation.

Better coordination is needed amoung regulatory agencies. A GAO study found two cities where agencies were not notifying each other of results (1977a: 28). The Finger Lakes HSA (1977: 106) cites the need for quality measures of outputs (patient goals) rather than inputs alone.

PROBLEM 6: Limited federal participation in LTC places an undue burden on state finances.

Medicare copayments and deductables have to be picked up by Medicaid for joint eligible patients. Medicare coverage is limited to 100 days of care, and then only after hospitalization. There is a homebound requirement for eligibility for HHC. LTC costs should be shared more equitably.

PROBLEM 7: Patients remain in acute care beds longer than necessary.

This is a result of the problems above. The simulation indicates that there is a shortage of SNF beds; this is a cause for longer stays, but partially is a result of the other problems itself. Another cause for this problem is an excess of acute care beds in New York (Cahill, 1977: 202). Excess beds cost money to maintain, with no income to offset the cost. There is therefore an incentive to keep patients longer.

SOLUTIONS

The values chosen limit the range of alternatives to increase quality and cost effectiveness of the Medicaid LTC program. In addition, the problems listed under the first problem area act as constraints as well.

The solutions here are orientated to changes that can be made in the near future to give better care and greater freedom to individuals while increasing accountability and cost effectiveness.

A keystone in bettering the present system is the establishment of central administration units patterned after the ACCESS program in Monroe County. This pilot unit has the responsibility for prior approval of service use, level of care determination, case management, and placement in the LTC system. Units would serve as a focal point for collection of data on care needs vital for planning future construction and service systems, thereby helping to reduce future costly backlogs and ensure facility availability for various levels of care.

The agency would serve all prospective LTC patients, eighteen years or older, regardless of their funding source. A casework system- using a team of physicians, nurses, and social workers to determine placement considering psychological, social, and physical needs- would ensure optimal match between patient needs and the level of care. This would result in cost reductions by eliminating misplacement in higher levels of care, freeing beds for patients and thus reducing hospital backlog. Part of these savings would result from serving as a focal point for HHC services, thus having adequate information to provide a mix of services for a patient from the scattered HHC and existing community services.

Tailoring the right level of care would aid in maintaining the dignity of the patient by considering all his needs, not just the medical ones. Maximum use of home facilities and lower levels of care will help keep the patient in familiar surroundings longer, cutting down on future possible institutional placement. By serving as a referral source for the private patient, some cost containment could occur through more effective placement of private patients and awareness of private patient needs for planning purposes.

The Monroe County LTC Program, Inc. (1977b) estimated savings of $1 144 329 to Medicaid alone for the fiscal year 1978 as a result of diverting 7% of SNF and 25% of HRF patients to more appropriate levels of care. They also claim that ACCESS would totally reduce the acute care patient backlog waiting for placement in other levels of care. Whether this complete reduction and subsequent savings would occur in Ames County is uncertain.

Accountability would be enhanced through the case system, as it would allow a better assessment of the quality of care received in relation to patient goals set in the assessment and placement process.

This one structure thus deals with problems 2, 4, and 5 and perhaps comes closest to fitting all the political values affected by a solution.

We recommend expanded study of such alternatives as hospice care, respite care, and enriched housing as providing increased flexibility to the system. Those found to be of merit, we recommend a grant system similar to that in N.Y.S. Senate Bill 1107 to provide aid for expansion of facilities. This would allow a better match of patient and care level and remove some of the current financial bias toward institutions. Construction or expansion of facilities should be controlled through the Certificate of Need process in conjunction with existing HSAs and the new ACCESS units. Greater dignity

would result from receiving more tailored care at more appropriate levels. Better care level match would reduce inefficiency in the system, saving dollars. More levels would allow easier movement between levels, reducing waiting times and costs.

Hospice care is an example. The GAO study on hospice care (1979a) indicates that although hospices do not fit into any Medicaid LTC category, certain functions are covered. Hospice use of palliative care rather curative care for terminally ill patients would appear to cut down unnecessary suffering and costs occured from extreme life prolonging measure. The family and patient are treated as a unit and given services, such as death follow up and care for the family, that ease suffering. This type of treatment should be encouraged.

Where possible, expansion of alternative levels should be through conversion of existing facilities, such as excess acute care beds. This would provide a disincentive for extended acute stays engendered by need to fill excess beds. The Certificate of Need program should also be used to facilitate multi-level care institutions and agencies; this would facilitate interlevel transfers and spread high-care patient costs. Quotas for the high cost patients should be established to spread institutional costs for these patients amoung facilities and facilitate earlier placement.

We recommend increased coverage of alternate care level services as well. At present this could be accomplished through initiatives such as N.Y.S. Senate bill 6345, "Nursing Homes Without Wheels," which expands HHC coverage. Results as to whether cost reduction would occur are mixed. Increased eligibility might lead to increased use and no overall cost reduction (GAO, 1977: 22). Some studies cite cost savings through addition of homemaker services (GAO, 1977: 30). Increased coverage would allow those treated at higher levels to switch

to lower levels, increasing individuals covered for the same cost.

Federal regulations mandating the reasonable cost reimbursement system should be changed to allow a negotiated reimbursement system. Rates set below market prices, as in Ames County, lead to problems cited previously. Rate inflation is a problem of the health care industry in general, and in the long term can only be cured at the federal level. Negotiated rates would allow operators to receive an amount commensurate with market rates, while offering better containment. Governor Garrahy of Rhode Island attested to the effectiveness of this strategy (Select Committee on Aging, 1977: 21).

Federal attention should be directed to the LTC industry. Efforts to expand private coverage should be initiated. Further grants to promising alternatives to existing systems should be given. Medicare coverage should be expanded by reducing eligibility restrictions and adding services. Institutional care is next to the most expensive level of care as far as cost is concerned. Reducing gaps in Medicare would help ease the burden on states and provide more state money for other types of care.

An ombudsman position should be created with adequate staffing and funding to provide a better voice for infirm patients. Many Medicaid recipients lack funds to press abuse litigation; the mostlseverely disabled patients, particularly those without families or whose families are geographically distant, lack an adequate voice for stating their complaints. Giving them that voice would increase accountability of the institutions and assist current auditing efforts.

Pilot programs with performance auditing should be instituted, possibly in conjunction with Professional Standard Review Organizations (PSROs). In conjunction with the ACCESS case management system, this would help to tie fiscal inputs with patient outputs, helping to better reveal unnecessary costs.

SUMMARY

This text has examined some of the problems, causes, and solutions with the LTC health sector and Medicaid reimbursement. The solutions cited are in concurrence with the political values we have stated. Streamlining the pla placement system and expansion of alternatives would insure care more in keeping with the maintenance of freedom and dignity for the patient by allowing better use of less institutionalized facilities and more effective use of existing institutions. Costs could be better accounted for and more adequately restrained with a negotiated reimbursement system. Accountability would be enhanced through the ombudsman program and through greater orientation of the system to patient outcomes.

These actions will not cure all Medicaids ills, some of which are beyond State control, but do represent significant improvements and steps towards eliminating many of them.

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