

UNCOVERING THE ISSUES

The goal in this chapter is to uncover the issues as viewed by the three student teams. First is a synopsis of the papers in the order they were presented at the competition in Brockport. Each is outlined in terms of stated values, problems and causes, and recommended solutions. A few of the questions and answers asked after the presentation are included at the end of each synopsis. An analysis of the similarities and differences among the team approaches to the problem is presented. The chapter concluded with some unanswered questions and paradoxes that arise in the long term phase of health care. The complete team answers may be found in the Appendix to this monograph.

Syracuse University: Medicaid Reimbursement for Long Term Care: Problems and Options

Stated Values

The Syracuse team stated that the following three political values have inadvertently shaped the problems underlying the entire Medicaid program:

1. Respect for individual rights
2. Private sector involvement and accountability
3. Economy, efficiency, effectiveness and equity

Problems and Causes

In addition, seven problems with the long term care (LTC) system exist under Medicaid. Briefly those problems are:

Problem #1 - Environmental factors. The LTC sector is a part of the health industry but deficiencies in other areas such as preventative medicine and ambulatory care affect the resources needed for long term care. Other environmental factors include changing demographic trends, and uncontrolled due to third party reimbursements which encourage inefficient use.

Problem #2 - Inefficient mechanism for long term care placement. Placing patients under a more costly care than needed is inefficient. An organized placement system is imperative for cost efficient long term care.

Problem #3 - Restricted levels of care definitions and limited reimbursement alternatives result in poorer care at higher cost. Patients who do not fit neatly into categories (levels of care) often receive inadequate care.

Problem # 4 - No incentive for institutions to take Medicaid patients. Lengthy periods in determining eligibility, price ceilings set below private rates and a cost reimbursement system based on a facility's equipment sophistication, lead to inequitable care.

Problem #5 - Greater accountability in the reimbursement system is needed.

Increased coordination among regulatory agencies to avoid overpayments as well as under-payments.

Problem #6 - Limited federal participation in LTC places an undue burden on state finances. LTC costs should be shared equally.

Problem #7 - Patients remain in acute care beds longer than necessary.

A shortage of SNF beds and an excess of acute care beds is the incentive for keeping patients longer than necessary.

Solutions

Short term solutions can be implemented almost immediately to provide better care, individual freedom and still be cost effective and accountable. To achieve this end, the Syracuse team recommends establishing central administration units to determine level of care, case management and placement in the LTC system. A casework system -- using a team of physicians, nurses and social workers would determine placement and ensure optimal match between patient needs and level of care. This system would result in cost reduction by eliminating misplacement, thus, freeing beds for needy patients and reducing hospital backlog. This casework system approach would enhance accountability by allowing better assessment of the quality of care actually received relative to the placement goals set for the patient. The Syracuse team felt this structure attacked problems 2, 4 and 5, while coming closest to meeting the political values.

Further recommendations include expanded study of alternatives such as hospice care (now used for terminally ill), to add flexibility to the system. To finance these alternatives they recommended a grant system similar to that of New York State Senate Bill 1107 which provides aid for facility expansion. Whenever possible, expansion of alternative levels should be through the conversion of existing facilities.

In conclusion, the Syracuse team recommended that federal regulations mandating the reasonable cost reimbursement system be changed to allow for a negotiated reimbursement system. Negotiated rates would allow operators to receive an amount commensurate with market rates.

Rate inflation is a problem of the health care industry in general and ultimately can only be cured at the federal level. Federal attention should be directed to the LTC industry, an ombudsman position should be created to give infirm patients a voice, and performance audited pilot programs should be instituted. These actions will not cure all Medicaid's ills but do represent significant steps toward eliminating many of them.

Questions and Answers

Question - Should the standards set by various states be lowered to the federal level?

Answer - With the creation of central administrative agencies or units, there would be a need for equity in formulas of reimbursement across the country. Many states currently reimburse at a level higher than the federal standard.

Question - Wouldn't ombudsmen put pressure on the system to provide increased levels of care in response to complaints?

Answer - It was pointed out that the Office for the Aging in Albany, New York, has an ombudsman who is attempting to set up a voluntary ombudsman system in regions or counties across the state. The team expressed the view that an ombudsman would lead to better understanding of what is adequate care for patients and inevitably to increased accountability.

Stated Values

Albany's team began its analysis with a quote from The Sociology of Health Care - Robert Enos, "Society has the obligation to assist the poor and the aged. Among the ways it should help them, is providing minimal levels of health care."

The analysis was based on the following values: 1) Quality health care should be provided by the government for those who need it, 2) Care should be provided as inexpensively as possible, and 3) Changes in the Medicaid System should not cause an increase in bureaucratic machinery. The team further stated that "while the basic goal of Medicaid has not changed since its inception in 1966, the means of achieving this goal has. A 'new' value, cost minimization, has entered the scene." Their basic premise is that government must learn to speak the language of the "profit motive". Government can do this by:

- 1) Recognizing that cost containment is a critical factor in providing Medicaid.
- 2) Eliminating the waste and inefficiency of Medicaid administration.
- 3) Providing appropriate placement for Medicaid patients.

Problems and Causes

How to provide quality care at minimal cost is the key problem. Currently there is overuse and inappropriate use of services by long term care patients. Government regulations make it more profitable for a nursing home to care for a private patient than a Medicaid patient through long delays in determination of eligibility and lags in the actual dollar reimbursement. There is an overall lack of coordination and consistency among the regulations put forth by three governmental levels - Federal, State, and County. These bury the private nursing home owner under a sea of bureaucratic "red tape". For example, discrepancies in Federal and State regulations require different numbers of professional staff per occupied bed and force the nursing home owner to meet the most demanding and/or expensive standard.

Solutions

The Albany team makes three general recommendations for the administration of Medicaid. Based on their belief that government has a choice in determining

the future of long term health care, they suggest the development of mechanisms that use the profit motive toward the end of improving long term health care. Second, a provision should be made in the Federal/State cost-sharing equation to reflect the number of state residents utilizing Medicaid services, and the quality of that state's service. The equation should reward states that have the most effective Medicaid program. Third, they call for the reduction of paperwork, duplicated regulations, and administrative inefficiencies. The three levels of government should strive for coordination of regulations to facilitate long term health care services.

Questions and Answers

Question - How do these recommendations decrease bureaucracy? It would seem that the better accounting and added supervision would increase it?

Answer - An actual reduction will be difficult. What we are suggesting is cutting down on the excesses -- the build up of regulations that have no end bearing on the patient. Some increases are necessary in order to put a check on the system but we foresee these increases offset by the decreases in excess paperwork and regulations that do not apply to the care of the patient. In the short run, an increase in bureaucracy is necessary to establish the needed system of auditing but in the long run costs will be minimized.

Question - Why wasn't it recommended that the family be made more responsible? Why aren't we responsible for our Mother and Fathers at least to a limited extent?

Answer - It really should be a family problem but what do we do with the patient whose family doesn't care? Can we not provide care to a sick patient because the family refuses responsibility? In light of the fact that the American family is not as cohesive as it used to be, we have not included this in our list of recommendations. Part of the lobbying that has gone on has taken the responsibility of the family away. There is no question that some of the placements in nursing homes are definitely social problems. Patients may have

some minor medical ailment that qualifies them but more often than not, it is because they are not wanted at home anymore.

Question - Why aren't patients questioned on the quality of care they are receiving? Have patients been polled in an attempt to measure the quality of care as seen by the patient?

Answer - Yes, there have been polls but we cannot speak to their results.

SUNY - Brockport: The Long-Term Care Medicaid Reimbursement Problem -
Public Policy Analysis and Strategy Development:

Stated Values

Using a systems approach, the Brockport team analyzed current public policy and explored alternatives. "Medicaid reimbursement costs reflect the system's failure to create a cost-effective balance between the supply and demand, government and the private sector, quality and price, provider and consumer, flexibility and control." The following are the political values central to their analysis:

- 1) All individuals should have access to basic health care and related social services.
- 2) Government has an obligation to ensure reasonable access for all to long term care.
- 3) Free enterprise is essential to our democratic and economic order.
- 4) The lower the level of government responsible for administering a service, the more responsive to the needs of the people and efficient the service provided.
- 5) The role of the family unit in providing long term care is of primary importance.

Problems and Causes

This team began by defining the Medicaid reimbursement problem as only the tip of an iceberg. They stated that, unfortunately, most people know very little about the reimbursement system and fail to consider the giant bulk of ills below the surface. It was for this reason that they chose the following three problem

sectors. Each sector encompasses a multitude of underlying complexities and they believe short term solutions are not realistic. An "ecology effect" exists within the health care system whereby a solution or change in one area in turn affects another.

Problem #1 - High Cost. Two elements are missing from the Medicaid system which lead to high costs -- 1) a cost control component, and 2) clearly delineated national spending priorities.

Problem #2 - Failure of the market mechanism. When there is no ceiling on the amount of resources made available, there is an incentive for both supplier (physician) and consumer (patient) to generate as much consumption as possible resulting in overconsumption. One possible cause of the failure of the market mechanism is the inelastic demand for services - the patient wants treatment irrespective of cost.

Problem #3 - Faulty allocation and distribution of resources. Physicians, facilities and services are clustered in and around middle-class urban areas, leaving rural citizens and the inner-city underserved. Government intervention would help ensure a fair and equitable allocation of long term health care resources.

Solutions

The Brockport team presented interim solutions that would eventually lead to a comprehensive, single-agency provider. These specific recommendations are addressed to 1) various levels of government, 2) institutions and 3) physicians. In short, they suggest the current Medicaid distribution formula be replaced with one similar to revenue sharing, and that government encourage policies which offer an incentive to cut costs and discourage excessive profits. Expansion of reimbursement policies to include outpatient services in ambulatory care centers, doctor's offices and home delivered health services, would greatly reduce deliberate misplacement of patients. Physicians should be required by law to

serve a percentage of Medicaid patients to help insure quality care and service delivery to all who need it.

Uniform cost-effective policies and procedures must be established and health care facilities should be assisted in implementing them. The current duplication of service encouraged by the element of competition can be eliminated through mergers and sharing of services. The American Medical Association must be urged to lift its restriction of medical student enrollment numbers each year. In addition, the medical students should be educated in use of cost-effective methods of health care.

The above suggestions will pave the way for a change over to single-agency solution called HEALTHPLAN. HEALTHPLAN is the framework for financing and delivering a comprehensive system for long term care. Primary beneficiaries are the elderly who become seriously ill. HEALTHPLAN applies the basic concept of insurance for acute care to cover long term care expenditures.

Everyone would be eligible at age 65 and could choose from a broad range of available services according to personal need, i.e., nursing home care, foster care, day care, home health care, meals on wheels, etc. By financing HEALTHPLAN through general revenues, there would be an intergovernmental transfer of resources. This transfer would be from current income earners to the current covered population. A built-in co-payment concept will help eliminate the present tendency to over-consume through exaggerated statements of disability. Through a certification method by a panel of professionals, U.S. residents age 65 or over would be deemed eligible. Once certified, the individual would pay a deductible fee for the services chosen. Ten percent of average income for a household is the suggested amount. States could participate in this program by paying part of the deductible for needy residents. Consumers would be expected to pay in full for additional cost of care more luxurious or service intensive than a set standard. Thus, rate setting and standard setting for a maximum standard of care by type is crucial.

The key value stressed in a national long term care insurance program is consumer choice. The consumer has better knowledge of his tastes and personal situation and, if provided with access to long term care resources and to sound information, can make decisions about care that will maximize his own quality of life.

Questions and Answers

Question - How does your team propose to better regulate physicians and thereby have them toe the mark, so to speak, and do their job?

Answer - We suggest a measurement system similar to one in California called TAR. In TAR a limit has been set on the cost of service for the individual patient. They have found this to be extremely cost effective. Another suggested watchdog is the computer. This can be used to analyze charges compared to treatment and the sophistication of the necessary equipment used in that treatment. The area of health care is unique in that it is one of the few supply and demand situations where the supplier is in complete control.

Question - The solution you have presented gives the impression that it is related to much more than just solutions to long term care problems. The whole plan seems to be fundamental revision of the method of providing all health services. Is this what you had in mind?

Answer - No, the solutions are not meant for any more than long term care. HEALTHPLAN is not a total national health insurance plan.

Question - Have you given any consideration to patients already in long term care facilities? Those on Medicaid have had to turn over all of their income under the current system. Where do they find funds to purchase any portion of the services they need?

Answer - Quite frankly, we had not considered this problem.

Analysis

In essence, all three teams outlines the underlying political values as 1) government has an obligation to provide quality health care and to ensure that it is accessible to all who need it, 2) that while providing that health care, respect for individual rights and freedom must be maintained, and 3) that this health care be provided as inexpensively as possible. There appears to be general agreement that the single most troublesome aspect of Medicaid is the provision of quality care at a minimal cost. The need for increased accountability at all levels of administration is a key recommendation made by all the teams.

A certain amount of disagreement exists in the values each team states. Syracuse and Brockport include free enterprise in their list while the Albany team does not. On the other hand, Albany emphasizes the need to avoid increasing bureaucratic machinery and includes this as a value. Brockport's team took their list of political values even further adding 1) that services administered at lower levels of government are more responsive to the needs of the people and more efficient to provide at that level and 2) the importance of the family role in providing long term health care.

As indicated under common ground, all three teams listed the need for increased accountability as a value but only the Syracuse team shows the current lack of accountability as a problem. Interestingly, Syracuse was also the only one pointing to limited federal participation as placing an undue burden on individual state finances. The Brockport team lists the failure of the market mechanism due to the inelasticity of the demand for services as the number 2 problem with the system. Patients want to be treated regardless of cost, they say, and with the lack of any ceiling on the amount of available resources, the result is overconsumption. The other teams did not include this in their problem analysis.

Both Syracuse and Brockport include the problem of inefficient allocation and distribution of resources as a major cause of sub-standard care for large segments of the population. Physicians, facilities and services are clustered around middle-class urban areas, leaving rural citizens and the inner-city poor underserved and their facilities underfunded.

Each team took an entirely different approach in recommending solutions to the problems they outlined. Albany's recommendations are general in nature. They suggest a change in the Federal/State cost-sharing equation that will reward states with the more effective Medicaid programs; urge that the three levels of government coordinate regulations to eliminate duplication and inefficiencies; and state that long term health care can be improved if the government develops a "mechanism" that uses the profit motive. While the mechanism is not specified, this approach appears to be in keeping with the current system of combined state and federal financing of long term care in locally controlled private and non-profit nursing homes.

The Syracuse team offers solutions that can be implemented in the near future. The establishment of central administrative units, increased levels of care and a negotiated reimbursement system are recommended. However, they fail to tell us how to successfully negotiate the rates of reimbursement and still keep costs down. Some facilities request increases based on their financial needs for general care that may not apply directly to the long term care patient. In other words, Medicaid may pay for upgrading services not associated with Medicaid long term care recipients. The creation of an ombudsman position to represent patients is also suggested by the Syracuse team. Although accountability would be enhanced through an ombudsman program, the very nature of this position suggests higher costs. While patients should have a voice regarding the kind of health care they receive, an ombudsman could conceivably pressure for even higher levels of care than necessary. The end result might add to already skyrocketing costs.

Creating central administration units to assume the responsibility for determining levels of care, case management, and patient placement is suggested by this team of students as the key solution to the many inefficiencies within the long term care system. However, they fail to say whether these units will replace any current levels of administration or if, instead, another layer of fat will be added to an already bulging bureaucracy.

The Brockport team presents us with interim solutions which ultimately set the stage for their long run recommendation called HEALTHPLAN. These solutions represent an intricate patching up of the many interrelated problem areas within the current system. They begin by suggesting a formula similar to revenue sharing in place of the present distribution formula for Medicaid, make numerous recommendations for various administration and health care facilities, and even suggest changes within the medical profession. How to implement these changes and who will monitor them is not clear, plus, the team does not mention the cost of such changes. There is the possibility that the expense to enact the solutions could far out weigh the ultimate cost savings.

The team's ultimate solution, HEALTHPLAN is a co-payment form of insurance designed to equalize the burden of long term care. Ideally, it will serve as a cost container through each patient's nominal contribution toward total costs. The patient will be purchasing a portion of the care he needs and therefore, will be more cost conscious eliminating the current tendency to over-consume services. Just how this will apply to the poor patients already on Medicaid and receiving public assistance is not evident. It is questionable if there is a way to avoid over servicing such a client. They cannot afford to contribute toward expenses as would be required under a co-insurance plan, thus, their situation would remain the same as under Medicaid. There will not be any incentive to be cost conscious and choose cost-efficient long term care.

A need for change within the current health care system is evident and the problems to be solved are numerous. The student teams in this competition have

showed innovation in meeting this challenge. They have approached the problem from different perspectives and uncovered many of the underlying issues. They have discovered that the task of making changes within this intricate system of health care is not an easy one. Changes made at any level have repercussions in all segments.

In analysing the political values, uncovering the issues and recommending solutions, they have faced some interesting paradoxes within the long term health care industry. For example, is it possible to contain costs and still provide quality care? In holding the line against the inflationary trend within this industry, the providers of care may well choose to cut corners on services patients are now receiving. There is also the question of whether the system should be administered at the state and local level under uniform federal guidelines or should there be more federal control? Some groups argue that the federal level is too far removed from the day-to-day problems of the patients, and therefore, cannot effectively administer the various health care programs. Other groups argue that the system of free enterprise is allowing the private facilities to "rip off" the Medicaid system. This brings up the patients, public or privately owned long term care facilities. Without the profit motive of the private facility, is there a way to insure up-to-date, quality care in a publicly owned unit? In the chapters that follow these conflicts will be further evaluated.