VERMONT

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Agency of Human Services

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Nursing Home Rate Setting Overview

The Division of Rate Setting sets the Medicaid rates for nursing homes

We are a small division with 8 positions. Our staff are mainly trained in accounting and finance except for one lawyer and one support person. Division of Rate Setting (DRS) is part of the AHS Central Office and is not part of DAIL. DRS sets the Medicaid rates for nursing homes pursuant to the Vermont Division of Rate Setting Rules.

DRS auditors determine the costs allowable for Medicaid reimbursement applying all the DRS rules and certain CMS reimbursement rules. Not all allowable costs are included in the Medicaid rates due to caps and limits on the rates, which will discuss later.

DRS receives an annual Medicaid cost report and audited financial statements from each nursing home provider within five months after the end of the provider's fiscal year. We would not see the results of a new owner's operations until years after a sale.

Each month we receive resident day information so we can see occupancy trends well before we receive the census data on the cost report.

We track loses and gains at facilities and have done so for many years. The Commissioner of DAIL meets with us regularly and we apprise her of the financial conditions of the Vermont nursing homes.

Nursing Home Revenues, Licensed Beds and Occupancy Trends

For those homes in the Medicaid program, total revenues were $262 million in 2015 with about 2,800 full time equivalents for staff.

There are currently 34 privately owned nursing homes and one State owned nursing home. Ten nursing homes have closed from 2004 to today, the most recent being Brookside White River. Licensed beds at facilities who participate in

the Medicaid program have decreased from 3,419 in 2005 to 2,913, a decrease of 506 licensed beds or 15%.

The average number of residents on Medicaid in Vermont nursing homes was 2,135 for 2005 and is now 1,543, a 28% decrease. There has been a huge shift with the 1115 waiver and then the Global Commitment waiver to giving the option of home and community-based care instead of care in nursing homes. The goal years ago was to get to a 60/40 balance of nursing home care to community care. That has now been surpassed and the balance is now 46/54, with 54% of nursing home level of care being home and community-based services.

Medicaid Rates

The Medicaid rates are cost based and are different at each home. This is because the expenses at each home are different. The hourly rates, fringe benefits offered, newness of the building all affect the level of the rate. The highest rate in the State is for Gifford's Menig Nursing Home in Randolph. (This is without considering the one State owned facility, the Vermont Veterans' Home.)

Our current rules require that we use resident days at no less than 90% of the licensed bed capacity for some of the groups of costs. The current average occupancy is about 82%. This provision of our rules limits the payment of allowable costs by about $800,000 per year. In SFY 2020, the effect of the 90% occupancy limit will be to limit reimbursement by about $1.5 million. The penalty for occupancy below 90% is growing because occupancy has continued to decline. Base year 2017 has much lower occupancy than was the case in the current 2013 base year. Some providers have occupancy as low as 65%.

The rates are broken down into seven cost groupings. These are Nursing Costs, Director of Nursing (DON) costs, Resident Care costs, Indirect Care costs, Property and Related costs, Ancillary (PT, OT, ST and medical supplies) and the Provider Assessment.

Three of these categories have caps. Caps are different from the occupancy limit and in addition to the occupancy limit effects. The nursing cap is at the 90th percentile of the per diem costs per case mix point. The Resident Care and Indirect Care caps are both at 105% of the median of the per diems. The caps limit the reimbursement of allowable costs by about $4.7 million each year.

The nursing portion of the rates is changed each quarter to consider the acuity of the residents as measured by their case mix score data from the MDS information. This acuity data is provided to the Division by DAIL.

Nursing homes get inflation from the base year period to the rate year period. Only the costs that are not over the caps or decreased by the occupancy limits are inflated. The base year for most cost categories changes every four years. At present for DON, Resident Care and Indirect Care costs, the base year is 2013. There will be a rebase to 2017 costs on July 1, 2019. Nursing salaries in Vermont are rising year to year. There seems to be a shortage of nursing staff available to nursing home operators. This has led to large increases in the use of Agency/Contract nursing. Contract nursing is significantly more expensive per hour than an employee and this increased cost will impact the facilities bottom line. However, if an employee is not available, the provider will turn to contract staff so that staffing will be adequate.

How are the nursing homes doing financially?

Some nursing homes take many more Medicaid residents, in proportion to their total residents, than other homes. For facilities with costs that are capped or affected by the 90% occupancy limit, the profit earned on Medicare and Private residents must cover the costs excluded from Medicaid reimbursement by these limits. Nursing homes that take disproportionately high levels of Medicaid residents often do not have these other revenues to use.

Decreasing occupancy in nursing homes and the increased use of contract/agency nurses have resulted in large losses at many nursing homes. On average, providers had a 2% loss for 2016. The range of financial results varied from a 29% loss to a 12% gain. Before Brookside closed, 18 of 36 homes had losses and some were very large losses. This is not an easy business.

Many Vermont nursing homes are being sold

The Division is seeing many Vermont nursing homes being sold, many more than ever happened in the past. Here is a list of those sold since the beginning of 2013.

- Crescent Manor
- Brookside and Green Mountain
- Burlington, Bennington, Berlin, Saint Johnsbury, Springfield - Five homes sold to Genesis Corp. (They owned four Vermont nursing homes before this and now Genesis owns nine of the 34 privately-owned Vermont nursing homes.)
- Redstone
- Rowan Court

This is 10 homes which have changed hands in the last four years. Before this we might see one sale every few years. Sales were infrequent. Recent purchasers of Vermont nursing facilities have been large out-of-state corporations that own hundreds of nursing homes nationwide and conglomerates owned by 3-20 separate investors.

Six more Vermont nursing homes are currently being sold.

- Birchwood and Starr Farm
- Newport
- Maple Lane, The Pines Health and Rehab (of Lyndonville) and Union House

We are also seeing a trend with the out of state ownership groups where the financial records are only maintained in New York or New Jersey. These owners use a complex web of companies to keep their records, manage their purchases and do their payrolls. This makes it harder for the Division to assess the financial records for these nursing homes.

Another trend that we have seen is where the nursing home building is sold away from operations and then rented back by the operator at an extremely high rate. As these rates are not reasonable, the Division cannot allow them in the Medicaid rates. This makes losses at these facilities inevitable. The corporate owner of the nursing home receives a large amount of money upfront when they sell the building and as part of this transaction they sign a lease that gives the

investors large returns each future year. Sometimes these investors in the nursing home buildings are real estate investment trusts and hedge funds.

Many homes are covering large loses each year. Some homes do not have the resources to cover loses and come to the Division to request Extraordinary Financial Relief (EFR) pursuant to Section 10 of the Division's rules.

DRS will analyze data on the financial condition of the provider and make a recommendation to the Secretary of AHS who makes the final decision. This could be an enhanced rate or a loan. EFR is for facilities in imminent danger of closing, where a need for beds exists and there is a foreseeable end to the financial difficulties. It is usually in place for a fixed term, often a year.

Our work is different from the CON work done by the GMCB

There is no redundancy between the work of the GMCB and the Division of Rate Setting. Our roles are very different. The GMCB looks forward into the future with their analysis and determines what operations will look like in the out years when determining whether a CON should be granted. DRS works with actual audited financial statements and cost reports with costs from a past year of operations to set rates based on actual past costs.

I hope this information will be useful to you.