Nursing Home Oversight

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Nursing Home Landscape

Capacity:

- 38 Nursing Homes
- 35 homes accept Medicaid, includes Vet's Home
- 2913 Medicaid beds currently
- 836 fewer beds in 2018 than in 1998
- Current average statewide occupancy **82.5%**

Utilization:

62% Medicaid (long term care)

16% Medicare (short stay, post acute care)

13% Private Pay (long term care)

Nursing Homes: Financial Considerations

Provider Tax:

- Assessed maximum allowable under federal law @ 6% revenues
- Assessed on a per bed basis @ $4,919.53
- Medicaid, Medicare and private pay beds
- Total SFY'16 provider tax paid $15.3 million
- Leverages FMAP for Vermont Medicaid program

Medicaid Shortfall in VT (most recent data):

- Difference between actual cost of care and Medicaid reimbursement
- Estimated $10.8 million in 2013
- Estimated difference in Medicaid rate v. Medicaid cost in 2015 $17.76/day

https://www.ahcancal.org/research_data/funding/Documents/2015%20Medicaid%20Underfunding%20for%20Nursing%20Center%20Care%20FINAL.pdf

Medicaid Rate Setting

- $232.85/day last quarter average Medicaid rate (does not include VVH)------ $9.70/hour

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- Rates are cost based, set quarterly for "allowable costs" using a base year
  - Nursing care (i.e. RN, LPN, LNA)- acuity adjusted as incentive to take higher acuity
  - Director of Nursing
  - Resident care (i.e. food, activities)
  - Indirect care (i.e. administrative, plant operation & maintenance, housekeeping/laundry)
  - Property (i.e. depreciation, interest, insurance)
  - Ancillary (i.e. medical supplies, incontinence supplies, therapies)

- Examples of penalties/disincentives within rate setting regulations:
  - Occupancy below 90% (current statewide occupancy 82.5%)
  - Median limits for resident care & indirect
  - Nursing at 90th percentile
  - Discourages admission of dementia/behavioral health issues

- Base year- nursing 2015 all other costs 2013
- Annual inflation adjustment to "catch up" for outdated base year costs- roughly 2%
- http://humanservices.vermont.gov/departments/office-of-the-secretary/ahs-drs/nursing-homes/adopted-rule-effective-6march2015.pdf

Regulatory Overview: Who Does What

- ***Centers For Medicare & Medicaid Services (CMS)****:* federal regulation of all aspects of care delivery, health and safety - federal inspections.
- ***DAIL/DLP/APS****:* state regulation to obtain a license to operate a facility consistent with federal and state health and safety regulations; conducts annual state and federal inspections and complaint investigations; conduct investigations related to allegations of abuse, neglect, exploitation.
- ***Office of Professional Regulation:*** licenses Nursing Home Administrators; requirements for training, and competency; regulates unprofessional conduct/discipline.
- ***Board of Nursing:*** licenses APRN, RN, LPN, MNA, LNA; regulates training, competency, standards of practice, and unprofessional conduct/discipline for these professions working in nursing facilities.
- ***Division of Rate Setting:*** establishes Medicaid rates for nursing facilities; determines Extraordinary Financial Relief when necessary.
- ***Green Mountain Care Board:*** Certificate of Need for transfer of ownership of nursing facility; or building a new nursing facility; or adding more nursing facility beds or services.

Regulatory: Federal Quality

- Medicare & Medicaid only pay facilities if in compliance with federal CMS regulations, 42 CFR Part 483, Subpart B, *Requirements for Long Term Care Facilities*

  - *Resident rights*
  - *Admission, transfer, discharge requirements*
  - *Resident behavior and facility practices*
  - *Quality of life*
  - *Quality of care*
  - *Resident assessment*
  - *Nursing services*
  - *Physician services*
  - *Behavioral Health*
  - *Dietary services*
  - *Dental services*
  - *Specialized rehabilitiative services*
  - *Pharmacy*
  - *Infection control*
  - *Physical environment*
  - *Administration*
  - *Compliance and Ethics*
  - *Emergency Preparedness*
  - *Training Requirements*

Regulatory- Ownership

Federal Rules- 42 CFR Part 483, Subpart B- CMS requires disclosure of ownership, or financial or controlling interest:

- Upon submission of provider application
- Upon execution of provider agreement
- Upon change of ownership
- At time of survey (compliance)

Failure to comply with federal rule- don't get paid

State (DLP) licensure requirements also govern disclosure of ownership, Rule 17.2:

- Upon application for licensure, which is required to operate- a license is required to receive a provider and billing number for Medicaid and Medicaid
- Ongoing obligations to disclose at time of any change, if a change occurs in:
  - Person with an ownership or controlling interest of 5% or more, or convicted of Medicaid Fraud
  - Officers, directors, agents, managing employees
  - Corporation, association, or other company responsible for management
  - Administrator or director of nursing

Regulatory: Certificate Of Need

GMCB Rule

4.203 Change in Ownership for Health Care Facilities Other Than Hospitals

1. If a health care facility other than a hospital undergoes a change in ownership, corporate structure or other organizational modification such that a new license from the appropriate state or federal licensing entity is required, such action shall be a new health care project.

2. The transfer or conveyance of an ownership interest in a health care facility other than a hospital that fundamentally changes the financial stability or legal liability of the facility shall be a new health care project.

18 V.S.A. § 9434(a): a new health care project includes

(3) The offering of any home health service, **or the transfer or conveyance of more than a 50 percent ownership interest in a health care facility other than a hospital**.

Regulatory: Certificate of Need

- GMCB held stakeholder process last year- consensus to eliminate CON for transfer of ownership.
- Looks at quality, cost of the project, purchasers' financials
- Relies on information from DAIL/DLP/Rate Setting.
- Quality is handled by DAIL/DLP/regulatory boards. Cost to Medicaid and rates by Rate Setting.
- Currently conducts an analysis of whether or not the purchaser is sufficiently capitalized but also does a financial/cost analysis of the project itself- is it a good project financially?
- Takes 12-18 months; costs several hundred thousand dollars to get through the process.
- Since transfers of ownership are not new health care projects but transfers of existing businesses, the only financial question should be can the entity obtain financing. This should be the role of the financial institution.
- CON review for transfer of ownership should be repealed.

Key Questions:

Primary goal: ensure high quality nursing facility services for residents.

1. How do we ensure potential purchaser is sufficiently capitalized to purchase an existing facility?

2. How do we evaluate potential purchasers to satisfy the desire for high quality owners?

3. What are the factors that impact financial stability and how do we ensure ongoing financial stability of facilities to prevent financial related collapse?

H.921
An Act Relating to Nursing Home Oversight

As originally passed the committee repealed CON for transfer of ownership effective July 1, 2018 except for transfers initiated prior to that date.

Amended on the House floor (Rep. Donahue) to extend effective date of repeal of CON to July 1, 2019 but allows for an expedited review by the GMCB for transfers between passage of the bill and repeal. This concept is important- those pending transfers that will not make the repeal date should have a less time consuming and less costly process. Does not appear existing expedited process contemplated in amendment will achieve the goal.

Establishes a working group to address the key questions identified by the Human Services Committee.

H.921
An Act Relating to Nursing Home Oversight

VHCA supports H.921 but recommends the following:

1. Include a specific charge to the working group to evaluate what changes, if any, are needed to the Medicaid rate setting rules to ensure ongoing financial stability of nursing homes;

2. Modify Sec. 3(a) of the bill to ensure the "expedited" process reduces time and money for those transfers between passage and repeal of the CON process;

3. Modify Sec. 3(b) of the bill as follows:

> "…the Board ~~may~~ shall permit an applicant to elect whether to complete the certificate of need process on a standard or expedited basis.