08. The Financing of Long Term Care

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THE FINANCING OF LONG TERM CARE

Two arguments, one for full Federal funding and one for a continuance of state-Federal funding of long term care, are made in this chapter. Both arguments have one important area of agreement; they both set forth cost containment as a primary objective of any funding scheme. Furthermore, both suggest that this can best be achieved through some form of prospective reimbursement. Under the present system of retrospective reimbursement Medicaid pays, without limit, for all eligible services provided. This, many believe, encourages the provision of unnecessary services which results in an unnatural escalation of costs. Prospective reimbursement simply means forecasting service needs for some future period (usually one year) and then determining how much will be paid for those services. This would establish a limit or "cap" on Medicaid expenditures which would presumably have the effect of containing run-away costs.

The fundamental difference between the two approaches is related to whether the funding and responsibility for long term care is best handled in a state-Federal partnership or solely at the Federal level. In this regard the burden of proof is on the full federally funded argument simply because it suggests a significant departure from the present arrangement. The argument for continuance of the state-Federal partnership is not, however, made without considerable difficulty due to the many existing criticisms of the status quo.
THE CASE FOR FULL FEDERAL FUNDING OF LONG TERM CARE

The case for full Federal funding of long term care is based on three interdependent conditions. First, it has become increasingly obvious that health care, of which long term care is a part, has become a national responsibility and should therefore be financed at the Federal level. Second, state and local government can no longer afford the rapidly increasing fiscal burden that results from financing long term care. Finally, the federal income tax is the most appropriate revenue source from which to fund long term care by virtue of the fact that it is our most progressive tax.

Federal Precedent

In this century the Federal government's role in public health has gradually evolved towards greater responsibility and increased involvement. In the early part of the twentieth century, for instance, the Federal government enacted the Chaberlain-Kahn Act of 1918 (to combat Venereal Disease) and the Sherphard-Towner Act of 1928 (for maternal and child health). These made public health grants available for the first time.¹ The next step, the Social Security Act of 1935, given impetus by the depression, placed Federal-State financing of public health on an enlarged and regular basis. Next in the chronology was the Federal government's participation in capital expenditures in the health field, or, as it was known legislatively, the Hill-Burton Act of 1946. In the first twenty-five years of its existence, the Hill-Burton Act provided for the construction or modernization of 457,000 hospital and LTC beds, and 1,500 outpatient and rehabilitation facilities at the cost of $12 billion. In 1960, the Kerr-Mills Act was passed which specifically provided for Medical Assistance to the Aged. (MAA).
The Federal government's policy of gradualism up to the mid-1960's seemed to advocate a commitment towards a Federal-State partnership in public health financing. However, in 1965 Congress added two new titles to the Social Security Act, (title XVII and title XIX), which illustrated Federal acceptance of a policy of substantially increased responsibility and involvement in public health, especially LTC. Title XVII, or Medicare, established a compulsory Federal insurance program for persons age 65 years and older. Title XIX, or Medicaid, established a single program to substitute for the four categorical programs previously under MA. In 1966 with the enactment of the Partnership for Health Act, the Federal government continued with the policy of increased involvement by engaging in sorely needed health planning. These measures, along with the Social Security Amendments of 1972 and the National Health Planning and Safety Act of 1974, exemplify the Federal government's role in the health care arena.

It is evident that the Federal government realized responsibility and took action in varied areas. It attempted to remedy special health problems of the nation, aid state and local governments that couldn't afford the cost of health assistance to their residents, subsidize capital expenditures in the health field, regulate the health field, engage in short and long term planning, and, most relevant to this analysis, provide long term care for the aged. It is the contention of this analysis that full Federal financing of LTC would be a natural and logical progression in Federal public health policy.

State and Local Precedent

The argument for full Federal financing of LTC can also be advanced from the perspective of state and local governments. The financial burden on state and especially local governments from public assistance expenditures
has become increasingly unbearable. Likewise, taxpayer discontent has resulted from rising state and local taxes levied to meet public assistance expenditures (see Revenues section for complete discussion on taxation). The Advisory Commission on Intergovernmental Relations (ACIR), a Washington based study group engaged in major policy studies, illustrates this point by noting that state and local expenditures for public assistance doubled several times from 1950 to 1974.\(^3\) In 1980 it is estimated that state and local Medicaid outlays for LTC will be $4.6 billion\(^4\) excluding administrative costs which in 1977 were estimated to be about $788 million.\(^5\) With these spiraling costs in mind, another ACIR study recommended "that the Federal government assume full financial responsibility for the provision of public assistance, including general assistance and Medicaid."\(^6\)

Full Federal takeover of LTC is aimed at resolving disparities in the Medicaid program's handling of LTC, resulting from differences in resource capacity from state to state. The resource capacity of a state, simply the amount of money a state wishes to spend through Medicaid on LTC, can vary according to the State's eligibility requirements, LTC services covered by the State, and the State's reimbursement policies, all of which are discretionary beyond Federal guidelines.\(^7\) The Federal takeover proposal is also designed to relieve the inequities of fragmentation and the inefficiency of multiplicity within Medicaid program categories relative to LTC. The potential for streamlining the present conflicting and overlapping regulatory deluge would be inherent in the Federal approach to financing LTC. The Federal takeover proposal suggests a single regulatory body to monitor LTC facilities and services as opposed to the present Federal, state, and local regulatory agencies monitoring LTC.
Having established precedent in the field, this analysis shall now suggest direction for the next step in the Federal government's policy of gradualism relative to LTC for the aged. The suggestions brought forth in this analysis will only address the financial aspects and implications of long term care. The Federal government will be considered the subsidizer, referral mechanism, and the provider of LTC in the setting of complete Federal takeover of LTC.

Reimbursement

In fiscal year 1976, government programs paid an estimated $10.5 billion for LTC services; of this $5 billion was paid for by the Federal government and $5.5 billion by state and local governments. Over half of all LTC expenditures ($5.7 billion) were paid through the Federal/State Medicaid programs.8 In 1979 it is estimated that $8.3 to $8.4 billion in Medicaid money will be spent on LTC services, and by 1985 an estimated $20.5 to $21.6 billion in Medicaid money will be spent on LTC services.9 To conclude that there is an uncontrolled upward spiral would not be an overstatement. Under existing guidelines and retrospective reimbursement practices Medicaid expenditures for LTC will increase by about 300% from 1976 to 1985.

Medicaid's open-ended categorical grants to state and local governments have been accused of spiraling costs upward through retrospective reimbursement practices. Under retrospective reimbursement a facility first delivers care to a patient who is presumed Medicaid eligible, and then bills Medicaid afterwards. As early as 1966, H.R. Sommers warned about Medicaid's uncontrolled costs due to retrospective reimbursement practices.10 The Health Care Financing Administration (HCFA) of the Department of Health Education and Welfare (HEW) is also skeptical of present reimbursement practices, as is illustrated by their funding of prospective reimbursement demonstrations under section 222 of the HCFA. In 1977, Robert Derzon, the administrator of the HCFA, said, "We (HCFA)
would like to initiate reforms in reimbursement and redirect incentives away from high cost technological care."  

In the full Federal takeover proposal for financing LTC a prospective reimbursement system would replace the retrospective system that currently exists. The reason for the departure from the current system is that it provides little incentive for LTC facilities to operate efficiently or with any sense of "cost conscientiousness". In prospective reimbursement systems the level of the receipts is fixed which will encourage LTC facilities to operate in an economically efficient manner. Thus, prospective reimbursement has the potential to reward efficient LTC facilities and penalize inefficient LTC facilities.

As of 1976, there were some twenty-six prospective reimbursement programs operating throughout the country and because they differed, there is a need for clarification as to what is meant by prospective reimbursement for the purposes of this analysis. In this analysis prospective reimbursement refers to predetermined regional budgets for the delivery of a well-defined array of LTC services for a fixed period of time. Current Health System Agency (HSA) regions would constitute the regional levels at which LTC budgets would be set. (Health Systems Agencies [HSA] are planning and development bodies created by the National Health Planning and Resources Development Act of 1974 [Public Law 93-641]). The United States has been divided into 213 "health services areas", each of which is served by an HSA. Budget allocations would be based upon planning activities of the region's HSA and would take into consideration such factors as the region's LTC resources, the region's current LTC needs, and the region's projected LTC needs. A region's budget would provide for the total LTC needs of the entire service area on a capitation basis. A region's budget allocation would reflect the region's financial responsibility to provide for only those services that meet the region's LTC demands as determined by the respective HSA. Facilities or services that are not needed in a region
would not be considered in the figuring of the region's budget allocation. Once a fixed dollar amount is arrived at and is received by the HSA, (a process which will be discussed below), yearly operating budgets will be apportioned to the LTC providers in the region. The LTC providers would be paid prospectively by the HSA at 1/52 of the providers approved annual budget each week.

With information supplied by the HSA's throughout the United States, a mandatory standard rate (MSR) of reimbursement would be set for each level of LTC offered. Rate adjustments could be made for capital expenditures, but only if the capital expenditure was approved previously by the certificate of needs program of the respective HSA. Another important aspect of this proposed reimbursement system would be that the MSR's would be tied to the Consumer Price Index so that LTC costs would not be allowed to rise faster than other prices in the economy.

**Implementation**

It would be necessary to amend certain administration procedures to implement this prospective reimbursement system for a full Federal takeover of LTC. First, LTC reimbursement would have to be severed from titles XVIII and XIX of the Social Security Act and be provided for as a complete entity in itself in an effort to improve the monitoring and evaluating of both the LTC program and the remaining Medicaid and Medicare programs. Medicaid and Medicare data would no longer be skewed by the inclusion of massive LTC expenditures. Likewise, LTC data would emerge in a "cleaner" form, free from the statistics of the remaining health field, arming policy makers with better information as a basis for their decisions relative to LTC. In the present system, this type of LTC information flow is impeded by fragmented jurisdictions and conflicting eligibility requirements and level of care categories.
Another administrative change, the establishment of uniform eligibility requirements and levels of care categories, would be the next step in implementing the full Federal financing of LTC proposal. Although it is commonly held that increased eligibility results in higher costs, there is evidence to show that these higher costs due to increased eligibility are only temporary and will slack off in time. In a study by Barbara Boland on the AFDC program it was noted that even under a continuation of the present Medicaid program, increases in the number of eligibles would be a much less important factor because current caseloads are stabilizing. Granting further support to this concept, John Holahan, in his book *Financing Health Care for the Poor*, suggests that "A program with broad population coverage would avoid the problem of continually rising costs because, while large increases in eligibility and utilization would occur following the initial expansion of coverage, they would not occur over time." While acknowledging that increased eligibility could increase inflationary pressure, Mr. Holahan estimates that prospective reimbursement would do much to mitigate these inflationary price effects.

The next step towards full Federal financing of LTC would be to designate current HSA regions as LTC reimbursement areas. As mentioned above the HSA would be the rate-setting body that would determine the regional capitation budgets for LTC services. The purpose behind using the HSA as the rate-setting body is an effort to tie the planning function (already inherent in HSAs) to the rate-setting function. In 1977 the Institutional Reimbursement Conference Report held that the coordination of the rate-setting function and the planning function should be an essential consideration to any prospective reimbursement system. To do this successfully would mean that the LTC services that are rendered are those that have been deemed necessary by extensive HSA studies on utilization review, needs assessment, accessibility, and resource availability. For too long, LTC utilization rose to the available supply of LTC services, a concept
which has received some support in recent economic studies.  

The use of HSAs is meant to foster the concept of regionalization. The aim of this regionalized system is to make substantial gains in access, efficiency, and equity through emphasis on the planning function of the HSA. Increasing access, a desired result of regionalization, might initially raise costs, but, once stabilized, costs would level off over time and the system would prove more cost efficient in the long run. Eli Ginzberg, Director of the Conservation of Human Resources Department at Columbia University, supports the concept of Federal regionalization. He states:

Many State and Local governments simply cannot cope with the range of complex issues involved in the regionalization of health resources and delivery systems. The widespread weakness of these non-Federal structures is a clue as to how fast and how far the Federal government can encourage regionalization.

In summarizing the attributes of regionalization, a 1952 Presidential Commission's finding are informative. It defined the range of desirable goals of developing regionalization to be (1) increased patient knowledge and convenience, (2) greater access to health care services, (3) higher quality care, and (4) improved efficiency at less cost for health care services.

**Revenues**

Under the present Federal/State Medicaid program, matching funds constitute the revenue source. The Federal share of a state's Medicaid program is between 50% and 80%, depending upon the per capita income of the state's population. The Federal government pays the remainder of the Medicaid bill after the state pays its share, within the 50% to 80% guidelines.

State and local governments have become increasingly aware of the growing burden of LTC costs, for the state and local shares of the Medicaid program are derived from property taxes and sales taxes. In 1972, ACIR reported that from 1951 to 1971 there were 480 tax rate increases and 40 new taxes enacted into
law by state legislatures to meet the increasing burden of general and public assistance costs. This entire concept, the use of state and local revenues to provide for costly income-redistributing purposes such as Medicaid, has been deemed "particularly questionable and economically inefficient" by ACIR.

Tax efficiency and tax equity are two qualities against which taxes can be evaluated. Tax efficiency measures the way a given tax affects the allocation of resources, taxpayer compliance, and collection costs. Tax equity is concerned with the tax treatment of economically unequal persons, and their ability to pay. Sales tax is usually ranked higher in the efficiency category because it is a broad based tax and has no effect on relative commodity prices; however, sales tax is viewed as a tax on consumption and has a regressive effect on the distribution of income. This phenomenon renders sales tax inequitable by putting a heavier tax burden on lower income people. Property tax ranks low in both efficiency and equity. This is due to the fact that property tax is disproportionately costly to administer and tends to distort the pattern of land use. Plugging the progressive income tax into the framework of tax equity and tax efficiency yields positive results. The progressive income tax is clearly justified on the ability to pay principle and has little effect on the operation of the economy; therefore, it is ranked high in both tax equity and tax efficiency.

Another way taxes can be evaluated is by determining their elasticity coefficient. The elasticity coefficient of a given tax illustrates the responsiveness of the tax to economic growth relative to its base. Therefore, elasticity measures the way in which the tax behaves in comparison with changes in national income. An elasticity coefficient of less than 1 indicates that the change in tax yields was proportionately less than the change in national income. An elasticity coefficient equal to 1 means that tax yields changed proportionately to the change in national income. The elasticity coefficient is greater than
l when the tax yield changes were greater proportionally, than the change in national income.\textsuperscript{24}

In 1965 ACIR published a summary report of the estimated elasticity coefficients of various taxes.\textsuperscript{25} The summary showed that the median elasticity coefficients for both property tax and sales tax were less than 1, reflecting that they are inelastic. Conversely, the median elasticity coefficient for the income tax (greater than 1), demonstrating that the tax yield changes were greater, proportionally, than the change in national income.

The evidence of both tax efficiency/tax equity framework for evaluating tax systems and the elasticity coefficient support the premise that LTC revenue would be more equitably derived from a progressive income tax than from state and local property and sales taxes.

Under full Federal financing of LTC, revenues would be derived from the Federal government whose primary revenue source is a progressive tax, income tax. Although this might increase the amount of individual income tax paid across the country, a severe financial burden would be lifted from state and local governments. ACIR concludes that if the Federal government were to take over the entire cost of Medicaid, about two-thirds of the benefit would go to the states and and one-third would go to local governments.\textsuperscript{26} Even though this proposal is not aimed at a Federal takeover of the entire Medicaid program, surely substantial savings could be realized by both state and local governments in a full Federal takeover of LTC.

Opponents of the full Federal financing of LTC point out that state and local tax decreases are not necessarily synonymous with this proposal. Opponents contend that state and local taxes will not decrease even though state and local outlays for Medicaid will. However, the intended tax relief properties of this proposal are not designed to force tax relief, but only to make the potential for tax relief available at the state and local levels. Potentially,
under the proposal for full Federal financing of LTC, state and local governments could decrease sales tax and property tax and spur economic growth as well as ease taxpayer discontent. It is beyond the consideration of this analysis to propose any mechanism to interfere with the taxation powers of state and local governments. The impetus for tax relief will have to come from the constituencies of states and localities as did California's Proposition 13, a grassroots initiated voter referendum which mandated tax cuts.

**Profit Motive**

If the profit motive was ever a positive force in the development of the LTC industry, it is no longer. Many people today charge that the profit motive is inconsistent with good LTC and the values of American society. There also seems to be a strong belief in this country that those market mechanisms that some say are missing and are the cause of the high costs in the LTC sector should not be encouraged in the LTC sector because of the nature of the services offered and powerlessness of the recipients. In his discussion of general assumptions in public choice analysis Robert Bish states that "Goods and services desired by individuals possess diverse characteristics, including characteristics which make them difficult or impossible to provide through market or purely voluntary activity." 27

Certainly LTC is one area in which normal market activity has been less than successful and has caused the eruption of myriad problems such as institutional scandals, patient abuse, and profiteering LTC operators.

Allegations that the profit motive is injurious to good LTC do not go unsubstantiated. In 1971 the Connecticut Department of Finance and Control, Budget Division, released a study that showed that the LTC industry had a rate on investments double that of the top 500 U.S. corporations. 28 In 1976 the Report of the New York State Moreland Commission on Nursing Homes and Residential
Facilities released findings that strongly associated poor LTC and high profit margins. In March 1977 the Executive Council of the AFL-CIO issued a statement recommending that Federal funds be limited to non-profit LTC facilities because of the windfall profits and poor care in for-profit facilities.

Political Feasibility

Full Federal financing of long term care would have a strong political impact and there are political factors which must be considered. First, there is the creation and elimination of jobs brought about by the implementation of the full Federal financing of LTC proposal; second, the issue of special interest group pressure and its impact on the Federal level vs. the state/local level; and last, the loss of control over the LTC field by state and local governments.

The political feasibility of this proposal is predicated, in part, upon its impact on the job market. It is almost certain that this proposal for financing LTC will eliminate certain state and local government positions that deal with the regulation, administration, and reimbursement of LTC. Conversely, there would be a need for manpower to staff the newly formed Federal program. To circumvent almost certain union and local political actions, the Federal government could give state and local government employees who were left jobless because of the implementation of this proposal top priority in hiring for the Federal positions. Another approach to this problem would be to make available Federal subsidies to state and local governments to keep these employees on until they can be placed in the respective state or local government office.

Special interest group pressure is also an issue related to the political feasibility of the full Federal financing of LTC. State and local decision-making on issues relative to LTC is plagued with intervention from self-serving special interest groups. A 1976 New York State Moreland Act Commission on
Nursing Homes and Residential Facilities substantiated this special interest group pressure in reporting that "Private nursing home interests were able to obtain and employ political influence to achieve their ends on an impressive scale." The findings of the Moreland Commission typify the extent of special interest pressure that is exerted at the state and local level. Under the proposed LTC program, special interest pressure at the state and local level would be useless because policy decisions would be made at the Federal level where special interests from a state or locality yield considerably less leverage.

The loss of state and local control, an issue which is often brought up in national health insurance discussions, would have minimal impact on this proposal. Full Federal financing of LTC would control only that part of the health field that provides LTC. The remaining Medicaid program would still be subject to local control. Since relatively little control over health care would be relinquished by state or local governments, and substantial savings could be realized by state and local governments, this factor should not detract from the political feasibility of the proposal.

Conclusion

The future of LTC is far from resolved. As the elderly population increases and resources remain finite or even decrease, difficult decisions will have to be made. Unless American society de-emphasizes institutionalized care, or positive changes in life-style prolong life and influence the quality of life, restrictive action in the health field will have to be taken. Either more of the gross national product will have to be spent on health care, (meaning less spent elsewhere), or health services and/or eligibility requirements will have to be restricted. The harsh realities of any health policy were summed up best by British politician, J. Enoch Powell, who ran his country's National
Health Service in the early 1960's. Mr. Powell noted that "Whatever the expenditures on health care, demand is likely to rise to meet and exceed it. To believe that one can satisfy the demand for health care if illusory."\(^{32}\)

This is not to imply that there is no chance of an efficient and responsive LTC plan. But LTC must be controlled if future demands are to be met rationally and equitably. The above-mentioned proposal for financing LTC has the systemic ability to control and monitor the LTC field on a nation-wide basis, which is sorely needed at this point in time if future demands are to be adequately met by the system.

THE CASE FOR CONTINUED STATE FUNDING OF LONG TERM CARE

The case for continued state funding is based upon the concept of states bearing at least part of the fiscal burden for services over which they maintain some control. If some state control over the quantity and quality of long term care is desirable, then so is state funding because it enhances the likelihood that states act responsibly. In this section we will briefly examine the present relationship between the states and the Federal government and between the states and service providers (i.e., nursing homes). The problems associated with these relationships will be explored and then recommendations designed to decrease the effect of these problems but still maintain the basic fiscal framework of Medicaid reimbursement for long term care will be proposed.

According to Title XIX of the Social Security Act which became effective January 1, 1966, the Medicaid program was established:

For the purpose of enabling each state, as far as practicable under the conditions in such state, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disable individuals, whose income and resources are insufficient to meet the cost of necessary medical
services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care (SEC 1901).

The population eligible under the Medicaid program consists of two categories: persons whose eligibility is mandatory, and persons whose coverage is optional. Mandatory eligibility, generally referred to as the categorically needy, is comprised of all individuals who receive aid or assistance under Title I, X, XIV, or part of Title IV and those receiving supplemental security income under Title XVI of the Social Security Act. Persons whose coverage is optional, generally referred to as medically needy, are individuals who fit into one of the categories of people covered by cash welfare programs, individuals who have enough income to pay for their basic living expenses (and so are not recipients of welfare) but not enough to pay for their medical care.

Medicaid services are divided into two categories: mandatory services and optional services. There are seven mandatory services: inpatient hospital care; outpatient hospital services; other laboratory x-ray services; skilled nursing facility services and home health services for individuals 21 and older; early and periodic screening, diagnosis, and treatment for individuals under 21; family planning; and physicians services. The law provides for 17 optional medical services including clinic services, prescribed drugs, dental services, prosthetic devices, eyeglasses, private duty nursing, physical therapy, services of optometrists, podiatrists, and chiropractors, skilled nursing facility services for patients under 21, emergency hospital services, care for patients over 65 and institutions for mental disorders and for tuberculosis, care for patients under 21 in psychiatric hospitals, institutional services in intermediate care facilities and other diagnostic, screening, preventative and rehabilitative services.

States have the option to provide non-mandatory services to both categorically and medically needy persons. Illinois, New York, Minnesota, Washington,
and Wisconsin are the only states which provide all 17 of the optional services under their Medicaid programs.

State expenditures eligible for Federal reimbursement are determined by state plans submitted to HEW for approval. The amount of the Federal share is determined by a formula which provides a matching percentage equal to the difference between 100 percent and 45 percent of the ratio of the squared per capita income of a given state to the squared per capita income of the United States. No state, however, may have a Federal Medical Assistance percentage of less than 50 percent and more than 83 percent. In addition, seven relatively small expenditure categories pertaining to administration are subject to fixed percentage Federal Payments. Per capita personal income incorporated into various grant need formulas is an attempt to redistribute funds from higher to lower recipient areas.

Perceived Problems in the Federal Medicaid Structure

Martha Derthick, the author of Uncontrollable Spending for Social Services Grants, points to significant problems related to the open-ended categorical grant model. Derthick states:

Spending for social services grants soared from $354 million in 1969 to 1.69 billion in 1972. The President's budget estimate of $937 million for social service grants in 1972 was too low by nearly $1 billion. Social services were "uncontrollable" primarily because they were open-ended. This was changed in the form of legislation in 1974 when Title XX was created and a ceiling of $2.5 billion on federal spending was set.34

The same dramatic increase in expenditures is currently evident in the Medicaid program. As was noted earlier, Medicaid expenditures are estimated to increase 66 percent from FY 1975 to FY 1978.
The Current Reimbursement Structure for Long-Term Care: State Level

At the present, the individual states have the responsibility of managing the Medicaid program. States reimburse monies to providers, set standards of care, assure that facilities meet standards, audit, license, certify service providers, and tax their constituents to meet the Federal match. The primary area of emphasis in this section shall be the means by which states reimburse long-term care providers. The states of Ohio, Connecticut, and New York have been pursuing new alternatives in this area and for this reason, have been selected as the primary states to be critiqued.

In Ohio, nursing homes are reimbursed on what the state terms as a prospective basis. A per diem rate to be paid in the future is calculated for each home based on past cost. Costs reported for the six months ending December 31, 1975, were used to set rates for calendar year 1977. The nursing home's rate is then multiplied by the number of patient days at the home each month to determine the monthly reimbursement. In cases of misrepresentation of cost and/or services rendered or concealment of data which would indicate a lower rate than a home is receiving, the rate is not adjusted retroactively. The average per diem rate for Ohio nursing homes was $19.32 in June 1977.

In June 1977, 77 homes were participating in the Medicaid program and were paid about $1.1 million. Ohio requires that cost reports be filled out within 90 days after the end of the reporting period. Failure to file a timely cost report results in a nursing home being paid at their current standing rate. The rate is revised when the nursing home submits its cost report. If the report indicates the home was over-paid during the period for which it failed to file, Ohio reduces future payments until the overpayment is recouped. If the home can justify an increased rate, the increase is delayed by the number of months the required reports are late.
Since 1974, Ohio has calculated the reimbursement rate by comparing nursing home reported costs to establish line-item-cost ceilings and overall cost ceilings. Ohio used the lower of the reported costs or line-item-cost ceilings. Ohio compares the resulting costs per patient day to the overall cost ceiling and reduces to this ceiling if necessary. 36

In Connecticut, the Department of Social Services (DSS) administers the Medicaid program together with other state welfare programs. Long-term care accounted for 53 percent of Connecticut Medicaid expenditures in FY 1976. Initially, Connecticut used a point system for reimbursement whereby a home could qualify for a higher classification and a higher reimbursement level by providing services beyond health code standards. This strategy resulted in general upgrading of institutions, but not necessarily care. A report developed by the Legislative Program Review and Investigations Committee entitled, Containing Medicaid Costs in Connecticut, states:

There was no rational relationship between points for classification and costs. Homes had an incentive to provide "services"--sometimes unrelated to patient needs--and many of them did.37

In 1975, a temporary system was developed using interim rates to reimburse providers while the point system was phased out and institution of a new cost-related system could be implemented. These rates were based on 1974 costs, plus 5 percent for inflation. The new cost-related system was slated to go into effect January 1, 1978.

The cost-related reimbursement system is based on a breakdown of costs and assets at each home as follows:

A. Controlled cost centers

1. Dietary
2. Nursing
3. Laundry
4. Housekeeping
B. Uncontrolled costs

1. Management services (reviewed for reasonableness)
2. Utilities
3. Accounting fees
4. Other

C. Asset Valuation

1. Building
2. Land
3. Appurtenances

Under the controlled cost centers category, dietary, laundry, housekeeping, and nursing expenditures will be contained. Nursing homes, profit and non-profit together, will be grouped by size and class, and rank ordered by cost in each of the controlled cost centers. Costs, up to the 80th percentile, for each size and class in each cost center will be fully reimbursed. The most expensive homes (top 20 percent) will be reimbursed at the rate of homes at the 80th percentile. The maximum annual cost increase which is reimbursable in any cost center, will be the previous years cost multiplied by the current gross national product (GNP) deflator.

The uncontrolled cost category, unlike nursing or dietary services, cannot be grouped across homes. The cost would include: utilities, employee benefits, self-employment taxes, and maintenance costs. These costs will be examined for their "reasonableness" and verified by field audit.

The asset valuation category bases the asset valuation in its proposed reimbursement system on the "Fair Rental Value System." Under this system, all homes are depreciated on a straight line basis with an average life of 40 years.

All long-term care facilities seeking Medicaid reimbursement will be required to submit to the Committee on state payments an annual report by December 31st of each year. Based on the detailed annual report, desk auditors will determine an interim rate for each facility. After independent field auditors verify the information provided, the interim rate, with adjustments if indicated, will become the actual rate for that year.
The Moreland Commission Report which reviewed the long-term care industry in New York State explains in detail the New York State rate setting system. The system developed by the state has been viewed by many observers as one of the several models that other states might follow in developing a "cost-related" approach to Medicaid reimbursement. In New York State, nursing home operators are required to submit to the state a detailed statement of operating costs for the preceding year certified by public accountants. Following this the statements are desk audited by the Division of Health Economics. Total allowable costs are divided either by the actual number of patient or resident days of care rendered in the year for which costs have been reported or by that number of patient days which would have been rendered had the facility experienced an average occupancy rate of 90 percent. Whichever number is greater is employed.

Nursing homes are then grouped by the division in accordance with bed size, location within the state, and sponsorship. There exist five bed size ranges, seven regional divisions, and three sponsorship classifications (proprietary, voluntary, and government). For each such group, weighted average per diem amounts of two kinds are calculated. The first is an average combined per diem cost of administrative, dietary, and housekeeping services. The second is the overall average per diem cost, excluding property costs, cost of therapy drugs, and return-on-equity. Per diem costs 15 percent above such group averages also would be disallowed. A "role factor" is applied to per diem costs. The "role factor" consists of the set of projections of inflation and the prices of various components of facility costs, i.e., wage rates, food prices, fuel, drugs, etc. When applied to base year per diem costs, the role factor fixes a "prospective" rate which would provide reimbursement to a facility sufficient to maintain its base year pattern of expenditures, despite changes in prices anticipated from the base year to the rate year. Should actual costs in the rate year be below those anticipated by the prospective rate, through the achieve-
ment of efficiencies of one form or another, a facility would earn a profit from operations. 38

Perceived Problems in the State Reimbursement of Long-Term Care

A problem commonly perceived by states is providing nursing homes with incentives related to cost containment. In Connecticut, under their new reimbursement system, efficient management will be rewarded by allowing a facility to keep 10 percent of the difference between its actual costs and ceilings set for each cost center, when the difference is $1,000 or more. In New York State, a fixed percentage of the difference between a home’s actual costs and reimbursement ceilings are used as an incentive.

A second problem, one focused on by the Moreland Commission concerns Medicaid reimbursement of nursing home property costs. The report states:

There has existed every temptation for owners to misrepresent costs of constructions or interest charges on mortgage loans and to misstate a variety of other real property costs in order to obtain higher reimbursement.... Clear incentives have existed for establishing "fictitious" costs based upon transactions among unrelated parties.

In response to the Moreland Commission Report, New York State has adopted the "Fair Rental System." The Fair Rental System does not permit reimbursement to vary, depending on whether a facility is leased or operated directly by an owner and does not change because of sales from one entrepreneur to another. This system mandates that all homes are depreciated based on an average life of 40 years. It is anticipated that the system shall end the practice of rapid turnover, inflated prices and lease-back arrangements. Thus, we have a valid example of a state able to rectify its errors and incorporate into its system a cost containing instrument which is responsive to its own needs.

States have also become increasingly aware of the negative impact of inappropriate placement of individuals in LTC and differing level of care within the
industry. The Comptroller General's report on the Ohio Medicaid program concludes that:

Ohio is wasting millions of dollars annually because the SNF benefit is not being effectively used as an alternative for high cost hospitalization. 39

The report goes on to predict that the cost of care for 10,000 intermediate care patients incorrectly classified as SNF (skilled nursing facility) patients could create an overpayment of $73 million per year if skilled and intermediate care facility rates are $45 and $25 per day respectively.

The problem of appropriate placement in relation to cost containment is discussed in the report prepared by the Connecticut Legislative Review and Investigations Committee studying containing Medicaid costs. It states:

While the number of Medicaid recipients has only doubled from about 90,000 in 1967 to about 180,000 in 1976, Medicaid expenditures were six times higher in 1976 (188 million) than in 1967 (32 million). A major cause of Medicaid cost increases in Connecticut is the imbalance in levels of care provided by the nursing home industry. Connecticut spends nearly half of its Medicaid budget on expensive skilled nursing care, while other states average only 20 percent. Conversely, other states average about 16 percent of Medicaid budgets for lower cost intermediate care, while Connecticut spends only 4 percent. 40

The Moreland Commission Report in New York State also suggests that significant inappropriate placement is impacting on cost containment activities since little, if any, variation in cost "can be explained by the assumption that higher cost homes are treating patients in need of more intensive care." 41

The report goes on to state:

Undermining many regulatory efforts is the near total lack of monitoring or control over decisions affecting the placement of individuals in homes. State regulatory agencies have failed to define explicit rules and to implement effective procedures to determine which patients or residents might require the most expensive "skilled nursing" level of care, which might require "health related" care, and which can be successfully cared for in domiciliary facilities. 42
Recommended Structural Changes in the Current Long-Term Care Reimbursement System

Thus far, this paper has explained existing structures related to long-term care reimbursement and illustrated perceived problems within the structures. The paper will now focus on recommendations applicable to long-term care funding.

It is recommended that the Federal and state roles in the financing of long-term care remain essentially as they are. That is, the Federal government should continue to provide matching moneys and states should continue to manage the long-term care industry. Further, states should continue to bear a fiscal tax burden for the provision of service to their constituents in their respective localities.

Recommendation #1
That the current "Medicaid" categorical grant-in-aid Federal program be altered to establish a separate Federal categorical grant-in-aid program exclusively for long-term care funding. It is further recommended that the categorical grant would have considerable impact on containing the rapid expansion of Medicaid costs. By splitting the current Medicaid categorical grant approximately in half, it may be possible to place ceilings on both the medical assistance and long-term care Federal allocations. Further, such a step should promulgate a similar separation of long-term care administration on the state level. This would service to heighten the amount of attention paid to the unique problems related to long-term care services. Utilizing the close-ended approach would promote sounder fiscal planning on the Federal and state level. The ceiling or "CAP" would force states to develop prospective expenditure estimates in order to assure federal reimbursement under the "CAP".

Recommendation #2
That the current formula used to determine the state-federal match be altered.

Application of the CAP concept currently used in the provision of Federal entitlement grants may have significant merit over the current use of the per capita
income formula element. The CAP concept is primarily related to the states' capacity to financially support efforts in relationship to its need for service weighted against other states. Further, adjustments for differences in costs of medical care from one state to another could be included in the formula. Examples of how these formula features may impact on individual states has been prepared by the Center for Governmental Research, working paper #3: The Medicaid Formula. The paper primarily addresses distributional and equalization effects of the Medicaid formula and Medicaid formula alternatives. These findings should be carefully considered on the Federal level as a means by which distributional objectives can be more equitably met.

**Recommendation #3**

That states create a separate office of Long-Term Care Administration. This state office should have the legislative power to license and certify facilities, enforce regulations, set rate structures, and determine long-term care needs. The office should develop a yearly prospective state plan which estimates total state expenditures for provision of long-term care. The state plan would be submitted to HEW where the long-term care categorical grant-in-aid formula would set the Federal match share of the requested state plan. The office should also have the power to rule on the appropriateness of any new facility or expansion of long-term care facilities as it relates to the prospective state plan developed.

**Recommendation #4**

That the state office of Long-Term Care Administration decentralize management functions by the creation of Regional Management Offices. The regional offices would be held accountable for region-wide coordination of long-term care planning, rate setting, auditing, and coordination with the central state office of regulatory oversight. Each region would be responsible for preparing a prospective yearly regional expenditure plan and need estimate. The regional office would be expected to coordinate its efforts with regional and local planners...
to best determine where gaps in service occur. The regional management office need not be a purely state function. The state central office could contract with a regional not-for-profit management association comprised of providers, state and local officials, and citizens of the region. This independent association comprised of providers, state and local officials, and citizens of the region. This independent association would hire appropriate staff to carry out the mandated functions of the state office. Such a scheme might be more politically feasible in areas where a high degree of leadership has produced superior long-term care services. This approach may work well in regions that are less densely populated. In rural regions Incorporated Provider Councils could exercise the regional management responsibility. The state central office would provide the regulatory enforcement and possibly the audit function. Only providers with superior facilities and proven administrative expertise should be selected. Being recognized as the "experts" in their region should enhance the acceptance of a closer state monitoring role. In congested urban areas it is recommended that the state central office provide a direct management function.

This continuum of options available to the state office of Long-Term Care Administration should produce an effective means by which the characteristics of individual regions within the state are recognized. It will also provide the state with significant flexibility in achieving its long-term care goals within the context of the regional perspective.

Recommendation #5
It is recommended that states adopt a prospective rate setting capability. Specifically, a scheme should be devised for dividing total per diem operating costs into cost categories, such as the Connecticut breakdown of controlled cost centers, uncontrolled costs, and asset valuation. Variation among homes in per diem costs for each of the categories selected should be explained by use of multiple regression techniques, such as the Moreland Commission applied in its
study of 1970 nursing home costs. From this analysis, statistically typical costs can be determined. Adjustments could then be made relative to size, class, wage rates, and patient mix. This implies a "group average" outcome. The Moreland Commission report suggests: "Efficient care standards would be defined by determining the percentage that actual costs of standard setting homes are of the calculated statistically typical costs for these homes." Thus, a standard setting home in dietary service may have actual costs which are 95 percent of its regression estimated (that is a statistically typical) dietary cost. Efficient care standards for each home would be calculated by applying this percentage figure to each home's regression estimated cost. The goal of this approach is to set standards by which nursing homes will be reimbursed. It is further recommended that rates set using this scheme be set on a regional basis and be used as the basic determinant of the Regional Fiscal Plan submitted to the state office for inclusion in the total state plan. In setting rates, states should apply the extent to which individual providers are meeting acceptable care standards. States should not reward providers for achieving superior ratings in care standard review audits. This will only prolong the increased development of "lavish facilities." The goal should be to equalize the quality of care provided in all state facilities.

Incentives should be given to proprietors who have demonstrated cost effectiveness and achieved acceptable ratings relative to care provision. It is recommended that states permit facilities to retain as profit a percent of unspent moneys for each cost category.

**Recommendation #6**

It is recommended that states adopt a property reimbursement cost system similar to the New York State "Fair Rental System." As was stated earlier, this system does not permit reimbursement to vary depending on whether a facility is leased or operated directly by an owner and does not change because of sales
from one entrepreneur to another. All homes are depreciated based on an average life of 40 years. This bold approach to eliminating nursing home abuses should be viewed with interest by every state. One criticism of the "Fair Rental System" is that it may hamper proprietors with sound track records in receiving a fair return on their investment. It is recommended that this feature be changed either through the use of a review process or point system which would award proprietors who have demonstrated "good faith" in the provision of service some measure of flexibility in receiving current asset valuations for the sale of properties.

CONCLUSION

The intent of this exercise has been to describe the current structure of finance applied to the long-term care industry. An effort was made to analyze various problems occurring within the structures and recommend corrective procedures. The recommendations provided do not alter the essential responsibilities currently existing within the Federal and state governmental structures. Rather, they suggest steps which will strengthen the system which currently exists.

The rapid growth and development of the long-term care industry coupled with the "skyrocketing" costs of the Medicaid program mandate a thorough re-examination on the Federal and state level of each governmental unit's commitment to long-term care. This can be best accomplished through a "partnership" effort between the Federal government and various states.
FOOTNOTES


9. Ibid., p. 20.


14. U.S. Congress, Joint Economic Committee, Participation in the Aid to Families with Dependent Children (AFDC) by Barbara Boland, Joint Committee Print, (Studies in Public Welfare), Paper No. 12, pp. 139-79.
FOOTNOTES


19 Ibid., pp. 178-187.


23 Ibid.

24 Ibid.


28 Report on Long Term Care, (Connecticut Department of Finance and Control, Budget Division, 1971).
FOOTNOTES


43. Moreland Commission Report, Long-Term Care Regulation.