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13. Long Term Care: Medicaid Reimbursement Does High Cost Yield High Quality?

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LONG-TERM CARE: MEDICAID REIMBURSEMENT

Does High Cost Yield High Quality?

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"Society has the obligation to assist the poor and the aged. Among the ways it should help them, is by providing minimal levels of health care."

From

The Sociology of Health Care

Darryl Enos

INTRODUCTION

As the Albany State team began to look at the problem of Medicaid reimbursement, we ran into a mass of regulations, data, and literature that said confusing, and often conflicting things about government policy in this field. Since we are not experts on Medicaid, and because of the limited time of the simulation, we set out to put this sea of material together.

Our paper was written in adherence to three values:

1. Quality health care should be provided by the government for those who need it.
2. That care should be provided as inexpensively as possible.

and

3. Changes in the Medicaid System should not cause an increase in bureaucratic machinery.

We began our study by asking: Where do these three values fit into the Medicaid system? What is the purpose of Medicaid? The Federal government said in 1966 that its purpose was to provide and finance quality health care for anyone needing it. That purpose of Medicaid is still in effect today. Yet, many people (we focus on the elderly in Ames County) are sick. They are sick because they are too poor to afford quality health care. Somewhere there is a problem. At this point we asked: Is Medicaid meeting its stated objectives as effectively as possible?

Next we tried to search for the roots of this problem. We looked at items such as the Federal/State cost sharing equation and the issue of reimbursement policy itself and asked: Are these causes of the problem, or are they just symptoms of a more fundamental dilemma? We view the problems of reimbursement policy as indicative of ills with the total Medicaid system.

We concluded that the root of this problem lies in the structure of the Medicaid system itself. 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. In 1966, cost was no object to a Medicaid administrator. The duplication of facilities, bookwork, and the staff functions between Federal, State and County agencies administering Medicaid is an example of the spendthrift values that characterize the system.

Today, however, cost is an object. Cost containments is a critical factor that plagues the administration and delivery of all Social Services. The Medicaid Administrator today wants to provide quality health care, but he wants to do it as cheaply as possible.

After eyeballing the problem of providing quality care at minimal cost, we thought that the government may better implement the Medicaid program today by facing up to the austere realities of cost containment. The Medicaid system must adapt itself to fiscal constraints. If the government can become a better businessman, the altruistic objectives of Medicaid may be met more effectively. In other words, the government must learn to speak the language of proprietary nursing homes - the language of the "profit motive". The symbols of that language are dollars and cents; their configuration meaning either "incentive" or "sanction."

We believe that the government can "tune in" to the language, and improve the delivery of long-term health care services by:

1. Recognizing that cost containment is a critical factor in providing Medicaid.
2. Eliminating the waste and inefficient of Medicaid Administration.

and

3. Providing appropriate placement for Medicaid patients.

The remainder of this paper will address: 1) The related causes and problems of Medicaid reimbursement, and 2) Recommendations for alleviating or soothing the effects of those causes.

THE PROBLEM: HOW TO PROVIDE QUALITY CARE AT A MINIMAL COST

The most troublesome aspect of Medicaid is its high cost. Presently, over ten percent of the Ames County budget is allocated for payment of Medicaid bills.

There are several causes for the excessive cost of Medicaid. First, a major portion of Medicaid reimbursement costs is due to the overuse or inappropriate use of services by long-term patients. For example, many elderly patients are forced to wait in acute care facilities (i.e. hospitals) before they gain admittance to either Skilled Nursing Facilities (SNF's) or Health Related Facilities (HRF's). Since hospital stays can be as much as five times as expensive as most nursing homes, Medicaid must bear the unnecessary financial burden. This delay in placement is compounded with the inappropriate placement of long-term care patients in facilities which provide a greater level of care that the patients may actually require. Inappropriate placement of patients is widespread in Ames County as evidenced by the one-day census statistics comparing occupancy in HRF's with that of SNF's. The data show that there is a surplus of space in HRF's with a corresponding increase in the number of "Unoccupied, Unavailable beds" in SNF's. In other words, the wasted space in SNF's is wasting Medicaid money.

Why is there such inappropriate use of Medicaid services? One reason is that private nursing home owners are reluctant to take Medicaid patients into their facilities. This is because government regulations make it more profitable for a nursing home to care for a private patient rather than a Medicaid patient.

For example, Medicaid reimburses nursing homes at a much lower rate than that which can be received from private patients. Also, long delays in the determination of patient eligibility for Medicaid, and, lags in the actual reimbursement, make nursing home operators skeptical of accepting Medicaid patients. The nursing home operator hears that his facility will have to bear the cost caring for a patient declared ineligible for Medicaid. Another reason for the inappropriate use of Medicaid services is the lack of coordination and consistency among the regulations put forth by three governmental levels (i.e., Federal, State, and County). For example, the myriad of stipulation placed upon Medicaid regulations as they proceed from Federal to State and County governments causes a private nursing home owner to drown under bureaucratic "red tape".

A second reason for the high cost of Medicaid underlies the growth of "red tape" in this system. The prevailing attitude among those who administer Medicaid is that quality care is accurately measured by the amount of dollars spent by a facility in pursuit of that care. The problem is that standards of quality care differ per level of government. For example, Federal and State regulations require different numbers of professional staff per occupied bed, in a nursing home. The nursing home operator has no choice in situations such as this but to meet the most demanding (i.e., expensive) standard in order to please each governmental level. This appeasement is a major cause of costly Medicaid bills because the most expensive standard is not always the most effective.

The inadequacy of equating quality health care with dollars spent on achieving that care is reflected in the amount of "wasted" services that government regulations force nursing homes to provide. For example, the literature documents cases of long-term patients receiving unnecessary x-rays, drugs, and therapy because they were prescribed by government regulations. In other words, there is no guarantee that a high cost program will be of high quality.

The third reason for high Medicaid reimbursement costs is the amount of inefficient and fraudulent practices which occur throughout the system. The root of this problem lies in the lack of coordination among Federal, State and County regulations, regarding Medicaid. In addition, each level agency consistently failed to supervise and enforce regulations dealing with the fraudulent abuses of the system. In effect, each level of government added regulations instead of supervision thereby aggravating not relieving the problem. This lack of supervision gave individuals the opportunity to manipulate the regulations to their advantage.

This practice was exposed by the Moreland Commission's Report which discussed how several nursing home owners had consistently overestimated operational costs. Also, property costs estimates were inflated due to other fraudulent practices. In addition, insufficient funds were allocated to government auditing departments. This reduced government effectiveness in controlling Medicaid costs. However, some improvement has been noted in this area (as a result of the Commission Report) but continued efforts are essential if abuses are to be eliminated.

Finally, the Federal/State cost sharing equation results in high Medicaid reimbursement costs to Ames County and the State of New York. In effect, this equation discriminates against wealthy states because it uses median income as the indication of a state's ability to pay for Medicaid. The equation does not consider the amount of optional Medicaid services provided by a state (e.g., vision care) or the number of residents utilizing Medicaid services. In other words, this equation provides no incentive for states to expand Medicaid services for more people.

To summarize, there are four causes of high Medicaid reimbursement costs in Ames County, New York:

1. The inappropriate use of Medicaid facilities and services.
2. A disparity between costs and quality of health care.
3. Inefficiencies, loopholes and fraud.

and

4. The discrimination of the Federal/State cost-sharing equation against wealthy states, such as New York.

GENERAL RECOMMENDATIONS FOR THE ADMINISTRATION OF MEDICAID*

We have emphasized throughout this paper that government values regarding the provision of long-term health care have changed since the inception of the Medicaid Program in 1966. The "new" value is saving money. In the dim light of the present fiscal crunch, government administrators must pay close heed to cost containment and ways to exploit the profit motive.

Therefore, we believe that the government has a choice in determining the future of long-term health care:

1. The government can take over proprietary facilities and operate long-term health care without profit. This course of action, however, violates our third value which seeks to limit the scope of the government in this issue.

*Some of our recommendations have been adapted from the Moreland Commission Report.

OR

2. The government can develop mechanisms that use the profit motive toward the end of improving long-term health care. This can be done by putting an end to the reward of inefficiency and duplication in the delivery of Medicaid services. Also, the government should try to reduce the mandatory expenditures of nursing homes which show no relation to improved care (i.e., reject the "equation" between higher costs and greater health care). This is our first general recommendation.

Our second general recommendation refers to the fourth cause of high Medicaid costs (as outlined in the previous section), the discriminating Federal/State cost-sharing equation. We believe that provisions should be made in the equation to reflect - 1) the number of state residents utilizing Medicaid services, and 2) the quality of that state's service. The equation should be structured so that it rewards states that the most effective Medicaid Program.

A third general recommendation refers to our third cause of high Medicaid costs and calls for the reduction of paperwork, duplicated regulations, and administrative inefficiencies of the Medicaid program (it has been said that some nursing home administrators spend up to forty percent of their work day doing paperwork!). The three levels of government should strive for coordination of regulations so to facilitate the dispensing of long-term health care.

SPECIFIC RECOMMENDATIONS FOR THE AMES COUNTY SOCIAL SERVICES DEPARTMENT

I. Regarding the placement of long-term patients:

A. Clear, consise placement procedures should be developed by the Ames County administrators. Also hospitals, nursing homes, and social service agencies

should hire "Placement Officers" to be responsible for all placement activities.

B. Placement procedures outlined by the "Placement Officer" should go into effect as soon as the patient contacts the local social service agency OR has been admitted to a hospital for acute care.

C. Utilization Review Procedures (as suggested by the Moreland Commsion should be continued and expanded).

D. Limits should be set on the number of beds a SNF or HRF may classify as being "Unavailable if Unoccupied". Also, each SNF or HRF must accept a certain percentage of Medicaid patients. This, we hope, will eliminate some patients being turned away because they were labeled as "difficult cases".

E. Eligibility procedures should be simplified so that nursing homes will be able to avoid the absorption of costs due to the rejected patients.

II. Regarding the definition of "Quality Care":

A. A Quality Care rating system should be developed in which "quality" is determined by three factors:

1. Patient response to received care, and
2. The patient's relative response to care, and
3. Testimony of expert reviewers (e.g., Doctors)

Also, quality is to be measured by the actual care received by a patient - not by the technological, staff, and fiscal resources of the facility.

Also, the facilities receiving the highest quality ratings should receive the highest medical reimbursement (i.e., operationalize the "profit motive").

Also, the facilities receiving the lowest quality ratings should lose certification, and be

conditionally subject to legal suit in violation of the patient's right to quality health care.

B. Quality Ratings should be made public by:

1. Conspicuous posting in the facility
2. Distribution to the Supervisory Social Service Agency
3. Distribution to the Media (in extreme cases)

CONCLUSION

The above recommendations suggest a new focus for government policy in the providing of Medicaid services. To put it simply, the government needs to provide incentives (and sanctions) that make the business of caring for the elderly profitable to proprietary nursing home. Although "profit" and "quality care" are strange bedfellows, the government must adapt the Medicaid system to keeping them close (i.e., maintaining a positive relationship between profit and quality care).

There are lessons from this specific problem that can be applied to other problems in the financing and disbursement of social services. The policy issues of Welfare and Social Security, for example resemble those of Medicaid in that these social services face austere futures, cries for cost containment, and demands for effective programming. One lesson that may be of use in dealing with these issues is:

> The government might become more effective in providing social services if it shapes its regulations in terms of the special needs of the organization (or people) which dispenses (or utilizes) that service.

For example, some of the abuses of Welfare or Social Security might subside if it becomes unprofitable for recipients to try to "beat the system".

Another lesson is that coordination between the three levels of government is essential for the provision of cost/effective social services. In other words, the right hand must know what the left is doing in order for them to work together effectively. We think that the three government levels must plan together (i.e., seek feedback from one another) in the provision of social services so that inefficiency in the administration of those services lessen.

We think that this systems approach to the cost/effective provision of social services is essential for the survival of these services in America.

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