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04. Introduction

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INTRODUCTION

The use of students to produce major policy studies has received some recent publicity with the publication of Energy Future by Roger Stobaugh and Daniel Yergin. These authors used Harvard doctoral candidates to do policy research in an area of major importance. MPA candidates at the State University of New York College at Brockport, the Maxwell School at Syracuse University and the State University of New York at Albany, participated in a recent policy study of this type initiated by the editors.

The Public Management Simulation (PMS) was conceived as a unique way to combine teaching and research in public administration. The ideal of combining teaching and research all too often finds its expression as a classroom lecture on somebody's pet study or as the lonely process of grinding out a dissertation or thesis. While both of these methods have undeniable merit, they tend to lack the vitality and challenge that comes from working with a group of intelligent and informed people to understand complex social phenomenon. PMS provides an alternative that utilizes the students as policy researchers with the added stimulus of an adversary setting. In this instance the PMS was used to develop alternatives for government funding of Long Term Care.

In the "normal" classroom situation a teacher should leave students with a more or less specified set of skills and knowledge. PMS attempts to provide a specified set of skills by showing students how to do policy research. The knowledge students gain is unspecified because it is unknown. It is up to the students to apply the skills to gain the knowledge.

Briefly, the PMS was done in two stages. In the First Stage, teams of students from three MPA programs were asked to develop policy alternatives to

the present system of Medicaid funded Long Term Care. Each team submitted their policy alternatives (see Appendices I, II and III) to a panel of judges who ranked them. In the Second Stage, a seminar composed of MPA students, who did not participate as team members, was formed to further develop policy alternatives. The students in the seminar were asked to develop policy to support one of two opposing strategies: the federal takeover of Medicaid funding for Long Term Care vs. the maintenance and possible strengthening of state control of Medicaid funding for Long Term Care. Each seminar participant was required to develop a paper in one specialized area that supported one of the strategies. These papers have been incorporated into this monograph.

In compiling the monograph the editors made every attempt to preserve the participants' papers in their original state. However, we did have to delete some portions of some papers that covered material in others. In addition, deletions and additions were made to aid transitions between chapters and sections of chapters. Finally, we engaged a professional editor to screen out grammatical and spelling errors. Other than that, the chapters in this monograph are solely the work of the seminar participants.

The object of the second stage of the PMS workplan was to use the team responses as a stepping stone for the development of even more rigorous policy alternatives to the funding of Long Term Care through Medicaid. None of the nine seminar participants had been a team member in the first stage; however, they all received copies of the packets sent to teams, were present at the Brockport conference where teams made their presentation, and were given copies of team position papers. The separation of team membership from seminar participation was considered beneficial because it allowed the seminar participants a better opportunity to critique the work of the teams and use it as a

base for the further development of policy alternatives. The key activities in stage two included: the subdividing of the problems into narrower issues associated with the Medicaid funding of Long Term Care; providing seminar participants with an opportunity to develop policy alternatives on Medicaid and Long Term Care; holding a debate which would allow the participants to test the viability of their positions; and critiquing the participant's written proposals to help them produce publishable final drafts.

The seminar used an adversary setting to analyze the problems before it. Half of the seminar developed policy alternatives based on the strategy that the federal government should take over the Medicaid funding of Long Term Care while the other half of the seminar was asked to support the maintenance and possible strengthening of state control. One of the unproductive outcomes of the adversary setting is that each side may attempt to damage the effectiveness of the other by withholding information, focusing on personalities rather than issues, ignoring the opponents' arguments and other similar behaviors of a destructive nature. It was felt that by having the participants work in dyads (teams of two) where each member advocated one of the strategies for a particular issue, many of the negative aspects of the adversary setting could be overcome. The seminar participants spent most of their time working in dyads and only broke into two larger debate teams (one to argue for federal control and the other to argue for state control) on two occasions. On the first occasion teams met to coordinate their debating strategy and on the second, the debate itself was held.

The subdivision of the Medicaid funding of Long Term Care into narrower issues was accomplished using the Norminal Group Technique.[1] The Seminar was

[1] Andre Delbecq, et.al., Group Techniques for Program Planning (New York: Scott, Forsman and Company, 1975)

randomly divided into small groups to develop a list of the most important issues. After this was accomplished, the groups were brought into a plenary session to combine their lists. In this way, five issues were uncovered regarding the Medicaid funding of Long Term Care:

1. What administrative structure is appropriate?
2. How will standards of care be developed and tested?
3. How will it be financed?
4. How will the moral issues be dealt with?
5. How will the appropriate options to the patient be determined?

Two seminar participants were assigned to each issue: one would develop policy based on the strategy of a federal takeover and the other would explore the continuation of state control.

The first assignment for each of the dyads was to submit an initial position paper of approximately ten pages. These papers were exchanged among dyad partners and submitted to the seminar directors. After reading each others initial position papers, the dyads worked to develop a common information base and an understanding of each others arguments. This was done to counter some of the negative aspects of the adversary setting mentioned earlier. The seminar directors intervened in instances where members of a dyad could not agree on which points of an issue should be argued or where the dyad had difficulty obtaining or interpreting information. In this way, the dyad partners prepared for the federal vs. state control of Medicaid funding for Long Term Care debate.

The dyads broke into larger debate teams for an all day session to coordinate arguments for the upcoming debate. During this session, the dyad members were given the opportunity to test their positions by presenting them orally

to a group that was working on different issues but using the same overall strategy (i.e., federal control or state control). During the debate itself, all seminar participants also made an oral presentation which provided a further test of the viability of their positions.

After the debate, each participant developed a fifteen page position paper for his or her issue. Each paper was read and criticized by the three seminar directors. Each of the seminar directors sat with the five dyads separately to discuss the criticisms of the papers done by the dyad members and to agree on necessary changes. The final drafts were submitted after the seminar participants had an opportunity to react to the directors' criticisms and are presented in the chapters that follow.

The next chapter entitled, "Uncovering the Issues" was done by Tracey Logel, who provided us with a summary and comparison of the responses made by each of the teams in the first stage of the PMS. Chapter III, "Standards for Long-Term Care Facilities: The Need for Reform" was done by Glenn Boetcher and Sharon Price. It looks at the relative difference between state and federally imposed standards for long term care facilities. Chapter IV, "Appropriate Levels of Care" was done by Judith Simpson and Robert Vogel. This chapter deals with the savings that could be effected by placing patients in the level of care most suited to their needs. Kevin O'Connor and Fred Volpe did Chapter V, "The Financing of Long Term Care." The relative merits of state vs. federal funding are uncovered in this chapter. Chapter VI, "Federalizing the Administration of Medicaid" was done by Sandra Caccamise. It explores some of the issues that surround the federal assumption of the administration of government funding of long term care. Lita Gonzalez and Kathy Palokoff did Chapter VII, "Ethics: The Quality of Life." This chapter takes a look at some of the tough

ethical issues surrounding Long Term Care and the potential impact of a federal vs. state takeover. Chapter VIII, Editor's concluding comments was done to summarize some of the most important points made by the participants.

Before, you the reader, become involved in the monograph itself, we ask you to examine the assignment given to the teams in Stage I. This assignment follows immediately, and will provide you with a greater appreciation of the many complex issues surrounding government funding of long term care.

PUBLIC MANAGEMENT SIMULATION PROBLEM

MEDICAID REIMBURSEMENT OF LONG TERM CARE FACILITIES

I. Introduction

This Public Management Simulation is concerned with the provision of Medicaid reimbursement to eligible long term care patients in a fictitious County. The assignment assumes that political values determine how the costs and benefits of Medicaid reimbursements for long term care are viewed. The determination of costs and benefits affect how Medicaid is perceived as meeting the goal of providing long term care for eligible clients. Recent rises in the cost of Medicaid have focused attention on the perceived cost-benefit ratio and thus the efficacy of the program. The concern for rising costs has resulted in a cost containment effort in New York State's Medicaid program.

Since the mid 1960's, the State of New York, in an attempt to assure a high level of quality in the delivery of long term care services to the elderly, instituted team surveys in compliance with Article 28 of the New York Public Health Law and the provisions of Federal Medicare and Medicaid Laws. Such survey teams are composed of nurses, dieticians, social workers, sanitarians,

and physicians, who make on site visits into long term care facilities. Deficiencies are reported, and corrective action is required of the facilities. This survey process determines facility eligibility for Medicare and Medicaid funds, as well as a New York State Operating License.

In the mid 1970's the issue of cost-containment in long-term care surfaced resulting from the nursing home scandals, the New York State fiscal crisis, and the resulting investigation by the Moreland Commission.* From this particular investigation, a number of recommendations were put forth by the commissioner to be implemented by the State of New York. For example, one cost-containment measure implemented dealt with the auditing procedures of the State Health Department. In the past, the Department had employed very few auditors to review financial statements issued by all long term care facilities in the State. In order to achieve a higher degree of accountability via financial reports, the State of New York hired a considerable number of additional auditors to assure only proper expenditures were reimbursed. The auditors compare reported costs to actual costs and disallow differences. Additionally, ceilings based on average costs of similar facilities were established. If facilities exceed a ceiling, they will not be reimbursed for their overrun. While efforts both in the delivery of quality care and the containment of costs have made some impact, you can assume that political authorities at the federal, state and local levels, as well as the public, are not satisfied with their results. All continue to see an ever expanding Medicaid program with long term care being a major factor in the increasing cost of government.

The Public Management Simulation requires you to state the political values which will guide you throughout the rest of the simulation. These values will assist in meeting the requirement of communicating your perceptions of the

*See attached report

costs and benefits and thus major problems associated with Medicaid reimbursement for long term care. After stating the major problems, you should determine their causes and develop strategies, structures and mechanisms that will diminish their effect. Some of the constraints you face are described in the following pages.

II. Federal Constraints

In 1966 the Federal Government introduced into the tangled web of programs which support health services, the Medicaid program. The Medicaid program provided open-ended categorical funding for medical assistance to welfare eligible clients. The only federal constraint is that the federal share of Medicaid must be equal to or greater than 50% but not more than 85% of the cost of the program, and that the state of local sources will fund the difference. States are free to accept the Medicaid Program or decline it. New York was one of the first states to adopt the program and only Arizona does not have a Medicaid program.

III. State Constraints

In the State of New York 45% of the cost of the Medicaid Program is attributable to long term care, but only 17% of the recipients of Medicaid are over 65 years of age. With this fact in mind you will be able to see the importance of the following constraints.

A. The state share of the Medicaid program, as specified by the Social Security Act, is described by the following percentage formula:

$$\text{State Share} = S^2/N^2 \times 45 \quad \text{or}$$

$$45/N^2 \times S^2$$

where N = 3 year average <u>national per capita income</u>

and S = 3 year average <u>state per capita income</u>.

The Federal Share is the balance, that is:

Federal Share = 100% - State Share,

but within the 50 - 83 percent limits.

This formula has the effect of systematically discriminating against states which have higher per capita incomes compared to a formula which does not contain an exponent. The following example illustrates how the Federal share would vary using the same ratio formula with and without the exponent.

With Exponent

Rich State: Assume state per capita income is $5000, and national per capita income is $4000.

$$1.00 - \frac{5000^2}{4000^2} \quad (.45)$$

$$1.00 - \frac{25,000,000}{16,000,000} \quad (.45)$$

$$1.00 - (1.56) \quad (.45)$$

$$1.00 - .703$$

= 29.7% viz., 50% because of prescribed limitations

Poor State: Assume state per capita income here is $3000 while national per capita income remains $4000

$$1.00 - \frac{3000^2}{4000^2} \quad (.45)$$

$$1.00 - \frac{9,000,000}{16,000,000} \quad (.45)$$

$$1.00 - (.56) \quad (.45)$$

$$1.00 - .253$$

= 74.6%.

Without Exponent

Rich State $1.00 - \frac{5000}{4000}\ (.45)$

$1.00 - (1.25)\ (.45)$

$1.00 - .563$

$= 43.7\%$, viz., 50%

Poor State $1.00 - \frac{3000}{4000}\ (.45)$

$1.00 - (.75)\ (.45)$

$1.00 - .337$

$= 66.3\%$

B. The Medicaid Program is becoming an increasingly large percentage of the state budget in New York which incidentally is the country's most expensive Medicaid program. In fiscal year 1976 the total payments for Medicaid in the U.S. and New York are shown below.

All expenditures U.S.*	$14,985,883,434
All expenditures N.Y.*	$ 3,241,796,716

*state, federal, local

New York spends approximately 24% of the total US Medicaid dollar! Of the 3.2 billion above, $2,958,316,016 was eligible for federal funding. The federal share in New York was $1,512,211,372 or 51.1% of the total eligible for federal funding. Table 1 shows how New York compares with six other selected states in this regard.

TABLE 1

SELECTED 1976 STATE EXPENDITURE PATTERNS: MEDICAID PROGRAM*

	% FED FUNDS (adj.)	% STATE FUNDS	% LOCAL FUNDS	TOTAL EXPENDITURES	THEORETICAL FEDERAL SHARE %
CALIFORNIA	43.5	40.8	15.6	2,045,304,289	50
INDIANA	56.8	43.1	0	209,075,461	57.47
MISSISSIPPI	80.3	19.7	9	118,926,914	78.28
NEW YORK	46.6	30.2	29.2	3,241,796,716	50
OHIO	55.1	44.9	0	449,070,708	54.49
TEXAS	53.4	36.6	0	631,608,025	53.59
WYOMING	60.5	37.05	2.45	6,721,190	60.94

*In this table the funding percentages are determined by taking total expenditures for Medicaid and computing the federal percentage after the federal government has determined which state expenditures are eligible for reimbursement. The formula-determined federal share is included for comparison purposes so that real federal share can be contrasted with theoretical share.

C. New York is now operating under severe internal funding constraints and, as a consequence, the political cost of increasing state and local expenditures is very high. Table 2 shows state and local taxes as a percentage of personal income for the seven states used in Table 1. It is obvious that New Yorkers are heavily taxed, with residents paying 16.6% of personal income as state and local taxes. No other state is comparable in this regard and one can assume that it would be difficult to increase already high taxes.

TABLE 2

SELECTED 1974-75 STATE AND LOCAL TAXES AS A PERCENTAGE OF PERSONAL INCOME

	Total		State		Local	
	Percent	Rank	Percent	Rank	Percent	Rank
CALIFORNIA	14.6	3	7.6	19	7.0	3
INDIANA	11.1	32	6.7	31	4.4	27
MISSISSIPPI	11.8	22	9.0	7	2.8	43
NEW YORK	16.6	1	8.0	13	8.6	1
OHIO	9.7	50	5.1	48	4.6	25
TEXAS	10.6	41	6.1	42	4.5	26
WYOMING	13.4	9	7.9	15	5.5	10

Source: NYS Statistical Yearbook, 1977.

IV. Local Constraints

Medicaid costs not covered by the Federal government are shared 50/50 by each county and New York State. The costs are a significant part of county budgets. In fiscal 1979 it is estimated that $68,650,000 will be spent in Medicaid in Ames County. Of this amount, the county will be responsible for paying $16,725,500 from local revenues which is approximately 10% of total local revenues. The 1979 Ames County Budget reveals that nearly 29,000 people are eligible for Medical Assistance, but only 26,600 currently utilize the service. The greatest number of eligible clients are children within the Aid to Dependent Children category. However, among the eligibles, those whose numbers are fewest create the highest cost. Here we refer to the approximately 2700 people

receiving services in nursing homes. The cost of nursing home care constituted over 47% of the entire Medical Assistance expense in 1977 and is projected to account for 48% of the program expenses in 1978.

Medical Assistance costs grow for many reasons beyond the control of local governments. The principal reasons are the continuing increase in hospital and nursing home rates (inflation), and the continuing "thaw" of the so-called "rate freeze" established by the State of New York. Medicaid rates which are set by the State Health Department are consistently and successfully challenged in the courts, resulting in higher rates granted to hospitals and nursing homes. The State has been taken to court over 1500 times, and in most instances, hospital and nursing homes were awarded what they sought in their law suits.

In the past, the Federal Government has taken over some programs such as the Aid to the Aged, Blind and Disabled (AABD). This program has now been folded into the Supplemental Security Income or SSI program; however, the County is still responsible for continued participation in supporting medical expenses for this group. Individuals within the SSI program account for nearly 68% of total Medical Assistance expenditures and are not public assistance grantees within Ames County. Thus, the SSI program has helped to swell the ranks of those eligible for Medicaid, thereby further increasing the costs. The aforementioned clearly establishes the basis for an increase of almost $5 million in the projected cost for the combined categories of hospital and nursing home care for 1978 over the demands of 1976.

In addition to the unmanageable vagaries of inflation, the rate freeze thaw, and the growing Medicaid roles are the following systems constraints.

A. Private pay rates at the two levels of long term care, Skilled Nursing Facilities (SNF) and Health Related Facilities (HRF), are higher than Medicaid reimbursement rates. Refer to the sample of nursing home rates in Appendix I.*

This results in the following effects:

1. Nursing homes are less inclined to take Medicaid patients.
2. Many Medicaid patients who are certified as eligible for care in SNF's are occupying hospital beds as acute care patients.

In Ames County, on the average, the patients must wait 44 days in the hospital at a cost to Medicaid of four to five times more per day (hospital costs per day for acute care average $208 in Ames County) than the cost that would be incurred if they were in a nursing home. It is estimated that if the 44 day waiting time was reduced to zero, Medicaid costs would be reduced by five million dollars in Ames County. Patient backlogs in Ames County are illustrated in Appendix II.* The five Ames County One Day Census in Appendix III* show the profile of available beds in nursing homes and waiting patients in acute care beds in hospitals.

3. Since private pay patients pay more than Medicaid patients it is argued that they subsidize the Medicaid patients. On the other hand if Medicaid reimbursement rates are increased to match private pay rates, there is no guarantee that private pay rates will not increase thus maintaining the inequity. The inequity may continue because nursing home proprietors might argue that the Medicaid increase simply makes up for low rates in the past but is not enough to meet spiraling health care costs.

*The appendices has been deleted from the text of the question.

B. Nursing homes are wary of taking patients whose present financial condition indicates that they will go on Medicaid in the near future. When a patient can no longer pay for nursing home services from non-Medicaid sources, the nursing home will apply for Medicaid. Unfortunately, it takes county, state and federal offices approximately three months to determine patient eligibility. During this time, the nursing home may provide care for the patient in the hopes of being reimbursed for that care after eligibility is determined. In instances where the patient is found ineligible, the nursing home has to absorb the costs incurred during the three month wait. Even when the patient is eligible it aggrevates the nursing homes cash flow problems because they have had to wait three months for payment.

C. The Medicaid reimbursement rate is different for each nursing home (see Appendix IV for the rates at Ames County Facilities). The method of determining the reimbursement rate is to divide a nursing home's operating costs and property costs for a given year by the patient days for that year. An inflation factor is also included. The method of calculating the reimbursement rates for the last three years is shown below:

$$\text{1979 reimbursement rate} = 1.236 \left(\frac{\text{1976 operating costs}}{\text{1976 patient days}} + \frac{\text{1977 property costs}}{\text{1977 patient days}} \right)$$

(Note the 23.6% adjustment for inflation in the 1979 rate.)

$$\text{1978 reimbursement rate} = 1.135 \left(\frac{\text{1976 operating \& property costs}}{\text{1976 patient days}} \right)$$

(Note the 13.5% adjustment for inflation in the 1978 rate.)

$$\text{1977 reimbursement rate} = 1.1245 \left(\frac{\text{1975 operating \& property costs}}{\text{1975 patient days}} \right)$$

(Note the 12.45% adjustment for inflation in the 1977 rate.)

Although the State Health Department determines these formulas, County Social Service Departments are responsible for disbursing the funds.

V. Simulation Assignment

Your team is charged with developing a ten page paper (double spaced) that meets the following demands:

1. Make a clear statement of the political values that your team will use to guide you through the simulation.
2. Using the political values stated in number one above, specify the major problem(s) associated with Medicaid reimbursement for long term care.
3. State the causes of the problems developed in number two above and develop specific strategies, structures and mechanisms that will diminish the effect of the causes.

If you wish to attach appendicies to your ten page paper you may do so, but please keep them to a minimum. Make eight copies of your paper and bring them with you to Brockport on June 22, 1979. On June 23 you will give a brief oral summary of your paper (15 - 20 minutes) to the judges and teams from the other schools. You should be prepared to answer questions from the judges and other teams regarding your paper. Your paper will be included in a monograph that will be published at the end of the summer.

The assignment before you is both complex and of real importance. It is hoped that your work will be beneficial to you and to the many people directly affected by Medicaid reimbursement for long term care.