SOWERS OF QUALITY IN LONG-TERM CARE

Resource Guide of Public Policy Matters
in the Long-Term Care Profession

August 2009 Update

Nebraska Health Care Association

A Profile of the Nebraska Health Care Association

The Nebraska Health Care Association (NHCA) is a private, nonprofit trade association that represents over 409 governmental, non-profit, and for-profit long term care facilities in the state of Nebraska, including both nursing facilities and assisted living facilities. NHCA is an affiliate of the American Health Care Association (AHCA). AHCA is the largest association of long term care facilities in the world. Each facility member of NHCA and/or NALA is also a member of AHCA.

NHCA members are individually and collectively committed to achieving excellence in the quality of care and services for all those served by long term care and strengthening public trust. Through membership activities, we seek to cultivate and sustain an environment of continuous quality improvement, public accountability, protection of resident and family rights, workforce excellence, community involvement, ethical practices, and financial stewardship. NHCA works with government and other policy makers to ensure that the regulatory environment fosters facilities' ability to achieve these goals.

Affiliated within NHCA are the following organizations:

- *Nebraska Assisted Living Association* (NALA), which has a membership of 205 for-profit, non-profit, and governmental assisted living facilities in the state of Nebraska as well as individuals and businesses interested in the profession of assisted living.

- *The Licensed Practical Nurses Association of Nebraska* (LPNAN) which is the sole Nebraska organization representing the Licensed Practical Nurse (LPN). Nebraska Health Care Association is the management company for LPNAN.

- *The Nebraska Health Care Foundation* (NHCF), a 501(c)(3) tax-exempt organization that provides scholarships for Nebraskans seeking education in long term care.

- *Long Term Care Workforce Institute of Nebraska* (LTCWIN), which provides education and training programs to members of the long term care workforce. LTCWIN combines computer-based technologies and traditional learning settings. By using a variety of teaching methods, we can provide cost-effective, flexible educational programs that will meet a multitude of needs in the community.

- *The Nebraska Hospice and Palliative Care Partnership* (NHPCP), a collaborative effort of approximately 50 organizations with an interest in caring for the terminally and chronically ill. Established as a 501(c)(3), NHPCP includes Nebraska's hospices, community end-of-life coalitions, and statewide health and elder care organizations. Nebraska Health Care Association is the management company for NHPCP.

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Executive Summary

Long Term Care (LTC) Funding

The three primary funding sources for nursing home stays are Medicaid (55%), Medicare (11%), and private pay (34%)[1].

The Medicaid rate paid to nursing facilities as adopted by the Nebraska Department of Health and Human Services (NDHHS), Division of Medicaid and Long Term Care significantly underfunds the cost of care in nursing facilities.

In 2009-10 facilities lose an estimated $19.81 per day for every Medicaid resident served.

There are a number of particularly negative consequences of the method of payment to long-term care facilities.

1. **Facilities receive significantly less funding per resident than the actual cost of care.** This is counterproductive to providing the highest quality care which places the health and safety of vulnerable seniors at risk.

2. **The inflation factor is not derived from actual health care inflation or any standardized calculation.** It is merely a variable in our reimbursement formula that the Department can freely manipulate to ensure that total estimated expenditures do not exceed the appropriation for the upcoming fiscal year. Considerable differences in calculation methods has resulted in large discrepancies between intended provider rate increases intended by the Legislature vs. actual rate increases received by providers.

3. The rate received by facilities for individual residents is determined heavily by the need for assistance with activities of daily living and the complexity of nursing functions. However, this is not necessarily reflective of the true cost of care. **The rate methodology must take into account the psycho-social/behavioral needs of residents because these needs significantly impact the cost of care.** They also impact capital costs such as the need for security and related facility design improvements. **"Behavioral health" reform, including moving individuals out of the regional centers into the "community" has increased placement in nursing facilities without a mechanism for compensating facilities for this new dimension in care.** This places Nebraskans at significant risk.

The state has hired a consultant, Myers & Stauffer LC, to study and provide recommendations for redesigning the payment regulations by July 1, 2010. The consultant must address these and other issues in its final recommendation.

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[1] Source: 2007-08 LTC Cost Report, days by payer source; "other" assumed primarily Medicare.

Certificate of Need

A Certificate of Need (CON) is a written authorization by the department that is required prior to the initial establishment, increase, or conversion of long term care beds or rehabilitation beds. The basic assumption underlying CON regulation is that excess capacity (in the form of facility overbuilding) directly results in health care price inflation.

A facility seeking to expand its number of beds by the lesser of 10 beds or 10 percent of its existing beds over two years must apply for and receive a certificate of need.

To receive a CON, a facility must either (a) provide a unique service or complexity of service not otherwise available in the locality or (b) demonstrate that existing occupancy rates are significantly high and therefore new beds are warranted.

No facility has ever been able to demonstrate the need for beds based upon existing high regional occupancy levels. The statutory algorithm used by the department relies on data unavailable to facilities and counterproductive high occupancy thresholds. The effect is that competition and innovation are stifled in long term health care.

Pursuant to NHCA-sponsored legislation in 2009, a CON is no-longer required for any relocation of long term care beds from a facility located in one "health planning region" to a facility in a different region. This becomes effective August 30, 2009.

NHCA's intent was that eliminating this limitation will allow facilities with lower occupancy to sell their licensed beds to facilities in other planning regions thereby providing the facility with financial capital to invest in developing other services such as home-based care and facility design improvements.

Eliminating this prohibition will promote development of home-based or behavioral services where they are lacking in rural Nebraska.

Workforce Challenges

In Nebraska between 2010 and 2030, the number of adults aged 65 and older will increase from 243,000 to 376,000, accounting for an increase from 14 percent of the Nebraska population to 21 percent.

Although this increase has been forecast for decades, little has been done to prepare the health care workforce for this phenomenon.

The education and training of the entire health care workforce with respect to the range of needs of older adults remains woefully inadequate.

The State must support attempts through legislation and partnership to (1) enhance the competence of all individuals in the delivery of geriatric care; (2) increase the recruitment

and retention of geriatric specialists and caregivers; and (3) redesign models of care and broaden provider and patient roles to achieve greater flexibility.

Between 2008 and 2020, the shortfall in Nebraska nurses will triple from a 6 percent shortage of demand for nurses over their supply to 20 percent.

A higher ratio of nurses to patients equates to greater quality of care and fewer deficiency citations in nursing facilities.

Nebraska must expand the capacity of schools of nursing for preparing registered nurses (R.N.s), licensed practical nurses (LPNs), advanced practice registered nurses (APRNs), and other masters and doctoral prepared nurses in Nebraska.

Licensure, Certification, and Survey

Nursing facility “certification” means the process by which the federal Centers for Medicare and Medicaid Services (CMS) deems a facility compliant with the federal requirements for participation in the federal Medicaid and/or Medicare programs.

Nursing facility “licensure” is the process by which the state grants a license to establish, operate, or maintain a “skilled nursing facility” or “nursing facility.” A “skilled” facility simply means that it provides Medicare-A services, which means rehabilitation services after a hospital stay.

All nursing facilities are surveyed (inspected) at least once annually, upon a complaint filed against the facility, and when it is necessary to revisit a facility to ascertain that a prior deficiency has been corrected.

“Deficiencies” (regulatory violations) can be written on a vast array of operational considerations. Sanctions include required training, denial of payment for new or existing residents, civil money penalties generally of $1,000 to $10,000, and termination of federal certification.

The federal Centers for Medicare and Medicaid Services (CMS) issues volumes of regulations. They also issue “interpretive guidelines” for those regulations. Nebraska facilities have a significant problem with NDHHS and State Fire Marshal surveyors “interpreting the interpretations” whereby citations are written based upon circumstances that are not specifically addressed in the regulation.

NHCA advocates that any deficiency written against a facility must include the specific regulatory citation or interpretive guideline as adopted by CMS or through other binding legislative or administrative processes. If the facility practice is not specifically prohibited under that citation, the deficiency should be withdrawn.

Medicaid Reform

In 2005, Nebraska commenced a Medicaid Reform initiative resulting in a series of reform recommendations pertaining to expanding home and community-based services (HCBS) as a percentage of facility-based care. NHCA supports and actively participates in this process.

The Medicaid Reform process resulted in the following recommendations:

1. Incremental expansion of the capacity of the Aged and Disabled Home and Community-Based Services waivers in Nebraska as Nebraska's population ages. This includes moving nursing facility residents into less-costly assisted living placement.

2. Contract with a consultant to evaluate existing comprehensive assessment tools for determining the appropriateness of persons for nursing facility, assisted living, and home health care. (This is being done in conjunction with the MFP grant.) He or she will be expected to identify quality-based performance measures to adequately assess the quality and effectiveness of care in assisted living and in-home settings.

3. Contract with consultants to revise the current reimbursement methods for long term care providers of nursing facility, ICF-MR, assisted living, and in-home services. *NHCA is concerned that the consultant that was hired is not looking comprehensively at rates; it is only redesigning nursing home payment. A comprehensive redesign could better allow for provider diversification. Currently, Medicaid payments for community-based services are cost-prohibitively low.*

4. Establish an advisory committee to work with NDHHS to encourage the development of HCBS, particularly in rural areas. This committee has been created. Pat Snyder, NHCA Executive Director, actively serves on this committee.

5. Collaborate with the Area Agencies on Aging (AAAs) to better inform older adults of available, appropriate, and cost-effective alternatives to nursing facility care.

6. Identify available, cost-effective technologies to improve distance delivery of health care services to Medicaid recipients, especially those in rural areas.

7. Encourage Nebraskans to plan to provide for their own long term care services as a part of their retirement planning. State Treasurer Shane Osborn has created the Nebraska Long Term Care Savings Plan. NHCA participated in creation of the enacting statutes and enabling regulations.

8. Develop a service delivery model of consumer directed home and community-based care. This service delivery model would improve recipient satisfaction by giving them the opportunity to direct a cash allowance to purchase home and community-based services as an alternative to nursing facility care. This is a goal of the Nebraska Money Follows the Person grant program.

Nebraska Money Follows the Person (NMFP)

In 2007, Nebraska was one of 17 states selected to receive a federal Money Follows the Person grant. The state will receive $35.7 million. Initially the state anticipated $75.5 million.

In June 2008, the operational protocols submitted by NDHHS were approved by CMS.

The grant will move 900 people from institutional services (NFs, ICF/MRs, and hospitals) to HCBS during the five-year grant cycle. The resident population will be broken down into four categories of eligibility: 400 elderly persons, 200 persons with mental retardation or developmental disabilities, 100 persons with traumatic brain injury, and 200 persons with physical disabilities.

The Protocol does NOT propose to close or eliminate funding for beds vacated by NMFP participants. Medicaid will need to realize savings, however, if funding to nursing facilities is to be maintained without additional appropriations of state funds.

Nursing facilities will become involved in NMFP through contact with "transition coordinators." Transition coordinators will present programs on NMFP to facility employees, residents, and family members. They will notify the facility when a resident has been determined suitable to participate, will ask the facility discharge planner to join the transition team, and will refer the resident to a HCBS services coordinator.

The lack of adequate home and community service providers is a major challenge to the success of NMFP, particularly in rural areas. The Operational Protocol envisions the involvement of nursing facilities to provide community services through diversification.

Nebraska Health Care Association's Recommendations:

NHCA submitted a number of recommendations to the Department pertaining to the operational protocol it ultimately submitted to CMS. We advocate that individuals selected to participate should not have cognitive impairment or no more than minimal cognitive impairment; individuals should not have a severe and persistent mental illness; individuals' levels of care as determined from the MDS; should have remained stable or have improved on each MDS completed in the past six consecutive months; and individuals' desire to return to the community should be documented on the most recent MDS.

NHCA further recommended that the state become familiar with and take into account the phenomenon of "transfer trauma." There is significant literature regarding negative effects associated with transfer of nursing home residents; most notably, that there is a significantly elevated death rate among those involuntarily relocated among nursing homes.

The Long Term Care Continuum

The NHCA Board has adopted a policy statement in support of the long term care continuum concept.

The continuum of long term care refers to an integrated system of health care services that provides a combination of housing, personal care services, and health care designed to respond to individuals who need assistance with normal daily activities in a way that promotes maximum independence.

The primary components of the long term care continuum include Personal Assistance Services, Adult Day Care Services, Assisted Living Facilities (ALF), Home Health Agencies, and Nursing Facilities.

HCBS providers are lacking in many rural parts of the state. Nursing facilities have an advantage in providing these services and are increasingly diversifying their service portfolios. Serving as a hub, a nursing facility has the capacity to offer the full continuum of care in-home and in a facility due to its employment of a diverse array of health care professionals and with the equipment and resources necessary to establish a critical mass of clients to make such ventures financially feasible.

What is needed to expand this diversification are (a) home and community-based rates that come closer to approximating the cost of delivering services and (b) an expanded ability for facilities to transfer/sell unoccupied beds across health planning regions into urban or other areas to free up the capital necessary to invest in development of home and community based services.

Certain individuals are most efficiently, safely, and effectively serviced in a nursing facility, i.e., those who require 24-hour skilled care and supervision. This includes those with more than minimal cog**nitive impairment, those with a severe and persistent mental illness, and those whose level of care, as determined from the most recent assessment, is unstable.**

Economic Impact of LTC Facilities

LTC facilities' direct economic impact on Nebraska represents 1.6 percent of the state's economic activity, 1.5 percent of labor income, and 2.2 percent of employment. When considering "indirect" and "induced" impacts, the total economic impact is 3.7 percent of economic activity, 2.7 percent of labor income, and 3.5 percent of employment. LTC facilities generate $369.5 million in tax revenue including $117.2 million in state/local taxes and $252.3 million in federal taxes.

Culture Change

As the general population ages and changes, skilled nursing facilities must evolve too. Skilled nursing facilities are changing to fit the varying health, social, emotional, and spiritual needs of this new perspective among seniors.

Examples of Resident-Centered Culture Change:

- Green House at Tabitha: The Tabitha Green House Project is a new and attractive choice for elders and their families. In May 2006, Tabitha opened Nebraska's first, and the nation's second, Green House Project. The Green House transforms the way care is delivered, departing from the traditional nursing home model by bringing long term care into a home setting.

- Memory Support Neighborhood at VHS: Wings of a facility may be transformed into a neighborhood-like concept for residents cared for by a regular team of caregivers. Vetter Health Service's Highland Park has renovated an Alzheimer's wing into a neighborhood setting to provide a homelike atmosphere. This enables the facility to take care of residents' medical needs and provide them with an atmosphere that is more like a household, including common living rooms and family-style dining.

Typical outcomes of resident-directed culture change include decreased usage and costs of psychotropic drugs as depression and boredom of residents ease with the more home-like environment.

The new dining styles have helped residents gain weight and decrease the use of supplements, while facilities have saved money since less food is wasted. Residents are generally happier in this environment.

Long Term Care Funding

The three primary funding sources for nursing homes:

- **Medicaid** – In the most recent reporting period, FY 2007-08, **56 percent** of resident days in Nebraska nursing homes were paid through the Medicaid Program. Of those days, approximately 60 percent are paid from federal funds ($214M) and 40 percent from state general funds ($155M).
- **Medicare** – In the same reporting period, the federal Medicare program financed **10 percent** of the total nursing home resident days served. Although Medicare does not pay for "long term care," it does cover medically necessary post-hospital, rehabilitation, and therapy services, known as "skilled nursing care" under Medicare Part A. Medicare is a 100 percent federally funded program; no state funds pay for Medicare services.
- **Private pay** (with either savings or long term care insurance) – The remaining roughly **34 percent** of nursing home days served were paid by private, out-of-pocket funds or through long term care insurance. According to the U.S. Centers for Medicaid and Medicare Services (CMS), of the private nursing facility financing, about 78 percent is out-of-pocket and 22 percent is from long term care insurance.

Medicaid

The Nursing Facility Rate

Nursing facility rates are called "prospective rates" (471 NAC 12-011.08D). That is, instead of direct reimbursement of costs, whereby a facility is reimbursed for the actual costs it incurred in caring for residents by adding together actual expenses after-the-fact, the rate is "prospective," i.e., it is an estimate of what it *should cost* to care for a resident at a particular level-of-care based upon its historical costs to treat residents at the same care level. These historical costs are multiplied by an "inflation factor." Thus each facility has its own prospective rates, one rate corresponding to each level of care, based on the facility's allowable costs for the fiscal year up to **two-years prior** (due to lag time in analyzing the most recent cost report).

The Inflation Factor

The inflation factor applied to the direct nursing and support services components is adopted each year in Medicaid regulations promulgated by the Department. **It is not based upon an estimate of actual inflation over the same time period**; rather it is an allocation of what was appropriated as the nursing facility component in the lump-sum Medicaid appropriation which includes most Medicaid providers in one huge budget program within NDHHS. The amount of that appropriation realistically is a result of compromise when attempting to balance the interests of state aid to schools, tax cut proposals, and the balance of the general fund budget. That being the case, rate setting is actuality a significant departure from its intended "prospective" nature.

There are a number of particularly negative consequences to the rate methodology:

1. Facilities receive **significantly less funding per resident than the actual cost of care.**

2. The **direct nursing maximum of 125 percent** of the median statewide direct nursing cost **harmfully impacts quality provision of care for the most vulnerable seniors**. In 2007, 31.5 percent of facilities were capped on their direct nursing rate.
   - When a larger percentage of often rural facilities have lighter care residents coupled by a few outlier facilities providing especially low-level care, possibly in areas where HCBS services are lacking, this lowers the statewide median. Then the balance of facilities, often urban, with heavier care have a capped direct nursing component and become penalized for adequate staffing levels.

3. As indicated, the **inflation factor is not derived from actual health care inflation**; rather it is a result of what will "fit" on the general fund financial status allowing for a politically acceptable financial reserve, tax reduction package, and other budget priorities. While controlling growth in state spending is critical, Nebraska elects to participate in the Medicaid program, but it is private business that bears the brunt of underfunding the cost of our participation.

4. After a base rate is calculated, a "case weight" is applied to determine the resident-specific daily rate. **The case weight is determined by the need for assistance with activities of daily living and the complexity of nursing functions. It does not take into effect the psycho-social/behavioral needs** of a resident which significantly impact the cost of care as well as facility design and capital costs.

The Prospective Rate
Each facility's prospective rates consist of three components:
1. The Direct Nursing Component increased by the inflation factor;
2. The Support Services Component increased by the inflation factor; and
3. The Fixed Cost Component.

Facilities submit a "cost report" each year to the state Medicaid Division that includes all "Medicaid-allowable" costs. All costs are categorized as either "direct nursing," "support services," or "fixed costs." The Direct Nursing Component and the Support Services Component are subject to maximum daily payments based on median/maximum computations.

Median: For each care classification, the median for the direct nursing and support services components are computed using nursing facilities with residents in that care classification with an average occupancy of 40 or more residents, with some exclusions.

Maximum: The maximum per diem is computed as 125 percent of the median direct nursing component, and 115 percent of the median support services component.

Direct Nursing (471 NAC 12-011.06M)
This includes salaries and wages of the director of nursing, registered nurses, licensed practical nurses, care staff and aides, medical records, consulting nurses, etc.

This component of the rate is computed by dividing the allowable direct nursing costs by the "weighted" resident days for a particular facility. The resulting quotient is the facility's "base"

per diem. Rate determination for the Direct Nursing Component for an individual facility is computed using the lower of its own base per diem, “weighted” for levels of care, or the maximum base per diem (125 percent of the statewide median), “weighted” for levels of care.

Support Services

This component includes the following:

- Administrative Costs: This includes items such as the administrator’s salary and benefits, other administrative staff salaries and benefits, board costs, licensing costs, telephone, limited promotional costs, and some travel (see unallowable costs for limitations).
- Dietary staffing salaries and benefits, food, education/training, short-term equipment, etc.
- Housekeeping salaries and benefits, education/training, short-term equipment, supplies, etc.
- Pharmacy, therapies, and other consulting services.
- Plant related costs including vehicles, building repairs, fuel, electricity, water/sewage, television, insurance, etc.
- Activities and social services salaries and benefits, education/training, short-term equipment, supplies, etc.

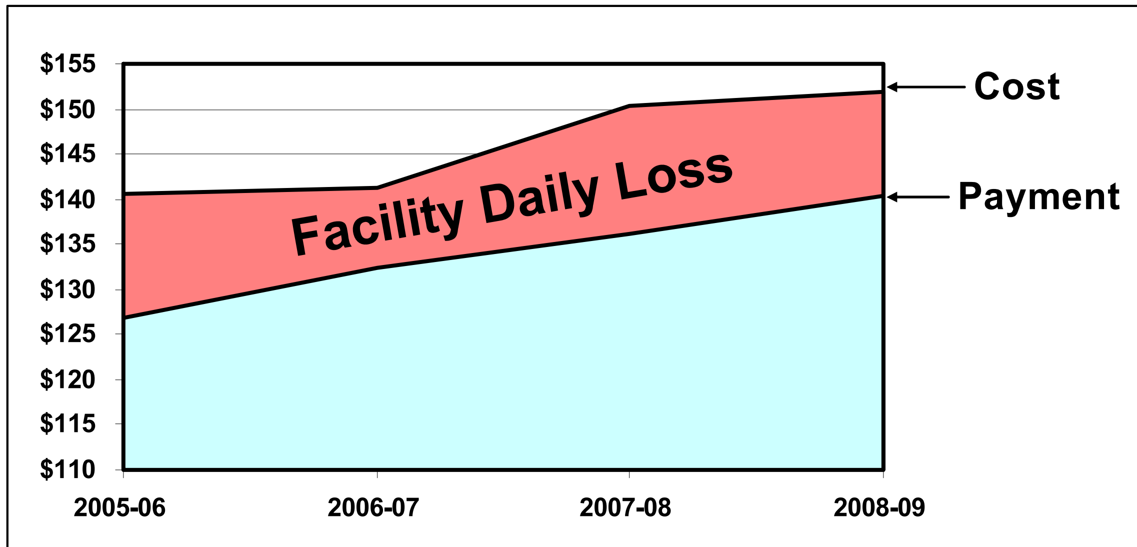
This component is computed by dividing the allowable costs for support services by the total inpatient days for each facility. A facility’s rate is computed using the lower of its own per diem or the maximum per diem (115 percent of the statewide median).

Fixed Costs

This component of the prospective rate is computed by dividing the facility's allowable interest, depreciation, amortization, long term rent/lease payments, personal property tax, real estate tax, and other fixed costs by the facility's total inpatient days. Rate determination for the Fixed Cost Component for an individual facility is computed using the lower of its own per diem as computed above, or a maximum per diem of $26.00 excluding personal property and real estate taxes.

Comparison of Medicaid Base Rates to Medicaid Allowable Costs

	2005-06	2006-07	2007-08	2008-09
Daily Base Rate	$126.91	$132.29	$136.21	$140.36
Daily Medicaid Allowable Cost	$140.57	$141.22	$150.38	$151.98
Daily Underfunding per Resident	($13.66)	($8.93)	($14.17)	($11.62)



Note: Although the underfunding estimate shown above is the best estimate available, there are two limitations in its calculation which result in it understating the level of underfunding.

1. The Daily Medicaid Allowable Cost figure comes from the Medicaid Cost Report filed by all facilities with NDHHS. This report only includes "Medicaid Allowable" costs which exclude many necessary business expenses such as promotional costs, certain taxes, travel, and others (full list at 471 NAC 12-011.05).
2. The lightest care levels, "Levels 35 and 36," are not paid according to the cost to treat individuals at those levels of care, although the "Daily Base Rate" figure above includes resident days at these levels. Instead, residents in these light care levels are paid the assisted living rate which is significantly less than a cost-based amount.

The Levels 35 and 36 Double Whammy

In 2000, assisted living facilities were established in statute and were authorized to serve eligible Medicaid "waiver" residents. Waiver eligible participants are those care needs that would place them at the two lowest nursing facility levels of care, meaning they have a lesser need for assistance with ADLs and no complex nursing needs. These levels are numbered Levels 35 and 36.

Assisted living facilities (ALF) receive a monthly payment for Medicaid waiver residents that far underfunds their costs of care. The rate is not based upon cost reports as it is with nursing facilities. In 2002, nursing facility payment regulations were amended to limit the payment to nursing facilities the same payment as is made to ALFs for those nursing facility residents at levels 35 and 36.

Due to far more stringent staffing, structural, and care requirements placed on nursing facilities under federal and state regulations than are placed on ALFs, the cost to care for a 35-36 resident is greater in a nursing facility than an ALF. For these residents, instead of underfunding their care by the $12 average as identified above, underfunding is far greater, even though the cost of care is largely driven by government mandates.

Levels of Care (Acuity Level) and Corresponding Weights

The Department assigns each resident to one of 19 levels of care based upon the resident's "ADL Index Score," which refers to the number of Activities of Daily Living with which he or she needs assistance, as well as the types of complex nursing care he or she requires. The regulations at 471 NAC 12-013 delineate the precise conditions and care needs used to assign a resident to a level of care and the equation for determining a resident's ADL index score.

Activities of daily living include bed mobility, toileting, transferring, and eating. A resident with a greater need for assistance with his or her ADLs will have a higher ADL index score.

Residents with higher ADL index scores with greater complex nursing needs will have higher "case weights." The case weight is multiplied by the facility's "base rate" to determine the per diem rate for that resident. Thus residents with greater needs receive a higher payment to compensate for the additional use of direct nursing and support services resources.

The level of care scoring methodology does not adequately take into account a resident's psycho-social needs. Residents with types of dementia require constant close supervision. Although the resident may not have a great need for dressing, bathing, or other ADLs and may not require complex nursing cares, the staffing cost to closely monitor the resident can be significant. The case weighting system fails to account for this.

NDHHS to Scrap the existing Medicaid Rate Methodology

The Department issued an RFP and ultimately hired the consultant Myers & Stauffer, LC to develop recommendations for re-formulation of Nebraska's Medicaid rate regulations for nursing facilities. In the fall of 2008, the consultant held four public input forums to discuss various rate setting methodologies employed in other states and get feedback and reactions from providers on particular options for calculating rate components. The consultant expressed an inclination to "increasingly utilize" characteristics of a "pricing model" as opposed to "cost-based model" for the direct nursing and support services component. They indicated a likelihood to use a "fair rental" system for the capital component and utilize a RUGS 34 system to assign case weight as opposed to the existing 19 levels of care.

Without knowing how these broad concepts would be implemented, it is difficult to predict a positive or negative outcome associated with each model. It is likely with any change there will be both winners and losers.

Terminology (There is significant variation in how these methodologies can be implemented; therefore, these definitions are only intended to describe the general concept.)

- Price-based: intended to reflect the "price" to purchase the items included in the cost-component within a particular geographical region.
- Fair Rental: a methodology whereby facility and equipment value is based upon a "fair rental" valuation determined by appraisal or standardized index and stated on a per bed basis and depreciated over a certain number of years at a certain rate to a minimum value.

A. Medicaid Appropriation vis-à-vis Medicaid Rate Regulations

Budget Process Background

Every odd-numbered year, during the Legislature's 90-day "long" legislative session, the state creates a two-year "biennial budget." State agencies submit a budget request to the Governor and Appropriations Committee by September 15th of the prior, even-numbered year. The Governor analyzes the requests and crafts a budget which is introduced by the Speaker of the Legislature. The Appropriations Committee then holds budget hearings with each agency and ultimately creates a "committee amendment" to the introduced mainline budget, which completely rewrites and replaces the Governor's original bill. This amendment is debated by the full Legislature and adopted. The Governor then considers line-item reductions to the Legislature's changes over his original introduced bill. The Legislature can override any line-item reductions with a vote of 30 or more senators.

In 2007, the Governor's budget included a 2 percent increase for nursing facilities in both FY 2007-08 and FY 2008-09. The Legislature increased the amount to 3 percent in both years. The Governor line-item reduced the amount back to 2.5 percent in both years. The Legislature did not attempt an override. These percentages are generally revealed in summary documents that explain what is included in the Medicaid appropriation; however, the actual appropriation is in lump-sum including all Medicaid services together so it may not be possible to see the dollar amount or percentage increase for subcomponents of the total Medicaid budget.

Medicaid Rate Regulations

Medicaid rate regulations are revised and adopted prior to July 1 of every year. The Department has indicated an intention to annually rebase to the most recent cost report, which is always a two-year-old report. There is no regulation or statute that binds the Department to annually rebase. After rebasing, the Department adds an inflation factor. The cumulative estimated percentage increase in spending resulting from rebasing and adding an inflation factor for each facility, care-level by care-level, cannot exceed what was appropriated by the Legislature.

The following is the formula used by the Department to determine what it can afford to provide as an inflation factor in the regulations derived from the appropriation set by the legislature.

1. Start with estimated current year-end expenditures (as of 06/30/08) including both state and federal funds.

2. Multiply estimated current year state expenditures by the percentage increase the Department intends to allocate from the total Medicaid appropriation increase to nursing facilities. This percentage per individual provider group has always been indicated in budgetary reports released by the Governor and Appropriations Committee, although there is no requirement that this be done. The Medicaid appropriation adopted in lump sum for all providers. The percentage increase to individual provider groups indicated in reports is merely non-legally binding intent language.

3. The product of expenditures times increase yields the estimated total future expenditures for the subsequent year.

4. Once DHHS has the estimated expenditure total for the upcoming year, it needs to "back-in" to the rate. To do this, it needs to estimate occupancy for upcoming year and any change in acuity. Often this is assumed to be flat.

5. Next, facility-by-facility, for each care-level, the future projected Medicaid days are multiplied by the facility's base rate for each care-level, then multiplied by an inflation factor that yields in statewide aggregate, no more than the appropriation.

B. Nursing Facility Reimbursement Study

Project History

In June, 2008, NDHHS issued a request for proposals to contract with a consultant to study Nebraska's current nursing facility reimbursement system. The department has maintained that its intent is to generate recommendations that are budget neutral, at least in the initial year or years of implementation. The Department has planned to implement a new rate plan pursuant to this contract on July 1, 2010. The following is the "project overview" excerpted from the RFP.

> Nebraska Department of Health and Human Services (DHHS), Division of Medicaid & LTC (hereafter, "Division") wishes to contract with consultants to study Nebraska's current nursing facility reimbursement structure, including levels of care; Minimum Data Set (MDS), special needs contracts and cost-based payment methodology; gather information for the purpose of comparing strengths and weaknesses of various systems; facilitate discussion with Stakeholders on efficiencies and inefficiencies of current system and suggestions for improvement; and make recommendations for changes that are cost-effective and efficient in the utilization of Division resources, oversight and service delivery, including new and innovative programs and approaches.
>
> This study would include review of Nebraska's current level of care system used in nursing facility reimbursement, which is tied to the MDS 2.0 and will soon be replaced by the MDS 3.0.
>
> The study would also include special needs services for people with medically complex care needs, people with traumatic brain injuries, people who are ventilator dependent, people who are bariatric, people with behavioral concerns and other populations.

The department maintains that this study was prompted by Medicaid Reform Plan, developed by Dick Nelson, then Director of DHHS – Finance & Support, as appointee of the Governor and Jeff Santema, Legal Counsel to the Legislature's Health and Human Services Committee, as appointee of the Chair of the Committee. The Plan was mandated by the Nebraska Legislature in LB 709 (2005).

The Plan's recommendation however was to look at the continuum of providers of long-term care and comprehensively develop reasonable and appropriate reimbursement methodologies. Specifically stated, the recommendation was the following:

> Recommendation 3.0c: We recommend that HHSS (Health & Human Services System) contract with consultants to revise the current reimbursement methods for long-term care providers of nursing facility, ICF-MR, assisted living, and in-home services.
>
> > Strategy 3.0c1: In SFY2007, HHSS will contract with a consultant to help update and revise the level of care system used in nursing facility reimbursement. Based on the revised levels of care, with the help of the consultant, the Medicaid program will develop reimbursement methodologies that are reasonable and appropriate for services provided in a nursing facility, assisted living facility, and in-home setting.
> >
> > Strategy 3.0c2: In SFY2008, HHSS will contract with a consultant to help update and revise the reimbursement methodology for both ICF-MRs and Community-Based Developmental Disability Services.

Myers & Stauffer LC (M&S) was awarded the contract. Myers and Stauffer is a professional accounting, consulting, data management and analysis services to state and federal agencies managing government sponsored health care programs. They have worked with

35 states on Medicaid and long-term care reimbursement issues and have developed long-term care payment systems for at least eight states including Colorado, Georgia, Nevada, Louisiana, Oklahoma, Hawaii, Idaho, North Carolina, and Indiana.

In the fall of 2008, the Department mailed to nursing facilities an invitation to attend one of three "stakeholder meetings" with department staff and to solicit input regarding the Medicaid payment methodology. Included in that mailing was a questionnaire covering provider preferences toward the central components of most Medicaid reimbursement formulas. Pertinent results of the questionnaire are the following, including what the ultimate recommendation was from M&S.

Capital reimbursement: The recommendation was to adopt a fair rental system.
– Current methodology should be retained – 35% agree, 35% disagree
– Change to a fair rental system – 35% agree, 30% disagree

Support services: The recommendation was to adopt a price based model or a cost based with an efficiency incentive for facilities coming in under the support costs ceiling.
– Current methodology should be retained – 52% agree, 25% disagree
– Change to a price-based model – 15% agree, 52% disagree
– Incentive for efficiency – 68% agree, 15% disagree

Direct Nursing: The recommendation was to adopt a price based model or a cost based without an efficiency incentive.
– Current methodology should be retained – 72% agree, 12% disagree
– Change to a price-based model – 6% agree, 61% disagree
– Include a quality improvement payment – 56% agree, 6% disagree

Acuity adjustments: The recommendation was to move to the RUG III 34 group model v. 5.12.
– Current methodology should be retained – 39% agree, 39% disagree
– Change to 34 RUG-III groups – 61% agree, 6% disagree

In May 2009, Myers & Stauffer released a draft report and sent each facility proposed rates under both proposed reimbursement models: price-based and cost-based. NHCA has concerns with key provisions in the report as well as the widely disparate financial impacts of these two models on reimbursements that would face facilities in 2010-2011. **Seemingly arbitrarily, certain facilities would be awarded massive increases in reimbursement while others would face crippling reductions.**

The M&S report was sent to each facility on a CD along with its estimated rates under both recommendations. The narrative report is available in its entirety at www.nehca.org/M&SRec09.pdf.
.
The NHCA Board of Directors adopted principles it feels must be incorporated into any reimbursement system, which are lacking in the Myers & Stauffer recommendation and the current reimbursement system. These principles balance the important interests of residents and families, the state, providers, and taxpayers. As the process moves forward,

we will continue to advocate that these principles must be inherent in any new rate plan adopted by the state. NHCA has shared these principles with the Nebraska Association of Homes and Services for the Aging (NAHSA). NAHSA's board of directors has adopted a position of support for these principles. They have also been shared with the Hospital Association. It is our position that the best chance for providers to have a positive outcome from this study is through a unified position with no internal conflicts on an appropriate rate provisions.

The principles and supporting definitions and explanatory materials are included on the following pages.

The report produced by Myers & Stauffer included a recommendation that the State form a work group "to assist in the implementation and transition planning should the state proceed with any of the recommended changes." The department formed an 18 member work group including 15 provider representatives and a representative from NHCA, NAHSA, and the NHA. The members are the following:

- David Burd, Vice President – Finance, Nebraska Hospital Association
- Dewey Callies, Payment Systems Manager, The Ev. Lutheran Good Samaritan Society
- Sharon K. Colling, Administrator, Belle Terrace
- Dave Jackson, CFO, Tabitha Health Care Services
- Ronald L. Jensen, Executive Director, NE Assn of Homes & Svs for the Aging
- Tony Johnson, Director of Operations, Golden Living Centers
- Tim Juilfs, President and CEO, The Ambassador Group
- S. Doug Kucera, CPA, Schroeder & Schreiner, PC
- Kevin Moriarty, Administrator, Holdrege Memorial Homes
- Paul Nathenson, Vice President of Long Term Care, Madonna Rehabilitation Hospital
- Jolene Roberts, President/CEO, Hillcrest Health Systems
- Earl Sheehy, Chief Executive Officer, Saunders Medical Center
- Keith Sladky, Administrator, Indian Hills Manor
- Pat Snyder, Executive Director, Nebraska Health Care Association
- Bob Tank, Administrator, Bethany Home
- Debra Thacker, CFO, Midwest Geriatrics, Inc.
- Jack Vetter, President, Vetter Health Services
- Bill Williard, Executive Director, Crowell Memorial Home

PRINCIPLES OF A MEDICAID RATE PLAN
NHCA PROPOSAL FOR PAYMENT PLAN PROVISIONS
JULY 15, 2009

Guiding Principle I: Access

Explanation: The Medicaid payment system must accommodate the breadth of consumer need and diversity of providers so the plan does not restrict access to care for any Medicaid eligible Nebraskan.

Payment Plan Provisions:

A. Identify payment methodology that recognizes the direct nursing cost of care and define this by use of the prospectively set case mix levels of care.

B. Allow for annual review and allocation of case mix weights to meet the goal of providing access.

C. Special rates for certain residents that are hard to place or need additional resources.

1. Special rates may be divided into two categories depending on the need of the resident.

    a. A specialized facility would be eligible for a contract rate for residents requiring specialized care

    b. A facility would be allowed an add-on rate for an individual resident who requires specialized services in addition to the existing rate

2. Identify the special needs categories that are required and whether the category is a contract or add-on, e.g.,

    a. Ventilator

    b. Brain-injury
    Rehabilitation potential
    Nonrehabilitation potential

    c. Alzheimer's and related dementia

    d. Pediatrics

    e. Neurological

    f. Behavioral

    g. Bariatric

    h. Dialysis (peritoneal and hemo)

D. Money follows person concept–redirect appropriation from other programs or agencies where nursing facilities are serving residents formerly served by other programs or agencies.

E. Continue IGT money for governmental facilities.

F. Add-on to non-governmental facilities if there is a 70% or greater Medicaid census

Guiding Principle II: Quality

Explanation: The Medicaid payment system should focus spending on direct care and be adequate to finance the quality provision of care.

Payment Plan Provisions (see attachment for explanations)**:**

A. Payment system must be cost-based controlled with caps on the maximum.

B. Establish "floors" for direct care cost center requiring a facility to pay back the difference between the facility costs and the floor if facility costs for direct care are below the floor.

C. Establish a quality incentive whereby a facility can voluntarily seek to qualify for a "wage pass-through" if it satisfies certain established thresholds related to direct-care staffing, operating expenses, staff turnover, staff retention, occupancy, survey findings, use of temporary/agency staffing, etc.

Guiding Principle III: Efficiency

Explanation: The Medicaid payment system should encourage efficiency of care without reducing costs that could impact quality.

Payment Plan Provisions:

A. Imputed occupancy rate for fixed costs (see attachment for explanation)

B. Caps on cost center expenditures

C. Limitations such as 16 percent of administrative costs

D. Annually identify benchmarks for the purpose of managing costs; i.e. average amount spent on raw food costs

E. Assure timely payment of providers for services to Medicaid Beneficiaries. Provider receivables for Medicaid beneficiaries should be paid within 30 days. If non-payment is made, interest penalties should apply increasing provider payment to recognize provider cost when serving as a creditor to the state.

Guiding Principle IV: Cost Containment

Explanation: The Medicaid payment system must control spending growth to ensure available appropriation.

Payment Plan Provisions:

A. Specifically identify items that go into each cost center

B. Caps based on maximum allowable costs

C. Contract for service where available, i.e., Cornhusker State Industries for laundry, if financially feasible

D. Imputed occupancy for fixed costs (see attachment for explanation)

E. Limitations on certain cost centers

F. Allowable and unallowable costs defined, i.e. specifically identify the allocation methodology for costs

G. Special rates for pilot/demonstration projects designed to reduce costs, promote wellness, etc.

H. Provider-developed program of all-inclusive care for the elderly utilizing the current providers of long-term care services. Current providers would have the first right of refusal as the provider of choice for covered services.

Guiding Principle V: Infrastructure

Explanation: The Medicaid payment system must allow for maintaining, improving or replacing facilities and equipment to meet standards and consumer expectations.

Payment Plan Provisions:

A. Maintain current cost based capital reimbursement system to assure providers' future and continued investment in facilities and equipment

B. Eliminate depreciation recapture if a building is fully depreciated as the state is getting the use of the building at a reduced rate by not paying depreciation

C. Need ability to ask for rate adjustment to recognize increased value resulting from capital investment for fixed costs

D. Incorporate a plan that allows facilities to reduce the length of depreciation by 25% for "green" improvements so as to allow for an expedited recoupment of costs and encourage investment in facilities

Guiding Principle VI: Equity

Explanation: The Medicaid payment system must equitably apply payment policies to all providers.

Payment Plan Provisions:

A. Payment rates for levels 35/36 are paid according to the nursing facility case-mix levels, not the assisted living rate.

B. Forego implementation of a provider tax. The tax is not equitable to providers due to different percentages of Medicaid residents. The inequity will be exacerbated if the State became "addicted" to the tax and continues to increase the tax rate.

C. Expand care classifications beyond "urban" and "non-urban" to reflect potential other geographic and/or facility characteristics inherent in economically similar peer groups for purposes of calculation of medians and maximums for each care classification. For example, some states have added a "trade-center" classification.

D. Hold harmless phase-in plan.

Imputed Occupancy

Using an "imputed" occupancy rate is a method states use in long term care facility Medicaid rate payment plans to hold the government harmless from potential inefficiencies and related costs resulting from low occupancy rates. The Myers & Stauffer plans in both Options 1 and 2 would implement an imputed occupancy of 85 percent applied to the capital component. They refer to it as the "minimum occupancy."

An imputed occupancy can be applied to the direct nursing component, support services component, fixed cost component, total rate, or some other/new rate component (such as "care-related" proposed by Myers & Stauffer). In the Myers & Stauffer Recommendation, it is only applied to the capital component.

How is imputed occupancy applied in the rate formula?
If Nebraska implemented an imputed occupancy of 85% on the capital (fixed) component, that would mean that the capital per diem would be calculated by dividing the facility's actual, allowable cost in a reporting period by the ***greater*** of the facility's impatient days for that period ***or*** the number of inpatient days the facility ***would have had*** if its occupancy rate had been 85%.

How does the imputed occupancy level impact facility rates?
A lower imputed occupancy rate results in a higher Medicaid reimbursement for facilities that have an occupancy rate lower than the imputed occupancy rate. This is because the occupancy rate is divided into a facility's costs, and the smaller the number divided into another number, the larger the result.

The lower the imputed occupancy percentage rate:
- the lesser it hurts lower-occupancy facilities and
- the fewer facilities it impacts

The higher the imputed occupancy percentage rate:
- the more it hurts lower-occupancy facilities and
- the more facilities it impacts

This is because if a facility's occupancy is above the imputed rate, the facility is not affected.

Ceilings and Floors

States have used ceilings and floors (maximums and minimums) to influence both efficiency and quality by either encouraging or discouraging spending.

Ceilings/maximums set a cap on reimbursement and discourage spending over the ceiling. Facilities spending above the ceiling receive only the ceiling as reimbursement. The intent is to incentivize efficient use of resources.

Floors/minimums set a minimum on reimbursement to encourage or focus spending on certain cost centers. They are generally used to incentivize quality.

- A properly implemented floor to encourage direct care spending and "care-related" spending (if the state has such a component) provides that a facility that spends less than the floor must reimburse Medicaid for the difference between their spending and the floor, thereby disincentivizing attempts to "profit" by reducing direct care/care-related spending and thus negatively impacting quality.
- A poorly implemented floor merely establishes a minimum on reimbursement and facilities spending below the floor are given the floor nevertheless.

Wage Pass-Throughs

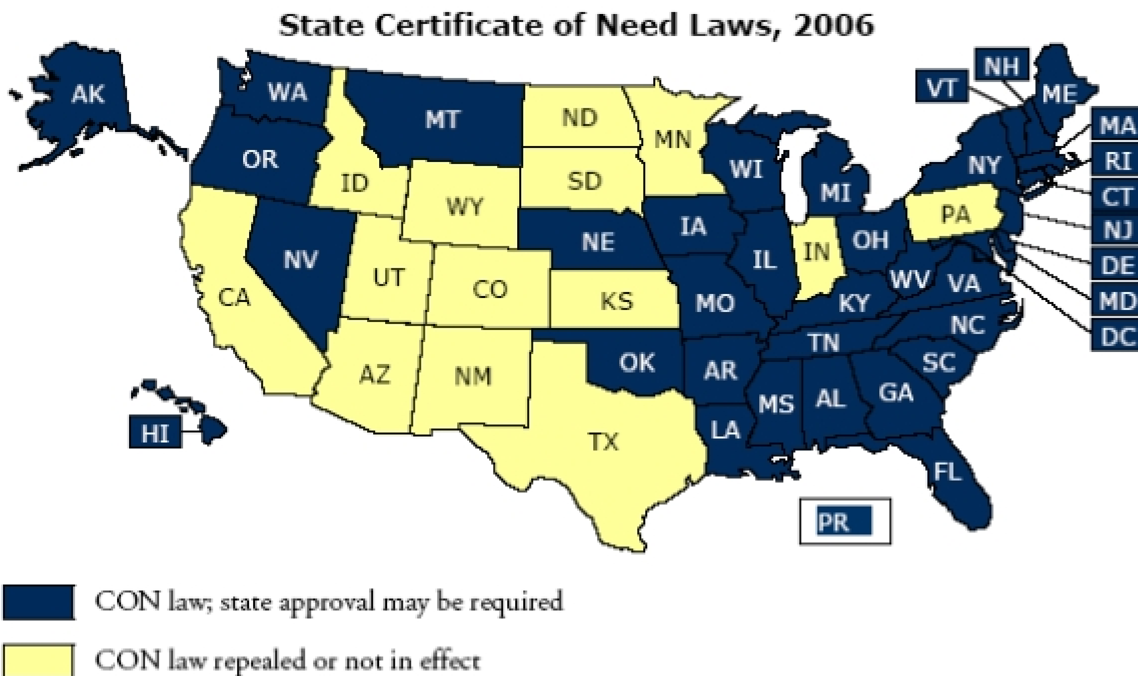
The intent of a wage pass-through is to enhance quality by reducing vacancies and turnover among direct care staff by ensuring funding is spent directly on staff wages and/or benefits. Nebraska could either identify a set dollar amount to increase worker wages within the Medicaid reimbursement rate or require that providers spend a percentage of a specific rate increase on higher compensation. The amount allocated is ensured to flow to staff as wage increases because it is "passed-through" as wages and not subject to a rate formula which discounts reimbursement under cost and is based upon a lag-time in cost reporting periods to appropriation years.

Studies demonstrate and NHCA's recommendation recognizes that low wages, by themselves, are not the sole cause of high vacancy and turnover among the direct care workforce. Furthermore, the sought outcome of higher-quality care is not necessarily ensured by higher wage levels. This is why NHCA recommends that to be eligible for a wage pass-through, a facility must agree to certain staffing levels, participate in satisfaction surveys, maintain a certain level on its surveys, and limit use of agency staff.

It would be possible to place a ceiling (maximum) on total spending within the direct care component while still passing-through direct wages.

Certificate of Need

A Certificate of Need (CON) is a written authorization by the Department that is required prior to the initial establishment, increase, or conversion of long term care beds or rehabilitation beds. Until August 30, 2009, a CON was also required for relocation of beds from one "health planning region" to another. Many "CON" laws were put into effect across the nation as part of the federal "Health Planning Resources Development Act" of 1974. CON programs are aimed at restraining health care facility costs and to allow coordinated planning of new services and construction. The basic assumption underlying CON regulation is that excess capacity (in the form of facility overbuilding) directly results in health care price inflation. Thirty-six states have CON programs identified in the following map.



Nebraska's CON Law (Neb. Rev. Stat. §§ 71-5801 to 71-5870 as amended)
Activities requiring a CON include the following:

Neb Rev Stat §71-5829.03

1. Except as provided in section 71-5830.01, **initial establishment of long term care beds or rehabilitation beds** except as permitted in (6) and (7) below.
2. **Increase in long term care beds** by more than **ten beds** or **ten percent** of the total long term care bed capacity, whichever is less, over **a two-year period** ("10-10-2").
3. **Increase in rehabilitation beds** by more than **10-10-2.**
4. ~~**Relocation of long term care beds** from a facility to another noncontiguous site **within the same health planning region** if the relocation will cause an increase in long term care beds between those locations of more than **10-10-2.**~~
5. ~~**Relocation of long term care beds** from a facility located in one **health planning region to a facility in a different region**~~
6. **Initial establishment of long term care beds through conversion** by a hospital of any type of hospital beds to long term care beds if the total beds converted by the hospital are more than **10-10-2.**
7. **Initial establishment of rehabilitation beds through conversion** by a hospital of any type of hospital beds to rehabilitation beds if the total beds converted by the hospital are more than **10-10-2.**
8. **Relocation of rehabilitation beds** in Nebraska from one health care facility to another health care facility.

Neb Rev Stat §71-5830.01
A certificate of need is not required for:
(4) **A transfer or relocation of long-term care beds from one facility to another entity in the same health planning region or any other health planning region.** The receiving entity shall obtain a license for the transferred or relocated beds within two years after the transfer or relocation. The department shall grant an extension of such time if the receiving entity is making progress toward the licensure of such beds.

Effective August 30, 2009:
71-5829.04 (1) All long-term care beds which require a CON under 71-5829.03 (above) are subject to a moratorium unless one of the following exceptions applies:
(a) DHHS establishes that the needs of individuals whose medical and nursing needs are complex or intensive and are above the level of capabilities of staff and above the services ordinarily provided in a long-term care bed are not currently being met in the health planning region; or
(b) Average occupancy for all licensed long-term care beds in a 25 mile radius of the proposed site for additional beds have exceeded ninety percent occupancy during the most recent three consecutive calendar quarters and there is a bed need as determined under this section. If average occupancy in a twenty-five mile radius has not exceeded ninety percent occupancy during the most recent three consecutive calendar quarters as reported at the time of the application filing, the department shall deny the application.
(2) The department shall review applications which require a CON and determine if there is a need for additional beds. No such application shall be approved if the current supply of beds

in the health planning region of the proposed site exceeds bed need for that health planning region. For purposes of this section:
(a) Long-term care bed need equals the population of the health planning region, multiplied by the utilization rate in health planning region, and the result divided by the minimum occupancy rate in health planning region;
(b) Population is the most recent projection of population for the health planning region for the year which is closest to the fifth year immediately following the date of the application. The applicant shall provide such projection as part of the application using data from the University of Nebraska-Lincoln Bureau of Business Research or other source approved by the department;
(c) The utilization rate is the number of people using long-term care beds living in the health planning region in which the proposed project is located divided by the population of the health planning region; and
(d) The minimum occupancy rate is ninety-five percent for health planning regions which are part of or contain a Metropolitan Statistical Area as defined by the United States Bureau of the Census. For all other health planning regions in the state, the minimum occupancy rate is ninety percent.
(The following requirement is new and a compromise with the Department due to lack of occupancy data required to calculate the equations above.)
(3) Each facility with long-term care beds shall quarterly report the number of residents at such facility on the last day of the immediately preceding quarter on a form provided by the department. Such report shall be provided to the department no later than ninety days after the last day of the immediately preceding quarter. The department shall provide the occupancy data collected from such reports upon request. Any facility failing to timely report such information shall be ineligible for any exception to the requirement for a certificate of need under section 71-5830.01 and any exception to the moratorium imposed under this section and may not receive, transfer, or relocate long-term care beds.

Health Planning Regions
The CON Act establishes regions, called health planning regions, defined as one of the twenty-six health planning regions established in the Nebraska State Health Plan, 1986-1991. (Interestingly, the referenced health plan did not establish 26 health planning regions, nevertheless the department uses 26 regions as pictured on the map below.)

NEBRASKA DISTRICTS/REGIONS

Attachment 1

Workforce Challenges

Baby Boomers and the LTC Workforce
In 2011 the first baby boomers will turn 65. The 65-and-older population of the future will be markedly different from in the past. They will have higher levels of education, lower levels of poverty, more racial and ethnic diversity, and fewer children.

Their numbers will be the most striking change. Several factors will result in the aged population encompassing a far greater percentage of the total population: the aging of the baby boom population, an increase in life expectancy, and a decrease in the relative number of younger persons

In Nebraska between 2010 and 2030, the number of adults aged 65 and older will increase from 243,000 to 376,000, accounting for an increase from 14 percent of the Nebraska population to 21 percent.

Although this increase has been forecast for decades, little has been done to prepare the health care workforce for this phenomena.

The education and training of the entire health care workforce with respect to the range of needs of older adults remains woefully inadequate.

Recruitment and retention of all types of health care workers is a significant problem, especially in long term care settings.

The entire health care workforce, including both formal and informal caregivers, need to have the requisite data, knowledge, and tools to provide high-quality care for older patients. The following steps have been identified by the Institute and are supported by NHCA:

1. Enhance the competence of all individuals in the delivery of geriatric care;

2. Increase the recruitment and retention of geriatric specialists and caregivers; and

3. Redesign models of care and broaden provider and patient roles to achieve greater flexibility.

Nebraska Population Changes by Age Group
In Individuals and Percentage Increases

	Population (in Thousands)				Percentage Increases			
Age Group	**2000 Actual**	**2010 Est.**	**2020 Est.**	**2030 Est.**	**2000-2010**	**2010-2020**	**2020-2030**	**2010-2030**
Total	1,711	1,769	1,803	1,820	3%	2%	1%	3%
0 - 19	504	496	508	507	-2%	2%	0%	2%
20 - 64	975	1,029	986	938	6%	-4%	-5%	-9%
65+	232	243	309	376	5%	27%	22%	54%
Aged Only								
65 - 69	59	67	98	97	12%	46%	-1%	46%
70 - 74	56	52	76	92	-8%	47%	20%	77%
75 - 79	48	44	51	76	-7%	15%	49%	71%
80 - 84	35	37	36	55	7%	-3%	52%	47%
85+	34	43	48	56	27%	11%	17%	30%

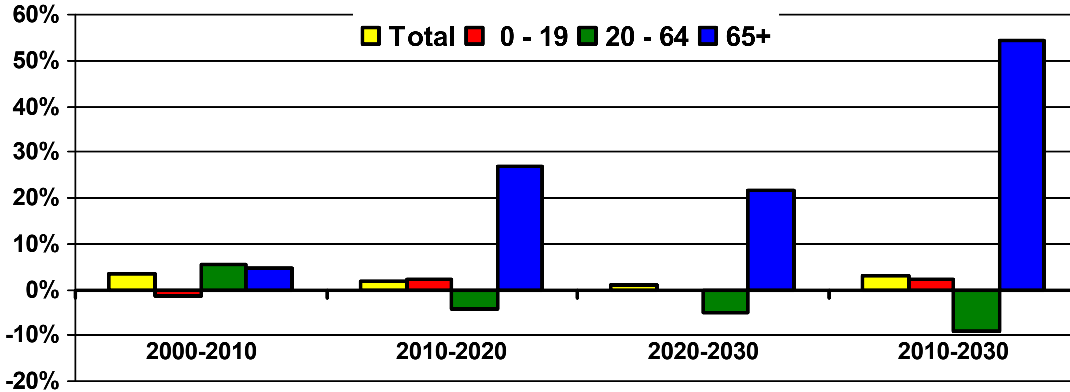
The Status of Today's Aged Population
Older adults receive health care in many different settings and are particularly high-volume users.

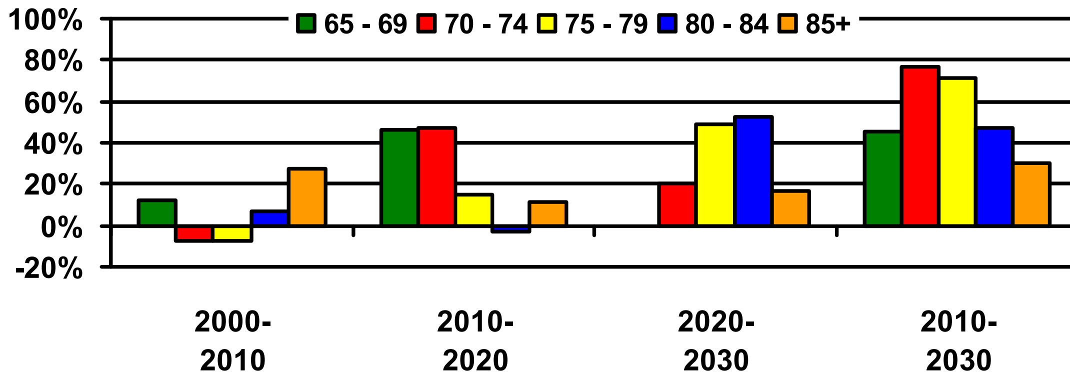
Although older adults make up only about 12 percent of the U.S. population, they account for approximately 26 percent of all physician office visits, 35 percent of all hospital stays, 34 percent of all prescriptions, 38 percent of all emergency medical service responses, and 90 percent of all nursing home use.

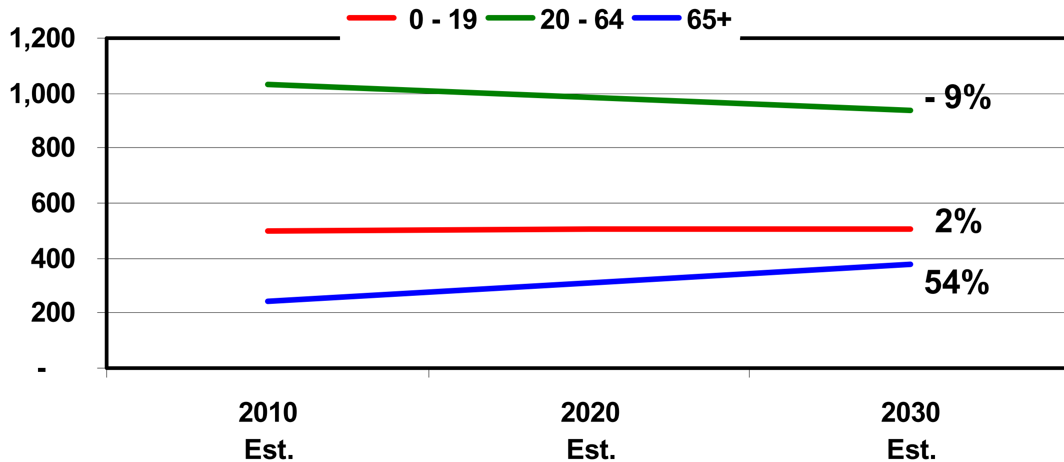
Just over 60 percent of disabled older adults living in the community obtain some long term care services, most commonly in the form of help with personal care and household chores. The vast majority of these services are provided by informal caregivers, typically a spouse or child.

The Aged Population of the Future
The demographic characteristics of older Americans will differ from previous generations in terms of their race, family structure, socioeconomic status, education, and geographic distribution, all of which can affect utilization of services.

Declines in smoking rates, for example, could lead to a decreased need for health care services, but that decrease could be offset by increased utilization associated with high rates of obesity. Medical advances and technologies such as telemedicine will also impact utilization.


Percentage Changes in Population Groups
60%
50%
40%
30%
20%
10%
0%
-10%
-20%
Total
0 - 19
20 - 64
65+
2000-2010
2010-2020
2020-2030
2010-2030


Percentage Changes in 65+
Population Groups
100%
80%
60%
40%
20%
0%
-20%
65 - 69
70 - 74
75 - 79
80 - 84
85+
2000-
2010
2010-
2020
2020-
2030
2010-
2030


Population Growth by Age Group (in Thousands)
0 - 19
20 - 64
65+
1,200
1,000
800
600
400
200
-
- 9%
2%
54%
2010
Est.
2020
Est.
2030
Est.

Building Capacity within the Health Care Workforce

- With few exceptions, all types of health care workers need to be educated and trained in the care of older adults. This will require incentives to those seeking professions in health care to select geriatrics programs. An example of such a program would be loan forgiveness programs in geriatrics upon working a certain number of years in long term care.
- Much of the care for older adults falls to informal caregivers, yet these unpaid workers receive very little preparation for their responsibilities.
- Finally, the management of chronic illness requires daily decision-making, and patients themselves lack knowledge or skills to do so.
- The current workforce is not large enough to meet older patients' needs, and the scarcity of workers specializing in the care of older adults is even more pronounced.
    - Among direct-care workers, nursing assistants provide 70 percent to 80 percent of the direct-care hours to those older adults who receive long term care, but their shortage is well documented (see below). The Bureau of Labor Statistics predicts that personal and home-care aides and home health aides will represent the second- and third-fastest growing occupations between 2006 and 2016, which will exacerbate current shortages.
    - Older adults account for about one-third of visits to physician assistants (PAs), but less than 1 percent of PAs specialize in geriatrics.
    - Less than 1 percent of both pharmacists and registered nurses are certified in geriatrics.
    - In 1987 the National Institute on Aging predicted a need for 60,000 to 70,000 geriatric social workers by 2020, yet today only about 4 percent of social workers—one-third of the needed number—specialize in geriatrics.

Nebraska's Nursing Shortage

Need for Increased Numbers of Nurses

In 2000, the Bureau of Health Professions, USDHHS, estimated that there was a shortage of 110,000 or 6 percent in the demand for full-time equivalent (FTE) registered nurses and projected shortages of 20 percent by 2015 and 29 percent by 2020.

Factors driving the growth rate include an 18 percent increase in population, a larger proportion of elderly compared to those of workforce age, and medical advances (National Center for Workforce Analysis, 2002).

Adequate Nursing Staff Correlates to Higher Quality

Volumes of research have demonstrated that health care facilities with high ratios of patients to nurses had a higher risk-adjusted 30-day mortality rate in patients and additional occurrences of quality of care related deficiency citations in nursing facilities. This would include the incidence of urinary track infections, pressure sores, accidents, other infections, etc.

Capacity Issues

Nebraska must expand the capacity of schools of nursing for preparing registered nurses (R.N.s), licensed practical nurses (LPNs), advanced practice registered nurses (APRNs), and other masters and doctoral prepared nurses in Nebraska. Baccalaureate, higher-level degree programs, and associate degree programs in nursing all have waiting lists of qualified students turned away because of capacity.

Nursing Faculty Shortages

Not only will it require additional faculty for schools to be able to admit more of the qualified applicants needed to meet the projected demands for R.N.s in the future, but there are existing vacancy rates of 6.4 percent in Nebraska and 8.6 percent nationally.

Several factors will exacerbate the ability to train nurses including an aging faculty, competition from other work settings, workload, and role issues.

Other Contributing Factors

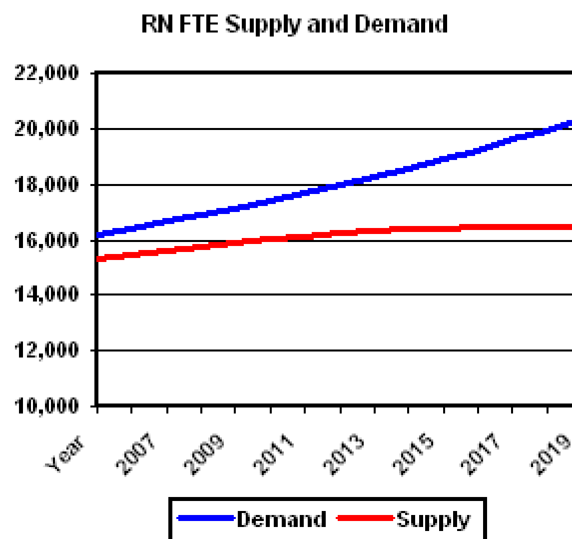
Budgetary constraints are clearly a primary factor contributing to the inability to increase capacity. In order to maintain capacity in Nebraska, the University of Nebraska has had to absorb two rounds of budget cuts. Future state budget cuts may be necessary.

The drop in the stock market from 2000 to 2002 has resulted in decreased earnings and decreased value of endowment funds held by foundations of institutions of higher education and has made contributions more difficult to solicit.

These budgetary restraints have made it difficult to expand classroom and laboratory space or buy new computers and other teaching equipment.

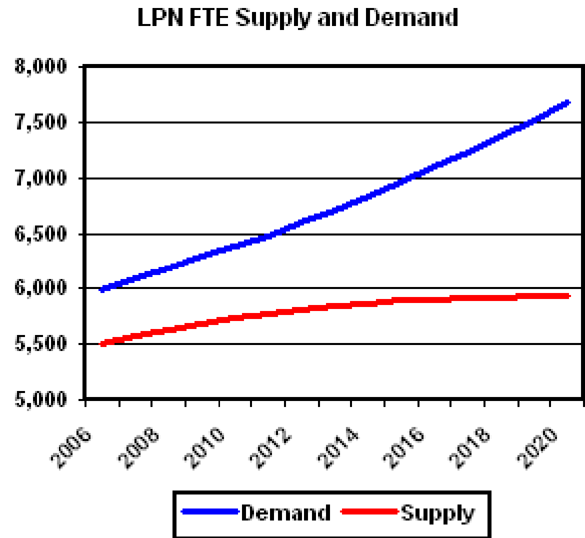
Estimated Surplus/Shortage of FTE RNs

Year	Demand	Supply	Shortage
2006	16,182	15,293	-889
2007	16,428	15,467	-961
2008	16,685	15,620	-1,065
2009	16,909	15,780	-1,129
2010	17,133	15,917	-1,216
2011	17,379	16,041	-1,338
2012	17,668	16,134	-1,534
2013	17,947	16,224	-1,723
2014	18,276	16,296	-1,980
2015	18,567	16,366	-2,201
2016	18,915	16,406	-2,509
2017	19,225	16,441	-2,784
2018	19,608	16,451	-3,157
2019	19,935	16,471	-3,464
2020	20,329	16,491	-3,838



Estimated Surplus/Shortage of FTE LPNs

Year	Demand	Supply	Shortage
2006	5,989	5,506	-483
2007	6,090	5,568	-522
2008	6,191	5,623	-568
2009	6,289	5,681	-608
2010	6,388	5,730	-658
2011	6,482	5,775	-707
2012	6,597	5,809	-788
2013	6,715	5,841	-874
2014	6,840	5,867	-973
2015	6,963	5,892	-1,071
2016	7,100	5,906	-1,194
2017	7,233	5,919	-1,314
2018	7,380	5,923	-1,457
2019	7,519	5,930	-1,589
2020	7,680	5,937	-1,743



Licensure, Certification, & Survey

Terminology:
Certification: The process by which the federal Centers for Medicare and Medicaid Services deems a facility compliant with the federal requirements for participation in the federal Medicaid and/or Medicare programs.

Licensure: The process by which the state grants a license to establish, operate, or maintain a "skilled nursing facility" or "nursing facility."

Nursing Facility: A facility where medical care, nursing care, rehabilitation, or related services and associated treatment are provided for a period of more than 24 consecutive hours to persons residing at such facility who are ill, injured, or disabled. (See "skilled nursing facility" below.)

Skilled Nursing Facility: A facility where medical care, skilled nursing care, rehabilitation, or related services and associated treatment are provided for a period of more than 24 consecutive hours to persons residing at such facility who are ill, injured, or disabled.

- Skilled nursing care simply refers to services provided under the Medicare program.
- In Nebraska, nearly all nursing facilities are "skilled," i.e., they participate in the Medicare program.

Overview
Nursing facilities in Nebraska are primarily regulated by the Nebraska Department of Health and Human Services (NDHHS) and the federal Centers for Medicare and Medicaid Services (CMS). The State Fire Marshal also conducts surveys for fire code compliance. Fire regulations are contained in the National Fire Protection Association (NFPA) Chapter 101, the "Life Safety Code" (2000), and Chapter 99, "Health Care Facilities" (2002).

The NDHHS Division of Public Health ensures that facilities fully comply with Nebraska-specific regulations and enforces federal regulations issued by CMS which are enforced upon any facility which accepts Medicare or Medicaid payments. CMS regional surveyors also inspect facilities for compliance with CMS regulations.

The federal Centers for Medicare and Medicaid Services (CMS) issues volumes of regulations. They also issue "interpretive guidelines" for those regulations to help understand their application.

Nebraska facilities have a significant problem with surveyors "interpreting the interpretations" and writing citations based upon circumstances that are not specifically addressed in the regulation.

This is the case with State Fire Marshal surveys for fire safety surveys as well as state and federal health care surveys.

NHCA's position is that any deficiency written to a facility should include the specific regulatory citation or interpretive guideline as adopted by CMS or through other binding legislative process. If the facility practice is not specifically prohibited under that citation, the deficiency should be withdrawn.

Applications/Licensure Requirements
Any person intending to operate a long term care facility must obtain a license from the Department. An applicant for an initial or renewal license must demonstrate that the facility meets the care, treatment, and operational and physical plant standards contained in 175 Nebraska Administrative Code (NAC) 12 Sections 006 and 007.

For initial licensure, the Department reviews the completed application and inspects the facility. The Department will then determine if the applicant meets the standards contained in the regulations and the Health Care Facility Licensure Act.

All long term care licenses expire March 31st of each year. For renewal licensure, the facility must submit a detailed application once again and pay the required fee (1-50 Beds $1,550, 51-100 Beds $1,750, 101+ Beds $1,950).

The Department may deny or refuse to renew a facility license for failure to meet the requirements for licensure, including failing an inspection; having had a license revoked within the two-year period preceding an application; or any of the grounds listed in the regulations for issuing a disciplinary action.

The Survey Process
Nursing facilities are required to be in compliance with the state and federal statutes and regulations to receive payment under the Medicare or Medicaid programs (and to gain and maintain certification and licensure). To *certify* a facility for participation in the Medicare or Medicaid programs, the facility must undergo at least a Life Safety Code (fire) survey and standard survey which reviews federal and state service delivery and plant-related requirements.

Surveyors enforce the provisions of the CMS "State Operations Manual" Appendix PP - Guidance to Surveyors for Long Term Care Facilities. This source provides the regulations as well as interpretive guidelines to assist in their understanding.

Licensure and certification surveys are conducted by a team of DHHS or CMS officials that must include a registered nurse. Surveys are conducted over three to four days. Federal standards are organized into groupings and identified by number and referred to as "F-tags."

The groupings include:

- resident rights
- admission, transfer, and discharge rights
- resident behavior and facility practices
- quality of life
- resident assessment
- quality of care
- nursing services
- dietary services
- physician services
- specialized rehabilitative services
- dental services
- pharmacy services
- infection control
- physical environment
- administration

Depending on the level of harm to residents caused by a deficiency, a degree of "scope and severity" is issued with the F-tag. Surveyors will inspect the facility medical records and health care plans and interview residents, family members, and employees.

Surveyors usually discuss deficiencies and violations with administrative staff at the end of the survey. The surveyors issue a final report on the survey and the facility has ten days to file a "plan of correction" to address problems.

State survey teams conduct an unannounced annual standard survey, a subsequent revisit survey when it is necessary to ensure that any deficiencies cited in the annual survey have been corrected, and upon a complaint against the facility. Sometimes, federal survey teams conduct surveys of facilities along with the state team, whereby they are able to review the state team's protocol vis-à-vis the federal requirements.

Federal surveyors also conduct facility surveys shortly after a state survey, at which time they are able to independently review a facility for compliance, which again serves as a check on the state team without the state team's awareness.

Survey Deficiencies

Terminology:

- Category 1 Remedies – Must complete a directed plan of correction, state monitors, directed in-service training may be imposed.
- Category 2 Remedies – Denial of payment for new admissions, denial of payment for all individuals, Civil Money Penalties of $50 - $3,000 per day or $1,000 - $10,000 per instance.
- Category 3 Remedies – Temporary management, termination of Medicare contract, civil money penalties of $3,000 - $10,000 per day or $1,000 - $10,000 per instance.
- Plan of Correction: A document a facility must submit to the survey agency subsequent to receiving a deficiency which must address how corrective action will be accomplished for affected residents; how to identify other residents having the potential to be affected; measures that will be put into place to ensure it will not recur; how to monitor performance to make sure that solutions are sustained; and dates when corrective action will be completed.
- Severity – refers to the degree of harm.
- Scope – refers to the number of affected residents.
- Scope and Severity – indicated by a letter from A – L.

Scope and Severity Grid for Deficiencies			
Deficiency Scope	Deficiency Scope		
	Isolated	Pattern	Widespread
Level 4 – Actual or potential for death or serious injury. Immediate jeopardy (IJ).	J POC Category 3, Optional: Category 1; Category 2.	K POC Category 3, Optional: Category 1; Category 2.	L POC Category 3, Optional: Category 1; Category 2.
Level 3 – Actual harm that is not immediate jeopardy.	G POC Category 2* Optional Category 1	H POC Category 2* Optional Category 1	I POC Category 2* Optional Category 1 Temporary Management
Level 2 – Potential for more than minimal harm.	D POC Category 1* Optional: Category 2	E POC Category 1* Optional: Category 2	F POC Category 2* Optional: Category 1
Level 1 – Potential for minimal harm, substantial compliance exists.	A Substantial Compliance	B POC Substantial Compliance	C POC Substantial Compliance

* This is required only when a decision is made to impose alternative remedies instead of or in addition to termination.

Denial of payment for new admissions must be imposed when a facility is not in substantial compliance within three months after being found out of compliance.

Denial of payment and state monitoring must be imposed when a facility has been found to have provided substandard quality of care on three consecutive standard surveys.

"Double G": If a facility receives a level 3 deficiency or higher, to determine whether "denial of payment" will be imposed, i.e., the facility is given "no opportunity to correct," the state looks back to the last annual survey or any intervening revisit or complaint survey to see if the facility received a level 3 deficiency or higher. If the facility has, then denial of payment is imposed.

Termination may be imposed by the State or CMS at any time.

Once the seriousness of the deficiencies is determined, and the decision is made to impose remedies instead of, or in addition to, termination, the regional CMS office, or the Department must select one or more remedies from the remedy category (or a CMS approved alternative or additional state remedy) associated with the specific level of noncompliance in accordance with the visual matrix above. The remedy category to be applied against facility noncompliance will be determined by the most serious deficiencies identified, i.e., the deficiencies falling into the box closest to Level L.

Informal Dispute Resolution

Pursuant to receipt of a survey deficiency, facilities may challenge the citation through an informal conference or informal dispute resolution (IDR) with a representative of the Department, in a more formal adjudicative administrative hearing, or through an independent IDR.

An independent IDR is conducted pursuant to statute by a "peer review organization" (PRO), a physician-directed organization operating under federal contracts under Medicare law. PROs are intended to share information about best practices with physicians and health care facilities.

In 2007, NHCA sponsored a legislative bill to add the independent IDR process due to a widespread perception that the Department was unable to be completely impartial when hearing an appeal to a citation that the state itself issued. The independent IDR process has been successful in Nebraska. They are conducted by CIMRO of Nebraska and cost in the vicinity of $1000 - $1500.

In 2007, the most cited survey violations were the following "F-Tags":

F309: (Quality of Care) Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Cited in 25 percent of statewide facility surveys

Intent: The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment and within the limits of recognized pathology and the normal aging process.

F324: (Quality of Care) Each resident receives adequate supervision and assistance devices to prevent accidents.

Cited in 25 percent of statewide facility surveys

Intent: Ensure that the facility identifies each resident at risk for accidents and/or falls and adequately plans care and implements procedures to prevent accidents. An "accident" is an unexpected, unintended event that can cause a resident bodily injury. It does not include adverse outcomes associated as a direct consequence of treatment or care, (e.g., drug side effects or reactions).

F281: (Quality of Care) The services provided or arranged by the facility must meet professional standards of quality.

Cited in 23 percent of statewide facility surveys

Intent: To assure that services being provided meet professional standards of quality and are provided by licensed, certified individuals. "Professional standards of quality" means services that are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body, or other regulatory agency. Recommended practices to achieve desired resident outcomes may also be found in clinical literature.

F225: (Facility Practices) The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law or have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property. It must report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.

Cited in 22 percent of statewide facility surveys

Intent: The facility must not hire a potential employee with a history of abuse, if that information is known to the facility. The facility must report knowledge of actions by a court of law against an employee that indicates the employee is unfit for duty. The facility must report alleged violations, conduct an investigation of all alleged violations, report the results to proper authorities, and take necessary corrective actions.

F371: (Dietary Services): Store, prepare, distribute, and serve food under sanitary conditions.

Cited in 20 percent of statewide facility surveys

Intent: To prevent the spread of food-borne illness and reduce those practices which result in food contamination and compromised food safety in nursing homes. Since food-borne illness is often fatal to nursing home residents, it can and must be avoided.

In 2006, the most cited survey violations were the following "F-Tags":
F371: Cited in 32 percent of statewide facility surveys

F324: Cited in 26 percent of statewide facility surveys

F281: Cited in 22 percent of statewide facility surveys

F323: (Quality of Care) The facility must ensure that the resident environment remains as free from accident hazards as is possible;

Cited in 22 percent of statewide facility surveys

Intent: Ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:

- Identifying hazard(s) and risk(s);
- Evaluating and analyzing hazard(s) and risk(s);
- Implementing interventions to reduce hazard(s) and risk(s); and
- Monitoring for effectiveness and modifying interventions when necessary.

F309: Cited in 21 percent of statewide facility surveys

Medicaid Reform

A. Medicaid Reform

In 2005, Nebraska commenced a Medicaid Reform initiative mandated by the Legislature in LB 709 (2005). The bill mandated "fundamental reform" of the state's Medicaid program and a significant rewriting of Medicaid-related statutes. It required the preparation of a Medicaid reform plan to make specific recommendations for reform which was ultimately submitted to the Governor and Legislature on December 1, 2005.

NHCA has continued to actively participate in the Medicaid reform process through membership on task forces and commissions, offering guidance and research, and providing recommendations from our vast experience in working with care and services for the aged. NHCA testified in support of LB 709 and has been supportive of expanding home and community-based reform. We continue to facilitate opportunities for existing long term care providers to diversify into provision of additional home and community - based services. The NHCA board of directors has adopted a position in support of the continuum of care.

Motivation for Medicaid Reform

Legislature codified the following motivations for Medicaid Reform in LB 709 (2005):

(1) The medical assistance program has resulted in significantly increased expenditures by the state of Nebraska;

(2) In response to such increased expenditures, the Legislature has taken various actions affecting the availability and adequacy of medical assistance benefits to Nebraska residents under the program;

(3) As a result of such increased expenditures, the medical assistance program may become fiscally unsustainable; and

(4) Fundamental reform of the medical assistance program is necessary in order to ensure future sustainability of the program for the benefit of Nebraska residents."

The Medicaid Reform Process

LB 709 (2005) required development of a Medicaid reform plan by two "designees," one appointed by Governor Dave Heineman (Richard "Dick" Nelson) and one appointed by Senator Jim Jensen as chair of the Legislature's Health and Human Services Committee (Jeff Santema, Legal Counsel to the HHS Committee). The designees were required to solicit public input, conduct at least one public meeting, provide monthly reports to the Governor and the Committee, meet with the Medicaid Reform Advisory Council, and submit a Medicaid reform plan to the Governor and the Legislature by December 1, 2005.

Medicaid Reform Advisory Council

The legislation created the Medicaid Reform Advisory Council consisting of ten persons, including Pat Snyder, NHCA Executive Director, appointed by Governor Heineman. The advisory council was required to meet monthly with the Medicaid reform designees, review monthly reports submitted to the Governor and committee by the designees, and review the Medicaid reform plan and provide recommendations relating to the plan to the Governor and the committee by December 14, 2005.

Medicaid Reform Findings, Recommendations, and Strategies

The full Medicaid Reform Plan is available at http://www.dhhs.ne.gov/med/reform/docs/FinalPlan.pdf. Below are listed those most pertinent to long term care.

FINDING 3: Long term care services for the elderly and disabled are the largest expenditure categories in the Medicaid program.

Recommendation 3.0a: We recommend that HHSS seek approval from CMS to incrementally expand the capacity of the Aged and Disabled Home and Community-Based Services waivers in Nebraska as Nebraska's population ages.

> Strategy 3.0a1: In SFY2006, HHSS will submit a waiver to CMS to expand the Home and Community-Based Services waiver capacity. Based on current population projections, the Medicaid Program estimates that approximately 180 slots will be added each year from 2005 through 2015, and 360 slots will be added each year from 2016 through 2025.

Recommendation 3.0b: We recommend that HHSS contract with a consultant to evaluate existing comprehensive assessment tools for determining the appropriateness of persons for nursing facility, assisted living, and home health care. The consultant will also assist the Medicaid program to identify quality-based performance measures to adequately assess the quality and effectiveness of care in assisted living and in-home settings.

> Strategy 3.0b1: In SFY2007, HHSS will contract with a consultant to evaluate existing comprehensive assessment tools, or if necessary, to develop comprehensive assessment tools, for determining the appropriateness of persons for nursing facility, assisted living, and in-home services. The assessment tool will include social as well as medical components to identify safe and appropriate environments and necessary services. While a result of the assessment tool will be to eliminate the existing bias in favor of institutional care, the purpose of the contract will be to identify what is appropriate for the individual, based on his or her medical and social needs. This strategy continues to recognize that some individuals may be most appropriately served in an institutional setting.
>
> Strategy 3.0b2: HHSS will include in the consultant's contract provisions for evaluating existing quality-based performance measures, or if necessary, to develop such performance measures. When implemented, the performance measures will be used to evaluate and improve the quality of care in each setting.

Recommendation 3.0c: We recommend that HHSS contract with consultants to revise the current reimbursement methods for long term care providers of nursing facility, ICF-MR, assisted living, and in-home services.

Strategy 3.0c1: In SFY2007, HHSS will contract with a consultant to help update and revise the level of care system used in nursing facility reimbursement. Based on the revised levels of care, with the help of the consultant, the Medicaid program will develop reimbursement methodologies that are reasonable and appropriate for services provided in a nursing facility, assisted living facility, and in-home setting.
Strategy 3.0c2: In SFY2008, HHSS will contract with a consultant to help update and revise the reimbursement methodology for both ICF-MRs and Community-Based Developmental Disability Services.

Recommendation 3.0d: We recommend that HHSS establish an advisory committee to work with HHSS to encourage the development of Home and Community-Based Services under the Aged and Disabled Waiver, particularly in rural areas of the state.
Strategy 3.0d1: In SFY2006, HHSS will establish an advisory committee that includes representatives of the Area Agencies on Aging, consumers, providers of long term care services, and local public officials, to identify the need for and barriers to the provision of Home and Community-Based Services. HHSS, in conjunction with the advisory committee, will consider cost-effective ways to allow existing facility providers and their trained personnel in rural areas to provide in-home services, in addition to facility-based services.

Recommendation 3.0e: We recommend that HHSS collaborate with the Area Agencies on Aging (AAAs) to better inform older adults of available, appropriate, and cost-effective alternatives to nursing facility care.
Strategy 3.0e1: Beginning in SFY2007, and building on the existing information program for aging persons, the new assessment tool, and increased availability of assisted living and in- home services, the AAAs will be better able to assist non-Medicaid eligible persons to make informed choices concerning the most appropriate and cost-effective services available. In communities with stable or increasing real estate values, clients also can be educated on the availability of reverse mortgages to enable them to remain in their own homes and pay for in-home services, where appropriate.

Recommendation 3.1a: We recommend that HHSS identify available, cost-effective technologies to improve distance delivery of health care services to Medicaid recipients, especially those in rural areas.
Strategy 3.1a1: In SFY 2007, HHSS will contract with a consultant to evaluate emerging technologies, such as telemonitoring, which can increase the ability of persons to remain safely and appropriately in their own homes. These technologies are rapidly changing and becoming increasingly cost-effective. As they are identified, they can be included through State Plan Amendments or Waivers as covered expenditures.
Strategy 3.1a2: Medicaid currently covers services provided by telehealth communications. HHSS will identify those facilities and providers that have telehealth capabilities and work with them to promote appropriate, cost-effective, and expanded use of telehealth services.

Recommendation 5.0c: We recommend that Nebraskans be encouraged to plan to provide for their own long term care services as a part of their retirement planning

Strategy 5.0c1: In SFY2007, HHSS will initiate a public service campaign to inform Nebraskans of the need to plan for long term care services. The campaign will include an explanation that Medicare does not pay for most long term care and that options are available to people in their planning.
Strategy 5.0c2: On December 1, 2005, HHSS is issuing a separate report in cooperation with the Department of Insurance on the subject of Long Term Care Partnership Insurance. That report includes recommendations that are contingent on a change in federal law. If and when the federal law is changed, the state can implement those recommendations.

Recommendation 5.1a: HHSS should develop a service delivery model of consumer-directed home and community based care. This service delivery model would improve recipient satisfaction by giving them the opportunity to direct a cash allowance to purchase home and community-based services as an alternative to nursing facility care.
Strategy 5.1.a1: In SFY 2007, HHSS will develop a pilot program of cash and counseling that will identify specific services to be included. The targeted population would include selected recipients with physical disabilities and high-cost service needs.
Strategy 5.1.a2: HHSS will monitor the success of the pilot program, including consumer satisfaction and cost effectiveness. Successes and failures in other states will be studied. HHSS will continue to analyze the appropriateness of cash and counseling for additional services and populations in Nebraska and expand the program as its benefits are demonstrated.

B. Nebraska Money Follows the Person (NMFP)

In 2007, Nebraska was one of 17 states that was selected to receive a federal Money Follows the Person Grant. States that were selected were then required to submit more detailed "operational protocols" spelling out the details of how grant funds would be utilized in order to actually commence their grant programs and receive federal dollars.

In June 2008, the operational protocols submitted by NDHHS were approved by CMS. With this approval, NDHHS may begin operation of its NMFP program. The following explanation of the NMFP program is taken in excerpt form from the report, "*Report to the Nebraska Health Care Association, An Analysis of the Nebraska Money Follows the Person Operational Protocol as Approved by the Centers for Medicare and Medicaid Services,*" July 1, 2008, Prepared by Dick Nelson, Esq., and consultant to NHCA.

Nelson Report (Abbreviated)

There was a major inconsistency between the language of the grant proposal and the attachments to that proposal regarding the size of the grant's fiscal impact. That inconsistency is resolved in the Budget Worksheet information contained in the Appendix C of the approved Protocol. The total budget expenditure for the five years of the grant project (FFY 2007-FFY2011) is $35,728,320 consisting of $2,042,154 for state administration, $239,600 for federal evaluators, and $33,446,566 for Home and Community-Based Services (HCBS). (Initially the department had announced that the size of Nebraska's grant would be $75,496,358 spread over five years.)

The Protocol continues to propose the movement of 900 people from institutional services (NFs, ICF/MRs, and hospitals) to HCBS during the five-year grant cycle. The resident population will be broken down into four categories of eligibility: 400 elderly persons, 200 persons with mental retardation or developmental disabilities, 100 persons with traumatic brain injury, and 200 persons with physical disabilities. The actual movement of residents is planned to occur during three federal fiscal years, FFY 2008, 2009, and 2010. The first year, FFY 2007, was used for planning, and the final year, FFY 2011, will be used to earn the full 12 months of enhanced federal funding for the persons moved to the community in FFY 2010.

The Protocol does NOT propose to close or eliminate funding for beds vacated by NMFP participants. Medicaid will need to realize savings, however, if funding to nursing facilities is to be maintained without additional appropriations of state funds.

Nursing facilities will become involved in NMFP through contact with the Transition Coordinators, who are state employees. The Transition Coordinator will arrange with the facility to present programs on NMFP to facility employees, residents, and family members. The Transition Coordinator will notify the facility when a resident has been determined suitable to participate, will ask the facility discharge planner to join the Transition Team, and will refer the resident to a HCBS Services Coordinator.

The lack of adequate home and community services and service providers is a major challenge to the success of NMFP, particularly in rural areas. The Operational Protocol envisions the involvement of nursing facilities to provide community services through diversification.

Additional information is available on the DHHS website at www.dhhs.ne.gov/nmfp.

Objectives
The NMFP assumes that consumers prefer to receive long term care services in a community setting and that home and community services are cost effective for the state. The Operational Protocol lists four program objectives:

- *Increase the use of home and community-based, rather than institutional, long term care services.*
- *Eliminate barriers or mechanisms, whether in state law, the state Medicaid Plan, the state budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long term services in the settings of their choice.*
- *Increase the ability of the state Medicaid program to assure continued provision of home and community-based long term care services to eligible individuals who choose to transition from an institution to a community setting.*
- *Ensure that a strategy and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based long term care services and to provide for continuous improvement in such services.*

NMFP will use existing Medicaid waivers to provide services to eligible participants. In addition, the program will provide information regarding community choice to individuals

and their families before they need long term care services or at the earliest opportunity when they enter or are about to enter long term care.

Transition Coordinators
The Transition Coordinators will play the instrumental role in identifying potential grant participants and coordinating for their transition in to HCBS. They will be located in the North Platte (Western), Norfolk (Central), and Lincoln (East). The Grant Manager, Bil Roby, the three Transition Coordinators, and the Administrative Assistant comprise the NMFP Team.

NDHHS Medicaid and Long Term Care Director Vivianne Chaumont has appointed a NMFP Advisory Panel consisting of 16 people: four representing consumers, families, and advocates; five representing institutional providers; and seven representing waiver service providers. Pat Snyder is a member of the panel on behalf of NHCA. It will advise the Department regarding the marketing plan and materials, monitor ongoing program quality, and assess progress toward goals. Key issues for the Advisory Panel include housing, information technology, barriers and gaps in services, and on-going program development. The Panel also is expected to work with associations and institutional facilities to develop responses to lost institutional revenues.

Outreach and Education
NMFP prepared and submitted marketing materials to CMS for approval. Based on the protocols, NMFP plans to use both written materials and mass media. NMFP will sponsor educational programs and workshops for residents and families and will ask to conduct these programs in facilities. Transition Coordinators will meet one-on-one with residents. They will contact each nursing facility, in advance, to arrange to conduct informational programs in the facility for residents and interested family members.

Identification of Potential Participants and Informed Consent
To be eligible for NMFP, a person must have been eligible for Medicaid for at least one month and must have resided continuously in one or more "qualified institutions" for at least six months. Nursing facilities, ICF/MRs, and hospitals (including Regional Centers) are the only qualifying institutions.

The Transition Coordinators will screen prospective participants. Anyone, including nursing facilities, can refer a potential participant to the NMFP central office. In addition to referrals, the NMFP Team will use completed MDS reports to screen for possible participants.

When potential participants have been identified through referral or screening, the Transition Coordinator will contact the resident, or his or her legal representative, as appropriate, to verify that the resident is interested in the NMFP demonstration. The Transition Coordinator will meet with any suitable resident, a second time, to obtain his or her Informed Consent. One of the Transition Coordinator's duties is to protect the right of the resident to make a voluntary choice about NMFP participation. The informed consent is intended to protect the resident's right to make a free and voluntary choice, without undue pressure from any other party to stay in the facility or move to the community. In some

cases, a legal representative, conservator, or person with a durable power of attorney or a power of attorney for health care will have to sign. The Operational Protocol also provides that a family member has authority to consent for an adult resident who has not been adjudicated incompetent but who, nevertheless, is incapable of giving consent.

Transition Planning and Service Coordination

With the exception of the TBI waiver, the existing HCBS waiver systems will be used to authorize and manage community services. Use of the TBI waiver and expansion of that waiver were contained in the original grant proposal but have been dropped from the Operational Protocol. The approved Protocol provides that all participants will be served through the Aged and Disabled Waiver, unless they qualify for the Comprehensive (Adult) or Children's Developmental Disability Waiver. Because NMFP is being implemented within the existing waivers, the HCB Service Coordinator's first responsibility is to determine whether the person is eligible for waiver services. Current assessment tools will be used, initially, to make the determination that the person meets the nursing facility level of care requirements.

The HCB Service Coordinator is responsible for developing an adequate safety plan. Risks will be considered and appropriate assumption of risk will be discussed. The following risk factors will be utilized:

1. *Documented abuse/neglect*
2. *Socially inappropriate behavior*
3. *Inability to communicate understandably*
4. *Incontinence*
5. *Recent falls with injury*
6. *No adequate housing*
7. *Diagnosis of dehydration or malnutrition*
8. *Self neglect*
9. *Lack of informal support*

CMS requires a 24/7 back-up plan for each resident who moves to the community. An agency-based community provider will be required to provide back up in the event assigned personnel are not available.

Housing and Assisted Living Placement

CMS has defined "qualified residences" to include a person's own home or apartment, a family member's home or apartment, and congregate living arrangements for four or fewer people. Even though some CMS materials have indicated that assisted living facilities are not "qualified residences," some other states' approved MFP Protocols include assisted living. NMFP has included assisted living units in its Operational Protocols and projected that up to 225 units would be used to meet housing needs. However, the Protocol includes the following statement: "Utilization of this qualified residence will not be used until finalized discussion with CMS takes place." As of year-end 2008, there is no final decision on this issue; however transition coordinators are currently considering the appropriateness of assisted living placement upon identifying a potential candidate for moving out of a nursing facility. The individual would be moved into an assisted living facility and the state would realize Medicaid savings but not get the "enhanced" match rate from the federal government for that person.

Even if CMS approves the use of assisted living, not all licensed assisted living units will qualify. At a minimum, the living unit in an assisted living facility would have to have a locked door and living, sleeping, bathing, and cooking areas over which the resident has dominion and control.

Quality Assurance and Improvement
The Advisory Panel is identified as having responsibility for monitoring on-going program quality and progress toward identified goals. Existing monitoring groups, however, have operational responsibility for quality oversight. The Quality Council monitors the A&D waiver. The monitoring groups will use existing critical incident and complaint processes.

Medicaid Reimbursement and Nursing Facility Financial Issues
The Operational Protocol is essentially silent on the issue of reimbursement. The issue is mentioned twice. First, HCBS providers will be reimbursed on a fee-for-service basis, using the existing N-FOCUS and MMIS payment systems. There is no further detail. Second, the Advisory Panel, as one of its duties, is supposed to work with the facility associations and individual facilities to address facility financial issues.

Information Technology Improvements
The Advisory Panel is also supposed to have input into IT issues and proposed improvements. DHHS is proposing to make several improvements to existing database systems and establish a database for NMFP participants and, presumably, other HCBS waiver participants.

The Operational Protocol also proposes to implement the interRAI MDS-Home Care assessment tool. IT issues have prevented it from being used to date. DHHS intends that this instrument will capture data currently recorded manually, make assessments more consistent across the state, and provide the MDS information to the CONNECT database.

Nebraska Health Care Association's Recommendations:
NHCA submitted a number of recommendations to the Department pertaining to the operational protocol it ultimately submitted to CMS.

We recommended that MFP promotional materials only be provided to residents who meet the following six criteria, and that all initial screenings would be based on a review of nursing facility MDS Data.

1. **The individual is Medicaid-eligible at the time of the screen.**
2. **The individual has resided in one or more eligible institutions for a minimum of six consecutive months.**
3. **The individual does not have cognitive impairment or no more than minimal cognitive impairment.**
4. **The individual does not have a severe and persistent mental illness.**
5. **The individual's level of care, as determined from the MDS, has remained stable or has improved on each MDS completed in the past six consecutive months.**
6. **The individual's desire to return to the community is documented on the most recent MDS.**

NHCA further recommended that the state become familiar with and take into account the phenomenon of “transfer trauma.” There is significant literature regarding negative effects associated with transfer of nursing home residents; most notably, there is a significantly elevated death rate among those involuntarily relocated among nursing homes. We submitted the following two articles:

- Thorson, J., & Laughlin, A. *The Dark Night of the Soul*. (2007) Existential and Spiritual Issues in Death Attitudes, New York: Lawrence Erlbaum, 257 287.
- Koyanagi, C., Bazelton, Judge D. (2007) *Learning from History: Deinstitutionalization of People with Mental Illness as Precursor to Long Term Care Reform*. Kaiser Commission.

These articles discuss the concept of transfer trauma and explore how its ill effects can be prevented from occurring in nursing home residents, which is primarily through an extensive planning process, open communication, and a minimization of changes in living arrangements in the new facility.

The Long Term Care Continuum

Both the NHCA Board of Directors and full membership have approved the following statement in support of the long term care continuum.

Policy Statement:
The Nebraska Health Care Association recognizes the need for a comprehensive continuum of care system of which the Long Term Care Facility is an integral part. NHCA supports appropriate placement of individuals within the continuum of the care system to ensure the highest practicable quality of life for the at-risk resident in the state of Nebraska. NHCA supports private and public policy which ensures appropriate funding of services in the most efficient way to meet the full array of services needed in our communities.

What is the "Continuum of Care"?
The continuum of long term care refers to an integrated system of health care services that provide a combination of housing, personal care services, and health care designed to respond to individuals who need assistance with normal daily activities in a way that promotes maximum independence. The concept embraces the concept of identifying long term care placement in a setting capable of cost effectively providing the right level of quality care to meet an individual's unique needs at the particular stage of one's life. Settings range from "personal services" provided in one's own home at one end of the continuum to a skilled nursing facility on the other.

Personal Assistance Services:
These services, generally provided in one's home, include the following:

- Basic personal hygiene – providing or assisting with bathing (tub, bed bath, shower); shampoo, hair grooming; nail care; oral hygiene; shaving; and dressing;
- Toileting/bowel and bladder care – assisting to and from bathroom, on and off toilet/commode, diapering, bedpan; external cleansing of perineal area; maintenance bowel care; and changing or emptying catheter bag;
- Mobility, transfers, comfort – assisting with ambulation with and without aids; repositioning; encouraging active range-of-motion exercises; assisting with passive range-of-motion exercise; and assisting with transfers with or without mechanical devices;
- Nutrition – preparing meals; planning and preparing special diets; assisting with fluid intake; and feeding; and
- Medications – assisting with administration of medications; reminding appropriate persons when prescriptions need to be refilled.
- Housekeeping tasks necessary to maintain the client in a healthy and safe environment (examples include changing the client's bed linens, laundering the client's bed linens and personal clothing, light cleaning in essential areas of the home used by the client; purchasing of food, and cleaning client's dishes. Note: These housekeeping activities may not be provided for the benefit of any other member of the household.)

Adult Day Service:
This is a freestanding facility or a distinct part of another licensed health care provider that provides an array of social, medical, or other support services for a period of less than 24 consecutive hours.

Individuals appropriate for adult day care include those with a safe permanent residence who for some period during the day require a minimum amount of supervision and assistance with personal care, ADLs, health maintenance activities, or other supportive services. Activities of daily living means transfer, ambulation, exercise, toileting, self-administered medication, and similar activities. Health maintenance activities means noncomplex medical care which can safely be performed according to exact directions, which do not require alteration of the standard procedure, and for which the results and client responses are predictable. Personal care means bathing, hair care, nail care, shaving, dressing, oral care, and similar activities.

Assisted Living Facility (ALF)
A facility where shelter, food, and care are provided for remuneration for a period of more than 24 consecutive hours to four or more persons residing at such facility who require or request such services due to age, illness, or physical disability. An assisted living facility does not include a home, apartment, or facility where casual care is provided at irregular intervals, or a competent person residing in such home, apartment, or facility provides for or contracts for his or her own personal or professional services if no more than 25 percent of persons residing in such home, apartment, or facility receive such services. An assisted living facility is not a nursing home and cannot provide complex nursing interventions. Many assisted living facilities are located on the same campus as a nursing facility but they must be physically distinct, separately licensed facilities.

Home Health Agency
A home health agency means a person or any legal entity which provides skilled nursing care or a minimum of one other therapeutic service which include physical therapy, speech pathology, occupational therapy, respiratory care, home health aide services, social work, intravenous therapy, or dialysis.

Nursing Facility (or Skilled Nursing Facility)
Skilled nursing facility means a facility where medical care, nursing care (or skilled nursing care), rehabilitation or related services and associated treatment are provided for a period of more than 24 consecutive hours to persons residing at such facility who are ill, injured, or disabled.

The distinction between a nursing facility or "skilled nursing facility" is merely a term that under federal regulations differentiates provision of rehabilitative care under the federally funded Medicare program vis-à-vis long term care paid privately or by the federally and state funded Medicaid program.

Nursing facilities are a critical component of the continuum of care. Each component may be the most appropriate care setting depending on particular needs of an individual.

Certain individuals are most efficiently, safely, and effectively serviced in a nursing facility, i.e., those who require 24-hour skilled care and supervision. This includes those with more than minimal cog**nitive impairment, those with a severe and persistent mental illness, and those whose level of care, as determined from the most recent assessment, is unstable.**

Diversification of Nursing Facilities

Home and community-based services are lacking in many rural parts of the state. Often times, it is not financially feasible for an individual living in rural Nebraska to independently provide home-based care due to insufficiency of the reimbursement rate to cover often considerable transportation cost caused be large geographic distances among consumers. Nursing facilities have begun diversifying their portfolio of services into assisted living and are increasingly expanding into providing home health care and personal care. Serving as a hub, a nursing facility has better capacity to offer the full continuum of care in-house and in the community due to its employment of a diverse array of health care professionals and with the equipment and resources necessary to establish a critical mass of clients to make such ventures financially feasible. What is needed to expand this diversification is:

- Home and community-based rates that come closer to approximating the cost of delivering services.

- An expanded ability for facilities to transfer/sell unoccupied beds across health planning regions into urban or other areas to free up the capital necessary to invest in development of home and community based services.

LTC Facility Economic Impact

Economic Impact of Nebraska Long Term Care Facilities (Produced by the American Health Care Association [AHCA] in consultation with The Lewin Group. Analysis used Impact Analysis for Planning (IMPLAN) software, Minnesota IMPLAN Group, Inc, 2006 data. Population data: U.S. Census Bureau, http://www.census.gov/)

Long Term Care (LTC) facilities support an estimated $2,692.0 million or 3.7% of the state's economic activity

Economic Impact Definitions

- **Direct Effect** represents the impact (e.g., change in employment or revenues) for the expenditures and/or production values specified as direct final demand changes.
- **Indirect Effect** represents the impact (e.g., change in employment or revenues) caused by the iteration of industries purchasing from industries resulting from direct final demand changes.
- **Induced Effect** represents the impacts on all local industries caused by the expenditures of new household income generated by the direct and indirect effects of direct final demand changes.
- **Total Impact** is the sum of the direct, indirect, and induced effects.
- **Labor Income** is the sum of employee compensation and proprietary income.
- **Long Term Care (LTC) facilities** include nursing homes, assisted living, and other residential care facilities. These facilities do not include government-owned or hospital-based facilities.

Overview

LTC facilities' **direct economic impact** on Nebraska represents…

- 1.6% of economic activity
- 1.5% of labor income
- 2.2% of employment

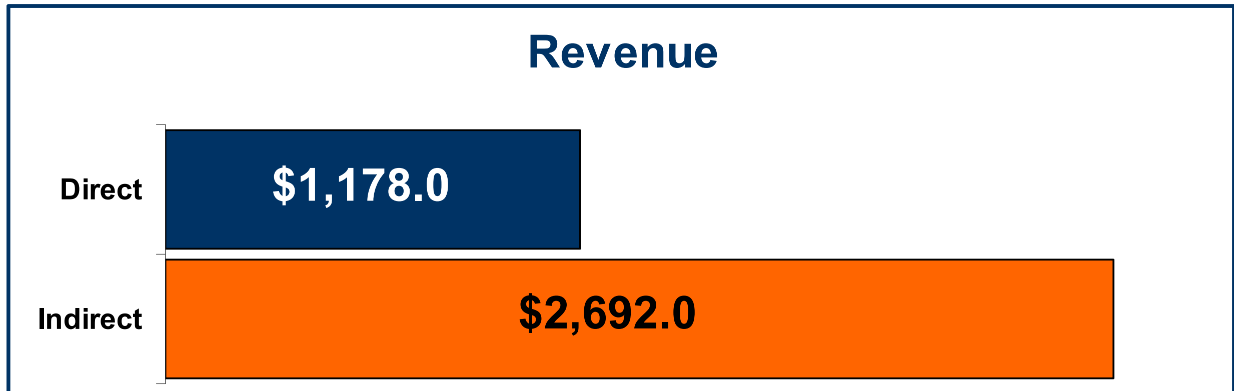
LTC facilities' **total economic impact** on Nebraska supports…

- 3.7% of economic activity
- 2.7% of labor income
- 3.5% of employment

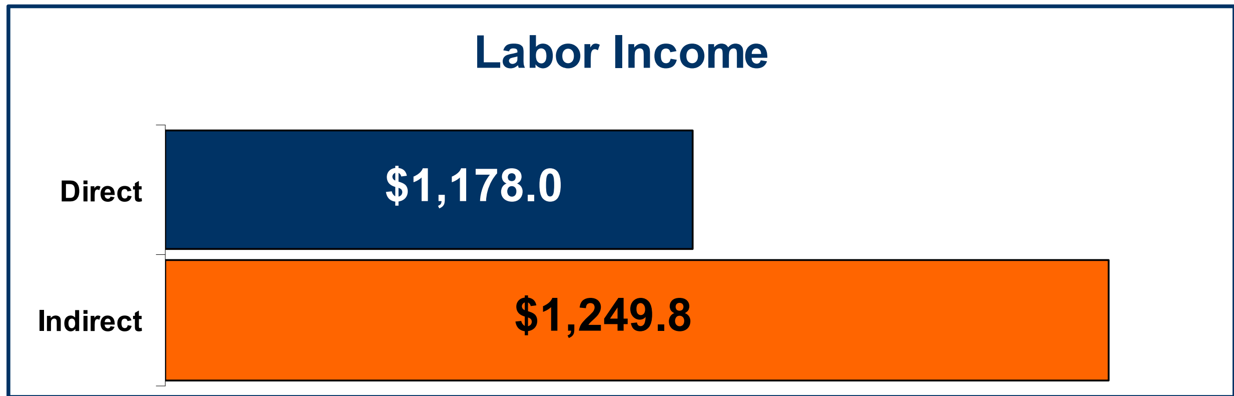
LTC facilities generate $369.5 million in tax revenue…

- $117.2 million in state/local taxes
- $252.3 million in federal taxes

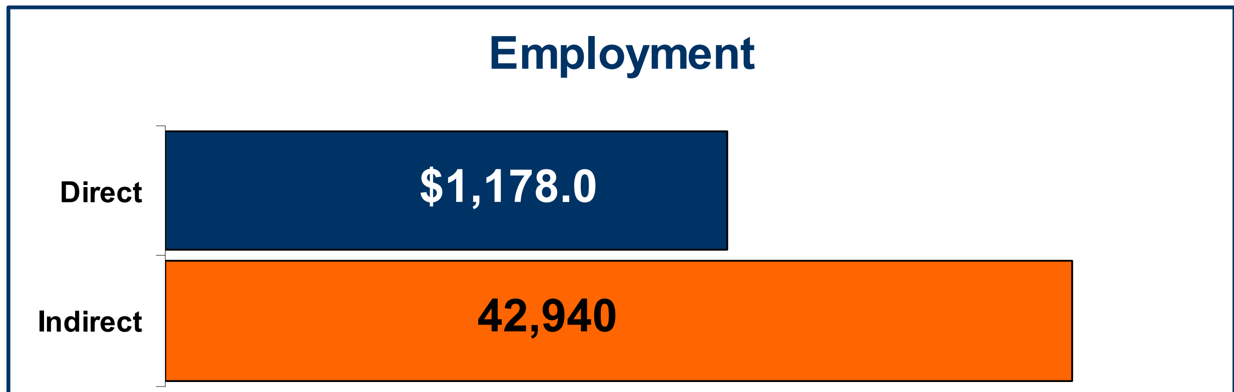
LTC facilities support $2,692.0 million in revenue…



LTC facilities support $1,249.8 million in labor income…



LTC facilities contribute to approximately 42,940 jobs…



Summary: Economic Impact of LTC Facilities

Estimated Impact	Direct	Indirect	Induced	Total	% of Total State Activity
Output (in $ millions)	$1,178.0	$338.6	$1,175.4	$2,692.0	3.7%
Labor Income (in $ millions)	$699.5	$105.1	$445.1	$1,249.8	2.7%
Employment (jobs)	26,570	3,700	12,680	42,940	3.5%
Estimated Impact			**State/Local**	**Federal**	**Total**
Tax (in $ millions)			$117.2	$252.3	$369.5

LTC facilities support other industries and sectors statewide…

Industry/Sector	Estimated Impact	
	Employment (jobs)	Economic Activity (in $ millions)
Health & Social Services	28,430	$1,320.3
Government and Non NAICS[1]	2,500	$290.7
Manufacturing	480	$154.6
Retail Trade	2,210	$124.5
Finance & Insurance	710	$113.6
Accommodation & Food Services	2,040	$90.6
Construction	800	$90.6
Real Estate & Rental	710	$82.6
Professional – Scientific & Technology Services	750	$78.3
All Other Industries	4,330	$346.2
Total[2]	42,940	$2,692.0

1. NAICS: North American Industry Classification System
2. Discrepancy (20 jobs) in total due to rounding

Culture Change

As the general population ages and changes, skilled nursing facilities must evolve too. The baby boomers will not be satisfied with the so-called “rest homes” of their grandparents. Skilled nursing facilities are changing to fit the varying health, social, emotional, and spiritual needs of this new perspective among seniors.

This evolution, or perhaps “revolution,” has already begun. Skilled nursing facilities across the nation are implementing “culture change” by focusing on resident-centered care that recognizes the individual needs of human beings.

“Culture change” turns upside-down the traditional hospital-like nursing facility. Decisions on such issues as personal care, activities, food, and décor are returned to the resident as often as and as much as possible.

Examples of Resident-Centered Culture Change (only a snapshot of many more examples statewide):

- Green House at Tabitha: The Tabitha Green House Project is a new and attractive choice for elders and their families. In May 2006, Tabitha opened Nebraska’s first, and the nation’s second, Green House Project. The Green House transforms the way care is delivered, departing from the traditional nursing home model by bringing long term care into a home setting. Nine people live in the first Green House, each with their own private room and bath. One of the first indications that life in the Green House was significantly different than a traditional nursing home was when one of the elders asked to eat her first meal outdoors on the patio. Her wish was immediately granted. Since then, her love of the outdoors has been served every day that weather has permitted. Why is this remarkable? For years, the same elder was cautioned “never” to go outside alone. Now, because she has the assistive technology that keeps her in touch with the caregivers whenever she is on her own outdoors, she is living on her own terms.

- Memory Support Neighborhood at VHS: Wings of a facility may be transformed into a neighborhood-like concept for residents cared for by a regular team of caregivers. Vetter Health Service’s Highland Park has renovated an Alzheimer’s wing into a neighborhood setting to provide a home-like atmosphere. This enables the facility to take care of residents' medical needs and provide them with an atmosphere that is more like a household, including common living rooms and family-style dining. In other neighborhood settings, residents may be encouraged to bring personal pieces of furniture into their rooms or pick out the color of paint for the walls or wallpaper border. Buffet-style dining is introduced and breakfast, lunch, and dinner hours are extended to satisfy different preferences and appetites. A refrigerator and toaster might be placed in each “neighborhood” allowing for late night snacks and additional freedom.

- **Hillcrest Country Estate "Cottage Living":** Designed to be a beautiful home, these 11 suite cottages include one floor of licensed skilled nursing facility rooms and another floor of independent living, enabling a couple to remain together despite one spouse requiring complex nursing care and the other not. The small size of the cottages promote walking and there is easy access to all areas of the ranch-style home including kitchen, laundry, spa, salon, library, outdoor garden, and lanai. Residents enjoy a private suite and bath, 400 square feet of living area, large windows, large closet and bookcase, 42-inch wall-mounted LCD televisions, fireplace, cable, and telephone. Suites are situated around an inviting common area and large eat-in kitchen.

- **Good Samaritan Sensor Technology:** In addition to providing cottage-style residences and converting large facility wings into a "neighborhood concept," The Evangelical Lutheran Good Samaritan Society is exploring ways to help seniors live at home longer using sensor technology. The technology collects information via sensors that are placed throughout a home in key areas, such as the kitchen, bedroom, bathroom, and doors. The sensors measure movement to assess how well a person is able to complete tasks of daily living. Other sensors can alert staff members to health concerns that require attention. Staff members of Good Samaritan Society – Home Care monitor the sensors' data at the Home Care office. In addition to regular visits, home care staff members will visit the person's home if the sensor information shows that a person might need assistance. Good Samaritan developed the technology in partnership with the University of Virginia and Volunteers of America.

- Across the state residents are now often given the option of when they want to bathe or shower and nurse aides' hours are adjusted to reflect the varying personal-care needs of residents. "Neighborhoods" sometimes schedule their own activities against the facility's regular activity schedule with residents often taking outings to community parks or shopping centers.

- We are seeing the landscaping surrounding facilities reflecting a peaceful garden setting with flower beds, ponds, and waterfalls. Raised gardens may be created to allow residents to continue their hobbies of growing flowers or vegetables. Staff members often bring their pets to work, as cats and dogs roam the halls like any home. Some facilities even begin day-care centers for the children of employees, giving workers peace of mind and the children a houseful of substitute grandparents.

Typical Culture Change Outcomes:

Typical outcomes of resident-directed culture change include decreased usage and costs of psychotropic drugs as depression and boredom of residents ease with the more home-like environment. The new dining styles have helped residents gain weight and decrease the use of supplements, while facilities have saved money since less food is wasted. Residents are generally happier in this environment.

Commonly Asked Statistics

FINANCIAL

- Estimated 2008-09 average annual Medicaid cost per NF resident: $55,473
- Total Statewide NF Medicaid Costs (FY2007): $369 Million
- Percent of NF stays paid by Medicaid (2006-07): 56.4% *(From 2006-07 Medicaid Cost Report)*
- Average NF payment per resident:
  - Daily: $151.98 (2008-09 est.)
  - Annual: $55,473
- Federal match rate (FMAP): Approximately 60%

OCCUPANCY (June 30, 2007, Cost Report):

- Total days served by Nebraska long term care facilities & hospitals: 5,015,692 (13,742 people) (From DHHS Division of Public Health
- Total Medicaid days: 2,569,602 (7040 people) *(From 2006-07 Medicaid Cost Report)*
- Average Length of Stay:

LICENSURE:

- The total licensed beds as of June 26, 2008: 16,988
- Total licensed nursing facilities in Nebraska: 233
- Total licensed assisted living facilities in Nebraska: 280

2006-07 Nursing Facility Occupancy - By County

County Name	Lic Beds	M0-64	M65-74	M75-84	M85+	F0-64	F65-74	F75-84	F85+	Total Occup.	Annual Census Days	Available Census Days	Occup Rate
ADAMS	296	13	12	17	29	16	15	53	86	241	91811	108040	85.0%
ANTELOPE	81		3	4	10	4	2	11	27	61	21837	29565	73.9%
BOONE	115	1	1	11	16	2	6	20	37	94	33829	41975	80.6%
BOX BUTTE	167	1	5	12	13	12	5	35	62	145	53765	60955	88.2%
BOYD	47		1	3	6	1		3	15	29	10864	17155	63.3%
BROWN	46	1	2	5	8		3	4	15	38	13942	16790	83.0%
BUFFALO	395	13	17	27	42	22	10	62	129	322	121080	144175	84.0%
BURT	156	5	6	10	17	4	8	18	60	128	43816	56940	77.0%
BUTLER	144	8	4	8	20	2	3	28	45	118	46704	52560	88.9%
CASS	184	6	5	13	10	4	19	35	58	150	52358	67160	78.0%
CEDAR	168	2	3	17	19	4	5	18	56	124	46021	61320	75.1%
CHASE	91	1	1	8	14	3	7	10	25	69	23505	33215	70.8%
CHERRY	58	1	2	5	8	1	3	9	19	48	16867	21170	79.7%
CHEYENNE	104	2	4	10	7	1	6	19	34	83	29413	37960	77.5%
CLAY	116	5	4	10	9	10	7	15	37	97	34828	42340	82.3%
COLFAX	109	4	2	10	6	3	3	23	33	84	27738	39949	69.4%
CUMING	141	3	6	9	22	2	10	15	40	107	39333	51465	76.4%
CUSTER	218	21	13	12	15	10	10	25	71	177	65601	79570	82.4%
DAKOTA	196	11	11	10	21	9	11	17	61	151	57103	71540	79.8%
DAWES	105	2	3	4	5	1	7	12	34	68	26353	38325	68.8%
DAWSON	234	6	4	16	19	9	10	30	66	160	58763	85410	68.8%
DEUEL	24			1	3	1	2	2	11	20	7041	8760	80.4%
DIXON	91	7	5	4	7	1	7	7	36	74	27293	33215	82.2%
DODGE	623	27	20	48	58	21	33	82	216	505	191651	227395	84.3%
DOUGLAS	2954	263	181	239	167	245	204	439	680	2418	900459	1099018	81.9%
DUNDY	55	1	1	2	5	1		7	17	34	12365	20075	61.6%
FILLMORE	164	5	1	9	14	3	6	22	71	131	47806	59860	79.9%
FRANKLIN	85	4	4	6	6	5	4	16	19	64	23641	31025	76.2%
FRONTIER	0									0	5364	8704	61.6%
FURNAS	92		2	7	8	2	5	21	35	80	29348	33942	86.5%
GAGE	341	5	14	37	25	9	16	52	125	283	99410	124894	79.6%
GARDEN	40	1	4		4		1	5	11	26	9738	14600	66.7%
GARFIELD	50			4	1	3	3	6	15	32	13475	18250	73.8%
GOSPER	47			2	8	1	4	9	7	31	13013	17155	75.9%
GREELEY	59			7	7		1	10	25	50	18059	21535	83.9%
HALL	790	35	35	104	83	18	42	103	164	584	214213	286928	74.7%
HAMILTON	157		1	12	15	4	4	35	66	137	49842	57305	87.0%
HARLAN	53	1	2	4	8	1	4	3	14	37	13752	19345	71.1%
HITCHCOCK	40			5	4	1	3	5	16	34	11413	14600	78.2%
HOLT	190	5	6	12	16	5	6	19	81	150	59276	69350	85.5%
HOOKER	31			1	5			3	12	21	7658	11315	67.7%
HOWARD	48	1	1	3	3	1	3	2	21	35	14404	17520	82.2%

County Name	Lic Beds	M0-64	M65-74	M75-84	M85+	F0-64	F65-74	F75-84	F85+	Total Occup.	Annual Census Days	Available Census Days	Occup Rate
JEFFERSON	139	2	3	8	11		2	19	65	110	39090	50735	77.0%
JOHNSON	67		1	8	4	2	2	15	28	60	22080	24455	90.3%
KEARNEY	87	1	5	9	10	5	6	16	23	75	26113	31755	82.2%
KEITH	82	1	2	2	8	3	2	7	22	47	19011	29930	63.5%
KIMBALL	49			4	8	2	1	4	25	44	15013	17885	83.9%
KNOX	228	7	2	14	17	6	7	42	77	172	66183	84312	78.5%
LANCASTER	1426	69	53	124	124	64	96	245	412	1187	432607	518680	83.4%
LINCOLN	324	5	7	27	30	10	14	69	134	296	109190	118260	92.3%
MADISON	637	30	13	64	83	24	22	90	200	526	195616	232505	84.1%
MERRICK	110	8	4	6	5	12	6	13	44	98	35765	41242	86.7%
MORRILL	94	2	3	5	2	5	6	15	41	79	26881	34310	78.3%
NANCE	120	23	10	6	6	10	9	15	23	102	39183	43800	89.5%
NEMAHA	102	2	5	8	5	1	4	20	44	89	31608	37230	84.9%
NUCKOLLS	120	2	1	6	10	3	1	13	44	80	27117	43800	61.9%
OTOE	268	6	9	21	32	13	12	50	91	234	84046	98182	85.6%
PAWNEE	64	2		9	2	2	3	7	26	51	18864	23360	80.8%
PERKINS	50	1	2	1	1	2	3	2	26	38	15461	18250	84.7%
PHELPS	190	5	3	16	10	4	4	34	64	140	55229	69350	79.6%
PIERCE	114	5	8	7	15	5	4	17	36	97	35667	41610	85.7%
PLATTE	197	8	4	15	24	12	10	39	70	182	69470	71905	96.6%
POLK	110		2	13	13	4	4	24	45	105	36560	40150	91.1%
RED WILLOW	120	2	2	13	19	2	2	19	44	103	37836	43800	86.4%
RICHARDSON	240	6	5	8	14	4	6	31	64	138	55133	87600	62.9%
ROCK	30			2	2	1	2	3	14	24	8817	10950	80.5%
SALINE	264	13	9	32	26	7	13	45	67	212	79311	96360	82.3%
SARPY	513	11	19	54	54	12	24	82	183	439	147339	169695	86.8%
SAUNDERS	233	7	8	22	20	7	14	42	80	200	69947	85709	81.6%
SCOTTS BLUFF	441	12	14	39	57	15	28	71	131	367	134140	160965	83.3%
SEWARD	290	23	9	24	19	26	21	27	48	197	75055	106574	70.4%
SHERIDAN	89	2	3	9	17	3	3	13	28	78	30221	32485	93.0%
SHERMAN	64		4	4	2		3	17	20	50	19739	23360	84.5%
STANTON	70	2	1	4	3		6	14	25	55	20233	25550	79.2%
THAYER	179	17	12	12	14	10	13	18	57	153	56015	65335	85.7%
THURSTON	67	10	4	4	5	6		8	13	50	18454	24455	75.5%
VALLEY	70		2	5	4		2	13	21	47	16168	25550	63.3%
WASHINGTON	180	7	3	10	20	6	7	30	70	153	56236	65700	85.6%
WAYNE	60		3	6	12	2	2	11	15	51	18226	21900	83.2%
WEBSTER	105	1	2	1	19		2	15	43	83	31241	38325	81.5%
YORK	171	2	8	14	20	5	12	27	70	158	56075	62415	89.8%
	16,869	755	631	1,364	1,510	737	876	2,552	5,185	13,610	5,015,692	6,170,804	81.3%

M = Male F = Female

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