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DEPT. OF HEALTH AND HUMAN SERVICES

LR 442
Appropriations Committee
October 19, 2018

Dr. Matthew Van Patton, Director
Division of Medicaid and Long-Term Care
Department of Health and Human Services

Good morning, Chairman Stinner and members of the appropriations committee. My name is Dr. Matthew Van Patton (M-A-T-T-H-E-W V-A-N P-A-T-T-O-N), and I serve as the Director of the Division of Medicaid and Long-Term Care within the Department of Health and Human Services here in the state of Nebraska. Thank you Mr. Chairman for inviting me here today to provide information related to LR 442, a study resolution looking at funding for long-term care providers, specifically skilled nursing and assisted living facilities.

Before I offer comments on the current payment methodology for skilled nursing facilities, I would like to note the place skilled nursing and assisted living facilities hold within the continuum-of-care. Included in our submitted documents, exhibit A, is a chart illustrating the full continuum-of-care. You will note the continuum runs along a bell curve which is divided into two sides - the acute and post-acute. Along the line, you will note the various care venues that define the continuum. Venues rising along the curve reflect increases in acuity, or level of care. Proper coordination of care and communication between providers is essential to maintaining continuity of care for patients as they transition from venue to venue along the continuum, thus ensuring safety, quality, and overall patient satisfaction.

While most services are delivered to Nebraska Medicaid members through the Heritage Health program, long-term care services, including the per diem payments made to skilled nursing facilities, are paid directly by the state using rates based on actual facility costs. According to national Medicaid data, Nebraska's spend, per skilled nursing facility resident, was above the national average of $175.41, at $180.22, and ranks 27th across all states. Regionally, Nebraska is consistent with neighboring state's per resident spend, with Iowa at 16th, Wyoming at 24th, Missouri at 26th, South Dakota 31st, Minnesota 32nd, Kansas 34th, and Colorado 39th.

Nebraska's regulations require the department to set payment rates annually for facilities on a defined cost-based methodology. Because each facilities cost are different, this methodology produces a significant range in payments to Nebraska's skilled nursing providers. In the current state fiscal year, the rates range from a facility per diem of $119.73 to $241.09. Given the methodology is based on cost, it can produce higher rates for less efficient operators. Furthermore, the methodology has no tie to the quality of services provided.

As the Director, I am very focused on the value of the buy Medicaid makes within the market place, quantified in terms of cost and consequences (quality bought or outcomes achieved). The federal Centers for Medicare and Medicaid Services, or CMS, has developed at five-star rating system for evaluating the quality of the nation's skilled nursing facilities. There is an overall five-star rating for each skilled nursing facility, and a separate rating for health inspections, staffing, and sixteen different physical and clinical quality measures. More information on the CMS star rating system is available at cms.gov.

In May of 2018, I asked our policy and communications team to perform an analysis of the star ratings corresponding to each of Nebraska's skilled nursing facilities. I then asked that those facilities be group according to their star ratings and an average of the per diem rates be tabulated for facilities within their respective star ratings group. In exhibits B and C, you are presented with pie charts detailing our findings. These charts reflect rates and ratings for 2017 and 2018. As you can see, nearly half of Nebraska's skilled nursing facilities are performing at a four- and five-star level, while the other half are performing at a three-,

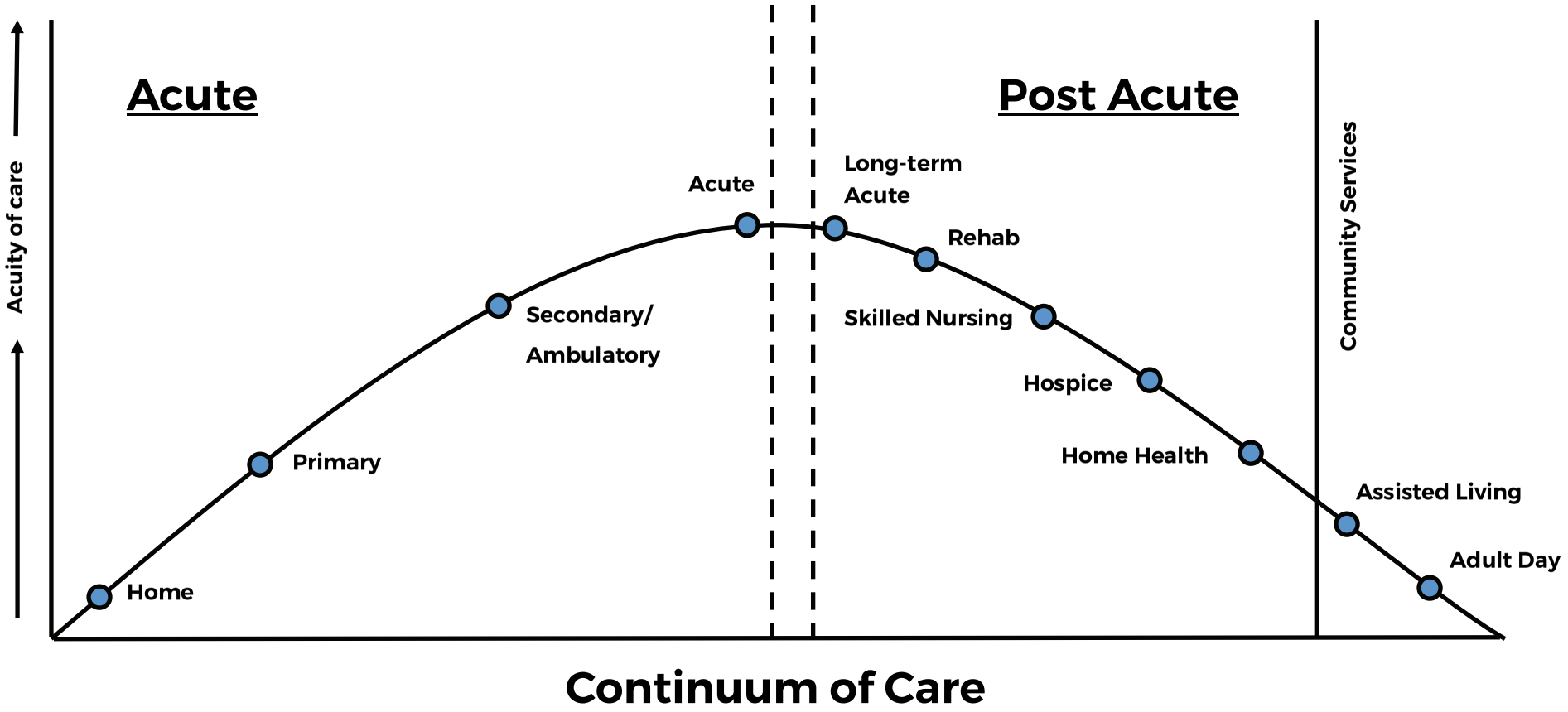
two-, and one-star level. From this data we can make two conclusions: one, we have a quality chasm; and two the delta between our top-quality performers, those at a five-star level, and our lowest-quality performers, those at a one-star level, provides very little incentive for providers to maintain quality or to improve. While not a perfect system, CMS star ratings have created a nationally recognized and industry accepted market assessment tool that is accessible to all.

Now equipped with this market knowledge, I believe the state of Nebraska has an opportunity to release the skilled nursing industry and Medicaid from the regulatory constraints of an outdated payment system that prohibits innovation and market adaptability. While providers have raised concerns regarding the cost-based methodology over the years, there has not been consensus on what changes need to be made. As a result, the methodology has been largely unchanged for decades. Highlighted in the 2018 DHHS Business Plan is the Medicaid division's plan to change the current cost-based methodology to a pay-for-performance model. We believe such a model would provide greater predictability for the state and provider community, while simultaneously rewarding top performers and incentivizing lower performers to improve.

I would also like to note for the committee work done by my staff with CMS and the Nebraska Health Information Exchange, or NeHII. We are partnering with NeHII to provide skilled nursing providers in Nebraska cost-free access to NeHII data for at least three years. We are drafting the advanced planning documents now in preparing for submission to CMS for review. With 70% of all Nebraska hospitals and 100% of pharmacies pushing data into the exchange, expanding access to the post-acute care skilled nursing environment represents a monumental step forward in improving quality and coordination of care across the continuum. Access to admission, discharge, and transition data, including the medication administration record, is paramount to sound continuity of care during patient transitions. Hospitals are keenly interested in ensuring high quality of care is delivered in skilled nursing facilities to which they refer and transition patients, as the Medicare readmission rule penalizes hospital providers for readmissions within 30 days of discharge. This federal policy change has pushed greater care coordination across the continuum of care, as well as heightened the importance of quality in the marketplace. Our work with NeHII will benefit the entire continuum-of-care in Nebraska, specifically improving the patient experience, provider experience, improving the health of populations, and reducing the per-capita cost of healthcare by helping to avoiding costly readmissions and reducing medical errors.

In closing, the market dynamics faced by skilled nursing providers are complex and multifaceted. Payer mix, patient mix, referral systems, population density, and adequacy of work force are just a few of the considerations faced by skilled nursing administrators across the state and nation. Another dynamic in the market rest with the rise of services utilized in the home setting rather than skilled nursing facility. Home- and community-based services are increasing in utilization and are often preferred by patients and their families. Home care allows seniors to age in place with the resources of family and other supports wrapped around daily care needs. In Nebraska we see increasing utilization of home- and community based services, which we believe is reflected in current nursing home occupancy rates. This is shown in the chart labeled exhibit D. Our most recent data shows a state-wide nursing facility census of 72%, with one county having an average census of only 34%. This information, by county, has also been provided to you as exhibit E. Lastly, I will note our State Unit on Aging is currently conducting a state-wide study of our home- and community-based services infrastructure. I expect the report to be completed by the end of this year.

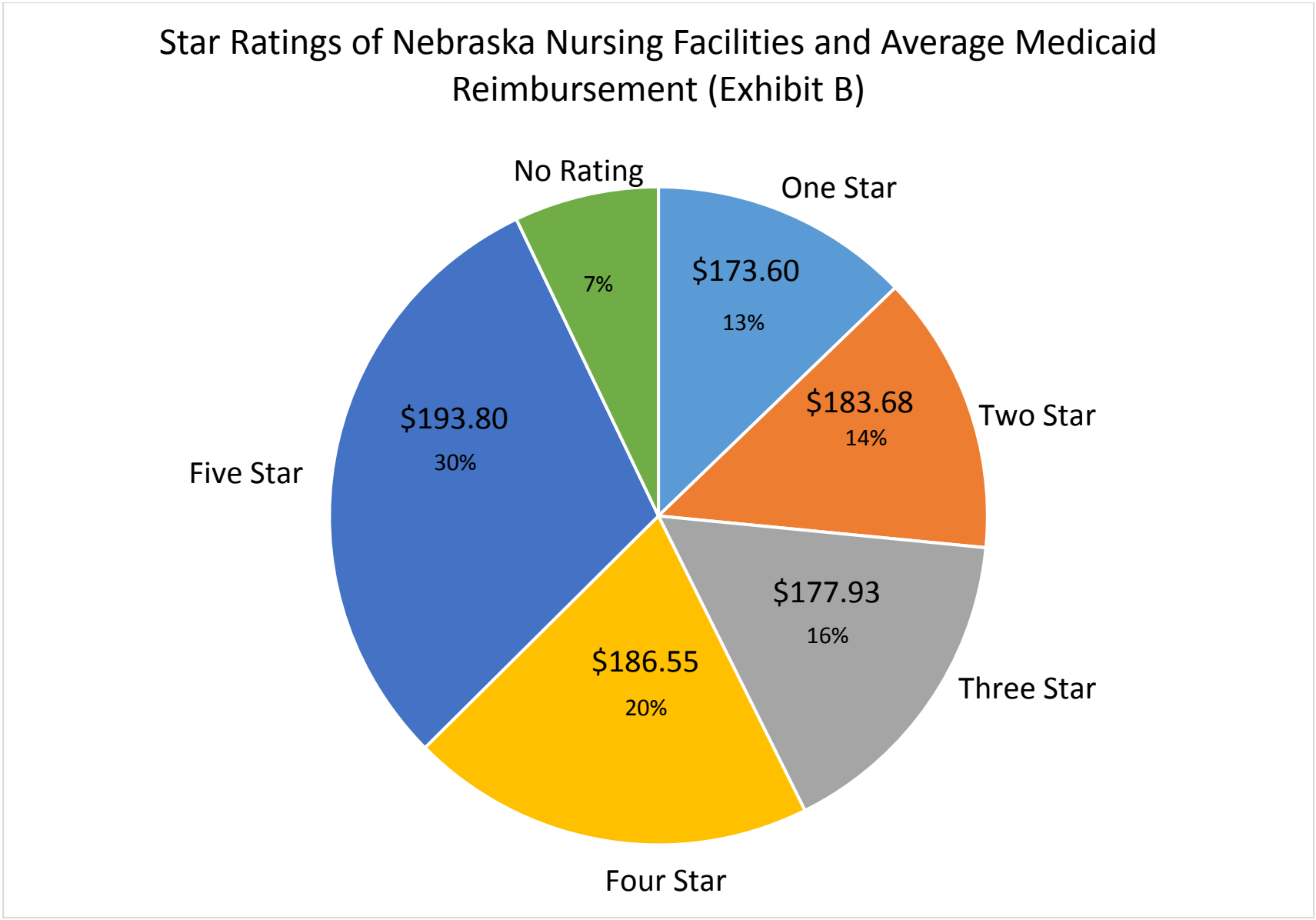
Thank you, Mr. Chairman, and members of the committee. I appreciate the opportunity to share insight and perspective related to LR 442. I am happy to answer any questions.



Challenges:

- Scheduling and placement dictated by capacity and volume.
- Access to complete records by providers at the needed point of recall.
- Records retained by providers are not accessible across the continuum of care.

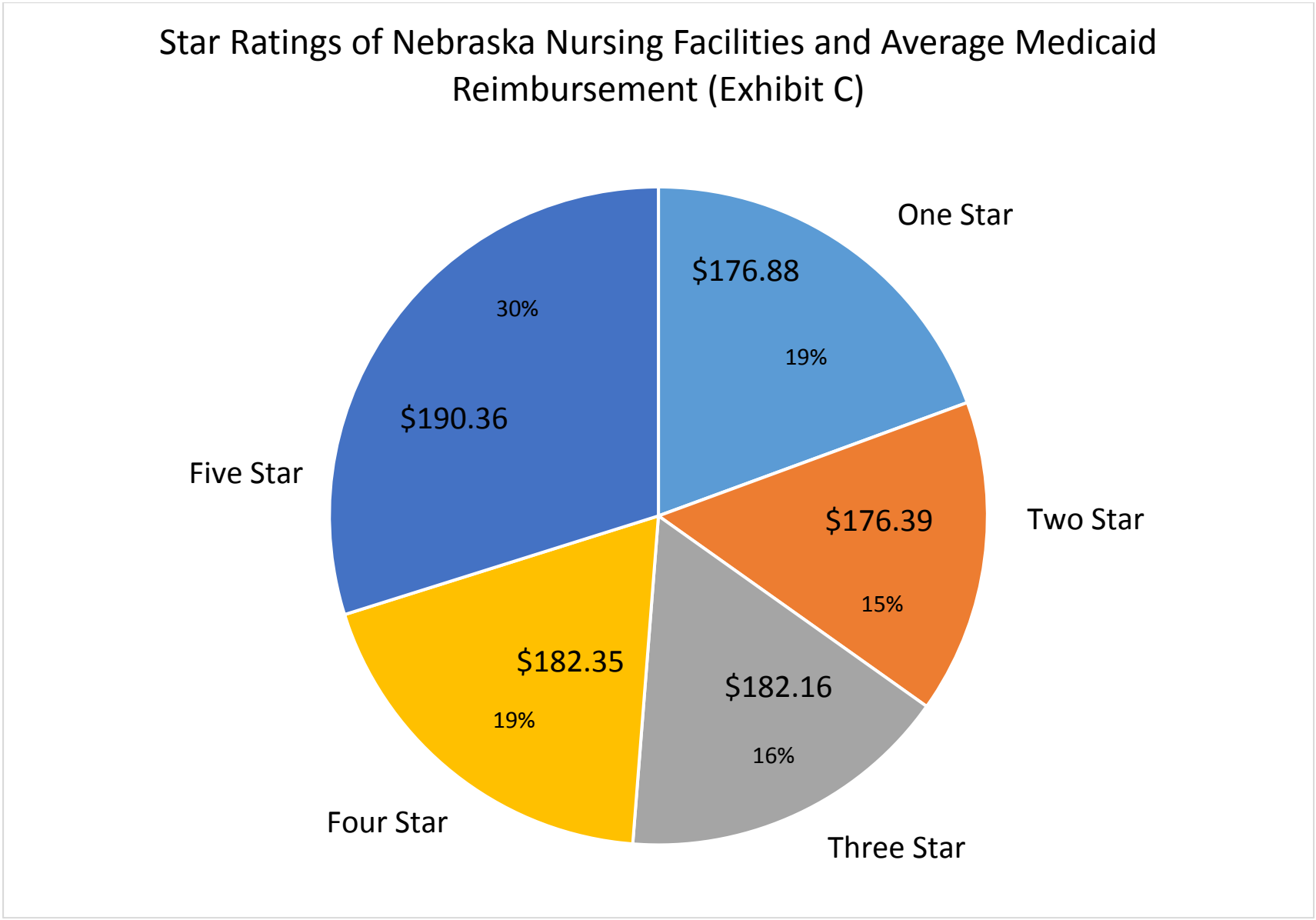
Exhibit A



Note: Only nursing facilities with CMS star ratings are included on this chart. Data is current as of April 2018.

There is a $20.20 difference between the average per diem of one star and five star facilities.

Sources: Nebraska Medicaid and medicare.gov



Note: Only nursing facilities with CMS star ratings are included on this chart. Data is current as of September 2018.

There is a $13.48 difference between the average per diem of one star and five star facilities.

Sources: Nebraska Medicaid and medicare.gov

Exhibit D

Type of Provider	Medicaid Patients			
	1999	2004	2018	Percentage Change
Nursing Facilities	16,487	11,109	6,284	- 62%
HCBS*	3,219	6,265	7,288	+ 126%

Type of Provider	Expenditures (Millions)		
	2001	2006	2017
Nursing Facilities	$370	$347	$323
HCBS*	$37	$67	$99.3

*The number is the total for the aged and disabled waiver, the traumatic brain injury waiver, and clients receiving personal assistance services. It does not include the HCBS waivers administered by the Division of Developmental Disabilities. An additional 4,712 Nebraskans are served by those waivers.

Sources: State Long-Term Care Reform in Nebraska, AARP Public Policy Institute, 2008; Nebraska Medicaid Annual Report, 2017; Nebraska Medicaid.

Occupany Rate Study for Medicaid Beds
December 2017 (Exhibit E)

COUNTY	Occupancy Rate
ADAMS	55%
ANTELOPE	69%
BOONE	72%
BOX BUTTE	62%
BOYD	76%
BROWN	34%
BUFFALO	79%
BURT	43%
BUTLER	76%
CASS	78%
CEDAR	68%
CHASE	73%
CHERRY	67%
CHEYENNE	61%
CLAY	83%
COLFAX	54%
CUMING	72%
CUSTER	64%
DAKOTA	73%
DAWES	54%
DAWSON	72%
DIXON	71%
DODGE	69%
DOUGLAS	75%
DUNDY	49%
FILLMORE	86%
FRANKLIN	53%
FURNAS	78%
GAGE	83%
GARDEN	70%
GARFIELD	81%
GOSPER	60%
HALL	76%
HAMILTON	75%
HARLAN	73%
HITCHCOCK	74%
HOLT	68%
HOOKER	80%
HOWARD	83%
JEFFERSON	61%
JOHNSON	76%

COUNTY	Occupancy Rate
KEARNEY	76%
KEITH	53%
KIMBALL	80%
KNOX	60%
LANCASTER	75%
LINCOLN	77%
MADISON	79%
MERRICK	78%
MORRILL	63%
NANCE	85%
NEMAHA	62%
NUCKOLLS	72%
OTOE	66%
PAWNEE	64%
PERKINS	62%
PHELPS	86%
PIERCE	56%
PLATTE	62%
POLK	76%
RED WILLOW	79%
RICHARDSON	53%
ROCK	73%
SALINE	69%
SARPY	79%
SAUNDERS	83%
SCOTTS BLUFF	78%
SEWARD	86%
SHERIDAN	64%
SHERMAN	78%
STANTON	89%
THAYER	64%
THURSTON	77%
VALLEY	65%
WASHINGTON	74%
WAYNE	54%
WEBSTER	63%
YORK	85%
TOTAL	**72%**

Sources: Provider Reported (QAA Reports)