

**June, 1989**

**Case Mix Reimbursement and the  
Nursing Home Resident  
in New York State**

**Suggestions for Change**

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*Funding for this project has been given by:*

The Robert Sterling Clark Foundation

The New York State Legislature

The Commonwealth Fund

The New York Community Trust

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## INTRODUCTION

On January 1, 1986, a new nursing home Medicaid reimbursement system began in New York State. Called RUGs - Resource Utilization Groups - it is a case-mix system that determines direct patient care costs.\* Direct costs include nursing, activities, social services, therapy, pharmacy as well as nursing administration. RUGs attempts to price the amount of direct care resources needed by each resident and to pay facilities a rate based upon the expected cost of these resources.

This system involves the use of 16 different care categories, each carrying a different price based upon differing needs of medical, nursing and staff time costs. Residents are assigned to one of these categories by the use of an assessment tool.

One goal of this system is to relate the reimbursement rate that a facility receives to the nursing home resident's present medical needs. Each resident is assessed every six months and reassigned to a new category if the assessment indicates a change. Another goal is to relate the reimbursement rate to the individual resident care costs rather than to the type of facility where the care is given. Thus, after taking regional differences into account, facilities caring for the same medically needy residents should receive the same direct care Medicaid reimbursement.

Prior to the introduction of RUGs, voluntaries, "not for profits", in New York State were receiving about 25% more reimbursement than proprietaries, "for profits". However, according to the first resident assessment, both voluntaries and proprietaries were caring for the same type of resident in terms of care needs.

RUGs attempted to equalize the system - to pay facilities based upon the needs of the residents they were caring for. There were two ways this could have been done: one was to raise the amount proprietaries received to the level of that of the voluntaries, that is, to hold the voluntaries "harmless;" or two, to lower the level of reimbursement given to the voluntaries and raise that given to the proprietaries. The latter course was chosen. This decision had the effect of shifting large quantities of money from the voluntary sector to the proprietary sector and, as we will see later, greatly affected the future activities of the voluntaries.

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\* Direct care accounts for between 40 and 60 percent of the total reimbursement rate. The remainder includes three other cost components: indirect (30 to 50 percent, e.g., laundry, housekeeping, general administration; non-comparable (2 to 3 percent, i.e., those services not available at all facilities such as laboratory, dental, radiology); and capital (5 to 7 percent, e.g., land, property, furniture).

RUGs included what are called "efficiency incentives" to give facilities an incentive to manage more efficiently. Advocates call these profit motives. Actual monies reimbursed varies from the price in a number of ways:

1. If a facility spends less than a base, or minimum, price set for each category, it will be allowed to keep the difference between the base and the actual expenditure. This will result in a profit.
2. If a facility spends more than the norm set for each category, it will be given only its actual cost, up to a ceiling, or maximum, rate. If the cost of care is above the ceiling rate, the facility will face a loss.

While RUGs was developed with the aim of creating an efficient and effective care system that related the reimbursement rate to the actual care needed and delivered, it has a number of built-in incentives which might negatively impact on resident care.

1. RUGs pays more for sicker residents.

Facilities are encouraged to admit only the sicker patient and have little incentive to get residents better or help them maintain themselves at their present level.

2. RUGs pays more the more dependent a resident is.

There is no incentive to promote independence.

3. RUGs allows facilities to make profits or cut losses in the direct care services by spending less than they receive.

Profits can be made and losses cut by admitting sick residents without hiring the staff or incurring the additional expenses necessary for their care.

The Nursing Home Community Coalition of New York State (NHCC)'s study is based upon three years of monitoring the effects of RUGs on the care of nursing home residents in New York State. This monitoring effort and the final report it generated were made possible by grants from the Robert Sterling Clark Foundation, the New York State Legislature (Assembly Health and Aging Committees), the Commonwealth Fund and the New York Community Trust.

The following report discusses NHCC's findings and makes recommendations for changes to better protect the state's frail elderly.

## NHCC STUDY\*

In 1988, NHCC conducted a study of the impact of RUGs on resident care. A series of questionnaires were designed to gather first-hand knowledge of this impact. The following organizations participated in the development and distribution of the questionnaires:

Alzheimer's Disease and Related Disorders Association;  
Coalition of the Institutionalized Aged and Disabled (CIAD);  
Friends and Relatives of Institutionalized Aged (FRIA);  
Local 1199 - Union of Hospital and Nursing Home Workers;  
Nassau County Long Term Care Ombuds Program;  
National Association of Social Workers - NYC Chapter;  
New York State Nurses Association;  
200 A - Service Employees International Union AFL-CIO; and  
SUNY - Old Westbury Gerontology Concentration

The questionnaires were sent to those individuals who either live in, work, or visit regularly in nursing homes in New York State. Thus, questionnaires were distributed to nursing home residents, relatives, nurses, aides, social workers and ombudspeople.

NHCC looked into the relationship between RUGs and the following issues: staff needs, use of restraints, resident rights, encouragement of independence, staff training, the accuracy of the patient assessment tool, the adequacy of supplies and the morale of staff.

Approximately 7,500 questionnaires were sent out across the state. 1,259 questionnaires were returned from primarily residents, nurses, aides and social workers. Each questionnaire asked the respondent to compare his/her experiences pre and post RUGs. The results indicate some alarming trends:

### Staff Needs

The information gathered by the questionnaires indicate that there may not be enough staff available for the sicker resident being cared for. Large numbers of the nurses, residents, and social workers who responded believe that, even though the nursing home population has gotten sicker, the amount of staff has either stayed the same or has even decreased. Of even greater concern, most of the aides (91%) that responded did not believe that they had the time to get residents up, fed and ambulated. Twenty-one percent of the aides got their residents up between 4 and 5 am to get them ready for breakfast in the morning. Many aides (76%) stated that they did not have the time to do exercises to prevent contractures. Many residents (30%) did not believe that staff had enough time to discuss care with a resident or relatives or even to give care at all.

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\* For a full copy of the study contact NHCC.

### Restraints

Advocates are concerned that if facilities do not hire the staff needed, they will use physical restraints (devices that control body movement) or chemical restraints (medication that controls moods and behavior for staff convenience) as substitutes. The information received indicate that both physical and chemical restraints are on the rise. Forty-two percent of the nurses, 32% of the aides and 25% of the social workers believe that there has been a rise in the use of these restraints since RUGs began.

### Resident Rights

Some nursing homes are restructuring their floors to accommodate different categories of RUGs groups. The questionnaire asks questions relating to resident rights under such situations. Large numbers of residents who responded stated that they were being moved from room to room and floor to floor. Almost one-half stated that the move was not explained to them, no special attention was given and they had not agreed to the move.

In addition, although under New York State regulations, every resident has the right to know her/his RUG category, almost 50% of the residents responding stated that RUGs had not been discussed with them.

### Encouragement of Independence

Almost one-third of the residents, nurses and social workers believe that there is a lack of encouragement of independence or that there has been a decrease in such encouragement since RUGs began.

### Staff Training

Most of the staff who responded believe that they are well trained.

### Accuracy of the Assessment Tool

Fifty-eight percent of the nurses believe that the admitting RUGs categories were inaccurate.

### Adequacy of Supplies

Seventy-four percent of the aides who responded believe that their institution is inadequately supplied.

## Morale of Staff

Results indicate that social workers feel overwhelmed (75%) and believe they have too much paperwork (25%). Aides believe they need more time to care for the residents.

These results raise the following questions:

1. Are facilities hiring enough staff as the resident population is getting sicker?
2. Are restraints being used as a substitute for staff?
3. Are residents being encouraged to be more dependent in order to add more revenue?

State Health Department data on expenditures and population changes help to answer these questions.

## ANALYSIS OF STATE DATA 1986 AND 1987\*

In order to examine the impact of RUGs on the nursing home system during its first two years of implementation, the State Health Department selected a representative sample of 330 nursing facilities to evaluate. The sample was selected randomly with the following stratified characteristics: sponsorship - proprietary, voluntary and public; bed size - over 300 beds and under 300 beds; location - upstate, NY suburban and NYC; and, corridor position - comparison of costs to average, maximum and minimum prices set.\*\* The sample reflected the overall proportion of the different strata to the total facilities in the state. Below are the results.

### Changes in Nursing Home Population

#### Case Mix Change

The data demonstrates that the State's nursing home population has gotten sicker. The case mix index, or severity of care needs of the nursing home population, in New York State rose 6.4% in 1986 and 4% in 1987. The nursing home population is changing: it is sicker and more frail.

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\*This is the most recent data available.

\*\*This report does not include discussion of corridor positions.

### Sponsorship Differences:

The voluntaries have clearly tried to cut the losses they incurred from the original redistribution of the money in the system by accepting sicker residents as quickly as possible. The case mix of the voluntaries went up 8.5% in 1986 compared to 6.2% for the proprietaries and 4.3% for the publics. By 1987, it was the proprietaries that raised its case mix the highest. Their case mix was increased by 5.15% compared to 4% for the voluntaries and 1.9% for the publics. The publics started with the highest case mix; they were taking the residents no one else would prior to RUGs -the heavy care resident - and thus could not continue to raise its case mix at a similar pace.

### Regional differences:

In New York City, where there are so many large voluntaries, the case mix increased by 9.13% in 1986. Suburban areas of Metropolitan New York City increased its case mix 5.42% and Upstate New York increased its case-mix 4.92%. In 1987, New York City increased its case mix 5.0%, Suburban New York 3.09% and Upstate 4.04%.

### RUG Category Prevalence Changes in Nursing Homes

In 1986, there were significant increases in residents falling into the rehabilitation, special care and clinical categories, which are the highest paying categories, and decreases in the lower paying, lighter care resident; in 1987, there were continued significant increases in residents falling into rehabilitation, special care and clinical categories, and continued decreases in the lighter care resident, especially those with behavioral problems. This is true across the state.

### Regional Differences

In New York City, there were large decreases in the number of the lightest care residents (dropping over 60%) and residents with behavioral problems. Suburban New York differs from other parts of the state only in its increase in dependent residents with behavioral problems. Here too, increases were found in rehabilitation residents, clinically complex residents and decreases were found in the lightest care residents. Upstate New York was similar to New York City with smaller increases and decreases.

Clearly, the system is squeezing out the residents falling into the four lightest care categories. This is leading to serious access problems for the lightest care patient. Many lighter care

individuals who are eligible for nursing home care cannot get into a nursing home; they are backing up in hospitals where they do not belong and cannot get the care and social supports they need. Data from discharge planners in hospitals indicates that while the length of stay for the heavy care residents has dropped, the length of stay for the lighter care resident has gone up significantly more. Many advocates are concerned that the lighter care resident may find herself/himself inappropriately sent home or to an adult home where she/he will be at risk.

#### Revenue and Expenditure Analysis\*

This analysis discusses both the direct (which is determined by case mix) and the indirect (which is unaffected by case mix) portions of each facility's rate. The direct costs consist of nursing services, nursing administration, activities, social services, transportation, therapy, and pharmacy. The indirect costs consist of administration, plant, grounds, security, laundry, housekeeping, patient food, cafeteria, medical records, and medical education.

#### Profits and Losses

As the population gets sicker and more dependent, there are indications that facilities may not be hiring appropriate numbers of staff to care for their changing population. In 1986, overall, facilities in New York State made a profit of almost \$9 million. They accomplished this by admitting sicker residents, increasing their direct care revenue and not spending enough for nursing, therapy, pharmacy or nursing administration. In fact, they took in \$16.5 million more in direct care revenue than they expended in those direct care costs. This trend continued in 1987. Facilities admitted sicker residents and took in more in direct care revenue (\$20.5 million) than they expended in direct care costs. Statewide, the facilities kept their losses to \$10.5 million by using direct care revenues. Combined with the staffing data collected on NHCC's questionnaires discussed above, this raises serious concerns. Are there enough staff in the nursing homes?\*

Hospital based facilities (38 statewide) show a different picture: they expended more in direct care areas than they received in revenue in both 1986 and 1987.

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\*Most of this discussion does not include hospital based facilities unless specifically noted. There are only 38 such facilities in New York State.

\*\* Although the nurse shortage is adding to this problem, in many areas of New York State, particularly in New York City, there are many aides looking for work.

### Sponsorship Differences

There were significant differences depending upon sponsorship.

In 1986, the first year of RUGs implementation, proprietary facilities, with a case mix rise (rise in severity of resident care needs) of 6.2%, made a profit of \$9.8 million by taking in \$7.5 million more in direct care revenue than they expended; in 1987, with a case mix rise of 5.15%, they made a profit of \$13.9 million by taking in \$16 million more in direct care revenue than they expended.

In 1986, voluntary facilities, with a case mix rise of 8.5%, made a profit of \$1 million by taking in \$5.5 million more in direct care revenue than they expended; in 1987, with a case mix rise of 4%, kept their losses to \$15.7 million because they used \$3.8 million of their direct care revenue to offset their losses.

The public facilities were the only facilities that expended more in both direct and indirect costs in both years. In 1986, with a case mix rise of 4.3%, they lost \$2.5 million; in 1987, with a case mix rise of 1.9%, lost \$8.7 million. Compared to the voluntaries and the proprietaries, public facilities always had a high case mix; they accepted the residents nobody else would, and prior to RUGs, these were the heaviest care residents. Thus, they could not increase their direct care revenue as much as the proprietaries and the voluntaries.

### Regional Differences

There are significant regional differences.

In New York City, in 1986, with a large case mix rise of 9.13%, facilities made a profit of \$18.7 million by taking in \$14 million more in direct care revenue than they expended; in 1987, with a case mix rise of 5%, New York City facilities made a profit of almost \$10 million by taking in \$20.7 million more in direct care revenue than they expended.

In Suburban New York, in 1986, with a case mix rise of 5.42%, facilities lost \$4.4 million; in 1987, with a case mix rise of 3.09%, facilities lost \$7.6 million. In both years they expended all or more in direct care costs than they had taken in.

In Upstate New York, in 1986, with a case mix rise of 4.92%, facilities lost \$5.9 million; in 1987, with a case mix rise of 4.04%, facilities lost \$12.8 million. In both years they expended more in direct care costs than they had taken in.

Thus, facilities in New York City, which house one-half the nursing home residents in New York State, admitted much sicker residents and received increases in money to care for them. These facilities then used the extra money to make profits or to lower their losses rather than expending the additional revenues to meet the needs of the sicker resident population.

### Specific Expenditures

How the facilities spend the money they received for the costs of caring for sicker residents also indicates some dangerous trends.

### Sponsorship Differences

In 1986, when proprietaries' case mix increased 6.2%, they appropriately increased their expenditures in the direct patient care areas. However, the rise was lower than that for administration. When looking at the nursing services portion of the direct care costs, (primarily nursing salaries) a dangerous pattern emerges: the rise in nursing services was one-third the rise in therapy and pharmacy costs and one-half the rise in nursing administration. More seriously, costs for general administration, which includes administrator salaries, business office expenses, etc., was increased over one and a half times more than nursing services and almost 33 times more than food services. This trend to put more into administration and less into staff continued in 1987: while receiving 9.15% more in direct cost revenues, nursing costs were up only 5.85% while nursing administration was up 17.35% General administration was up 18.17% over the year before.

Similar patterns are found for the voluntaries. While case mix for the voluntaries was up 8.5% in 1986, nursing costs were increased less than one-half the rise for therapy and one-third the rises for pharmacy and nursing administration. General administration was increased twice as much as nursing services and 18 times more than food services. This trend, although slower, continues in 1987: although direct care revenue rose 8% and nursing costs were up almost 9%, therapy, pharmacy and nursing administration were up between 9 and 12.8% and general administration was up 12.66%. Food costs were added to in 1987 - up 7.24% from the previous year.

In 1986, the publics spent less in almost everything except nursing, therapy and nursing administration, dropping substantially in food services and pharmacy. In 1987, although suffering additional losses, they increased nursing 7.24% and laundry 12%.

## Regional Differences

In New York City, where the largest voluntaries are found and where the highest profits were made and where the case mix rose 9.13%, patterns were similar to those found across the state and for the voluntaries as a whole: much more was spent in administration than for staff and the direct care area as a whole.

Administration costs rose more than twice that of nursing services and almost twice that of direct care services as a whole in 1986 and more than four and a half times that of nursing services and more than twelve times that of direct care services as a whole in 1987.

In Suburban New York, where the case mix rose 5.42% in 1986, large rises were found in nursing administration: over three times as much as nursing. General administration rose only a little more than that of nursing services, less than that of direct care services as a whole but ten times that of food services. In 1987, the trend to add to administration rather than nursing services was more dramatic: although receiving over 9% more in direct care revenue, nursing rose only 5% while nursing administration and general administration rose more than twice as much (12.5% and 11.21%).

Upstate New York shows a different picture for 1986. While case mix was up 4.92% for upstate New York, nursing increased less than nursing administration but almost three times that of general administration. However, food services dropped substantially. In 1987, there is a small shift to expend more in administration than in nursing: although direct cost revenues were increased by 8%, nursing rose only 3.92%, less than one-half, while nursing administration rose 4.39% and general administration rose 5.34%.

How can we "encourage" facilities to spend more in the area of direct care services, to hire more staff and to encourage independence? A knowledge of what other states have done in this area might suggest some solutions.

## EXPERIENCES IN OTHER STATES

### BALANCING COST CONTAINMENT AND QUALITY

The following discussion is based upon individual state reimbursement regulations, a paper by the Center for Health Services Research (Butler and Schlenker, 1988) discussing the case mix systems in use in March of 1988, as well as telephone interviews with advocates, governmental officials, nursing home administrators, researchers and ombudspeople in the various states listed below.

## 1. ILLINOIS

Illinois' system is the oldest case-mix system in use. It went into effect in July, 1976. In response to problems over the years, Illinois has made many changes in its system related to encouraging good care and resident independence:

1. paying more for care of residents at more independent levels of functioning if the independence is due to staff intervention, e.g. a continent resident is continent because the staff helps the resident to the bathroom on an appropriate schedule;
2. paying more for preventive care, e.g, paying for efforts to prevent decubiti (bed sores), and for residents in independency training programs;
3. paying more for passive range of motion for those residents who would not benefit from training programs; and,
4. paying more for intervention programs that address psycho/social needs.

Unfortunately, advocates and ombudspeople in the state do not believe that these changes have worked well. The changes require an enormous amount of paperwork which has added to the burden of the facilities and some facilities are "gaming" the system by hiring staff to document programs never carried out.

Illinois also pays more for discharge planning that anticipates discharge to a less restrictive environment. According to some advocates, there is an incentive, for those facilities filled to capacity, to inappropriately discharge residents who are not able to be sent home or to a lower level of care.

## 2. WEST VIRGINIA

West Virginia's system went into effect in 1977. To encourage quality care West Virginia:

1. has no efficiency incentive in nursing cost areas; all costs up to a ceiling are reimbursed; and,
2. links its reimbursement system to its surveillance system by allowing facilities to earn an efficiency incentive (a profit) in dietary, laundry, housekeeping or maintenance costs only if they have no more than one deficiency in those areas.

### 3. OHIO

Ohio's system went into effect on July 1, 1980. To encourage good care, Ohio :

1. has no efficiency incentive in their direct resident care costs; all costs up to a ceiling are reimbursed;
2. pays more for spoon (hand) feeding than for tube feeding;
3. recovers money if services are not delivered; and,
4. reimburses raw food costs up to a ceiling; has no efficiency incentive for these costs.

Advocates have stated that they wanted to reward facilities for positive outcomes such as healing decubiti, less restraint use and removal of catheters. However, some were concerned that facilities should not be paid extra to do what they are already being reimbursed for. At any rate, the extra money was not included in this year's budget.

### 4. MARYLAND

Maryland's system went into effect in 1983. To encourage good care, Maryland:

1. continues to pay a facility a higher rate after a resident's functioning abilities or condition improves;
2. prohibits payments for care of decubiti obtained in the facility; and,
3. links reimbursement with surveillance by sending deficiency reports written by their reviewers, who audit resident assessment for reimbursement purposes, to their surveillance bureau.

According to one governmental official, the system has squeezed out the lighter care patient and there has been a growth in personal care (what New York calls Adult Home care). Another official stated that six or eight months ago a new provision paid more for the use of restraints than for positioning and turning. Within three months "everybody was in restraints." One advocate stated that she believes that there is no incentive to improve care and that there are major care problems in the state, one of which, because of the efficiency incentive allowed, has been the cutting of food to cut costs.

## 5. MINNESOTA

Minnesota's system went into effect in October, 1985. To encourage good care and expenditures in direct care costs Minnesota:

1. has no efficiency incentive for direct care costs.
2. pays all care related costs up to a ceiling and direct care rates are based upon cost reports of the year before; thus, a facility must spend more to get more;
3. requires minimum staffing standards based upon a facility's case-mix;
4. assesses all residents once per year as part of its inspection of care process; and,
5. caps administrative expenditures at 15% of total operating costs;

Advocates and governmental officials raised concerns about the need for documentation and the need to reward rehabilitation.

## 6. MASSACHUSETTS

Massachusetts system is now being slowly implemented. The system went into effect for some facilities in October of 1988 and others are now coming on line. The entire state will be using the case system by 1991. As one state official said, she has had the advantage of seeing the problems in other states and hopefully learning from them. Massachusetts:

1. has no efficiency incentive for nursing services; if the nursing costs are lower than 90% of the casemix adjusted costs the underspent amount may be recouped;
2. encourages facilities to spend in the area of nursing services: if facilities spend below a base, they are given the extra money to spend in nursing; if they do not spend it in nursing, the money is returned;
3. has no efficiency incentives for rehabilitation or raw food costs;
4. links the reimbursement system to the surveillance system by giving the allowed efficiency incentives in non-resident costs only if the facility receives a certain compliance score given by the surveillance bureau, and only if the facility is complying with standards of care; and,
5. does not allow administrative costs to exceed a very tight schedule.

## 7. TEXAS

Texas' system went into effect in April, 1989. To encourage good care, Texas:

1. pays more for staff encouragement for independence than it does for staff doing things for residents, e.g. pays more for hand feeding than for tube feeding, for helping to dress than for dressing, for bowel and bladder training rather than for diapering a resident.

A state official stated that she had wanted to require facilities to spend at least 90% of direct care revenue on patient care but was unable to get the necessary agreement. She intends to follow the expenditures in the direct care area very closely.

## 8. PENNSYLVANIA

Pennsylvania's system is in draft form. It will be implemented on January 1, 1991. After studying the many systems in use in the country, Pennsylvania is considering the following provisions:

1. having a higher cap for costs related to patient care than for administrative costs;
2. putting constraints on administrative spending;
3. giving a financial incentive for discharge to a less restrictive environment. A facility might be given a payment for each resident that is restored to a functioning status that allows the resident to be discharged to his/her home or to a community-based non-medical setting. The resident must not be readmitted for a period of at least six months;
4. giving a financial incentive for patient care. When a patient improves and therefore drops to a lower paying category, the facility will continue to be paid at the higher classification for the next full quarter after the quarter in which the change in classification has occurred; and,
5. a requirement for an automatic resurvey if the facility expends below the direct care base a certain percentage.

Recommendations for Modifying the RUGs System

in New York State\*

A reimbursement system is more than just a fiscal method for reimbursing facilities for the care they give to Medicaid patients. A reimbursement system shapes facility behavior; in many ways its financial incentives drive how care is provided. The makeup of a reimbursement system has as much to do with good care as a surveillance system. A reimbursement system must have incentives that enable good care.

One cannot rely solely on its surveillance system to protect New York State's nursing home residents. Given the State's fiscal problems and resource needs, the surveillance system is underfinanced and understaffed. It cannot do the job alone. New York State must, as many other states have done, build patient protections into its reimbursement system as well as continue the development of its surveillance system. Below are recommendations for building in these protections or removing incentives that do not foster good care:

**1. REQUIRE THAT ALL MONEY TAKEN IN AS DIRECT CARE REVENUE BE EXPENDED IN THE DIRECT COST CENTER**

The statistical data discussed above, demonstrates, that for both 1986 and 1987, as case-mix has gone up, facilities have taken in substantially more revenue in direct care costs than they have expended in this area.

Thus, although direct care revenue is determined by what it will cost to care for the patients they are admitting, facilities are using large portions of this revenue, not for direct care, but to offset losses in the indirect area or to make profits. This puts our nursing home residents at great risk.

There is evidence that there is not enough hands-on-staff (staff such as aides that do not suffer from the same shortage problems as nurses in many parts of the State) in our State's nursing homes:

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\* These recommendations were formulated with the help of The Coalition of Institutionalized Aged and Disabled (CIAD); Friends and Relatives of the Institutionalized Aged (FRIA); and New York Statewide Senior Action Council.

1. The study on the impact of RUGs discussed above demonstrates that many residents, nurses, aides and social workers believe that there is a shortage of staff at the same time sicker residents are coming in.
2. Advocacy groups across the State, have received numerous complaints from residents, family members and staff that facilities keep telling them that they don't have enough staff and that this is due to a lack of money.
3. Unions across the State are so concerned that some have developed, what they call, "Short Staffing Forms." These forms require an aide to submit such a form if she/he believes the staffing numbers are less than what she/he needs to provide proper and safe nursing care. It is important to note that the unions believe that the short staff is a result, not only of the state and national shortage problem, but also of a management decision not to hire enough staff.
4. According to an Occupational Experimentation project Director at HCFA, New York State, in comparison with other states with similar nursing home populations, is low on the number of aide hours per resident, and that 38 states have higher numbers of hours per resident.
5. According to a report from the Controller's Office of New York State (February, 1989), New York State has, on the average, more administrative, maintenance and housekeeping staff and less aides and orderlies than 8 other states they compared it to. This report raises the question: "Do New York nursing homes have too many employees who do not provide direct health care services?"

**2. SHIFT A PERCENTAGE OF PATIENT FOOD SERVICES FROM THE INDIRECT TO THE DIRECT**

Basic nutritional needs are directly related the care needs of the nursing home resident.

**3. PUT A CAP ON GENERAL ADMINISTRATIVE SPENDING**

Allow facilities to spend no more than 12% of total operating costs for general administration.

State data indicates high raises for administrative costs in comparison to nursing costs for both 1986 and 1987. This cap will help to shift costs from administrative to direct care costs in the future.

**4. GIVE HIGHER REIMBURSEMENT FOR HAND-FEEDING THAN FOR TUBE FEEDING**

This will encourage the least intrusive treatment.

The experience of advocates has been that some nursing homes have given family members a choice of hiring a private nurse to feed the resident or putting in a tube because of lack of staff. Thus, tube feeding was being suggested, not to meet the medical needs of the resident, but to meet the needs of the facility.

Thus, we need to modify the incentives in this area.

This suggestion did not include recommendations to pay more for staff intervention and for residents' independence training programs as Ohio has, because of the experience that advocates have had in terms of facility "gaming". It is too easy to document services such as these without giving them.

**5. ALLOW FACILITIES TO KEEP A HIGHER REIMBURSEMENT RATE FOR SIX MONTHS AFTER THE PRI DEMONSTRATES THAT A PATIENT'S CONDITION HAS IMPROVED**

Although the fact that New York assesses residents every six months rather than more often already allows facilities to keep a higher reimbursement if a resident improves soon after the assessment, it does not offer an incentive if a resident takes more time to improve. This suggestion will help to counteract the negative incentive for permitting patient deterioration.

We did not suggest the method that Maryland has of prohibiting the payment for care of decubiti obtained after admission. Although we understand the desire to prevent bed sores, we were concerned that not paying for such care would mean there would be no care.

**6. LINK THE SURVEILLANCE SYSTEM TO THE REIMBURSEMENT SYSTEM**

We suggest three options for penalties for facilities that have had enforcement actions taken against them:

1. Reduce the indirect portion of the next year's reimbursement rate;
2. Reduce the profit margin in the indirect portion of the next year's reimbursement rate; and,
3. Freeze the next year's reimbursement rate at the present casemix level.

We did not suggest that the reimbursement penalties be tied to deficiency reports and survey scores as West Virginia and Massachusetts has because it is only after an enforcement action that a facility has exhausted all of its due process rights to an appeal.

**7. REQUIRE FACILITIES TO MAINTAIN AN ADEQUATE REPRESENTATION OF ALL RUGS CATEGORIES**

This should relate to the needs of the different areas in the state and should exclude those nursing homes designed to serve a specialized population.

There are two reasons for this proposal:

1. Many patients are "slipping through the cracks." There are not enough alternatives to nursing home care. Many are backing up in hospitals further exacerbating the problem of hospital access.
2. The atmosphere of nursing homes must be maintained as a home or residence. This is important for the quality of life of both the residents and the staff. Stopping the trend toward making nursing homes post-hospital acute settings or hospices will help attract and maintain staff.

FOR MORE INFORMATION, PLEASE CONTACT:

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