SB

344

Alaska State Legislature

SENATOR JIM DUNCAN

P.O. BOX V JUNEAU, ALASKA 99811-3100

(907) 465-4766

COMMITTEES:
VICE CHAIR – FINANCE
VICE CHAIR – STATE AFFAIRS
RULES
BUDGET & AUDIT
ETHICS REFORM

DATE: January 15 1992

TO: Senator Arliss Sturgulewski, Chair
Senate Health, Education, & Social Services Committee

FROM: Senator Jim Duncan

SUBJECT: Senate Bill 344, an Act prohibiting a nursing facility that participates in the Medicaid program from charging a rate for a resident that is higher than the rate approved for Medicaid purposes.

Scheduling a hearing for SB 344 at the earliest convenience of the committee would be greatly appreciated.

Senate Bill 344 prohibits the Department of Health and Social Services from paying for services at a nursing facility unless the facility has agreed that the Medicaid rate will apply to all its residents. In the bill, nursing homes which receive payments from Medicaid are also prohibited from charging rates for private patients which are higher than the Medicaid rate of payment. This bill will provide equity in rates charged Medicaid and private patients by nursing homes in Alaska.

There are a small group of private payers in the state of Alaska who are being disadvantaged by this inequity. For their sakes, expedient consideration of this bill would be of great value.

Thank you very much for your consideration.

Attachments

7-LS1724\G
Lauterbach
1/27/92

CS FOR SENATE BILL NO. 344 ( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR DUNCAN

A BILL

FOR AN ACT ENTITLED

"An Act relating to rates for skilled nursing facilities; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 47.07 is amended by adding a new section to read:

Sec. 47.07.067. PAYMENT FOR SKILLED NURSING FACILITIES. (a) Except as provided in (b) of this section, a skilled nursing facility

(1) may not require a non-Medicaid resident to pay more for a service than the department would pay on behalf of a Medicaid resident for that service if the facility is receiving payments from the department under this chapter or AS 47.25.120 - 47.25.300; and

(2) is not eligible to receive payments under this chapter or AS 47.25.120 - 47.25.300 if it requires payment for a service for a non-Medicaid resident that is greater than the payment made by the department under this chapter for a similar service for a Medicaid resident.

(b) Notwithstanding (a) of this section, a skilled nursing facility may require a non-Medicaid resident to pay a higher rate for a private room than the department pays for a private

room on behalf of a Medicaid patient. A skilled nursing facility may also require payment for special services that are not included in the daily rate determined under AS 47.07.070 if

(1) residents eligible for care under this chapter and residents eligible for care under AS 47.25.120 - 47.25.300 are required to pay separately at the same rate for the same services in addition to the daily rate paid by the department;

(2) services covered by the payment rate are the same regardless of payment source;

(3) special services, if offered, are offered to all residents;

(4) residents are free to select or decline special services;

(5) the special services do not include services that must be provided by the facility in order to comply with licensure or certification standards and that if not provided would result in a deficiency or violation by the facility; and

(6) services beyond those required to comply with licensure or certification standards are not charged separately as a special service if they were included in the payment rate for the previous reporting year.

(c) A skilled nursing facility that violates (a)(1) of this section is subject to an action by the state or any of its subdivisions or agencies for civil damages. A non-Medicaid resident or the resident's legal representative also has a cause of action for civil damages against a skilled nursing facility that violates (a)(1) of this section. The damages awarded in an action under this subsection shall include three times the excess payments that result from the violation, together with costs and attorney fees awarded under court rules.

(d) In this section, "non-Medicaid resident" means a nursing facility resident on whose behalf the facility is not receiving payments under this chapter or AS 47.25.120 - 47.25.300.

* Sec. 2. AS 47.07.070(a) is amended to read:

(a) The department shall set the prospective rate of payment to a health facility under this chapter and AS 47.25.120 - 47.25.300 based on a fair rate for reasonable costs incurred by the facility <u>for the care of patients eligible for medical assistance under this chapter or AS 47.25.120 - 47.25.300 except that, for a skilled nursing facility, the prospective rate of payment determined under this section shall be based on a fair rate for reasonable costs incurred by the facility for all of its residents</u>. The department may not set a rate until after a public hearing before the Medicaid Rate Advisory Commission except that this hearing

requirement is not applicable if a new rate is immediately necessary to afford exceptional relief to a facility as determined under regulations adopted by the department. The department shall by regulation list the factors it considers in making its rate determinations under this section. A rate set under this section does not take effect until it is approved in writing by the commissioner of health and social services or the agency assigned by the commissioner to perform this function. The written determination of a rate set by the department after a hearing must include a statement of the department's findings, a description of the basis of the findings and conclusions, a citation to the regulations supporting the findings and conclusions, and a statement of the decision.

* Sec. 3. AS 47.07.070(b) is amended to read:

(b) In determining a rate of payment to a health facility under this section, the department shall consider the proportionate share of the facility's financial requirements for patient care for

(1) costs of current operations, including salaries and wages, purchased services, supplies, insurance, leases, depreciation, taxes, interest expense, maintenance and other health facility operating expenses; [AND]

(2) education, research, and appropriate capital development; and

(3) in the case of a skilled nursing facility, costs attributable to bad debt and uncompensated charity care.

* Sec. 4. CONFLICTS WITH FEDERAL LAWS. If a provision of this Act is determined by an agency of the federal government to be in conflict with a requirement of the agency with respect to federal participation under AS 47.07 or with respect to the eligibility of a health care provider to take part in other federal programs, the federal requirements supersede the requirements of this Act. However, the department shall seek any federal waiver that may be applicable to the conflicting requirement and shall implement the conflicting provision of this Act if the waiver is granted.

* Sec. 5. This Act takes effect January 1, 1993.

STATE OF ALASKA

WALTER J. HICKEL, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

MEDICAID RATE ADVISORY COMMISSION

4792-1 BUSINESS PARK BLVD, BLDG F
ANCHORAGE, ALASKA 99503
PHONE: (907)562-1996
FAX: (907)563-7309

M E M O R A N D U M

Date: December 4, 1991 (FAXED)

TO: Roxanne Stewart
Senator Jim Duncan's Office

FROM: Jack Nielson
Executive Director

SUBJECT: Douglas Gregg/St. Ann's Nursing Home

At your request, Medicaid Rate Advisory Commission (MRAC) staff have prepared the attached summary of issues raised by Mr. Gregg regarding the level of charges and Medicaid payments at St. Ann's Nursing Home.

MRAC staff have not discussed this summary with St. Ann's, and charges information contained in the summary is taken from Mr. Gregg's letters and attachments.

Please let me know if you have questions or comments, or if you feel it would be helpful for a department person to sit down with you or St. Ann's representatives to discuss these things further. The department is available to assist in any way possible in clearing up outstanding questions.

Enclosure

MEDICAID RATE ADVISORY COMMISSION
December 4, 1991
St. ANN'S NURSING HOME

CONDITION: Letters received by Jay Livey, Deputy Commissioner, Department of Health and Social Services (DHSS) from Douglas Gregg, attachments enclosed, indicate that as of St. Ann's Board Action November 21, 1990 (Attachment F), St. Ann's charges all patients $210 per day plus ancillary charges. Those letters also indicate that the facility writes off Medicaid ancillary charges while private pay patients are required to pay all ancillary charges. Further the letter states that Medicaid does not pay it's share of the facility's costs and consequently cost shifting to private pay patients occurs.

CRITERIA: The department does not have control over what a nursing home charges its patients and therefore the Medicaid Rate Advisory Commission staff is not familiar with St. Ann's charge structure. Based on a review of the Douglas Gregg letters and attachments, our best guess is that the St. Ann's charging structure set by the St. Ann's Board Action November 21, 1990, Attachment F, did charge all patients a per diem rate of $210 plus a separate charge for ancillary services provided to the individual patients and, as indicated by Attachment B, the Medicaid ancillary charges were then written off. Note that Attachment A, the private pay bill sample, does not write off ancillary charges in comparison to the Medicaid pay bill sample, Attachment B. At approximately the same time the Board Action, Attachment F, charging structure was in effect, the Medicaid all inclusive rates $207.96, $209.94 and $210.62 in effect in 1990 (Attachments C, D and E) generated Medicaid payments in excess of costs related to the care of those Medicaid patients approximating $464,000.

Attachment Sources:

Private Pay and Medicaid Pay bill samples for St. Ann's Nursing Home provided to Jay Livey, Deputy Commissioner, DHSS with November 1, 1991 letter from Douglas Gregg. Attachments A and B. These attachments assist in illustrating St. Ann's Charging structure.

Decision & Order Letter from Jack Nielson, Executive Director, Medicaid Rate Advisory Commission to Grant Asay, Administrator, St. Ann's Nursing Home. Attachments C, D and E. These documents outline 1990 Medicaid rates by component and include a Medicaid specific ancillary component based on average actual base year ancillary usage by Medicaid patients .

1990 Medicaid rate summary Attachments C, D, and E:

Effective date	1-1 to 6-30	7-1 to 9-30	10-1 to 12-31
Routine	$127.22	$128.90	$128.90
Routine Capital	19.03	19.03	19.03
Ancillaries	43.56	43.56	43.56
1988 YEC adjustment (ancillaries)	18.15	18.15	18.15
OBRA Increment	0.00	0.00	0.98
Total	$207.96	$209.64	$210.62
Total Ancillary Component in 1990 Medicaid rates	$61.71	$61.71	$61.71

Private Pay rate schedule by Board Action November 21, 1990 for St. Ann's Nursing Home provided to Jay Livey, Deputy Commissioner, DHSS with November 1, 1991 letter from Douglas Gregg. Attachment F. This schedule outlines specific per diem and ancillary charges used by St. Ann's.

Letter dated October 30, 1991 to Douglas Gregg from Jay Livey, Deputy Commissioner, DHSS. Attachment G. This letter explains the Medicaid rate and the fact that Medicaid reimbursement at the established Medicaid rates exceeded facility costs associated with Medicaid.

CAUSE: The Medicaid Rate Advisory Commission staff has not discussed this analysis with St. Ann's and is not aware of the reasons for St. Ann's charging structure. Our comments are based on a review of the source documents provided with Douglas Gregg's letters.

EFFECT: From the review discussed above, it appears that private pay patients at St. Ann's are charged the same as Medicaid patients, however, because the Medicaid rate is an all inclusive rate with an ancillary component, the Medicaid patient ancillary charges are written off. During our regular year end review of St. Ann's Medicaid costs it was determined that even after the write off of the individual ancillary charges to Medicaid patients, 1990 Medicaid payments to St. Ann's exceeded their cost of providing care to Medicaid patients by $464,000.

CONCLUSION: It appears from a review of the documents received from Mr. Gregg that indeed his family is paying more for Mrs. Gregg's care than the department is paying for Medicaid pay patients. From information provided to Mr. Gregg by Jay Livey, it is also evident that Medicaid payment rates in 1990 more than covered the cost of providing care to Medicaid patients.

PRIVATE PAY BILL SAMPLE

COPY

SALES INVOICE

Invoice Date: 12/31/90 Invoice # 3171

ST. ANN'S NURSING HOME
415 6TH STREET
JUNEAU, AK 99801

Patient:
Address:
JUNEAU, AK 99801
Phone: 907-586-1367

Tax ID:
Billed to: 7-Private

Patient number: /

Revenue Account	Description	Days	Rate	Charges	Subtotal
3610	Skilled routine care	31	210.00	6510.00	
3610	SKILLED ROUTINE CARE		subtotal:		6510.00
4110	MEDICAL SUPPLIES		subtotal:		125.00
4150	DRUGS SOLD		subtotal:		595.90
4510	PHYSICAL THERAPY		subtotal:		800.00
4530	OCCUPATIONAL THERAPY		subtotal:		191.96

TOTAL: 8,222.8

Attachment A

COPY

MEDICAID PAY BILL SAMPLE

SALES INVOICE

Invoice Date: 12/31/90 Invoice # 2135

ST. ANN'S NURSING HOME
415 6TH STREET
JUNEAU, AK 99801

Patient:
Address: 415 6TH ST,
JUNEAU,AK.99803
Phone:

Tax ID:
Billed to: 2-Medicaid

Patient number: /

Revenue Account	Description	Days	Rate	Charges	Subtotal
3610	Skilled routine care	31	210.00	6510.00	
3610	SKILLED ROUTINE CARE		subtotal:		6510.00
4110	MEDICAL SUPPLIES		subtotal:		51.80
4150	DRUGS SOLD		subtotal:		324.90
4510	PHYSICAL THERAPY		subtotal:		493.34
4530	OCCUPATIONAL THERAPY		subtotal:		157.33
4910	OTHER ANCILLARY CHARGES		subtotal:		25.50
5922	Contractural write-off	31	0.62	19.22	
5920	Contractural write-off subtotal:				19.22
5921	Ancillary write-off				-1052.87

TOTAL: 6,529.22

Attachment B

STEVE COWPER, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

MEDICAID RATE COMMISSION

P.O. BOX 240249
3601 "C" STREET, SUITE 592
ANCHORAGE, ALASKA 99524-0249
PHONE: (9)562-1996

December 22, 1989

Grant Asay, Administrator
St. Ann's Nursing Home
415 Sixth Street
Juneau, AK 99801

Dear Mr. Asay:

Your facility's rate for the fiscal period January 1, 1990 through December 31, 1990 was reviewed by the Medicaid Rate Advisory Commission on December 15, 1989.

In accordance with 7 AAC 43.701 your facility's long term care rate for Medical Assistance services is established at $207.96 consisting of $127.22 for routine services for the period January 1, 1990 through June 30, 1990, $19.03 for routine capital, $43.56 for ancillaries, and an adjustment of $18.15 in accordance with 7 AAC 43.691 for the period January 1, 1990 through December 31, 1990.

In accordance with 7 AAC 43.685(i) the department anticipates 12,000 long term care patient days for Medical Assistance services for the period January 1, 1990 through December 31, 1990.

Per 7 AAC 43.703 a party aggrieved by a decision of the Executive Director shall, within 30 days after the date of the mailing of notice of a decision, request reconsideration to the Executive Director or request an administrative appeal to the Commissioner of the Department. If the party chooses the reconsideration request

Attachment C

and is aggrieved by the reconsideration decision the party shall, within 30 days after mailing of the notice of the decision, request an administrative appeal to the Commission of the Department.

If you have any questions or comments please call me.

Sincerely,

Jack Nielson
Executive Director

cc: Donna Herbert
Stephen Rose
Karen Perdue
Randy Super
Eric Hansen

Attachment C (CON'T)

STATE OF ALASKA

STEVE COWPER, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

MEDICAID RATE COMMISSION

P.O. BOX 240249
3601 "C" STREET, SUITE 592
ANCHORAGE, ALASKA 99524-0249
PHONE: (907) 562-1998

June 27, 1990

Gary Asay, Administrator
St. Ann's Nursing Home
415 Sixth Street
Juneau, Alaska 99801

Dear Mr. Asay:

In accordance with 7 AAC 43.685(g) the maximum routine services rate has been calculated for the period July 1, 1990 through December 31, 1990. The maximum routine rate allowable for freestanding facilities is $130.81.

In accordance with 7 AAC 43.701 your facility's long term care rate for Medical Assistance services for the period July 1, 1990 through December 31, 1990 is established as follows:

Routine	$128.90
Routine Capital	19.03
Ancillaries	43.56
1988 YEC	18.15
TOTAL RATE	209.64

If you have any questions or comments please call me.

Sincerely,

Jack Nielson
Executive Director

cc: Donna Herbert
Stephen Rose
Karen Perdue
Randy Super
Eric Hansen

Attachment D

STEVE COWPER, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

MEDICAID RATE ADVISORY COMMISSION

P.O. BOX 240249
3601 "C" STREET, SUITE 260
ANCHORAGE, ALASKA 99524-0249
PHONE: (907) 562-1996

October 1, 1990

Grant Asay, Administrator
St. Ann's Nursing Home
415 Sixth Street
Juneau, Alaska 99801

Dear Mr. Asay:

In accordance with Emergency Regulation 7 AAC 43.685(o) your facility's OBRA increment has been calculated for the period October 1, 1990 through December 31, 1990.

In accordance with 7 AAC 43.701 you facility's long term care rate for Medical Assistance services for the period October 1, 1990 through December 31, 1990 is established as follows:

Routine	$128.90
Routine Capital	19.03
Ancillaries	43.56
1988 YEC	18.15
OBRA Increment	.98
TOTAL RATE	$210.62

If you have any questions or comments please call me.

Sincerely,

Randall Gillespie For
Jack Nielson
Executive Director

cc: D. Herbert
S. Rose
F. Shuler
E. Hansen
J. Livey
R. Super

Attachment E

ST. ANN'S NURSING HOME

415 Sixth Street, Juneau, AK 99801 (907) 586-3883

COPY

PRIVATE PAY RATE SCHEDULE

Board Action November 21, 1990

PATIENT CHARGES

Description	Account #	Amount	Date Revised
1. Routine Charges - ICF	3640	$210.00/day	4/1/89
SNF	3610	$210.00/day	4/1/89
2. Isolation Charge	4000	$80.00/day	1/1/91
3. Laboratory	4210		
a. Blood Draw		$22.00	11/1/90
b. Urinalysis Draw		$16.00	11/1/90
c. C & S Draw - Culture		$25.00	11/1/90
d. Blood Glucose		$35.00	1/1/91
e. Occult Blood		$35.00	1/1/91
4. EKG	4290	$45.00	11/1/90
5. Respiratory	4420	(attached)	1/1/91
6. Physical Therapy	4510	$80.00/hr	11/1/90
a. Capital K-Pads	4510	$15.00/hr	1/1/91
7. Occupational therapy	4530	$85.00/hr	11/1/90
8. Recreational therapy	4570	No charge	11/1/90
9. Other Ancillarys	4910		
a. Transportation		Cab Fare	1/1/91
10. Speech Therapy	4920	$95.00/hr	11/1/90
11. I.V. Therapy - Set-up	4930	$30.00	1/1/91
12. Feeding Pump	4940	$5.00/day	1/1/91

13. Pharmacy X 20%

14. Med. Supplies X 40%

Attachment F

STATE OF ALASKA
MEDICAID RATE ADVISORY COMMISSION
COMPARISON OF MEDICAL ASSISTANCE REIMBURSEMENTS TO PROGRAM SHARE OF FACILITY EXPENSES

	1985	1986	1987	1988	1989	1990	
	Long Term Care						
	ST. ANN'S	ST. ANN'S	ST. ANN'S	ST. ANN'S	ST. ANN'S	ST. ANN'S	CUMULATIVE
UTILIZATION (PDs)							
T.F.	14,366	13,686	14,393	13,994	13,884	14,943	85,186
M.A.	13,274	11,944	12,251	11,558	12,766	14,600	76,393
% M.A.	92.40%	87.78%	85.12%	82.59%	91.95%	97.70%	89.68%
COSTS							
Routine T.F.	1,815,049	1,950,051	1,845,609	1,952,665	2,128,433	2,264,035	11,956,842
Routine M.A. %	1,677,882	1,712,551	1,570,941	1,612,921	1,957,042	2,212,066	10,742,503
Program Ancil	237,077	199,429	286,105	451,425	425,143	347,171	1,946,351
Recoveries	(25,237)	(15,565)	(11,639)	(33,998)	(6,297)	(53,950)	(146,686)
M.A. Allowable	1,888,922	1,896,414	1,845,407	2,030,348	2,375,889	2,505,288	12,542,268
AVG PER DIEM RATE FY #	$145.44	$150.44	$156.93	$160.35	$185.90	$209.85	
M.A. REIMBURS	1,930,571	1,796,855	1,922,549	1,853,364	2,373,199	3,052,130	12,928,669
M.A. PROFIT (LOSS)	41,649	(99,559)	77,143	(176,984)	(2,689)	546,842	386,401
TOTAL ST. ANN'S	41,649	(99,559)	77,143	(176,984)	(2,669)	546,842	386,401

STATE OF ALASKA
Department Of Health And Social Services
Medicaid Rate Advisory Commission

St. Anna information from Independent Audited Financials

	1985	1986	1987	1988	1989	1990	Total
Net Income	(21,123)	(46,841)	224,277	(87,647)	82,115	480,628	631,409
Net Cash Provided By Operations	(91,104)	(213,909)	391,885	(40,854)	66,465	544,620	657,103

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

240 Main Street, Suite 500
Juneau, Alaska 99801-2101

MEMORANDUM January 10, 1992

SUBJECT: Nursing Home Rates (SSSB 344)

TO: Senator Jim Duncan
ATTN: Roxanne

FROM: Terri Lauterbach
Legislative Counsel

This memo is a progress report and a request for further instructions about drafting a sponsor substitute for SB 344.

As you directed, I have been in consultation with Jack Nielson since the meeting about nursing home rates on December 30, 1991. Initially, he provided me with the names of states that had all-payor systems for their hospitals. Upon review, these statutes didn't seem particularly helpful. However, Jack later came up with the names of two states that have established "equalized" rates for their nursing homes: Minnesota and North Dakota. These states do, in fact, seem to have the system established that you are seeking to establish in Alaska.

Enclosed is a copy of North Dakota's laws on the subject. [1] Rather than putting them into bill form right now, I thought I'd check with you to see if you had time to review these laws and determine if they are what you want.

The section of the North Dakota law that lays out the main principle you are interested in is "50-24.4-19 (1.)" on page 150 of the attached. However, your bill can probably not be as simple as repeating just this language, without also laying out the rate structure described in the other sections.

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[1] I have enclosed the North Dakota laws because they are most recently passed (1987, applicable to rate years beginning 1/1/90, I think) and seem to have been based on the earlier Minnesota laws (which are longer and more technical because there have been many one-time rate adjustments added to their laws after initial enactment).

As I recall, there was general agreement at the December meeting between DHSS and the representatives of the nursing homes that Alaska's rate-setting structure should also change if the rates for Medicaid and private payors were to be equalized. To achieve that goal would involve more than a one-section bill. Most probably, it would mean repeal of our current rate-setting section, AS 47.07.070, and enactment of most of what you see in the attached North Dakota laws, with appropriate changes to give the Medicaid Rate Advisory Commission a role in the process. Is this what you want to do?

I am sending this letter and a copy of the North Dakota Laws to Jay Livey as well, per your instructions to work with the department on this matter.

Do you want a bill embodying the enclosed North Dakota law? Or do you wish to wait while the department, the advisory commission, and nursing home representatives review North Dakota's laws for their applicability here? Also, do you wish to limit the bill to skilled nursing facilities, or should it be applicable to board and care homes, ICF/MR's, and other convalescent or residential care institutions?

I hope you find the enclosed information helpful. I understand that Jack Nielson is awaiting the arrival of a HCFA report about "all-payor" systems, which I will forward to you when I get a copy from him. Please let me know if I can be of further assistance at this time.

TML:lmb
92-006.lmb

Enclosure

cc: Jay Livey, Deputy Commissioner
Health and Social Services

NORTH DAKOTA
LAWS

CHAPTER 50-24.4
NURSING HOME RATES

50-24.4-01. Definitions. For the purposes of this chapter:

1. "Actual allowable historical operating cost per diem" means the per diem operating costs allowed by the department for the most recent reporting year.
2. "Actual resident day" means a billable, countable day as defined by the department.
3. "Department" means the department of human services.
4. "Depreciable equipment" means the standard movable resident care equipment and support service equipment generally used in long-term care facilities.
5. "Direct care costs" means the cost category for allowable nursing and therapy costs.
6. "Final rate" means the rate established after any adjustment by the department, including, but not limited to, adjustments resulting from cost report reviews and audits.
7. "Fringe benefits" means workers' compensation insurance, group health or dental insurance, group life insurance, retirement benefits or plans, and uniform allowances.
8. "General and administrative costs" means all allowable costs for administering the facility, including, but not limited to: salaries of administrators, assistant administrators, accounting personnel, data processing personnel, security personnel, and all clerical personnel; board of directors' fees; business office functions and supplies; travel, except as necessary for training programs for dietitians, nursing personnel and direct resident care related personnel required to maintain licensure, certification, or professional standards requirements; telephone and telegraph; advertising; membership dues and subscriptions; postage; insurance, except as included as a fringe benefit under subsection 6; professional services such as legal, accounting, and data processing services; central or home office costs; management fees; management consultants; employee training, for any top management personnel and for other than di-

rect resident care related personnel; and business meetings and seminars.

9. "Historical operating costs" means the allowable operating costs incurred by the facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective, after the department has reviewed those costs and determined them to be allowable costs under the medical assistance program, and after the department has applied appropriate limitations such as the limit on administrative costs.
10. "Indirect care costs" means the cost category for allowable administration, plant, housekeeping, medical records, chaplain, pharmacy, and dietary, exclusive of food costs.
11. "Nursing home" means a facility, not owned or administered by the state government, described in subsection 3 of section 43-34-01.
12. "Operating costs" means the day-to-day costs of operating the facility in compliance with licensure and certification standards.
13. "Other direct care costs" means the cost category for allowable activities, social services, laundry, and food costs. 14. "Payment rate" means the rate determined under section 50-24.4-06.
15. "Payroll taxes" means the employer's share of Federal Insurance Contributions Act taxes, governmentally required retirement contributions, and state and federal unemployment compensation taxes.
16. "Private-paying resident" means a nursing home resident on whose behalf the nursing home is not receiving medical assistance payments and whose payment rate is not established by any other third party, including the veteran's administration or medicare.
17. "Rate year" means the fiscal year for which a payment rate determined under this chapter is effective, from January first to the next December thirty-first.
18. "Real estate" means improvements to real property and attached fixtures used directly for resident care.
19. "Reporting year" means the period from July first to June thirtieth, immediately preceding the rate year, for which the nursing home submits reports required under this chapter.
20. "Top management personnel" means owners, board members, corporate officers, general, regional, and district managers, administrators, nursing home administrators, and any other person performing functions ordinarily performed by such personnel.

Source: S.L. 1987, ch. 582, § 1; 1991, ch. 29, § 16.

Effective Date.

The 1991 enactment of subsections 5, 10, and 13 of this section by section 16 of chapter 29, S.L. 1991, became effective July 1, 1991, pursuant to N.D. Const., Art. IV, § 13.

Note.

The definitions in this section were renumbered in 1991 upon the enactment of new subsections 6, 10, and 13.

50-24.4-01.1. Nursing home resident payment classifications — Procedures for reconsideration.

1. For purposes of this section "resident's representative" includes the resident's guardian or conservator, a person authorized or required to pay the nursing home expenses of the resident, or any other person designated by the resident in writing.
2. The department shall establish resident payment classifications for the care of residents of nursing homes.

3. The department shall assign nursing home residents to the appropriate payment classification based upon assessments of the residents.
4. The department shall notify each resident, and the nursing home in which the resident resides, of the payment classification established under subsection 3. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the department, and the opportunity to appeal the classification. The notice of resident classification must be sent by first-class mail. The individual resident notices may be sent to the resident's nursing home for distribution to the resident in which event the nursing home is responsible for the distribution of the notice to the resident and to the resident's representative, if any. This notice must be distributed to the resident and sent first-class mail or hand-delivered to the resident's representative within three working days after the nursing home's receipt of the notice from the department.
5. The resident or the nursing home may appeal the assigned payment classification to the department. The appeal must be submitted in writing to the department within thirty days of the receipt of the notice of resident classification. For appeals submitted by or on behalf of the resident, the time period for submission of the request begins on the date the classification notice is delivered to the resident, or mailed or delivered to the resident's representative, whichever is latest. The appeal must be accompanied by the name of the resident, the name and address of the nursing home in which the resident resides, the reasons for the appeal, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the appeal is limited to documentation intended to establish that the needs of the resident, at the time of the assessment resulting in the disputed classification, justify a change of classification.
6. Upon written request, the nursing home shall give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the department to support the assessment findings. The nursing home shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's appeal. A copy of any requested material must be provided within three working days of receipt of a written request for the information. Upon request, the nursing home shall assist the resident in preparing an appeal.
7. In addition to the information required in subsection 5, an appeal by a nursing home must be accompanied by the following information: the date the resident payment classification notices were received by the nursing home; the date the classification notices were distributed to the resident or the resident's representative; and a copy of a notice of appeal sent to the resident or to the resident's representative. This notice must tell the resident or the resident's representative that the resident's classification is being appealed, the reason for the appeal, that the resident's rate will change if the appeal is approved by the department and the extent of the change, that copies of the nursing home's appeal and supporting documentation are available for review, and that the resident also has the right to appeal. If the nursing home fails to provide this information with

[redacted]

Source: S.L. 1989, ch. 584, § 1.

50-24.4-02. Authority. The department shall establish, by rule, procedures for determining rates for care of residents of nursing homes which qualify as vendors of medical assistance, and for implementing the provisions of this chapter. The procedures must be based on methods and standards which the department finds are adequate to recognize the costs that must be incurred for the care of residents in efficiently and economically operated nursing homes. The department shall identify costs that are recognized for establishing payment rates.

Source: S.L. 1987, ch. 582, § 2.

50-24.4-03. Federal requirements — Supremacy. If any provision of this chapter is determined by the United States government to be in conflict with existing or future requirements of the United States government with respect to federal participation in medical assistance, the federal requirements prevail.

Source: S.L. 1987, ch. 582, § 3.

50-24.4-04. Payment rates. Payment rates paid to any nursing home receiving medical assistance payments must be those rates established pursuant to this chapter and rules adopted under it.

Source: S.L. 1987, ch. 582, § 4.

50-24.4-05. Requirements. No medical assistance payments may be made to any nursing home unless the nursing home is certified to participate in the medical assistance program under title XIX of the federal Social Security Act and has in effect a provider agreement with the department meeting the requirements of state and federal statutes and rules. No medical assistance payments may be made to any nursing home unless the nursing home complies with all requirements of North Dakota law including, but not limited to, this chapter and rules adopted under it that govern participation in the program. This section applies whether the nursing home participates fully in the medical assistance program or is withdrawing from the medical assistance program.

Source: S.L. 1987, ch. 582, § 5.

50-24.4-06. Rate determination. The department shall determine prospective payment rates for resident care costs. For rate years beginning on or after January 1, 1990, the department shall develop procedures for determining operating cost payment rates that take into account the mix of resident needs and other factors as determined by the department.

The department shall establish, by rule, limitations on compensation recognized in the historical base for top management personnel. Compensation for top management personnel must be categorized as a general and administrative cost and is subject to any limits imposed on that cost category.

Source: S.L. 1987, ch. 582, § 6.

50-24.4-07. Nonallowable costs. The following costs may not be recognized as allowable: political contributions; salaries or expenses of a lobbyist, as defined in section 54-05.1-02, for lobbying activities; advertising designed to encourage potential residents to select a particular nursing home; fines and penalties; legal and related expenses for unsuccessful challenges to decisions by governmental agencies; memberships in sports, health, or similar social clubs or organizations; and costs incurred for activities directly related to influencing employees with respect to unionization. The department shall by rule exclude the costs of other items or services not directly related to the provision of resident care.

Source: S.L. 1987, ch. 582, § 7.

50-24.4-08. Notice of increases to private-paying residents. No increase in nursing home rates for private-paying residents is effective unless the nursing home notifies the resident or person responsible for payment of the increase in writing thirty days before the increase takes effect. A nursing home may adjust its rates without giving the notice required by this section when the purpose of the rate adjustment is to reflect a necessary change in the category of care provided to a resident. If the department fails to set rates at least forty days prior to the beginning of a rate year, the time required for giving notice is decreased by the number of days by which the department was late in setting the rates.

Source: S.L. 1987, ch. 582, § 8.

50-24.4-09. Interim rates. In setting rates for payment for services furnished by nursing homes prior to January 1, 1990, the department shall operate the ratesetting process as it presently exists, or in any other fashion which may be permitted by law. The department may, in its discretion, prior to July 1, 1988, direct that nursing homes engage in any activity which will be reasonably necessary to permit an orderly transition to the establishment of payment rates under this chapter.

5. 244-10. Operating costs after January 1, 1990.

1. For rate years beginning on or after January 1, 1990, the department shall establish procedures for determining per diem reimbursement for operating costs.
2. The department shall maintain access to national and state economic change indices that can be applied to the appropriate cost categories when determining the operating cost payment rate.
3. The department shall analyze and evaluate each nursing home's cost report of allowable operating costs incurred by the nursing home during the reporting year immediately preceding the rate year for which the payment rate becomes effective.
4. The department shall establish limits on actual allowable historical operating cost per diems based on cost reports of allowable operating costs for the reporting year that begins July 1, 1987, taking into consideration relevant factors including resident needs, nursing hours necessary to meet resident needs, size of the nursing home, and the costs that must be incurred for the care of residents in an efficiently and economically operated nursing home. The limits established by the department may not be less, in the aggregate, than the sixtieth percentile of total actual allowable historical operating cost per diems for each group of nursing homes established under this chapter based on cost reports of allowable operating costs in the previous reporting year. The limits established under this subsection remain in effect until the department establishes a new base period. Until the new base period is established, the department shall adjust the limits annually using the appropriate economic change indices established in subsection 5. In determining allowable historical operating cost per diems for purposes of setting limits and

50-24.4-11. Adjustment of historical operating costs.

1. For rate years beginning on or after January 1, 1991, the department may allow a one-time adjustment to historical operating costs of a nursing home that has been found by the department to be significantly below care related minimum standards appropriate to the mix of resident needs in that nursing home when it is determined by the department that the nursing home is unable to meet minimum standards through reallocation of nursing home costs and efficiency incentives or allowances. In developing procedures to allow adjustments, the department shall specify the terms and conditions governing any additional payments made to a nursing home as a result of the adjustment. The department shall establish procedures to recover amounts paid under this section, in whole or in part, and to adjust current and future rates, for nursing homes that fail to use the adjustment to satisfy care related minimum standards.
2. If the department learns that unallowable expenditures have been included in the nursing home's historical operating costs, the department shall disallow the expenditures and recover the entire overpayment out of future payments otherwise due to the nursing home under chapter 50-24.1, or otherwise, as the department may determine.

Source: S.L. 1987, ch. 582, § 11.

50-24.4-12. Avoiding detrimental effect on quality of care. If the department learns that expenditures for direct resident care have been reduced in amounts large enough to indicate a possible detrimental effect on the quality of care, the department shall notify the state department of health and consolidated laboratories.

Source: S.L. 1987, ch. 582, § 12.

50-24.4-13. Exclusion. Until procedures for determining operating cost payment rates according to mix of resident needs are established for nursing homes that exclusively provide residential services for the nongeriatric physically handicapped, such nursing homes may not be included in the calculation of the percentiles of any group. Each of these nursing homes shall receive their actual allowed historical operating cost per diem adjusted by a percentage amount equal to the increase, if any, in the national or state economic change index, made available under section 50-24.4-10, and which the department determines to be relevant to residential services for the nongeriatric physically handicapped.

Source: S.L. 1987, ch. 582, § 13.

50-24.4-14. General and administrative costs after January 1, 1990. For rate years beginning on or after January 1, 1990, all general and administrative costs must be included in general and administrative costs in total, without direct or indirect allocation to other cost categories. In a nursing home of sixty or fewer beds, part of an administrator's salary may be allocated to other cost categories to the extent justified in records kept by the nursing home. Central or home office costs representing services of consultants required by law in areas including, but not limited to, dietary, pharmacy, social services, or activities may be allocated to the appropriate department, but only if those costs are directly identified by the nursing home. Central, affiliated, or corporate office costs representing services of consultants not required by law in the areas of nursing, medical records, dietary, other care related services, and plant operations may be allocated to the appropriate operating cost category of a nursing home according to subsections 1 through 5.

1. Only the salaries, fringe benefits, and payroll taxes associated with the individual performing the service may be allocated. No other costs may be allocated.
2. The allocation must be based on direct identification and only to the extent justified in time distribution records that show the actual time spent by the consultant performing the services in the nursing home.
3. The cost in subsection 1 for each consultant must not be allocated to more than one operating cost category in the nursing home. If more

than one nursing home is served by a consultant, all nursing homes shall allocate the consultant's cost to the same operating category.
4. Top management personnel must not be considered consultants.
5. The consultant's full-time responsibilities are to provide the services identified in this section.

Source: S.L. 1987, ch. 582, § 14.

50-24.4-15. Property-related costs after January 1, 1990. For all rate years beginning on or after January 1, 1990:

1. The department shall reimburse nursing home providers that are vendors in the medical assistance program for the use of real estate and depreciable equipment.
2. In developing the method for determining that part of the payment rate for the use of real estate and depreciable equipment, the department shall consider factors designed to:
   a. Simplify the administrative procedures for determining payment rates for property-related costs;
   b. Minimize discretionary or appealable decisions;
   c. Eliminate any incentives to sell nursing homes;
   d. Recognize legitimate costs of preserving and replacing property;
   e. Recognize the existing costs of outstanding indebtedness allowable under the statutes and rules in effect on July 1, 1985; and
   f. Reward efficient management of capital assets.

Source: S.L. 1987, ch. 582, § 15. See Note, next page

~~50-24.4-16. Special rates for nursing homes with a capacity in~~crease and for newly constructed nursing homes, which first provide services on or after July 1, 1988, and which are not included in the calculation of the percentile for any group, the department shall establish by rule procedures for determining interim operating cost payment rates. The interim payment rate may not be in effect for more than fifteen months. The department shall establish procedures for determining the interim rate and for making a retroactive cost settle-up after the first year of operating; the cost settled operating cost per diem may not exceed one hundred ten percent of the sixtieth percentile established for the appropriate group.

See next page for 50-24.4-16.

Source: S.L. 1987, ch. 582, § 16.

50-24.4-17. Adjustments and reconsideration procedures.

1. Rate adjustments may be made to correct errors subsequently determined and must also be retroactive to the beginning of the facility's rate year except with respect to rates paid by private-paying residents. Any adjustments that result in a cumulative change of more than twenty-five cents per day from the desk rate will be included in

nursing home payment rates, the department shall divide the allowable historical operating costs by the actual number of resident days; except that where a nursing home is occupied at less than ninety percent of licensed capacity days, the department may establish procedures to adjust the computation of the per diem to an imputed occupancy level at or below ninety percent. The department shall establish efficiency incentives as appropriate. The department may establish efficiency incentives for different operating cost categories. The department shall consider establishing efficiency incentives in care-related cost categories. The department may combine one or more operating cost categories and may use different methods for calculating payment rates for each operating cost category or combination of operating cost categories.

5. The department shall establish a composite index or indices by determining the appropriate economic change indicators to be applied to specific operating cost categories or combination of operating cost categories.
6. Each nursing home shall receive an operating cost payment rate equal to the sum of the nursing home's operating cost payment rates for each operating cost category. The operating cost payment rate for an operating cost category must be the lesser of the nursing home's historical operating cost in the category increased by the appropriate index established in subsection 5 for the operating cost category plus an efficiency incentive established pursuant to subsection 4 or the limit for the operating cost category increased by the same index. If a nursing home's actual historic operating costs are greater than the prospective payment rate for that rate year, there may be no retroactive cost settle-up. In establishing payment rates for one or more operating cost categories, the department may establish separate rates for different classes of residents based on their relative care needs.
7. Effective July 1, 1991, the efficiency incentives to be established by the department pursuant to subsection 4 for a facility with an actual rate below the limit rate for indirect care costs must include the lesser of two dollars and sixty cents per resident day or the amount determined by multiplying seventy percent times the difference between the actual rate, exclusive of inflation indices, and the limit rate, exclusive of current inflation indices. The efficiency incentive must be included as a part of the indirect care cost rate.
8. Effective July 1, 1991, each nursing home must receive an operating margin of at least three percent based upon the lesser of the actual direct care and other direct care costs and the limit rate prior to inflation. The operating margin will then be added to the rate for direct care and other direct care cost categories.

Source: S.L. 1987, ch. 582, § 10; 1991, ch. 29, § 17.

Effective Date.

The 1991 enactment of subsections 7 and 8 of this section by section 17 of chapter 29, S.L. 1991, became effective July 1, 1991, pursuant to N.D. Const., Art. IV, § 13.

50-24.4-15. Property-related costs after January 1, 1990.

Note.

Section 1 of chapter 517, S.L. 1991, effective July 1, 1991, pursuant to N.D. Const., Art. IV, § 13, through June 30, 1993, and after that date ineffective, provides:

"Property reimbursement study—Reimbursement in certain cases.

1. The department of human services shall study the medical assistance property cost reimbursement system for the nursing home industry in the state of North Dakota. The department shall establish a nine-member advisory committee for the study consisting of departmental staff, at least three representatives of the long-term care industry, and three legislative members appointed by the chairman of the legislative council. The department may expend funds to engage a qualified consulting firm to assist in the study and shall from time to time report on the progress of the study and any findings to the legislative council or a committee designated by the council. The legislative council shall report any findings and recommendations, together with any legislation required to implement the recommendations, to the fifty-third legislative assembly.
2. The department shall reimburse nursing home providers that are vendors in the medical assistance program for the use of real estate and depreciable equipment that was purchased by the nursing home provider after July 1, 1985, and before January 1, 1991, based on property costs created by good faith, arm's length purchase agreements. For purposes of this Act, "property costs" means property taxes including special assessments, lease and rental costs of personal property and reasonable legal expense, all to the extent allowable under chapter 50-24.4 and rules adopted by the department; interest expense allowable under rules adopted by the department without the application of subdivision f of subsection 1 of section 75-02-06-04 of the North Dakota Administrative Code; personal property depreciation based upon purchase price paid by the buyer; and real property depreciation based upon current reproduction cost of those assets depreciated on a straight-line basis over their useful lives to the date of acquisition by the buyer and increased by one-half of the percentage increase in the consumer price index for all urban consumers (United States city average) from the date of acquisition by the seller to the date of acquisition by the buyer, or the purchase price paid by the buyer, whichever is lower."

Section 2 of chapter 517, S.L. 1991, makes an appropriation of $75,000 out of moneys in the general fund and of $75,000 from special funds to the department of human services for the purpose of undertaking the study provided for in section 1 of chapter 517, for the period beginning July 1, 1991, and ending June 30, 1993. Section 3 of chapter 517, S.L. 1991, directs that the department provide additional property cost reimbursement required by the act from funds appropriated to the department by chapter 29, S.L. 1991, and declares that it is the intent of the legislative assembly that the $783,345, of which $184,086 is from the general fund, necessary to fund the additional reimbursement required, will be available through the department's recapture of depreciation related to sales between the Benedictine health systems and Beverly enterprises.

50-24.4-16. Special rates.

1. For nursing homes with a significant capacity increase and for newly constructed nursing homes, which first provide services on or after July 1, 1988, and which are not included in the calculation of the percentile for any group, the department shall establish procedures for determining interim operating cost payment rates. The interim payment rate may not be in effect for more than eighteen months. The department shall establish procedures for determining the interim rate and for making a retroactive cost settle-up for periods when an interim rate was in effect.
2. As soon as is practicable following the establishment of the procedures required by subsection 1, the department shall apply the special rates for all affected facilities for rate periods beginning on or after January 1, 1990.

the next subsequent cost report to the extent not corrected by a rate adjustment made pursuant to this subsection.

2. Any requests for reconsideration of the rate must be filed with the department's medical services division for administrative consideration within thirty days of the date of the rate notification.

Source: S.L. 1987, ch. 582, § 17.

Source: S.L. 1987, ch. 582, § 16; 1991, ch. 518, § 1.

50-24.4-18. Appeals.

1. A nursing home dissatisfied with the final rate established may, upon completion of the reconsideration, appeal. An appeal may be perfected by mailing or delivering the information described in subdivisions a through e of this subsection to the department, at such address as the department may designate, mailed or delivered on or before five p.m. on the thirty-first day after the date of mailing of the determination of the medical services division made with respect to a request for reconsideration. An appeal under this section is perfected only if accompanied by written documents including the following information:
   a. A copy of the letter received from the medical services division advising of that division's decision on the request for reconsideration;
   b. A statement of each disputed item and the reason or basis for the dispute;
   c. A computation and the dollar amount which reflects the appealing party's claim as to the correct computation and dollar amount for each disputed item;
   d. The authority in statute or rule upon which the appealing party relies for each disputed item; and
   e. The name, address, and telephone number of the person upon whom all notices will be served regarding the appeal.
2. Repealed by S.L. 1991, ch. 637, § 9, effective July 1, 1991.

Source: S.L. 1987, ch. 582, § 18; 1991, ch. 637, § 9.

Effective Date.

The 1991 amendment by section 9 of chapter 637, S.L. 1991, which repealed subsection 2, became effective July 1, 1991, pursuant to N.D. Const., Art. IV, § 13.

50-24.4-19. Prohibited practices. From and after January 1, 1990, a nursing home is not eligible to receive medical assistance payments unless it refrains from all of the following:

1. Charging private-paying residents rates for similar services which exceed those rates which are approved by the department for medical assistance recipients, as determined by the prospective desk audit rate, except under the following circumstances: the nursing home may (1) charge private-paying residents a higher rate for a private room, and (2) charge for special services which are not included in the daily rate if medical assistance residents are charged separately at the same rate for the same services in addition to the daily rate paid by the department of human services. Services covered by the payment rate must be the same regardless of payment source. Special services, if offered, must be offered to all residents and charged separately at the same rate. Residents are free to select or decline special services. Special services must not include services which must be provided by the nursing home in order to comply with licensure or certification standards and that if not provided would result in a deficiency or violation by the nursing home. Services beyond those required to comply with licensure or certification standards must not be charged separately as a special service if they were included in the payment rate for the previous reporting year. A nursing home that charges a private-paying resident a rate in violation of this chapter is subject to an action by the state or any of its subdivisions or agencies for civil damages. A private-paying resident or the resident's legal representative has a cause of action for civil damages against a nursing home that charges the resident rates in violation of this chapter. The damages awarded shall include three times the payments that result from the violation, together with costs and disbursements, including reasonable attorneys' fees or their equivalent.
2. Requiring an applicant for admission to the home, or the guardian or conservator of the applicant, as a condition of admission, to pay any fee or deposit in excess of one hundred dollars, loan any money to the nursing home, or promise to leave all or part of the applicant's estate to the home.
3. Requiring any resident of the nursing home to utilize a vendor of health care services who is a licensed physician or pharmacist chosen by the nursing home.
4. Providing differential treatment on the basis of status with regard to public assistance.
5. Discriminating in admissions, services offered, or room assignment on the basis of status with regard to public assistance. Admissions discrimination shall include, but is not limited to:
   a. Basing admissions decisions upon assurance by the applicant to the nursing home, or the applicant's guardian or conservator.

THE COST OF LONG TERM CARE IN ALASKA
December 16, 1991

Over the past three years, St. Ann's Nursing Home has experienced annual increases in expenses of 4.2% for 1989, 3.7% for 1990 and an estimated 3.2% for 1991. These annual increases are much lower than the national and State of Alaska Healthcare inflation indices. However, nursing home costs in Alaska are still high in comparison to the lower 48 states. The justification for these higher costs can be classified in at least two categories, Alaska Specific Costs and St. Ann's Specific Costs.

ALASKA SPECIFIC COSTS

Higher Acuity: Alaska regulations require patients to have specific medical needs in order to be eligible for nursing home placement. These heavier medical needs require more staff, professional and non-professional. Many states do not have stringent medical restrictions and consequently do not have the higher per patient cost.

Higher Quality: Alaska has the highest quality nursing homes and some of the most restrictive regulations than nearly any other state. For example, Alaska currently requires a Registered Nurse on duty 24-hours per day, seven days a week. The federal regulation requires a Registered Nurse only 8 hours a day. Alaska Nursing Homes have much higher staff per patient ratios than other states. Abuse and neglect stories are nearly non-existent.

Alaska's Remoteness: Because of Alaska's geographic logistics, some very basic services and operations are much more expensive; i.e., continuing education, travel, utilities, etc. Freight can be as much as 15 to 20 percent of the supply cost.

Economies of Scale: Most of Alaska's nursing homes are very small and cannot realize the economies of scale experienced by large 200-300 bed nursing homes down south. Both large and small nursing homes must provide one administrator, one nursing director, one dietitian, one chief financial officer, a certified audit and other staff and services. Unlike the large facility, a small nursing home must spread these common costs to a smaller patient base. Most of the large nursing homes in the lower 48 also are owned by or participants of multi-facility chains which allows them to take additional advantage of economies of in a grander scale.

Competition for State Wages and Benefits: St. Ann's is located in the middle of a state and federal government environment. The nursing home must compete with government entry level wages and their cadillac benefit plans. This again drives wages up in all classifications of nursing home employment. The Pioneer Home currently starts Nurse Assistants at $2.30/hr. higher than St. Ann's.

Juneau's Lack of Contractual Services: In the lower 48, there is ample competition for outside contractual services that are significantly less expensive than providing them in house. For example, laundry service at St. Ann's is very expensive and there is no one outside that can provide this service. The hospital is also looking for someone to do their laundry service.

Non-Multi Facility: Unlike other free-standing nursing homes in the lower 48 and also in Alaska, St. Ann's is unique in that it is not a participant in a multi-home system. Because of our distinct identity, we cannot take advantage of multi-user purchasing agreements. Malpractice insurance through a multi-home system is a fraction of what St. Ann's pays. Many other services may be obtained cheaper through multi-home systems.

Juneau's Mobile Population: Particularly for younger, entry level workers, Juneau is especially transient. The increased turnover results in a higher training expense.

Duplication of Services: Alaska is unique in that many facilities cannot take advantage of economies of scale because the same service is duplicated in the community through the Pioneer Home system. In a larger physical facility, St. Ann's could provide care for 30 more patients (Juneau Pioneer Home) with minimal staffing increases and incremental supply costs. While competition can be healthy, it can be detrimental particularly in the fully subsidized arena of State and Federal government.

Underutilized Facilities: Many facilities in Alaska are operating with empty beds. Because of the fixed costs associated with operating a nursing home (as explained above in economies of scale) these empty beds are expensive to maintain and must be spread to paying patients. In 1990 when St. Ann's average census was 42 or 43, we operated at approximately $185 average expense per patient day. This compares to 1991's average census of 38 and $206 average expense per patient day.

Labor Costs: Alaska has extremely high costs associated with labor. The entry level wage in health care (nurse assistants, housekeeping, etc.) can be twice as high as other states. Professionals are likewise paid more. Pension plans and medical, dental and vision benefits for employees and dependents is the norm in Alaska. For the most part, this coverage is not a benefit for employee dependents in many other states.

ST. ANN'S SPECIFIC COSTS

High Acuity: Currently St. Ann's is experiencing tremendously high acuity. We have more tube feeding patients than the entire Pioneer Home system. Several St. Ann's patients are comatose. Others require continuous oxygen. This heavy care requires increased staff, and more medical supplies and equipment.

Juneau's Cost of Living: Although this is not peculiar to Juneau alone, this city does have extremely high housing expenses. Juneau's cost of living is at least 30% higher than the U.S. average. An entry level employee requires a minimal wage to survive in Juneau. This wage is nearly twice as high as an entry level employee in the lower 48. The effects of a high minimal wage "trickles up." A Nurse Assistant in Alaska earns as much as an LPN down south, but an L.P.N. in Alaska will not work for Nurse Assistant wages so must be paid proportionally higher. Likewise, an R.N. will not work for L.P.N. wages. Consequently wages and the accompanying benefits create a huge disparity between Alaska and the lower 48.

ALASKA NURSING HOMES CENSUS

AS OF: NOVEMBER 30, 1991

FACILITY	MEDICAID PERDIEM RATE	CERTIFIED CAPACITY		MEDICAID/GRH PLACEMENTS		NON-DNA PLACEMENTS		TOTAL CENSUS	VACANT BEDS	% OCCUPANCY OF TOTAL BEDS	
		SNF/ ICF	SWING BEDS	ICF	SNF	MEDI-CARE	* OTHER			OVERALL	MEDICAID
CORDOVA HOSPITAL LTC	$311.34	10	4	10	0	n/a	0	10	4	71%	71%
DENALI CENTER (Fairbanks)	200.34	101	0	44	15	4	9	72	29	71%	58%
HERITAGE PLACE (Soldotna)	221.90	45	0	27	4	3	5	39	6	87%	69%
ISLAND VIEW MANOR	264.65	46	0	13	3	4	2	22	24	48%	35%
KOTZEBUE SENIOR CITIZEN CARE CTR.	205.87	9	0	4	3	0	0	7	2	78%	78%
KODIAK ISLAND HOSPITAL LTC	246.83	19	4	14	0	0	2	16	7	70%	61%
MARY CONRAD CENTER (Anchorage)	220.64	84	0	81	0	n/a	2	83	1	99%	96%
OUR LADY OF COMPASSION (Anchorage)	184.92	224	0	142	48	6	20	216	8	96%	85%
PETERSBURG HOSPITAL LTC	271.60	14	4	12	0	0	1	13	5	72%	67%
QUYAANA CARE CENTER (Nome)	310.95	15	0	14	0	n/a	0	14	1	93%	93%
SOURDOUGH PLACE (Valdez)	232.99	16	0	12	0	n/a	2	14	2	88%	75%
SOUTH PENINSULA HOSP. LTC (Homer)	301.47	18	4	14	1	n/a	0	15	7	68%	68%
ST. ANN'S NURSING HOME (Juneau)	203.08	45	0	27	7	0	6	40	5	89%	76%
WESLEY REHAB. CARE CTR. (Seward)	177.37	66	0	41	2	n/a	3	46	20	70%	65%
WRANGELL GENERAL HOSPITAL LTC	265.78	14	4	7	1	0	2	10	8	56%	44%
SWING BEDS (Acute to LTC):											
CENT. PENINSULA HOSP (Soldotna)	198.18	0	4	0	0	0	0	0	4	0%	0%
SEWARD GENERAL HOSPITAL	198.18	0	2	0	0	0	0	0	2	0%	0%
SITKA COMMUNITY HOSPITAL	198.18	0	2	0	0	0	0	0	2	0%	0%
VALDEZ COMMUNITY HOSPITAL	198.18	0	6	0	2	0	0	2	4	33%	33%
VALLEY HOSPITAL (Palmer)	198.18	0	4	0	1	0	0	1	3	25%	25%
	TOTAL	764		462	87	17	54	620	144	81%	72%

* - Includes VA, private pay insurance and other.

SNF--skilled nursing care
ICF--intermeadiate nursing care
SWING BED--patient has been moved from acute care to room where they are awaiting discharge.

KAREN MARTZ, ADMINISTRATOR
DIVISION OF MEDICAL ASSISTANCE (907) 561-8081
DEPARTMENT OF HEALTH & SOCIAL SERVICES

1/16/92
DATE

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ICF/MR AND IMH CENSUS

AS OF: NOVEMBER 30, 1991

PSYCHIATRIC BEDS	PERDIEM RATE	CERTIFIED BEDS	CURRENT OCCUPANCY					
			TOTAL	MEDICAID UNDER 22	MEDICAID OVER 65	NON-MEDICAID	TOTAL CENSUS	VACANT BEDS
ALASKA PSYCHIATRIC INSTITUTE Anchorage	$336.59	160	26	22	4	67	93	67
CHARTER NORTH HOSPITAL Anchorage	N/A	60	24	24	0	25	49	11
NORTH STAR HOSPITAL Anchorage	N/A	34	20	20	0	10	30	4

ICF/MR BEDS	PERDIEM RATE	CERTIFIED BEDS	CURRENT OCCUPANCY			
			MEDICAID	NON-MEDICAID	TOTAL CENSUS	VACANT BEDS
HARBORVIEW DEVELOPMENTAL CENTER Valdez	339.61	64	47	0	47	17
HOPE COTTAGES Anchorage	335.70	40	40	0	40	0

Karen Hartz 1/6/92

KAREN HARTZ, ADMINISTRATOR DATE
DIVISION OF MEDICAL ASSISTANCE (907) 561-8081
DEPARTMENT OF HEALTH & SOCIAL SERVICES

JAN 14 '92 13:02 AK LEG RESEARCH AA P.3/3

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

January 24, 1992

Senator Jim Duncan
Room 119, Capitol
P.O. Box V
Juneau, AK 99811

Subject: SB 344 - "An Act prohibiting a nursing facility that participates in the Medicaid program from charging a rate for a resident that is higher than the rate approved for Medicaid purposes."

Dear Senator Duncan:

The Alaska State Hospital and Nursing Home Association (ASHNHA) has reviewed SB 344 which you sponsored earlier this month.

The ASHNHA members are opposed to SB 344 as introduced.

The bill would require nursing homes to reduce the amount they charge all patients other than Medicaid patients. This provision would impact the existing Federal Medicare reimbursement formulas.

The nursing homes currently negotiate discounts or allowances with high volume purchasers such as the Veteran's Administration, Champus, and commercial insurers. Senate Bill 344 would preclude those negotiations which are used by the facilities to make sure they recover costs not covered by Medicaid and Medicare.

Under this bill the amounts charged private pay patients and those with commercial insurance would be reduced to the same level that is paid by Medicaid.

This would create a hardship for the nursing homes because SB 344 contains no provision for Medicaid or any one else to cover the costs that Medicaid and Medicare don't cover now. The ASHNHA members believe this could bring about nursing home failures and prevent Alaskans from having access to needed long term care services.

ASHNHA members understand that, with this bill, you are trying to develop a system where all payers would pay the same amount for nursing services. Developing such a system however, needs to be done with the objective of making sure the full cost of nursing home care is being covered. In order to do that, the State's entire Medicaid reimbursement system needs to be reworked.

319 SEWARD STREET #11 • JUNEAU, AK 99801 • (907) 586-1790 • FAX (907) 463-3573

ASHNHA has been working with the Department of Health and Social Services (DHSS) for the past six months to develop the design of a new Medicaid reimbursement system. ASHNHA believes the kind of change proposed in your SB 344 should be made in the context of the design of a completely new reimbursement system.

DHSS and ASHNHA have formed a steering committee that has met regularly to work on new system design. The four ASHNHA steering committee members would be happy to meet with you at your convenience to discuss the process and status of the new system development.

Currently, Alaska's Medicaid reimbursement system does not even attempt to cover costs at all of the nursing homes. A cap is imposed on the amount of daily reimbursement allowed by Medicaid. The cap is an amount equal to the state wide average costs per patient day at all Alaska nursing homes. If a specific facility has costs per patient day that exceed the statewide average, their routine rate reimbursement is limited to the statewide average.

Using St. Ann's Nursing Home as an example, the 1992 cap that is being imposed on reimbursement is $6.00 per patient per day lower than St. Ann's 1991 cost per patient day. That difference alone costs St. Ann's nearly $100,000 per year.

If Medicaid continues to cap the reimbursement at an amount lower than St. Ann's cost and SB 344 forces the facility to reduce all non Medicaid patient's bills, the negative financial impact becomes even more burdensome.

The Alaska Superior Court has ruled that the regulations used to implement the cap on long term care Medicaid reimbursement are void. The State has appealed that decision to the State Supreme Court and continues to impose the cap.

Medicaid does not reimburse facilities for Charity care or bad debts.

If Senate Bill 344 was to pass, the facilities would have to reduce their bills to private pay and commercially insured patients. It could also result in a drop in Medicare reimbursement for the facilities.

As the long term care cap continues to be imposed, some facilities are already operating at a built in loss.

The ASHNHA members do not believe it is reasonable to remove their financial operating options. They support continued development of a new Medicaid reimbursement system.

If it should be done, equalization of amounts paid by all payers should be done in the context of the new system. The rates set should be at a level that covers full cost of providing the nursing care which would mean increasing the amount Medicaid currently pays.

Please let me know if I can provide you with additional information or get answers to your questions on this issue.

Sincerely,

Garrey M. Peska, C.P.A.
Vice President for Financial Affairs.

cc: Harlan Knudson
ASHNHA Long Term Care Committee Members

FAX (907) 463-3055

(907) 586-3539

DOUGLAS L. GREGG, ESQ.
A PROFESSIONAL CORPORATION
ATTORNEY-AT-LAW
107 MUNICIPAL WAY, SUITE 2
JUNEAU, ALASKA 99801

December 30, 1991

Honorable Jim Duncan
The State Senate
P.O. Box V
Juneau, Alaska 99811

Re: Proposed Legislation for Nursing Home Care

Dear Senator Duncan:

I agree that the health care system as a whole needs an overhaul. Medicaid is currently a big part of the problem. I'd like to point out one facet you may be unaware of, reiterate the cost shifting issue, and suggest a partial solution.

1. Many retired state employees will never qualify for Alaska Medicaid, no matter how desperate their circumstances become. Even after you have spent all of your money and sold your home and all of your other assets, if your retirement income from all sources, including any social security, is one cent more than an arbitrary cutoff (currently about $1,300/mo) you don't qualify for Alaska Medicaid. It doesn't matter that you give all of that income to the Nursing Home, and that it's $7,000 or more short. Alaska is one of a few states that won't pay the difference. Since you can't shut off a pension, the Department of Health and Social Services has had to tell such people to leave Alaska for a state that will help.

2. In the U.S., the Medicaid program is underfunded and is not "universal." This results in "cost shifting" wherein private patients can go bankrupt subsidizing Medicaid patients. Yet since service providers are unable to fully recover Medicaid underpayments through cost shifting, on a national basis that Medicaid care is often substandard.

My suggestion addresses only nursing home care. This is the most onerous bill most families will ever face, costing as much every year as the face amount of a typical home mortgage, where people have 30 years to pay. It affects young and old alike; at St. Ann's at least three of the patients are currently under 45 years of age.

I am not proposing "free" nursing home care. Private patients would pay for their care. But the burden of any Medicaid underpayment would be borne by the State Department of Health and Social Services, which controls those rates. Further, the bill provides that those who cannot qualify for Medicaid due to the State's income test would receive non-Medicaid assistance moneys sufficient to make up the difference between their income and the nursing home bill.

When you review the draft bill, it may occur to you that it is similar to the Canadian Health Care System, in that nursing homes could only bill the State. But the similarity stops there, because the State would then invoice private patients at the Medicaid rates set by the State. The State's non-Medicaid funds would pay any difference between the Medicaid and private rates, but the private rates would be negotiated. Unlimited cost shifting would cease, and remaining cost shifting would be borne by the State.

Such a bill would ensure that the Department of Health and Social Services would find evidence of cost shifting when it occurs, since their budget would absorb it. Currently, private patients are "out of sight" to the Department; see Mr. Livey's letter, attached.

It would not be prohibitively costly to stop nursing home cost shifting. You can often count the number of private pay patients at an Alaska Nursing home on the fingers of one hand. The cost shifting amounts to perhaps $25,000 of the annual bill. Every two or three patients amounts to the salary of a single state employee, hardly an unreasonable sum to stop such an inequity.

The cost to provide help for those in need who fail the income test would likely be much higher. This bill may not be the best place to correct that inequity. An appropriate change to Alaska's Medicaid rules, for example, could make federal matching funds available to help with that problem.

Very truly yours,

DOUGLAS L. GREGG

DLG:wmg
Enclosures
1. Draft Bill.
2. Jay Livey's Letter.

SENATE BILL _____

AN ACT RELATING TO NURSING HOMES, PROVIDING FOR CONTINUED PAYMENT OF BENEFITS ON BEHALF OF INSURED PATIENTS "AS THOUGH" THE STATE WERE A PROVIDER OF SERVICES, AND SETTING AN EFFECTIVE DATE.

PREAMBLE. The legislature finds and declares that the State of Alaska, through its Department of Health and Social Services, has the responsibility to maintain equity between private and Medicaid payment rates.

Section 1. Billing. Nursing homes in Alaska may use different billing structures for private patients than for Medicaid patients but shall invoice the Department of Health and Social Services, only, for both kinds of service. The Department in turn shall bill the private patients at the all-inclusive Medicaid rate, regardless of the individual patient's ancillary usage, adding only charges for any services not available to Medicaid patients. All insurers doing business in Alaska shall pay benefits to insured nursing home patients as though the Department's bills were issued directly by the nursing home provider. The Department's non-Medicaid budget shall absorb any difference between the nursing facility's private pay rates and the Department's Medicaid rates, as well as any losses on uncollectable accounts.

Section 2. Private Rates; Arbitration. Individual nursing homes

and the Department shall negotiate the private pay rates based on the nursing home's income and expenses, including the expenses of charity care. Where the two cannot agree, the matter shall be submitted to arbitration. The State and the nursing home shall each select an arbiter, those two shall agree upon a third, and the decision of the three shall control; provided, however, that either side may, within thirty (30) days of the decision, appeal an adverse decision to the superior court, otherwise the decision of the arbiters to be binding.

Section 3. Universal Coverage. No patient shall be denied care in Alaska due to inability to pay. The Department shall bill patients, including interest at money market rates or 10.5%, whicever is less, until such patients meet the asset-limitation test for Medicaid. It shall then continue to bill patients whose income is sufficient to pay the entire bill, excepting exempt income for a spouse at home, but for others it shall accept assignment of their non-exempt income, less $75 per month allowance, as payment in full. If the patient qualifies under the Department's income test for Medicaid, the balance shall be paid by Medicaid funds. If the patient does not so qualify, the balance shall be paid from the Department's non-Medicaid funds.

Section 4. This act becomes effective etc. etc.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

WALTER J. HICKEL, GOVERNOR

THEODORE A. MALA, COMMISSIONER

P.O. BOX H
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030

December 17, 1991

Douglas L. Gregg, Esq.
Attorney at Law
107 Municipal Way, Suite 2
Juneau, AK 99801

Re: St. Ann's Nursing Home (St. Ann's) Medicaid Payments.

Dear Mr. Gregg:

I received your November 1 letter and copies of your letters written to others outlining your continuing concern over St. Ann's charges and Medicaid payments.

As I described in my October 30, 1991 letter to you, Department of Health and Social Services (department) 1990 data shows Medicaid payments were properly made to St. Ann's under law, and the Medicaid program paid $464,000 more than its fair share of the facility's cost of caring for Medicaid patients. The department has no evidence that indicates the state has underpaid St. Ann's for caring for Medicaid patients and, actually, the opposite is true. The department paid St. Ann's more than the facility's full cost of providing services to Medicaid patients. Under these circumstances, I cannot agree that private pay patients are subsidizing Medicaid patients at St. Ann's or that the Medicaid program has transferred any unreimbursed cost burden (cost shifted) to St. Ann's private pay patients. I also cannot agree with your statement that the facility rate for Medicaid patients set for St. Ann's is not a "fair" rate, merely a "capped" rate.

One of the confusing aspects with regard to this issue is the method that St. Ann's uses to bill patients. Copies of St. Ann's billing documents included with your letters suggest that St. Ann's charges all patients a flat per diem rate which approximates the all inclusive Medicaid per diem rate (including ancillaries) and in addition charges all patients for actual ancillary services

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provided. The department does not control facility charges. If you have questions about the facility's charging structure, I suggest you may want to take those questions up with St. Ann's.

The department's obligations under state and federal Medicaid statutes do not extend beyond paying facility costs attributable to services provided to Medicaid patients. According to 1990 data, Medicaid paid for more than its share of St. Ann's costs attributable to Medicaid patients. Further analysis shows that Medicaid paid more than St. Ann's total costs, including the costs of caring for all of the facility's private pay patients.

If you have any questions or if you would like to meet personally to discuss these issues please call me at 4 5-3030.

Sincerely,

Jay Livey

Jay A. Livey
Deputy Commissioner

cc: Grant Asay
Jack Nielson

STATE OF ALASKA

WALTER J. HICKEL, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

P.O. BOX H-07
JUNEAU, ALASKA 99811-0660
PHONE: (907) 465-3355

DIVISION OF MEDICAL ASSISTANCE

December 28, 1991

Honorable Jim Duncan
Post Office Box 690
Juneau, Alaska 99802

Dear Senator Duncan:

I asked Dave Campana, our pharmacist, to research and prepare information for this letter. He has reviewed the charges for pharmaceuticals at St. Ann's Nursing Home for Inez Gregg.

It is true that the pharmaceutical charges are twice what she would pay on her own. The main cause of this high cost is the addition of St. Ann's pharmacy charges to the Juneau Drug charges. The nursing home provides medication services and must meet specific regulations involved with dispensing medications.

Mrs. Gregg's pharmaceutical charges are comprised of charges from both the pharmacy, Juneau Drug Co., Inc. and St. Ann's. Juneau Drug Co., Inc. bills the usual charges for Mrs. Gregg's prescriptions that it charges the normal walk-in customer. This charge includes the cost of the drug, a professional fee or markup, packaging, and once daily delivery to the nursing home; this accounts for 50% of the final pharmaceutical charge to the patient at St. Ann's. The other 50% of the final pharmaceutical charge to Mrs. Gregg is a charge that St. Ann's adds to each prescription a patient receives. This charge covers administration of the medication, record keeping, storage, and the fee for the consultant pharmacist who must by law review the patient's charts: (see 42 CFR 442.336).

We know this doesn't solve Mrs. Gregg's financial problem with the cost of pharmaceuticals at St. Ann's, but I believe this answers the immediate question of the relative higher cost.

As always, I appreciate your sincere interest in the cost of health care in Alaska and the effects of this cost on citizen access to necessary services. If we can be of further assistance, please don't hesitate to contact Dave Campana, RPh or me. I can be reached in Juneau at 465-3355 and Mr. Campana can be contacted in Anchorage at 561-2171.

Respectfully,

Kim

Kim Busch
Acting Director

KBB:jg

06-F145LH

SB

FAX (907) 463-3035

(907) 586-3539

DOUGLAS L. GREGG, Esq.
A Professional Corporation
ATTORNEY-AT-LAW
107 MUNICIPAL WAY, SUITE 2
JUNEAU, ALASKA 99801

Melissa

October 16, 1991

The Honorable Arliss Sturgulewski
The State Senate
P.O. Box V
Juneau, Alaska 99811-3100

Dear Senator Sturgulewski:

I am sending you this copy of an inquiry to the Board of St. Ann's Nursing Home in Juneau concerning a $27,000 billing discrepancy relating to "ancillary" charges (explained in the enclosure) being collected from my Mother, who does not currently qualify for Medicaid assistance.

The Home's administrator has asserted that they bill the State for such ancillary charges for Medicaid patients, but that the State does not pay, necessitating "cost shifting" to make up the Home's expenses. But "cost shifting" as explained in my letter is illegal. More disturbing, I have since learned that the State calculates the Medicaid per diem rate to include all such charges, and that despite this even their all-inclusive per diem rate is less than the "base" rate imposed on my Mother.

In your capacity as Chairman of the Senate Health, Education, and Social Services Committee I thought you should be aware of the extreme burden being placed on private pay patients and being blamed on the State's administration of the Medicaid system.

Very truly yours,

Douglas L. Gregg

DOUGLAS L. GREGG

DLG:wmg
Enclosure

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JUNEAU, ALASKA 99801

October 16, 1991

The Honorable Jim Duncan
The State Senate
P.O. Box V
Juneau, Alaska 99811-3100

Dear Senator Duncan:

Enclosed for your information is a courtesy copy of my most recent communication covering the issue of St. Ann's Nursing Home's circumvention of Federal Statute concerning cost shifting.

Very truly yours,

DOUGLAS L. GREGG

DLG:wmg
Enclosure

FAX (907) 463-3055

(907) 586-3539

DOUGLAS L. GREGG, Esq.
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ATTORNEY-AT-LAW
107 MUNICIPAL WAY, SUITE 2
JUNEAU, ALASKA 99801

COPY

October 16, 1991

Board of Directors
St. Ann's Nursing Home
415 Sixth Street
Juneau, Alaska 99801

Dear Director:

Most of you know that my mother, Inez Gregg, is a resident of St. Ann's Nursing Home and has been since August 30, 1990. Overall, the family has been satisfied with her care.

What you may not know is that as a private pay patient, we are being forced to pay some $27,000 per year more than is paid on behalf of almost everyone else in the facility, for identical services rendered. Over the last four months, her bills have increased to an average of $8,227 per month, while you have made no effort to collect more than $6,071.10 per Medicaid patient. Over the last thirteen months, you have charged my Mother -- and we have paid -- over $104,500. Medicaid has paid only $78,924.30 per patient.

Shortly after my mother entered the home, Mr. Asay assured me that she was being charged exactly the same as Medicaid patients. I was shocked, then, when the Ombudsman disclosed that Medicaid pays only a per diem rate, which includes all expenses, whereas St. Ann's has "unbundled" charges for Mom. That is to say, Mom is charged separately for her medical supplies, drugs, lab, physical therapy, occupational therapy, and occasional other charges, in addition to the per diem she pays. These "ancillary" charges make up the majority of the difference between Mom's monthly charges and the Medicaid Rate.

When I asked Mr. Asay about this, he explained that St. Ann's does bill Medicaid for these services, but that they don't pay. But I have learned from the State's Medicaid Rate Advisory Commission and the State's Medicaid Plan that Medicaid's per diem rate is calculated to cover these services.

Nevertheless, it is constantly claimed that private pay patients are overcharged because Medicaid underpays. Senator Duncan stated it this way:

> Your assessment of the situation is correct, private pay patients are essentially subsidizing Medicaid care through payment of higher rates than Medicaid will pay.

As board members with personal liability, you need to know that this is <u>forbidden</u> by Federal Statute:

> Reasonable and "...necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter [Medicaid and Medicare] will not be borne by individuals not so covered...." 42 USC §1395x(v)(1)(A) (1982)

There is a federal regulation which some may argue alters this. That regulation reads:

> The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in §483.10(a)(5)(i) describing the charges. 42 CFR 483.12(c)(2)

You must realize, however, that regulations <u>cannot</u> conflict with statute -- and if they do, courts will always hold that that statute <u>prevails</u> over regulations. Thus this section of the regulations must be read to refer to services <u>not available</u> to Medicaid patients but which a private pay patient may elect to purchase (e.g., dentures).

In addition, you should be aware that the <u>Federal</u> government does <u>not</u> set the Medicaid rates. These rates are set by the <u>State</u> with input from the <u>State's</u> Medicaid Rate Advisory Commission. See AS 47.07.120. Furthermore, the State certifies to the Federal Government that these rates are indeed "reasonable and adequate." 42 CFR 447.250(a)

Federal regulation states that Medicaid rates <u>must include</u> the cost of complying with the

comprehensive care requirements of part 483 subpart B (for example, drug dispensing costs and the quarterly medications review). (42 CFR 447.253(b)(iii)(a)) The State's own Medicaid manual states that "the rate paid to a long term care facility includes all services, supplies (including drugs), and equipment required for complete care...." The Federal statute requires that the calculated rate include provision for a reasonable return on equity capital and working capital invested in the facility, and that the State include provision for retroactive payments to nursing homes in the event that the aggregate reimbursement proves inadequate. State law provides that the cost of capital development is included in the per diem rate. (AS 47.07.070(b)(2).)

According to the State's Medicaid Rate Advisory Commission, St. Ann's is paid approximately $6,000 per month per Medicaid patient (the quoted daily rate was $202.37). If this rate is in fact not reasonable and adequate, then St. Ann's has a cause of action against the State, and a clear duty to all its patients to pursue that action. Federal law provides for judicial review of "reasonable cost," thus reserving to the courts the final authority to interpret this aspect of the statute. There is case law to support this. In addition,

> The regulations "must avoid the result of shifting costs to non-Medicare patients." St. John's Hicky Memorial Hospital, 599 F.2d at 813 n. 17 (emphasis added.)

While Medicare and Medicaid are separately administered, the same Federal statute stands behind both programs. Case law concerning one is case law concerning the other.

To come to the point, I believe that my mother is being grossly and illegally overcharged. If you -- as directors -- agree with your administrative staff that the Medicaid reimbursement for care at St. Ann's is in fact too low, then you have a duty to protest your inadequate reimbursement. You are not allowed to shift costs to private pay patients.

You must take action to collect the legitimate bills owed by Medicaid. You must reimburse overcharges made for my mother's care going back to her admission, and begin charging on a schedule that results in total billings substantially equivalent to the Medicaid rate.

I have written to you, with copies to several other interested parties, in the hope that someone, somewhere, will decide that justice must be served. I am frustrated by what I perceive as a tacit acceptance of a status quo that is acknowledged, and easily proven, to be contrary to law.

On my own, I have only a few alternatives:

- take the whole matter before the public with a media senior rights campaign;
- invite an investigation by the U.S. Department of Health and Human Services into the operation of our state's Medicaid program; or
- file suit.

None of these are pleasant alternatives, and the last would be a major expense for my family. But cost shifting in direct conflict with statute is a wrong that must be addressed and redressed.

Very truly yours,

DOUGLAS L.

DLG:wmg
cc: Alaska Congressional Delegation
Juneau Legislative Delegation
Senate and House Health and Social Services Committees
State Department of Health and Social Services and Advisors
William M. O'Connor, Long Term Care Ombudsman
Grant B. Asay, Administrator, St. Ann's Nursing Home

FINANCIAL CONSULTANTS OF ALASKA

Donna Herbert, owner

174 S. Franklin St.
Suite 229
Juneau, Alaska
99801

(907) 586-9565

October 21, 1991

Dear Board Members:

As you are all aware, Mr. Gregg has challenged the charging mechanism at St. Ann's Nursing Home, and proposed the question, of why Medicaid is paying less monies per year on long term care patients than he must pay on his mother who is a private patient.

All nursing homes in the state are subject to the federal and state laws which govern nursing homes. There is a federal, as well as state law, which mandates that all nursing home patients whether Medicaid, Medicare, or private pay, etc. be charged exactly the same rates for services. This regulation is sometimes referred to as "customary charges".

Each patient at St. Ann's, regardless of payment category is charged the same rate for routine and ancillary services. The routine per diem rate charged to Medicaid patients is the same as the routine per diem rate charged to private patients, and does not include the ancillary services of occupational therapy, physical therapy, medical supplies, etc. These ancillary charges are charged separately to each individual patient regardless of payment category according to their usage.

The Department of Health and Social Services pays one payment for Medicaid patients. This payment is broken into the following components: Routine, Ancillary, Capital and Year-end-conformance. The Medicaid ancillary reimbursement paid by the Department is based on the ancillary services charged to the Medicaid patients. Currently the Medicaid ancillary portion is $41.97 per patient day which includes a year-end-conformance factor.

The state Medicaid regulation that mandates that all patients be charged as described is 7AAC 43.685 (e) and 7AAC 43.685 (2). The federal regulation is 413.13 referred to as "customary charges".

Again to reiterate, at St. Ann's Nursing Home, a private patient is charged exactly the same as a Medicaid patient for the same services regardless of whether they are routine or ancillary. The actual payment received by a third party payor is determined by the complex formula specific to that particular program methodology. St. Ann's is audited regularly by the State Department of health and Social Services to assure our compliance with this regulation. Attachments A and B are actual billings for a private patient and a Medicaid patient for all charges and services for the month of December, 1990.

In his letter to St. Ann's board of October 16, 1991, Mr. Gregg is questioning the discrepancy in private pay charges to Medicaid over a thirteen month period, and although his numbers are somewhat incorrect, there is no question that a discrepancy exists and an explanation is warranted.

State Patient

State Rate		time frame	payment
210.62	(1990)	4 months 121 days	$25,625
203.08	(1991)	9 months 273 days	$55,441
		394 days	$81,066

Private Pay Patient Gregg

	394 days	$104,500
DIFFERENCE IN PAYORS:		$ 23,434

Mr. Gregg has stated in his letter that over the course of the thirteen months, his family has paid $23,434 in excess of what the State has paid for an average Medicaid patient.

I would like to explain some of the discrepancy in the above analysis, and then generally explain the State Medicaid program methodologies.

In 1990 the State of Alaska opted to discontinue paying for long term care patient prescription drugs in the facility. The Department elected instead to pay to an outside pharmacy directly for those drugs. Therefore the charge and cost associated with medicaid prescription drugs is no longer on the medicaid patient records or charges at St. Ann's. The charge for those drug costs are still on the private pay records since St. Ann's still pays for private patients drug costs.

The average charge for a Medicaid patient's drugs over a thirteen months period is approximately $6,722.

In 1990 St. Ann's received a high Medicaid payment from the State for Medicaid patients of $210.62, that rate however dropped in 1991 to $203.08. The major drop in the rate was a $19.74 per day drop in the ancillary portion.

Please see Attachment C: 1990 medicaid rate
Attachment D: 1991 medicaid rate

That drop represents $7,778 in ancillary charges per patient over the 394 days that Mr. Gregg is questioning.

All third party payors operate under state and federal regulations. Federal law states that medicaid will pay for ancillary costs, if the charges for those costs are higher than the cost. This is called the lower of cost or charge principle.

In 1989 which is the base year for the 1991 Medicaid reimbursement rate, St. Ann's ancillary charges were $78,722 below their ancillary cost of $487,072.

In this situation, Medicaid pays the lower - that is charges instead of cost. Therefore our Medicaid ancillary portion dropped $19.74 a patient day. Please see attachment E for the ancillary cost and charge formula. The State Attempted to drop St. Ann's even further because the ancillary charges were so low. After a six month battle and many conferences and presentations, the State agreed that the $19.74 was the maximum penalty they would impose.

Please see attachment F of St. Ann's state report and I will generally attempt to explain how routine costs are calculated.

The state has devised a formula to cap or reduce routine costs. That cap on routine costs changes from year to year but can be anywhere between $1.50 per day to $20.00 per day. For St. Ann's the cap was $8.53 a day for the four months in 1990 and $6.17 per day for the nine months in 1991.

1990 - $1032.13
1991 - $1684.41

In summary the $23,434 of costs over the thirteen months Mr. Gregg is questioning can be explained in the following manner:

	$23,434
Elimination of prescription drugs/medicaid only patients:	$(6,722)
Lower of cost or charges on ancillaries:	$(7,778)
Upper limit cap on St. Ann's:	$(2,717)
Remaining:	$ 6217

Mr. Gregg's mother is one of the highest ancillary utilized patients in the facility. Her percentage of ancillary usage is 35% over the average Medicaid patient. Mrs. Gregg's average ancillary charge per day over the thirteen months period is $56.62 while the average Medicaid patients ancillary is $41.82. The $6,217 of unexplained difference represents that higher ancillary usage.

Thank you for the time you have given today trying to understand some very complicated concepts. If I can be of any further assistance or offer further explanation in this matter please feel free to call.

Sincerely,

Donna Herbert

CC: Avrum Gross
Douglas Gregg

Enclosures:

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

MEDICAID RATE ADVISORY COMMISSION

WALTER J. HICKEL, GOVERNOR

4792-1 BOEKOVEN PARK BLVD, BLDG 7
ANCHORAGE, ALASKA 99503
PHONE: (907) 562-1996
FAX: (907) 563-7109

August 30, 1991

Grant Asay, Administrator
St. Ann's Nursing Home
415 Sixth Street
Juneau, Alaska 99801

Dear Mr. Asay:

The proposed OBRA increments have been adopted as amendments to 7 AAC 43.685, specifically amending 7 AAC 43.685 (o) and adding 7 AAC 43.685 (u). The calculations are enclosed for your review.

In accordance with 7 AAC 43.701, 7 AAC 43.685(o) through (u), and the Staff Analysis, your facility's 1991 long term care rate for medical assistance services for the period September 1, 1991 through December 31, 1991 is established as follows:

	9/1/91-12/31/91
Routine	$138.87
Routine Capital	20.22
Ancillaries	35.00
7 AAC 43.691	6.95
OBRA Adjustment	0.75
OBRA (p) and (q)	0.58
OBRA Amendment	0.71
Total Rate	$203.08

41.97

If you have any questions or comments please call me at (907) 562-1996.

Sincerely,

Randall Sellapie
for

Jack Nielson
Executive Director

cc: Donna Herbert
Fred Shuler
Eric Hansen
Jay Livey
Randy Super
Terri Keklak

Attachment D

INPATIENT ANCILLARY COST APPORTIONMENT

SUPPLEMENTAL WORKSHEET S-4

TITLE V ____ HOSPITAL ____ SNF ____ PPS ____
TITLE XVIII-PT A ____ SUB I ____ ICF XXX (02-0000) TEFRA ____
TITLE XIX XXX SUB II ____ S/B-SNF ____ OTHER XXX
SUB III ____ S/B-ICF ____
SUB IV ____

COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COSTS 3	
ANCILLARY SERVICE COST CENTERS				
LABORATORY				44
RESPIRATORY THERAPY	.320151	1397	447	49
PHYSICAL THERAPY	.441525	.20151	89431-	50
OCCUPATIONAL THERAPY	2.648322	30633	213543-	51
SPEECH PATHOLOGY	2.812000	1080	3037-	52
MED SUPPLIES CHARGED TO PATS	1.064614	30981	86214	53
DRUGS CHARGED TO PATIENTS	.793062	117453	93148	54
RECREATIONAL THERAPY				55
OTHER ANCILLARY	.188087	6655	1252	55A
OUTPATIENT SERVICE COST CENTERS				
OTHER REIMBURSABLE COST CENTERS				
TOTAL		408350	487072	101
LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES				102
NET CHARGES		408350		103

78,722 Diff Cost to charges

Why diff btwn costs & charges?

Attachment E

ST. ANN'S NURSING HOME
1988 BASE YEAR EXPENSES

FISCAL YEAR 1990

ATTACHMENT
11/16/8

	LTC	LTC CAPITAL	MED/GRM	MED/GRM CAPITAL	TOTAL
Direct Expenses	$707,773	$26,181	0	0	$733,95
Employee Benefits	112,210	0	0	0	112,21
Rents/Leases	0	126,706	0	0	126,70
Admin & General	176,141	11,862	0	0	188,00
Operation of Plant	64,823	16,729	0	0	81,55
Laundry & Linen	73,871	6,026	0	0	79,89
Housekeeping	93,104	961	0	0	94,06
Dietary	308,946	40,449	0	0	349,39
Nursing Admin	43,595	2,550	0	0	46,14
Medical Records	11,578	1,520	0	0	13,09
Social Services	45,022	7,552	0	0	52,57
Subtotal	$1,637,063	$240,536	$0	$0	$1,877,59
Ancillaries					
Recreational Therapy	75,102	29,291	65,899	16,029	186,32
Respiratory Therapy	(9,193)	(93)	13,465	137	4,31
Physical Therapy	(22,981)	(1,190)	103,498	7,296	86,62
Occupational Therapy	5,122	164	1,418	44	6,74
Speech Pathology	29	0	680	7	71
Medical Supplies	(9,236)	54	101,200	9,743	101,76
Drugs Chgd to Patients	29,693	348	143,832	1,583	175,45
Transportation	(3,342)	(34)	5,500	56	2,18
Transportation	5,500	56	(5,500)	(56)	
Total Ancillaries	70,694	28,597	429,992	34,838	564,12
TOTAL NET EXPENSES	$1,707,757	$269,133	$429,992	$34,838	$2,441,72
Adjustments					
Malpractice Insurance	108,164	0	0	0	108,16
Non-Reimbursable					
Rental Property	0	0	0	0	
Blank	0	0	0	0	
TOTAL EXPENSES	$1,815,921	$269,133	$429,992	$34,838	$2,549,88

Attachment F

GENERAL HOSPITAL

X-RAY CHARGE: $50.00
X-RAY APPROXIMATE COST: $45.00

PATIENT 1: WORKMAN'S COMPENSATION INSURANCE

Hospital Charge: $50.00
Insurance Payment to Hospital: $50.00
Patient Payment: $ 0.00

PATIENT 2: NO INSURANCE - PRIVATE PATIENT

Hospital Charge: $50.00
Private Patient Payment: $50.00

PATIENT 3: BLUE CROSS INSURANCE

Hospital Charge: $50.00
Blue Cross "Reasonable and Customary" charge for this X-ray is: $47.00
Blue Cross Payment (80% of Reasonable and Customary): $37.60
Patient Pays Balance ($50.00-$37.60): $12.40

PATIENT 4: MEDICAID PATIENT

Hospital Charge: $50.00
State Total Medicaid Payment (Formula Based): $40.00
Patient Payment: $ 0.00
Hospital Contractual Write-off (uncollectable): $10.00

NURSING HOME CHARGES
October 1991

Please note that St Ann's practice is no different than any other facility

Wesley Rehab. Care Center (Seward, 66 beds)

Routine Charge:	$165/day
Physical Therapy:	$85/hr
Occupational Therapy:	$85/hr
Medicaid per diem:	$177/day (all inclusive)

St. Ann's Nursing Home (Juneau, 45 beds)

Routine:	$210/day
Physical Therapy:	$80/hr
Occupational Therapy:	$85/hr
Medicaid per diem:	$203.08/day (all inclusive)

Our Lady of Compassion Care Center (Anchorage, 224 beds)

Routine Charge:	$215/day
Physical Therapy:	$135/hr
Occupational Therapy:	$135/hr
Medicaid per diem:	$185/day (all inclusive)

Petersburg Long Term Care (Petersburg, 18 beds)

Routine Charge:	$260/day
Physical Therapy:	$100/hr
Medicaid per diem:	$257/day (all inclusive)

STATE HEALTH NOTES

INTERGOVERNMENTAL HEALTH POLICY PROJECT

The George Washington University
WASHINGTON DC

Washington State, Hospitals Settle Boren Amendment Suit for $62 Million

After months of intense negotiations, **WASHINGTON** State has reached a tentative agreement with hospitals that will increase total Medicaid payments by $62 million over the next two years but that will also foreclose further litigation against the state for the next six years.

Although federal approval still is needed before the settlement can be finalized, the agreement announced on October 21 will have the effect of raising average Medicaid reimbursement levels by 10 percent ($28 million in state funds plus $34 million in federal funds). The lawsuit initially involved only 10 plaintiff hospitals, but a last-minute move that converted the case into a class action means that a total of 141 hospitals—including several border institutions in **IDAHO** and **OREGON**—will also realize the more generous payment levels.

Thus ends a significant test of the Boren Amendment, a 1981 law in which Congress directed states to pay economically and efficiently run hospitals and nursing homes rates that are "reasonable and adequate" to meet the costs incurred in caring for Medicaid patients. In June of 1990, the U.S. Supreme Court upheld the standing of these institutions to sue states for redress, and in the wake of that ruling, the number of lawsuits has mushroomed.

At last count, according to the American Hospital Association, 22 states have had one or more Boren Amendment suits filed against them, in most instances by the state hospital association. Of the total number of cases, 12—including the Washington case—have been resolved, although only 4 have gone to trial. All four of those cases were decided in the hospitals' favor.

(see "State Medicaid Suits," back cover)

Momentum Builds in Congress for Bill to Nullify HCFA Regs

Attempting to deflect yet another blow to state budgets, Members of Congress are gearing up for a legislative battle with the Bush Administration over a plan to limit federal Medicaid funds. The controversy centers on Health Care Financing Administration (HCFA) regulations, first proposed nearly two years ago and republished in late September, that would discontinue federal matching funds for Medicaid expenditures financed by donations and certain provider taxes—an increasingly popular revenue source for strapped state programs. (See *SHN*, October 21, 1991.) Thus far, at least one bill (HR 3550) has been introduced to block the regulations, which without intervention would take effect on January 1.

(see "HCFA Regs Battle," page 2)

IN THIS ISSUE

Number 119
November 4, 1991

State Medicaid Suits (from pg. 1)

Similarly, the American Health Care Association's most recent tally found that nursing homes have filed Boren Amendment suits in 22 states. Seven were either settled or won by the institutions; 15 are still pending.

The rash of suits and settlements, coinciding as it does with pressure from the Bush Administration to do away with provider tax and donation plans that all but a few states now use to draw down additional federal matching funds to run their Medicaid programs, makes the states' shaky budget situation even shakier. The Washington State ruling is expected to intensify pressure on other states where Medicaid rates fall short of the costs that hospitals and nursing homes incur.

The case is especially significant because it is the first in which the court so strongly addressed the spirit as well as the letter of the law. Earlier rulings tended simply to direct states to draw up a new Medicaid plan amendment that meets the so-called Boren test. Washington officials must do that as well, but with the stern words of U.S. District Court Judge Thomas Zilly ringing in their ears.

In his July 3 opinion, which ran well over 100 pages, Zilly said the desire to meet budget targets was the "driving force" behind the state's move in 1988 to revise its Medicaid payment system. The state, he said, not only failed to define an objective benchmark of the cost of running an efficient, economic hospital but also failed to consider whether the cuts it proposed to institute were in compliance with federal law. He also rejected the state's assertion that the new system was justified because it covered the marginal costs associated with Medicaid patients—a ruling that could affect other states confronting challenges to their rates.

In sum, Zilly said, assurances by the Department of Social and Health Services' "that its rates were substantively adequate had no reasonable factual basis" and the adoption of its plan was "arbitrary and capricious and contrary to law."

Under terms of the settlement reached in mid-October—Zilly is expected to approve it later this month—the 1988 lawsuit ends with a promise by Washington to find money for the enhanced rates without cutting other hospital care; in return, the hospitals have agreed to accept

"We're looking to close the books on the past."

the new rates as meeting the merits of the Boren test and to refrain from suing for at least six years.

The rate increase, retroactive to October 1, will affect 23 hospitals, mostly in urban areas, that contract with the state to provide Medicaid services, as well as all non-contract hospitals. Although the increase will average 10 percent, most rural hospitals are expected to be paid at 100 percent of their Medicaid costs. The second-generation DRG system at issue in the court case will remain the vehicle for reimbursement, but the state will build in a "less arbitrary" formula for factoring in inflation and will rebase hospitals periodically, in the event rates fail to keep pace with inflation.

James A. Peterson, Washington's Medicaid director, said that because the suit is being dropped without prejudice, with Zilly sanctioning that the settlement satisfies the Boren test, "its impact on other states will be minimal. There is no judgment that requires other states to do anything. There's nothing we're doing that will jeopardize other states," said Peterson, who continues to maintain that the 1988 rates were adequate.

Leo Greenawalt, president of the Washington State Hospital Association, argued, however, that the implications of the case "are tremendous. The court decision was not vacated," he said, which means it will be cited in future Boren cases.

Despite disagreement over the potential fallout, both sides are clearly glad the legal battle is over. Pronouncing the settlement "wonderful" and himself "elated that it's over," Greenawalt said the end result will be that hospital services for the poor that "were put on hold" for lack of funds can now be revived.

Said Peterson: "We're looking to close the books on the past. We want to turn now to making the system good for hospitals, the state and the people of Washington." • *LD*

Of Interest . . . Update on Bare Bones Laws

Since *Notes* last reported on the subject, two more states—**NEVADA** and **OREGON**—have approved laws authorizing small businesses to offer their employees "basic benefit" health insurance plans. That boosts the number of the so-called bare bones laws to 22: 8 enacted in 1990 and 14 so far this year. (For background, see *SHN's* May and July-August issues.) Oregon, which is in the midst of overhauling its Medicaid program, requires that basic benefit plans "provide for maximum accessibility and affordability of needed health care services and substantially meet the social values that underlie the ranking of benefits by the Health Services Commission" and that the plans be "substantially similar to the Medicaid reform program." Meanwhile, basic benefit bills are still under consideration in **CALIFORNIA, OHIO, PENNSYLVANIA** and **WISCONSIN**. In addition to requiring insurers to offer both a basic and a standard benefit plan to small groups (those with 3 to 50 employees), the Ohio bill (HB 478) restricts premium increases, caps insurers' administrative expenses, prohibits physician specialists from balance billing and encourages hospitals to "single bill" patients.

OCTOBER 1991
VOL. 12, NO. 10

McKnight's
Long-Term Care NEWS

The Newsmagazine of Nursing Homes, Retirement Housing and Extended Care Facilities

First national LTC PPO introduced

by Suzanne Powills

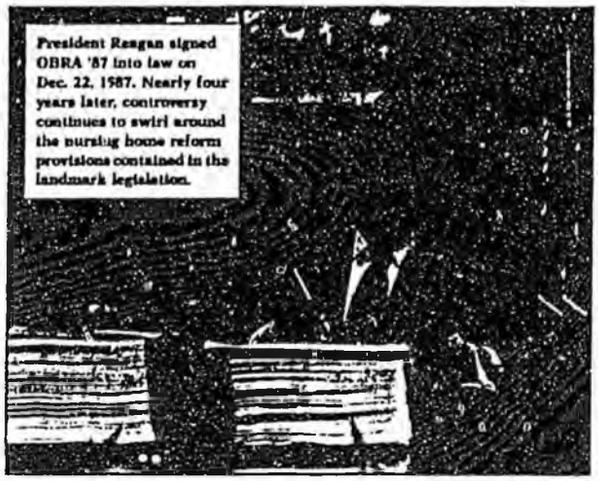
In what is believed to be the first national program of its kind, Beverly Enterprises Inc., Fort Smith, AR, and the Lincoln National Life Insurance Co., Fort Wayne, IN, have teamed up to launch a preferred provider organization (PPO).

A familiar acronym to acute care, PPOs have been in existence for more than 10 years. The creation of the partnership between Beverly and Lincoln National now brings the concept to long-term care.

A PPO is a negotiated payment arrangement between an insurer and a provider. The insurer typically receives a discount on provider rates in exchange for creating an incentive for policyholders to use a particular provider. Policyholders experience savings in copayments if they use the "preferred provider" — in this, case Beverly.

Under this program, Beverly will offer reduced rates to group long-term care policyholders of Lincoln National. According to William Ihle, vice president of communications for Beverly, the nursing home chain has agreed to offer Lincoln National a 10% discount off its regular

Continued on page 18.



President Reagan signed OBRA '87 into law on Dec. 22, 1587. Nearly four years later, controversy continues to swirl around the nursing home reform provisions contained in the landmark legislation.

OBRA: Year one

by John O'Connor

It was nearly four years ago — on Dec. 22, 1987 — when President Ronald Reagan signed into law a mishmash package of legislation known as the Omnibus Budget Reconciliation Act of 1987.

The landmark statute promised new reforms for the nursing home industry to ensure the highest level of care. Already, the law has made progress in substantially reducing restraint use and enhancing residents' rights.

But one year after becoming effective, OBRA's promise continues to be compromised by yet unpublished regulations. And the law's ultimate legacy remains on hold while industry members wonder aloud if the final law may do more harm than good.

"The biggest challenges that remain for providers include the lack of final regulations, survey guidelines and the insufficient state plan reviews guaranteed under the Boren Amendment," said Linda Keegan, a representative of the American Health Care Association.

The coming year will likely provide most of the still-missing pieces. But there's no guarantee that what the future holds will be seen by many as relief.

For residents, one area where the promise of better care has manifested itself during the past 12 months is in the form

Continued on page 23.

Few nursing facilities market for private pay

by Suzanne Powills

Unlike many long-term care facilities, Westshire Health Care Center has discovered the advantages of marketing for private paying residents.

The Cicero, IL-based long-term care facility recently spent $4,526 on 14 newspaper advertisements. The result was a 1,000% return on investment — or $42,000 in total patient days.

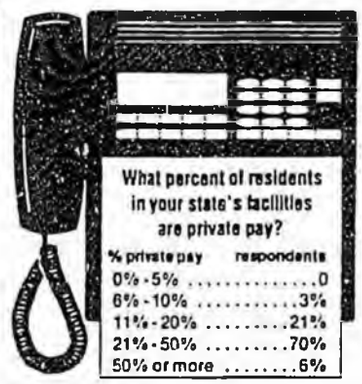
But Westshire's experience is hardly typical. "Marketing is viewed as an expense, and usually ends up at the bottom of the 'to-do' list," according to Phyllis Thornton, president of Signum Marketing, Louisville, KY.

While facilities have taken a lax approach to marketing in the past, the future may force a change in attitude. In fact, experts predicted that as public funding for the long-term care industry dries up, more facilities will take the lead of Westshire and begin marketing for private paying residents.

Continued on page 12

McKnight's LTC News FAX POLL

McKnight's LTC News conducted a poll by fax machine of all state affiliates of the American Health Care Association and the American Association of Homes for the Aging. The response rate for the poll was 42%.



What percent of residents in your state's facilities are private pay?

% private pay	respondents
0% - 5%	0
6% - 10%	3%
11% - 20%	21%
21% - 50%	70%
50% or more	6%

Governors call on feds to cover long-term care

SEATTLE — The nation's governors have decided that the federal government should be solely responsible for funding long-term care for the elderly.

At the National Governor's Association annual meeting here, the governors unanimously approved a health care reform package. The plan would shift funding responsibilities of all care for the elderly from the mishmash of state and federal programs currently covering such care to one source — the federal government.

The governors' proposal called the Medicaid system "broken" and stated that it has become a "rigid and overly complex program." The reform package said existing Medicaid resources should fund a new public program designed to meet the needs of the "non-disabled population from birth through age sixty-four."

Conversely, long-term care — as well as the whole continuum of services for the elderly and disabled — should be covered under one program, according to the reform package. "The Social Security/Medicare programs provide the obvious framework for such a program," the governors agreed.

"Elderly people shouldn't have to shift from one program to another to obtain care," said Ann Danelski, a representative of the association.

Continued on page 11

Late Breaking News

- **The U.S. Department of Health and Human Services released regulations that will prohibit the federal government from matching state Medicaid funds that are collected through provider donation or tax programs.** The rule stated that funds donated or collected through taxes from providers will be subtracted from state Medicaid totals before the federal matching share is calculated. In releasing the regulation, the department stated that donation and provider tax programs will cost about $3 billion in federal matching funds in fiscal year 1991
- **The American Health Care Association dropped its suit against the federal government over review of state plan amendments.** The association has withdrawn its notice of appeal against HHS Secretary Louis Sullivan, M.D.
- **Of the 7,298 U.S. hospitals, more than 1,000 are providing nursing home services,** according to new statistics from the U.S. Department of Commerce. The for-profit hospitals are generating about $744 million in receipts. And the non-profit facilities are generating about $18 billion in revenue

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Private pay market

From page 1

Currently, the percentage of private pay residents in most states runs between 21% and 50%, according to the fax poll conducted by McKnight's Long-Term Care News of state nursing home and homes for the aging associations.

Results from the informal poll also indicated that non-profit facilities attract a higher percentage of private pay residents. In fact, none of the responding non-profit associations said the percentage of private pay in their states was below 21%. Conversely, the for-profit association responses went down to the 6% to 10% range.

Midwest values

The proportion of private pay residents was also somewhat higher in the Midwest, according to the survey. This phenomena, however, appears to have little to do with marketing.

For example, the percent of private paying residents in Kansas is about 55%. But facilities in the state are more concerned with providing the best possible care than with marketing, said John R. Grace, president of the Kansas Association of Homes for the Aging in Topeka.

Further, Grace indicated that marketing may not even be necessary. "Word-of-mouth creates the demand for services," he said.

So how have Kansas facilities kept their private pay mix at 55%? Grace speculated that a lower cost of living in some areas of the state slows the speed of Medicaid spend down, thus increasing private pay census.

He also suggested that the high private pay mix may be the result of Midwestern values. Grace noted that for many people in Kansas, "government is the choice of last resort."

Paul Romans, executive vice president of the Iowa Health Care Association in Des Moines, agreed.

Romans said that the 50% to 51% private pay mix in his state results from the "nature and character of Iowa people." He cited one facility resident who qualified for Medicaid but didn't want to be on the state's rolls.

However, some facilities in Kansas are marketing for private payers, according to Romans. "A number of facilities are working with their communities and individuals, which results in increasing private pay," he said.

Minnesota, which has a rate equalization law on its books, offers no incentives to facilities for marketing. "We're locked in," according to Rick E. Carter, president of Care Providers of Minnesota, Bloomington, MN.

Carter said that there were only two advantages for marketing to private payers in Minnesota — facilities receive payment up front, and they can charge more for private rooms.

"Assuming that nursing homes can generate demand [by marketing], they can't change the total number of private paying residents available," Carter said. Nursing homes, therefore, could only lure private paying residents from other facilities, he added.

The state of the nation

The lack of interest in marketing by Midwest facilities appears to be in line with facilities throughout the states. Nursing facilities are not generally marketing for private paying residents, according to Signum's Thornton. "Facilities are more focused on internal operations and quality. But the focus stops there — internally," she said.

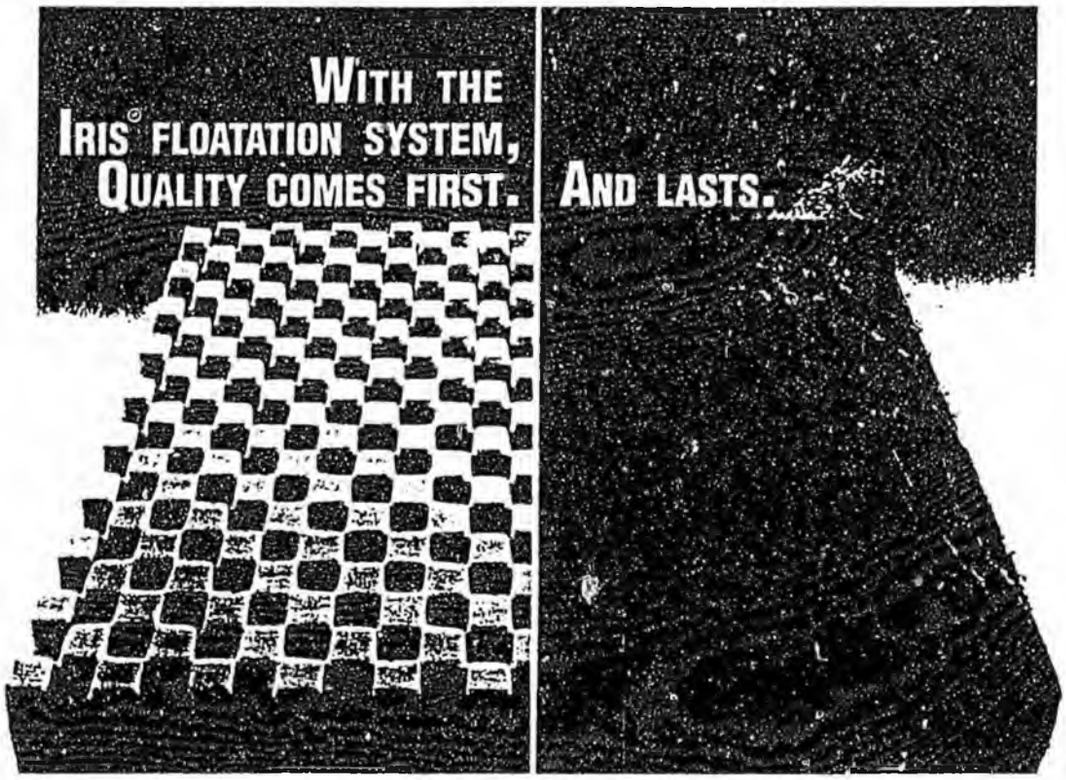
Thornton said most nursing homes still rely on hospital discharge planners. "But that feeder source is being cut off as hospitals get into long-term care," she added.

"Facilities can no longer depend on discharge planners," echoed George Molloy, president of M & M Associates, Vero Beach, FL.

Molloy explained that the 80s marked the end of what he called "the gravy train" of Medicaid spending. States began denying benefits and cutting costs. In addition, nursing homes began seeing more acutely ill residents resulting from the prospective payment system imposed on hospitals, he said. "Profitability plunged," Molloy said.

Tom Jazwiecki, national advisor for Ernst & Young, Washington, predicted that the trend will likely continue. "State and federal governments are currently struggling to adequately fund existing Medicaid programs. Their continued ability to fund service expansion or further increases in program scope is highly questionable," he said.

Continued on next page



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New book explains how to market long-term care services

"Nursing homes are still marketing in the 80s as they did in the 60s."


Molloy

This observation comes from George Molloy, president of M & M Associates, Vero Beach, FL, and author of a just-released book on marketing. In a recent interview with McKnight's LTC News, Molloy said that many nursing homes fail to distinguish between marketing and public relations.

"Nursing homes confuse the two and end up doing an ineffective job at both," Molloy said. "Balloons and pet therapy is not marketing," he added.

He explained that the purpose of marketing is to increase revenues. While public relations may foster good will, "marketing fills empty beds and increases the private pay mix," he said.

Marketing requires a comprehensive four-part integrated strategy, Molloy said. Facilities need to examine the product and its quality, service, ambiance and amenities, he said. Facilities then need to promote the product.

In addition, nursing homes must learn how to sell — which includes knowing the importance of sales attitudes, scripts and closings. And lastly, facilities must deliver what they promise.

As Molloy stated, "Unless we [as an industry] change, we will continue in the lunacy of this profit plunge."

Copies of Marketing Success are available for $149.95, plus $3.05 postage, from M & M Associates, 294 Morristown Cay, Vero Beach, FL 32966. □

Private pay market

From previous page.

Federal legislative mandates are exacerbating the problem, according to Jazwiecki. He cited studies conducted by Ernst & Young on the impact of OBRA. "Ernst & Young OBRA cost projections in every state [studied] indicate a propensity for significant cost increases as a result of implementing federal nursing home reform requirements," he said.

A crystal ball

"Meeting the future long-term care needs of an increasing elderly population represents a great challenge. Provider marketing efforts will need to reflect changing consumer expectations. As the public becomes more educated about the impact of catastrophic illness and the cost associated with chronic care, emphasis will focus on financial protection and the development of greater alternatives to institutional services," Jazwiecki said.

Thornton concurred. Many people who would have been nursing home residents five years ago are now receiving home health care or are living in retirement housing, she said. "While there may be more private dollars coming into the system, there are also more alternatives to care. Seniors now have options." □

Feds should cover LTC

From page 1.

While addressing long-term change, the governors also proposed stop-gap measures for achieving that change. As a first step toward creating a comprehensive health care program for the elderly, the proposal stated that Medicare should fully cover all qualified beneficiaries.

As a short-term goal, the governors called for repeal of the "so-called Boren Amendment." They also requested authority for states to match federal Medicaid dollars without restrictions.

An amendment to the reform package stated that the governors' association will call for a meeting with President Bush and Congress "to begin immediate work with the governors to achieve this system."

Although the governors were faced with a full agenda of state issues, health care dominated the annual meeting. □

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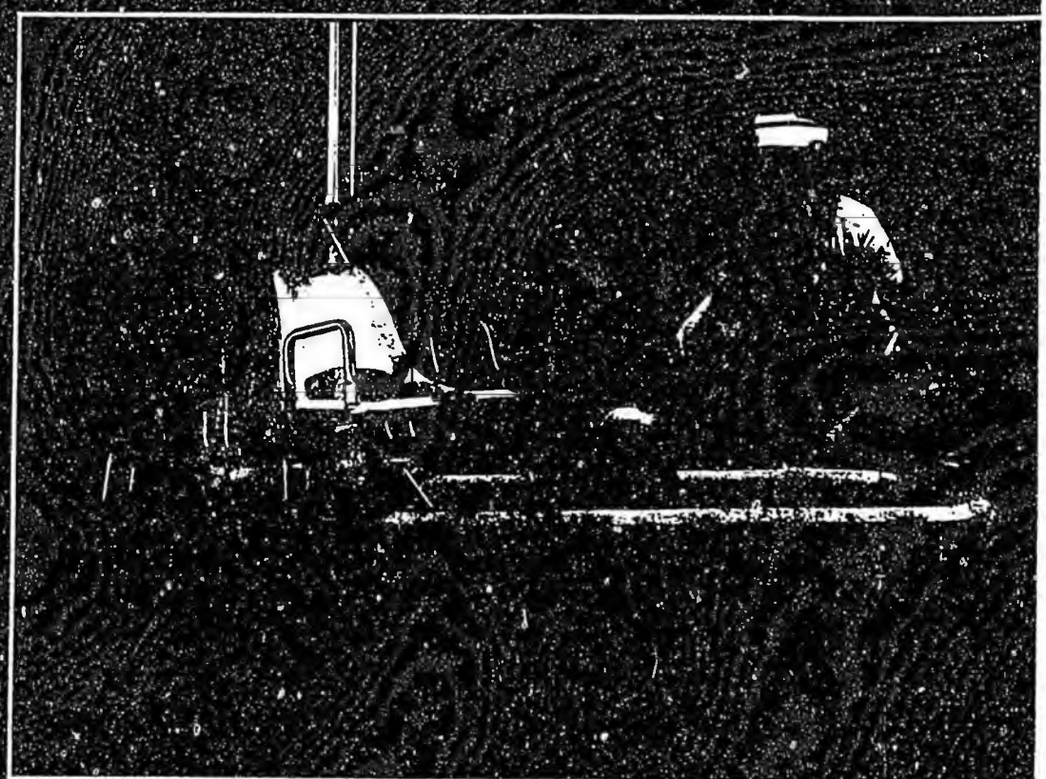

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Payment policies forcing Minn. homes to cut corners on upkeep

Legislature responds to study's findings by eyeing funding hike

By Fred Bazzoli

A financial report on Minnesota's nursing homes raised enough legislative eyebrows to ensure that its recommendations wouldn't be left on a shelf and forgotten.

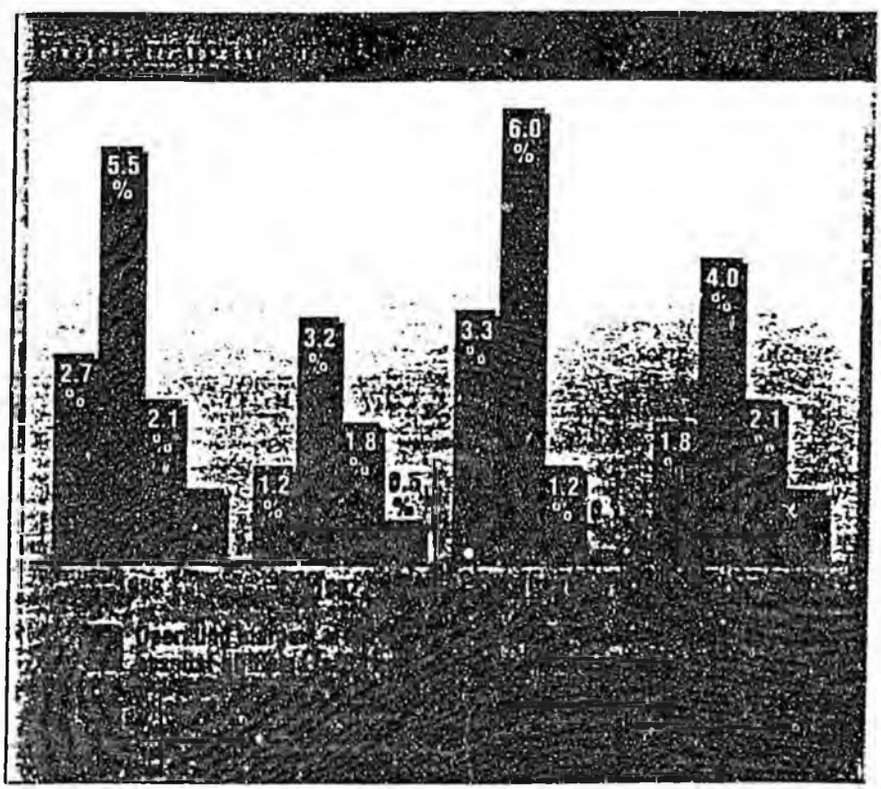
The state's Legislature is working to find funding to pay facilities more for costs related to property maintenance. The survey, "Nursing Homes: A Financial Review," compiled by Minnesota's Office of the Legislative Auditor, found that many administrators were delaying routine maintenance and repairs so they could use the money to sustain operations.

The action is welcome news to the state's 446 providers and representative groups, which for the three previous years had been publicizing problems they've had operating in Minnesota's strict rate-setting environment and under a pervasive moratorium on construction.

The report has highlighted the issues that must be addressed, and legislators are sympathetic, said Dean Neumann, public relations coordinator for Care Providers of Minnesota, the state group affiliated with the American Health Care Assn. Care Providers, which had issued three reports on the financial plight of the state's facilities, generally was pleased with the findings, although the report's writers seemed to soften the potential seriousness of industry problems, Mr. Neumann said.

Still, the report has pointed to the importance of states providing sufficient reimbursement to maintain facilities' physical structures. So much attention has been paid to the care residents are receiving that "the bricks-and-mortar aspect has been neglected," Mr. Neumann said. Other state association executives have expressed similar concerns, he added.

The report notes that the percentage of nursing facilities that broke even or made money between 1986 and 1989 has ranged from 60% to 75%, but it noted that profit margins were extremely thin, particularly for nursing facilities that weren't affiliated with or operated by acute-care hospitals.



For example, operating margins for hospital-linked facilities ran from 1.2% to 3.3% from 1986 to 1989, while non-hospital nursing homes had operating margins of 0.1% to 0.9%. In terms of total operating margins, which include revenues from all sources, including contributions, hospital-affiliated providers had margins of 3.2% to 6% during those years, while unaffiliated homes reported total operating margins of 1.2% to 2.1%.

The report's authors said that the state's "nursing home industry has experienced considerable financial stress," and they termed the industry's condition "weak."

Minnesota homes are under particular pressure because it's one of three states in the country that regulate all rates so that shortcomings in Medicaid payments can't be made up by charging private-pay residents higher rates. Thus, if Medicaid rates aren't sufficient, the effect is doubly bad. Adjusting rates typically involves a 21-month time delay that's daunting to cash-starved facilities that can't afford to make an expenditure decision and then wait almost two years for the new reimbursement to kick in.

Minnesota also uses a case-mix system that prospectively sets rates for residents needing different levels of care.

A component of facilities' reimbursement is for property expenses, which is determined through a fair-rental formula intended to cover property costs and provide a return intended for eventual replacement of capital assets. Also, facilities can qualify for an efficiency incentive of as much as $2 per resident day if they can stay under established spending limits in a category covering administrative, dietary, housekeeping, laundry and maintenance services.

The report notes that administrators have adopted the tactic of deferring routine maintenance and repairs because they are allowed only $325 per bed annually for such expenses and because they're trying to maximize efficiency incentive payments.

"Administrators who said their operating budgets were inadequate were more likely to report using property reimbursement for operating expenses," the report said. For example, 64% of administrators who said operating rates were rarely or sometimes adequate used property reimbursement for operating costs.

"Many administrators told us they have no real choice but to limit spending on nursing homes' appearance and upkeep in favor of earning the efficiency incentive, which . . . is a necessity for financial health," the report's writers indicated.

Administrators are deferring maintenance to maximize efficiency incentive payments.

As a result, 28% of administrators in 1990 said their facility was in poor structural or mechanical condition, compared with 10% in 1988. Two-thirds said building upkeep, maintenance, decorating and furnishing had deteriorated since 1985.

Prospects of gaining sufficient capital from operations are dim, as 75% of administrators said their facilities were in poor or fair financial condition. Some 43% of the hospital-affiliated homes were under financial stress, compared with 40% of the non-hospital homes, according to a study by the state's Dept. of Health in 1990.

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Circle 302 on Action Card

As part of a solution, the report suggests that the efficiency incentive be raised to $2.20 per resident day. Mr. Neumann said plans are being discussed by the Legislature to index the incentive to inflation, which would raise it this year to about $2.12 per resident day.

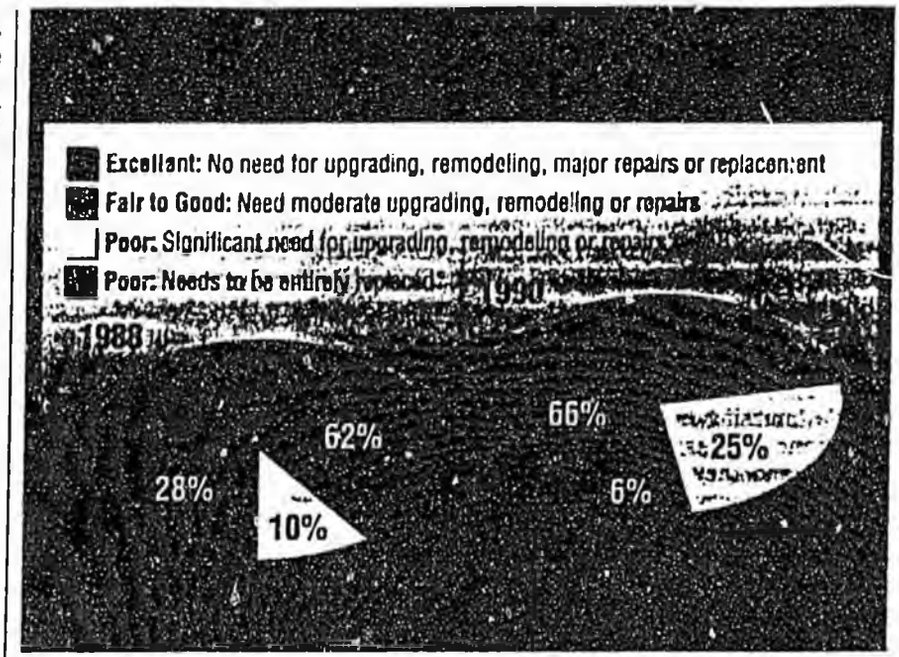
The report also suggests the state determine a standard for what constitutes adequate financial performance for nursing homes, which can be used to direct reimbursement policies.

Still at issue is Minnesota's strict moratorium on licensed beds; it controls any erection, building, alteration, reconstruction, modernization or improvement. Only 12 such projects were allowed in all of 1990, Mr. Neumann said. And from 1985 to 1989, there's been a decline of 44 certified beds in the state to a total of 45,452.

The moratorium is a difficult hurdle to modernization efforts, especially as the state's population of people older than 85 is expected to grow 32% to almost 91,000 by the year 2000.

"The nursing home industry may be unable to meet the future needs of the elderly, both in amount and in adequacy of services," the report said. "The Legislature should examine whether and how to continue the moratorium on nursing home construction."

While some of the report's suggestions have legislators' support or can be easily implemented, dealing with the moratorium will be difficult, Mr. Neumann said. "We're sitting at the beginning of a tremendous explosion," he said. "Federal and state governments haven't addressed the problem yet, (but) demographics will push the issue to the front burner." ■



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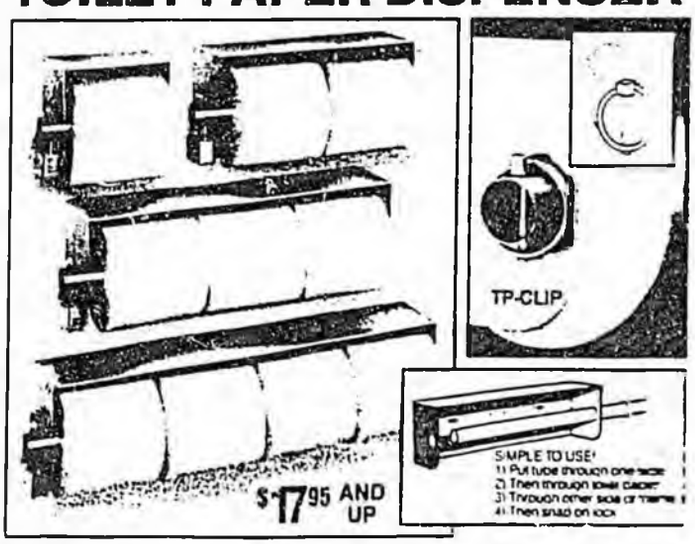

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OCTOBER 1991
VOL. 12, NO. 10

McKnight's
Long-Term Care NEWS
The Newsmagazine of Nursing Homes, Retirement Housing and Extended Care Facilities

First national LTC PPO introduced

by Suzanne Powills

In what is believed to be the first national program of its kind, Beverly Enterprises Inc., Fort Smith, AR, and the Lincoln National Life Insurance Co., Fort Wayne, IN, have teamed up to launch a preferred provider organization (PPO).

A familiar acronym to acute care, PPOs have been in existence for more than 10 years. The creation of the partnership between Beverly and Lincoln National now brings the concept to long-term care.

A PPO is a negotiated payment arrangement between an insurer and a provider. The insurer typically receives a discount on provider rates in exchange for creating an incentive for policyholders to use a particular provider. Policyholders experience savings in copayments if they use the "preferred provider" — in this case, Beverly.

Under this program, Beverly will offer reduced rates to group long-term care policyholders of Lincoln National. According to William Ihle, vice president of communications for Beverly, the nursing home chain has agreed to offer Lincoln National a 10% discount off its regular

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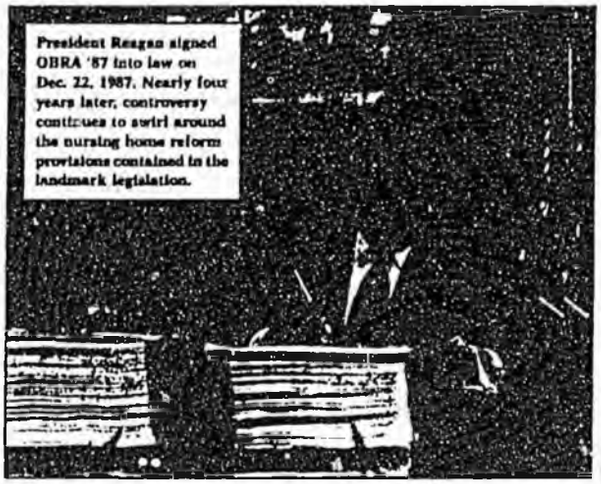


President Reagan signed OBRA '87 into law on Dec. 22, 1987. Nearly four years later, controversy continues to swirl around the nursing home reform provisions contained in the landmark legislation.

OBRA: Year one

by John O'Connor

It was nearly four years ago — on Dec. 22, 1987 — when President Ronald Reagan signed into law a mishmash package of legislation known as the Omnibus Budget Reconciliation Act of 1987.

The landmark statute promised new reforms for the nursing home industry to ensure the highest level of care. Already, the law has made progress in substantially reducing restraint use and enhancing residents' rights.

But one year after becoming effective, OBRA's promise continues to be compromised by yet unpublished regulations. And the law's ultimate legacy remains on hold while industry members wonder aloud if the final law may do more harm than good.

"The biggest challenges that remain for providers include the lack of final regulations, survey guidelines and the insufficient state plan reviews guaranteed under the Boren Amendment," said Linda Keegan, a representative of the American Health Care Association.

The coming year will likely provide most of the still-missing pieces. But there's no guarantee that what the future holds will be seen by many as relief.

For residents, one area where the promise of better care has manifested itself during the past 12 months is in the form

Continued on page 23.

Few nursing facilities market for private pay

by Suzanne Powills

Unlike many long-term care facilities, Westshire Health Care Center has discovered the advantages of marketing for private paying residents.

The Cicero, IL-based long-term care facility recently spent $4,526 on 14 newspaper advertisements. The result was a 1,000% return on investment — or $42,000 in total patient days.

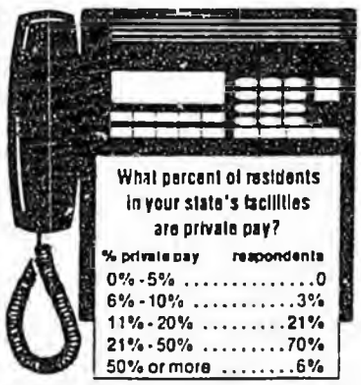
But Westshire's experience is hardly typical. "Marketing is viewed as an expense, and usually ends up at the bottom of the 'to-do' list," according to Phyllis Thornton, president of Signum Marketing, Louisville, KY.

While facilities have taken a lax approach to marketing in the past, the future may force a change in attitude. In fact, experts predicted that as public funding for the long-term care industry dries up, more facilities will take the lead of Westshire and begin marketing for private paying residents.

Continued on page 12

McKnight's LTC News FAX POLL

McKnight's LTC News conducted a poll by fax machine of all state affiliates of the American Health Care Association and the American Association of Homes for the Aging. The response rate for the poll was 42%.



What percent of residents in your state's facilities are private pay?

% private pay	respondents
0% - 5%	0
6% - 10%	3%
11% - 20%	21%
21% - 50%	70%
50% or more	6%

Governors call on feds to cover long-term care

SEATTLE — The nation's governors have decided that the federal government should be solely responsible for funding long-term care for the elderly.

At the National Governor's Association annual meeting here, the governors unanimously approved a health care reform package. The plan would shift funding responsibilities of all care for the elderly from the mishmash of state and federal programs currently covering such care to one source — the federal government.

The governors' proposal called the Medicaid system broken and stated that it has become a "rigid and overly complex program." The reform package said existing Medicaid resources should fund a new public program designed to meet the needs of the "non-disabled population from birth through age sixty-four."

Conversely, long-term care — as well as the whole continuum of services for the elderly and disabled — should be covered under one program, according to the reform package. "The Social Security/Medicare programs provide the obvious framework for such a program," the governors agreed.

"Elderly people shouldn't have to shift from one program to another to obtain care," said Ann Danelski, a representative of the association

Continued on page 11

Late Breaking News

- **The U.S. Department of Health and Human Services released regulations that will prohibit the federal government from matching state Medicaid funds that are collected through provider donation or tax programs.** The rule stated that funds donated or collected through taxes from providers will be subtracted from state Medicaid totals before the federal matching share is calculated. In releasing the regulation, the department stated that donation and provider tax programs will cost about $3 billion in federal matching funds in fiscal year 1991.
- **The American Health Care Association dropped its suit against the federal government over review of state plan amendments.** The association has withdrawn its notice of appeal against HHS Secretary Louis Sullivan, M.D.
- **Of the 7,298 U.S. hospitals, more than 1,000 are providing nursing home services,** according to new statistics from the U.S. Department of Commerce. The for-profit hospitals are generating about $744 million in receipts. And the non-profit facilities are generating about $18 billion in revenue.

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Private pay market

From page 1

Currently, the percentage of private pay residents in most states runs between 21% and 50%, according to the fax poll conducted by **McKnight's Long-Term Care News** of state nursing home and homes for the aging associations.

Results from the informal poll also indicated that non-profit facilities attract a higher percentage of private pay residents. In fact, none of the responding non-profit associations said the percentage of private pay in their states was below 21%. Conversely, the for-profit association responses went down to the 6% to 10% range.

Midwest values

The proportion of private pay residents was also somewhat higher in the Midwest, according to the survey. This phenomena, however, appears to have little to do with marketing.

For example, the percent of private paying residents in Kansas is about 55%. But facilities in the state are more concerned with providing the best possible care than with marketing, said John R. Grace, president of the Kansas Association of Homes for the Aging in Topeka.

Further, Grace indicated that marketing may not even be necessary. "Word-of-mouth creates the demand for services," he said.

So how have Kansas facilities kept their private pay mix at 55%? Grace speculated that a lower cost of living in some areas of the state slows the speed of Medicaid spend down, thus increasing private pay census.

He also suggested that the high private pay mix may be the result of Midwestern values. Grace noted that for many people in Kansas, "government is the choice of last resort."

Paul Romans, executive vice president of the Iowa Health Care Association in Des Moines, agreed.

Romans said that the 50% to 51% private pay mix in his state results from the "nature and character of Iowa people." He cited one facility resident who qualified for Medicaid but didn't want to be on the state's rolls.

However, some facilities in Kansas are marketing for private payers, according to Romans. "A number of facilities are working with their communities and individuals, which results in increasing private pay," he said.

Minnesota, which has a rate equalization law on its books, offers no incentives to facilities for marketing. "We're locked in," according to Rick E. Carter, president of Care Providers of Minnesota, Bloomington, MN.

Carter said that there were only two advantages for marketing to private payers in Minnesota — facilities receive payment up front, and they can charge more for private rooms.

"Assuming that nursing homes can generate demand (by marketing), they can't change the total number of private paying residents available," Carter said. Nursing homes, therefore, could only lure private paying residents from other facilities, he added.

The state of the nation

The lack of interest in marketing by Midwest facilities appears to be in line with facilities throughout the states. Nursing facilities are not generally marketing for private paying residents, according to Signum's Thornton. "Facilities are more focused on internal operations and quality. But the focus stops there — internally," she said.

Thornton said most nursing homes still rely on hospital discharge planners. "But that feeder source is being cut off as hospitals get into long-term care," she added.

"Facilities can no longer depend on discharge planners," echoed George Molloy, president of M & M Associates, Vero Beach, FL.

Molloy explained that the '80s marked the end of what he called "the gravy train" of Medicaid spending. States began denying benefits and cutting costs. In addition, nursing homes began seeing more acutely ill residents resulting from the prospective payment system imposed on hospitals, he said. "Profitability plunged," Molloy said.

Tom Jaszlecki, national advisor for Ernst & Young, Washington, predicted that the trend will likely continue. "State and federal governments are currently struggling to adequately fund existing Medicaid programs. Their continued ability to fund service expansion or further increases in program scope is highly questionable," he said.

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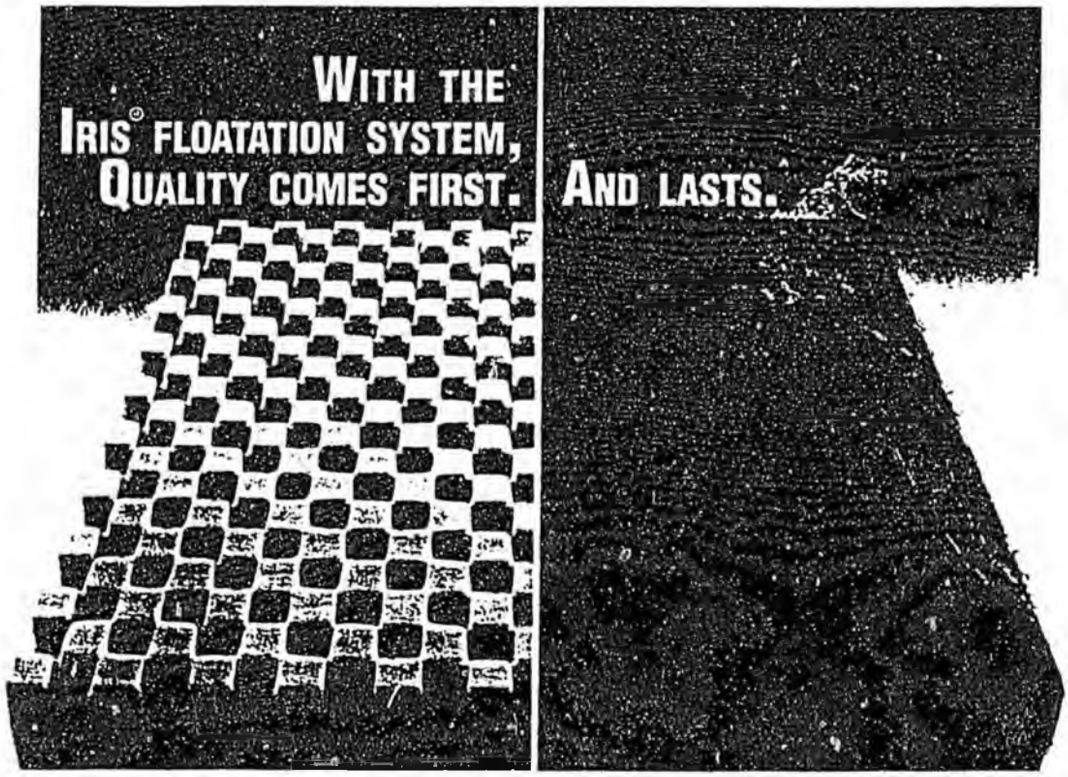

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CIRCLE 330 ON READER SERVICE CARD

New book explains how to market long-term care services

"Nursing homes are still marketing in the 80s as they did in the 60s."

Molloy

This observation comes from George Molloy, president of M & M Associates, Vero Beach, FL, and author of a just-released book on marketing. In a recent interview with McKnight's LTC News, Molloy said that many nursing homes fail to distinguish between marketing and public relations.

"Nursing homes confuse the two and end up doing an ineffective job at both," Molloy said. "Balloons and pet therapy is not marketing," he added.

He explained that the purpose of marketing is to increase revenues. While public relations may foster good will, "marketing fills empty beds and increases the private pay mix," he said.

Marketing requires a comprehensive four-part integrated strategy, Molloy said. Facilities need to examine the product and its quality, service, ambiance and amenities, he said. Facilities then need to promote the product.

In addition, nursing homes must learn how to sell — which includes knowing the importance of sales attitudes, scripts and closings. And lastly, facilities must deliver what they promise.

As Molloy stated, "Unless we [as an industry] change, we will continue in the lunacy of this profit plunge."

Copies of *Marketing Success* are available for $149.95, plus $3.05 postage, from M & M Associates, 294 Morristown Cay, Vero Beach, FL 32966. □

Private pay market

From previous page.

Federal legislative mandates are exacerbating the problem, according to Jazwiecki. He cited studies conducted by Ernst & Young on the impact of OBRA. "Ernst & Young OBRA cost projections in every state [studied] indicate a propensity for significant cost increases as a result of implementing federal nursing home reform requirements," he said.

A crystal ball

"Meeting the future long-term care needs of an increasing elderly population represents a great challenge. Provider marketing efforts will need to reflect changing consumer expectations. As the public becomes more educated about the impact of catastrophic illness and the cost associated with chronic care, emphasis will focus on financial protection and the development of greater alternatives to institutional services," Jazwiecki said.

Thornton concurred. Many people who would have been nursing home residents five years ago are now receiving home health care or are living in retirement housing, she said. "While there may be more private dollars coming into the system, there are also more alternatives to care. Seniors now have options." □

Feds should cover LTC

From page 1.

While addressing long-term change, the governors also proposed stop-gap measures for achieving that change. As a first step toward creating a comprehensive health care program for the elderly, the proposal stated that Medicare should fully cover all qualified beneficiaries.

As a short-term goal, the governors called for repeal of the "so-called Boren Amendment." They also requested authority for states to match federal Medicaid dollars without restrictions.

An amendment to the reform package stated that the governors' association will call for a meeting with President Bush and Congress "to begin immediate work with the governors to achieve this system."

Although the governors were faced with a full agenda of state issues, health care dominated the annual meeting.

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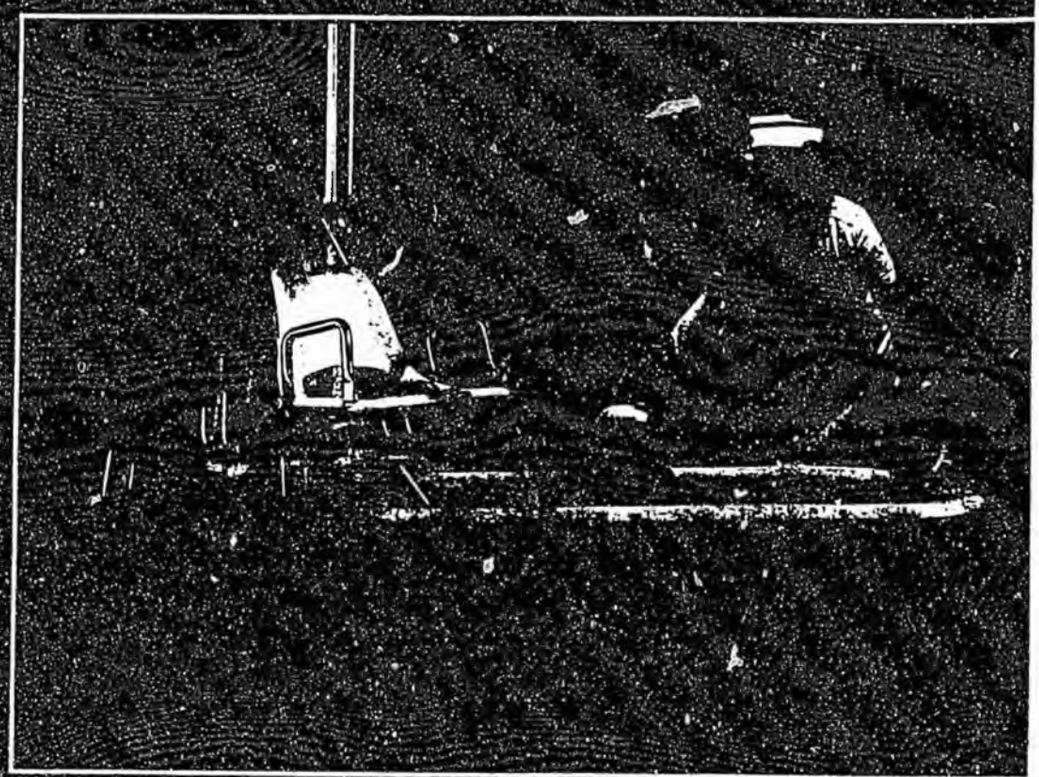

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