HOUSE OF REPRESENTATIVES
COMMITTEE ON
ELDER & LONG TERM CARE
ANALYSIS

BILL #: HB 1569

RELATING TO: Nursing Home Facilities

SPONSOR(S): Representative Argenziano

TIED BILL(S): SB 1908

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) ELDER & LONG TERM CARE YEAS 6 NAYS 3
(2) HEALTH & HUMAN SERVICES APPROPRIATIONS
(3) FISCAL RESPONSIBILITY COUNCIL
(4)
(5)

I. SUMMARY:

HB 1569 provides that the Agency for Health Care Administration (AHCA) must require that a portion of a nursing home's Medicaid per diem payment is earmarked for increases in wages or benefits for eligible staff.

The bill takes effect July 1, 2002.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No []	N/A [x]
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

The Legislatively created Task Force on Availability and Affordability of Long-Term Care (Task Force) in 2000 studied a wide variety of issues related to long term care in the state. By way of background, the Task Force noted that national nursing home reform passed in 1987 (known as OBRA 87) focused significant attention on staffing as a key component in assuring quality care.[1]

Providing care to elderly patients is according to most experts a complex challenge because it is a mix of both health and social programs. Recent reports indicate that Florida's nursing home population is older, more medically complex, more dependent in activities of daily living, and likely to have cognitive impairments than ever before. This more challenging resident population requires that all of the caregivers develop greater expertise and skill. Florida is struggling to provide adequate staffing in its nursing facilities. The Informational Report of the Task Force cited this finding:

> While nationwide, the percentage of facilities receiving deficiency citations for inadequate staffing has remained relatively stable, deficiency citations for inadequate staffing on the part of Florida nursing homes has increased from 5.6% in 1993 to 12.4% in 1999 (Harrington, et.al, 2000).

In the 1999 session, the Legislature passed a nursing home improvement bill (99-394, L.O.F.) Section 28 directed the Department of Elder Affairs to study recruitment, training, employment and retention issues related to certified nursing assistants in Florida. In January 2000, the Secretary of DOEA submitted the report.

The report found that almost all regions of the state are experiencing a shortage of trained CNAs. This despite the fact that the available data suggested that number of persons being trained and certified appeared to be adequate. The report concluded that the low unemployment rate and ample job openings contributed to CNA turnover. To quote the report, ***"Therefore, the primary cause of the CNA shortage is that CNAs are not remaining CNAs."***

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[1] From the Task Force's Informational Report: By establishing minimum standards for licensure level of "nursing" staff, OBRA87 recognized the relationship among licensure level, numbers of nurses per resident and resident outcomes in long-term care facilities. In 1996 and again in September 2000, the Congressionally mandated studies by the Institute of Medicine (IOM) on the adequacy of nurse staffing in long-term care reiterated the link between nurse staffing and resident outcomes (Wunderlich, Sloan, & Davis, 1996). Page 512, PDF: http://www.fpeca.usf.edu/Task Force/Publications/Documents/finalreportnew.PDF

DOEA report went on to note the range and impact of what was described as the "CNA crisis" by some:

- The problems with recruitment and retention were found to be twice as high (costly) as facility administrators thought when objective cost accounting procedures were used.
- CNA wages and benefits need to be improved (i.e., increased).
- The CNA shortage contributes to the use of staffing agency personnel to meet state minimum staffing requirements. The average staffing agency CNA cost is $6.07 an hour greater than the average facility-employed CNA.
- Since November 1, 1998, on a statewide basis, 16 percent of Florida's nursing homes surveyed have restricted admissions due to their inability to meet their own facility CNA staffing requirements. (In addition, nine percent of the facilities surveyed have restricted admissions to maintain compliance with the state nursing staffing requirements.)

Nursing Home Reimbursement

Nursing home care is paid by *Medicare* (up to 100 days following a qualifying hospitalization), *Medicaid*, *private insurance*, the *Veteran's Administration*, and finally by *individuals and their families*.

As of July 1, 2000, there were 648 nursing homes participating in the Florida Medicaid program. These facilities provide slightly more than 79,000 beds and more than 25 million bed-days. Medicaid reimburses for the costs associated with 64.9 per cent of those days according to the Panel on Medicaid Reimbursement (December 8, 2000 Report). Nursing home per diem rates are facility specific and are an aggregation of four separate accounting components: operating costs; patient care; property; and return on equity (ROE) for money invested and used in providing patient care (Reimbursement Panel).

The Medicaid agency is required to develop and file with the Center for Medicare and Medicaid (CMS, formerly known as HCFA) a "state plan" that describes how reimbursement will be made to participating nursing facilities. The current reimbursement plan is referred to as the "Gainesville Plan" (apparently because Gainesville was a convenient location for a set of meetings in which core elements of the plan were discussed by stakeholders in 1983). Reimbursement would be calculated using a single rate that reflected costs in four major domains: operating expenses, patient care, property, and return on equity. Rates reflect prior costs, with an adjustment for inflation, and intentionally meet the full costs experienced by a proportion of the state's nursing homes. Operating efficiently enough to be among those organizations with reimbursement rates that meet costs is the major incentive to make management, staffing or other changes that control or reduce costs. The program intends to meet the documented costs of some, but not all of the state's nursing homes. In 1985 then HCFA Administrator Bruce Vladek described the tacit, if not explicit agreement, between public dollars and private providers of nursing home care:

> *Take care of our [government] clients exactly the way that you take care of your private customers…and we will pay the costs associated with that care.*

Direct Care Staffing Adjustment

The direct care staffing adjustment was implemented April 1, 2000 as an adjustment to each nursing home's patient care component. The adjustment was intended to assist nursing homes to recruit and retain direct care staff (RNs, LPNs, and CNAs) based on research that suggested a correlation between quality of care and low staff turnover, and adequate staffing ratios. The annualized budget was $31.7 million dollars. The legislation directed that nursing homes with the poorer staffing ratio would receive a higher adjustment or "add-on" than those homes that had a higher staffing ratio.

According to the report of the Medicaid Reimbursement Panel, as of April 1, 2000, the increase ranged from fifty cents to $2.81 per Medicaid patient day. The average was $1.96.

Other States: Wage Pass-Through Legislation
In 1998-99 budget cycles, Michigan implemented a wage pass-through provision and continued through 1999-2000. The goal appears to have been to improve staff retention.[2] The pass-through was available only for an increase in wages or benefits. Bonuses were not allowed.

California, Michigan, Wisconsin, and Massachusetts, have passed "wage pass-through" legislation. Former Wisconsin Governor Tommy Thompson signed a five percent wage pass through for CNAs and cited his concern about the high rate of turnover as one justification. The governor also vetoed a wage pass-through for dietary, housekeeping, and laundry workers arguing that "most nursing homes" contract out those services and thus did not need the wage pass-through.[3] In 2000, the Massachusetts Legislature passed a "wage pass-through" provision in their state budget. [4]

The Massachusetts "CNA Pass Through" began in the 2000 nursing facility MassHealth rate process and was amended in the Legislature's fiscal year 2001 budget appropriation. The report of Division of Health Care Finance and Policy to the Legislature wrote: "The initiative provided funds to nursing facilities to be "passed-through" to certified nursing aides ("CNAs"), who provide much of the direct care to nursing facility residents. Nursing facilities have reported a shortage of these personnel and difficulty attracting and retaining qualified CNAs." The 2001 budget provided an additional appropriation of $35 million "for the exclusive purpose of funding increases in wages and related employee costs for certified nursing aides at nursing facilities".

In February 2001, California passed a wage pass-through provision in Sec. 43.5. Section 14110.65 of the Welfare and Institutions Code. California provided significant particularity in its law regarding enforcement, retroactive recovery of dollars not spent correctly, and a written plan from nursing homes as to how it would use the supplement. In part, it reads:

> (A) Proof of a legally binding, written commitment to increase the salaries, wages, or benefits of existing and newly hired employees, excluding managers, administrators, and contract employees, during the rate year.

California has slightly more than 1,000 nursing facilities that are required to provide a total of 3.2 nursing hours per patient per day. The California Legislature estimated that funding their bill would require $7 million dollars in general revenue and about $7 million dollars in Medicaid (federal financial participation.)

C. EFFECT OF PROPOSED CHANGES:

The "wage pass-through" provides an increase of $1 per hour in wages or benefits. The administrator and director of nursing, agency, temporary, pool or home-office staff are excluded from the wage pass-through.

D. SECTION-BY-SECTION ANALYSIS:

This section need be completed only in the discretion of the Committee.

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[2] Medicaid Reimbursement Panel: Final Report. December 8, 2000. Based on material included in Appendix H.

[3] From an issue paper published by the Wisconsin Association of Homes and Services for the Aging (WAHSA). WASHA is in its words, " a statewide membership organization of not-for-profit corporations principally serving elderly and disabled persons." http://wahsa.org/isswpt.htm

[4] Division of Health Care Finance and Policy Report to Ways & Means Committees: http://www.state.ma.us/dhcfp/pages/pdf/hwm_cna.pdf

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill does not appropriate new dollars, but requires that a portion of the existing Medicaid per diem payment be allocated for a salary or benefits increase for eligible staff.

2. Expenditures:

The bill requires no new expenditures. However, according to AHCA, the measure would redirect approximately $51 million dollars (state and federal).

Reporting facilities	*total staff hours*	63,749,901
Nursing Facilities included in report		523
Avg annual staff hours per facility		121,893
Percent of Medicaid patient days		65.27%
Avg annual Medicaid reimbursed staff hours per facility		79,558
Nursing Facilities not included in report		129
Total staff hours for non-reporting facilities		15,724,163
based on avg for reporting facilities		
Medicaid % of NF patient days		65.27%
Non-reporting facilities.	*Medicaid staff hrs*	10,263,030
Total staff hours for reporting and non-reporting NFs		**79,474,064**
Total Medicaid pro-rated staff hours for reporting and non-reporting facilities		**51,872,057**
Total Medicaid costs ($1.00 x hours)		**$51,872,057.40**

** data from Medicaid Program Analysis Cost Reimbursement from forms submitted by nursing facilities with cost reports*

AHCA estimates that this plan would require a general revenue match of $21,459,470 for year one and $21,996,398 for year two Medicaid only reimburses for Medicaid allowable costs; therefore, the costs of the salary increase not reimbursable by Medicaid would be borne by other payers

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Additional wages and benefits benefit the facility staff and the local economy. Higher wages and benefits could, arguably, help to attract and retain sufficient high quality employees.

D. FISCAL COMMENTS:

Medicaid may have to request from CMS an amendment to its State Medicaid Plan to allow this change in reimbursement. Representatives from the nursing home industry report that the current Medicaid per diem fails to meet their current costs by about $14 per day. To the extent that costs are not met now, a reallocation of existing dollars could require the facility to subsidize this deficit from other revenue streams.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

N/A

B. REDUCTION OF REVENUE RAISING AUTHORITY:

N/A

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

N/A

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

No new rule authority is granted.

C. OTHER COMMENTS:

This bill appears to further the policy direction supported by the legislature in SB 1202 and in HB 1971 by directing that public funding first be allocated to patient care services, specifically to those staff who provide the bulk of the hands-on care.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON ELDER & LONG TERM CARE:

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