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Note: citations to research on negative features of pricing systems page 3 (below) and following.

COST-RELATED VERSUS "PRICING" SYSTEMS

Nursing home payment systems that pay a price for care regardless of individual facility expenditures traditionally have been called "flat rate" systems; increasingly these systems are referred to as "pricing systems." Flat rate systems encourage facilities to reduce expenditures because they can profit on the difference between the payment rate and expenditures. But reductions in expenditures can reflect either improved efficiency or reduced quality—spending less on food and nursing care that patients actually need.[1] Thus, the key dilemma in rate-setting is appropriately balancing incentives for both cost containment and quality. In theory, an entire nursing home system could achieve balanced objectives with a rate-setting system that has strong cost-containment incentives, balanced by an equally strong and effective quality assurance system. As illustrated in Exhibit 2, rate-setting is only one of the policy tools that states and the federal government have available for balancing competing policy objectives. Many State Medicaid program officials have historically been concerned about the ability of even a well-functioning quality assurance system to counter-balance exceptionally strong cost containment rate-setting incentives, in light of the difficulty of defining,

[1] During the 1970s there was considerable debate about whether using Medicare principles (retrospective, cost-based) in paying for nursing home care was inherently inflationary. Virtually all studies found prospective systems better in terms of cost containment (Smith, et. al, 1985 ; Buchanan, 1981; Harrington and Swan, 1984; Vogel and Palmer, 1985). But further studies indicated that prospective systems with frequent rebasing operate like retrospective payment systems (e.g., Scanlon, 1988; Holahan, 1985). In brief, it is now concluded that the issue is less a matter of retrospective versus prospective rates but the degree to which rates are a function of facility spending. The more facility-independent the rate, the greater the incentive for providers to reduce expenditures-a theory borne out by empirical investigations.

measuring, and assuring actual nursing home quality. This concern, in substantial part, accounts for the fact that only a handful of states use flat rate payment systems.[2]

Exhibit 2

Key Goals and Policy Instruments[3]

Typical Goals for a Nursing Facility Payment System	Some Relevant Policy Instruments
• Beneficiary access to appropriate care • Appropriate spending and cost containment • Equity for payers and providers • Administrative feasibility	• Medicare: --Rate-setting (for SNFs & other providers) --Coverage rules & enforcement procedures • Medicaid: --Rate-setting (for NFs & other providers) --Policies related to NF supply (e.g., Certificate of Need and/or licensure moratoria) • Federal (and state) quality assurance standards and procedures

To achieve a balance between both cost containment and quality objectives, nearly all states use prospective payment systems, with payments based in part on

[2] Further, as explained in the text, even those Medicaid nursing facility payment systems that are commonly called "flat rate system" are not pure flat rate systems; they have some cost-related features.

[3] Note that (1) Medicare and Medicaid typically have the same general goals for their respective nursing home payment systems' design and (2) efforts at either the federal or state level to achieve balanced objectives (cost, quality, access, equity, administrative feasibility) are substantially influenced by both federal and state policies, which may or may not be optimally in concert.

individual facility expenditures, but also with various limits and incentives designed to constrain costs. Many states during the late 1980s and throughout the 1990s, implemented rate-setting systems that placed stronger cost-containment incentives (e.g., paid flat rates) for the portion of rates less directly related to resident care (e.g., administration), and weaker cost-containment incentives (e.g., by limiting profit) on the portion of rates most directly related to care (e.g., nursing).[4] This continues to be a popular payment model. For example, each one of the four states (South Dakota, Maine, Mississippi, and Kansas) that implemented their first Medicaid case-mix systems as participants in the National Case-mix Payment Demonstration implemented just such "modified" cost-related case mix systems.[5]

Only five states rely heavily on a nearly pure flat rate (pricing) system. Texas and California have long been the purest examples, but Texas is now changing its system as discussed below. Oklahoma, Louisiana, Oregon, and Nevada also have systems that are typically classified as flat rates. In each of the five flat rate systems, however, there are special features that make the system more cost-related than the Medicare system. In many of the five states, certain portions of the rates (e.g., capital and/or ancillaries) are paid on a facility (or patient) specific basis. All provide for special exceptions (and payments more reflecting the costs of care) for limited numbers of patients with atypical needs.

There is strong evidence that the choice between a cost-related and a pricing system makes a difference with regard to quality of care. A recent, sophisticated study based on a nationally representative sample of nursing homes and residents found that nursing homes in flat-rate states had lower quality of care, measured by case-mix adjusted staff-to-patient ratios and selected outcome measures.[6] The structure of the Medicaid payment system was more important to quality than the level (amount) of the payment. In addition, the researchers found "that the difference in RN staffing intensity between cost-based and flat-rate systems is greater" where there are more available beds. Since nursing home occupancy is declining nationally, this study suggests that

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[4] This model stems in large part from recommendations made by researchers who conducted various analyses of nursing home rate setting systems, including an extensive longitudinal study of systems in eight states (Feder & Scanlon, 1985; Holahan, 1985; Scanlon, 1988).

[5] New York and Texas--the other two demonstration states--had already implemented Medicaid case-mix payment systems.

[6] JW Cohen and WD Spector, "The Effect of Medicaid Reimbursement on Quality of Care in Nursing Homes," *Journal of Health Economics*: v.15 (1996) Pp. 23-48.

Medicare's flat rate pricing system may have a greater potential for adverse effects on quality if current occupancy trends continue.

The study discussed above compares nursing homes in all the states at one point in time. These cross-sectional findings, however, appear consistent with the experience over time of two states that implemented Medicaid case-mix systems using different structural designs. In the first few years after Minnesota introduced its modified cost-related case-mix adjusted system in 1985, expenditures on nursing increased in pace with increases in case-mix (i.e., the money paid by Medicaid for increasing patient acuity was actually spent on nursing care). In addition, the State found only about one percent of patients misclassified when assessment records were reviewed. That finding probably occurred in part because there was little incentive to over classify patients, given the particular way the case-mix part of the payment system was explicitly and closely tied to facility costs, as well as to patient assessments.[7] In Texas, however, experience has been different. Texas is the only state in the nation that paid nursing facility rates for many years using both a case-mix system[8] and a nearly pure pricing system. The Texas Medicaid nursing facility payment system (prior to changes in 1999) is thus most comparable to the new Medicare SNF payment system. Studies of the Texas system found that after the nearly pure flat rate case-mix system was implemented provider profits increased and expenditures on nursing declined—despite an apparent increase in patient acuity, including the fact that more patients were tube-fed and had urinary track catheters (treatment elements that resulted in patients being placed in a higher paying class). In addition, the State found nearly 40 percent of patients classified in a too-high case-mix class when assessment records were initially audited.[9]

The choice between a cost-related and a pricing system also makes a difference with regard to how much Medicaid or Medicare spends to achieve policy objectives. Carefully constructing a modified cost-related payment system can help Medicaid or Medicare better target their total expenditures to achieve policy objectives. By contrast, paying flat rates (using a pricing system) raises the potential for inefficiently-targeted

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[7] Minnesota Department of Human Services, 1998 (unpublished document).

[8] Texas developed its own methodologically sophisticated case-mix classification system called "TILES." It has 11, rather than 44, groups but is otherwise relatively similar to the RUGs case-mix classification and weighting system.

[9] B. Manard, et. al., *Analysis of Texas/ Reimbursement System for Nursing Facilities and ICFs-MR*, prepared for the Texas Department of Human Services, January 1993.

public spending where profits are greater than necessary either to attract needed investment or appropriately reward efficiency, rather than luck, poor quality, or other factors.[10]

For example, many states consider themselves to have an over-supply of nursing homes. Nursing facility occupancy is falling nationwide and many states would prefer a much greater role for home care and assisted living in long term care. Thus, many states believe they do not need to pay high profits (e.g., by paying flat rates) to attract more nursing facility beds.

Recognizing that paying facilities for the entire difference between Medicaid rates and facility expenditures is frequently both costly and unnecessary to achieve policy objectives, many states limit profits to a specified proportion of the difference between facility expenditures and rates. For example, Vermont had a limited profit factor ("efficiency incentive") on indirect care costs (e.g., administration) for the past several years. Recently, however, Vermont decided to target that money even more precisely than before to meet State quality and efficiency policy objectives. The State took the pool of money previously paid simply to any facility whose indirect care costs were lower than the rates and created a special award of up to $50,000 for each of a selected set of facilities meeting precise quality standards and a special mathematical model of "efficiency."[11] By contrast, profits are intrinsic in flat rate systems, and the difference between costs and the rates may not be due to factors the state would like to encourage. Regardless, it is important to understand that in the few states that do pay flat rates, the amount spent on profits for facilities with low costs is substantial.

The states' experience and research regarding flat rate pricing systems, such as Medicare has just implemented, suggest at a minimum that it will be very important to monitor closely the effect of the new Medicare system for quality problems. In addition,

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[10] The difference between a facility's costs and its rate is technically called an "efficiency incentive." There are many different ways to construct an efficiency incentive. A flat rate is technically referred to as a "100 percent efficiency incentive." As previously noted, modified cost-related nursing facility PPS used by many states today tie rates more loosely to facility costs on the portion of the rate (e.g., administration and overhead) less closely related to patient care than nursing costs. Those states are technically said to pay "an efficiency incentive targeted to selected components." There are many different ways to construct that type of component-specific efficiency incentive; some approaches are more cost-effective than others.

[11] Analysts conducted a regression analysis relating nursing facility costs to various factors such as size, location and case-mix. With that, analysts calculated for each facility the difference between the facility's observed (i.e., actual) and expected expenditures. Facilities with the lowest actual expenditures, controlling for other factors, were said to be the most "efficient."

national policy-makers might be well advised to study the amount of money that Medicare is spending, where patient care expenditures are less than the rates paid.

Recognizing that such facilities might simply be those with the worst quality, the state is using an additional test of quality before paying the facility a bonus.

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Background and Experience

Barbara Manard is a health policy researcher and consultant with over twenty years' experience. In 1998, she served as a Special Expert Consultant to the Office of the Secretary (ASPE), US Department of Health and Human Services, to assist with technical and policy issues related to implementing payment changes mandated by Congress. From 1981-1996 she served as a Vice President of The Lewin Group, managing a substantial practice prior to resigning that position to form The Manard Company. Prior to joining The Lewin Group, Dr. Manard served as a Policy Analyst at ASPE and as an Assistant Professor of Sociology at The University of California (Riverside). She received her Doctorate in Sociology from the University of Virginia, a Certificate in Health Planning from the U. VA. School of Medicine, and an AB from Vassar College.

Highlights of Relevant Projects

Dr. Manard is a nationally recognized expert in post acute and long term care payment and services; and in additional aspects of Medicare, Medicaid, and private-sector health care issues, particularly those related to the elderly. She has developed and/or evaluated Medicaid payment systems in over half the states for nursing facilities, home and community-based services, ICFs/MR, and/or hospitals. She has completed numerous policy studies, including large-scale evaluations, regarding Medicare. These include a recently completed analysis of proposed and potential refinements to the Medicare SNF payment system, an award-winning study of Subacute Care, an evaluation of a congressionally mandated demonstration of Prior Authorization of Medicare Home Health and SNF Payments, and an evaluation of the cost-effectiveness of the Medicare Hospice Benefit. Her current work includes conducting a congressionally mandated national study of changes in state payment policies for nursing facilities, a study of options for "bundling" Medicare payments (for MedPAC), analyzing quality indicators in post acute care settings for the American Association of Retired Persons; and providing analyses of the changing post acute market and strategic planning for a wide range of clients such as health care systems, state Medicaid officials, and Wall Street firms.