



Committee #4 | Nursing Home Finance Reform

Draft Priorities December 1st, 2022

The following is broken down into two parts: an executive summary and the original, detailed committee submission. Since original committee submissions often contain technical references, we've provided the executive summary for broader understanding of the priority recommendation.

Executive Summary

How to pay for nursing home care to incentivize high-quality, and how to determine actual costs of care in the context of limited data and a lack of accountability in how public funds are spent emerged as topics across committees. Committees discussed whether there is government under-investment and whether some nursing homes are taking dollars away from direct care.

Short-Term Priority

Design and promote a demonstration project to explore the use of alternative payment models (APMs) for long-term nursing home care along with a requirement that a certain percentage of Medicare and Medicaid payments are targeted for nursing home direct-care services. This APM would use a pre-set (global capitated) budget, making care provider organizations or health plans accountable for the total costs of care.

Long-Term Priority

We will work with Housing and Urban Development (HUD) to incentivize providers to change the architecture of nursing homes and to create a fair and competitive wage for nursing home direct care services.



NASEM Report Recommendation(s)

4A: To move toward the establishment of a federal long-term care benefit that would expand access and advance equity for all adults who need long-term care, including nursing home care.

4C: HHS should require a specific percentage of nursing home Medicare and Medicaid payments to be designated to pay for direct-care services for nursing home residents, including staffing (including both the number of staff and their wages and benefits), behavioral health, and clinical care.

4E: To eliminate the current financial misalignment for long-stay residents introduced by Medicaid's coverage of their nursing home services and Medicare's coverage of health care services, the U.S. Department of Health and Human Services and the Centers for Medicare & Medicaid Services should conduct demonstration projects to explore the use of alternative payment models (APMs) for long-term nursing home care, separate from bundled payment initiatives for post-acute care. These APMs would use global capitated budgets, making care provider organizations or health plans accountable for the total costs of care.

Detailed Committee #4 Submission

Introduction

Goal 4 of the NASEM report focuses on creating a more rational and robust financing system. To that end, five major recommendations were put forward including:

- 1) To move toward the establishment of a federal long-term care benefit that would expand access and advance equity for all adults who need long-term care, including nursing home care;
- 2) To ensure that adequate funds are invested in providing comprehensive care for long-stay nursing home residents;



- 3) To require a specific percentage of nursing home Medicare and Medicaid payments to be designated to pay for direct-care services;
- 4) To extend bundled payment initiatives to all conditions for short-stay post-acute nursing home care; and,
- 5) To conduct demonstration projects to explore the use of alternative payment models (APMs) for long-term nursing home care, separate from bundled payment initiatives for post-acute care.

The Financing committee has met three times over Zoom to discuss the particulars of the recommendations and sub-recommendations in the NASEM report. To move the conversation forward in as expeditious a manner as possible, we decided on the following approach.

First, individuals put forward their ideas about how to operationalize the broad recommendations and more specific sub-recommendations into concrete proposals. This provided the committee with a pool of ideas to examine and prioritize, all of which were directly related to the core NASEM recommendations. To assist in the prioritization process, individuals who put forward specific ideas developed a simple SWOT analysis (i.e. **S**trengths, **W**eaknesses, **O**pportunities, and **T**hreats) of their idea and these were distributed to the entire committee for a follow-up discussion.

At the second committee meeting we discussed the specific ideas and associated risks and benefits. We did not get through all the discussion at that meeting and decided that we would send out a poll with links to the proposals and their SWOT analyses. In this way, people could rank policy options along the following dimensions: (1) sustainable impact and ability to make an important difference; (2) feasibility regarding advancing initiative over coming two years; (3) advancing equity; and. (4) generating positive collaboration. Then everyone was asked to put forward their first and second choices among the options.

At the third committee meeting, we discussed the results of the vote and further refined our approach for how to move forward with implementation of these ideas. The result of this process has led to the following concrete initiatives and one proposal based on the three NASEM recommendations listed below.



Our Approach

Initiative #1

The recommendations that received the highest number of votes for moving forward and would appear to have the greatest likelihood of movement in the short-term include:

Alternative payment models that focus on expanding institutional special needs plans (I-SNP) Models. These include:

- 1) **I-SNP + Medicaid (fully capitated).** A CMS-state partnership demonstration that would address the Medicare-Medicaid financial misalignment and reinvest savings into enhanced quality of life and quality of care for residents. A fully capitated model would build on the Medicare I-SNP model, with a health plan as the accountable entity. CMS and the state would pay a Medicare and Medicaid capitation, respectively. Prospective savings from reduction in hospitalizations would be reinvested via Medicaid in a menu of interventions to improve care for residents.
- 2) **I-SNP Expansion with Wage Requirement.** A redesigned APM could require that participating nursing homes pay a % over local minimum wage that would be tied to market basket of competitive positions and be at least \$1 over local minimum wage. Alternatively, a share of the per member per month (PMPM) could be required to be devoted to improving direct-care worker pay and retention.

Initiative #2

The other proposal that was supported, and that represents a broader more “visionary” LTSS financing policy proposal with implementation prospects over a longer time frame includes:

Hill-Burton 2.0* and Adjusted Medicaid Rate. Build on Hill-Burton Act to incentivize providers to change the architecture of nursing homes. What is needed is guaranteed and incentivized loans, which could be through HUD to convert existing buildings to private rooms/private bathrooms or knock down



aging buildings and replace with small house models. Create a fair and just Medicaid payment rate for nursing homes to assure competitive wages for staff. This needs to include requirements for transparency and accountability on how funds are spent across budget categories like labor-related service costs, administration, related third party expenses, and profit.

Additional Proposal

Everyone also agreed that a clear priority was establishing a new federal long-term care benefit (NASEM 4A) which would have direct and major impacts across all the areas examined by the NASEM report. For that reason, and because no one believed that this is something that could come about over a two-year period, the idea was taken out of the Financing Committee. Based on steering committee and financing committee discussion, we propose that a group be established to how best to move that objective forward in parallel with other policy options supported by the committee.

***The Hill-Burton Act** is a federal law passed by Congress in 1946. The drive behind the legislation was to promise loans and to supply grants to hospitals and certain other health care settings to work on improvement (construct and modernize). Any health care settings receiving funding had to offer unique financial care to low-income patients, even including free health care. However, not all services are covered, and coverage may depend on the type of insurance that someone has. To qualify, patients must apply for financial assistance at the particular health care setting. The Health Resources and Services Administration has a complete list of Hill-Burton [facilities by state](#).