



the cedars
Your life. Your community.

Nursing Facility Labor Reimbursement

September 2014

thecedarsportland.org

Importance of Labor Funding

- **60-70% of operating costs relate to labor**
- **60% of labor costs relate to Direct Care**
- **Around 70% of Maine's NF residents today are funded by the existing rates set by the MaineCare reimbursement system.**
- **Quality of care is directly related to staffing:**
 - **Inadequate nursing hours per patient day are directly correlated with an increase in deficiencies of resident harm**
 - **Medicare quality rating heavily weighted on staffing to acuity**

What we should be working towards

- **A reimbursement system that:**
 - Responds to labor demands of the communities within which care is delivered to ensure access to care
 - Accommodates labor costs of all existing service delivery models, not just some
 - Responds quickly to demands put upon the labor force such as Minimum Wage increases, mandatory health care coverage, and labor shortages
 - Rewards providers who match staffing levels to their reported resident acuity and invest in their service delivery
 - Educates and trains our labor force

Cost of our Labor

W-2 wages:

- Regular wages, Overtime, Double-time, shift differentials, call-in incentives, premium pay, holiday and vacation pay

Payroll Taxes:

- FICA, Medicare, unemployment taxes

Benefits:

- Health, dental, life, disability insurances, child care, retirement

Types of Labor

- **Direct Care**
 - RNs, LPNs, CNAs
 - MDS RNs, QA RNs
 - Therapeutic Recreation staff

- **Routine Cost Labor**
 - Everyone else

Critical Drivers of Labor Costs

- **Labor market drives hourly rates/benefit structure**
 - Urban, rural, metropolitan locations
 - **Competitive labor environment or not**
 - Hospitals, multiple NFs, physicians, hospice, home health, unions
- **Acuity drives nursing hours per patient day**
- **Payer Mix impacts acuity; need for licensed staff**
- **Facility design/size; impacts staffing ratios**
- **Service delivery model**
 - Multi-facility ownership vs Freestanding
 - For-profit, governmental, private nonprofit

Failure of Current System

Fails to recognize critical drivers of cost of labor and as a result:

- **Fails to allocate state resources based on acuity**
- **Limits funding for free-standing, high acuity, high cost labor market providers to the costs found in low acuity, low cost labor markets and/or low overhead, multi-facility ownership**
- **Fails to fund the staffing required for quality care in too many of Maine's facilities**

How badly does it fail?

As a reminder, the annual shortfall quantified by LD 1776 approached \$36-37 million:

Direct Care:

- **State shortfall annually exceeds \$18 million**
- **Many facilities receive less than 80% of actual Direct Care costs**

Routine Costs:

- **State Shortfall annually exceeds \$18 million**
- **Many facilities receive less than 75% of actual costs; some less than half actual cost**

What Causes it to Fail?

Answer: The method of establishing upper limits deeply discounts the critical drivers of labor cost to the point you can't recover that labor cost.

Direct Care Limit:

- a) Start with a Peer Group Median that is bed-size based**
- b) Use a grossly inadequate wage index to “adjust” for labor cost variances**
- c) Apply current acuity index to an unrecoverable starting point**

Routine Cost Limit:

- a) Start with a Peer Group Median that is bed-size based**
- b) Leave it at that**

Wage Index for Direct Care Flawed

Direct Care Wage Index:

- Based on case mix adjusted costs, not actual cost
- Compares average costs in four regions
- Variance within regions range from 50-200%*
- Variance between regions as high as 250%*

YET*:

- Region 3 received no wage index even though it includes Bangor area
- Region 4 received 3/10ths of a percent
- Region 2 received 3.4%
- Region 1 received 8.9%

The Problem with our Direct Care Labor Funding Method?

Even the highest possible indices available in the state rate setting rules (as shown below) cannot make up labor cost variances of 80-250%*:

• The increase in the median from LD 1776*	10%
• The highest wage index used in new rates*	9%
• The <u>average acuity index</u> adds 49%*	<u>49%</u>
Total	<u>68%</u>

*Source: DHHS Rate Setting Spreadsheet for LD 1776

Result: Inequitable Direct Care Underfunding

- 40% of providers in Peer Group 2 and 25% of providers in Peer group 1 cannot recover actual Direct Care costs even after an increased median and the application of wage, acuity indices
- Impacts urban, rural, large, small, for-profit, nonprofit providers
- Infusion of funding did not address the inequities
- There are still rural providers who cannot improve their Direct Care funding despite an infusion of funds into the system as new funds are allocated to those shouldering the greatest underfunding burden

Routine Cost Labor Funding is Worse

Who are included in Routine Cost Labor?

- **Administrators**
- **Director of Nursing, Asst. DON**
- **Case Managers, Social workers, Admissions staff**
- **Food Service Director, Dieticians, Cooks, Aides**
- **Plant Operations Director, Maintenance techs, Laundry, Housekeeping, Purchasing**
- **Accounting, Billing, Payroll, Medical Records**
- **Reception, administrative assistants, security**
- **CEO, CFO/Controller, Human Resources, IT**
- **Marketing, Fundraising**

Routine Cost Upper Limit

Current method of rate setting ignores every critical labor variance that exists:

- Peer Group Median as much as 60%* lower than actual costs and there is:
 - No wage index to apply
 - No acuity index to apply
- No recognition of service delivery model variances-
 - High acuity vs low acuity; payer mix
 - High admissions turnover vs low admissions
 - Multi-facility vs freestanding; for-profit/nonprofit

Existing Routine Cost rate setting method funds to the low cost, low acuity, multi-facility ownership service delivery model robbing many providers of essential labor funding for Routine Cost Staff.

Rate Structure Needs Change

- Existing rate setting structure disproportionately robs many providers of adequate labor funding for no good reason:
 - Medicare margins are lower than state underfunding and not a reliable cost shifting policy to pay for labor
 - Private Pay are a narrow part of the entire taxpaying public yet are subsidizing the lion's share of state shortfalls
 - The Health Care Provider Tax hits some providers harder than others, will phase out under the ACA and displaces labor funding
 - Minimum Wage increases are on the way and our existing system will not capture that cost until a rebasing and many providers will see little if any of that funding

What we should be working towards

- **A reimbursement system that:**
 - Responds to labor demands of the communities within which care is delivered to ensure access to care
 - Responds to demands put upon the labor force such as Minimum Wage increases, mandatory health care coverage, staff education
 - Rewards providers who provide staffing levels related to their reported resident acuity to ensure quality of care
 - Accommodates labor costs of all existing service delivery models, not just some
 - Educates and trains our labor force