Talking Points in Support of HF2374

Nursing Facility Rate Equalization Modification

1. **This is a compromise bill.** In the past year, this committee has had vigorous discussion regarding a repeal or phase out of the rate equalization law. This bill reflects the compromise developed in the 2011 HHS Budget Conference Committee. It does not repeal the rate equalization law, but simply allows a care center to increase private pay rates up to 2% each year. This is designed to balance the widely recognized concern of underfunding of the state’s nursing home rates with other concerns raised in committee discussion.

2. **State and Federal Antidiscrimination Laws will remain in place.** Proponents of the rate equalization law were also concerned about discrimination against Medicaid recipients. Since the establishment of the law in 1976, and the amendments in 1983, a series of federal laws have passed prohibiting discrimination by payer source. For example, the federal conditions of participation for nursing facilities states at 483.12(c)(1) “Equal Access to Quality Care: A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment;”

3. **There is a robust market of services that will help control costs.** As care centers will consider increasing private pay rates, they will have to consider their competitors: other nursing homes, assisted living establishments, and home care providers.

4. **Privately-paying individuals not paying full cost of care:** Currently the MA reimbursement rate for skilled nursing care falls below the actual cost of care by over $28 per resident per day. Given the proposed cuts to MA reimbursement rates, the gap between costs and rates will grow. Because of the equalization law, those individuals that pay for their care with private funds are also not required to cover the full cost of their care.

5. **Personal Responsibility Disincentive:** Equalization discourages saving for long-term care. The message to consumers has been clearly sent that regardless of payment source, the exact same care and services will be made available to you—encouraging the transfer of assets to family members and general spend-down of personal assets. Removing this disincentive is a step towards long-term care financing reform and can help spark additional collaborative efforts to identify incentives that the state could offer to encourage individuals to save for their own long-term care needs.

6. **Current law should reflect changing use of skilled nursing facilities:** Minnesotans use skilled nursing facilities differently today than when the rate equalization law first passed in 1976. For instance, in 1990, the average length of
stay was 658 days; the median length of stay was 99 days. Today, the average length of stay is 248 days and the median length of stay is 27.5 days. While proponents of the rate equalization law were concerned about slowing spend-down in the 1970s, today’s trend towards shorter lengths of stay minimizes this concern because few residents stay long enough to qualify for Medicaid.

7. **Financial stress on nursing homes is increasing:** The Medicare program has been crucial to offset the funding shortfalls related to the MA rates. According to the 2012 Survey conducted by the LTC Imperative, the number one way care centers have addressed shortfalls is by maximizing their Medicare Part A operations. However, last year, on Oct. 1, CMS decreased Medicare rates for nursing homes by more than 11% and further cuts are likely as the federal government moves to address the budget deficit. Meanwhile, in Minnesota four more nursing homes have closed in the past year, continuing a trend going back for over a decade. As the economy improves, nursing homes will need additional funding to compete for labor to address staffing needs, but revenue sources are frozen or declining.

8. **There is no mechanism in state law to catch up to costs.** The 2011 HHS Budget bill repealed rebasing, which was a state policy designed to recalibrate MA rates to actual costs of care. There is nothing in place to replace that policy at this time.

9. **Caregivers bear the burden of underfunding.** Over 70% of nursing home operating budgets cover staff wages and benefits. According to a survey just completed by the LTC Imperative, nearly 69% of nursing homes have frozen caregiver base wages in the last year. 40% of nursing homes have reported that they have frozen employee base wages since 2009. In addition, many have passed on increasing costs of health insurance benefits to employees or completely eliminated health insurance benefits.

10. **Underfunding of nursing facilities impacts in other ways.** According to the 2012 LTC Imperative survey, care centers are making tough choices to address shortfalls: delaying physical plant expenditures, reductions in direct and non-direct staff hours, and reductions in resident activities.

11. **Our proposal has no fiscal impact to state budget and has minimal impact on private pay residents:** Some proposals introduced previously have had negative fiscal impact based on accelerated spend-down with no ongoing protection for private pay residents. However, HF2374 is budget neutral, and limits increases to private pay rates to any MA rate adjustment plus no more than an additional 2% each year.