



Long term care providers are feeling the pressure of a nationwide economic downturn that has left states reeling from a growing budget crisis and spurred a rash of Medicaid cuts to offset plummeting tax revenue.

At least 30 states and the District of Columbia face an estimated \$53.9 billion in combined budget shortfalls for fiscal year (FY) 2009, which in most states began July 1, 2008, according to an August report from the Center on Budget and Policy Priorities (CBPP). At least three additional states expect to face budget gaps in FY 2010, CBPP reported.

“The bursting of the housing bubble has reduced state sales tax revenue collections from sales of furniture, appliances, construction materials, and the like,” the report said. In addition, property tax revenue is down, and consumption of other consumer products has weakened, cutting into states’ sales tax revenue, the report said. CBPP warned that if employment continues to slide, income tax revenue will further erode, and there will be even greater “downward pressure on sales tax revenue as consumers become reluctant or unable to spend.”

Medicaid is a prominent target for state lawmakers scouring for options to

balance their budgets, due to the sheer size of the program. According to the National Governors Association’s most recent fiscal survey of states, Medicaid was the single largest budget item in FY 2007, accounting for about 22 percent of \$1.46 trillion in total state expenditures.

Target Long Term Care

Within Medicaid, long term care “sticks out like a sore thumb,” because it represents such a large portion of program spending, says Steven Chies, senior vice president of long term care operations for the Benedictine Health System in Cambridge, Minn.

Lynn Wagner

Providers Feel The **SQUEEZE** As States **Target** Medicaid

Administrators grapple with rate cuts and states' rekindled interest in managed care.

Nursing facility and home health services together accounted for \$72 billion in Medicaid outlays in calendar year 2006, according to the most recent national health spending data from the Centers for Medicare & Medicaid Services (CMS). An additional \$26.76 billion was spent on home- and community-based long term care services. Together, these three categories of long term care expenditures comprised 41 percent of the \$285 billion spent on all Medicaid-funded health services in 2006. Medicaid outlays for nursing facility care totaled \$52.2 billion in that same year, or 43.3 percent of all expenditures on nursing facility services.

Despite its importance to long term care financing, nursing facility providers contend with a chronically underfunded system. In 2007, the gap between Medicaid payment and providers' allowed costs averaged \$13.15 per patient per day, according to an annual report on the shortfall authored by Joseph Lubarsky, president of Eljay. The daily rate deficit amounts to an aggregate loss of \$4.4 billion nationwide, said the report, which was produced jointly with BDO Seidman for the American Health Care Association (AHCA).

"The only way nursing homes really achieve a break-even margin is from the Medicare program," Lubarsky says.

Even with positive Medicare margins factored in, however, providers end up with a net 2.5 percent shortfall from the two programs, he says.

"Medicaid represents about 60 percent or better of the patient days for nursing homes in this country," Lubarsky says. With such a large volume of care funded through a losing revenue stream, "those kinds of deficits are almost impossible to make up unless you have another payer balancing them," he says. Nursing facilities are increasingly reliant on Medicare to provide that balance, as private-pay residents choose assisted living or other alternative settings, Lubarsky says.

Florida is one of many states whose fortunes have turned dramatically, and which has leaned on nursing facilities for a sizeable portion of the budget offsets needed to staunch the red ink. In the middle of the decade, Florida was a leader in the housing and construction boom, following a series of severe storms that ravaged parts of the state. Disasters created a demand for rebuilding and fueled a surge in state revenue, says Tony Marshall, senior vice president and chief operating officer for the Florida Health Care Association (FHCA).

Today, the state leads in shrinking revenue, triggered by plunging real estate values. For the second year in a row, Florida faces a multi-billion dollar deficit—\$5.1 billion according to CBPP projections—and a precipitous revenue drop, Marshall says.

In an emergency session last year, the legislature cut \$75.2 million from nursing facilities' Medicaid payments, effective Jan. 1, 2008. The 3 percent rate reduction was equivalent to \$4.75 per patient per day. In May of this year, state lawmakers compounded that reduction by cutting the fiscal 2009 appropriation for nursing facility rates by \$163.7 million.

The action equaled a 1 percent reduction from existing reimbursement levels and a 6.5 percent reduction in projected rates, inclusive of the increase that would normally be factored in to compensate for rising costs, according to an FHCA analysis.

Though the new fiscal year began July 1, the second round of rate cuts has not taken effect because provider costs have stayed below projected levels, says Marshall. Anticipating ongoing budget woes, however, state lawmakers looked to the future during their 2008 session and approved a two-year rate freeze for all providers, including nursing facilities, effective July 2009.

In addition, the nursing facility budget was reduced by \$88.6 million due to an expected decrease in utilization, as 4,000 new slots were made available



States With Highest Budget Gaps As Percent Of FY2009 General Fund

State	Total Gap	Percent Of General Fund
1. California	\$22.2 billion	22.0%
2. Arizona	\$2.0 billion	19.9%
3. Florida	\$5.1 billion	19.9%
4. Nevada	\$1.2 billion	16.0%
5. Rhode Island	\$430 million	13.1%
6. New York	\$5.5 billion	9.8%
7. Alabama	\$784 million	9.5%
8. Georgia	\$1.8 billion	8.7%
9. New Jersey	\$2.5 billion	7.7%
10. Maryland	\$1.1 billion	7.2%

Source: Center for Budget and Policy Priorities

to the state's nursing facility diversion program, which places individuals in alternative home- and community-based settings. That reduction did not come out of the rate structure.

No End In Sight

Despite the succession of Draconian measures, it's possible that Florida's budget crisis has not yet hit bottom. Just two months into the current fiscal year, the state predicted a \$1.8 billion shortfall in projected revenue, Marshall says.

Nursing facilities, which in 2007 were already contending with an average Medicaid deficit of \$13.38 per patient day, are now reaching a point where they are "out of options," he adds.

To ease the pain, the legislature imposed a one-year moratorium on enforcement of the state's mandatory staffing ratio, implemented in 2007, which requires a minimum of 2.9 hours of certified nurse assistant (CNA) time per patient per day.

While the standard was left in place, providers cannot be sanctioned for failure to meet it, though they are still required to comply with the previous

minimum of 2.6 hours of CNA time per patient per day.

"Providers are having to look at their cost structure, and 65 percent of all costs in nursing homes are personnel-related," Marshall says. The \$75.2 million cut wiped out nearly the entire rate increase that providers had received to enable them to meet the 2007 staffing standard. FHCA has never sought a reduction in the staffing ratio, but has insisted on adequate funding for it.

For the short term, providers will likely respond to the funding cut with staffing reductions and deferred maintenance on projects that do not threaten quality, Marshall says. In the long term, Marshall says he fears that without rate relief, Medicaid beneficiaries could face access problems or service reductions.

"When the Medicaid rate is \$15 to \$20 below costs, and you have gotten to the lowest level of staffing necessary, you are just out of options," he says.

New Jersey Takes A Hit

Providers in New Jersey have also been plagued for the past two years by multi-billion dollar budget deficits. CBPP projected a fiscal 2009 shortfall of \$2.5 billion to \$3.5 billion for the state. To close the gap, lawmakers have sought "significant cuts from the Medicaid budget," says Paul Langevin, president of the Health Care Association of New Jersey in Hamilton.

Since long term care is a large part—about \$1.6 billion—of the state's \$3 billion Medicaid budget, New Jersey has dug deeply into nursing facility rates to make up shortfalls, cutting \$76 million (including a 50 percent federal match) from the FY 2009 rate, Langevin says. The state suspended the usual rate-setting process and instead raised existing rates by an inflation factor. The result was a lower update than facilities would have otherwise received.

Furthermore, only providers with a Medicaid census of 75 percent or more received the full update, Langevin says. The rest received just half of that in-

crease. In addition, the state cancelled a long-planned rebasing of Medicaid's outdated nursing facility rate structure.

But as bad as the outcome was, it could have been worse. The initial budget proposal would have taken \$97.2 million from nursing facilities, providing no inflation update and eliminating all Medicaid payments for bed-holds.

"We got \$20 million back into the mix," Langevin says.

In 2007, New Jersey nursing facilities had an average shortfall of \$28.64 in their Medicaid rates, the second-highest in the nation, according to the Eljay/BDO Seidman report. To contend with an ever-deepening loss, many providers have "focused on Medicare as a more reliable, reasonable government payer and looked to control the Medicaid portion of their census tightly," Langevin says.

"We have been predicting, and it is coming to fruition, that it will be very difficult to place individuals in the long term care facility [of their choice] if they come as a direct Medicaid admission and are very sick," he says. "That will be a very difficult admission."

Case Mix Can Help

At the Christian Health Care Center (CHCC) in Wycoff, N.J., President and Chief Executive Officer (CEO) Douglas Struyk says it becomes more difficult every year to "hold onto the inadequate funding you have," leaving little or no room for "working to get where you need to be" from a reimbursement standpoint. CHCC is more fortunate than many of the state's providers. The 100-year-old organization has high occupancy, a favorable location, and a wide continuum of services, all of which have contributed to a larger-than-average share of private-pay residents and Medicare beneficiaries, Struyk says. Medicaid accounts for 45 percent to 50 percent of residents, which is comparatively low, Struyk says.

CHCC services include a 252-bed nursing facility; a 40-bed special-care nursing facility for behavioral-man-

agement treatment; an 80-unit assisted living community; adult day services; a 39-bed residence and 40-unit apartment complex for independent seniors; and a range of mental health services, including a 58-bed psychiatric hospital for adult and geriatric patients.

CHCC also operates a post-acute care unit, which has bolstered its Medicare census, and is in the planning stages of a 258-unit continuing care retirement community.

The organization's ability to withstand the vicissitudes of Medicaid, however, has depended in part on raising rates for private-pay residents. Private-pay rates "are a function of the shortfall between costs and Medicaid reimbursement, which is not moving in the right direction," Struyk says. CHCC also depends on Medicare to mitigate those losses. As a result, this year's battle over a potential \$770 million Medicare cut, stemming from a government forecasting error, kept the organization on pins and needles. The impact of the cut would have been "significant," leaving the organization more exposed to built-in Medicaid losses, Struyk says.

"The Medicare Payment Advisory Commission may take the position that [it is only concerned with] Medicare funds, not Medicaid," he adds. "But the reality is that it is all one system."

Providers in the tiny state of Rhode Island have been battered by oversized

Medicaid cuts and are awaiting the outcome of a controversial waiver proposal that would transform the state's entire Medicaid program to managed care.

Small State, Big Problems


Despite its diminutive size, Rhode Island is home to the fourth-largest percentage of elderly over the age of 85, and 75 percent of nursing facility residents are covered by Medicaid, says Virginia Burke, president and chief executive officer of the Rhode Island Health Care Association in Warwick. "This means that the Medicaid program has more people to cover proportionately per taxpayer," she says. "It also means that nursing homes are very vulnerable to shifts in Medicaid payment policies."

Providers lose \$5 to \$10 a day for every Medicaid resident and must rely on revenue from 25 percent of residents to cover the shortfall left by three-quarters of the population, Burke says.

This year, the state had to close a budget gap of \$430 million, equivalent to 13.1 percent of its entire general fund, according to CBPP. "For a state of our size, that is an enormous" deficit, Burke says.

In early June, the legislature cut \$11 million from nursing facilities by imposing a six-month delay on the annual inflation increase for payment rates and reducing the maximum allowed cost

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for labor. The 2008 inflation update is based on 2006 costs, Burke says, with food, energy, and other expenses having risen dramatically in that time.

"Anybody trying to run a nursing home where you have to pay for food and shelter in 2008 with an income stream [based on 2006 costs] is going to have a problem," she says.

Elmhurst Extended Care, which is part of the Roger Williams Medical Center in Providence, was especially hard hit. The facility, which has been a certified Eden community for five years, is home to more than 190 elders and is in high demand as both provider and employer.

The facility is full with a waiting list, and "staff longevity is phenomenal," says Rick Gamache, vice president and administrator. Turnover among CNAs is at an almost unheard of rate—4 percent. "People are happy here," he says. "The Eden philosophy is very powerful."

Eden communities are set apart by the belief that "the most pain that is suffered is not caused by a broken hip or a stroke, but by the loneliness, boredom, and helplessness" experienced by residents in nursing facilities, Gamache says. "What we do to make a difference is create a community, a human habitat. Our focus is on companionship."

Staff are trained to understand that the companionship they provide is at least as important, and often more

important, than the medical care provided, Gamache says.

But a few months ago, Elmhurst's ability to sustain its mission was challenged by a nearly \$1 million blow to its Medicaid revenue. The six-month delay in the rate increase cost the facility \$185,000, while the reduction to the labor portion of the Medicaid rate resulted in an added \$850,000 loss, effective almost immediately, on July 1. The labor cut was crafted so that only about a third of facilities in the state were affected, Gamache says, by lowering the maximum wage and benefit expenses that would be reimbursed by Medicaid from the 125th to the 112th percentile of provider costs.

Almost overnight, Elmhurst had to figure out how to absorb a \$1 million loss in a \$17 million budget. The action was unexpected, says Gamache, who had been assured by several lawmakers that elders would be protected in budget deliberations.

Working On A Fast Fix

Gamache met with all levels of staff, residents, and family members for guidance and suggestions about how to weather the crisis with the minimum impact on staff, and without compromising care or Elmhurst's commitment to the Eden philosophy. He also reached out for ideas to other Eden providers.

Gamache says he was "overwhelmed

by the generosity of spirit" of his staff, who offered to take pay cuts and forgo raises. "In this economy, people on the low end of the wage scale who struggle paycheck to paycheck to put food on the table said we'll do it for less money," Gamache says.

Before the budget cut, Elmhurst had 245 staff members, and each CNA cared for an average of eight elders on an assigned basis, meaning they cared for the same eight residents every day. Gamache's goal was to continue to drive quality without cutting caregiver wages or eliminating raises and with as few staffing cuts as possible.

To achieve that, Elmhurst reached outside the box and developed a new staffing model in which CNAs were cross-trained to become care partners and provide a generalist array of services, including laundry and dining and activity assistance. Before launching the program, however, an assessment was made of the time it would take for each new function and what jobs could be eliminated if the position was created. In addition, Gamache put together a focus group of CNAs to determine whether this was an option they would support.

"They gave us critical feedback, and at the end [they] said we could make this work," he says.

Ultimately, a total of 12 staff members were laid off, and several positions filled with per diem staff were eliminated. As part of the new staffing paradigm, Elmhurst hopes to launch a training program for care partners to become medication technicians, which will make it possible for them to dispense medications to their assigned residents from locked medication cabinets in individual rooms. This is a dramatic change from the usual routine of a licensed nurse dispensing medications to dozens of residents from a mobile cart.

Gamache is hoping to demonstrate that the new system can reduce medication errors and is reaching out to universities for training grant funds

and to spark interest in conducting that research.

The transition to the new staffing model had to be fast-tracked. While other Eden providers have taken 18 months to make the transition to a similar model, Elmhurst had only a couple of weeks to put it in place. Now the challenge is working to ensure that the program is embraced throughout the community, Gamache says.

“We are trying to take this awful, shameful reduction in dollars and make something positive out of it,” he says.

Managed Care Makes A Comeback

The last time the economy soured, which happened in 2002, states sought to rein in Medicaid long term care costs by shifting more services to home- and community-based settings, said an April report from the Kaiser Commission on Medicaid and the Uninsured. In addition, all states “adopted measures to control provider payments and spending for prescription drugs,” the report said.

States were just starting to recover from that malaise, and restore some of the funds that had been taken out of the program, when the economy again faltered. According to Kaiser, states have fewer options this time around for controlling Medicaid costs, suggesting that a bigger axe may be taken to the program.

One avenue that has been significantly curtailed since 2002 is states’ use of provider taxes. In the early part of the decade, states were able to lean on provider assessments to generate additional revenue, softening the blow to payment rates and moderating the use of other austerity measures when the economy weakened, says Lubarsky. Today, however, “many states are tapped out or close to the maximum [provider assessment rate] allowed,” he says.

Nursing facility provider taxes contribute significantly to state Medicaid programs, generating a combined \$3.8 billion in federal matching funds, according to the Eljay/BDO Seidman

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study. This translates to an average rate impact of more than \$14 per patient day. In January 2008, however, the federal government lowered the ceiling on provider taxes to a maximum rate of 5.5 percent, leaving most states at the limit of their assessment.

Changes to federal rules on the use of intergovernmental transfers has also eliminated states’ ability to use those funds to offset budget deficits, Lubarsky says.

In the absence of other options, managed care is gaining ground.

“One thing we’re seeing now is a resurgence of states looking at Medicaid managed care for long term care,” Lubarsky says. States are hoping to “shift risk” for Medicaid expenditures to managed care organizations (MCOs), with the expectation that they will do a better job achieving savings than they have historically, he adds.

In New Jersey, the legislature included language in the current budget that requires the state’s health commissioner to create a five-year plan and timetable for moving Medicaid into managed care by next April.

CHCC’s Struyk says that in a state that “has been so fiscally driven in its policy setting,” there is a danger that

managed care will be a drain on an already underfunded system, implemented “simply to take the issue out of the hands of the department of health and give it to another entity—but one that will consume additional resources.”

While managed care would likely expand access to home and community-based services (HCBS), Struyk says that in his facility “there aren’t a whole lot of residents that could be in a setting other than this one.”

New Mexico Takes Action

Other states have moved more aggressively. In August, New Mexico started phasing in a statewide Medicaid managed care program for long term care services that will be completed by the end of the fiscal year. Medicaid beneficiaries must enroll in one of two MCOs, Amerigroup or Evercare, and providers must contract with one or both of the MCOs. The state pays MCOs a capitated payment, and the MCOs negotiate daily rates with providers, says Linda Sechovec, executive director of the New Mexico Health Care Association.

The initiative, which will cover an estimated 38,000 Medicaid beneficiaries, has been under discussion and evolving for at least four years as part of an effort “to give the state greater predictability in the budget process,” Sechovec says.

The so-called Coordinated Long-Term Services (CLTS) program will be budget-neutral with respect to current expenditures, according to state documents. One of the goals, however, is to shift more services to home- and community-based settings and decrease nursing facility utilization.

A report from AARP found that New Mexico has already tipped the scales in favor of HCBS, spending 53 percent of its Medicaid long term care funds on it. In the five years from FY 2001 to 2006, “the increase in Medicaid spending on HCBS was nearly five times the increase in spending on nursing homes,” AARP reported.

During that time, HCBS spending rose from \$87 million to \$227 million, while nursing facility outlays increased from \$166 million to \$196 million.

There has been “explosive growth” in the number of people served by HCBS, Sechovec says. “Some have come out of nursing homes, but it’s largely a new pool for expanding services.”

As providers enter into negotiations with MCOs, they “need a comprehensive understanding of what negotiated rates would cover” and how that compares to the current rate, she says.

Providers are also concerned about ensuring the timeliness of payments and are worried about their ability to protect quality in a managed care system, Sechovec says. “These are ques-

al Compact Waiver is to “rebalance” long term care services and achieve significant savings by expanding the use of HCBS. The state has set a goal of achieving a 50-50 split in the state’s budget for long term care services between nursing facilities and HCBS by 2013.

The state would establish a central authority, the Assessment and Coordination

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Providers are concerned about the adequacy of rates that will be paid by MCOs and fear they are “moving from one underfunded payment system to another,” Sechovec says. In 2007, New Mexico had a projected Medicaid shortfall of \$19.30 per patient day, according to the Eljay/BDO Seidman report, ranking 11th among 41 states and the District of Columbia.

In the initial phase of the CLTS roll-out, 23 of the state’s 70 Medicaid-certified nursing facilities have begun participation, Sechovec says. By June 30, 2009, all providers will be under contract with one of the two MCOs.

Many providers are still in the process of negotiating contracts, using the current Medicaid rate in the interim, she says. A key concern is whether MCOs will be willing to provide adjustments for unavoidable cost increases during a contract period. Essential capitol projects, such as a new roof or an increase in the minimum wage, have generally been covered on an interim basis through the fee-for-service Medicaid program, Sechovec says. Such safeguards could be lost under managed care.

tions we’ve been asking for months,” she says.

Thinking Things Through

A closely watched managed care waiver proposal in Rhode Island would encompass the state’s entire Medicaid program, including long term care. The plan has raised concerns and protests all the way to Capitol Hill for the way it would restructure the federal share of Medicaid funding and for the state’s failure to gain adequate input from stakeholders.

“If you make Medicaid waiver policy in the dark, you’re more likely to get bad policy,” said a statement released from Sen. Max Baucus (D-Mont.), chairman of the Senate Finance Committee. Warning that the plan “could hurt a lot of folks in need,” Baucus called the proposal a “prime example of the need for more transparency and public input in the Medicaid waiver process.” Baucus and Sen. Jay Rockefeller (D-WV) sent a joint letter to Health and Human Services (HHS) Secretary Michael Leavitt outlining a series of concerns with the waiver.

A key objective of the five-year Glob-

alization Organization, with a broad range of decision-making responsibilities, including determination of the level of care needed for each beneficiary, placement decisions, development of individual service plans and a budget for those services, and tracking utilization and outcomes. Centralizing these activities through a single stage agency “is designed specifically to shift the loci of decision making away from providers and to beneficiaries and their families,” the proposal said.

The plan would create three tiers of long term care benefits and eligibility. At the highest level, eligible beneficiaries would receive nursing facility care or a wide range of HCBS.

The mid-level tier would provide a wide range of HCBS, including assisted living, personal care, home health, adult day care, meals on wheels, family support, and companion services. A more limited range of supportive services designed to prevent a nursing facility admission, such as home modifications, homemaker services, and respite care, would also be available at this level.

The third tier would provide only

the more limited category of supportive services only.

Medicaid funds would also be used in nontraditional ways, such as rental deposits, utility connection costs, and home modifications, to help people transition from a nursing facility to the community.

Elderly Medicaid beneficiaries would be required to enroll in PACE, a program of all-inclusive care for the elderly that uses case managers to help beneficiaries select care mixes, or a managed care program called Rhody Health Partners. The dually eligible population would choose between PACE or a Medicare Special Needs Plan.

A Block Grant Approach

A feature of the plan that has drawn intense scrutiny and criticism is the way the state would restructure federal

participation. The 93-page waiver proposal, submitted to HHS for approval in early August, describes the transformation of Medicaid to a block grant program, in which the existing federal matching rate system would be replaced with a fixed annual allotment from the federal government, trended forward each year by a negotiated amount. The state would determine its share of expenditures based on the percentage of the total budget comprised by Medicaid in the base year.

The result would be a projected five-year spending cap of \$12.3 billion for all Medicaid services and first-year savings of \$67 million. More than half of those savings—\$34.23 million—would come from “rebalancing long term care.” The state’s timeline for implementation begins Oct. 1, 2008, pending approval by HHS.

Providers are concerned about the

process for determining eligibility and their exposure to risk for providing care that is ultimately denied, says the Rhode Island Health Care Association’s Burke. More broadly, there is fear about the ability to “maintain footholds we’ve gained with respect to quality” and the viability of the financing and benefit structure in the plan, she says.

While “Rhode Island nursing homes do an excellent job under difficult conditions,” Burke says, the expansion of HCBS “could be done in a way that’s financially catastrophic for the state.” With no end in sight for Rhode Island’s annual budget battles, she fears that “as the state’s economy worsens, its ability to pay providers appropriately will also worsen.”

Need For Comprehensive Reform

As providers face deepening Medicaid deficits in FY 2009 and beyond, the

role of Medicare in offsetting those losses is becoming increasingly crucial to the fiscal stability and viability of nursing facilities, experts say.

In August, for example, nursing facilities in New York state were threatened by more than \$1 billion in Medicaid cuts proposed by the governor over the next 18 months. The state's revenue base has been shattered by turmoil on Wall Street, leaving a budget deficit of \$5.5 billion that had to be closed, according to CBPP.

The governor's plan would have frozen rates, eliminated the inflation update, and taken away transition funds for a redesigned payment system, says Richard Herrick, president and CEO of the New York State Health Facilities Association. Providers escaped the harrowing proposal when the legislature rejected it for a more modest 1 percent reduction in the inflation factor.

Providers may not be entirely out of the woods, however. "We potentially could have to revisit the budget in November," Herrick says.

In this climate, any threat to Medicare revenue raises alarms, he says. CMS' recent proposal to cut \$770 million from the Medicare program was successfully defeated, or at least put on hold. But if the proposal had been implemented alongside a \$1 billion Medicaid cut, there would have been a "double barrel effect" in New York that would have been "devastating to everyone," Herrick says.

Leonard Russ, owner and administrator of the Bayberry Care Center in New Rochelle, N.Y., says providers were "feeling a lot of despair and uncertainty" throughout the tumultuous months when so much was at stake.

"Arguably half of facilities in the state could have faced bankruptcy in 18 to 24 months," he says. "I don't think that's overstating it."

Russ says his facility's Medicaid census represents about half of the resident population, compared with a statewide average of 80 percent or more. "We've dodged the bullet for the time being,"

he says, but Russ expects the issues "will come back on the table in a few months."

There remain "the makings for a perfect storm."

"The reality is that as we confront this economic downturn and the flattening of Medicaid dollars coming into the system, we are also confronting a Medicare system that is locked into a payment structure that does not have a lot of growth and evolution to it, but is based on a historic snapshot," says Laurance Lane, vice president of government relations for Genesis HealthCare in Kennett Square, Pa.

"This is the first time that [an economic downturn] has occurred when we've been on an almost pervasive prospective payment structure," in which reimbursement is "predicated on prior year issues," Lane says. As a result, at a time when the acuity of residents is rising, providers who take on capital costs and add clinical specialties to accommodate a shifting case mix must do so at their own risk.

Providers' "ability to replace capital and significantly retool service delivery is constrained because there is little or no incentive for significant capital investment" in either the Medicare or Medicaid programs," Lane adds.

A Broken System

As Medicaid continues to be buffeted annually by national budget priorities, and subject to a variety of piecemeal structural reforms, experts say that the only way to secure the future of long term care financing is with comprehensive reform.

"What we have tried to do is say the system is broken," says Bruce Yarwood, president and CEO of AHCA.

The organization has developed a reform proposal that would restructure long term care financing, infusing new streams of private funding to cover front-end costs and providing federally funded benefits for costs above a certain threshold, depending on an individual's income.

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Yarwood says that while long term care reform has not been part of the presidential debate, there may be opportunities to advance the issue over the next two years, as part of the health care reform initiatives of a new administration.

What's needed is "a five- to 10-year vision" for long term care reform that will attract broad-based support from consumers, providers, and the workforce, encompassing both financing and quality measures, Yarwood says.

"People are demanding that we do a better job, and that's appropriate," he says. But providers and consumers need a "definition of quality measures" that offer greater transparency and consistency than the current survey system—in addition to a reimbursement system that rewards value, Yarwood says.

Despite the depth of the flaws in the current system, few decision makers at the state or federal level have a vision of how to reshape long term care.

"The post-acute care system is broken, and people don't want to recognize the elephant in the room," Yarwood says. ■

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