Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER)

Report to
the Mississippi Legislature

Mississippi's State Veterans' Homes: An Analysis of Increasing Reliance on State General Funds and an Examination of Cost Reduction and Funding Options

When the Veterans Affairs Board (VAB) sought authority for creation of the state's four veterans' homes, VAB told the Legislature that, aside from one-time state general fund appropriations necessary to start up each of the homes, operations costs would be funded entirely through non-state sources (e.g., federal funds and resident charges). However, general fund support for operations has grown from 0% in fiscal years 1990 through 1994 to 13% in FY 1999. In FY 1999 and current FY 2000, VAB will have received approximately $5.2 million in state general funds for operation of the veterans' homes.

The increase in general fund expenditures is primarily due to increased staffing of the homes and insufficient non-state revenues to cover the costs of the staffing increase. Non-nursing staffing levels for the veterans' homes exceed non-nursing staffing levels of comparably sized nursing homes.

VAB could reduce reliance on state general funds by implementing one or more of the following options:

- reducing requests for general funds when the amount of special funds received exceeds initial budget projections;
- reducing non-nursing staff to average staffing levels of comparably sized nursing homes in the state;
- discontinuing payment of residents' in-patient hospital costs;
- exercising diligence in collecting Medicare Part B and secondary insurance reimbursements;
- increasing resident fees to the extent necessary to support efficient operations.

May 9, 2000

PEER: The Mississippi Legislature's Oversight Agency

The Mississippi Legislature created the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) by statute in 1973. A standing joint committee, the PEER Committee is composed of five members of the House of Representatives appointed by the Speaker and five members of the Senate appointed by the Lieutenant Governor. Appointments are made for four-year terms with one Senator and one Representative appointed from each of the U. S. Congressional Districts. Committee officers are elected by the membership with officers alternating annually between the two houses. All Committee actions by statute require a majority vote of three Representatives and three Senators voting in the affirmative.

Mississippi's constitution gives the Legislature broad power to conduct examinations and investigations. PEER is authorized by law to review any public entity, including contractors supported in whole or in part by public funds, and to address any issues, which may require legislative action. PEER has statutory access to all state and local records and has subpoena power to compel testimony or the production of documents.

PEER provides a variety of services to the Legislature, including program evaluations, economy and efficiency reviews, financial audits, limited scope evaluations, fiscal notes, special investigations, briefings to individual legislators, testimony, and other governmental research and assistance. The Committee identifies inefficiency or ineffectiveness or a failure to accomplish legislative objectives, and makes recommendations for redefinition, redirection, redistribution and/or restructuring of Mississippi government. As directed by and subject to the prior approval of the PEER Committee, the Committee's professional staff executes audit and evaluation projects obtaining information and developing options for consideration by the Committee. The PEER Committee releases reports to the Legislature, Governor, Lieutenant Governor, and the agency examined.

The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

PEER Committee
Post Office Box 1204
Jackson, MS 39215-1204

(Tel.) 601-359-1226
(Fax) 601-359-1420
(E-mail) http://www.peer.state.ms.us

The Mississippi Legislature

Joint Committee on Performance Evaluation and Expenditure Review

PEER Committee

SENATORS
WILLIAM CANON
Chairman
HOB BRYAN
BOB M. DEARING
WILLIAM G. (BILLY) HEWES III
JOHNNIE E. WALLS, JR.

REPRESENTATIVES
HERB FRIERSON
Vice-Chairman
MARY ANN STEVENS
Secretary
WILLIAM E. (BILLY) BOWLES
ALYCE G. CLARKE
TOMMY HORNE

TELEPHONE:
(601) 359-1226

FAX:
(601) 359-1420

Post Office Box 1204
Jackson, Mississippi 39215-1204

Max K. Arinder, Ph. D.
Executive Director

OFFICES:
Professional Building
222 North President Street
Jackson, Mississippi 39201

May 9, 2000

Honorable Ronnie Musgrove, Governor
Honorable Amy Tuck, Lieutenant Governor
Honorable Tim Ford, Speaker of the House
Members of the Mississippi State Legislature

On May 9, 2000, the PEER Committee authorized release of the report entitled **Mississippi State Veterans' Homes: An Analysis of Increasing Reliance on State General Funds and An Examination of Cost Reduction and Funding Options**.

William Canon

Senator William Canon, Chairman

This report does not recommend increased funding or additional staff.

Table of Contents

Table of Contents (continued)

List of Exhibits

Mississippi's State Veterans' Homes: An Analysis of Increasing Reliance on State General Funds and An Examination of Cost Reduction and Funding Options

Executive Summary

The Veterans Affairs Board Has Become Increasingly Reliant on State General Funds to Operate the Veterans' Homes

The Mississippi Legislature created the four state veterans' homes with the understanding that the homes would be self-supporting for ongoing operations, primarily through federal funds and resident fees. The first home, built in Jackson in 1989, was self-supporting for the first five years of operation. Since the opening of three additional homes in Collins, Kosciusko, and Oxford during Fiscal Year 1997, the Veterans Affairs Board (VAB) has become increasingly reliant on state general funds to support the ongoing operation of the homes. General fund support for operations has grown from 0% in fiscal years 1990 through 1994 to 13% in FY 1999, the most recently completed fiscal year. General fund support continues to grow, as the Legislature appropriated $2.8 million in general funds for operation of the homes in FY 2000. Further, VAB has requested $3.9 million in general funds for operation of the homes in FY 2001, even though the board will realize an approximately $2 million increase in revenues during the upcoming fiscal year from non-state sources. This increase will occur as a result of a $6.63 increase in VA per diems (effective October 1, 1999) and a $3 per day increase in resident fees (effective December 31, 1999).

Staffing Costs for the Homes Have Doubled Since FY 1995

VAB's increasing reliance on general funds is due primarily to costs associated with increases in the number of staff per resident. On a per-resident basis, salary expenditures for operation of the state veterans' homes increased from $21.23 in FY 1995 to $50.98 in FY 1998. Part of this increase is due to the hiring of more non-nursing staff than employed by comparably sized nursing homes in the state.

PEER Proposes Several Options for Reducing VAB's Reliance on General Funds

PEER explored several options for reducing VAB's reliance on state general funds, as presented in the following table. Based on conservative estimates, PEER identified $3.2 million in cost savings or additional net income which VAB could realize from implementation of these options. However, these totals do not include the option of increasing residents' fees, which could be used to further reduce reliance on general funds. These options, combined with diligent control of other costs not examined in this review (e.g., costs of management company overhead), could significantly reduce VAB's reliance on state general funds.

Recurring and One-Time Items for Reducing VAB's Reliance on State General Funds

Recurring Items:	**Estimated Cost Savings or Additional Revenues**
Reduce non-nursing staff to average number of staff for comparably sized nursing homes in Mississippi	$1,600,000
Discontinue payment of residents' hospital expenses	45,000
File all eligible Medicare Part B expenses*	25,000
One-Time Items:	
Reduce requests for general funds by the amount by which actual special funds exceed budget projections for FY 2000	1,100,000
Recover funds from Diversified Health Services for payment of services not rendered	477,000
TOTAL	**$3,247,000**

* Annualized savings

PEER also determined that the option of the homes becoming federally certified to receive Medicare Part A reimbursement would result in increased revenues to VAB, but that these revenues would be used to provide a higher level of post-hospitalization care, and would therefore not be available to offset state general fund expenditures for the homes.

PEER also explored the option of the homes becoming federally certified to receive Medicaid, but determined that given current income levels of state veterans' home residents, this option could increase state expenses by approximately $177,000 annually.

PEER Found Problems with VAB's Management and Operation of the Veterans' Homes

During the course of this review, PEER also identified the following specific problems related to management and operation of the homes:

- From July 1, 1999, through February 29, 2000, Diversified Health Services provided an average of 3.33 direct care nursing hours per resident per day in the four VAB homes instead of the 3.74 hours per resident per day specified in the management contract. VAB paid Diversified Health Services at least $477,000 for 59,000 direct care nursing hours not rendered during this period.

- In FY 1999, the Legislature appropriated to VAB $3.1 million for the hiring of new direct care nursing staff over a fifteen-month period, beginning April 1, 1999. VAB did not incur expenses for the new staff until July 1, 1999; however, the board inappropriately used $1.62 million of the appropriation to pay VAB homes' operating expenses for the period April 1, 1999, through June 30, 1999. Further, on July 1, 1999, rather than reducing the amount of its expenses for new nursing services by $620,000 for the three-month period when it did not receive these services, VAB obligated the entire $3.1 million appropriation amount for a twelve-month contract with its management company, resulting in a higher monthly cost for these services than contemplated in the appropriations bill.

- VAB's practice of paying hospitalization costs of its veteran residents is not authorized by state law establishing the homes. Further, the practice presents a potential liability to the state in the event that VAB funds cannot cover the hospitalization expenses and VAB's Executive Director requests the funds from the state.

- VAB is not legally protected to ensure its entitlement to Medicare Part B reimbursements, because its contracts for physicians' services do not contain language specifying the reassignment of benefits from physicians to VAB.

- VAB compensates its Medicare billing contractor on a percentage of billings basis, which violates the intent of a Health Care Financing Administration regulation designed to prevent fraud in the Medicare program.

Recommendations

Staffing

1. VAB should require Diversified Health Services to provide direct care nursing staff in accordance with terms of the management contract. Should Diversified Health Services fail to meet required levels of staffing, VAB officials should consult with the VAB attorney and the Attorney General's Office in exercising remedies available under the management contract or any other remedies available under law for breach of contract.

2. VAB officials should consult with the VAB attorney and the Attorney General's office to determine possible actions for seeking reimbursement of funds paid to Diversified Health Services for direct care nursing services never rendered.

3. VAB should reduce non-nursing staff at the veterans' homes to non-nursing staff levels of comparably sized nursing homes in Mississippi.

VAB Management and Operations

4. VAB should diligently review management company costs in order to ensure that the company is delivering quality services to VAB as efficiently and economically as possible.

   - Prior to consideration of a new management company contract, VAB should use existing resources to procure an economy and efficiency study to determine the most efficient organization and operation of the veterans' homes.

   - VAB should carefully consider the terms of future contracts to ensure that VAB's interests are protected. In particular, the board should not adopt contractual language that limits the board's use of remedies provided in a contract for breach of contract.

5. The Veterans Affairs Board should return $620,000 to the state general fund for three months of service it did not receive when it wrote a twelve-month contract rather than a fifteen-month contract for new direct care nursing staff. If VAB does not return the $620,000 to the state's general fund by June 30, 2000, the Legislature should enact legislation during the 2001 session to transfer the funds from VAB to the state's general fund.

6. VAB should use special funds to replace the $1.62 million in general funds that were inappropriately spent for general operating expenses.

7. Whenever VAB has a budget request or appropriations bill pending before the Legislative Budget Committee or the Legislature and VAB learns of a change in federal per diem funding levels, the Executive Director should inform the Legislative Budget Committee or the Appropriations chairs of the changes that could impact the VAB's need for special fund or general fund spending authority.

8. VAB should improve quality of care by meeting the necessary requirements to provide a certified level of care to VAB residents.

Medicare Part B

9. The board should ensure that it receives all federal and other insurance revenue available to it by strictly enforcing its contract with the Medicare billing contractor to provide such services. Specifically, VAB should implement the procedures necessary to ensure that all eligible Medicare claims are filed and reimbursements received and that all secondary insurance claims are filed and payments received.

    - With respect to collection of secondary insurance, VAB should ensure that secondary insurance (e.g., MediGap, Blue Cross) information on its residents is up to date and that any Medicare Part B filings returned to VAB with a notation of incorrect secondary insurance policy numbers are re-filed with the correct numbers.

    - If the board elects to continue to contract for such services, it should pay the contractor a flat amount for services provided rather than a percentage or a fee per billing.

    - VAB must ensure that its medical service providers are properly completing the forms necessary to ensure Medicare Part B reimbursement to the maximum extent allowable.

10. The board should include language in contracts with physicians and other medical service providers to reassign their Medicare B reimbursements to the VAB. The assignment language is required by HCFA in those instances in which the board receives Medicare reimbursements on behalf of doctors who provide services for nursing home patients. As outlined in the HCFA document, "Claims, Filing, Jurisdiction and Development Procedures," Section 3060.2 C, the suggested assignment language should be signed and dated by both the facility and the physician and should read as follows:

It is agreed that only (name of facility) will bill and receive any fees or charges for the services of (name of physician) furnished to patients at the above-named facility (or specify other limitations of the reassignment).

11. The board should review all past remittance notices (explanations of benefits) and secondary insurance contracts of residents to determine whether secondary insurance reimbursement due to the board can be recovered. The board should continue to attempt to recover all possible Medicare Part B reimbursements which were never filed (e.g., podiatrist's services, flu vaccinations).

Medicare Part A

12. After becoming certified, VAB should evaluate the feasibility of filing for Medicare Part A reimbursement and assigning responsibility to residents for Medicare Part A co-payments which can be paid through secondary insurance or family resources.

Hospital Costs

13. VAB should officially amend its resident hospitalization policy to state that all hospital costs, whether at VA hospitals or private hospitals, are the responsibility of the resident (both veteran and non-veteran) and should amend its pre-admission application accordingly.

Resident Fees

14. VAB should consider increasing resident fees to the extent necessary to support efficient operations of the veterans' homes in lieu of asking for general fund support.

Medicaid

15. The Veterans Affairs Board should periodically reassess the feasibility of the homes becoming federally certified to receive Medicaid, in light of changing income levels of state veterans' home residents.

For More Information or Clarification, Contact:

PEER Committee
P.O. Box 1204
Jackson, MS 39215-1204
(601) 359-1226
http://www.peer.state.ms.us

Senator Bill Canon, Chairman
Columbus, MS 662-328-3018

Representative Herb Frierson, Vice Chairman
Poplarville, MS 601-975-6285

Representative Mary Ann Stevens, Secretary
West, MS 662-967-2473

Mississippi's State Veterans' Homes: An Analysis of Increasing Reliance on State General Funds and An Examination of Cost Reduction and Funding Options

Introduction

Authority

The PEER Committee authorized a revenue and expenditure review of the state veterans' homes. PEER conducted this review pursuant to the authority granted by MISS. CODE ANN. Section 5-3-57 et seq. (1972).

Scope and Purpose

Because Mississippi's state veterans' homes were established to be self-supporting (primarily through federal funds and resident fees), PEER focused its review on the Veterans Affairs Board's increasing reliance on state general funds to operate its four state veterans' homes. PEER also examined options for reducing reliance on state general funds, ways to reduce costs, maximizing current sources of non-state revenues, and exploring new federal revenue sources.

Method

PEER analyzed expenditure reports, budget requests (from FY 1990 through FY 2001), appropriations bills for FY 1990 through FY 2000, and state and federal laws and regulations governing operation of the four state veterans' homes.

PEER interviewed staff and analyzed documents from the federal Department of Veterans Affairs and the Health Care Financing Administration.

PEER also interviewed staff and analyzed documents from the following state agencies: Division of Medicaid, the Department of Health's Licensure and Certification Division, and the Veterans Affairs Board (VAB). In addition, PEER interviewed staff of Blue Cross/Blue Shield and United Health Care responsible for Medicare reimbursements and claims and staff of state veterans' homes in Tennessee and Oregon.

Background

The Mississippi Veterans Affairs Board has established state veterans' homes in Collins, Kosciusko, Jackson, and Oxford, each with a 150-bed capacity. The homes housed 593 residents as of November 30, 1999.

MISS. CODE ANN. Section 35-1-19 (1972) authorizes the Veterans Affairs Board to establish homes to "provide domiciliary care and other related services for eligible veterans of the State of Mississippi." To date, the board has established four state veterans' homes in the following locations: Jackson (January 1989), Collins (August 1996), Oxford (October 1996), and Kosciusko (March 1997). (See Exhibit 1 on page 4). Each of these homes was built to accommodate 150 residents.

The state veterans' homes provide residents with comprehensive care, including room, board, nursing and physician's services, prescription drugs, ambulance service, and hospitalization.

The homes are licensed by the state's Department of Health, but are not certified to receive Medicare or Medicaid funds. The homes do, however, meet federal Department of Veterans Affairs (VA) construction and staffing standards necessary to receive a VA per diem for each veteran resident.

While state law established these homes for veterans, the board also admits non-veteran spouses of veterans. As of November 30, 1999, there were 584 veterans and nine non-veteran spouses residing in Mississippi's state veterans' homes.

Organizational Structure

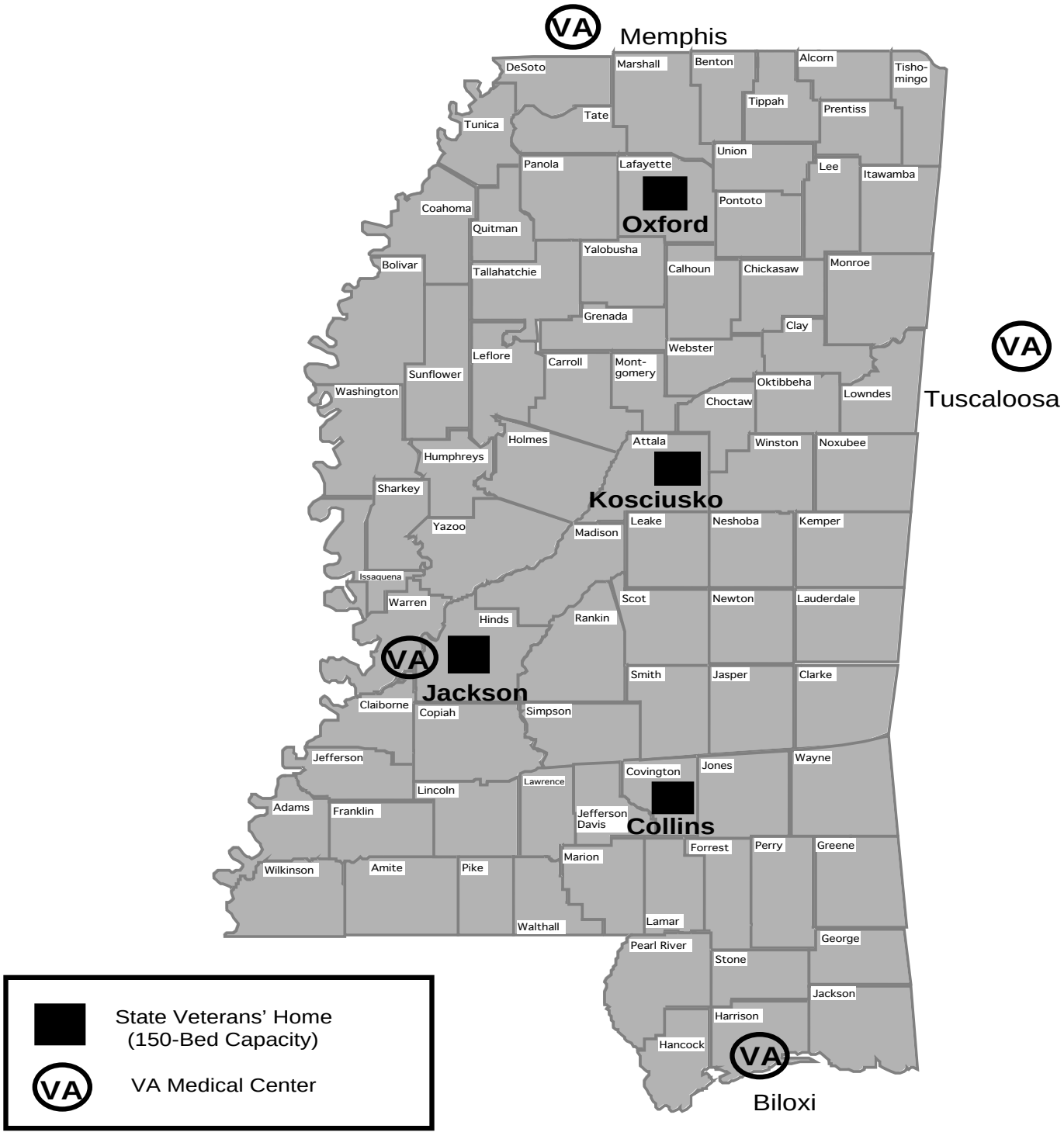
Fifty state employee full-time equivalents (FTEs) and 417 contractual FTEs provide direct services and management to the state's four veterans' homes.

The Veterans Affairs Board has three operational divisions, as well as a central administrative staff. VAB's Claims Division assists veterans in obtaining state and federal veterans' benefits. VAB's State Approving Agency Division approves education and training programs for compliance with federal regulations governing the distribution of General Issue (G.I.) bill funds to veterans. VAB's Nursing Homes Division is responsible for operation of the four state veterans' homes.

As of November 30, 1999, VAB's Nursing Homes Division had forty-nine authorized full-time state employee positions, forty of which were filled. The authorized positions consist of the Director of the Nursing Homes Division and twelve state employees at each home, which include a branch director, staff to assist residents in obtaining funding assistance, other administrative staff, a pharmacist, a nurse practitioner, and general service employees.

According to the Board's Executive Director, in addition to the Nursing Homes Division staff, the board's central office employees spend 90% of their time on tasks related to the state veterans'

Exhibit 1: Location of Mississippi State Veterans' Homes and Federal Veterans Administration Medical Centers



SOURCE: State Veterans' Affairs Board

homes--time that is equivalent to ten additional employees devoted to the veterans' homes. Adding these central office employees to the forty Nursing Home Division employees results in fifty full-time employees devoted to the veterans' homes.

In addition to the fifty state employee FTEs with responsibilities for operation of the homes, the Veterans Affairs Board contracts with a management company, Diversified Health Services, to handle day-to-day management of the four homes. This company, which employs an administrator at each home to oversee operations, is responsible for hiring and supervising all direct care staff (i.e., certified nursing assistants, registered nurses, and licensed practical nurses) and other support personnel such as laundry staff, kitchen workers, dieticians, and housekeeping employees. The company sub-contracts rehabilitative services (occupational, physical, and speech therapy). Diversified Health Services has managed the Collins, Kosciusko, and Oxford homes since FY 1998, and the Jackson home since FY 1999. As of November 30, 1999, Diversified Health Services employed 417 FTEs in the state's four veterans' homes.

In addition to its contract with the management company, the Veterans Affairs Board independently contracts for the following services at each of its homes: physician, podiatrist, relief pharmacist, and ambulance.

Costs of Care in Mississippi's State Veterans' Homes

The FY 2000 daily cost per resident of operating the state's four veterans' homes is $104.90.

During FY 1999, the daily cost per resident of operating the homes was $88. Seventy-four percent of these costs ($64.99) were fees paid by VAB to the management company.

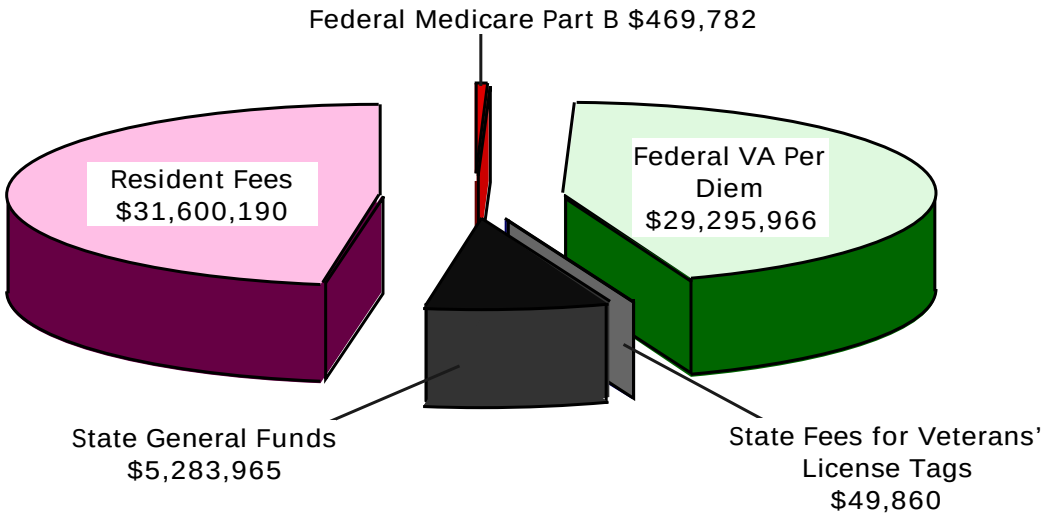
During FY 2000, the estimated cost per day increased to $104.90, seventy-five percent ($78.35) of which represents management company fees. The costs of state VAB employees, contractual physicians, other direct service providers, and medications make up the remaining $26.55 (25% of total costs) per resident per day.

Revenue Sources for Operation of the State Veterans' Homes

Since inception, VAB has received $66.7 million from all revenue sources.

VAB has received a total of $66.7 million for operation of the veterans' homes since FY 1988. Federal funds comprise 45% ($29.8 million) of total funding since inception, resident fees 47% ($31.6 million), and state funds 8% ($5.3 million). Exhibit 2, page 6, shows a breakdown of the revenues supporting operation of the four homes since inception through FY 1999, by major category. A discussion of each of these major revenue categories follows.

Exhibit 2: VAB State Veterans' Home Program Operating Revenues by Source, FY 1988 through 1999



State Revenues*	**$ 5,333,825**	**8%**
Federal Revenues*	**$29,765,748**	**45%**
Resident Fees	**$31,600,190**	**47%**
Total Revenues	**$66,699,763**	**100%**

*Not included are sources of funding for construction of the four homes. Construction funds include an additional $21,612,010 in federal funds and $9,988,707 in state bond issues.

NOTE: This exhibit includes veterans' homes startup costs of $765,824 in FY 1989 and $1,641,090 in FY 1997, operating expenditures of $2,703,935 from the general fund for FY 1995 through FY 1999, and $173,116 in indigent care in FY 1998 and FY 1999. This exhibit excludes $1,541,730 provided by the Legislature in FY1997 from the Liability Contingency Fund, a special fund created by the Legislature in 1994 from state general fund revenues.

SOURCE: PEER analysis of VAB financial reports, budget requests, and DFA bond reports.

Federal Funds

VA Per Diems

Mississippi's four state veterans' homes receive a per-day payment from the Department of Veterans Affairs (referred to as a VA per diem) for each veteran resident in the homes. This payment is not made for each day that a resident is in a non-VA hospital for more than ninety-six consecutive hours or for other absences of more than ninety-six consecutive hours. In addition, a VA per diem payment is not made to the homes for any day a resident is hospitalized in a VA medical center.

The federal Department of Veterans Affairs increased the per diem rate from $43.92 per resident per day to $50.55 per resident per day effective October 1, 1999. The federal Department of Veterans Affairs is responsible for auditing the daily state veterans' home resident census that the state's Veterans Affairs Board reports to the Department of Veterans Affairs. As shown in Exhibit 2 on page 6, VAB has received $29.3 million in VA per diem revenues since the first home began operations in FY 1989.

Medicare Part B Reimbursements for Medical Services

Medicare Part B is medical insurance available to persons sixty-five or older (and in certain cases, disabled individuals who are under sixty-five years of age) who pay a monthly premium. It primarily covers physician's services, outpatient care, diagnostic tests, durable medical equipment, and ambulance services. Medicare Part B reimburses 80% of eligible charges for physician's and medical services rendered to residents of the state veterans' homes, after the deductible of $100 per resident per year has been met.

In FY 1997, the Veterans Affairs Board began contracting with physicians serving the Jackson, Oxford, and Kosciusko homes on a flat monthly fee basis (not affected by the number of medical services performed) in exchange for the reassignment to the board of their Medicare Part B insurance claims for services provided to residents of the homes. The Health Care Financing Administration allows physicians to reassign their claims to a contractual employer such as the Veterans Affairs Board. VAB has chosen to allow physicians serving the state veterans' home in Collins to file their own reimbursement for Medicare Part B. The Collins physicians receive a higher Medicare Part B reimbursement amount than can be received at the other three homes because the Collins doctors operate out of a federally designated health professional shortage area, which qualifies for a reimbursement rate approximately ten percent higher than those of non-shortage areas.

As shown in Exhibit 2 on page 6, VAB has received $469,782 in Medicare Part B reimbursements since it first contracted with physicians to reassign these benefits to the VAB in FY 1997.

State Funds

State General Funds

Since creation of Mississippi's first state veterans' home, VAB has received $5.3 million in state general funds for operation of the homes (through FY 1999). In addition, the Legislature appropriated $2.8 million in general funds for operation of the homes in Fiscal Year 2000, and VAB has requested $3.9 million in general funds for the homes in FY 2001. A more in-depth discussion of VAB's increasing reliance on state general fund appropriations to operate the state's four veterans' homes follows in the next chapter.

Veterans' Specialty License Tag Fees

MISS. CODE ANN. Section 27-19-56.12 (1972) allows veterans to purchase, for an additional thirty-dollar charge, special motor vehicle license tags or plates which identify them as veterans. State law specifies that the Tax Commission shall deposit these fees "to the credit of a fund to be administered by the board overseeing the veterans nursing homes in this state for the benefit of indigent residents who are residents of such nursing homes." As shown in Exhibit 2 on page 6, VAB has received $49,860 in fees for veterans' specialty tags since the tags were first sold in FY 1998.

Resident Fees

Effective December 31, 1999, VAB increased its charge to veteran residents from $41 per day to $44 per day. Non-veteran spouses (nine as of November 30, 1999) are charged $88 per day. Veteran residents who meet VA income requirements may receive a maximum of approximately $40 daily reimbursement from the VA for their daily charge. This federal reimbursement to veterans is called "aid-and-attendance." As shown in Exhibit 2 on page 6, the VAB has collected $31.6 million in resident fees since inception.

Increasing Reliance on State General Funds to Operate the State Veterans' Homes

Although the state veterans' homes were established to be self-supporting, following the opening of the three homes in Collins, Kosciusko, and Oxford in Fiscal Year 1997, VAB has become increasingly reliant on state general funds to support operation of the homes.

Increases in General Fund Expenditures

State veterans' homes were established to be self-supporting, yet state general funds provided thirteen percent ($2.4 million) of total funding in FY 1999. The portion of VAB's revenues provided by state general funds is increasing at a faster rate than other sources of funds.

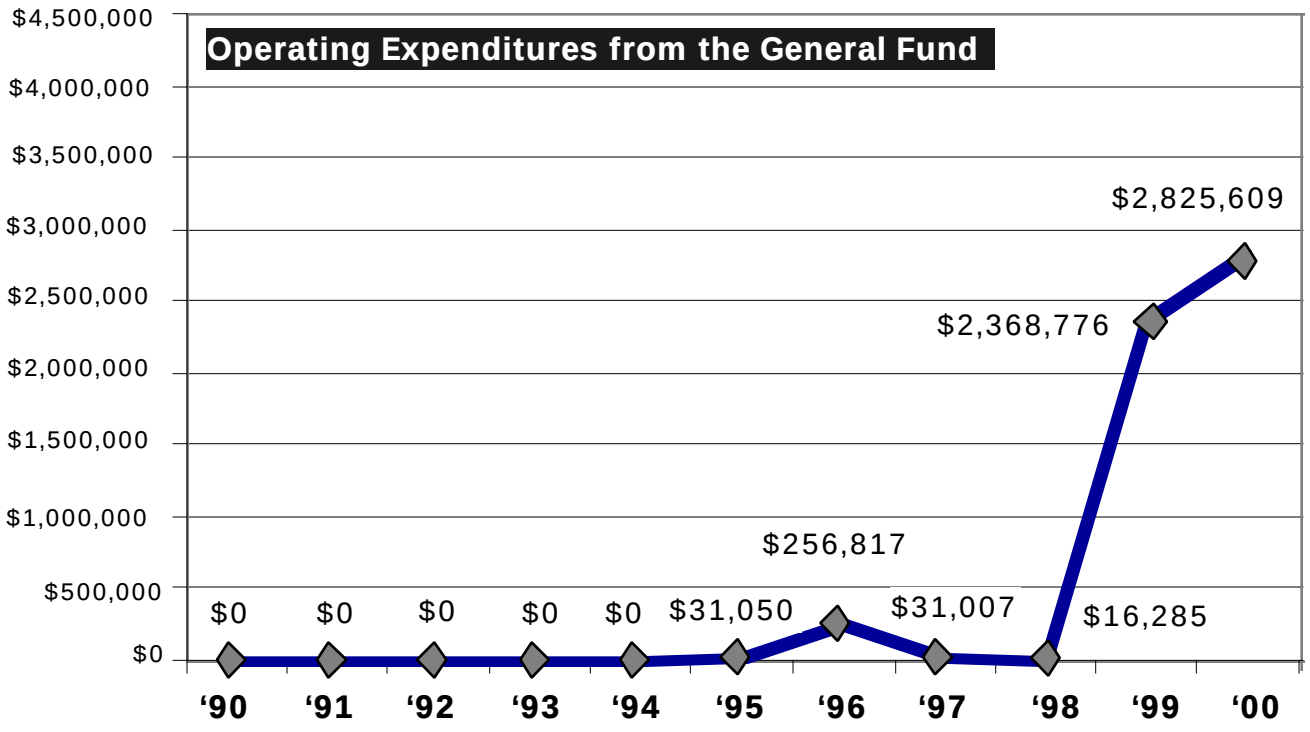
Mississippi's state veterans' homes were established to be self-supporting, primarily through federal funding sources and resident fees. However, in FY 1999 state general funds provided $2.4 million (13% of the total funds) in support to the homes for operation. The portion of VAB's revenues provided by state general funds is increasing at a faster rate than other sources of funds.

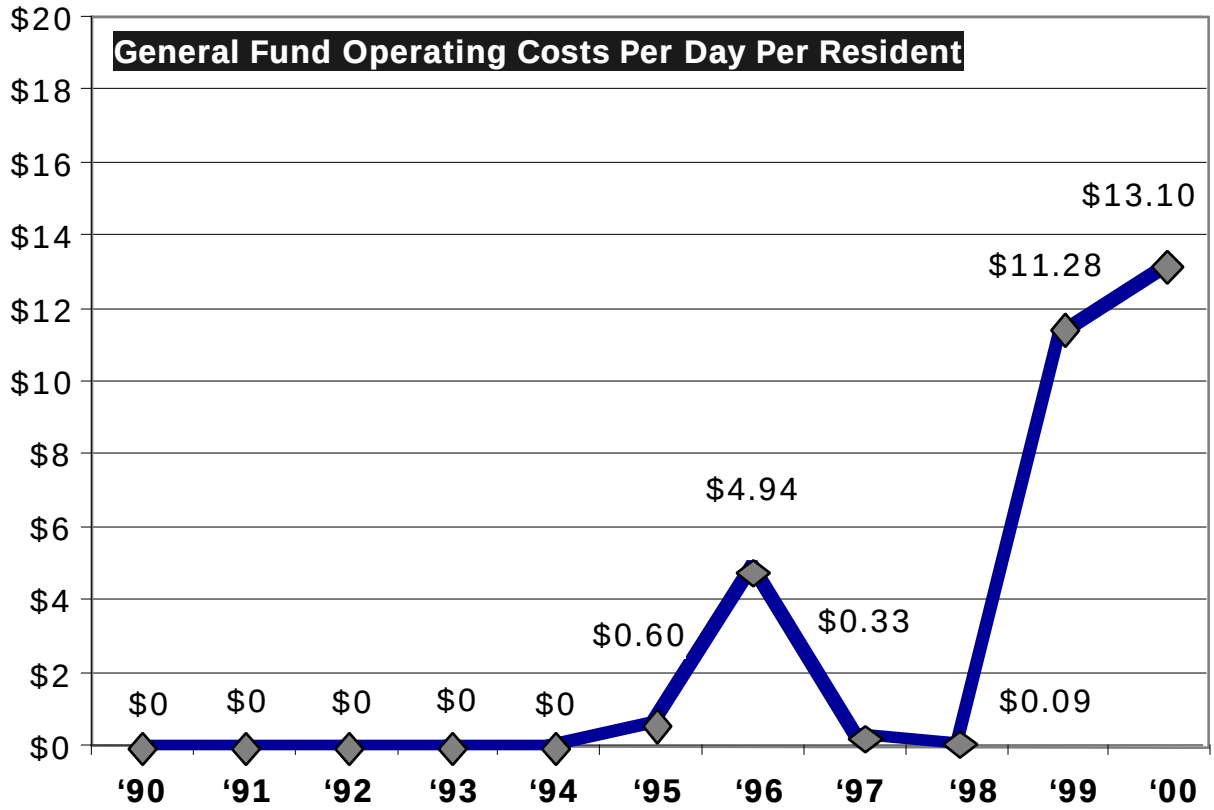
As shown in Exhibit 3 on page 10, state general fund expenditures for operation of the state veterans' homes increased from zero in fiscal years 1990 through 1994 to $2.4 million in FY 1999. Estimated state general fund expenditures for operation of the state veterans' homes for FY 2000 total $2.8 million and VAB has requested $3.9 million in state general funds for FY 2001.

As shown in Exhibit 3 on page 10, on a daily per-resident basis, general fund operating expenditures increased from zero in fiscal years 1990 through 1994 to $11.28 in FY 1999. Estimated general fund operating expenditures on a daily per-resident basis for FY 2000 are $13.10.

Between FY 1995 and FY 1999, per-resident general fund expenditures increased by $10.68, the VA per diem rate increased by $8.55, and resident fees increased by $2 per resident per day.

Exhibit 3: General Fund Veterans' Home Operating Expenditures and Costs per Day: FY 1990 to 1999, FY 2000 Appropriations, and FY 2001 Budget Request





NOTES: The exhibit excludes the veterans' homes' start-up costs of $765,824 in FY1989; $1,641,090 spent from the general fund and $1,541,730 from the Liability Contingency Fund in FY1997; and excludes amounts spent for indigents from the general fund ($88,882 and $84,234 in FY1998 and 1999, respectively).

SOURCE: VAB budget requests, reports to the Federal Veterans Administration, and other information.

Increases in Per-Resident Staffing Costs

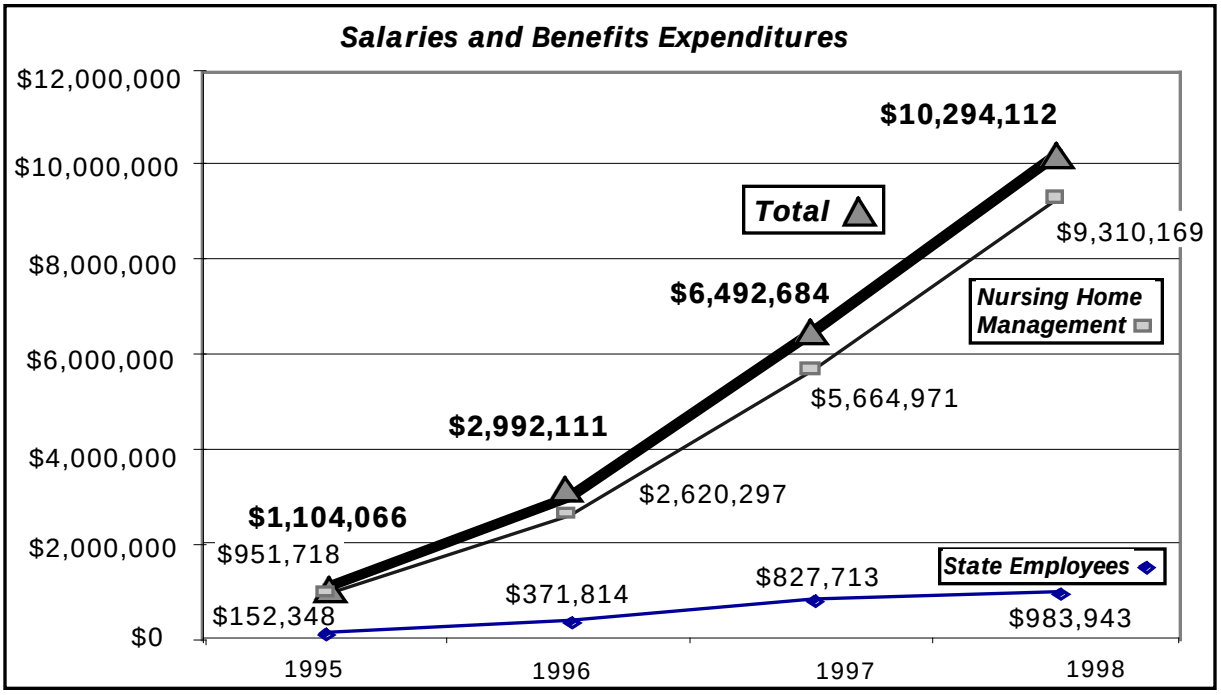
The increase in state general fund operating expenditures is due chiefly to increases in state employee and contract staffing, both in the VAB central administrative office and in the homes.

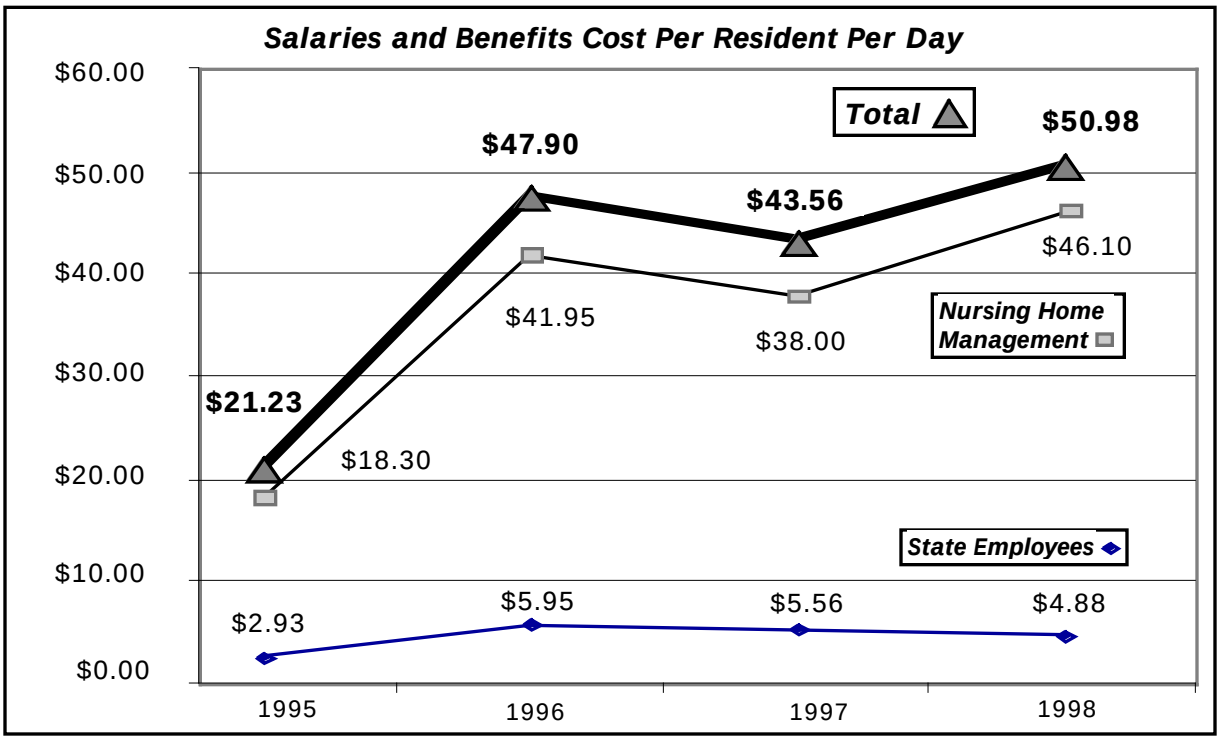
The increase in state general fund operating expenditures is primarily attributable to increases in costs associated with an expansion of staffing for the state veterans' homes. As shown in Exhibit 4 on page 12, VAB staffing costs increased from $1.1 million ($21.23 per resident) in FY 1995 to $10.3 million ($50.98 per resident) in FY 1998.

VAB violated legislative appropriation language by spending $1.62 million in state general funds on state veterans' home operating expenses rather than using the funds to pay salaries of new staff, as mandated by the Legislature.

In the 1999 Regular Session, the Legislature appropriated $3.1 million in general funds to VAB "for the purpose of providing the funds necessary to increase the direct care nursing staff that is needed to properly care for the men and women who reside in the four (4) State Veterans Homes." VAB requested the funds in order to increase the number of direct nursing care hours per resident to 3.74. The bill took effect from and after passage (on April 1, 1999) and therefore made available to VAB $206,667 per month over the fifteen-month period for employing new nursing staff. VAB, however, did not incur costs for the new staff until July 1, 1999. The cost of VAB's FY 2000 contract with its management company increased by an estimated $3.1 million over the FY 1999 contract cost. In violation of the appropriations language, VAB spent $1.62 million of the $3.1 million general fund appropriation during FY 1999 on other state veterans' home operating expenses. PEER determined that VAB had sufficient cash on hand in special funds to cover these expenses. VAB's Executive Director told PEER that he used the general funds instead of the special funds to pay these operating expenses, because it allowed VAB to pay vendors in a more timely manner.

Exhibit 4: VAB Veterans' Home Salaries and Benefits Expenditures and Cost Per Day per Resident, Calendar Years 1995 to 1998





NOTES: Because nursing home management company expenditure information provided to PEER was incomplete in some months, PEER adjusted amounts on a prorata basis. Any differences from actual amounts are immaterial.
SOURCE: PEER analysis of nursing home management company financial statements and VAB reports.

Options for Decreasing the State Veterans' Homes' Reliance on General Funds

Reduce Requests from the General Fund when Special Fund Revenue Exceeds Budget Projections

VAB's FY 2000 Special Fund Revenues Will Exceed Its Budget Projections by $1.1 Million

VAB underestimated VA per diem payments by $1 million for FY 2000.

In its FY 2001 budget request dated July 30, 1999, VAB projected payments from the Department of Veterans' Affairs for FY 2000 based on the then-current per diem rate of $43.92. However, effective October 1, 1999, the VA per diem increased to $50.55, which will result in approximately $1 million in revenue above VAB's projections for FY 2000. VAB did not give notice to the Legislative Budget Office or the Appropriations chairs that actual special fund revenue will exceed the special fund budget projections for FY 2000.

VAB underestimated resident payments by $100,000 for FY 2000.

VAB estimated revenue from veterans' home residents' payments during FY 2000 based on a daily charge of $42. However, VAB did not increase its charge to residents (from $41 to $42 per resident per day) on July 1, 1999, but increased the charge to $44 per resident per day on December 31, 1999. This will result in $100,000 in revenue above VAB's projections for FY 2000. In the VAB board-approved FY 2001 budget request, the resident payments are projected to increase to $46 per resident per day on July 1, 2000.

In its FY 2001 budget request, VAB estimated revenue from the VA based on a per diem rate of $50.55 for FY 2001. In March 2000, the VA indicated the per diem will increase to $51.38 effective October 1, 2000, which will result in $126,000 in additional revenues above the VAB estimates for FY 2001. Should the anticipated per diem increase become effective during FY 2001, the Executive Director should inform the Legislative Budget Committee or the Appropriations chairs of the changes that would impact VAB's needs for special fund or general fund spending authority.

Since actual revenue from the VA and veterans' home residents will exceed the FY 2000 budget estimates by $1.1 million and FY 2001 revenues should exceed budget estimates by $126,000, VAB's reliance on state general funds could be reduced accordingly without negatively impacting total funds available to VAB.

Reduce Current Expenses

VAB Should Reduce Its Number of Non-Nursing Staff to the Average Levels of Comparably Sized Nursing Homes and Deliver a Certified Level of Care

VAB employs more non-nursing staff than other Mississippi nursing homes of similar size.

VAB employs more non-nursing care staff than do comparably sized nursing homes in the state (i.e., homes with 130 to 170 beds). Specifically, for every 100 residents on December 31, 1998, VAB employed non-nursing staff of thirty-six full-time state and contractual employees and eight contractual part-time employees. Department of Health data shows that comparably sized nursing homes employed only twenty-eight full-time and six part-time non-nursing employees for every 100 residents on that date, as shown in the table below.

VAB Non-Nursing Staff Per 100 Residents Compared to Non-Nursing Staff of Comparable Homes

	Full-time	Part-time
VAB (including contract staff)	36	8
Comparable homes	28	6

Based on this data, VAB, including Diversified Health Services staff, employs eight more full-time and two more part-time non-nursing staff for each 100 residents (i.e., a total of approximately forty-seven full-time and twelve part-time) than the state's other comparably sized nursing homes. PEER estimates the annual cost of this staff to be $1.6 million. Exhibit 4 on page 12 shows that the size of VAB's non-nursing staff was already larger than that of the ten other comparably sized nursing homes prior to the hiring of two additional full-time equivalent positions on November 30, 1999.

VAB's Executive Director noted the additional non-nursing staff serving the state's four veterans homes is due in part to the additional layer of state staff who supervise contractual staff and also to the fact that VAB has chosen to employ certain personnel (e.g., a driver and a nursing assistant to transport patients to their doctors' appointments) not usually employed at other nursing homes.

VAB Should Discontinue Payment of In-patient Hospital Costs for State Veterans' Home Residents

PEER estimates that VAB could save approximately $45,000 annually by discontinuing the practice of paying veteran residents' hospitalization costs.

VAB's policy regarding hospitalization of state veterans' home residents is partially stated as follows in its veterans' home admission package:

> ***The daily charge for care at the Veterans Home is $44.00. This charge includes comprehensive medical care (hospitalization at the VA Medical Center, staff doctors and medication, nursing care, laundry, and room and board).***

Because residents of the three veterans' homes outside of the Jackson area do not have easy access to a VA hospital (see Exhibit 1, page 4), the board took official action on July 12, 1996, to allow the billing of residents for care-related costs of services in facilities other than VA hospitals. However, in practice, VAB has been paying hospital costs for all of its veteran residents, whether incurred in a VA or non-VA hospital, provided the VAB medical staff determines that the resident's medical condition mandates the non-VA hospital admission. VAB assumes none of the hospitalization costs of its nine non-veteran residents, even though resident fees collected from these residents help to pay the hospital bills of veteran residents.

State law specifically authorizes the State Veterans Affairs Board to administer homes for veterans, but it does not authorize the board's acceptance of the obligation to pay resident in-patient medical expenses. Specifically, MISS. CODE ANN. Section 35-1-19 authorizes the establishment of veterans' homes and states:

> ***The object and purpose of the establishment of the Mississippi State Veterans Home shall be to provide domiciliary care and other related services for eligible veterans of the State of Mississippi.***

Clearly, this language allows the home to provide services usually and customarily provided to residents of nursing homes, such as care provided within the home by nurses and physicians, as well as dietary and therapeutic support that are generally thought of as being related to "domiciliary care." Paying for the cost of in-patient hospital care cannot be considered to be necessarily implied in the phrase "domiciliary care and related services."

During FY 1999, VAB paid $45,704 in hospital charges for veterans' home residents.

The Veterans Affairs Board has accepted a financial risk by agreeing to pay hospitalization costs of veterans' home residents. During FY 1999, VAB paid $14,563 in VA hospitalization charges and $31,141 in non-VA hospital charges.

Concerning those veterans' home residents utilizing VA hospitals, the VA provides service-connected treatments to veterans at no charge and charges for non-service-connected treatments based on the veteran's ability to pay. Thus costs of VA hospitalization have built-in limits. However, there is no limit to the expenses that VAB could incur for residents treated in non-VA hospitals. Uninsured veterans accounted for sixty-nine percent of VAB's hospitalization costs during FY 1999.

According to VAB's Executive Director, in the event of insufficient funds to pay hospitalization costs, the board would ask the Legislature for a deficit general fund appropriation.

VAB's Executive Director has stated that if a veterans' home resident requiring a costly procedure could not be stabilized and safely moved to a VA hospital, the board might not have sufficient funds to cover the resident's expenses and would have to approach the Legislature for additional funds. Thus, VAB has accepted a responsibility not specifically authorized by the Legislature (and, in the case of non-VA hospitalization costs, contrary to the board's own policy) that has the potential to be very costly, but plans to rely on a deficit appropriation if costs exceed its available funds.

Maximize Special Fund Revenue from Medicare Part B and Secondary Insurance

VAB Should Increase Medicare Part B Collections by Ensuring that All Eligible Claims Are Filed

As of November 1999, 476 (80%) of the state veterans' homes' 593 residents were Medicare Part B insured. During FY 1999, the board collected $193,095 in Medicare Part B reimbursements for physician's services performed on these residents for the Jackson, Oxford, and Kosciusko homes.

VAB's Medicare billing contractor does not verify that the homes are forwarding all eligible Medicare Part B claims to her for submission to HCFA.

VAB has contracted with a billing contractor to file Medicare Part B with the Health Care Financing Administration (HCFA). The billing contractor does not verify that the homes are forwarding all eligible claims to her. Further, no one at the homes is sufficiently familiar with Medicare Part B regulations to submit all eligible claims to the billing contractor for filing.

The service component of VAB's contract for Medicare billing states:

> ***The contractor shall submit charges for applicable services at the Homes electronically to Medicare Part B in such a way that any secondary coverage, such as a "Medigap Policy," that a resident may have will be automatically filed with the proper company.***

Under the terms of the contract, VAB's Medicare biller is responsible for ensuring that all charges for Medicare Part B reimbursable services are filed. Further, the method of compensation provided for in the contract (i.e., a percentage of Medicare allowable charges, rather than a flat fee) suggests that the intent was for the Medicare biller to take an active role in ensuring that all eligible charges at the homes are filed.

In practice, however, VAB's Medicare biller only submits to Medicare charges submitted to her by employees of the homes (without

verifying whether the homes are submitting all eligible charges). VAB's contract with the Medicare biller contains provisions allowing VAB to terminate the Medicare biller for failure to perform contracted duties and responsibilities satisfactorily, yet VAB has not challenged the Medicare biller's failure to verify that the homes are filing all eligible charges as a breach of contract, even though VAB's Executive Director stated that the billing contractor is responsible for ensuring that VAB receives all Medicare Part B reimbursements to which it is entitled.

The Veterans Affairs Board has not enforced contract provisions to ensure that it maximizes Medicare Part B and other potential insurance reimbursements. During FY 1998 and FY 1999, the board did not collect an estimated $48,000 in Medicare Part B reimbursement for podiatrist's services and at least $1,167 for flu vaccines.

VAB could increase Medicare Part B collections by aggressively filing for reimbursements.

PEER reviewed VAB expenditure records for FY 1998 and FY 1999 and found $1,167 in Medicare Part B eligible expenses for flu vaccinations which staff of the homes had not reported to the billing contractor for collection and which was therefore not collected.

PEER also determined that during fiscal years 1998 and 1999, VAB failed to collect an estimated $48,000 in Medicare Part B reimbursements for podiatrist's services because no one coded the procedures for filing. The podiatrist serving the Jackson and Kosciusko homes during these two years submitted written notes of his procedures to the billing contractor in Jackson, but did not code his procedures, which is necessary to collect from Medicare Part B. The billing contractor said that coding medical procedures was not part of her job duties.

Prior to PEER's review, VAB began trying to recoup some of the lost Medicare Part B revenues for the podiatrist's services by having the podiatrist go back and code all of the specific procedures that he performed. On July 30, 1999, the board collected $725 from HCFA retroactively for some of these podiatrist's services. Because of the late filing, HCFA deducted a $47.16 penalty from VAB's claim for $772.16 in back filings. VAB's Executive Director stated that the podiatrist was continuing to review his records and code services performed for the residents so that the homes could recoup additional Medicare Part B reimbursements.

VAB compensates its Medicare billing contractor on a percentage of billings basis, which violates the intent of a federal Health Care Financing Administration regulation designed to prevent fraud in the Medicare program.

VAB compensates its Medicare billing contractor by paying her a percentage (8%) of Medicare billings that are rendered allowable by HCFA.

This method of compensation violates the intent of the Health Care Financing Administration's Medicare regulation 3060.10 (Claims,

Filing, Jurisdiction and Development Procedures), designed to prevent fraud in the Medicare program. This regulation prohibits a billing contractor who receives assigned payments directly from Medicare from receiving a percentage of the billings as compensation. More specifically, the regulation prohibits the contractor from receiving compensation which is "related in any way to the dollar amounts billed or collected" or from receiving compensation which is "dependent on the actual collection of payment."

While VAB's Medicare billing contractor receives her reimbursement from the board rather than directly from Medicare, a HCFA representative stated that the situation nevertheless violates the intent of the regulation and should therefore be reviewed in detail by HCFA or the insurance carrier that is responsible for investigating irregularities in the billing process (United Health Care).

Although doctors at three veterans' homes verbally assign their Medicare Part B reimbursements to the board in exchange for a monthly fee, the contracts do not assign the Medicare billings to the board. As a result, the board has not been legally protected to ensure its entitlement to Medicare Part B reimbursements.

The physicians for the Jackson, Kosciusko, and Oxford homes receive flat monthly payments (regardless of the number of services provided) from the Veterans Affairs Board for providing medical services to residents. In return, the physicians verbally reassign their Medicare reimbursements to the board. However, physicians of the Collins home do not receive a flat payment from the board, but file for Medicare reimbursements directly and receive payment for remaining deductibles and copayments from the board. These physicians receive the Medicare rural reimbursement rate. According to the Medicare carrier, United Health Care, this rate is ten percent over that of the non-shortage areas.

PEER knows of no instances in which physicians at the three homes have filed for themselves rather than allowing the board to collect the Medicare Part B reimbursements. However, the physicians' contracts do not contain a clause explicitly stating that these reimbursements will be reassigned to the board. Only the podiatrist's contract reads, "The physician will assist the Board in seeking reimbursements." However, this clause is not sufficient to protect the board. Furthermore, the other physicians' contracts have no clause whatsoever regarding the handling of reimbursements.

The lack of written assignment from doctors to the board is against Health Care Financing Administration (HCFA) regulations. The regulations [HCFA's "Claims, Filing, Jurisdiction and Development Procedures," Section 3060.2 C] are in place to reduce the opportunity for fraud against HCFA.

Subsequent to PEER's inquiries, VAB's Executive Director stated that he would revise the contracts to include the assignment.

VAB Should Improve Efforts to Ensure Payments are Received From Secondary Insurance

Because VAB's billing contractor does not verify secondary insurance policy numbers forwarded to HCFA, VAB is not receiving all secondary insurance claims payments to which it is entitled.

VAB's contract also requires the billing contractor to send information to HCFA regarding patients' secondary insurance so that HCFA can notify the secondary insurance company of the balance remaining after Medicare has paid. VAB is entitled to collect the amount due from the secondary insurance provider. The billing contractor stated that she forwards the information provided to her by the homes concerning secondary insurance, but that it is not her responsibility to follow up to see that this information is correct.

On numerous occasions, Medicare reported to VAB that the secondary insurance had not been filed because the insurance policy number submitted was invalid; however, neither the billing contractor nor anyone else at VAB corrected the policy numbers so that the board could receive additional insurance reimbursements.

Increase Resident Fees to the Extent Necessary to Support Efficient Operations

Average income of veterans' homes residents is sufficient to support future increases in VAB resident fees.

As noted on page 8, effective December 31, 1999, VAB resident fees increased to $44 per resident per day. Based on the November 1999 resident census of 593, this increase will yield approximately $649,000 in additional revenues during the next calendar year, which VAB should use to offset dependence on state general funds. For each $1 that VAB raises its fee per day per resident, it could generate an additional $216,445 (based on the November 30, 1999, census of 593 residents) in income for operation of the homes annually. As shown in the Appendix on 33, on average, single residents of the state veterans' homes have $7,756 and married residents have $15,696 in annual income after payment of resident fees, which indicates that resident financial resources should be available to support an increase in resident fees. Therefore, VAB could continue to reduce its general fund dependence by further increasing the daily resident fee.

The FY 2001 budget approved by VAB includes a $2 increase of resident fees to $46 per day. With the increase, total revenue from resident fees is projected to be $9.9 million in FY 2001.

Explore New Sources of Federal Revenues

Because Mississippi's state veterans' homes are not federally certified, the homes cannot receive Medicaid benefits or Medicare Part A reimbursements for rehabilitative and skilled care in a nursing home following hospitalization. While 98% of other nursing homes in Mississippi are federally certified, certification is not as critical to the state veterans' homes because they already receive federal VA funding.

However, by becoming federally certified, the veterans' homes would be eligible to receive Medicare Part A reimbursements for rehabilitative and skilled care rendered in the homes following the hospitalization of residents. The impact on VAB revenue would depend on the level of Medicare reimbursements, the costs associated with rehabilitative care, and VAB's willingness to assign responsibility for Medicare Part A co-payments to residents or their families.

VAB could also realize a net increase in federal funding by making its homes Medicaid certified, assuming all current residents participated. However, this increase would be realized at significant cost to the veterans in terms of their personal income.

Becoming Federally Certified to Receive Medicare Part A Funds Would Result in Increased Federal Funding, but Would Require Increased Contributions from Either VAB or Residents

If VAB became federally certified to receive Medicare Part A funds, it could receive reimbursement for skilled nursing services currently being rendered, but would also have to pay for rehabilitative services from these funds which are currently paid through Medicare Part B.

Medicare Part A is insurance available to persons sixty-five or older (and in certain cases, disabled individuals who are under sixty-five years of age) who have contributed to Social Security. In addition to paying hospitalization costs, it pays up to 100 days of reimbursement to patients released to nursing homes who require rehabilitative services or skilled nursing care as a result of their hospitalization.

Nursing homes assess residents eligible for Medicare Part A reimbursement based on the intensity of treatment the resident requires and assign the resident a resource utilization group rating which determines the amount of Medicare reimbursement which the home can receive for the resident's care. During 1999, reimbursement rates for the resource utilization groups ranged from $89.46 to $318.90. Reimbursement rates include payment for ancillary (medication, therapies), routine (room and meals), and capital (building usage or depreciation) costs.

During the first twenty days of rehabilitative or skilled nursing services, Medicare Part A regulations do not allow the home to collect resident fees. After twenty days of rehabilitative or skilled services in the nursing home, Medicare requires the resident to

contribute up to $97 per day for his or her care and the homes can begin to once again collect resident fees.

During FY 1999, 555 state veterans' home residents were covered by Medicare Part A insurance. However, VAB could not receive Medicare Part A reimbursements for rehabilitative or skilled nursing services received in the homes following hospitalization because VAB management has chosen not to become Medicare Part A certified.

The federal certification process involves compliance with building codes and meeting staffing and program requirements. Certification is conducted by the Health Department's Facilities Licensure and Certification Division. According to the Licensure and Certification Division director, the state veterans' homes meet most, if not all, of the building codes and most of the staffing requirements. The main areas which VAB would have to address in order to become federally certified would be in programs.

Program Changes Needed to Become Medicare Part A Certified

From a program standpoint, to become Medicare certified, each state veterans' home would have to address the following four program areas: use an assessment tool to determine each resident's level of functioning and rehabilitative needs, put a HCFA certified quality assurance process in place, provide ongoing training for certified nursing assistants, and develop cost reports for Medicare.

Of the four program areas the board would have to address for certification, three would have no cost or negligible costs and one (developing Medicare cost reports) would have a relatively minor recurring cost of approximately $3,000 per year.

More specifically, with respect to assessment of residents' rehabilitative or skilled nursing needs, VAB's management company has already implemented software in each of the homes which records each resident's level of functioning and rehabilitative needs. With respect to a quality assurance process, VAB could implement a program utilizing existing staff who would have to be trained to carry out these new quality assurance responsibilities. The quality assurance system would also require completion of new forms. With respect to training, while certified nursing assistants would have to receive twelve hours of training each year in areas such as quality assurance and Occupational Safety and Health Administration regulations, this training could be done on an in-service basis by the director of nursing.

Drawbacks of Medicare Part A Certification

In order to receive a Medicare Part A reimbursement for rehabilitative or skilled care received in a nursing home, the resident must be covered by Medicare insurance, must have stayed in the hospital for at least three days, and must reside in a nursing home

which is federally certified to receive Medicare Part A. Currently, residents returning to the VAB homes following hospitalization receive skilled nursing services from the nursing staff of the management company and rehabilitative services from therapists who file for their own Medicare Part B reimbursement. If VAB became certified to receive Medicare Part A reimbursement, therapists would no longer file for their own reimbursements through Medicare Part B. Therapist charges would be paid from Medicare Part A reimbursements.

Under Medicare Part A regulations, VAB must forego resident payments during the first twenty days of the reimbursement period and must pay for rehabilitative services from the Medicare Part A reimbursements. If the amount of Medicare reimbursement remaining after paying for rehabilitative services is less than the resident per diem charge of $44, VAB would experience a decrease in revenues.

During the last eighty days of the reimbursement period, either VAB or the residents must be responsible for the $97 Medicare co-payment. If VAB makes the co-payments by using the residents' $44 daily per diem charge and the $50 VA per diem, VAB would have to contribute an additional $3 daily toward the co-payment. Such an arrangement would divert the residents' daily per diem and the VA per diem to expenses associated with Medicare and away from expenses currently paid by this revenue source.

If the resident must pay the $97 Medicare co-payment and the $44 VAB daily charge, residents would experience a large increase in expenses and the majority of the residents would be unable to make such payments without secondary insurance, which currently is not required by VAB. For Medicare Part A reimbursements to be a viable alternative for increasing federal revenues, residents would have to be responsible for the $97 Medicare co-payment through secondary insurance or family resources.

Veterans' homes in Tennessee require residents or family members to sign an agreement which states that the resident or family is responsible for the Medicare co-payment. The Tennessee veterans' homes urge residents to obtain secondary insurance to assist in paying the Medicare co-payment.

During FY 1999, residents of the four state veterans' homes were hospitalized 702 times for three days or more. However, given PEER's project time limitations, VAB could not determine which of these residents required rehabilitative or skilled nursing care following hospitalization or the level of services received.

Once certified, a home's failure to maintain compliance with federal regulations governing certification could result in fines. The State Department of Health conducts an intensive four-day survey of federally certified nursing homes once a year and determines whether these homes meet HCFA requirements. VAB would have to amend the contractual agreement with its management company to

specify who assumes responsibility for fines resulting from failure to comply with federal certification requirements.

VAB Should Periodically Reassess the Feasibility of Becoming Federally Certified to Receive Medicaid

If the state veterans' homes became Medicaid-approved, the state's fiscal impact could range from an annual savings of $578,000 to an annual increase in expenses of $103,000, depending on the number of residents participating in Medicaid. However, qualifying residents could lose up to a net total of approximately $962,000 annually in personal income.

More than half of state veterans' home residents have a qualifying income that is low enough to qualify for Medicaid. If the state veterans' homes became Medicaid-approved and all residents qualifying for Medicaid participated in the program, the state could save $578,000 annually. However, under Medicaid regulations, qualifying single veterans could lose $1.47 million annually in personal income, while qualifying married veterans would be allowed to retain an additional $514,000 annually in personal income.

Participation in the Medicaid program is voluntary; therefore, it is likely that single residents who would lose money by participating in the Medicaid program would choose not to participate and that married residents who would gain money by participating in the Medicaid program would participate. Under this scenario, state expenses could increase by approximately $103,000 if the state veterans' homes became Medicaid-approved.

Under current Medicaid regulations and average resident incomes, the state veterans' homes would most likely not benefit financially from becoming federally certified to receive Medicaid. However, the VAB Executive Director should monitor changes in these conditions that could make such certification advantageous to the homes. The benefits of any savings to the state would have to be considered in light of qualifying residents experiencing a net loss of personal income.

Calculation of Increases in Personal Savings or Expenses

The maximum annual amount that Medicaid would pay toward each resident's care would be $37,836. However, this maximum amount would be reduced by other sources of payment, such as the $18,451 in VA per diems that the VAB receives annually for each veteran resident. State veterans' homes residents qualifying for Medicaid would be required to contribute income above their personal needs allowance, and the spouse allowance for married residents, toward the remaining expense of $19,385. According to federal VA regulations, residents of a Medicaid-approved state veterans' home may still receive payments from the VA for unreimbursed medical

expenses, provided they meet all income and unreimbursed expense requirements.

Under Mississippi Medicaid regulations, qualifying single residents of veterans' homes would be allowed a monthly personal needs allowance of $90, or $1,080 annually. Qualifying single residents would be required to contribute income above $1,080 toward the expense of their care (up to the $19,385 maximum cost of care).

Qualifying married residents of veterans' homes would receive a monthly personal needs allowance of $90 and a $2,049 monthly spouse allowance. Therefore, qualifying married residents would be allowed to shelter $2,139 monthly, or $25,668 annually, before being required to use the remainder of their income to contribute toward the expense of their care (up to the $19,385 maximum cost of care).

PEER calculated the following examples of the impact of Medicaid certification on both state funding of the homes and personal income of the residents, based on a current average annual income of $9,176 for each of the 221 single residents and $19,709 for each of the 128 married residents that the board reports as being qualified for Medicaid.

According to PEER's calculations, a single qualifying resident would retain $7,756 of that average income annually under the current funding structure, but would lose $6,676 of this amount under Medicaid. On the other hand, the married qualifying resident would retain $15,696 annually under the current funding structure, but would gain an additional $4,013 under Medicaid.

Calculation of State Fiscal Impact

With respect to the impact of Medicaid on state funding, as noted above, if the homes became Medicaid-approved and all residents qualifying for Medicaid participated in the program, VAB could save up to $681,000 annually for qualifying single veterans and could experience increased expenses of up to $103,000 annually for qualifying married veterans, with a net savings of approximately $578,000.

Under the current funding structure, the state pays an average of $4,938 annually for the care of single and married residents. Under Medicaid, the state would only have to pay $1,857 annually for the care of each single resident ($3,081 less than currently), but would have to pay an additional $805 annually for each qualifying married resident.

If all single residents who would lose money by participating in Medicaid chose not to participate and all married residents who would gain financially by participating did so, the state would realize a total increase in expenses of approximately $103,000 annually. The Appendix on page 33 shows PEER's calculations for arriving at these amounts.

Improving Quality of Care Without Additional Expense

Ensure Receipt of the Number of Direct Care Nursing Hours Required by Contract

From July 1, 1999, through February 29, 2000, VAB paid Diversified Health Services at least $477,000 for over 59,000 hours of direct care nursing hours not actually provided to veterans' home residents.

From July 1, 1999, through February 29, 2000, Diversified Health Services provided an average of 3.33 direct care nursing hours per resident per day in the four VAB homes instead of the 3.74 hours per resident per day specified in the contract.

From July 1, 1999, through February 29, 2000, Diversified Health Services provided an average of 3.33 direct care nursing hours per resident per day in the four veterans' homes instead of the 3.74 direct care nursing hours per resident per day required by the management contract. The staffing shortfall resulted in over 59,000 hours of direct care nursing hours required by the management contract not being rendered. According to VAB's Executive Director, Diversified Health Services attributed the shortfall in the contractually required number of direct care nursing hours per resident to difficulties in recruiting qualified personnel.

VAB paid the management company at least $477,000 for 59,000 direct care nursing hours not rendered.

Using the certified nursing assistant's average hourly wage of $8.06 noted in Diversified Health Services' bid proposal, PEER calculates that VAB has paid the company at least $477,000 for direct nursing hours not rendered. This conservative overpayment estimate assumes that all staffing shortages occurred at the certified nursing assistant level, when it is likely that shortages also occurred at the higher paid levels of licensed practical nurse and registered nurse. Therefore, the actual amount of overpayment could be higher.

VAB's management contract with Diversified Health Services allows VAB to withhold up to 15% of the monthly compensation should the company fail to supply personnel in accordance with the contract's specifications. The contract also allows Diversified Health Services to terminate the contract with 120 days' written notice should VAB withhold compensation. VAB's Executive Director was aware of the staffing shortage but failed to exercise remedies available under the management contract (i.e., withholding compensation) because he feared Diversified Health Services would cancel the contract. He also did not pursue any other remedies available under law for breach of contract.

VAB's failure to withhold payment to Diversified Health Services for inadequate staffing levels represents a mismanagement of funds and is troubling given the agency's increasing reliance on state general funds. Quality of care in the veterans' homes could be improved by requiring Diversified Health Services to provide the staffing levels specified in the contract and withholding payment if staffing does not meet the terms of the contract.

Meet Certification Regulations and Thus Improve Quality of Care

Nursing homes in Mississippi have the choice of being either licensed or certified (see discussion of general requirements in the following subsection of this report). State licensure regulations apply to nursing homes not receiving Medicare and Medicaid funds. Certification signifies that a nursing home has met the federal guidelines (written by HCFA) necessary to receive Medicare and Medicaid funds. The Mississippi Department of Health's Licensure and Certification Division is responsible for licensing or certifying nursing homes.

VAB has elected to have its veterans' homes meet state licensure requirements rather than the more stringent federal certification requirements. (Only nine homes in Mississippi are not certified; four of the nine are state veterans' homes.) However, VAB sought and the Legislature passed legislation in the 2000 session to break VAB's contract with Diversified Health Services, take over management of the veterans' home in Collins, and operate it at a certification level (see page 28).

Advantages of Certified Care over Licensed Care

Certification regulations are designed to provide nursing home residents with a high level of care and external oversight. Licensure regulations are less stringent and require less external oversight.

For example, federal regulations require certified homes to report sentinel events, such as a resident experiencing a greater than twenty percent weight loss, on the minimum data set (MDS). The MDS is a nationally accepted system for rating the health of nursing home residents. Federal regulations require certified homes to develop a plan of care to address the patient's health needs. The Department of Health's Certification and Licensure Division reviews certified homes' plans of care during on-site inspections or investigations to determine whether residents are receiving an adequate level of care.

State regulations do not require licensed homes to report patients' health status to the Department of Health's Certification and Licensure Division or to develop plans of care to address sentinel events. Accordingly, there is no follow-up review of plans of care to measure adequacy of care.

Certification regulations grant the Department of Health's Certification and Licensure Division the authority to prescribe federally mandated remedies to correct and improve quality of care. Failure to comply with remedies can result in civil and monetary penalties.

Licensure regulations do not grant such authority to the Health Department's Certification and Licensure Division and do not provide for civil or monetary penalties if corrective action to improve care is not taken.

VAB Can Meet Certification Requirements Without Additional Staff

The Mississippi Department of Health's Licensure and Certification Division issued new regulations effective March 1, 2000, requiring certified and licensed nursing homes to provide 2.8 direct care nursing hours per resident per day for non-Alzheimer's residents and 5.2 direct care nursing hours per resident per day for Alzheimer's residents. Because one-third of each veterans' home's beds (50 of 150 beds) is designated for patients with Alzheimer's or dementia, VAB should be staffing its homes with 3.6 direct care nursing hours per resident per day.

The management contract stipulates that Diversified Health Services is to staff the veterans' homes at 3.74 direct care nursing hours per resident per day. If Diversified Health Services continues to provide staffing at the current level of 3.33 direct care nursing hours per resident per day (see related discussion on page 25), the state veterans' homes will not comply with revised staffing requirements of the Department of Health's Licensure and Certification Division.

VAB homes provide more direct care nursing hours than comparably sized homes.

Even with the VAB homes staffed at an average of 3.33 direct care nursing hours per resident per day (below the 3.74 direct care nursing hours per resident per day stipulated in the management contract), VAB homes are staffed at higher levels than comparably sized homes providing the certified level of care. According to staffing levels reported to the Department of Health's Licensure and Certification Division, ten certified nursing homes with a similar number of residents provided nursing care at an average of 2.89 direct care nursing hours per resident per day prior to March 1, 2000. Thus, VAB homes have sufficient direct care nursing staff to provide nursing care at the certified level.

Including Diversified Health Services staff, VAB employs forty-seven more full-time and twelve more part-time non-nursing staff than do comparably sized certified nursing homes. (See related discussion of non-nursing staff on page 14) Therefore, VAB and Diversified Health Services should be able to reduce non-nursing staff to levels more in line with certified homes and still meet certification requirements.

Quality of Care in VAB Homes Should Improve Under Certification Regulations

VAB officials have expressed concern regarding the quality of care received by residents in the state veterans' homes. This concern prompted VAB to seek legislation during the 2000 regular legislative session that would grant VAB the authority to break its contract with Diversified Health Services and take over the management of the state veterans' home in Collins and operate the home at a certification level. Officials at the Health Department's Certification and Licensure Division also expressed concern about the quality of care in the veterans' homes based on complaints received regarding care in the veterans' homes.

Certification of state veterans' homes should improve quality of care assurance and the level of external oversight through the following mechanisms.

Certification regulations require completion of the minimum data set, which provides information regarding the health of residents and care provided.

The minimum data set is used to identify patterns that could indicate poor care, such as increasing numbers of residents being tube fed or requiring catheters.

Certification regulations require certified nursing homes to rate the condition of residents on a quarterly basis using the minimum data set (MDS). The information from the MDS is recorded in the Department of Health's Licensure and Certification Division MDS database and can be used to monitor the care rendered in a facility. For example, the MDS database can be used to identify patterns that may indicate patterns of poor care, such as an increase in the number of residents being tube fed or residents requiring catheters.

The Department of Health's Licensure and Certification Division reviews each facility's MDS at least twice annually and can access the MDS database at any time to investigate a complaint. The Department of Health also uses the MDS database for follow-up visits stemming from complaints and to monitor corrective actions taken by the home.

Although licensed nursing homes are not required to maintain a MDS, the veterans' homes in Jackson, Kosciusko, and Oxford currently maintain a partial MDS and the Collins home maintains a full MDS. However, VAB does not forward this information to the Department of Health's Licensure and Certification Division and thus the Department of Health cannot use the data to monitor the quality of care or identify patterns of poor care in the VAB homes.

By meeting certification requirements, the MDS would become available to the Department of Health's Licensure and Certification

Division and would increase the amount of information available to facilitate external oversight of care rendered in state veterans' homes. This information would also aid in investigation and follow-up of complaints and increase accountability of the VAB and the management company for the quality of care given to residents.

Certification requirements have more safeguards for the prevention of abuse of residents.

Licensed homes are not required to have preventive measures regarding the abuse of residents.

Certified and licensed homes must report alleged instances of abuse to the Department of Health's Licensure and Certification Division and to the Attorney General's Office. Certified homes must also have clear, written definitions and policies regarding the prevention of abuse, train personnel on the prevention of abuse, perform background checks of employees, and perform thorough investigations of any allegations of abuse. Licensed homes are not required to have these additional preventive measures in place. Under certification regulations, preventive measures, such as employee background checks, are required instead of being optional, as in licensed homes.

Certification regulations have specific requirements for the care of residents.

Certification regulations have specific guidelines for the care of residents, while licensure regulations are vague.

Certification regulations have specific requirements regarding resident care in the areas of restraints, dehydration, malnutrition, and pressure sores. The regulations give specific definitions and requirements concerning the bathing, grooming, and care of residents. These detailed requirements are listed in eighty-six pages of the certified regulations, while the same areas require only three pages in the licensure regulations.

Due to the broad scope of the licensure regulations and lack of specific guidelines, the Department of Health's Licensure and Certification Division is hindered in investigating complaints in these areas and requiring corrective actions. Requiring the VAB homes to meet more specific, higher standards for the care of residents should improve the care rendered to veterans' homes residents.

Recommendations

Staffing

1. VAB should require Diversified Health Services to provide direct care nursing staff in accordance with terms of the management contract. Should Diversified Health Services fail to meet required levels of staffing, VAB officials should consult with the VAB attorney and the Attorney General's Office in exercising remedies available under the management contract or any other remedies available under law for breach of contract.

2. VAB officials should consult with the VAB attorney and the Attorney General's office to determine possible actions for seeking reimbursement of funds paid to Diversified Health Services for direct care nursing services never rendered.

3. VAB should reduce non-nursing staff at the veterans' homes to non-nursing staff levels of comparably sized nursing homes in Mississippi.

VAB Management and Operations

4. VAB should diligently review management company costs in order to ensure that the company is delivering quality services to VAB as efficiently and economically as possible.

   - Prior to consideration of a new management company contract, VAB should use existing resources to procure an economy and efficiency study to determine the most efficient organization and operation of the veterans' homes.

   - VAB should carefully consider the terms of future contracts to ensure that VAB's interests are protected. In particular, VAB should not adopt contractual language that limits the board's use of remedies provided in the contract for breach of contract.

5. The Veterans Affairs Board should return $620,000 to the state general fund for three months of service it did not receive when it wrote a twelve-month contract rather than a fifteen-month contract for new direct care nursing staff. If VAB does not return the $620,000 to the state's general fund by June 30, 2000, the Legislature should enact legislation

during the 2001 session to transfer the funds from VAB to the state's general fund.

6. VAB should use special funds to replace the $1.62 million in general funds that were inappropriately spent for general operating expenses.

7. Whenever VAB has a budget request or appropriations bill pending before the Legislative Budget Committee or the Legislature and VAB learns of a change in federal per diem funding levels, the Executive Director should inform the Legislative Budget Committee or the Appropriations chairs of the changes that could impact the VAB's need for special fund or general fund spending authority.

8. VAB should improve quality of care by meeting the necessary requirements to provide a certified level of care to VAB residents.

Medicare Part B

9. The board should ensure that it receives all federal and other insurance revenue available to it by strictly enforcing its contract with the Medicare billing contractor to provide such services. Specifically, VAB should implement the procedures necessary to ensure that all eligible Medicare claims are filed and reimbursements received and that all secondary insurance claims are filed and payments received.

   - With respect to collection of secondary insurance, VAB should ensure that secondary insurance (e.g., MediGap, Blue Cross) information on its residents is up to date, and that any Medicare Part B filings returned to VAB with a notation of incorrect secondary insurance policy numbers are re-filed with the correct numbers.

   - If the board elects to continue to contract for such services, it should pay the contractor a flat amount for services provided rather than a percentage or a fee per billing.

   - VAB must ensure that its medical service providers are properly completing the forms necessary to ensure Medicare Part B reimbursement to the maximum extent allowable.

10. The board should include language in contracts with physicians and other medical service providers to reassign their Medicare B reimbursements to the VAB. The assignment language is required by HCFA in those instances in which the board receives Medicare reimbursements on behalf of doctors who provide services for nursing home patients. As outlined

in the HCFA document, "Claims, Filing, Jurisdiction and Development Procedures," Section 3060.2 C, the suggested assignment language should be signed and dated by both the facility and the physician and should read as follows:

> ***It is agreed that only (name of facility) will bill and receive any fees or charges for the services of (name of physician) furnished to patients at the above-named facility (or specify other limitations of the reassignment).***

11. The board should review all past remittance notices (explanations of benefits) and secondary insurance contracts of residents to determine whether secondary insurance reimbursement due to the board can be recovered. The board should continue to attempt to recover all possible Medicare Part B reimbursements which were never filed (e.g., podiatrist's services, flu vaccinations).

Medicare Part A

12. After becoming certified, VAB should evaluate the feasibility of filing for Medicare Part A reimbursement and assigning responsibility to residents for Medicare Part A co-payments which can be paid through secondary insurance or family resources.

Hospital Costs

13. VAB should officially amend its resident hospitalization policy to state that all hospital costs, whether at VA hospitals or private hospitals, are the responsibility of the resident (both veteran and non-veteran) and should amend its pre-admission application accordingly.

Resident Fees

14. VAB should consider increasing resident fees to the extent necessary to support efficient operations of the veterans' homes in lieu of asking for general fund support.

Medicaid

15. The Veterans Affairs Board should periodically reassess the feasibility of the homes becoming federally certified to receive Medicaid, in light of changing income levels of state veterans' home residents.

Appendix: Calculations of Feasibility of State Veterans' Homes Becoming Federally Certified to Receive Medicaid

State Veterans' Homes Residents' Comparative Incomes, With and Without Medicaid

Resident Average Income Without Medicaid

	Single Resident	Married Resident
Annual Average Resident Income	$ 9,176	$ 19,709
Unreimbursed Medical Expense Payment	14,640	12,047
Payment to the Board	(16,060)	(16,060)
Income Remaining	$ 7,756	$ 15,696

Resident Average Income With Medicaid

	Single Resident	Married Resident
Annual Average Resident Income	$ 9,176	$19,709
Personal Needs Allowance	(1,080)	(1,080)
Spouse Allowance	N/A	(18,629)*
Income Available for Medicaid	8,096	0
Unreimbursed Medical Expense Payment**	8,096	0
Payment to Medicaid	(16,192)	0

* Income after personal needs allowance is less than annual spouse allowance of $24,588. Therefore, all remaining income is sheltered under the spouse allowance.

** The unreimbursed medical expense payment is adjusted to the amount the resident would pay toward his or her care under Medicaid.

Effect of Medicaid on Resident Average Personal Income

	Single Resident	Married Resident
Income Remaining Without Medicaid	$ 7,756	$ 15,696
Income Remaining With Medicaid	1,080	19,709
Increase or (Decrease) in Resident Income	(6,676)	4,013

State Expenses With and Without Medicaid

State Expense Without Medicaid

	Single Resident	Married Resident
Annual Current State Expense*	$4,938	$4,938

* Current average daily expense of $13.53 x 365 days.

State Expense With Medicaid

	Single Resident	Married Resident
Annual Maximum Medicaid Payment	$37,836	$37,836
Less Veterans Administration Per Diem	18,451	18,451
Less Resident Payment†	16,192	0
Medicaid Payment	3,193	19,385
State Portion of Medicaid*	766	4,652
Portion not covered by Medicaid**	1,091	1,091
Total State Payment	1,857	5,746
Increased or (Decreased) cost to the State	(3,081)	805

† Average payment as calculated above.
* Approximately 24% of Medicaid payments is derived from state funds.
** This is the portion of expenses above the maximum Medicaid payment.

Expense and Income Recap

	Single Residents	Married Residents	Total
Resident Income*	$(1,475,396)	$513,664	$(961,732)
State Expenses**	(680,901)	103,040	(577,861)

* Change in resident average income multiplied by the number of qualifying residents in each category. For singles, $(6,676) x 221. For married, $4,013 x 128.

** Change in the state's expenses for each category. For single, $(3,081) x 221. For married, $805 x 128.

State of Mississippi

State Veterans Affairs Board

May 1, 2000

PEER Committee
Post Office Box 1204
Jackson, Mississippi 39215-1204

RE: An Analysis of Increasing Reliance on State General Funds and an Examination of Cost Reduction and Funding Options.

Dear Committee Members:

The State Veterans Affairs Board (SVAB) commends your staff for the professionalism shown during the recently completed review of the increasing reliance on State General Funds and examination of cost reduction and funding options relative to operation of Mississippi's State Veterans Homes. We are most appreciative for the opportunity to provide a response, for inclusion with the PEER Committee (PEER) report, to your recommendations and/or findings.

The SVAB is responsible for the operation of Mississippi's four (4) State Veterans Homes for the purpose of providing nursing home care to disabled Mississippi veterans. U. S. Department of Veterans Affairs (VA) regulations allow State Veterans Homes to admit up to 25% non-veterans as residents. During 1997, the SVAB adopted policy to admit non-veteran spouses of veterans who are residents of the homes and non-veteran widows and widowers. However, non-veterans can only be admitted when there are no veterans on the waiting lists who desire admission at that time.

Prior to approval for the first Home in Jackson, the SVAB stated that the Home would be self-supporting. However, in the FY 1998 budget request, the SVAB requested State Funds be used to support operation of the Homes. SVAB's request was for the purpose of providing funds to increase direct care nursing staff at the State Veterans Homes. The desire to increase direct care nursing staff was based on information showing that care needs of residents were not being adequately met, due to a combination of worsening health of the residents and insufficient staff to properly provide the needed care. The SVAB relied on information relative to characteristics of residents of the State Veterans Homes that is used to predict the level of staffing needed in a facility; this information is not collected to the same extent as would be required for "certified facility" purposes. The SVAB first increased, above State Health Department minimums, direct nursing care staffing in 1997 -

before asking for State General funds.

During FY 2000, the cost of care in the four (4) State Veterans Homes is expected to increase by $3,817,253 while revenue from the VA per diem ($1,072,389) and resident payments ($433,685) is expected to increase by $1,506,074. Based on these projections, it is readily apparent that the increases in the VA per diem and residents' payments were considered by the Board in determining what General Funds would be necessary to allow the desired increase in direct care nursing staff.

Statistics Concerning State Veterans Home Residents[1]
(Average among the four Homes)

9.69 - number of medications per resident

10.82 - number of decubitus patients

10.25 - number of residents with weight loss

4.5 - number of residents with dehydration

11 - number of tube fed residents

35.75 - number of spoon-fed residents

66 - number of residents totally dependent upon staff for care

88.5 - number of residents in wheel and geriatric chairs

165 - average weight for male residents

96 - percentage of male residents

133 - average weight for female residents

4 - percentage of female residents

[1] In preparing this response, the SVAB has used data from the Health Care Financing Administration's (HCFA) website, the U. S. Department of Veterans Affairs (VA), Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1991 through 1997, January 1999, by Charlene Harrington, Ph.D., Helen Carrillo, M.S., Susan C. Thollaug, C.Phil., and Peter R. Summers M.A. of the Department of Social and Behavioral Sciences, University of California at San Francisco; the California Department of Veterans Affairs, and Mississippi's State Veterans Homes

76.75 - average age of residents

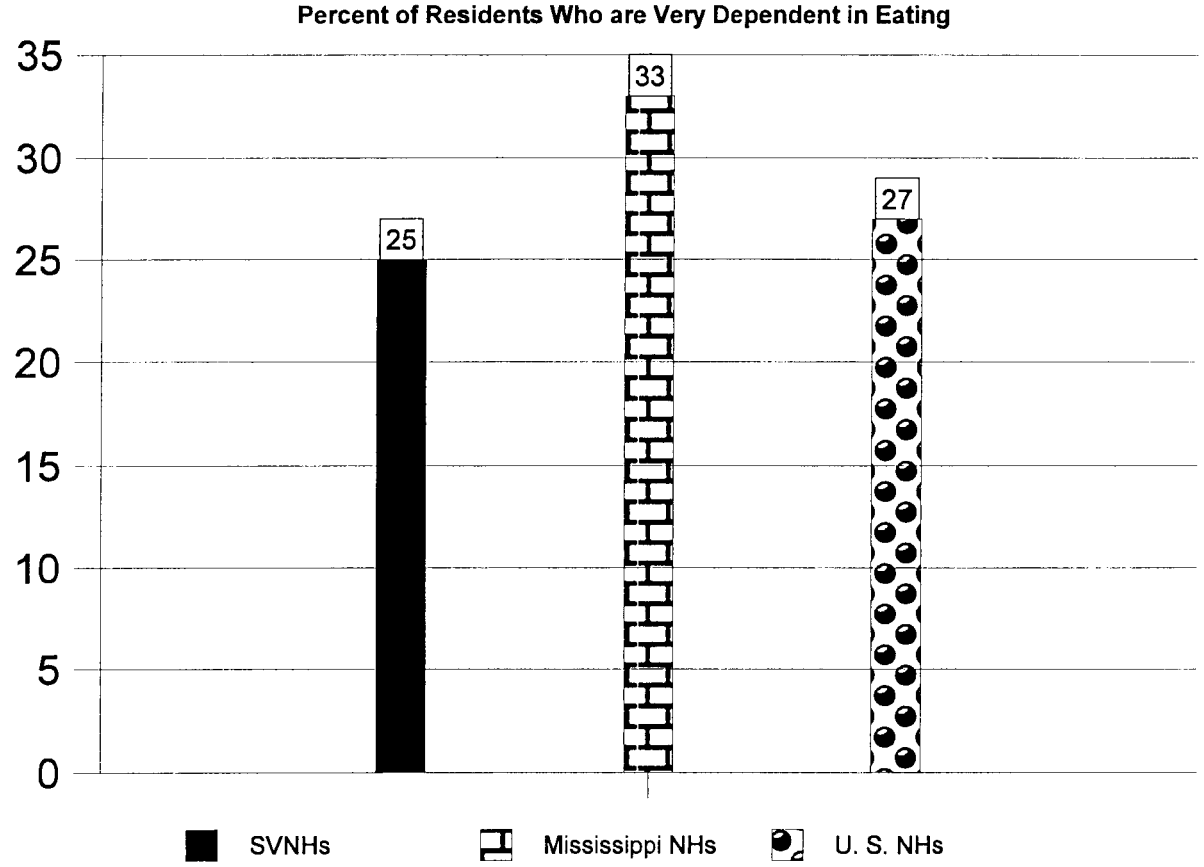
501 - average length of stay in days

Characteristics, Veterans Homes' Residents, and Comparably Sized Mississippi and U. S. Homes[2]

NOTE: In the following charts, SVNHs = State Veterans Nursing Homes, NHs = Nursing Homes

A. Percent of Residents Who are Very Dependent in Eating

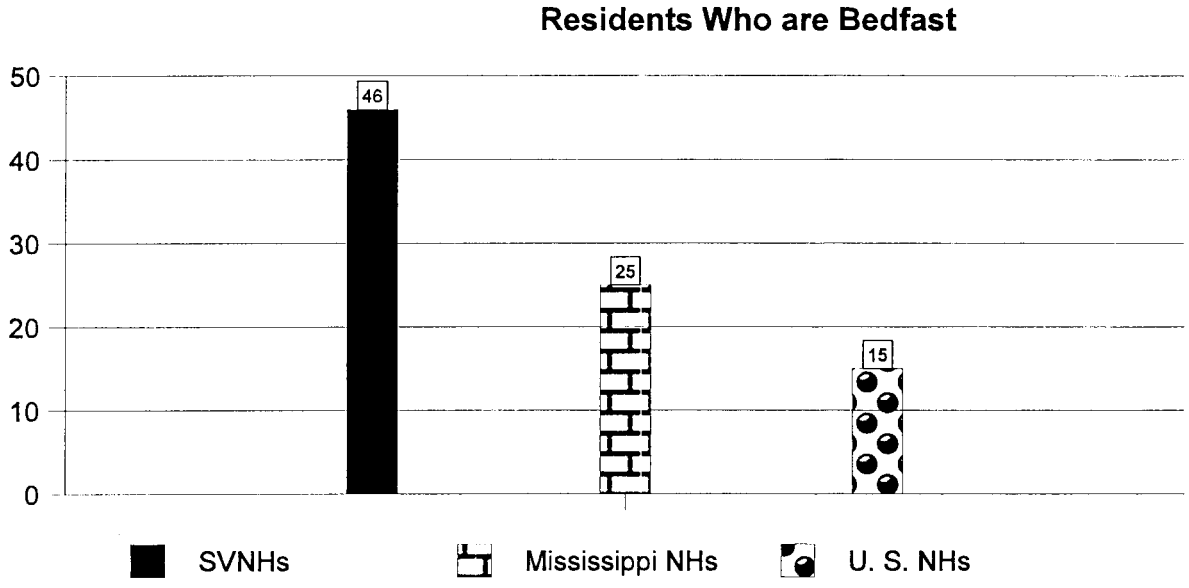
Why is this measure important? Residents who are physically dependent and need help with eating require extra resources from the nursing home. It is important for the nursing home to have adequate staffing to meet this need.



[2]See footnote 1.

B. Percent of Residents who are Bedfast

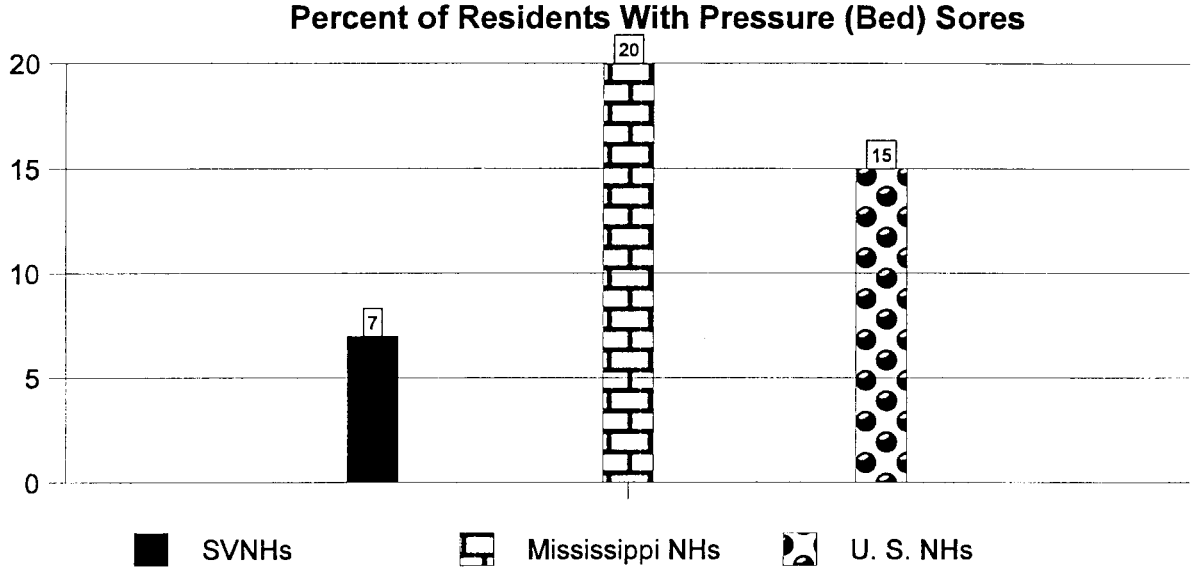
Why is this measure important? Residents who are willing, able, and want to be out of bed should be out as much as possible. Those who are unable to be out of bed those who are unable to position themselves are at risk of having pressure (bed) sores. They must be turned and moved in bed frequently to prevent this condition. Please note that the average male resident of a Mississippi State Veterans Homes weighs, on average, approximately 30 pounds more than a female resident. This has a definite impact on staffing needed to insure that these residents are gotten out of bed as much as is possible and/or that the are repositioned frequently thus reducing the risk that pressure sores will develop. There is little chance of recovery once a patient becomes bedfast, and these staffing needs will not become obsolete over time.



C. Percent of Residents With Pressure (Bed) Sores

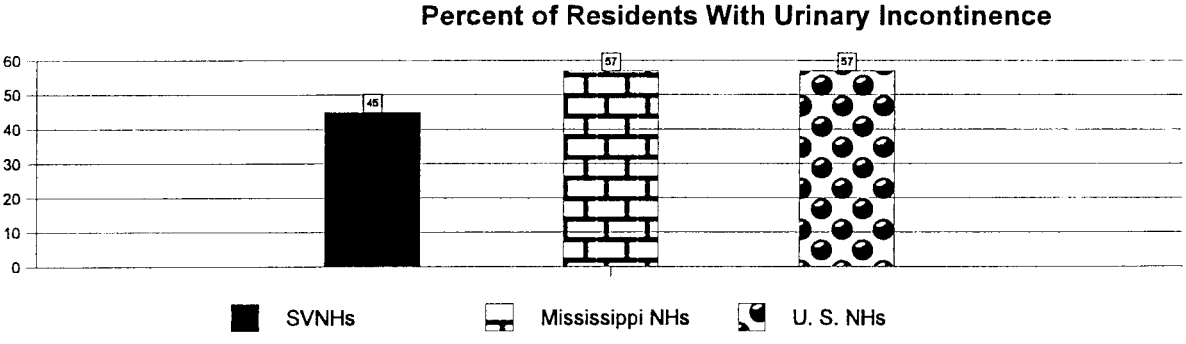
Why is this measure important? Pressure (bed) sores, usually occurring on the skin over bony parts of the body such as the hips, buttocks, or heels, can range from a large or small reddened area to a deep wound and may be very painful and/or become infected. For residents at risk, the development of pressure sores may be greatly reduced if they are turned, fed, given liquids, kept clean and dry, and pressure relieving methods are used. Once a pressure sore has developed, it takes time to heal. It is important that the nursing home have adequate staff to keep pressure sores at a minimum. The SVAB feels that the comparatively low percentage of bed sores in residents of its Homes is directly

related to the level of staffing which it provides.



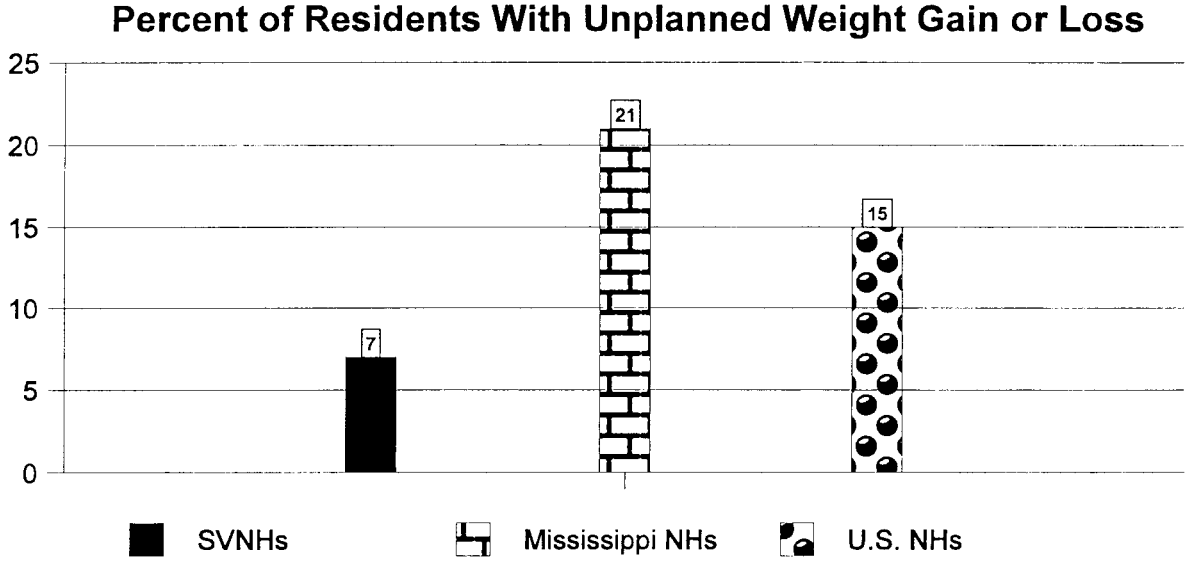
D. Percent of Residents With Urinary Incontinence

Why is this measure important? Incontinence can cause many problems such as skin rashes, falls, isolation, pressure sores, odors, and embarrassment to residents. If residents are given individualized care and help in toileting, incontinence of the bladder can be managed and sometimes prevented or greatly reduced. It is important that the nursing home have adequate staff to ensure that bladder incontinence among residents is kept to a minimum. The SVAB feels that the comparatively low percentage of residents with urinary incontinence in its homes is directly attributable to the level of staffing per resident which it provides.



E. Percent of Residents With Unplanned Weight Gain or Loss

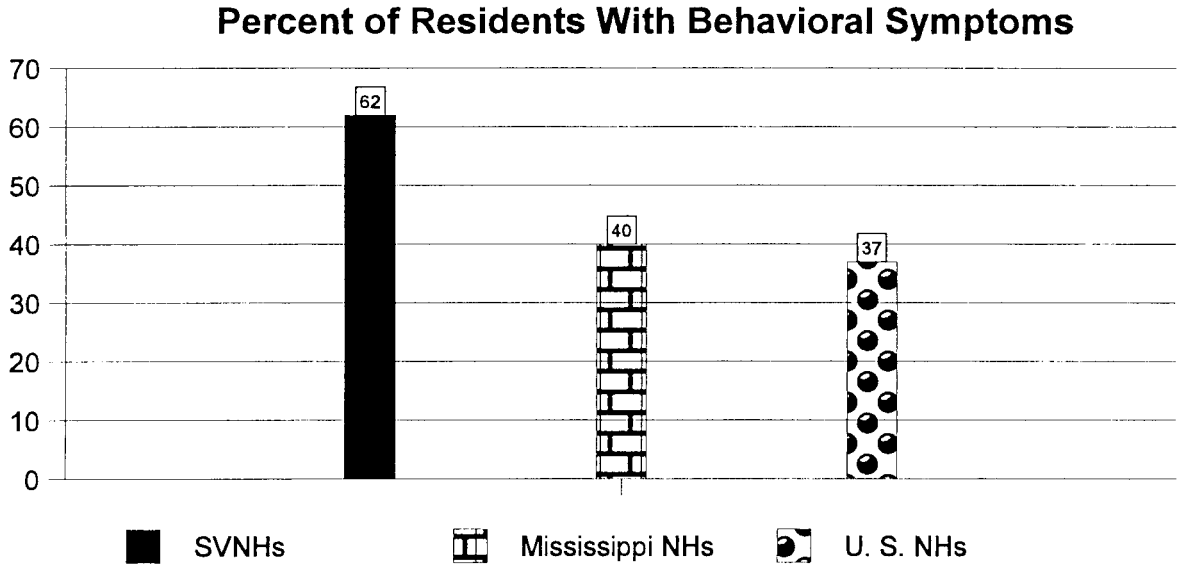
Why is this measure important? Unplanned weight loss or gain may mean that residents are refusing to eat or have a medical condition that leads to weight loss or gain. This could mean that the residents are not being properly fed, that the nutritional program is poor, or that medical care is not being properly managed. Some residents may have trouble swallowing due to disease or have other conditions, such as a stroke, that make eating difficult. Due to the multitude of problems that result from inadequate food and liquid intake, it is important that the nursing home have sufficient staff to insure that residents receive proper nutrition and liquids. The SVAB feels that the relatively low percentage of unplanned weight loss among its residents is directly attributable to the quality of care it is able to provide due to its per patient staffing ratio.



F. Percent of Residents With Behavioral Symptoms

Why is this measure important? Behavioral symptoms can be difficult for staff, residents, and families to cope with. Treatment and management techniques may include support and communication by staff as well as changes in the environment. Residents with Alzheimer's disease and dementia often exhibit behavioral symptoms and need special treatment and sensitive care. Some studies indicate that the staffing ratio for residents who exhibit behavioral symptoms should be double that for other residents. It is important for the nursing home to have adequate staff to insure that residents with

behavioral symptoms receive the care that they require, as the alternatives of physical restraint and over-medication are against the policy of the SVAB as well as those of the VA and the State Board of Health.



The foregoing statistics are provided to give the Committee the benefit of viewing at least some of the information used by the Board when making the determination as to what direct nursing care requirements were necessary to properly care for its resident population.

RESPONSE TO PEER RECOMMENDATIONS

1. **VAB should require Diversified Health Services to provide direct care nursing staff in accordance with terms of the management contract.**

   The SVAB monitors and closely tracks the direct care nursing hours provided by Diversified Health Services under the management contract. SVAB has had a number of discussions and/or other contacts with Diversified Health Services relative to contract requirements, including a formal written notice (April 11, 2000) of unacceptable performance in regards to the provision of the contracted number of nursing hours. The SVAB feels that the formal written notice was the first necessary step prior to exercising possible remedies that are in the SVAB's best interest under the terms of the contract.

   The SVAB will continue consulting with its attorney and will, as necessary and appropriate, consult with the Attorney General's office relative to available remedies under law for breach

of contract.

2. **VAB should consult with the VAB attorney and the Attorney General's Office to determine possible actions for seeking reimbursement of funds paid to Diversified Health Services for direct care nursing services never rendered.**

   The SVAB will, with assistance and advice from its attorney and the Attorney General's Office, expeditiously and diligently seek reimbursement from Diversified Health Services for direct care nursing hours that were not provided.

3. **VAB should reduce non-nursing staff at the veterans' homes to non-nursing staff levels of comparably sized nursing homes in Mississippi.**

   Recently enacted legislation which prohibits the SVAB from using a management contract company for operation of the State Veterans Home in Collins from July 1, 2000 thru June 30, 2002, will afford the SVAB the opportunity to determine which positions at the homes may be consolidated, thereby reducing non-nursing staff levels.

   The SVAB would like to point out that any comparison, of non-nursing staff levels at the State Veterans Homes to non-nursing staff levels of comparably sized nursing homes in Mississippi, must take into consideration those characteristics which make the State Veterans Homes distinctively different from other comparably sized nursing homes in Mississippi. Those characteristics include (not all inclusive): (1) a predominantly male population; (2) regional as opposed to local facility locations; (3) additional VA requirements (especially if State Veterans Home is contract operated); and (4) the complexity and technology of facility operating systems.

4. **VAB should diligently review management company costs in order to ensure that the company is delivering quality services to VAB as efficiently and economically as possible.**

   Recently enacted legislation which will have the SVAB operate the State Veterans Home in Collins from July 1, 2000 thru June 30, 2002 will allow the SVAB to compile data on both service quality and costs associated with that facility, which will then be most useful in determining whether the management company is delivering quality services to SVAB as efficiently and economically as possible.

   - **Prior to consideration of a new management contract, VAB should conduct an economy and efficiency study to determine the most efficient organization and operation of the veterans' homes.**

     As noted above, the SVAB will be operating the State Veterans Home in Collins, beginning July 1, 2000, for a two (2) year period. This will allow the SVAB to make this determination.

- **VAB should carefully consider the terms of future contracts to ensure that VAB's interests are protected. In particular, the VAB Board should not adopt contractual language that limits the board's use of remedies provided in the contract for breach of contract.**

  The SVAB will be diligent in ensuring that the terms of any future contracts are written so as to ensure maximum protection of the SVAB's interests. In addition, the SVAB will make every effort to amend its current management company contract toward the end of removing limits on the Board's use of remedies provided in the present contract for breach of contract.

5. **The Veterans Affairs Board should return $620,000 to the State General Fund for three months of service it did not receive when it wrote a twelve-month contract rather than a fifteen-month contract for new direct care nursing staff. If VAB does not return the $620,000 to the state's general fund by June 30, 2000, the Legislature should enact legislation during the 2001 session to transfer the funds from VAB to the state's general fund.**

   Since direct care nursing staffing was not actually effected until July 1, 1999, it stands to reason that $620,000 of the funds provided in the additional appropriation will not be needed and will lapse (be returned to the State) to the State General Fund at the end of FY 2000. At the time of the additional appropriation, the SVAB had received bids for a new management contract for the State Veterans Homes and was in the middle of negotiating that contract. Hence, the delay in effecting the increase in direct care nursing staff.

   The SVAB has requested, due to State budgetary shortfalls that resulted in the Legislative Budget Committee recommending less in State General Funds, than provided in FY 2000, for operation of the State Veterans Homes, that the $620,000 be reappropriated for use by the SVAB. If the $620,000 is not reappropriated, the SVAB will return those funds to the State General Fund by June 30, 2000.

6. **VAB should use special funds to replace the $1.62 million in General Funds it inappropriately spent for general operating expenses.**

   The SVAB acknowledges that, in failing to strictly reserve and use the funds provided in the additional appropriation for increased direct nursing care costs, its expenditures from those funds from April 1999 thru June 1999 can be characterized as having been inappropriately spent. As noted by PEER, the additional appropriation was for use during fiscal years 1999 and 2000 and sufficient special funds were available for the SVAB's operation. The SVAB has traditionally used all appropriated funds, without strictly drawing the funds down on a proportional percentage basis. This practice will be changed such that funds will be expended on a proportional basis to pay operating costs.

7. **Whenever VAB has a budget request or appropriations bill pending before the Legislative Budget Committee or the Legislature and VAB learns of a change in federal per diem funding levels, the Executive Director should inform the Legislative Budget Committee or the Appropriations chairs of the changes that could impact the VAB's need for special fund or general fund spending authority.**

   The SVAB will ensure that changes in federal per diem funding levels and the impact on SVAB's need for special or general fund spending authority will be provided, as soon as known, to the Legislative Budget Committee or the Appropriations chairs.

   The SVAB's budget requests for fiscal years prior to 2001 included its projection of federal per diem funding levels for the next fiscal year. The SVAB decided to stop this practice because there was no basis, other than historical (and that has ranged from $0.26 to $6.63 over the past few years) for this projection. The actual federal per diem funding level for any fiscal year is not known until Congress adopts the VA's budget. Please note that this is approximately 90 days into the State's fiscal year and some 60 days after budget requests for the next fiscal year are due.

8. **VAB should improve quality of care by meeting the necessary requirements to provide a certified level of care to VAB residents.**

   Recently enacted legislation whereby the SVAB will operate the State Veterans Home in Collins without a management company contractor contains language (see below) that will result in that Home being brought up to a certified level of care. The SVAB will use that experience to bring the other three (3) homes up to that same level as soon as feasible.

   > "The State Department of Health shall perform an initial certification survey of the State Veterans Home in Collins, Mississippi, on or about July 1, 2000. The purpose of this initial survey is to provide a baseline for measuring the quality of care during the period for which this section applies. In addition to the initial certification survey, the State Department of Health shall, as appropriate and in its discretion, conduct periodic follow-up certification surveys, during the period for which this section applies, of the State Veterans Home in Collins, Mississippi."

9. **The Board should ensure that it is receiving all federal and other insurance revenue available to it by strictly enforcing its contract with the Medicare billing contractor to provide such services. Specifically, VAB should implement the procedures necessary to ensure that all eligible Medicare claims are filed and reimbursements received and that all secondary insurance claims are filed and payments received.**

   SVAB staff is continuing to review all Medicare Part B submissions and remittals to ensure that all eligible claims are filed and reimbursements received and that all secondary insurance claims

are filed and payments received. In addition, an SVAB staff member is scheduled to attend a Medicare billing workshop on May 22, 2000. The SVAB is also currently recruiting, with the added requirement that the individual have Medicare billing experience, to fill a vacant Accounting Auditing Technician position. As soon as SVAB staff has the necessary expertise for Medicare billing, any Medicare billing contract will be terminated.

- **With respect to collection of secondary insurance, VAB should ensure that secondary insurance (e.g., MediGap, Blue Cross) information on its residents is up to date, and that any Medicare Part B filings returned to VAB with a notation of incorrect secondary insurance policy numbers are re-filed with the correct numbers.**

  The SVAB will continue to collect secondary insurance information from residents at the time of admission and will periodically remind residents of the need to keep this information current. The SVAB will also explore institution of policy whereby residents may be liable for any insurance payments that are not received due to failure on their part to keep insurance information on file and up to date.

  SVAB staff is now ensuring that the Medicare billing contractor re-files all Medicare Part B filings that are returned due to incorrect insurance policy numbers or other technicalities.

- **If the board elects to continue to contract for such services, it should pay the contractor a flat amount for services provided rather than a percentage or a fee per billing. Many nursing homes contract with a Medicare Part B consultant to maximize revenues from this source.**

  The SVAB recently advertised for a flat fee Medicare Part B contractor; however, no bids were received. The SVAB then contacted the two (2) individuals who had requested copies of the Request for Bids and the current contractor. The only proposal received, to date, is from the current contractor with terms being same as under the current contract. As indicated above, the SVAB will bring this service in-house as soon as possible.

- **VAB must ensure that its medical service providers are properly completing the forms necessary to ensure Medicare Part B reimbursement to the maximum extent allowable.**

  The SVAB's operation of the State Veterans Home in Collins and bringing Medicare Part B billing services in-house should enhance efforts being made to ensure that forms are properly completed.

10. **The board should include language in contracts with physicians and other medical service providers to reassign their Medicare *(Part)* B reimbursements to the VAB. The assignment language is required by HCFA in those instances in which the board receives Medicare reimbursements on behalf of doctors who provide services for nursing home**

patients. As outlined in the HCFA document, "Claims, Filing, Jurisdiction and Development Procedures," Section 3060.2 C, the suggested assignment language should be signed and dated by both the facility and the physician and should read as follows:

It is agreed that only (name of facility) will bill and receive any fees or charges for the services of (name of physician) furnished to patients at the above named facility (or specify other limitations of the reassignment).

This language is being included in all contracts effective July 1, 2000.

11. VAB should review all past remittance notices and continue to attempt to collect payment for past services rendered.

The SVAB is continuing efforts to recover all possible revenues for past services.

12. After becoming certified, VAB should evaluate the feasibility of filing for Medicare Part A reimbursement and assigning responsibility to residents for co-payments.

The SVAB has and will continue to evaluate the feasibility of filing for Medicare Part A reimbursement. In previous evaluations of the feasibility of becoming Medicare Part A certified, the SVAB was not able to determine that Medicare certification would be advantageous. With current staffing levels and the SVAB's operation of the State Veterans Home in Collins, SVAB will be able to fully evaluate the impact that being Medicare certified will have on its operating revenues.

If the SVAB determines that becoming Medicare certified is advantageous, the SVAB will consider policy whereby residents will be responsible for co-payments.

13. VAB should officially amend its resident policy to state that hospital costs, whether at VA or private hospitals, are the responsibility of the resident.

The SVAB will consider at its May 12, 2000 statutory meeting adoption of policy changes that will make residents responsible for hospital costs.

14. VAB should consider increasing resident fees to the extent necessary to support efficient operations of the veterans' homes in lieu of asking for general fund support.

The SVAB has and will continue increasing residents' fees as a first resort. Please note that, during the period 1993 until now, resident fees increased by 51.7% while income (primarily VA pension and Social Security) for the vast majority of residents increased by only 18% over that same period. When the State Veterans Home opened in Jackson in 1989, a single veteran receiving the maximum VA pension benefit (including the Aid and Attendance allowance)

needed only 87.4% of that benefit to pay for his care at the State Veterans Home. Today, the cost to that individual is 107% of his pension benefit. There is still currently a financial incentive for a veteran to reside in a State Veterans Home. The SVAB feels strongly that it is approaching the point with resident fees where that incentive is less than his desire to remain in or near his home community and friends. When that point is reached, the veteran will either seek admission to a local nursing home (in most cases under Medicaid and a considerably greater cost to the State) or will attempt to remain at home and, thus, be deprived of the care that he needs and has earned.

15. VAB should periodically reassess the feasibility of the Homes becoming certified for medicaid.

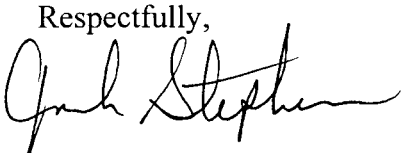
The SVAB has and will continue to periodically reassess the feasibility of having the State Veterans Homes certified for Medicaid. If the SVAB determines that having the State Veterans Homes certified for Medicare, the Legislative Budget Committee, chairs of the Appropriations committees, and the chairs of the Military Affairs and Veterans and Military Affairs committees will be informed so that any necessary legislative action may be initiated.

CONCLUSION

The SVAB feels strongly that its request for State General Funds for operation of the State Veterans Homes was made only after a determination that revenues from other available sources was insufficient. As evidence supporting its commitment to operate the State Veterans Homes at the lowest possible cost to the State, while providing the level of service to the veterans of this state that they require and deserve, the SVAB points to: (1) the 51.7% increase in residents' fees over the last seven (7) years, (2) the request and passing of legislation to permit purchase of medications and other products through the VA or off of VA contracts at substantial cost savings, (3) the request and passing of legislation permitting multi-year contracts with non-governmental vendors, and (4) continuing assessment of the feasibility of having the Homes certified for Medicaid and/or Medicare.

The information presented in this response, in SVAB's opinion, indicates that the SVAB's determination of the need for additional direct care nursing staffing was somewhat ahead of other sectors and show that the State Veterans Homes compare quite favorably with comparably sized non-veteran nursing homes in Mississippi and the U. S.

Respectfully,



Jack Stephens
Executive Director

PEER Committee Staff

Max Arinder, Executive Director
James Barber, Deputy Director
Ted Booth, General Counsel

Evaluation
Sam Dawkins, Division Manager
Linda Triplett, Division Manager
Pamela O. Carter
Kim Cummins
Kimberly Haacke
Barbara Hamilton
Joyce McCants
David Pray
Lee Anne Robinson
Katherine Stark
LaShonda Stewart
Lynn Watkins
Tanya Webber
Larry Whiting
Julie Winkeljohn

Editing and Records
Ava Welborn, Editor and Records Coordinator
Tracy Bobo
Sandra Haller

Administration
Mary McNeill, Accounting and Office Manager
Pat Luckett
Jean Spell
Gale Taylor

Data Processing
Larry Landrum, Systems Analyst

Corrections Audit
Louwill Davis, Corrections Auditor