Small-Home Medicaid Rate Enhancements in Arkansas: A Case Study

Southern Administrative Services CEO John Ponthie became inspired to create small-house nursing home alternatives when he first visited a Green House community in Tupelo, Miss. Like many longtime operators in the sector, Ponthie was initially skeptical, but was soon convinced after performing his own research and due diligence into the model's financial stability.

Southern Administrative Services has since developed six Green House campuses in Arkansas. But because not every operator is willing to take a chance on a new paradigm of care, Ponthie and his team realized that some type of incentive was necessary to stimulate development of more small-home alternatives across the state.

Medicare and Medicaid

Nursing homes derive the vast majority of their income from Medicare and Medicaid, which cover different types of care: Medicare pays for short-stay rehabilitation for up to 100 days after a hospital stay, while Medicaid covers long-term residential care services. Medicare reimbursements are significantly higher than Medicaid payments, with many individual nursing homes relying on surpluses generated from individual Medicare patients to cover losses incurred on long-stay residents.

In general, investors are wary of putting money into nursing home developments meant to serve substantial numbers of Medicaid residents, leading to stark inequities in care along socioeconomic lines – while also generally preventing the construction of new alternatives to traditional facilities.

In short, as long as there are traditional facilities whose operators can figure out how to squeeze enough money out of the current Medicare/Medicaid binary, investors would rather place a bet on a "sure thing" than hope the Medicaid math will pay off on something new. In an industry where well-capitalized for-profit operators can easily outbid non-profits and progressive for-profits such as Southern Administrative Services, these payment dynamics conspire to keep the sector – and, by extension, elders and people with disabilities – stuck in an outdated institutional model first developed in the 1960s.

Ponthie and his team were able to self-fund their Green House developments, but driven by a desire to see wider adoption of private rooms and other Green House principles in Arkansas, they set out to lobby for a small-home incentive program in the late 2000s.

Approaching the Governor

Medicaid sits at the intersection of state and federal spending policy. States fund their Medicaid programs and receive federal matching dollars; while Washington oversees the operation of the Medicaid program, states are generally then free to spend the total budget how their leaders see fit.

To implement changes to Medicaid rates or policies, state Medicaid officials must submit what's called a state plan amendment (SPA) to the federal Centers for Medicare and Medicaid Services (CMS) for approval. SPAs can be politically tricky, as they present an opportunity for a variety of interest groups to lobby for their desired changes to rates and policies; health care providers satisfied with the existing Medicaid structure may also see the submission of an SPA as a threat to their comfortable status quo.

Any expansion of Medicaid spending can also create significant political pushback in states with Republican majorities, adding to the potential difficulty of achieving a rate increase.

When making his pitch to then-Arkansas Gov. Mike Beebe, a Democrat, Ponthie emphasized a few key points to head off any potential opposition:

- The proposed Medicaid rate increase would be funded primarily through the federal match, and not the state's money – in this case, a roughly 80%-20% breakdown between the two sources, respectively.
- The boost would be relatively small in total, working out to about $4 extra per Medicaid resident per day.
- The increase would only apply to residents covered under Medicaid, ensuring that the increased spending would directly benefit those who needed it most – and not operators that cater to people with the private means to pay for long-term care.
- Operators would need to meet a variety of small-home standards to receive the funding.

The Beebe administration signed onto the rate increase and submitted the SPA to CMS, which actively supported the proposal and approved it on an expedited timeframe in 2009.

Conclusions

Ponthie's advocacy for small-home developments came before COVID-19 violently exposed the longstanding problems with our current nursing home infrastructure, and even still, he found willing partners in both the state and federal government.

With lawmakers at all levels searching for ways to avoid a repeat of the COVID-19 disaster in long-term care, the potential for creating novel solutions such as these has never been greater.

In addition, while that rate increase may appear small, it adds up over time, and crucially offers capital providers some assurance that their upfront investment will pay off over the course of a potentially decades-long loan.

Ponthie's strategy shows that success can be found in acknowledging two truths that are often presented as oppositional in the discussion around nursing home funding: The current level of Medicaid reimbursements is often insufficient to support new development, but the nursing home sector should not expect additional funding for pursuing the same flawed physical and cultural model of care.

Sidebar: Inside the Rate

In Arkansas, the Medicaid rate for nursing homes is split into four domains: direct care, indirect care, quality assurance, and property and insurance.

The small-home boost is part of the property and insurance domain, which Arkansas uses to measure the approximate value of the entire facility when determining the final rate. This methodology acknowledges the increased upfront cost of developing a Green House community either from scratch or through a renovation.