

Wisconsin Association of Homes and Services for the Aging, Inc.

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To: State Representative Jean Hundertmark, Chair
Members, Assembly Aging and Long-Term Care Committee

From: John Sauer, Executive Director
Tom Ramsey, Director of Government Relations

Subject: Long-Term Care Provisions Contained in 2003 Senate Bill 44, the Biennial Budget Bill

The Wisconsin Association of Homes and Services for the Aging (WAHSA) is a statewide membership organization of 190 not-for-profit corporations principally serving the elderly and persons with a disability. WAHSA members own, operate and/or sponsor 185 nursing facilities, including 47 county-operated facilities, 22 intermediate care facilities for the mentally retarded (ICF-MR), 72 community-based residential facilities (CBRF), 50 residential care apartment complexes (RCAC), and 117 senior apartment complexes. Members provide the full continuum of long-term care, ranging from nursing home care and assisted living to hospice, Alzheimer's support and homecare.

We appreciate the opportunity Chairperson Hundertmark and the members of the committee have provided us today to discuss the key long-term care issues contained in the biennial budget bill. Specifically as it relates to the proposed federal Medicaid waiver to reform the long-term care system, while we are learning more each day about the contents of the proposal, there is still much we do not know and our testimony will focus on those unknowns. In addition, since our membership has not had the opportunity to review the document and provide us direction, our comments are simply that, not the official position of the association.

Federal Medicaid Waiver to Reform the Long-Term Care Delivery System

WAHSA members strongly support the Doyle Administration's efforts to attract substantial additional federal funding to support the State's Medical Assistance program. We cringe at the thought of the potentially draconian cuts to the Medicaid program that might have to be imposed if the additional federal funds are not available, cuts that would be borne by our State's frailest and poorest citizens. By the same token, we are more than a little reluctant to raise questions which might in any way play a role in jeopardizing Wisconsin's receipt of these much-needed federal funds. But ultimately,



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we owe it to the people we serve to raise those questions to ensure that the long-term care system we devise is a system that meets the needs and preferences of the elderly and disabled it will serve while remaining affordable to the taxpayers who will be asked to fund it.

In reviewing the waiver proposal, one key question needs to be addressed: In advancing this proposal, is the State of Wisconsin “selling its soul” to balance a budget through a plan which in the short-term could deliver +\$400 million in desperately needed federal aid, but in the long-term could leave the State of Wisconsin unable to meet the growing needs of its elderly and persons with a disability?

Attached please find a series of questions we raised a week ago just prior to when we first received a copy of the waiver proposal. While some answers appear to be provided in the document, we believe all still need either to be clarified or addressed. In our testimony, we will attempt either to elaborate on those questions or raise new ones.

At the outset, please be assured that WAHSA members are not afraid of change, they embrace it. They began to shift their focus from nursing home care to assisted living and community-based services long before this waiver proposal was developed and offered to representatives of the Bush Administration. Many of the changes it recommends have been on-going for some time. The waiver proposal is not a threat to their existence, current or future; indeed, many are extremely well-positioned to provide the service delivery system the waiver proposal envisions. We hope our comments are taken in that context.

Bed Closures: The primary concern WAHSA members have expressed with the waiver proposal is many of its assumptions. Key among those is the assumption outlined on Page 7 of the document (“State of Wisconsin Medicaid Waiver to Restructure and Reform the Long-Term Care Delivery System,” a preliminary draft dated March 31, 2003) under Wisconsin’s Proposed Demonstration Waiver:

“Waiver funding combined with savings from significantly reducing nursing home patient days and costs will support additional waiver placements and nursing home relocations, eliminating statewide waiting lists.”

The assumption is that nursing home bed closures will generate the savings needed to eliminate the home- and community-based waiver programs waiting lists. However, if those nursing home bed closures are assumed to be from the beds identified on Page 11 of the document (under Federal DHHS Medicaid Reform Goals), we are hard pressed to see where the majority of those savings will come from.

First of all, as the document points out, these closures are not mandated, they are simply Departmental projections. We happen to believe they are inflated projections. For instance, the projection is 600 nursing home beds will be closed through “downsizing.” This is the number of people currently in nursing homes that also are on waiting lists but the Department itself admits not all would choose to utilize community long-term care services if they became available: some will die before those services become available, some will choose to remain in the nursing home. In addition, we believe there most likely is significant duplication in the 2,870 beds which are projected to close because of the increase in the nursing home bed tax and the 2,678 beds projected to close as part of the “historical decline in occupancy.”

While we can exchange guesses over the projected number of beds that may close by 2008, of greater concern is the fact that the vast majority of the beds projected to close by DHFS are empty beds. Medicaid does not pay for empty beds; the closure of those beds will not reduce nursing

home patient days, as was asserted on Page 7 of the document, and, therefore, will not generate the savings anticipated to fund the elimination of the waiting lists. Real savings occur only if a Medicaid nursing home resident is relocated to a lower-cost setting, a prospective Medicaid nursing home resident is diverted to a lower-cost setting and/or a facility closes.

Medicare Savings: The waiver assumes that savings will be produced when persons are diverted from entering a nursing home. It is possible that the actual savings that are realized from a diversion are to the federally-funded Medicare program while costs are shifted to the Medicaid program, which the State intends to administer under a federal funding cap. In 2001, 68% of the 52,101 nursing home admissions were admitted with Medicare as their primary funding source. This is as expected since nearly 80% of all admissions were from hospitals. In contrast, during the same year, Medicaid was the primary payor for only 12% of all nursing home admissions. By making it more difficult for persons to access nursing home care, Medicaid dollars likely will substitute for Medicare dollars. The feds should be appreciative of our efforts.

Facility Closures: The other concern we have with the beds projected to close as listed on Page 11 of the document is the lack of criteria to determine which beds should close. The Department, obviously, has no plan to identify beds that should be closed; their plan simply appears to adopt the position that “if the bed’s empty, close it.” It doesn’t ask where the bed is located or what kind of facility it is. Without asking such questions, don’t we run the risk of closing quality facilities and subjecting some parts of the state to a nursing home bed shortage? According to some, such problems already exist in certain regions of Wisconsin. The State needs to develop a plan to close nursing home beds based on the appropriateness/availability of alternative care, the cost-effectiveness of that care, and the assurance of adequate statewide access to quality nursing home care. This waiver proposal does not do that.

Family Care Without an Evaluation: We also are somewhat curious by the proposal in the waiver (Page 8) to “facilitate the establishment of multi-county Family Care Districts and public/private partnerships to provide a framework for the implementation of Family Care on a statewide basis by the end of a 10-year period.”

WAHSA members, especially those which operate in a Family Care pilot county, strongly affirm the program’s popularity. They also have indicated Family Care has had a negligible impact on their nursing home census, or on any aspect of their operation, and wonder where the projected savings is coming or will come from. The question then is can the State of Wisconsin afford the statewide expansion of the popular Family Care program in the next 10 years?

Part of the answer to that question is expected to come from an analysis of the Family Care program being conducted by The Lewin Group, Inc., at the direction of the Legislative Audit Bureau. One of the key questions the Lewin Group was to address, and one that certainly is relevant to the waiver proposal discussion, is whether it is generally less expensive to provide care to a person in the community who has the exact same care needs as a nursing home resident (The evidence that has been produced on this topic has shown that Wisconsin’s nursing homes residents are generally sicker, older and more frail than persons served under the waiver and community options programs). The Lewin Group was expected to provide a report on the outcomes and cost-effectiveness of Family Care in early 2003; that report has yet to be received. The final implementation report is expected in June 2003.

Is it prudent to use a strategy of statewide expansion of a pilot program before an analysis of that pilot is concluded? What if upon review of this analysis, the Legislature were to decide Family Care is a good program which the State cannot afford? We would suggest that the Family Care pilot be expanded to

Kenosha County, as proposed in SB 44, but further expansion be tabled pending a thorough review of The Lewin Group's analysis.

Federal Medicaid Cap: Under the waiver proposal, Wisconsin would agree to an overall five-year cap on Medicaid expenditures, beginning in state FY 2004, for all services for the elderly population and persons with a disability. Has the Department taken into account in its assumptions the "woodwork effect" which has been quite evident in the Family Care pilot counties, where people who otherwise might not utilize government services "come out of the woodwork" to use the services of a widely expanded and popular program?

SB 44 contains a provision to close loopholes in the State's Medicaid divestment statute. If a divestment problem currently exists which finds well-to-do people divesting of their assets in order to receive nursing home care under the Medicaid benefit, can you imagine how widespread divestment might become for a program that offers significantly expanded service options to persons who would not have otherwise sought admission to a nursing home? Has the State taken increased divestment into account?

The waiver also would "create an opportunity where a smaller number of institutions with significantly fewer licensed beds will be financed at a level that is consistent with their mission for intensive, high quality care." We believe this means fewer nursing homes will be paid a better Medicaid rate.

If our assumptions are correct, that many more people will utilize the popular services the waiver would offer, that divestment will run rampant for such a popular program, that the anticipated savings from nursing home closures won't be met and, indeed, will be even less than anticipated because of increased reimbursement rates for the remaining nursing homes, we simply ask how will we be able to afford such a system if expenditures are capped?

Our hope is that the State of Wisconsin will not agree to a federal Medicaid funding cap if that cap will leave the State in no position to adequately fund the care and service needs of the elderly population and persons with a disability.

Participation in the Plan: One final point: In the attached September 3, 2002 letter from WAHSA Executive Director John Sauer to then-DHFS Secretary Phyllis Dube, Sauer decries "the lack of a plan, a strategy or even discussion within your Department on how to address the well-documented nursing home funding and quality crisis." Despite the Department's assertion in the waiver proposal that it wishes to work with a broad group of stakeholders and the Legislature to develop the specifics of this proposal, to our knowledge only a select few were permitted input to this document. As one WAHSA member put it, the State's nursing home policy appears to be "downsizing by starvation." We are tremendously disappointed with the process the DHFS has used to develop this plan and its heavy-handed tactic of "take this or risk losing \$461 million." We are more disappointed that the Department chose to begin formulating a nursing home policy, which we requested, without giving us any opportunity to participate in those discussions. Ever the optimist, however, we are pleased to report that the DHFS now has agreed to listen to our concerns and to meet with our representatives. Given the tight timeframe for federal waiver approval, we only hope our input is not too little, too late.

MA Eligibility – Personal Needs Allowance

Under SB 44, a projected biennial savings of \$3.4 million GPR and \$8.2 million AF would result from a reduction in the personal needs allowance of nursing home residents from the current \$45/month to the federal minimum level of \$30/month, effective July 1, 2003.

Under current law, MA enrollees in nursing homes may retain \$45 unearned income per month to support their personal needs, for such things as socks, underwear, hair care, telephone service, cosmetics, stationery, basic cable television, stamps and denture repair. Any income that exceeds this amount must be applied to the cost of the individual's care in the facility.

This reduction might be expected in Mississippi or Alabama but is this how we treat our elderly and disabled poor in Wisconsin? We all recognize the fiscal difficulties the State faces but must we sacrifice our personal values to balance the budget? The people affected by this reduction are, by definition, in need of services and poor. Do we really need to add to their problems with this cut? This, simply, is a bad idea and should be dropped.

There may be some room for compromise, however. Admittedly, some nursing home residents are so severely infirmed that they won't/can't spend the \$45/month, while others are active enough to easily spend that amount. The Legislature could direct the DHFS to develop an assessment or some other method of determining the ability and willingness of nursing home residents to spend their personal needs allowance and establish a sliding scale to determine what each individual can spend.

Bed Taxes and Nursing Home Rate Increases

Bed Tax: The current nursing home bed tax is \$32/month on all occupied nursing home beds, excluding Medicare beds, and \$100/month on all ICF-MR beds. SB 44 would raise the tax to \$116/month on all licensed beds, and \$435/month on all licensed ICF-MR beds in FY 04 and \$445/month on all licensed ICF-MR beds in FY 05.

The bed tax, whether in its current or proposed form, is poor public policy. It asks private pay nursing home residents to further subsidize the care of Medicaid nursing home residents which government is responsible for but either is unwilling or unable to do. It creates a nursing home payment system for today which can't be sustained in the future. It enables those who are responsible for the care of indigent care recipients to escape that responsibility. There simply is no justification for the imposition of such a tax, except for the fact that at the end of the day, that care must be provided. Nursing facilities take their care responsibilities seriously and though they believe this tax is patently unfair, they reluctantly support it because most facilities couldn't adequately care for their residents without the funds the tax generates.

Based on that premise, WAHSA members reluctantly accept the Governor's bed tax proposal because the revenues generated by the tax provide funding for a 3.3% Medicaid rate increase in each year of the biennium for nursing homes. But even that is somewhat misleading, because nursing homes only receive \$49.8 million of the \$51.7 million the tax generates in FY 04 and \$47.9 million of the \$49.8 million the tax generates in FY 05. The reality is the loss of this \$3.9 million lowers the actual rate increase from 3.3% to 3.09%. WAHSA members urge the Legislature to return all funds generated by the nursing home bed tax to the nursing homes and residents who paid the tax.

There may be some discussion on whether the bed tax should be applied to licensed or occupied beds. WAHSA members support the Governor's proposal to apply the tax to all licensed beds, which would keep the tax lower than its application to occupied beds (assuming in either case the intent is to generate the \$51 million needed for a 3.09% - 3.3% rate increase). Our goal is to keep the tax as low as possible and to limit the exposure of our private pay residents, who already are paying on average \$44/day more for their care (2001 figure) than are Medicaid residents in order to subsidize the underfunding of the

Medicaid program. In addition, applying the bed tax to all licensed beds would provide a greater incentive for those with significant numbers of empty beds to close those beds rather than pay a tax on them.

Medicaid Rate Increase: Of equal concern to WAHSA members, however, are some of the provisions in the budget which dictate how the rate increase dollars are to be distributed through the nursing home payment formula.

Under the former payment system for nursing homes, Medicaid payments were limited to the lesser of reimbursement targets (maximum payments in each of seven cost centers) or a home's actual costs. In July 2001, the DHFS imposed a modified price-based system, which would establish a price that each facility would be paid in each of the non-direct care cost centers (direct care would remain cost-based), regardless of what their costs were. The system is being phased in over a four-year period. In FY 04, 75% of a facility's rate in the non-direct care cost centers will be price-based, 25% will be cost-based. In FY 05, the rate in the non-direct care cost centers will be 100% price-based.

WAHSA members strongly oppose the price-based system, which we have argued creates an unchecked incentive for homes to either pocket profits for costs they never incurred or cut costs, resulting in a reduction in the quality of resident care and life. Instead of spending scarce Medicaid payments to improve resident care, facilities with costs lower than their price would be able to pocket those dollars as profit. Generally speaking, a price-based payment system helps facilities which pay and staff lower and hurts facilities which pay and staff higher. In addition, other States with price-based experience have expressed concerns with inadequate expenditures for food, activities and housekeeping. When Wisconsin's nursing home payment system on the one hand is widely recognized as providing rates insufficient to pay for quality nursing home care, why would we embrace a system that spends scarce dollars for incentives that are often incompatible with resident and staff needs?

SB 44 would continue the transition to a price-based system in the non-direct care cost centers. Because of that, the nursing home formula will distribute more of the rate increase dollars generated by the bed tax to facilities which don't staff or pay their employees as well. That distribution mechanism hurts WAHSA's not-for-profit and government-operated members. We would prefer bypassing the nursing home payment formula during the 2003-05 period the bed tax increase and the 3.3% rate increase are in effect and instead distribute the rate increase dollars through a "rate-on-rate," which would provide a 3.3% rate increase in each year of the biennium to all facilities. WAHSA members believe this more equitably distributes the rate increase dollars generated by the bed tax increase and gives more facilities a greater opportunity to offset the impact of the bed tax on their private pay residents.

Health Facility Regulation and Penalties

- The Governor's budget proposal would fund an additional forfeiture specialist in the DHFS Bureau of Quality Assurance (BQA) through the imposition of a 6% surcharge on nursing home forfeiture assessments. In addition, the maximum forfeiture assessment for CBRFs would be increased from \$1,000/day to \$10,000/day for each violation.
- According to an internal DHFS analysis conducted late last year, 192 nursing homes out of the 379 facilities analyzed by the DHFS are at "financial risk:" 138 facilities were operating at a net loss, 111 facilities were operating with negative working capital, and 57 facilities were operating both at a net loss and with negative working capital. Now certainly is not the time to ask this financially-strapped

provider community to pay out additional dollars for a FTE position whose need is questionable. If the state believes there is an undeniable need to fill this position, the state should fund the position.

- There is no empirical evidence to show that the imposition of monetary penalties serves as a deterrent to the provision of poor care. Indeed, the DHFS left the forfeiture specialists' positions vacant in 2000-01: If the assessment and collection of forfeitures is so needed to deter nursing home and CBRF noncompliance, why were these positions left vacant?
- Nursing home and CBRF forfeitures, as well as other state forfeitures, are deposited in the State Common School Fund, which is used to make loans to local governments and to fund the purchase of instructional materials and library books by school districts. They cannot be used by providers to improve care or to rectify the problems that caused their assessment.
- 49% of the 1,361 CBRFs in Wisconsin are between 5-8 beds; 87.1% are 20 beds or under. It's safe to say that a \$10,000 forfeiture assessed against one of these small operations could close down that operation. It seems odd for a department which historically has sought to institute policies which preserve and expand the number of smaller providers to pursue a provision which could drive many of those providers out of business.
- If 87.1% of the CBRFs in Wisconsin are 20-bed-and-under "mom and pop" operations, where is the proliferation of these "large corporations" that is causing the DHFS such great concern?
- The BQA has a variety of intermediate sanctions it can impose on noncompliant CBRFs other than forfeitures. Those sanctions include directed plans of correction, the suspension of new admissions, conditional licenses, license suspensions or revocations, state monitoring, receivership and state criminal charges. Simply stated, the forfeiture is not the only CBRF enforcement tool and it may not be the most effective.
- The imposition of forfeitures is strictly a punitive measure with no direct benefit to long-term care residents. While federal and state laws limit or outright prohibit the collaboration and sharing of technical assistance between nursing home providers and state surveyors, no such prohibition restricts such a working relationship in CBRFs. WAHSA members believe working together to better serve residents is a much more effective way to ensure quality and improve care than the imposition of purely punitive forfeiture assessments.
- **WAHSA Position:** Oppose both the imposition of a 6% nursing home forfeiture surcharge and the 10-fold increase in the maximum forfeiture for CBRFs.

County Nursing Home IGT Payments

SB 44 would reduce the annual supplement paid to county and municipally-owned nursing homes to fiscal year 2001 levels, a decrease from \$77.1 million to \$37.1 million. This reduction is a result of fewer dollars being available under the nursing home Intergovernmental Transfer Program (IGT). SB 44 assumes that IGT revenues will decrease from \$327 million in FY03 to \$27 million in FY04.

The loss of \$40 million to approximately fifty homes will be devastating. However, it is possible that that IGT revenues will be greater than assumed under SB 44. WAHSA requests that statutory provisions be added to enable these county and municipally-owned homes to receive additional dollars above the

\$37.1 million if federal IGT claims enable Wisconsin to receive an amount greater than assumed under the bill.

We again express our appreciation to Chairperson Hundertmark and the members of the Committee for the opportunity to discuss with you the key long-term care issues contained in the biennial budget bill.