Planned Parenthood®
of Wisconsin, Inc.

Sen. Moen
AH

302 North Jackson Street, P.O. Box 514006, Milwaukee, Wisconsin 53203 414•271•8045 FAX: 414•271•1935

Hi, my name is Lisa Boyce. I am the Vice President of Public Affairs for Planned Parenthood of Wisconsin. Joining me today from our patient services department is Emily Wellerritter, manager of clinic systems and community partnerships.

Through our 31 clinics across the state, we serve 65,000 patients by providing breast and cervical cancer screening, STI testing and treatment, pregnancy counseling, contraception services and abstinence based, age appropriate sexuality education. Almost half of our patient base is at or below the poverty level, so continued public assistance to allow these families to access vital health services and information is essential.

Our mission at PPW is to provide women and men with the education and direct clinic services to enable them to make responsible choices, have a healthy future and when they are ready, to have healthy wanted children. We have served the reproductive health care needs for the men and women of Wisconsin for over 66 years and as such are experienced in assessing and addressing the reproductive health care needs of our population.

We are here today to articulate our support of the proposed funding to support health care services for the needy included in Governor McCallum's budget proposal as well as to suggest three other proactive, cost savings measures that could be added to improve health care services for the people of Wisconsin.

The current budget proposal continues to allocate a stable level of funding to support family planning programs. Family planning programs are important in protecting the health care status of women and men in Wisconsin. Wisconsin's family planning program has been in place since 1979 and provides breast and cervical cancer screening, testing and treatment of sexually transmitted infections, contraception services as well as pregnancy testing and counseling for low-income women who make between $8,000 – $20,000 per year.

Our clinic here in West Allis serves approximately 11,000 patients per year and is one of 2 clinics that has on-site colposcopy services for women who test positive for cervical cancer.

Statewide approximately 150,000 women seek the services of Wisconsin's publicly supported family planning clinics. Approximately half of Planned Parenthood of Wisconsin's 65,000 patients each year are at or below the poverty level. ($8,000 single; $11,000 two; $14,590 three) Consequently, most of these patients have no health insurance or access to affordable health care.

We applaud the inclusion of this important funding provision because they allow low income women and men to access these basic health services in a cost-effective manner.

For every dollar spent on family planning services, the taxpayer is saved $3.00 in short-term health care services that would go toward medical costs associated with unintended pregnancy and birth. A recently conducted survey by **the Alan Guttmacher Institute** (The Alan Guttmacher Institute (AGI) is a non-profit organization focused on reproductive health research, policy analysis and public education.) also found that in Wisconsin, 35,200 unintended pregnancies and 17,600 abortions are averted through publicly supported family planning clinics.

Despite the health and fiscal benefits of these programs, Assembly Speaker Scott Jensen and Assembly Majority Leader Steve Foti have announced their intention to eliminate state funding for family planning programs.

In a tax payer funded mailing, Speaker Jensen and Assistant Majority Leader Steve Foti discussed their intent to eliminate state funding for family planning organizations. This attack on family planning by leadership is unprecedented and is based on false pretenses.

No state or federal family planning funds are used for abortion services. State law s. 253.07 (1) (b), stats. explicitly **prohibits the use of family planing funds** for the "performance, promotion encouragement or counseling in favor of, or referral either directly or through an intermediary for voluntary termination of pregnancy." Likewise, no public employee or public facilities can be used in abortion related services.

We urge you to support Wisconsin's current family planning system and vote to maintain state funding for family planning agencies in the state budget to prevent unintended pregnancies, abortion, sterility and further health complications as a result of undiagnosed disease.

There are two additional areas where we could further improve the health care needs of our community members that would also provide cost savings to the state including: support of Human Growth and Development curricula and improved support of Sexually transmitted infection testing and treatment. Improved assistance in both program areas could potentially be funded through federal assistance and would work to reduce the rate of unintended pregnancy and improve the detection and transmission of sexually transmitted infections amongst the constituents of Wisconsin.

In those schools that decide to teach Human Growth and Development, there is typically little or no assistance for teacher training and material development available. As a result some of the information taught to our children is not factually based and is misleading. Some of our educators, for example, are teaching our kids that they can get AIDS from dirty toilet seats and mosquito bites.

By implementing a plan proposed by Governor Thompson's Brighter Futures Report, we could go a long way toward better informing our kids to make responsible choices, reduce teen pregnancy and transmission of STI's if we committed to provide teachers with needed training and curricula assistance that wouldn't cost Wisconsin tax payers.

Thanks to funding through the Temporary Assistance for Needy Families, Wisconsin has a ready resource to help us improve our teen pregnancy rates through education - we just need to make that commitment.

Finally, additional resources to go toward the prevention, testing and treatment of sexually transmitted infections would also serve the health needs of our community in a cost effective manner. Undetected sexually transmitted infection can lead to poor health, cancer, infertility, death and transmission amongst the public.

For African American women aged 25-44, HIV is the second leading cause of death and the third leading cause of death for latinas. African American women are also three times more likely to die from cervical cancer caused by Human Papilloma virus, the most common STI in the U.S.

The commitment of TANF funds or other available funds would go a long way toward addressing increasing STI rates and would help to improve the health outlook for these women and their children.

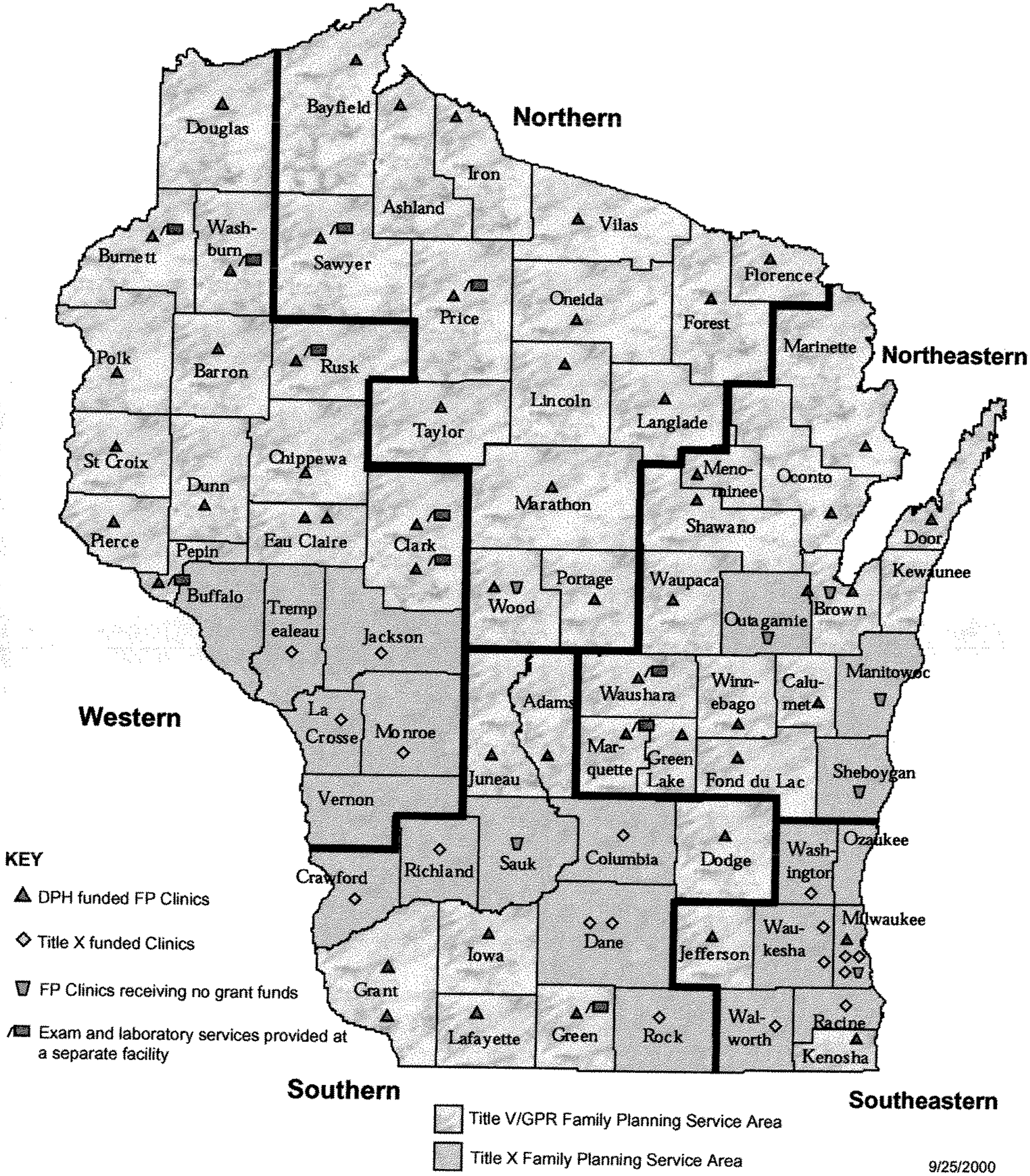
A recent citation from the Children and Youth Funding Report reveals that Wisconsin is one of five states that are currently using their TANF funds for tax cuts and to shore up budget shortfalls instead of going toward programs to fight poverty.

If these funds were appropriately directed to assist the poor, the healthier outcomes would result in tax payer savings in Medicaid costs.

In closing, we urge you to listen to the 80% of the Wisconsin voters and our Governor and work to protect public funding of family planning for low income families - we also ask that you consider the cost savings and importance of these public health care proposals.

Thank you for your time and consideration of our testimony.

Wisconsin Family Planning Program
Family Planning Clinic Services in Wisconsin
By Division of Public Health Regions



9/25/2000

Petersen Health Care of WI, Inc
Mary Jane Kuivanen, Director of Human Resources
Friday, January 26, 2001

Recruitment and Retention Difficulties/Restraints

Instability of the business and the highly publicized financial woes of our industry do not make us favorable for potential employees who want to be a part of a thriving business that offers some stability. This past fall we were out until the 11 hour before being able to sign with an insurance provider so that we could communicate with our staff what that benefit might look like. Everyone knows the sky rocketing health care costs. This year our budget is set realistically at 2 million dollars for approx. 300 employees and their families. Everyone was scrambling to get a reinsurance company to take on our stop loss. The BUSINESS is just too risky. The long-term care industry is too precarious.

Yet the caps stay the same, in fact overall they have been shrinking in recent years. ***Coupled with current legislation mandating an increase in staffing minimums***. Mandating that we must now have more people caring for our residents and clients – I can only believe that this was done with the understanding that previous staffing levels were considered inadequate. Inadequate staffing, but not inadequate funding? Facilities received no more additional funding for the additional staff they were required to have in their buildings.

The squeezing continued when in ***May of 2000 the state mandated that all criminal background checks***, which are required of all employees working in long-term care facilities would now have to submit their requests to the Department of Justice for a fee of $2.00 for non-profits, $5.00 for Government entities and $13.00 for all 'others' in addition to the $2.50 are ready being charged by the Dept of Health and Family Services for caregiver checks/*the Nurse Aide Registry*. Again, without additional funding.

We ***practice open and honest communication*** with our co-workers. They know the bottom line of our organization; they know we are trying to survive. We continue to remain committed to quality care, but this nail biting business over extended periods of time change a corporate culture. The inequities in the Medicaid system tie our hands in both recruitment and retention; today's environment is out right fearful.

OSHA Targeting Nursing Facilities
The new OSHA Ergonomic Standard
State and Federal Survey Processes
Corporate Compliance
Lack of Competitive Wages/Benefits

Wanting to do the right thing, wanting to care for the individual, constantly being compromised. We will not jeopardize our residents; we are committed people who care for our community members. We are continually taking loses and looking for ways to make up the debt, but it has gone too far, too deep. Raise the ceilings.

Consistently trying to reinforce that the job that they do is of value. That it is one of the most valiant professions one can perform. The skill of establishing relationships and trust at a time of such vulnerability is unmatched. Consider the degree of trust you would have if your co-workers were caring for you when you are most venerable. Weak, frail, compromised health, debilitating circumstances such a stroke or Alzheimer's Disease.

These are people of integrity, yet through the media they are slug from one headline to another as individuals of less than honorable credentials. Through the Wisconsin reimbursement systems they are told time and time again that their jobs are pathetically under valued.

Ask yourself if you would provide skilled care for someone's grandmother for 24 hours a day for $4.16 an hour? Would you take care of anyone for $4.16 an hour? Because that is what we are getting; our "low labor region" average Medicaid rate is approximately $100.00 a day, that's $4.16 an hour for skilled Certified Nursing Assistants, Licensed Nurses, social services, recreation, dietary, clean clothing and linens, clean rooms, heat, lights and furnishings.

How do I provide hope, career ladders or other opportunities for advancement in an environment that is so volatile that I can't get health insurance reinsure companies to cover our stop losses because many have simply stopped insuring long-term care organizations.

Currently we have ***7 full-time RN openings and 18 Direct Care positions open*** in our organization. I cannot imagine a time when we will not need nurses. Skilled individuals who can properly assess and treat the needs of those we serve.

We have consistently lowered our turnover statistics 38% in '99 and 33% in '00 and we by far surpass the average turnover statistics of long-term care which are 50-60%, but it is not enough. This industry must be addressed. Inadequate funding, facilities in bankruptcy, inability to staff buildings can only negatively impact our most vulnerable populations.

Labor impact-expansion of new local businesses. Over the next 18 months it is projected that 1200 new jobs will open up in our area. We'll have a Home Depot, a Menards, a Super Wal-Mart, an expanded JC Penny, a new grocery store, possibly two, various restaurants, the list goes on. Our population is not expanding, it is shrinking and our work force will get smaller and the competition tighter.

The Business Journal
Serving Greater Milwaukee
February 2, 2001
(Front Page)

AUDIT:
Nursing homes didn't pass along wage increases

By Phill Trewyn

A new state audit has concluded that 61 nursing homes in Wisconsin did not pass through any of the state dollars they received to boost wages for nursing home workers.

The preliminary audit by the state's Division of Health Care Financing reveals that $1.9 million of state money, out of an available $8.3 million, was not used by nursing homes for its intended purpose of increasing the wages of certified nurse's assistants (CNAs). The nursing home industry had requested assistance to pay higher wages to recruit and retain workers in a tight labor force.

Robert Kraig

If the results of the audit withstand appeal, the nursing homes will have to return the funds to the state.

Some members of the nursing home industry are questioning the methodology used in the audit to determine whether wage increases were implemented. They will be granted a chance to appeal their cases at a Feb. 12 meeting that will include representatives of the state, the nursing home industry and the

Please turn to page 44

PASSING BY

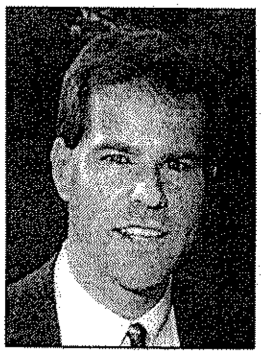
- **OCTOBER 1999**
  Gov. Tommy Thompson approves a $19.4 million wage pass-through for nursing homes to increase wages of nurse's assistants.
- **JULY 2000**
  Rep. Peggy Krusick and Sen. Gary George call for state audit of wage pass-through funds used by nursing homes.
- **JANUARY 2001**
  State audit finds $1.9 million of available $8.3 million budgeted for 2000 was not used for wage increases.
- **FEBRUARY 2001**
  Meeting planned to allow individual nursing homes chance to appeal audit findings.

Audit says nursing homes didn't pass through wage increases

Continued from page 1

two labor unions representing nursing home workers.

However, some state legislators and union members representing the workers are upset about how the state money has been used in an industry that had requested millions in tax dollars to make up for shortfalls in Medicaid and Medicare reimbursements.



Brian Burke

"To me, this represents a real break of faith," said Sen. Brian Burke (D-Milwaukee), co-chairman of the Joint Committee on Finance. "I had representatives of the nursing home industry sit in my office and promise to use these funds for wage increases. I think the audit shows that did not happen often enough."

"This is an industry screaming that it can't retain workers," said Robert Kraig, political director of the Service Employees International (SEIU), which represents 4,500 workers at 51 Wisconsin nursing homes. "It's very disappointing that they did not use the money to increase wages when they said that's what they needed it for."

The audit is labeled "preliminary" by Dave Lund of the Division of Health Care Financing, who oversaw the study. He said the $1.9 million figure could decrease, depending on the number of appeals that are accepted, but he expected a sizable portion of that figure to remain.

The audit identified 61 nursing homes that did not use any of the allocated money for wage increases and 52 nursing homes that used only portions of allocated funds for wage pass-throughs. The audit found 294 nursing homes that used all of the allocated money for wage increases.

The audit was conducted after some nursing home workers, represented by the SEIU, complained to legislators about not receiving a 5 percent wage increase, for which a $19.4 million "wage pass-through" was written into the 1999-2001 state budget.

Peggy Krusick

The budget allowed for $8.3 million to be used for wage increases between Oct. 1, 1999, and June 30, 2000, the end of the state's fiscal year. An additional $11.1 million is to be used for wage increases in fiscal 2001.

If a nursing home did not use money allotted for wage increases in the first year, it can't receive any state money for wage increases during the second year of the budget, which is the current year.

"That (audit) is not the end-all, be-all," said John Sauer, executive director of the Wisconsin Association of Homes & Services for the Aging Inc., Madison, which represents mostly nonprofit nursing homes in the state.

Among the flaws in the audit being pointed to by nursing home officials is a complicated set of formulas that misinterpreted wage-per-day estimates and thereby miscalculated wage increases, according to Sauer.

Another factor not taken into account by

An official from Extendicare Inc., a national operator of long-term care facilities, including nursing homes in Wisconsin, agreed with Sauer's assessment that flawed calculations were used in determining whether wage pass-throughs actually took place.

Randy Krentz, regional director of operations for Extendicare, points to three homes in the Sheboygan area, two of which were found to have properly used allocated funds for wage pass-through. A third was found to have used only half of the $21,569 for wage pass-through. However, more than $23,000 has been spent on wage increases at that facility, according to Krentz.

NO THRU STREET

The following Milwaukee-area nursing homes were among 61 throughout the state that failed to pass through any state-allocated funds to their employees, according to a preliminary state audit. The nursing homes can appeal the results of the audit. If their appeals are not upheld, they will be forced to return the funds to the state.

	FUNDS ALLOCATED FOR NURSE'S ASSISTANT WAGE INCREASES
Friendship Village, Milwaukee	$4,616
Heartland of Milwaukee	$13,314
Jackson Center Nursing Home, Milwaukee	$29,988
Luther Manor, Milwaukee	$42,440
Masonic Health Care Center, Dousman	$10,393
River Hills West HealthCare Center, Pewaukee	$41,494
Samaritan Health Center, West Bend	$39,486
Shores Health Care & Rehab, Glendale	$6,792
Sunrise Care Center Inc., Milwaukee	$20,328
Tudor Oaks, Muskego	$6,653
West Allis Care Center	$13,060
Westmoreland Health Center, Waukesha	$51,838

Source: Wisconsin Division of Health Care Financing litical director of the Service Employees International (SEIU), which represents 4,500 workers at 51 Wisconsin nursing homes. "It's very disappointing that they did not use the money to increase wages when they said that's what they needed it for."

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Among the flaws in the audit being pointed to by nursing home officials is a complicated set of formulas that misinterpreted wage-per-day estimates and thereby miscalculated wage increases, according to Sauer.

Another factor not taken into account by the audit were labor negotiations taking place as the wage pass-through was implemented, he said. Bonuses and pay increases that came from those negotiations were not accounted for, according to Sauer.

"Members of AFSCME (American Federation of State, County & Municipal Employees) even said the calculations don't work," Sauer said.

AFSCME represents workers at nursing homes that are in the public sector, including Dunn County Health Care Center. That facility received $52,204 for wage pass-through assistance, yet according to the audit did not use a penny for that purpose.

"I've seen documentation from managers and staff representatives that show the money was passed along to (certified nurse's assistants)," said Greg Spring, an AFSCME representative in Madison. "In my opinion, it passed through."

The Dunn County documentation will be taken to the meeting Feb. 12, along with similar accounts from 15 other homes represented by AFSCME, Spring said.

"I'm hoping the vast majority (of appeals) can be taken care of Feb. 12," Spring said. "If (nursing homes) can't prove they spent the money on wage pass-through, they're going to have a hard time (keeping the money)."

Source: Wisconsin Division of Health Care Financing

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"We did not misuse these dollars," Krentz said.

If the state money was not used for wage increases at nursing homes, it could have been used for a variety of purposes, including the expansions of nursing homes or corporate profits, Kraig said.

The SEIU would like the money that is returned to the state to be passed along to workers.

The union has received six requests from nursing homes asking for help in their appeals, but only one of those cases is worth considering, Kraig said.

State Rep. Peggy Krusick (D-Milwaukee) and Sen. Gary George (D-Milwaukee) sent a letter last July to Wisconsin Health & Family Services Secretary Joe Leean asking for an audit of wage pass-through funds.

Krusick is working on a budget amendment that would funnel any money recovered by the state back to the employees.

"I want (the money) to go where it was intended to go," Krusick said.

Krusick said any future money allocated to the state's nursing home industry will have strict requirements on how the money can be spent.

"I want assurances that any new dollars are used to maintain and improve staffing levels," Krusick said.

The charge that Wisconsin's nursing homes deliberately failed to distribute state money to their workers last year is preposterous. The story was also journalistically misleading.

First, the headline and lead are not true. A new "state audit'' has not concluded anything.

In accordance with state law, the state surveyed Wisconsin's nursing homes to determine whether they gave to their certified nursing assistants (CNA) the $8.3 million given to them as a "wage pass through'' (WPT) by the Legislature. Following that preliminary fact-finding, a panel of labor, nursing home and state officials now will review the surveys to determine who failed to comply with the law. The surveys are in, but the follow-up review is not. There is no "preliminary audit,'' as the story suggests. The state simply has collected the data it needs to conduct further reviews. The story eventually explains this on Page 44 – under a similar misleading headline that repeats the charge.

What makes this charge preposterous is the union leader making the charge sits on the panel that will be performing the reviews. Robert Kraig, the political director for the Service Employees International Union, is distributing the survey list and implying guilt even before he's seen any documents from nursing homes showing how they spent the money. Further, he's using the "preliminary audit'' to urge lawmakers to crack down harder on a profession which, by any measure, is near financial collapse.

We believe the methodology used to determine whether a facility appropriately spent the WPT dollars was too complex and ignores the key question: Did facility wages, benefits and/or staffing increase over the past year by the dollar equivalent of 5%?

We are absolutely confident our members did the best they could to follow a complex law. Even the other union representing Wisconsin nursing home workers, AFSCME, has said it thinks most homes did the best they could to pass the money to its workers. Despite these efforts, a relatively small number of homes to forego the benefits of the WPT program.

The article itself failed to indicate the true financial distress of some the homes noted in the story. For example, Luther Manor in Wauwatosa, one facility reported as not spending the WPT funds, increased CNA wages by 9% last year at a time the facility was incurring a Medicaid direct care loss of over $1.1 million. Despite these facts, this facility was listed in the article as a home that "didn't pass along wage increases."

What's left? We have a review that isn't yet completed. We have a profession that insists it did the very best it could to follow the law and one union representing nursing home workers that agrees.

Finally, we have a union leader subverting the review process by making allegations and seemingly imposing a guilty verdict before he's even seen the evidence he's supposed to judge – and using that incomplete evidence to muster anger among lawmakers.

Last year, the average nursing home lost $300,000 caring for the state's Medicaid patients. If Mr. Kraig is successful in turning the Legislature away from addressing our long-term care problems, the losses will mount – and Wisconsin's long-term care system will be in jeopardy.

So will the livelihoods of those who work in it, including the workers Mr. Kraig represents.

And we're the ones accused of acting in bad faith?

John Sauer, Executive Director
WAHSA

Thomas Moore, Executive Director
WHCA

To Sen Moen
From MOK
02/14/01
Questions to consider

- Did you reduce the number of beds your facility in the last 2 years ?
- Why ?
- How Many ?

- Has your facility filed bankruptcy, closed or had an ownership change in the past year ?

  Do you believe the increase in major enforcement sanctions are an indiction of severe payment system distress ?

- Where do local people go for care if they can not be admitted to your facility ?

- What effect if any has " Family Care " had on your occupancy ?

- Are you able to reruit staff at your current wage rates ?
  Why not ?

- Why don't you raise wages to meet the competition ?

- How Many CNAs do you employ ?
- How Many RNs & LPNs do you employ ?
- Do you use temporary agency or pool help ?
- Why ?

To Sen Moen
From MOK
02/14/01
Questions to consider

[illegible]

- Have your labor costs have been driven up faster than the MA reimbursement system is able to accomodate them ?

- Has increased turnover affected your costs ?
  How & Why ?
  Are more people required to provide the same care as previously ?

Background Checks

- Has your facility experienced turnover in leadership positions ie NHA & DON
  Why ?
  How Many ?
- Do you believe that it indicates serious problems within the Nursing Home reimbursement & care system ?

- Are resident care & compliance with rules & regs extremely dependent on adequate competent staff ?

Single [illegible] worker

- What efforts have you taken to maintain or increase your level of staffing ?

- Do you provide transportation incentives for staff ?
- What kinds ?

- Do you privide day child care for staff ?
  Why not ?

- Are you able to staff at the level you need to ?

- Why haven't you been able to staff at the needed levels ?

- How do you comply with the law ?

- Did you restrict admissions during the last year because of inability to staff at needed levels ?

PRESS RELEASE
FOR IMMEDIATE RELEASE

Contact: Tom Moore, Executive Director
WHCA Phone: 608-257-0125
John Sauer, Executive Director
WAHSA Phone: 608-255-7060

Sept. 18, 2000

Medicaid funding threatens Wisconsin nursing home care

Wisconsin's Medicaid program paid the state's nursing homes $100 million less than the cost of caring for the state's most elderly and frail long-term care consumers, according to a report released today by a national accounting and business consulting firm.

The study found that 83 percent of the state's Medicaid-certified facilities do not receive a payment rate that meets the daily cost of providing care to their Medicaid recipients. The state's Medicaid program is responsible for paying the long-term care bills for 70 percent of the residents in Wisconsin's nursing homes.

"I believe Wisconsin has among the worst payment systems of any in this country," said Joseph Lubarsky, a CPA and partner in the BDO Seidman firm which conducted the study. "Without question, the inadequacies of the Wisconsin Medicaid payment system have had the greatest impact in the financial and operational condition of Wisconsin's nursing facilities," said Lubarsky, who authored the report.

"We are outraged by the level of Medicaid funding that has been committed to serving the needs of the state's poorest and sickest residents," said Tom Moore, executive director of the Wisconsin Health Care Association. "We are expected to provide a home-like environment and the highest quality of care to individuals with complex needs. Yet the average Medicaid payment is $4 per hour – an hourly rate lower than most teenage baby sitters receive."

"The state's Medicaid program has been on a decade-long journey of being ratcheted down," added John Sauer, executive director of the Wisconsin Association of Homes and Services for the Aging. "Policy makers are prudent to try to contain health care costs, but not if it produces a system that dictates the erosion of quality, limits access, and provides inadequate wages to the 57,000 caregivers employed by nursing homes."

"Nursing facilities are a valuable and indispensable part of our long term care system," Sauer and Moore said. "A major infusion of funding is required if facilities are to maintain the quality of care for the state's most elderly and disabled citizens."

# # #

FACT SHEET

The Financial Crisis In Wisconsin's Nursing Facilities

Confronting a fiscal crisis unparalleled in the history of their membership, the state's two largest nursing home associations* jointly engaged the national accounting firm of BDO Seidman, LLP, to conduct an in-depth analysis of the condition of Wisconsin's nursing home facilities. The study found that Wisconsin's nursing facilities are in fact in serious financial condition.

It identified several factors contributing to their distressed status, but concluded "the inadequacies of the Wisconsin Medicaid payment system have, without question, had the greatest impact in the deterioration of the financial and operational conditions of the Wisconsin nursing facilities."

The BDO Seidman** study examined nursing home cost and payment information collected by the Wisconsin Department of Health and Family Services (DHFS) for its Medicaid rate setting database. The data base consists of state-audited facility-specific resident care cost data the state uses in setting 328 nursing home rates for the 1999-2000 payment year, which commenced July 1, 1999. (While there are 417 nursing homes participating in the state's Medicaid program, DHFS had established 1999-2000 Medicaid rates for 328 when the BDO study commenced on May 15, 2000.)

The following are some of the major findings contained in the BDO study:

- Wisconsin's Medicaid program is the source of payment for nearly 70% of the 43,000 individuals living in Wisconsin's nursing facilities.

- State Medicaid payment to nursing facilities are woefully inadequate; In 1999-2000, Medicaid paid facilities $100 million less than the cost of providing resident care.

- In 1999-2000, 83% of the state's Medicaid certified facilities did not receive Medicaid payments sufficient to meet the cost of providing resident care.

- In 1999-2000, facilities' Medicaid losses average nearly $11 per day for each Medicaid resident. For an average 100-bed facility with 70% Medicaid census, this translates into an annual loss of $250,000.

- Wisconsin's nursing facilities operate in the red. Taking into account all payment sources (Medicare, Medicaid, private payment and insurance) the average operating margin for all Wisconsin nursing facilities in 1999-2000 was a negative 4.79%.

- BDO Seidman's analysis documents that, without question, inadequate Medicaid payments had the single greatest impact on the deterioration of the financial and operational conditions of Wisconsin's nursing facilities.

- During 2000-2001, the projected financial and operational conditions of Wisconsin's nursing facilities is even more bleak. The state Medicaid program has announced the Medicaid's 2000-2001 cost recognition ceilings used to determine facility payments will be further reduced and these cuts will be applied retroactively beginning July 1, 2000.

- Wisconsin's 2000-2001 Medicaid payment ceilings, measured as a percentage of nursing facility costs paid, are the lowest in the United States. In 2000-2001, the average facility Medicaid loss for a 100-bed facility with 70% Medicaid census is expected to reach $300,000.

- To improve Wisconsin's Medicaid nursing facility payment system to a level where only 40% of the state's facilities experience Medicaid deficits, compared to 83% currently, will require additional Medicaid funding of more than $80 million.

**The Wisconsin Health Care Association represents 250 for-profit, not-for-profit, and government-operated nursing facilities. The Wisconsin Association of Homes and Services for the Aging represents 198 not-for-profit and government-operated facilities. (Some facilities belong to both organizations.)*

***BDO Seidman is a national accounting and business consulting firm with 40 offices around the United States. The author, Joseph Lubarsky, is a CPA and partner in the firm. He specializes in the redesign and development of state Medicaid payment systems.*

BDO Seidman, LLP
Accountants and Consultants

Special Report

On the Financial Condition of Nursing Homes in Wisconsin

PREPARED BY
BDO SEIDMAN, LLP
ACCOUNTANTS AND CONSULTANTS

September 2000

Table of Contents

EXECUTIVE SUMMARY

BDO Seidman, LLP was engaged by the Wisconsin Health Care Association and the Wisconsin Association of Homes and Services for the Aging to conduct a study on the financial condition of nursing home facilities in Wisconsin. Specifically, we were asked to determine whether facilities are experiencing serious financial difficulties, identify the major contributing factors, and estimate the fiscal impact of establishing a more reasonable Medicaid reimbursement system.

Wisconsin's nursing facilities are in serious financial distress. We identified several factors leading to their poor financial condition, including federal Medicare payment reductions, declining nursing home occupancy levels and acute labor shortages. However, our analysis indicates, without question, that the inadequacies of the Wisconsin Medicaid payment system have had the greatest impact on the deterioration of the financial and operational condition of Wisconsin's nursing facilities.

KEY FINDINGS

Our key findings, summarized here, and more fully detailed elsewhere in this report, are as follows:

- Wisconsin's Medicaid program is the source of payment for almost 70% of the 43,000 individuals residing in Wisconsin's nursing facilities.

- State payments to the nursing facilities for providing care to Medicaid recipients are currently $100 million less than the costs facilities incur in providing that care.

- 83% of the state's Medicaid certified facilities do not receive payment rates that meet the cost of providing care to their Medicaid residents.

- In fiscal year 2000, the average Medicaid loss per patient day was $10.90. For a 100 bed facility, with a 70% Medicaid census, this translates into an annual loss of $250,000.

- Taking into account all sources of payment (Medicare, Medicaid, private payment and insurance) the average margin for all Wisconsin nursing homes in 1999 was a negative 4.79%.

- The level at which the state proposes to establish Medicaid payment ceilings for the current rate year of July 1, 2000 through June 30, 2001 is the lowest in the United States. These lower ceilings, representing the maximum cost level that Medicaid will reimburse, will result in average Medicaid facility losses increasing by an additional $2 - $3 per resident day. The average facility loss for the 2000-2001 rate year is expected to reach $300,000.

- To improve the state's present system to a level where only 40% of the state's facilities experience rates below their costs will require an appropriation of $57 million in new funds. This is exclusive of an additional $22 million needed to eliminate further reductions in payment ceilings for the current rate year of July 1, 2000 to June 30, 2001.

REDUCTIONS IN MEDICAID PAYMENT CEILINGS

Wisconsin's Medicaid payment system establishes various cost centers (most notably direct care, support services, and administrative services) and within these cost centers sets payment ceilings based on a percentage of the median of nursing facilities' costs. The median is determined by arraying per patient day costs of facilities from high to low and identifying the costs of the facility at the midpoint. By definition, payment ceilings established at the median assures that only one-half of all homes within each cost center are fully paid their Medicaid costs.

These payment ceilings have been substantially reduced over the past decade because budgeted funding for the nursing facility Medicaid payment system has failed to keep pace with increasing costs of care. These shortfalls have occasioned the collapse of the Medicaid payment ceilings within the State's reimbursement system. As a result, for the rate year ended June 30, 2000, only 17% of all nursing facilities were reimbursed their Medicaid costs; average Medicaid losses were almost $11 per patient day; and aggregate Medicaid losses for all Wisconsin facilities exceeded $100 million.

The Wisconsin State Medicaid program recently announced that further reductions in Medicaid payment ceilings will be imposed effective July 1, 2000. These reductions will make Wisconsin's Medicaid nursing home payment ceilings, expressed as a percentage of the median, the lowest in the country. As a result, 20% of facilities will receive a rate decrease for the 2001 fiscal year while another 46% will receive rate increases less than their actual cost increases. Average Medicaid facility losses will increase by an additional $2-$3 per resident day, or in excess of $300,000 per year for a 100 bed facility with a 70% Medicaid census.

Margins from other payors such as the federal Medicare program and private pay residents are not enough to subsidize losses of this magnitude. Such subsidies are declining due to Medicare payment reductions and growing competition and expanded housing and service options for private pay residents. Indeed, when comparing total revenues from all sources to total costs, the average margin for Wisconsin nursing homes in 1999 was a negative 4.79%.

CORRECTING THE PROBLEM

Increases in facility per diem care costs above the general rate of inflation are due to a number of factors including dramatic increases in resident acuity, the unparalleled labor shortage, record high levels in admissions and discharges, and higher vacancy rates. These factors, coupled with the recent Medicare nursing facility payment reductions under PPS, places facilities in a financially and operationally unstable situation. In short, facilities cannot afford to lose $11 per day on each Medicaid resident and still remain financially solvent. The Medicaid program, whose patients represent almost 70% of the nursing home population, must better compensate facilities for the costs of Medicaid patients.

We modeled the impact of modifying Wisconsin's Medicaid payment system for the rate year of July 1, 1999 to June 30, 2000 to establish ceilings at levels comparable to what other states have done that have recently redesigned their payment systems. Our analysis indicates that doing so would have required an annual increase in 1999-2000 Medicaid funding of approximately $57 million ($27/GPR, or state funds). This does not include the cost to eliminate the payment cuts for the current rate year of July 1, 2000 to June 30, 2001. We project an additional $22 million will be required to achieve that end.

Such a system would be reasonable, but not generous, reimbursing the Medicaid costs of approximately 60% of facilities. This approach can best be viewed as maintaining the status quo; it does not provide additional funding to remedy current staffing shortages or enhance employee wage and benefit packages.

INTRODUCTION AND PURPOSE

BDO Seidman, LLP (BDO) was engaged by the Wisconsin Health Care Association (WHCA) and the Wisconsin Association of Homes and Services for the Aging (WAHSA) to conduct a study on the financial condition of nursing home facilities in Wisconsin. Specifically, we were asked to determine whether facilities are experiencing serious financial difficulties, identify the major contributing factors, and estimate the fiscal impact of establishing a more reasonable Medicaid reimbursement system. BDO has worked extensively in the redesign of Medicaid payment systems throughout the country and a synopsis of their experience and expertise is included as Appendix 1.

Wisconsin's nursing facilities are in serious financial distress. We identified several factors leading to their poor financial condition, including federal Medicare payment reductions, declining nursing home occupancy levels and acute labor shortages. However, our analysis indicates, without question, that the inadequacies of the Wisconsin Medicaid payment system have had the greatest impact on the deterioration of the financial and operational condition of Wisconsin's nursing facilities.

ADEQUACY OF MEDICAID PAYMENT IN WISCONSIN

Medicaid is the primary payor source for nursing home care. In Wisconsin, almost 70% of nursing home residents have Medicaid as their payor source. Only 23% of the residents are private pay, with Medicare and managed care making up the difference.[1] As such, adequate Medicaid payment is the most important element in the fiscal equation.

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[1] Wisconsin Nursing Homes and Residents - 1998 Fact Book

We examined the adequacy of Medicaid payment by identifying the number and percentage of facilities being fully reimbursed their Medicaid allowable costs and analyzed the magnitude of the losses being incurred by facilities on Medicaid patients. We also compared Wisconsin to other states in relation to where they set their reimbursement ceilings or maximums. The higher the ceilings, the greater the number of facilities being paid all their Medicaid allowable costs in that cost center. Finally, we estimated the cost to develop a Medicaid payment system comparable to what other states have recently done to ensure fair and adequate payment for quality patient care.

EXISTING MEDICAID PAYMENT

In analyzing the adequacy of Medicaid payment, we utilized cost and rate data obtained from the Department of Health and Family Services, Division of Health Care Financing for the rate year of July 1, 1999 to June 30, 2000. Information was obtained in electronic format for 328 facilities whose rates had been set by the time we began this engagement. These 328 facilities represent approximately 75% of the nursing homes and Medicaid patient days statewide. The cost data, from 1998 "desk or field audited" cost reports, was inflated forward to the rate year using the Skilled Nursing Facility Market Basket Index, a nursing home inflation estimator. The inflation estimate was conservative, in that historically, nursing home inflation in Wisconsin exceeds this nursing home index by one to two percent annually. In other words, the allowable Medicaid expenses that were compared to Medicaid rates were likely understated.

The analysis revealed that only 17% of facilities in Wisconsin (57 out of 328) were fully reimbursed their allowable Medicaid costs for the rate year of July 1, 1999 to June 30, 2000. The average loss for 83% of Wisconsin facilities was almost $11 per patient day (ppd.). For a 100 bed facility, with a 70% Medicaid census, this represents an annual loss of approximately $250,000. Total Medicaid losses for the 271 facilities losing money on Medicaid exceeded $78 million. Extrapolating this loss to the universe of all Wisconsin nursing homes resulted in Medicaid losses for all Wisconsin facilities exceeding $100 million in 1999-2000. A breakdown, by type of ownership, is as follows:

Rate Year Ending 6/30/00	***For Profit***	***Non-Profit***	***Governmental***	***Total***
Numbers of homes paid 100% of Medicaid allowable costs	40	10	7	57
Percent of total	25.8%	8.5%	12.7%	17.4%
Number of homes losing money on Medicaid	115	108	48	271
Percent of total	74.2%	91.5%	87.3%	82.6%
Weighted average Medicaid loss per patient day	$7.23	$10.56	$15.88	$10.90

Even the proprietary sector, traditionally representing the lowest cost homes in the state, had only 26% of their facilities being fully reimbursed their Medicaid costs. Their losses were also substantial with an average loss of over $7 ppd, or $160,000 annually, for a 100 bed facility with a 70% Medicaid census.

Our analysis indicated that of the 271 homes (82.6%) experiencing Medicaid losses, over 70% (191) lost $3 ppd. or more, with over half losing at least $6 ppd. To be fiscally sound, facilities must not only be able to subsidize these losses which represent the costs that Medicaid allows but does not pay for, but also subsidize other costs incurred that Medicaid does not even recognize as allowable. Costs such as marketing, public relations, contributions, income taxes, out of state travel for education and training, bad debts, and certain legal and professional fees are simply not recognized by Medicaid in rate setting. Others, such as central office costs, are subject to limitations before recognition for rate setting.

BDO's experience, in Wisconsin and in other states, is that, on average, such cost disallowance's represent $2-$3 ppd. or $40,000-$50,000, for a 100 bed facility with a 70% Medicaid census. These losses have traditionally been subsidized by the Medicare program and private pay residents. As explained later in this report, due to

Medicare PPS, the Medicare subsidy for most homes is gone, leaving the burden on private pay residents.

In Wisconsin, 23% of the residents are private pay. A 100 bed nursing facility incurring a Medicaid loss of $11 ppd., plus $2 ppd. of disallowed expenses, must now charge private pay residents $50 more per day than the rates paid by Medicaid just to cover costs; let alone generate any margin. In 1998, rate differentials between Medicaid and private pay residents were approximately $30-$35 per day.[2] Facilities cannot simply raise private pay rates another $15-$20 per day. The market for these residents is highly competitive, not only among nursing facilities, but also because of the availability of other housing and service options such as assisted living. In addition, for many private pay residents, increasing rates simply means becoming Medicaid eligible that much sooner.

We examined the ability of facilities to subsidize Medicaid losses by determining whether total revenues covered total costs incurred by facilities in 1999. Revenue and cost data for 404 facilities was derived from 1999 "as filed" cost reports obtained in an electronic format from the Department of Health and Family Services, Division of Health Care Financing.

The average margin, expressed as net income or loss as a percentage of total revenue was a negative 4.79%. The analysis indicates that margins on other payor types are no longer adequate to fund Medicaid shortfalls.

As detailed further in both the Executive Summary and in subsequent sections of this report, the situation is only projected to get worse. Due to insufficient budgetary funding for the rate year of July 1, 2000 to June 30, 2001, 20% of facilities will receive a rate decrease for this period while another 46% will receive rate increases that will not cover their cost increases. The result for 2001 will be greater Medicaid

[2] Wisconsin Nursing Home and Residents - 1998 Fact Book

losses and fewer facilities being fully reimbursed their Medicaid costs than what is reflected in this report.

MEDICAID REIMBURSEMENT - WISCONSIN VS. OTHER STATES

Medicaid rate comparisons are often made among states, but higher rates are not necessarily an indication of a better or more equitable payment system. What is relevant is whether Medicaid reimbursement adequately covers the Medicaid costs incurred by nursing homes in that state.

For example, Medicaid rates in Mississippi are lower than in Wisconsin. The primary reason is that salaries and benefits paid to Mississippi nursing home employees are much less than in Wisconsin. However, more facilities in Mississippi are fully reimbursed their Medicaid costs than in Wisconsin because Mississippi sets ceilings at a higher percentage above the median cost of nursing home facilities. Thus, Mississippi's Medicaid payment system is more equitable in reimbursing Medicaid costs being incurred by facilities in their state.

There are no published comparisons among states of the percentage of homes being reimbursed their total Medicaid costs. Historically, many state agencies and provider associations did prepare such cost coverage analysis to insure compliance with the now repealed "Boren Amendment," a federal law which required that Medicaid rates be adequate to meet the costs that must be incurred by economically and efficiently-operated facilities. The standard or benchmark that evolved from that legislation was that adequate payment meant that at least 50% of facilities were fully reimbursed their Medicaid costs. Wisconsin, at 17.4%, fell woefully short of that mark in fiscal year 2000, and will do even worse in fiscal year 2001.

Our experience, based upon having prepared cost coverage analyses in over 20% of the states, and having worked in the development or application of Medicaid payment systems in numerous others, is that Wisconsin ranks near the bottom in adequately reimbursing the Medicaid costs of nursing homes. The reasons are twofold:

1. Wisconsin payment ceilings are now set at the lowest level of any state; and
2. Wisconsin has more cost centers than most states. Since each cost center has a separate ceiling, more cost centers mean fewer facilities are being fully reimbursed their total Medicaid costs.

The basic framework of Wisconsin's nursing home payment system has not changed significantly in over fifteen years. However, in that time, payment ceilings have been reduced in every cost center to compensate for Medicaid budgetary shortfalls. In direct care, for example, the ceiling, expressed as a percentage above the median, has been reduced from 13% above the median to just over 2% in fiscal year 2000. This represents a decline in the ceiling of about $6.00 per patient day or the equivalent of approximately five full-time direct care workers each day in a 100-bed facility. The following table reflects the dramatic change in ceilings between 1990 and 2000 and the estimated per patient day dollar impact. Appendix 2, on pages 20 to 22 of this report, graphically reflects the annual reduction in ceilings by cost center over the past decade in Wisconsin.

CEILINGS EXPRESSED AS A PERCENTAGE ABOVE MEDIAN

COST CENTER	*1990*	*2000*	*ESTIMATED REDUCTION IN CEILING AMOUNT P.P.D.*
DIRECT CARE	13%	2.3%	$6.00
SUPPORT SERVICES	9.5%	2%	$1.50
AMINISTRATION	12%	2%	$1.00
UTILITIES	15%	2%	$.25

We compared Wisconsin to other states in relation to where they set their reimbursement ceilings or maximums. Ceilings are usually set as a percentage above the median; the higher the percentage, the greater number of facilities being paid their allowable Medicaid costs, and the lower the Medicaid losses.

Data from 25 other states was obtained from a number of sources.[3] For each of these states, we identified the level above the median at which ceilings were set in direct patient care, indirect care (support services), and other operating costs (typically administration).

The data, reflected in Appendix 3 on page 23 of this report, indicates that the majority of the states (17 out of 25) set Medicaid ceilings in direct care at least 15% above the median. The lowest was 5% with the highest being 35%. Wisconsin, in comparison, set direct care ceilings at only 2.3% above median costs in fiscal year 2000, and will reduce that further to 0.3% above the median in fiscal year 2001. As a result of this reduction, nursing facilities in Wisconsin will be paid $6.5 million less for hands-on patient care than what they would have been paid had ceilings remained at the fiscal year 2000 level.

Relative to the indirect care and other operating cost centers, the data similarly indicates that ceiling levels in other states are also much higher than in Wisconsin. In these cost centers, the majority of states set ceilings at 10-15% above medians. In Wisconsin, support services, administration, and utility ceilings were established at only 2% above median costs in fiscal year 2000. In fiscal year 2001, these ceilings will be reduced to 5% below the median in support services, 8.8% below in administration and to the median in the utility cost center. As a result of this reduction, nursing facilities in Wisconsin will be paid $18.7 million less for support services, administrative costs, and utilities than what would have been paid had ceilings remained at the fiscal year 2000 level.

[3] The data was obtained from various sources including copies of state plans maintained by BDO, The 1999 Guide to the Nursing Home Industry and The 1998 State Data Book on Long-Term Care Programs and Market Characteristics. Data on ceilings for all states is not reflected. The ceiling data for some states was not provided in the publications or the state's reimbursement system was not cost-based or similar enough in design to that in Wisconsin to provide a valid comparison.

ADDITIONAL FUNDING NEEDS

We estimated the additional Medicaid funding required to increase ceilings to levels comparable with other states. We increased ceilings in direct care, support services, and administration to 15%, 10%, and 10%, above the median, respectively. Doing so, would require increased annual Medicaid funding of approximately $30 million ($14.3 GPR) for fiscal year 2000. However, doing so still results in only 26% of nursing home facilities receiving all of their allowable Medicaid costs, which leads to the second major problem with the system: that being too many cost centers.

The current Medicaid system has seven different cost centers, of which five have separate ceilings. The other two (property taxes and over-the-counter drugs) are reimbursed based upon actual costs incurred. Historically, many state agencies set multiple ceilings hoping to insure efficiency in each cost center. However, doing so has proven to be administratively burdensome, reduces facilities' flexibility in managing overall costs, and ignores the reality that expenditures in one cost center can impact those in another.

For example, a greater expenditure in Human Resources (an administrative cost) may lower turnover, increase productivity, and reduce costs in another cost center. Overall costs are reduced, but the provider may be penalized because of higher administrative costs. Establishing multiple cost centers, each with their own ceilings, is simply designed to reduce the number of facilities being reimbursed their Medicaid costs. It also often leads to gaming as facilities try to cost shift due to exceeding ceilings in one cost center while being below in another. States that have redesigned their payment systems in the past few years have reduced the number of cost centers to three or four; typically direct care, support services, and property.

We modeled the impact of modifying Wisconsin's payment system for fiscal year 2000 to one with three cost centers (direct care, support, and property) plus a pass-through of property taxes. Ceilings for direct care and support services were set at

15% and 10% above the median, respectively. The property payment was adjusted to be comparable to other states that provide adequate capital payment to cover both reasonable mortgage debt and costs associated with remodeling and renovation. This was accomplished by increasing the property payment ceiling by 2% from its current level of 7.5% of facility value to 9.5%. At one time, the ceiling was as high as 10.75% of facility value. Revising the payment system in this fashion would require increased annual Medicaid funding of approximately $57 million ($27/GPR) for 1999-2000. This approach would result in approximately 60% of facilities being fully reimbursed their Medicaid costs, with 40% still losing money on Medicaid.

Such a proposed system is not "generous" by any standard. It is equitable, given existing nursing home expenditure patterns and payment parameters in other states. However, it does not represent adequate funding for other initiatives such as rectifying staffing shortages, meeting nurse aide staffing levels for optimum care as defined in the Health Care Financing Administration's (HCFA) recent report to Congress on minimum nurse staffing, providing more competitive wage and benefit packages, or moving to a new classification and payment system similar to the Medicare PPS concept.

OTHER FACTORS CONTRIBUTING TO FACILITIES' FINANCIAL DIFFICULTIES

MEDICARE PPS

The financial condition of nursing home facilities has been adversely impacted by the Federal Medicare Prospective Payment System which reduced Medicare payments to nursing homes by 10%, or $1.3 billion, from 1998 to 1999. For major nursing home companies, Medicare per diem payments fell by 20% from the second quarter of 1998 to the fourth quarter of 1999. Since July 1998, more than 1,800 skilled nursing facilities across the country have declared bankruptcy including five of the seven largest nursing home companies.[4] Over the past two and one-half years,

[4] LTC Payment and Regulatory Alert - June 8, 2000

the equity market for major nursing home companies fell by nearly $12 billion with the average share price falling by 77%.[4] In Wisconsin, 43 facilities are in bankruptcy, representing over 10% of the facilities in the state. This percentage is over double that of surrounding states in the Midwest where the percentage of facilities in bankruptcy is 4.8%.[5]

Congressional Budget Office projections now show that Medicare nursing home spending between 1998 and 2004 will be $15.8 billion less than projected, which is twice the payment reduction intended by Congress for nursing home facilities.[6] Based upon these projections, the reduction in Medicare payments to Wisconsin nursing homes is estimated at $772 million.[7]

The severe Medicare cuts have serious Medicaid rate implications. Historically, Medicaid programs, like that in Wisconsin, paid only 90-95% of facilities' Medicaid costs, knowing that the difference could be subsidized by private pay patients and Medicare margins. With Medicare margins substantially reduced, or in many cases, totally eliminated, Medicaid programs must now pay a higher percentage of Medicaid costs for facilities to be financially and operationally viable.

OCCUPANCY

Occupancy in nursing homes has declined significantly. Based upon 1998 data, average occupancy in Wisconsin nursing homes is down to 87%; a decline of almost five percent from 1993.[8] Service delivery options such as assisted living and home and community-based programs have greatly expanded, resulting in lower nursing home census.

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[5] Survey of state affiliates by the American Health Care Association

[6] Lewin Group - "Briefing Chartbook on the Effect of the Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999 on Medicare Payments to Skilled Nursing Facilities" - May 10, 2000.

[7] Lewin Group - "Impact of the BBA and BBRA on Medicare Payments to Skilled Nursing Homes in Each State" - August 4, 2000.

[8] Wisconsin Nursing Homes and Residents - 1998 Fact Book

That census, however, is a sicker, more frail population requiring more costly services. In Wisconsin, the number of nursing home residents in need of skilled services or intensive skilled nursing care at time of admission has increased from 79.4% in 1988 to 97% in 1998. In addition, while average skilled nursing home census in Wisconsin has declined by some 3,300 residents since 1990, average admissions in that same time period have increased 93% from 26,451 to 51,005[9]. As a result, lengths of stay are much shorter, indicating treatment of patients with more complex medical and rehabilitative problems and an elderly population entering nursing homes at much later stages in their lives. In addition, many facilities have experienced a significant increase in the number of residents with significant behavioral symptoms and problems requiring additional staff and treatment resources.[10]

The combination of greater vacancy rates and a more costly nursing home patient has increased annual per diem costs in nursing homes greater than the general level of inflation. Unfortunately, Medicaid budgetary increases over the years have not kept pace, forcing reductions in Medicaid payment ceilings and increased Medicaid losses for most facilities.

LABOR SHORTAGE

Unemployment rates are at all time lows, making it extremely difficult to recruit and retain employees in an industry that struggles to develop a positive image, and where the workload is extremely demanding and difficult. A recent study by the University of Wisconsin-Milwaukee places the position of certified nursing assistant at the top of the list of most difficult positions to fill.

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[9] Wisconsin Nursing Homes and Residents - 1998 Fact Book
[10] Legislative Audit Bureau Evaluation 00-01; County Nursing Home Funding, January 2000

As such, nursing homes have had to increase salaries and benefits significantly beyond normal price inflation simply to remain competitive. Even after doing so, most facilities still have a significant number of unfilled positions. The May 1999 Report of the Workforce Development Group indicates that 14% of available positions for long term care workers statewide are vacant.

A 100 bed nursing facility, with 14% of its positions unfilled, is short approximately 70 hours per day of needed patient care services. These staffing shortages put an added burden on existing employees often leading to increased turnover (which already stands at over 100% for all long term care workers[11]) and forces facilities to utilize contracted temporary nursing help at a much higher cost. Staffing shortages also increase the probability of serious deficiencies. The HCFA's recent report to Congress on "The Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes" indicates strong associations between low staffing and the likelihood of quality problems.

The recent Medicaid wage pass-through, targeted at certified nursing assistants, has helped, but it has not made a serious dent in the ability of facilities to obtain a full complement of needed staff. This is due to a number of factors including the availability of thousands of other job opportunities for prospective employees, the high stress levels and physical demands of nursing home work, a compensation package that is not competitive with other industries, and a negative public image.

The labor problem has been exacerbated by inadequate Medicaid payment. Reductions in Medicaid ceilings over the past decade have not allowed facilities to remain wage and benefit competitive with other industries or even with other nursing homes whose compensation packages are at the high-end of the compensation scales. The Medicaid payment system (with the exception of the wage pass-through funding) also does not timely reimburse cost increases that exceed the general level of inflation. A provider, under ceilings, that substantially enhances their wage and

[11] Workforce Development Group Report - May 1999

benefit package beyond normal inflation is not reimbursed that cost for at least 18 months, and then only prospectively. Most facilities do not have the cash flow to absorb such shortfalls for eighteen months.

CONCLUSION

Nursing home facilities are in a well-documented financial crisis. The reduction of Medicaid payment ceilings over the past decade, plus the reductions in fiscal year 2001, places the Wisconsin Medicaid payment system among the worst in the country. The system has eroded to the point where other payors can no longer compensate for the significant Medicaid shortfalls in payment. The problem has been compounded by excessive cuts in Medicare payment, higher vacancy rates, increasing patient acuity, an unparalleled shortage of labor, and greater competition for private pay residents.

The elderly, their families and advocates, and nursing home regulators demand and expect a high quality of care and improved patient outcomes. Such expectations come with a price tag. For the system to work, nursing home facilities and the state must partner together; facilities meeting quality of care expectations, and the state compensating them fairly and equitably for high quality care.

In summary, the Wisconsin nursing home Medicaid payment system needs simplification and an estimated increase in funding of nearly $80 million[12] to:

- Erase the erosion in payment levels that has occurred over the past decade;
- Equitably compensate facilities for the cost of Medicaid patients;
- Achieve comparability with others states in Medicaid cost coverage; and
- Assure the financial and operational viability of nursing home facilities in Wisconsin.

[12] The $80 million represents $57 million in new funds to increase ceilings above fiscal year 2000 levels plus an additional $22 million to eliminate the proposed reduction in cuts for fiscal year 2001.

APPENDICES

About BDO Seidman, LLP

BDO Seidman, LLP (BDO) is an accounting and consulting organization servicing clients through more than 40 offices and 50 alliance firm locations across the United States. As a member firm of BDO International, BDO leverages a global network of resources to serve clients abroad through more than 490 members firm offices in over 80 countries.

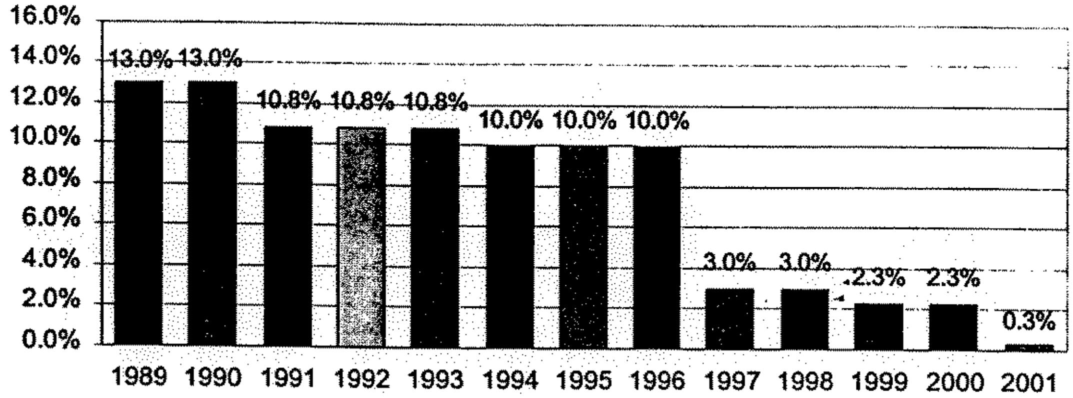
The firm maintains a number of specialized service lines, one of which is healthcare. BDO services hundreds of long-term care facilities, of all ownership types, throughout the United States, providing accounting, auditing, tax, feasibility, and specialized consulting in areas such as reimbursement, clinical operations, and corporate compliance.

The primary author of this report is Joseph M. Lubarsky, a partner and the firm's National Director of Long Term Care Services. He personally has provided consulting services to nursing home associations in 20 states. His work includes conducting cost impact studies and studies on the adequacy of payment systems, designing and developing new Medicaid payment systems, and providing litigation support.

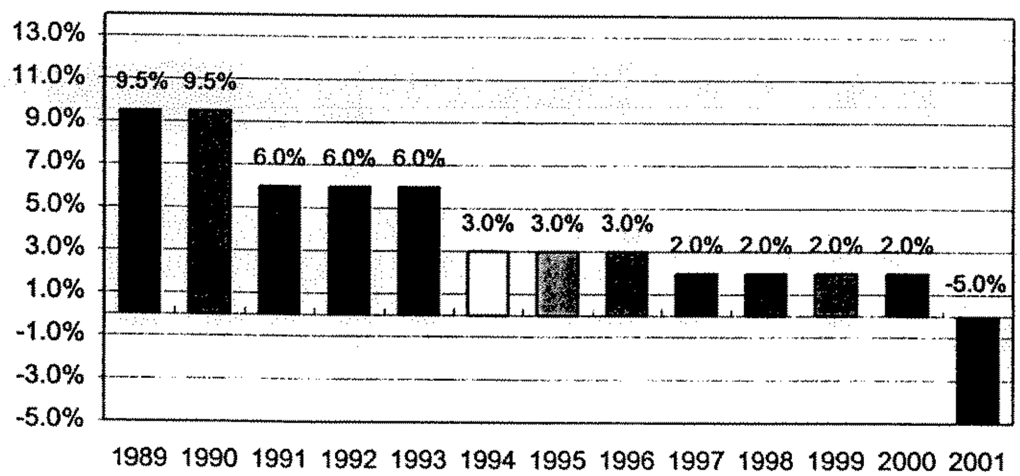
In the past two years, Mr. Lubarsky has served as lead consultant to associations on the redesign of Medicaid payment systems in Kentucky, Idaho, and Colorado. He is currently involved in the redesign of the Medicaid payment systems in Virginia, New Jersey, and Arkansas.

WISCONSIN NURSING HOME MEDICAID PAYMENT CEILINGS BY YEAR

CEILINGS EXPRESSED AS A PERCENTAGE ABOVE (OR BELOW) MEDIAN



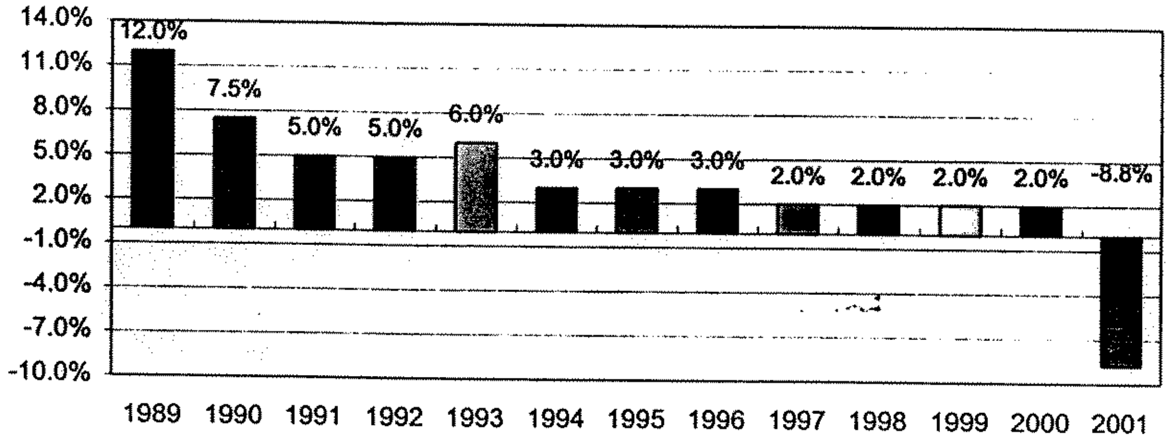
DIRECT CARE



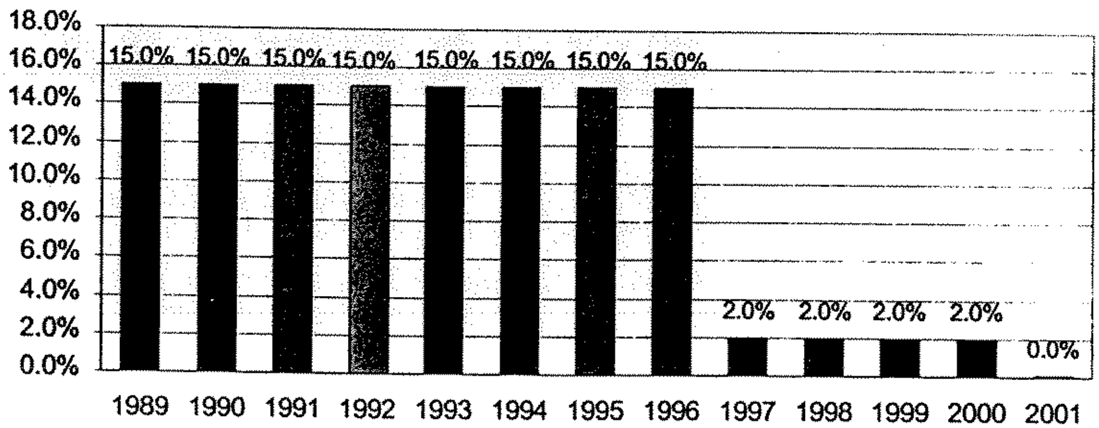
SUPPORT SERVICES

WISCONSIN NURSING HOME MEDICAID PAYMENT CEILINGS BY YEAR

CEILINGS EXPRESSED AS A PERCENTAGE ABOVE (OR BELOW) THE MEDIAN

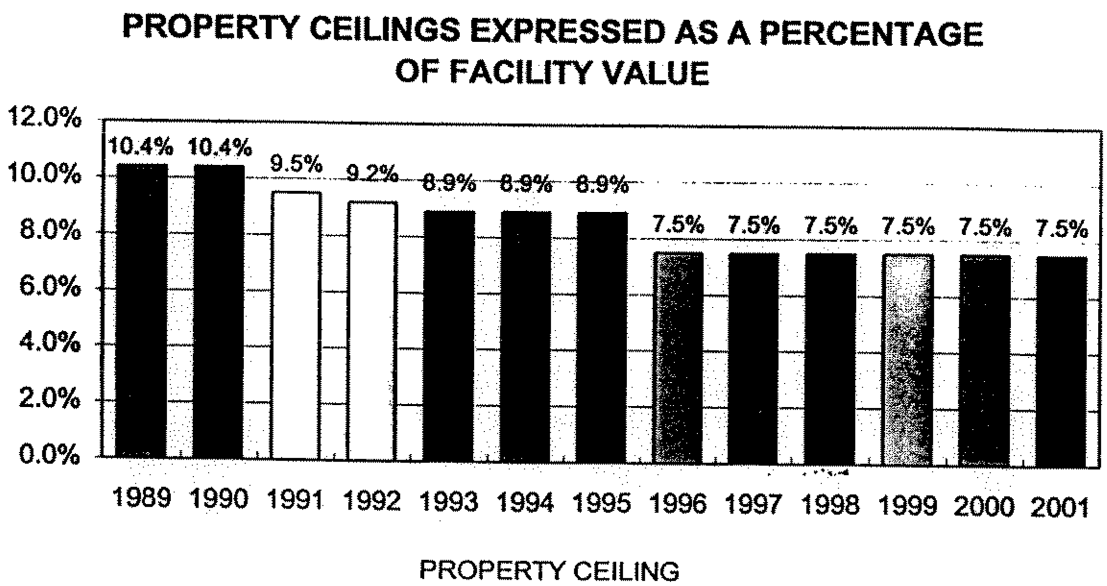


ADMINISTRATION



UTILITIES

WISCONSIN NURSING HOME MEDICAID PAYMENT CEILINGS BY YEAR



Medicaid Component Ceilings as a Percentage of Median Costs

State	Direct Care (1)	Indirect Care (1)	Operating Cost (1)
Connecticut	135%	115%	100%
Idaho	128%	123%	
Colorado	125%	120%	
Kansas	125%	130%	115%
Minnesota	125%	110%	
Nebraska	125%	115%	115%
South Dakota	125%	110%	
Wyoming	125%	105%	
Ohio	124%	113%	
Mississippi	120%	120%	109%
Missouri	120%	110%	
Pennsylvania	117%	112%	104%
Hawaii	115%	110%	
Vermont	115%	100%	
Maine	112%	110%	108%
Virginia	112%	108%	
Alabama	110%	110%	105%
Indiana	110%	100%	
New York	110%	108%	
Montana	109%	103%	
South Carolina	105%	105%	105%
Georgia	90th (2)	85th (2)	70th (2)
North Carolina	80th (2)	Flat Rate	
Maryland	75th (2)	119%	114%
Kentucky	(3)	(3)	
Wisconsin	**100%**	**95%**	**91.8%**

(1) Some states have two cost centers, while others have three; the third usually being administration.

(2) Ceiling is computed as a percentile, rather than percentage of the median. For example, 90th percentile represents that ceiling is set at a level whereby 90% of facilities are fully reimbursed their costs.

(3) Kentucky reimburses under a price system based upon a model rate for all facilities (adjusted for acuity). The model rate is set high enough so that 60-70% of facilities are fully reimbursed their costs.

Trempealeau County Health Care Center

PHILLIP J. BORRESON, EXECUTIVE DIRECTOR JO SMIEJA, ADMINISTRATOR

TO: Senate Health, Utilities, Veterans, and Military Affairs Committee

FROM: Trempealeau County and Pigeon Falls Health Care Centers

DATE: 2/19/01

RE: ***Nursing Home Reimbursement Rates and Staffing***

Present Status of Facilities

Financial Condition:

The Trempealeau County Health Care Center is a 154-bed facility with 98 to 100% of its resident population "medicaid eligible". Our medicaid loss in calendar year 2000 was $596658 (unaudited).

- The facility was just advised of its medicaid rates retroactive to July 1st, 2000. The rates at all care levels were reduced increasing our loss to over $600,000 for the year. The primary reason for the reduction is that we were moved from the moderate to low medicaid labor region reimbursement.
- The facilities cost for Health Insurance increased by $25000 dollars a month effective December 1st, 2000 in addition to energy costs and other like costs experienced by all.
- We provide "specialized services" for the chronic mentally ill and for the behaviorally disturbed. For specialized services we are to receive $9.00 day. This was the rate determined in 1988 to be the cost for the provision of specialized services. This rate has not increased since then, but certainly the acuity has.
- Our medicaid loss in excess of $25.00 day results from our direct care cost center as our administration, dietary, and environmental cost centers are largely reimbursed.
- A long waiting list exists for admission to our facility.

The Pigeon Falls facility is a 41 bed nursing facility that is 80% plus medicaid with a loss of $129,351 for calendar 2000. This loss of $9.59 a day would be considerably larger but we have been able to keep our administrative costs some $2.38 a day below the medicaid target resulting in a $.32 a day incentive and our support service costs have been below target allowing a $.16 a day incentive there.

- The facility just received its medicaid rate notice effective July 1st, 2000 reducing its rates, dependent on level of care, from $1.83/day to $4.35/day.
- The facility has a small waiting list for services.

Staffing:

- We are fully staffed with a fine staff of Certified Nursing Assistants with the exception of a couple of odd hour staffing shifts that are vacant i.e. every other weekend PM shift (occasional).
- We have a number of applications on file for C.N.A.'s most of course looking for benefit eligible positions. Our wages and benefits exceed most nursing facilities. For instance in 1999 our wages per a Nursing Home Association comparative report averaged $10.16/hr compared to all homes statewide of $9.31/hr and our fringes at 39.23% of wages vs. all homes at 19.17%. We since have provided a wage pass through that exceeded the 5% pass through by $31072 (the latter was calculated by DHFS). Wages and benefits do make a difference when retaining and/or recruiting staff.
- Our turnover rate is approximately 3% for nursing services
- For the wages and benefits we pay our employees we (meaning County Health Facilities) are considered high cost and inefficient.
- We await payment for the final nursing home wage pass through settlement.
- We are presently looking for ways to reduce our number of Certified Nursing Assistant's due to the reduction in Medicaid rates. The only real way of doing this results in a decrease in direct care staff to residents.
- Licensed nursing staff are increasingly difficult to recruit especially for evenings, nights and weekends. We are looking at replacing licensed nursing staff with medical technician's but are somewhat apprehensive because of our large psychiatric population and the disproportionate share of psychotropic administered.

Future Status of Facilities

At the present time we are losing substantial dollars resultant from our commitment to the quality we have elected to provide our residents. The options are clear:

- Work with the State legislature to add State dollars to the medicaid formula so as to continue providing the quality care, rehabilitation, and treatment we provide today.
- Work with the Legislature and the DHFS to provide innovative methods, incentives, to provide care.
- Request more money from the Trempealeau County tax payer.
- Reduce staff to required minimums providing marginal care. Currently our staffing pattern is significantly above the minimums, as are our Bureau of Quality Assurance survey results.
- Sell the facility to an organization that will provide less pay and benefits to its direct care employees.

Thank you for being here today to listen to our needs. We need fiscal relief if we are to continue. Thank you!!

A PROPOSED LEGISLATIVE SOLUTION TO THE UNDERFUNDING OF NURSING HOMES BY THE WISCONSIN MEDICAID PROGRAM

The Issue: The Wisconsin Medicaid Program fails to fund/reimburse 83% of the nursing facilities in this State for the costs they incur to serve their Medicaid residents. Stated differently, the deficit between the costs nursing facilities incur to care for Medicaid residents and the reimbursement government provides to pay for the costs to care for those Medicaid residents is $100 million. These findings came from a September 2000 study of the financial condition of Wisconsin nursing facilities conducted by BDO Seidman, LLP, an accounting and consulting firm which concluded the Wisconsin nursing facility payment system "ranks near the bottom in adequately reimbursing the Medicaid costs of nursing homes" compared to payment systems in other States.

The Proposed Solution:

1) Provide for a 4% Medicaid rate increase for nursing facilities in each year of the 2001-03 biennium.
2) Restore the $22 million in cuts made to the 7/1/00 – 6/30/01 Nursing Home Payment Formula.
3) Collapse the current seven nursing facility cost centers funded through the Nursing Home Payment Formula into three: direct care, indirect care, and capital.
4) Establish the Medicaid payment ceilings for services provided under those three cost centers (also known as "targets") at 115% of the statewide median of nursing facility direct care (nursing) costs, 110% of the statewide median of facility indirect care costs (laundry, housekeeping, dietary, maintenance, fuel and utilities, property taxes, and administrative/general), and capital costs at 9.5% of a facility's value.

The Cost to Fund This Solution: $48.7 million GPR in 2001-02 and $65.4 million GPR in 2002-03.

The Rationale:

1) Because the 2% Medicaid rate increase the Governor and the Legislature provided nursing homes in 2000-01 did not approach the 4.58% increase in Medicaid costs the average nursing facility was incurring, the Nursing Home Payment Formula had to be cut by $22 million for July 1, 2000 – June 30, 2001.

2) In order to cut the 7/1/00 – 6/30/01 nursing home formula by $22 million, the cost center targets had to be lowered. The direct care target, the maximum amount Medicaid will pay Wisconsin nursing facilities for the nursing costs they incur, was cut from 102.3% of the statewide median to 100.33% of the statewide median under the 7/1/00 – 6/30/01 formula. In support services (laundry, housekeeping, dietary and maintenance), the target was dropped from 102% of the statewide median to 95%.

3) By contrast, the BDO Seidman study found that in 25 state nursing home payment systems reviewed, 17 of those 25 states set direct care targets at least 15% above the median. The range was from 5% above the median to 35% above the median, compared to Wisconsin's 0.33%. The same was seen in indirect care, where the majority of states reviewed set targets between 10-15% above the median. In Wisconsin, the target is 5% <u>below</u> the median in support services, is at the median for fuel and utilities, and is 8.8% <u>below</u> the median for administrative costs.

4) The Wisconsin Department of Health and Family Services has stated Wisconsin's Medicaid rates for nursing facilities are 28th highest in the nation. We are not certain whether that is something to be proud of or ashamed of. However, according to the BDO Seidman study, "higher rates are not necessarily an indication of a better or more equitable payment system. What is relevant is whether Medicaid reimbursement adequately covers the Medicaid costs incurred by nursing homes in the state….Our experience, based upon having prepared cost coverage analyses in over 20% of the states, and having worked in the development or application of Medicaid payment systems in numerous others, is that Wisconsin ranks near the bottom in adequately reimbursing the Medicaid costs of nursing homes."

5) The BDO Seidman study stated there are two primary reasons why Wisconsin's Medicaid payment system for nursing homes ranks near the bottom: Because the targets now set are at the lowest level of any of the 25 states studied and because our seven cost centers are more than most states. More cost centers mean fewer facilities are being fully reimbursed for their Medicaid costs since each cost center has its own target.

6) In order to modify Wisconsin's payment system to make it comparable, though clearly not superior, to other states, BDO Seidman recommended the current seven cost centers be collapsed into three and that the targets be set at 115% of the statewide median for direct care, 110% for indirect care, and 9.5% of a facility's value for capital. Under this proposal, the number of facilities which would be fully reimbursed for their Medicaid costs would increase from 17% to 60%.

7) Even making Wisconsin's payment system comparable to nursing home payment systems in effect throughout the country will still leave 40% of the state's 442 nursing facilities not being fully paid for the Medicaid costs they've incurred.

8) Collapsing the number of cost centers and raising the targets of the three new cost centers will only attack the $100 million "structural deficit" nursing facilities currently face. It merely is an approach to maintain the status quo; it does not provide additional funding to remedy current staffing shortages or enhance employee wage and benefit packages.

9) The 4% Medicaid rate increase proposed for nursing facilities in each year of the 2001-03 biennium is a realistic projection of facility inflationary costs. Any percentage increase lower than real inflation will exacerbate the current Medicaid deficit and will fail to address the critical staff recruitment and retention problems facing nursing facilities today. If those problems aren't adequately addressed, access to quality care may be jeopardized.

Grand View Care Center Blair Wi

Adding Life to Years

Generations Caring for Generations

July 1,- June 30,Audit Data

09/15/00

Fiscal Years	1999-2000	1998-1999	99-00 less 98-99
Total Wages & Benefits Paid	$2,697,989	$2,411,846	
Increase in Wages & Benefits			$286,143
Labor Costs As % of Tot Costs	71%	69%	
Care Days basically the same	34,306	34,259	47
Financial Information			
In $ per day of care			
Total Revenue	$105.66	$102.56	$3.10
Total Expenses	$110.23	$101.42	$8.81
Net Loss	($4.56)	$1.14	($5.71)
Av Medicaid Revenue	$93.34	$93.34	$0.00
Av Medicaid Exp	$104.94	$96.75	$8.19
Net Medicaid loss	($11.60)	($3.41)	($8.19)
Susidization by other Payors	$7.03	$4.55	$2.48
Total Wages & Benefits Paid	**$78.64**	**$70.40**	**$8.24**
Nursing Care	$43.57	$39.32	$4.26
Fringe benefits	$12.14	$10.70	$1.45
Dietary Services	$6.34	$5.38	$0.96
Administration	$5.89	$5.57	$0.32

COLUMBIA "Building Bridges To Better Health"
HEALTH
CARE
CENTER

March 20, 2001

Dear Members of the Senate Health, Utilities, Veterans and Military Affairs Committee,

Columbia Health Care Center (C.H.C.C.) is a 149 bed nursing facility located in beautiful Wyocena. We are a County facility and give excellent care to 120 residents. Our residents are not your average nursing home resident; they require a lot of skilled care and behavior interventions. We often take residents who other facilities will not admit.

Our census continues to decline due to alternative care options in the community. Due to declining admissions and reimbursement rates we are investigating alternative revenue sources to better utilize our staff and resources. Currently we have 3.3 professional F.T.E. positions available; these positions have not been filled for over two years because there are no applicants. The professional hours have been covered through over time and nurse staff agencies. We also have 12.5 C.N.A. F.T.E. positions available. Some of these positions have not been filled in years due to availability of staff. Columbia Health Care Center provides C.N.A. training in house and often runs classes every other month. C.N.A. students are paid while in class so there is no lapse in income for people changing careers. Currently we are working with CESA 5 to train high school students to become C.N.A.s. The turnover in these is often due to stress, both emotional and physical. We have developed an employee retention committee that addresses retention for both long term and new employees. Through this committee we have developed a peer system to assist new employees as they orientated to C.H.C.C.

The cost of providing care continues to escalate and the reimbursement received from Medical Assistance does not begin to cover the costs. C.H.C.C. receives $101.06 for each skilled resident each day. C.H.C.C. continues to exceed the direct care cost ceilings in order to provide the care our residents require. Last year C.H.C.C. had a medical assistance deficit of $704,691.00, of which $487,438.00 was direct care. Please increase the direct care ceilings to 13% above the median to cover our staffing hours, wages, benefits and care we provide our residents.

Thank you for your attention to this matter.

Sincerely,

The Staff of Columbia Health Care Center

323 W. Monroe St. P.O. Box 895 Wyocena, WI 53969 - 0895
Telephone : (608) 429 - 2181

Linda Hoel - Administrative Assistant
Bonnie Palmer - RN, Nurse Manager
Betty Tilmoh RN, C
Angie Billiott CNA/CMA
Jennifer Larson CNA/CMA
Angela Stensrud, RN
Joan Farrington LPN
Jerri L. Coyle CNA
Helen Driell C.N.A.
Dawn Banks CMA
Bea Stahl CNA
Sue Steiner CMA/CNA
Donna J. Farrington CNA
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Mary A Yansma CMA
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Anastasia Balden
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Nancy Alexander
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Heidi Otto CMA
Lilac Sundsmo
Raine Schroeder
Frank Mossa
Sharon [illegible] Director of Nursing
Mary Bendick LPN
Lisa Calkins Medical Records
Traci C. Hohn, Human Resources Mgr.
Paula Branton SSA + CNA
[illegible] Housekeeping [illegible]
Marie Bartels Housekeeping Aid
Amy E Yamasita, NHA

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