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The Health Care Council of Illinois was formed in late 2007 to serve as the public policy entity for both the Illinois Health Care Association and the Illinois Council on Long Term Care.

This new entity provides the framework for a unified message on all issues involving legislation, regulatory and political activities. The Health Care Council of Illinois-PAC was also formed in conjunction with HCCI to orchestrate the political contributions and activities for the new organization.

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Testimony before Senate Deficit Reduction Committee

Co-Chairs: Senator Donne Trotter & Senator Matt Murphy

By

Pat Comstock, Executive Director
March 10, 2009

Good Morning Chairman Trotter, Chairman Murphy and members of the Committee. My name is Pat Comstock and I am the Executive Director of the Health Care Council of Illinois, the merged public policy arm of the Illinois Health Care Association and the Illinois Council on Long Term Care. In addition to the comments we have already provided, the time I have with you today will be spent explaining our funding priorities going forward.

Sufficient funding to provide needed services for nursing home residents and payment predictability are the top two issues for the long term care profession in Illinois.

These issues are not just about the profession's bottom line; they have dramatic consequences on the state's frailest and poorest elderly residents, whose care is being paid for by the State of Illinois. The profession values its relationship with state government, both regulators and funders, and prides itself on its willingness to work with advocates and other providers to ensure the highest quality of services is provided to seniors regardless of whether they receive their care in a nursing home or a private residence.

The face of nursing home residents has changed dramatically over the last few years. **Over 40% of our residents leave and return to the community within 90 days of admission.** In fact, the Department of Public Health recently reported that nursing homes experience, on the average, a **200% turn-over** in residents each year. This number was only a 100% a few years ago.

A typical longer term resident is:

- Over 80 years old
- Cognitively impaired.
- Unable to perform such basic activities as eating, toileting, walking, personal hygiene, bathing, transferring, bed mobility, and dressing.
- Involved in at least 2 restorative programs, such as a scheduled toileting program.
- Requires intensive nutrition services.
- Needs pain management services.

It is easy to get caught up in the numbers. But what we do in long term care is not about the numbers...it is about the residents we serve.

The Numbers

But it takes dollars and cents to provide services and providing for the housing, nutrition and medical care for our state's frailest and poorest elderly is no exception.

I hope you will bear with me as I give you a short tutorial on how the nursing home rate it built, funding sources, our current funding dilemma, and how we stack up to other states.

Rate Components: The nursing home rate is made up of 3 components: Capital, Support, and Nursing.

In theory each nursing home is reimbursed for its actual overhead - food, heating, and cooling - as they are reported annually to the state on verified costs reports. In reality, facilities today are being paid on the basis of their costs in 2004. This occurs because the state has historically managed cash flow by manipulating which cost report year is used as the basis for calculating reimbursements.

Nursing Component: The General Assembly passed legislation in 2006 to shift the states reimbursement system to one based on the federally designed Minimum Data Set (MDS), which promotes high quality services. This new funding mechanism is in its 3rd year of implementation. It is imperative that this commitment be honored and the phase-in proceeds as agreed.

Nursing Home Revenue Sources: Nursing homes are paid from two sources: the Long Term Care Provider Fund and GRF. The Long Term Care Provider Fund is the first payer and GRF is appropriated to fill the gap between the fund and the actual cost of providing care. The nursing home licensure tax and a portion of the state's tobacco taxes are among the revenue streams that flow into the Long Term Care Provider Fund.

FY 09 Funding Crisis: The nursing home appropriation is a balancing act between the two funds. If the state appropriates from the Long Term Care Provider Fund an amount in excess of what revenues will flow into the fund and under appropriates from GRF, appropriation authority to reimburse nursing homes for care provided will fall short. This is the situation we are in this year. When nursing homes are paid for care provided in SEPTEMBER ---- let me repeat that – yes we have been carrying the state since August. When nursing homes are paid for care provided in September, GRF appropriation authority will be fully expended. This coupled with what appears to be a shortfall in revenues flowing into the Long Term Care Fund could result in the state carrying approximately 7 to 10 months of nursing home debt in to FY 10. At a cost of about $120 million a month, we are talking about a billion dollars of old debt moving into FY 10, unless more GRF appropriation authority is granted this spring.

Why are we in this situation? A full five months of nursing home payments were carried into FY 09 from FY 08 and paid out in the month of July. In addition, the FY 09 budget cut approximately $300 million of what was characterized as excess spending authority from the nursing home budget lines.

Opportunity: The Federal Stimulus Package, signed into law in February, provides the state with the opportunity to get caught up on old Medicaid bills by using the increased federal match to pay back debt. At the same time, Illinois can not qualify for the enhanced 60% match, unless certain Medicaid providers achieve a 30 day payment cycle by June 1 of this year. Yes.....nursing homes would have to go from the current 150 days of payment delays to a 30 day payment cycle in less than 3 months. While this can't happen without some sacrifice and we believe short term borrowing, it does give the state the opportunity to get on track and put a halt on carrying massive amounts of nursing home debt into the new fiscal year.

Maintaining the Cycle: Maintaining a reasonable payment cycle is only one of the challenges the state faces as we move into FY 10. In reality the lack of predictability of when payments will be received has been even more problematic. For example, facilities received 5 months of back payments in July and then waited until September to be paid for services rendered in July. No additional payments were received until short term borrowing occurred at the end of December.

Facility operators are business people. Given the state's payment history, they have built into their business plans payment cycle delays, managing them through bridge loans with no reimbursement for interest paid. In our current economic crisis, creditors who routinely provide bridge loans for even the largest operators have raised grave concern about the erratic payment schedules.

A Place Called Home: For some, nursing homes may seem like a cash cow industry that if we just trim back their rates, move residents out, and shut down beds, the state can afford to bring other kinds of programs on line. Yet in reality, as of January 1, 2009, Illinois pays, on the average, $117.51 each day for 24-hour skilled care for elderly Medicaid residents. At the same time, it costs about $150.39 per day to provide the complex medical care most residents require. This creates a $32.88 per day shortfall. Since two thirds of all nursing homes residents have their care paid for by Medicaid, private pay residents can no longer bridge this gap. For many nursing homes, Medicare is what allows them to keep their doors open and underwrites an ever growing portion of the states Medicaid reimbursement rate shortfall.

The nursing home profession in neighboring states faces a much less onerous outlook, although shortfalls do exist. Iowa has only a $9 per day shortfall, Missouri $14.88 per day shortfall, and Indiana a $6 per day shortfall. Nationally, Illinois ranks 49th in the nation for Medicaid reimbursement for nursing home residents. While some rating services rank Illinois slightly higher, Illinois ranks consistently in the bottom 10% of the states. Tables produced by Eljay, LLC, a consulting firm engaged by the American Health Care Association to track Medicaid expenditures can be found in your packets.

Other real problems exist with taking this cavalier attitude towards reducing the state's commitment to providing residential medical care to the elderly.

- Long term beds and rehab beds are not licensed separately. It would be fool hardy to reduce rehab beds with the trend of releasing people of all ages from the hospital before they can safely care for themselves on the rise.
- Stripping beds without thoughtful planning can have the consequences of separating families and forcing loved ones to live out their last years isolated from family and friends.
- While closing beds reduces expenditures it also reduces revenue, because provider taxes are paid on the basis of the number of licensed beds.

In reality, government must refocus its attention on the elderly person in the nursing home bed and remain ever mindful that 52,000 frail elderly Illinoisans call a skilled nursing facility their home. It is incumbent on all of us to work together to make sure that when the need arises, a bed will be available, an elderly person will get the medical care they need, and will always have a place to call home.

TABLE I
STATE-BY-STATE COMPARISON OF RATES AND COSTS

State	Rate 06	Cost 06	Difference 06
Arizona	$ 139.98	$ 158.40	$ (18.42)
Arkansas	$ 130.40	$ 129.16	$ 1.24
California	$ 144.53	$ 152.61	$ (8.08)
Colorado	$ 159.27	$ 167.42	$ (8.15)
Connecticut	$ 204.50	$ 215.90	$ (11.40)
Delaware	$ 212.95	$ 237.35	$ (25.00)
Florida	$ 165.69	$ 179.43	$ (13.74)
Georgia	$ 117.51	$ 128.78	$ (11.27)
Hawaii	$ 196.25	$ 203.88	$ (7.63)
Idaho	$ 153.89	$ 159.44	$ (5.55)
Illinois	$ 98.94	$ 125.10	$ (26.16)
Iowa	$ 111.29	$ 122.47	$ (11.18)
Kansas	$ 116.78	$ 130.32	$ (13.54)
Maine	$ 164.78	$ 177.57	$ (12.79)
Maryland	$ 186.41	$ 192.28	$ (5.87)
Massachusetts	$ 180.40	$ 199.04	$ (18.64)
Michigan	$ 171.61	$ 173.92	$ (2.31)
Minnesota	$ 143.33	$ 165.69	$ (22.36)
Missouri	$ 109.45	$ 128.23	$ (18.78)
Montana	$ 150.31	$ 151.02	$ (0.71)
Nebraska	$ 136.41	$ 143.99	$ (7.58)
Nevada	$ 164.80	$ 171.27	$ (6.47)
New Jersey	$ 189.46	$ 212.43	$ (23.03)
New Mexico	$ 135.60	$ 157.46	$ (21.86)
New York[1]	$ 196.72	$ 219.59	$ (23.87)
North Carolina	$ 133.99	$ 144.62	$ (10.63)
North Dakota	$ 148.72	$ 151.23	$ (2.51)
Ohio	$ 162.88	$ 170.09	$ (7.21)
Oklahoma	$ 117.15	$ 123.27	$ (6.12)
Oregon	$ 179.59	$ 184.15	$ (4.56)
Pennsylvania	$ 180.08	$ 197.56	$ (17.48)
Rhode Island	$ 169.53	$ 184.67	$ (15.14)
South Dakota	$ 113.10	$ 127.31	$ (14.21)
Tennessee	$ 131.05	$ 132.38	$ (1.33)
Texas	$ 105.46	$ 112.57	$ (7.11)
Utah	$ 142.85	$ 156.22	$ (13.37)
Vermont	$ 160.70	$ 189.82	$ (29.12)
Virginia	$ 132.52	$ 137.74	$ (5.22)
Washington[2]	$ 138.74	$ 160.30	$ (21.56)
Wisconsin	$ 130.73	$ 152.94	$ (22.21)
Wyoming	$ 139.54	$ 163.96	$ (24.42)

[1] Prior to 2006 in New York State, pharmaceuticals were reimbursed through the Medicaid daily rate. Beginning in 2006, under the Medicare Modernization Act, the state is no longer responsible for the majority of drug costs for dual-eligible's and as such, the Medicaid rates and costs were adjusted to reflect this change.

[2] The shortfall for the state of Washington only represents a comparison of the operating cost to operating rate. Accurate allowable property cost data were not available so the comparison excludes property costs and the property component of the rate.

Eljay, LLC (Eljay), was engaged by the American Health Care Association (AHCA) to work with its state affiliates and other sources to compile information on the shortfall between Medicaid reimbursement and allowable Medicaid costs in as many states as feasibly possible.

TABLE I
STATE-BY-STATE COMPARISON OF RATES AND COSTS
(Continued)

State	Rate 08	Projected Cost 08	Projected Difference 08
Arizona	$ 149.42	$ 161.94	$ (12.52)
Arkansas	$ 137.96	$ 133.14	$ 4.82
California	$ 153.19	$ 161.26	$ (8.07)
Colorado	$ 167.33	$ 176.56	$ (9.23)
Connecticut	$ 214.99	$ 228.41	$ (13.42)
Delaware	$ 225.53	$ 249.22	$ (23.69)
Florida	$ 174.26	$ 186.45	$ (12.19)
Georgia	$ 133.27	$ 139.84	$ (6.57)
Hawaii	$ 214.47	$ 212.13	$ 2.34
Idaho	$ 172.67	$ 173.65	$ (0.98)
Illinois	$ 112.07	$ 133.85	$ (21.78)
Indiana	$ 145.53	$ 151.68	$ (6.15)
Iowa	$ 120.13	$ 129.19	$ (9.06)
Kansas	$ 127.09	$ 136.86	$ (9.77)
Maine	$ 170.07	$ 187.67	$ (17.60)
Maryland	$ 202.92	$ 207.37	$ (4.45)
Massachusetts	$ 189.23	$ 207.92	$ (18.69)
Michigan	$ 184.49	$ 185.73	$ (1.24)
Minnesota	$ 153.61	$ 176.87	$ (23.26)
Missouri	$ 120.38	$ 135.26	$ (14.88)
Montana	$ 153.73	$ 157.27	$ (3.54)
Nebraska	$ 139.75	$ 148.74	$ (8.99)
Nevada	$ 170.02	$ 184.01	$ (13.99)
New Hampshire	$ 186.97	$ 211.13	$ (24.16)
New Jersey	$ 200.21	$ 222.91	$ (22.70)
New Mexico	$ 154.78	$ 165.98	$ (11.20)
New York[1]	$ 215.62	$ 234.39	$ (18.77)
North Carolina	$ 150.33	$ 154.09	$ (3.76)
North Dakota	$ 165.45	$ 164.17	$ 1.28
Ohio	$ 164.89	$ 179.75	$ (14.86)
Oklahoma	$ 124.24	$ 127.34	$ (3.10)
Oregon	$ 194.39	$ 196.16	$ (1.77)
Pennsylvania	$ 194.94	$ 208.86	$ (13.92)
Rhode Island	$ 181.74	$ 193.93	$ (12.19)
South Dakota	$ 122.09	$ 134.63	$ (12.54)
Tennessee	$ 139.59	$ 141.79	$ (2.20)
Texas	$ 108.63	$ 119.45	$ (10.82)
Utah	$ 154.62	$ 164.07	$ (9.45)
Vermont	$ 179.14	$ 200.61	$ (21.47)
Virginia	$ 141.91	$ 148.73	$ (6.82)
Washington[2]	$ 147.30	$ 165.06	$ (17.76)
Wisconsin	$ 134.70	$ 161.13	$ (26.43)
Wyoming	$ 151.81	$ 170.70	$ (18.89)

[1] Prior to 2006 in New York State, pharmaceuticals were reimbursed through the Medicaid daily rate. Beginning in 2006, under the Medicare Modernization Act, the state is no longer responsible for the majority of drug costs for dual-eligible's and as such, the Medicaid rates and costs were adjusted to reflect this change.

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