Elements of Medicaid Reform for Long Term Care

On behalf of the nearly 60,000 residents served in long term care facilities state-wide, the Health Care Council of Illinois (HCCI) appreciates this opportunity to provide comments for consideration by the Medicaid Reform Task Forces.

The long term care community in Illinois has consistently supported the expansion of home and community-based services. Over the years we have jointly worked on legislation such as the Older Adult Services Act, as well as engaged in coordinated grassroots lobbying efforts with our home and community-based service partners.

Last Spring, the General Assembly passed legislation (SB 326) which dramatically reformed the way all nursing homes operate in Illinois, regardless of payer source. This initiative, in combination with the Older Adult Services Act passed several years ago, provides the foundation for Medicaid reform for long term care.

HCCI believes in a Medicaid system that is recipient driven system that does not sacrifice one model of service delivery at the expense of another piece of the continuum. Some of the elements of our suggested program are detailed below.

• Equitable and Just Funding for all Medicaid Services

Nursing homes serve as the backbone of the long term care profession in Illinois, providing Medicaid services to over 60,000 individuals in Illinois in 800 facilities statewide.

While Illinois' long term care providers are held to the same standard of quality that providers in all States are required to meet under Federal law, reimbursements are not equitable across the states. In fact, Illinois ranks 50th in the nation for reimbursement for care of residents in our nursing homes.

The state has also failed to implement the "new" reimbursement system mandated by statute to be fully-implemented by 2007.

Funding for home and community-based services has also fallen behind national averages.

Our Request: Fully fund the MDS reimbursement system and update the support component of the rate to reflect actual costs incurred by the facility for the services provided.

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- ## A Measured Approach to Restructuring LTC Services

We urge the committee to avoid a rushed decision on Medicaid Reform for long term care or what some have referred to in previous hearings as "rebalancing". We ask instead that the current laws on the books be fully implemented.

The Older Adult Services Act provides a roadmap for restructuring long term care services in Illinois to reflect the changing demographics and desires of Illinois' aging population.

> "Financing for older adult services shall be based on the principle that "money follows the individual" taking into account individual preference, but shall not jeopardize the health, safety, or level of care of nursing home residents. The plan shall also identify potential impediments to delivery system restructuring and include any known regulatory or statutory barriers." (320 ILCS 42/45 (2))

The Act required an inventory of institutional and non-institutional services in Illinois, to serve as the cornerstone to expansion of home and community based services and restructure the long term care continuum. That inventory has never been completed by the State.

> "Inventory of services. The Department shall develop and maintain an inventory and assessment of (i) the types and quantities of public older adult services and, to the extent possible, privately provided older adult services, including the unduplicated count, location, and characteristics of individuals served by each facility, program, or service and (ii) the resources supporting those services." (320 ILCS 42/20 (c))

The Act also called for the development of a conversion program, which also remains unimplemented.

> "Bed reduction. The Department of Public Health shall implement a nursing home conversion program to reduce the number of Medicaid-certified nursing home beds in areas with excess beds. The Department of Healthcare and Family Services shall investigate changes to the Medicaid nursing facility reimbursement system in order to reduce beds. Such changes may include, but are not limited to, incentive payments that will enable facilities to adjust to the restructuring and expansion of services required by the Older Adult Services Act, including adjustments for the voluntary closure or layaway of nursing home beds certified under Title XIX of the federal Social Security Act." (320 ILCS 42/45 (16))

Our Request: Audit the implementation of the Older Adult Services Act and all provisions before any further plans are made or requirements increased.

• Evaluation of Existing Medicaid Reform Projects

Other existing Medicaid reform proposals - including Money Follows the Person, Cash and Counseling, managed care Community Care Program sites, and others - need to be thoroughly evaluated with advantages and disadvantages carefully weighed before any binding action is taken. Evaluations should be conducted by objective, impartial third party evaluators.

Our Request: Objective, ongoing, and transparent auditing of all current Medicaid reform measures should be completed before any further plans are made or requirements increased. Any future Medicaid reforms should mandate such reviews.

Other Responses You Requested

Federal Funding: It is our understanding that there may be federal matching funds available for some programs, such as the ombudsman program, that Illinois may not be fully pursuing. There also may be funds available for other home and community-based programs. The Department of Healthcare and Family Services should be challenged to pursue all aspects of federal match.

Medicaid System Inefficiencies: As far as long term care, since the early to mid-90's, our payment situation required us to take full advantage of all efficiencies possible in our operations. There is no more to cut. The task force may want to talk to the Department of Healthcare and Family Services who have a much broader view of the Medicaid System.

Reduce Medicaid Costs: It is hard to imagine our costs being cut further than we have done already. This has been necessary to survive in this rate environment. Looking at the big picture, we do not think it is appropriate to comment on the cost of delivering services by other providers. At the same time, all efficiencies that can be achieved through increased automation or training should certainly be pursued.

In addition, we often hear home and community-based service providers argue that care in nursing homes, referred to as institutional care, is much more expensive than home care. HCCI believes that nursing homes are partners in the community and do serve as the home or legal residence of those we serve. When listening to cost arguments, we ask that care be taken to ensure that comparisons are being made appropriately as the cost of such things as 24-hour a day care, rent and food are often not considered in the cost comparisons.

Loopholes that allow for Fraud: HCCI has worked willingly with state regulators and the Attorney General toward increasing penalties and expanding disincentives for fraud in the long term care system (SB 326 and SB 2863 last spring). The task force should investigate the opportunity for

fraud and the penalties imposed by all Medicaid providers. It has come to our attention that certain home and community-based service providers receive funds with little or no regulatory oversight and accountability for services delivered. Attention needs to be paid to adopting guidelines consistent across all Medicaid providers.

Prepare for integrated system: Long term Care facilities in Illinois are preparing to participate in a pilot project on managed care for some residents. The results of our experiences in the pilot will identify bed practices and approaches to be shared with the entire long term care profession.

The Health Care Council of Illinois appreciates the opportunity to share our thoughts on Medicaid Reform. As always, we stand ready to assist all task force members and to work collaboratively with you on Medicaid reform.

Medicaid Reform: Looking At the Big Picture

This packet contains a compilation of documents previously distributed to Governor Quinn and the General Assembly.

Specific Items Included:

1. Overview of HCCI Positions on Reform
2. Response to the Report presented by the Taxpayer Action Board
3. Memo to the Governor and the General Assembly in response to the Lucas Group Report and the Response from the Senate Republican Caucus.

Distributed to Senate Special Committee on Medicaid Reform
December 14, 2010

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Overview

Nursing homes are a lot like Social Security and dentists. You don't want to think about them. You deny that you will ever need them. Then, you are grateful they are there when you or a loved one needs them. AARP's research illustrates this.

> *As the percentage of older people living in nursing homes has declined, the number of stays has grown because of increasing use for short-term post-acute care. There were close to 3.2 million total nursing home stays in Medicare and Medicaid certified facilities during 2005, up from 3 million in 2000.*[2]
>
> *Projecting future trends is difficult, since nursing home use is driven by care preferences as well as life expectancy and disability trends. Current estimates are that 35% of Americans age 65 in 2005 will receive some nursing home care in their lifetime, 18% will live in a nursing home for at least one year, and 5% for at least five years.*[3] *Women, with longer life expectancy and higher rates of disability and widowhood, are more likely than men to need nursing home care, and especially likely to need lengthy stays.*
>
> Nursing Homes, By: Ari N. Houser, AARP Public Policy Institute , October 2007

As traditional nursing homes for the aged and infirmed have evolved into the Rehab and Skilled Nursing Centers of today, commonly held images of the profession have not kept pace. For example:

- Centers are still referred to as long term care facilities or nursing homes.
- Community based care is so narrowly defined that Centers are not included in the definition.
- Proponents of the expansion of Home and Community Based Services call for the closing of beds, assuming that all facility beds are competing with them for the same long term client.
- Each year, a variety of legislative initiatives are put forward to move long term residents out of nursing homes based on the belief that many are kept there against their own wishes or those of their family.
- Money Follows the Person has been unable to meet its goals. From individuals selected based on their MDS (minimum data set) score, 247 have been identified as potential candidates for transition. Of these, 15 were determined to be qualified for transitioning, of which only seven have agreed to participate in the program. None of the seven qualified to live independently. All are being transferred to Supportive Living Facilities, a step-down, non-skilled facility

operated under a Medicaid assisted living waiver. The state's savings, (SLF's receive 60 percent of the nursing home rate), is offset by the cost of Money Follows the Person.

Yet according to the Center for Disease Control, approximately half of all nursing home residents are short term post acute or rehab stays. The lack of understanding of the role rehab and skilled nursing centers play in today's acute health care delivery system and the fluidity of the need for long term beds complicates the discussion about the future of institutional care and the long term care and services delivery system in Illinois.

The Story of Peg Keeley

As a former AARP volunteer, Peg Keeley, indicated, "You don't think you will ever need or want senior services or nursing home care until you are faced with the harsh reality of your life." One day, Peg was a self-sufficient 65-plus retiree and the next she was an amputee. Living alone and faced with needing skilled wound care and physical therapy, she moved from the hospital to a nursing home for a rehab and post-acute stay. State services built a ramp in her garage that allowed her to enter and exit her house until she was able to sell it and move to one with a lower grade. During her at-home recovery, home health provided wound care once she went home, home delivered meals brought lunch 5 days a week, and in-home senior services assisted her with the activities of daily living that she could not do for herself. Peg's car was fitted with a scooter lift and with the aid of prosthesis, a walker, and a scooter she regained significant mobility. She continued to lobby for AARP in the state Capitol and work as an office temp for several years after the amputation. Years later, after suffering a stroke that left her unable to live on her own, Peg moved to a skilled care facility where she lived until her death.

Peg's story isn't the exception; it is the reality. Yes, Peg had two daughters and one adult granddaughter living nearby. Both daughters were heads of households and the sole caretaker of younger children. Neither daughter had homes large enough to accommodate their immediate family and Peg. Peg's home was not large enough to accommodate them. More importantly, Peg wanted to live with dignity. She wanted her independence. She did not want to be dependent upon her daughters or granddaughter.

Understanding Peg's story, gives us critical insight into the problems facing the nursing home profession. For Peg, entering a nursing home for a short, post-hospital stay was about getting the care she needed to return to her home. Just as for Peg, entering a nursing home after her stroke was about retaining her independence and not being dependent upon her family. In reality, it took both in-home services and facility-based care to allow Peg to live her life with dignity. Peg's only concern was that the services were available, that they were in her community so her children could visit, and that they were of the highest quality. Yet, many continue to equate nursing homes with loss of dignity and loss of independence.

In reality, none of us want to contemplate turning 65 and receiving Social Security, none of us want to contemplate needing a root canal, and none us want to contemplate needing the services of a nursing home. But when the need arises, we all want to make sure that Social Security is viable and there for us, that a dentist is available to perform the root canal, and that a nursing home bed is available in our community when we or our family needs it.

Preparing for the Future: Demand for Services

Projecting demand trends for long term and short term stays and in-home services is difficult in the best of circumstances, but impossible without solid hard data. It is for this reason that the framers of the Older Adult Services Act required that an inventory of services be completed before any realignment of services be undertaken. Sadly, **this inventory has never occurred.** State resources were used to fund focus groups around the state on service issues. The researcher employed to gather and analyze the data concluded that the methodology selected by the Department was not conducive to developing an inventory of services.

Projecting Demand for Long Term Stay Beds

As AARP points out in their nursing home issue brief, the fluidity of the factors influencing the demand for long term stay beds make supply decisions difficult. While a greater percent of seniors may initially choose home services and eventually move to an assisted living facility, the shear volume of the future senior population will drive up demand for nursing home beds when you factor in such influences as informal caregiver availability, living status, and the shortage of health care workers.

Longevity – Research has found that the longer one lives, the greater the likelihood one will need some form of facility-based care. With those 85 year of age and older expected to increase by 51 percent between 2007 and 2030 and the availability of informal caregivers declining, it can be argued that the need for facility based care – short and long term stays – will only increase over time. This is in contrast to what some argued – that the need for skilled care facilities and rehab centers would diminish over time.

Disability – While we know that the 65-plus population today in general is higher functioning at more advanced years than ever before, we all know strokes, heart attacks, diabetes, accidents and other catastrophic events can leave their victims in diminished capacity regardless of age.

While we can't predict when skilled residential care will be needed, we do know that skilled care residents are "among the most frail Americans," according to the previously sited AARP brief. Their stats indicate that more than half are confined to a bed or wheelchair, which would make it difficult from to live independently even with the assistance of an in-home senior services worker. Nearly 80 percent of the residents needed help with four or five activities of daily living, such as dressing, eating, toileting, and transferring/mobility.

Preference – While it is true most people do not look forward to living out their remaining years in an institutional setting, it is the only medical solution for many. While we can all agree that seniors should have the choice of where they receive their care, the state must balance preference against self-neglect statutes, economies of scale, and service delivery mandates.

Rarely is the decision to move into a long term stay bed made solely by the senior. These decisions involve the senior's physician and his or her family. Many families do not have the time, space, or ability to care for an infirmed loved one in their home. Others simply do not live close enough to be able to help out. Whether a senior receives care in a facility or at home should be left to the family, the senior, and his or her medical advisory.

Gender and Marital Status -- While not specifically mentioned in the earlier quote from AARP, the association's literature speaks to gender and widowhood as a key predictor of the use of residential skilled care. They site that over half of residents at the time of admission are widowed. Only one in five were married or living with a partner. Over a third of Illinois' population age 75-plus lives alone, a trend that is expected to accelerate in the future.

Projecting Demand for Short Term Stay Beds

The percent of hospital discharges transferred to rehab and skilled care centers is expected to continue to grow, although the number of hospital discharges is expected to diminish over time. Some experts believe short term stays will continue to grow as a percent of the resident population, not only changing the mix of residents to one of predominately short term stays, but off-setting in any loss of demand for longer term beds. This trend is influenced by many of the same factors explored above: marital status, nursing shortage, and decreasing informal caregiver availability.

In studies completed by Larson Allen LLC, an accounting firm, for Minnesota and Florida, the researcher contended that not only will short term stays fill the beds left empty by diminishing demand for long term beds, but the state's inventory of skilled care beds will need to increase as we near 2030. The studies also found that existing facilities would need major upgrades to better serve this changing resident population and meet the demands of today's discerning public. Yet, owners are ill-positioned to finance such renovations without assistance from the state. This is especially true in Illinois, where the state reimbursement rate ranks 49th in the nation.

Achieving the Right Balance

Rather than argue over who gets how much of the pie, HCCI has chosen to work with home and community based services providers and assisted living owners to secure additional resources. HCCI and its forerunners, the Illinois Health Care Association and the Illinois Council on Long Term Care, have held joint lobby days with AARP and HCBS providers as far back as 2002. Yet, many HCBS providers and state agency personnel continue to villainize the long term care profession.

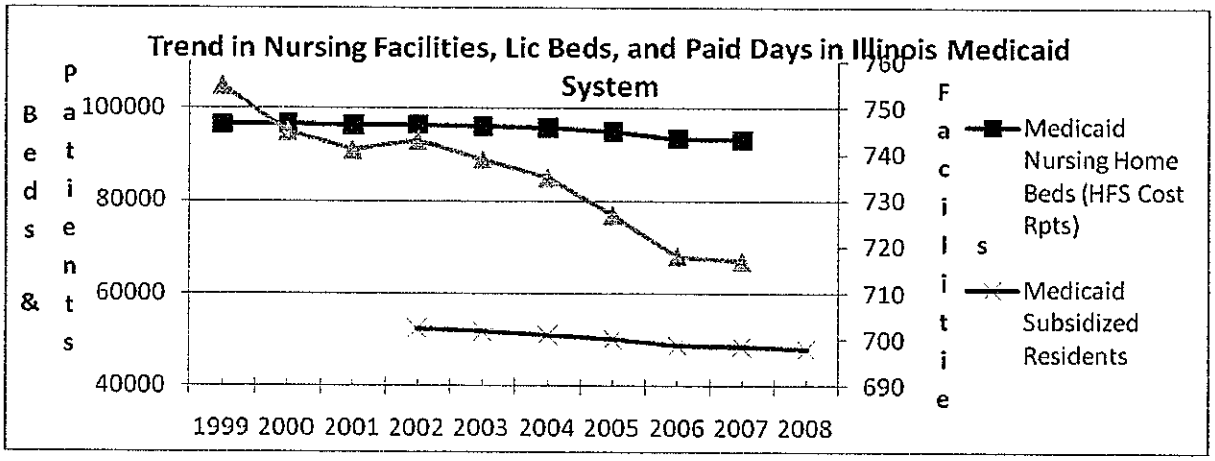
To coin a phrase from New York, Illinois' long term care and services system will only reach its optimum ***"rightsize"*** when we focus on the real work ..... integrating all facets of the long term care and services delivery system to insure that the needs of all seniors and their families can be met. Regardless of how we want to live out our last years, if you live alone and do not have adult daughters unemployed outside the home and living nearby, there is every likelihood that you will need residential services. Absent this facility-based safety net, countless elderly will be condemned to living in substandard conditions.

Reports such as the TAB report (see the response document) and statements made by senior Governor's Office staff, which ignore the progress that Illinois has already made to expand HCBS services and Medicaid funded assisted living and instead focus on how money can be taken from one group and shifted to another, have served only to further widen the gap between facility-based providers and HCBS providers. Yet in these tight economic times, it is imperative that we try harder to find a common meeting ground.

Long Term Care "Rebalancing" is Working in Illinois

Advocates in Illinois have been working on rebalancing since 1982. Detractors have not acknowledged **the progress that has already been made.** Although incremental, Illinois' progress far exceeds the national average.

As the chart below depicts, the number of Medicaid subsidized residents in Illinois is decreasing at a steady pace. Between FY 02 and FY 08, the number of Medicaid residents dropped by 8 percent, while nationally Medicaid home residents dropped by only 3 percent. Similarly, between FY 00 and FY 07, the number of Medicaid certified beds decreased by 4 percent, double the reduction in beds nationwide.



Other indicators also show Illinois' rebalancing progress far exceeds progress in other states:

- In Illinois, for every 100 Medicaid nursing home residents, 67 individuals participated in the Medicaid aged and disabled waiver program, which is double the national average of 34. (2005)
- Illinois' per capita ratio is double the national average, with 4.1 participants in the Medicaid aged/disability waiver compared to 2.0 nationally (2005).
- Between FY 02 and FY 07, Medicaid home and community based services spending for the aged and the disabled waiver participants increased by 106 percent, compared with an increase in spending nationally of only 68 percent during the same time frame.
- Between FY 02 and FY 07, spending decreased by $157 million or 10 percent. Nationally, spending for facility based care increased by 7 percent during the same timeframe.

Several key factors working in combination have enabled Illinois' incremental approach to "rebalancing" to be so successful.

- Creating a Single Assessment Entity
- 1982 court decree that requires the Community Care Program to be operated as an entitlement program

- 1996 Strong Universal Prescreening/Diversion Program
- 2004 Older Adult Services Act
- 2004 Nursing Home Transition Demonstration
- 2006 Hospital-based Diversion Initiative
- 2006 Universal Assessment Tool
- 2007 Money Follows the Person Demonstration

Rebalancing, Not Rationing

This is not to say that more cannot be done. For example, the state needs to increase the array of services in the Community Care Program; bring additional Supportive Living Facilities on-line, especially for unique populations; and expand home and community based services into our harder-to-serve rural areas of Illinois. Simultaneously, the state must assist the nursing home profession to retool, thus diminishing the negative economic impact on the workers currently employed and the communities they serve, and insure that an adequate supply of skilled care beds is available throughout the state.

It is critical, however, that we guard against care "rationing" being instituted in the name of 'rebalancing." It is imperative that a big-table approach to these discussions be undertaken with egos and preconceived ideas checked at the door. Taken as a whole, the TAB report advocated rationing of care, not rebalancing the long term care and services system. It simultaneously sought to reduce the number of nursing home admissions AND reduce the amount of in-home services provided and the number of people who qualified.

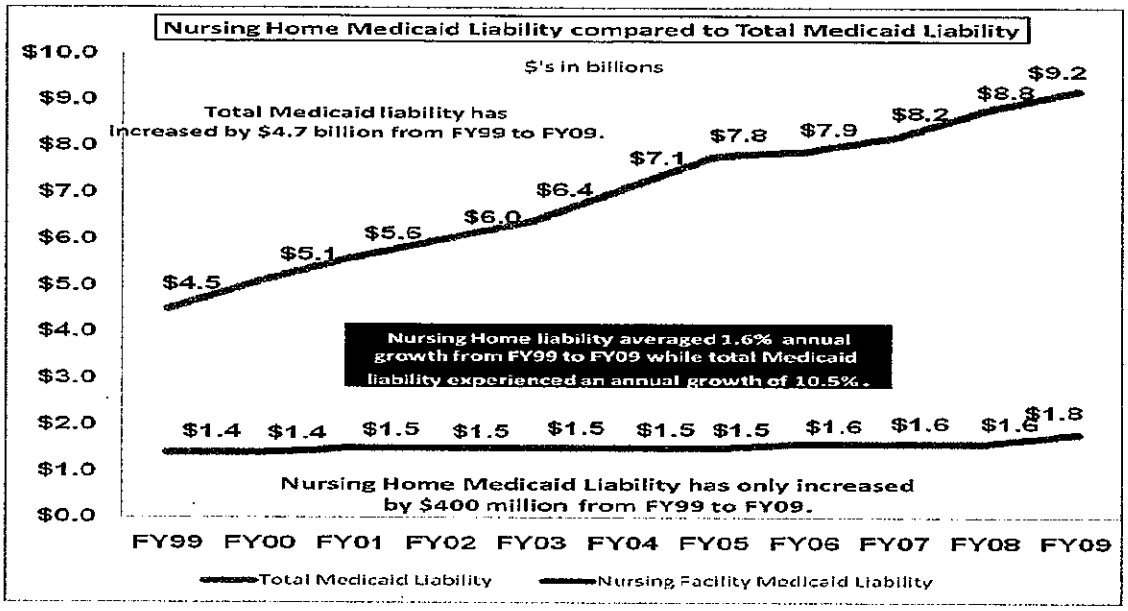
This spring, Illinois came dangerously close to fulfilling the TAB prophecy with calls for policies and funding levels that would have left many nursing homes with few choices but to close. At the same time, there were calls for denying in-home services to all but those who qualify for Medicaid, raising co-pays, and reducing hours of services to pay for increased reimbursement rates. Thus, the state's safety net for the frail elderly would have sprung significant leaks.

While nursing home providers and in-home service advocates were successful in defeating anti-nursing initiatives and proposals to cut non-Medicaid eligible in-home clients, the previous administration's commitment to increase again the reimbursement rate for the in-home senior program was honored and the previous administration's commitment to the fourth installment of the new MDS reimbursement system was not. This week, it was revealed that the very seniors who have expressed an interest in aging at home are now being forced to pay more for less hours of service – two actions that beg the need for a continued robust system of facility based service.

Cost of Care

As noted in an AARP report released this spring (2009), every state is experiencing an increase in Medicaid costs, but seniors are not driving these escalating costs. The skilled care facility appropriation has increased less than 1.6 percent a year during the last decade, while Medicaid in general has grown by 6.9 percent a year.

At the same time, the home and community based services budget has expanded 169.2 percent in the past ten years – nearly a 17 percent increase annually. Similarly, the growth in Medicaid funded nursing bed days has been fairly static, with short term stays offsetting diminished demand for long term stays. In contrast, the number of clients served by the Department on Aging's Community Care program increased by 42 percent between FY 99 to FY 09.



Illinois Nursing Home Rates

The amount paid by the State of Illinois for residential skilled care under the Medicaid program continues to lag well behind the other states, with Illinois ranking 49th in the nation. Full implementation of the MDS reimbursement system and payment predictability will continue to head the top of the profession's priority list.

MDS Reimbursement Methodology

In recognition that nursing home residents have far more complex medical needs today than a decade ago, the new MDS reimbursement system was embraced by the legislature and Governor George Ryan in 2002. This methodology is based on the Minimum Data Set, a person-centered clinical assessment program, which skilled care facilities are required to use by the federal government. Coupling the reimbursement to the MDS assessment has resulted in a methodology that rewards quality and acknowledges restorative and rehabilitative care, specialized Alzheimer's services, ventilator technology, and other high skilled specialized care.

During the 2006 legislative session, lawmakers approved the first year of the 5 year MDS phase-in, which will run in tandem with the old reimbursement system until 2011. Current nursing rates are determined by blending 50 percent old rate methodology with 50 percent new MDS rate.

Because the fourth installment of the MDS phase was not included in the FY 10 budget, the FY 11 budget will need to include both the fourth and fifth installments.

Tying reimbursement to the national MDS assessment tool is not a new concept. Currently Medicare uses a similar system along with approximately half of the states. Their experience indicates that it ensures that a detailed, comprehensive look at the medical needs of the today's resident is completed. This individualized and objective review gives long term care doctors, therapists, nurses, certified nurse aids and others involved in care delivery the information they need to custom tailor a health care plan for every resident – and get fairly reimbursed for delivering that care.

Getting and keeping implementation of the MDS reimbursement system back on track is of the highest importance. Not only does it mean that providers will be appropriately reimbursed for the care they provide, but it will allow them to provide the high quality of services that they believe their residents require and deserve.

Support Rate Adjustments

Rehab and Skilled Care Centers are responsible for meeting their residents' basic health and quality of life needs, including making sure residents are well-nourished; using technology to provide the highest quality of care; preventing the spread of infectious diseases; keeping them comfortable with proper heating and air conditioning; and ensuring that residents are safe and secure. The cost of providing for these basic needs is reflected in the support component of the Medicaid rate, which is currently frozen at 2004 cost levels. Reimbursing centers at the 2004 cost level does not limit the center's liability to 2004 prices; they must pay 2009 costs based on the 2009 needs and demands of their residents. Between 2004 and 2006, utilities and maintenance costs increased by 14.4 percent, health care wages by 11.5 percent, employee benefits and payroll taxes by 12.1 percent and therapy costs by 29.4 percent.

Prior to the Edgar Administration, the support component of the rate was adjusted each year to the most current cost report year. With the downturn of the economy in 1991, the state adopted the practice of balancing its budget in part by placing on hold regular updates to the support rate component. Quality and consistency of care is dependent on the state devising a plan to bring the support rate up to date and providing for regular updates.

Payment Predictability

While the federal stimulus package has made payment predictability a non-issue for now, the issue remains a priority moving forward. It is essential that the state remain on a 30-day payment schedule once the federal mandates end.

Rehab and Skilled Care Centers provide medical care, therapy, food, shelter and security 24/7. They do not have the luxury of turning away new admissions or discharging residents because the state fails to pay for their care for up to six to seven months. Ironically, the state prosecutes deadbeat Dad's who fail to pay their child support monthly.

As devastating as waiting seven months from the date of service before being paid is to a provider's ability to stay afloat, the unpredictability of the state's payment cycle is even more problematic. Bridge loans have become a business necessity for long term care providers in Illinois, but bankers demand regular payments even if the state is failing to issue any payment at all. For example, in FY 09, providers were paid for care provided in the last five months of FY 08 in the first month of FY 09. They then did not receive another check until December or a full six months later. This lack of predictability is what has made bankers reluctant to grant bridge loans to many providers.

Quality of Care

Just as Peg Keeley wanted and expected high quality services in her home and when she moved to a residential setting, operators of skilled care centers strive to provide care of the highest quality. A regulatory system focused on assisting providers to achieve these standards, rather than one aimed at generating revenue is a critical first step. While the vast majority of standards are dictated by the federal government, additional demands are placed on the facilities at the state level. Equally problematic are pragmatic implementation issues and unintended consequences of layering regulations upon regulations and then underfunding both the regulatory system and the providers they regulate.

Enforcement System

Residents and their families deserve an enforcement system that works to ensure quality of care and does not impede it. For the past six years, enforcement has been more about generating revenue for the state than it has been about addressing physical plant and quality of care issues. A recent court ruling provided hope to financially strapped providers, which held that the regulators could not exceed penalty limits prescribed by law. Providers have reported that regulators have protected the state's bottom line by simply issuing multiple citations for the same violation. While no one will argue that enforcement must occur, the idea that facilities are low-hanging fruit for the taking must be addressed. Unreasonably high penalties serve as barriers to correcting physical plant deficiencies, instituting innovative programming, and maintaining staffing ratios.

As problematic as excessive penalty awards is the lack of sufficient field surveyors and central office supervisors. Insufficient field supervision leads to inconsistently applied regulations across the State. Further, insufficient central office staff causes delays in reviewing plans of correction and completion of annual and follow-up survey cycles.

Once the annual survey is completed, the facility is mandated to provide a plan of correction and to clear the deficiency within a prescribed number of days. In turn, the State is required to approve the plan of correction within a certain number of days. The facility is liable for every day the facility is considered out of compliance. So, due to insufficient staffing at the Department of Public Health, facility survey cycles are remaining open far longer resulting in potential increased fines and penalties although the facility is back in compliance.

Quality Assurance Consulting Teams

In 2008, HCCI put forward the issue of establishing Quality Assurance Consulting Teams to assist facilities with compliance issues. While it got caught in inter-chamber squabbles, it did enjoy the support of the administration and the Department of Public Health. In 2009, HCCI did not move the bill forward, after being told that the Department would no longer be permitted to support the concept. Yet, it is a clear win for the residents.

Other Issues of Interest

Collaboration Needed for Federal Action

HCCI, along with other groups affected by the enhanced Medicaid match in the federal stimulus package, has been actively lobbying Congress and the White House to extend the enhanced match indefinitely. It is HCCI's intent to offer a resolution this fall calling upon our Congressional delegation to support these efforts. **While provider groups will continue their individual efforts, our chances for success would greatly increase if we could all come together under the umbrella of the Governor's Office. HCCI stands ready to work with you and your staff to advance our mutual interest.**

Further, the Congress is considering at least a $21 billion in cuts to the Medicare program in the long term care area over a 10-year period. This will have a severe impact on Illinois providers, as it is the Medicare rate that helps providers off-set the $30 per-resident per-day shortfall between the cost of services provided to Medicaid residents and the amount reimbursed by the State for resident care. **Again, collaboration with the Governor's Office to reach the Illinois Delegation quickly on this issue would greatly increase our chances of stopping these cuts.**

Public/Private Collaboration

HCCI has prided itself on its relationship with the State of Illinois, the agencies it interacts with, legislative offices and the Governor's staff. HCCI has repeatedly joined with other provider groups, advocates, and state administrators to troubleshoot problems and craft appropriate responses that met the needs of the client, the provider, and the state. There is growing concern that the era of cooperation, coordination, and collaboration could end.

HCCI has requested that a point person be identified in the Governor's Office for HCCI to work with as the need arises. This is consistent with the arrangements that HCCI has with each of the four legislative leaders. It has proven to be mutually beneficial.

Cuts to Other Programs for Seniors

We understand the needs to balance the State budget. However, sweeping the Monitor and Receiver Fund in the long term care division of the Department of Public Health has had an unintended consequence on the Ombudsman Program. This fund was completely swept. As the Department relied on this fund to support staff and programs, the only recourse is to turn to the Civil Monetary Penalties Fund, which are funds generated by federal fines. **As a result, the**

Ombudsman Program is not going to get the funds they normally get from this fund for their programs, resulting in a 40 percent cut to the program, rather than the intended 10 percent cut.

Capital Modernization

As noted earlier, facilities will need to retrofit to meet the ever-changing needs and demands of Illinoisans needing rehab, post acute and long term residential care. Establishing a state bonding program or permitting nursing homes to be part of the Capital Bill is a win/win for the state, the resident, and the provider. Each approach has its advantages and disadvantages.

Staff Advancement and Empowerment

Our residents need and deserve well-trained, committed and empowered caregivers. It is imperative that the state invest in improving and expanding the quality of bedside caregiving with increased recruitment, career advancement and specialized training of staff through consistent assignments, mentoring programs, career ladders, leadership training for nurses, medication technician education programs, and targeted nursing scholarships for long term care nurses. Establishing one set of caregiver rules and designations for hospitals and another for rehab and skilled care centers is an inconsistency we can no longer afford.

Our nurses and caregivers are at the very heart of the relationship of care, and we need to advance, empower and support these dedicated individuals. We need to break down the barriers that prevent more people – caring people, competent people, and trained people – from coming into field. The current worker shortages make this no longer an option, but a necessity.

Response to Taxpayer Action Board Report

Submitted by

The Health Care Council of Illinois (HCCI)

June 26, 2009

[redacted]

June 26, 2009

Long Term Care Has Historically Supported Home & Community-Based Services

HCCI and its two parent organizations (Illinois Health Care Association and the Illinois Council on Long Term Care) have a long history of supporting the rights of older adults to live in the least restrictive setting. The long term care profession has fully supported the expansion of home and community based services.

For over a decade, the nursing home groups have partnered with senior advocates and various Administrations to put in place programs and funding to make expansion of home and community based services a reality. Our support has been critical to the success of these efforts. Yet, there are still those who continue to mischaracterize the services we provide and the vulnerable population were serve, resulting in a continued villainization of the nursing home profession and its workers. Now is the time to set the record straight and to recognize the critical role played by nursing homes in the overall health care delivery system for our vulnerable senior population.

Use Caution in Implementing the Lucas Group and Taxpayer Action Board Reports
There have been a number of initiatives this year that have focused on reforms. We sent you our response previously on the Lucas Group Report and the additional report the Senate Republican Caucus released on reforms. The latest report to surface is the Taxpayer Action Board (TAB) Report on suggested reforms and potential cost-cutting measures.

As we approach additional expansion of home and community based services and the concept of "rebalancing," we caution you to ensure that the current infrastructure is protected for seniors and those who will need skilled care either on a **short-term or longer-term basis in the future**. Further, there must be appropriate community placements available for individuals that have a proven track record of service. Nursing homes operate with a massive set of federally driven regulations to ensure quality care and resident safety. We ask that corresponding safeguards and standards be put in place to ensure resident safety and appropriate care delivery in the community as well.

The TAB Report Contains Inaccurate and Misleading Information

The strategies contained in both the Human Services and Medicaid Sections of the Taxpayer Action Board (TAB) Report are based on two inaccurate premises.

- Existing strategies to rebalance the long term care system have failed.
- Nursing home expenditures have been driving the escalating Medicaid costs.

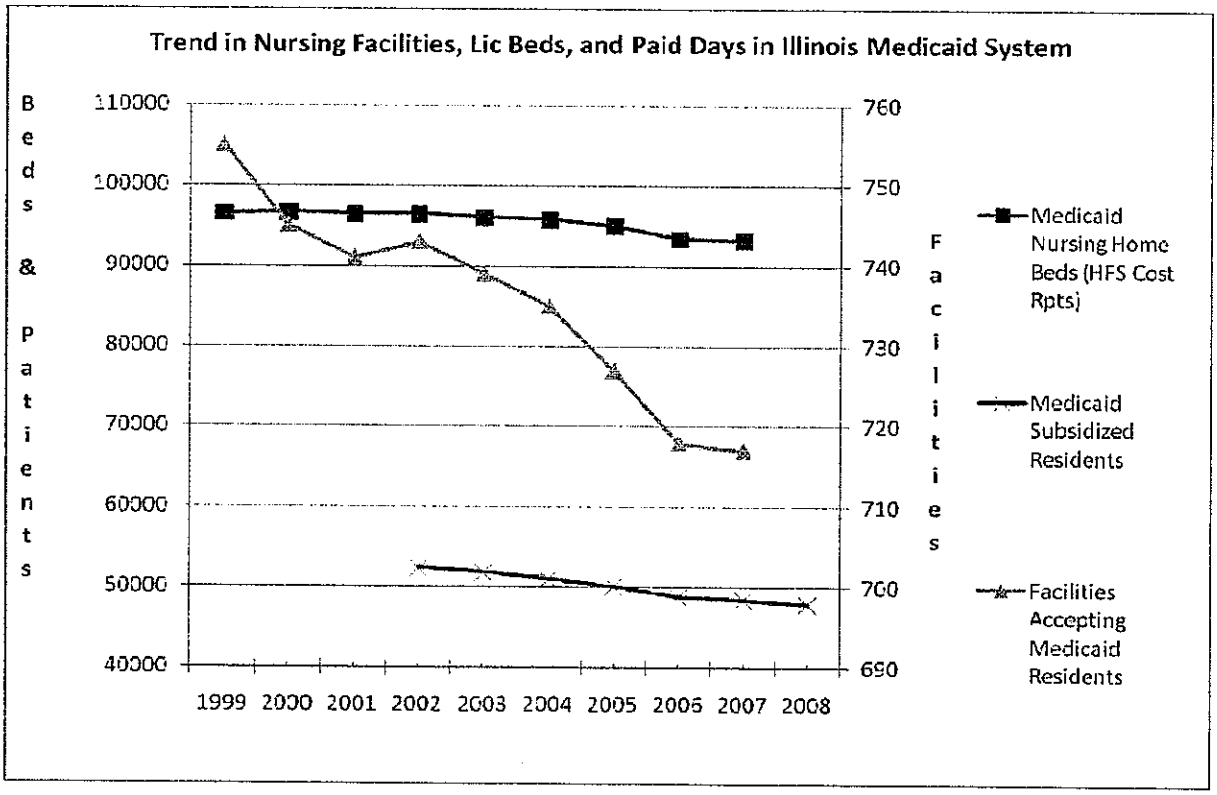
Specifically, the TAB report contains so many misleading statements and faulty assumptions that the recommendations made cannot be trusted. **Appendix A (see page 7) to this document contains our response to the strategies suggested and Appendix B (see page 12) summarizes the misleading statements and faulty assumptions made by both the Medicaid and Human Services subcommittee reports of the TAB.**

The TAB report fails to recognize the progress Illinois has made with existing long term care rebalancing initiatives. Further, if the TAB recommendations were implemented, Illinois' existing senior services delivery system would be dismantled, resulting in the elimination of the safety net that tens of thousands older residents and their families have come to depend on.

Long Term Care "Rebalancing" is Working In Illinois

Advocates in Illinois have been working on rebalancing since 1982. **The reports issues and discussions facilitated this legislative session have not fully recognized the progress already been toward "rebalancing."** While progress has been incremental, Illinois' progress far exceeds the national average.

As the chart below depicts, the number of Medicaid subsidized nursing home residents in Illinois is decreasing at a steady pace. Between FY 02 and FY 08, the number of Medicaid nursing home residents dropped by 8%, while nationally Medicaid nursing home residents dropped by only 3%. Similarly, between FY 00 and FY 07, the number of Medicaid certified nursing home beds decreased by 4%, double the reduction in beds nationwide.



Other indicators also show Illinois' rebalancing progress far exceeds progress in other states:

- In Illinois, for every 100 Medicaid nursing home residents, 67 individuals participated in the Medicaid aged and disabled waiver program, which is double the national average of 34. (2005)
- Illinois' per capita ratio is double the national average, with 4.1 participants in the Medicaid aged/disability waiver compared to 2.0 nationally (2005).
- Between FY 02 and FY 07, Medicaid home and community based services spending for the aged and the disabled waiver participants increased by 106%, compared with an increase in spending nationally of only 68% during the same time frame.
- Between FY 02 and FY 07, nursing home spending decreased by $157 million or 10%. Nationally, nursing home spending increased by 7% during the same timeframe.

Several key factors working in combination have enabled Illinois' incremental approach to "rebalancing" to be so successful.

- Creating a Single Assessment Entity
- 1982 court decree that requires the Community Care Program to be operated as an entitlement program.
- 1996 Strong Universal Prescreening/Diversion Program
- 2004 Older Adult Services Act
- 2004 Nursing Home Transition Demonstration
- 2006 Hospital-based Diversion Initiative
- 2006 Universal Assessment Tool
- 2007 Money Follows the Person Demonstration

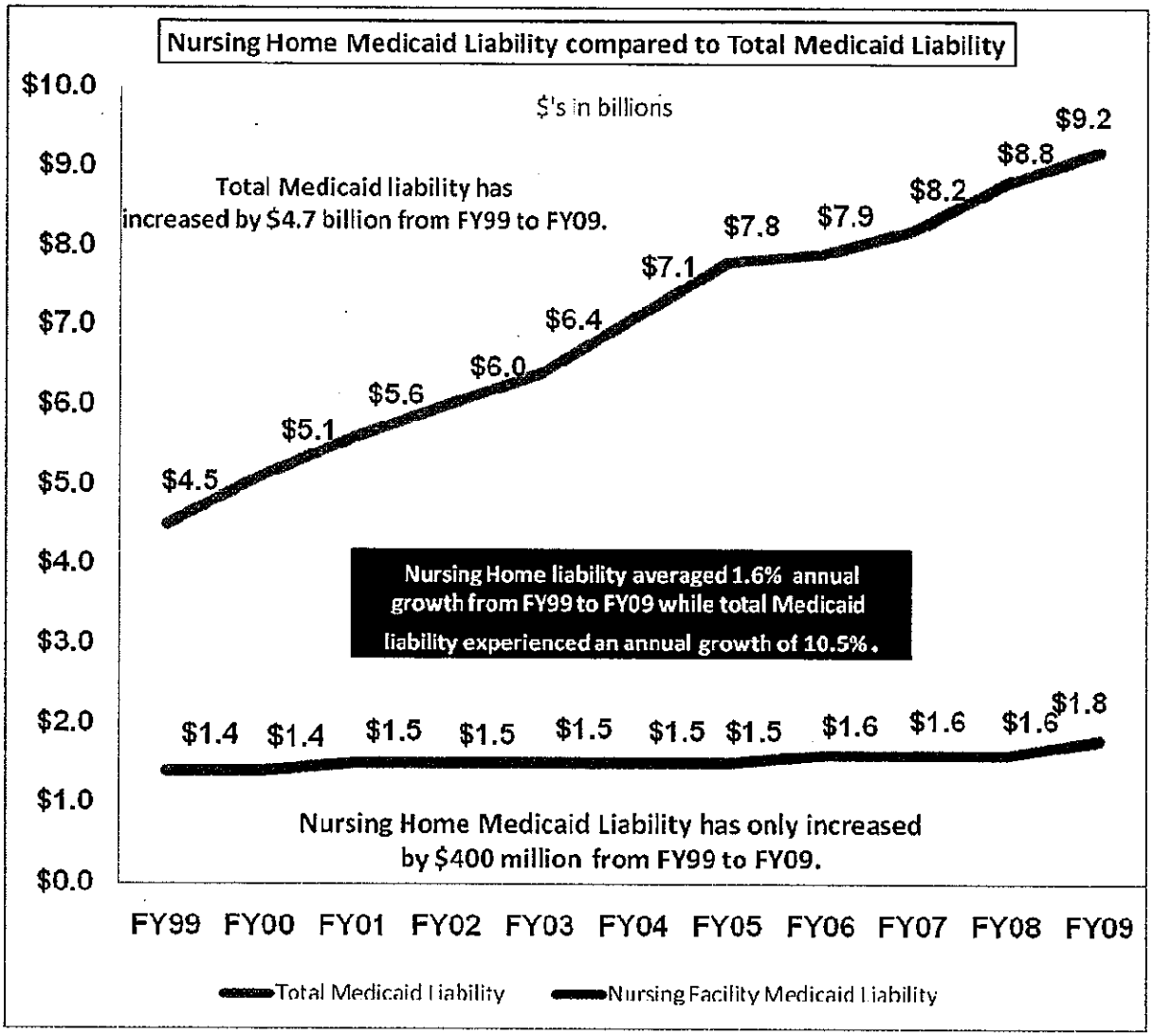
More Work is Needed on Rebalancing

This is not to say that more can not be done. For example, the state needs to increase the array of services in the Community Care Program; bring additional Supportive Living Facilities on-line, especially for unique populations; and expand home and community based services into our harder-to-serve rural areas of Illinois. Simultaneously, the state must assist the nursing home industry to retool, thus diminishing the negative economic impact on the workers currently employed and the communities they serve, and insure that an adequate supply of skilled care beds is available throughout the state. Only then will a true rebalancing effort be able to occur in Illinois.

Seniors and Nursing Homes Are Not Driving the Escalating Medicaid Costs

As noted in an AARP report released this spring (2009), every state is experiencing an increase in Medicaid costs, but seniors are not driving these escalating costs. As the chart below demonstrates, the nursing facility line item has increased less than 1.6% a year during the last decade, while Medicaid in general has grown by 6.9% a year. At the same time, the home and community based services budget has expanded 169% in the past ten years –

nearly a 17% increase annually. The chart below shows the comparison between overall Medicaid growth in Illinois and the growth in nursing home Medicaid liability.



TAB Includes Unrealistic Strategies

The TAB report included a number of strategies related to rebalancing of long term care in Illinois. Appendix A to this document details all of those strategies and our response (see page 7). Included here are a number of strategies that cause us to be the most concerned for the residents we serve.

Strategy: Reduce nursing home admissions by 10% each year for 5 years. (Medicaid Report)

Reality: It is suggested that denying 10% of nursing home admissions each year for 5 years will save significant moneys. It is one thing to deny someone a Medicaid bed who does not meet established criteria. To arbitrarily deny someone a nursing home bed that needs 24-hour skilled care simply because an

arbitrary quota has been reached is just bad public policy. A savings of $70 million is suggested in the first year. This number represents the cost of reducing projected nursing home reimbursements by 10% and does not allow for the need to fund caseload growth in the Community Care Program, the home delivered meal program, the home health program, and the supportive living facility program to absorb the elderly turned away from nursing home placement.

It is also important to make a clear distinction between short term post-hospital stays and longer term stays and between Medicaid and non-Medicaid beds. It is HCCI's assumption that the proposed reduction is in the number of long term stays, not short term post-hospital stays, which would result in much less savings than projected.

Reduce institutional bed count to prevent backfilling of waitlisted clients. (Human Services Report)

Reality: Arbitrarily reducing bed counts by 40% over a 5-year period has the potential of leaving families desperate to find a residential 24-hour skilled care program for their loved one without options in their local community. Before a target number is set, a survey of all beds at the township level must be completed and solid projections established for short term and long term bed needs now and in the future. The Community Care Program is not permitted – due to a 1982 court decree – to waitlist anyone who qualifies for the program. Since backfilling is not an option and the state pays for residents not beds, reducing bed count will not save money.

Enhance diversion and transition strategies to make community-based care the primary option. (Medicaid Report)

Reality: While in theory you must reject nursing home placement before you can access home and community based services, in reality, home and community based services are the primary option in Illinois. Illinois' aggressive prescreening diversion program requires you to reject a package of home and community based services before you can be approved for nursing home admission. The only loop hole is the Department on Aging has told pre-screeners that they can wait up to 2 weeks after admission to complete a prescreening on a senior transferring from a hospital for a short term stay. Individual case management agencies have criticized this practice.

Create an effective and efficient screening process, before and after any institutional placement, to ensure that Medicaid meets the goal of doing all it can to provide the least restrictive setting for beneficiaries that want to remain in the community. (Medicaid Report)

Reality: Illinois has one of the strongest prescreening initiatives in the nation using Community Care Program care coordinators. During the prescreening process, nursing home applicants are informed of alternative services available in their community and care planning services are provided.

Ensure that discharge planning supports the State's priorities and re-align resources to reflect this focus effectively. (Medicaid Report)

Reality: A diversion law passed in 2006 requires hospital discharge planners to notify the appropriate prescreening agency 24 hours prior to the discharge of a Medicare beneficiary. Further, discharge planners are prohibited from transferring a Medicare beneficiary to an unlicensed facility.

Manage admissions to ensure a short institutionalization period and to facilitate rapid reintegration to a community setting. (Medicaid Report)

Reality: When a Medicare beneficiary living in a nursing home moves from Medicare to Medicaid, the Department of Healthcare and Family Services performs a desk audit to determine the viability of the individual's reintegration. If reintegration appears to be possible, the individual's name is turned over to the appropriate administering agency for a face-to-face assessment. In addition, the Money Follows the Person initiative is designed to facilitate rapid reintegration of those who can not return to the community without help.

Additional Reforms May Be Needed

The long term care profession has a long history of partnering with Illinois to provide quality care for our seniors. As experts in the issues facing the residents we serve, we again offer our expertise to the General Assembly and Administration to enact needed reforms.

What concerns us most is the method by which reforms are being considered. We must put people first. "Rebalancing" should not be allowed to occur in such a way as to put residents at risk. Reforms should not be made simply for the sake of reform. The system in Illinois is not broken and the programs we have in place are already working. Further, individuals unfamiliar with the services delivered in skilled nursing facilities should not be making decisions that will impact the lives of thousands of residents and family members across Illinois without input from the individuals who care for those residents 24 hours each day.

We stand ready to assist you in your efforts and bring our expertise to the table. For further information, please call Pat Comstock, Executive Director, at 217-527-3615.

Appendix A: Response to the TAB Report: Goals and Strategies

The Medicaid and Human Services sections of the TAB Report outlined a number of goals and strategies for consideration. This section of our report takes each one of those goals and strategies and responds specifically related to our position on the stated issue.

Medicaid Report Goal:
Prioritize a unified, state-wide commitment to reduce the reliance on institutional care in the Medicaid long term care system, so individuals who are aged or living with a disability or serious mental illness can remain in the communities in which they live with quality services as long as it is medically practical and cost-effective.

> **HCCI Response: HCCI agrees with the goal, which is consistent with our philosophy.**

Human Services Report Goal:
Adopt an integrated service delivery model.

> **HCCI Response: HCCI agrees with the need for integration of administration and technical support functions, but cautions that the unique needs of the frail elderly must take precedence over the desire to streamline administrative functions. Older adults often suffer some level of dementia, are not computer literate, or do not have computers or phone service.**

Human Services Report Goal:
Improve approaches to long term care by transitioning the state from being a provider of generous, uninterrupted, institutionalized care to a locator of rapid, varied, and sustained pathways to quality community vendors.

> **HCCI Response: While HCCI supports the expansion of home and community based services and believes that every older adult should have the opportunity to live in the least restrictive setting, we disagree with the subjective nature of a second goal contained in the Human Services Report.**
>
> **Care plans for nursing home residents are based on the specific health care needs of each individual resident. The Department of Healthcare and Family Services monitors facilities to make sure care plans are consistent with the needs of the residents and that the resident is receiving the services promised. To characterize this process as driving "generous" care plans suggests that the drafter is advocating for nursing homes to ignore a portion of the care needs of their residents, which would be in conflict with federal regulations.**
> **The state "provides" community based services in much the same way it "provides" institutional care. This statement also implies that the state would cease to subsidize community based care and simply make referrals to private or religious based charities.**

Strategies HCCI Supports:

Enhance the Community Care Program for Medicaid-eligible seniors. (Medicaid Report)

HCCI agrees with this strategy, although we do not believe it goes far enough. HCCI believes Illinois should fund a full array of home and community based services and the entire Community Care Program should be adequately funded, not just the Medicaid subsidized component.

Adopt a unified and coordinated "Money Follows the Person" approach to allow beneficiaries to transition to the community from a nursing home or institution. (Medicaid Report)

HCCI worked with Department and Legislative staff on the drafting of the money follows the person legislation and services on the MFP advisory committee.

Federal Medicaid Assistance Percentage (Medicaid Report)

HCCI has already begun its lobbying effort to extend the enhanced FMAP, and met this spring with members of the Congressional delegation, CMS, and the White House.

Shift demand for institutional care by identifying high-risk populations and proactively offering services needed to maintain these individuals in (less costly) community care settings. (Human Services Report)

Reality: This strategy describes Illinois' existing senior services system. To the extent that this strategy simply affirms the state's existing system, HCCI supports this strategy. It is not necessary to "shift demand" away from nursing home care. Every nursing home applicant is already required to be prescreened by a CCP care coordinator and offered the option of alternative community services.

According to the Department on Aging, the most common reasons why seniors choose nursing admission, even after being provided with information about community care options, include:

- **An individual's medical needs are too complicated to be met by the community based services;**
- **The individual's physician orders nursing facility placement; or**
- **The individual's family chooses nursing home placement.**

AARP research shows that 4 out of 5 new nursing home residents are living alone at the time of admission. What both the Human Service and Medicaid Reports do not take into account is that many elderly do not have family who can provide care during the hours that home and community based services are

not available, or that the family is not able to augment Medicaid funded services with private pay services.

Self Service Channels (Human Services Report)

Reality: HCCI supports offering older adults and their families the opportunity to use the internet to locate facility and non-facility based services and determine their eligibility for state subsidized services, but not if it means eliminating Illinois' highly refined CCP care coordination system, which allows the elderly to be assessed and to receive assistance in making application for individual programs in their own homes. HCCI recommends that the concept of self-service be expanded to include full implementation of SB 1349 of the 95th GA, which would permit nursing homes to submit Medicaid applications for residents via the internet, similarly to the system hospitals are already using.

Accelerate the capacity of DoA caseworkers to receive individuals from institutions or those waitlisted for institutional care and to find them alternate care settings. (Human Services Report)

Reality: While HCCI does not oppose increasing the capacity of CCP care coordinators to more effectively serve their elderly clients, Medicaid certified institutions are not permitted to turn away or place on waitlists applicants for nursing home care. Expanding the array of services available at the community level and insuring the availability of an adequate level of services throughout the state – even rural areas – would be a more appropriate first step.

Strategies HCCI Cannot Support

Reduce nursing home admissions by 10% each year for 5 years. (Medicaid Report)

Reality: The Lucas Group contends that denying 10% of nursing home admissions each year for 5 years will save significant moneys. It is one thing to deny someone a Medicaid bed who does not meet established criteria. To arbitrarily deny someone a nursing home bed that needs 24-hour skilled care simply because an arbitrary quota has been reached is just bad public policy. The Lucas Group promises a savings of $70 million in the first year, which represents the cost of reducing projected nursing home reimbursements by 10% and does not allow for the need to fund caseload growth in the Community Care Program, the home delivered meal program, the home health program, and the supportive living facility program to absorb the elderly turned away from nursing home placement.

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long term stays, not short term post-hospital stays, which would result in much less savings than projected.

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Create an effective and efficient screening process, before and after any institutional placement, to ensure that Medicaid meets the goal of doing all it can to provide the least restrictive setting for beneficiaries that want to remain in the community. (Medicaid Report)

Reality: Illinois has one of the strongest prescreening initiatives in the nation using Community Care Program care coordinators. During the prescreening process, nursing home applicants are informed of alternative services available in their community and care planning services are provided.

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Global Budgeting (Medicaid Report)

Reality: The loss of transparency that occurred when the Department on Aging secured permission to lump all Community Care Program allocations into one pot tells the complete story on this strategy. In fact, lack of transparency is the reason why the Medicaid long term care budget was broken out by facility type a few years ago. Illinois has a generous transferability authority, which has been used in the past to permit the transfer of appropriation authority between programs.

Section 1115 "Global" Waiver (Medicaid Report)

Reality: As the TAB report indicates, Rhode Island has received permission for a global waiver, which has garnered criticism from such notable think tanks as the Kaiser Foundation and the Center on Budget and Policy Priorities. Not only do these organizations believe that the state will use up its lump sum Medicaid appropriation before the end of the waiver period, they also caution that the state will create waiting lists for home and community based services and for nursing homes. A three-tiered senior service delivery system will be set up that guarantees only the neediest will receive services.

Existing customers would be diverted to services outside State management (but not outside federal oversight and standards). (Human Services Report)

Reality: Within the senior services delivery system, there are no programs providing services similar to those administered by the state, but which operate under federal oversight and standards. This implies again that the state will no longer be funding direct care.

The opportunity exists to freeze or discontinue previous state-run efforts, and more easily enable case managers to locate customers within less restrictive, community-based settings. (Human Services Report)

Reality: This implies that there are non-state administered, less restrictive programs. While there are some charitable and religious based direct service opportunities, they have very limited capacity.

Appendix B:
Faulty Assumptions & Misleading Statements in the TAB Medicaid & Human Services Workgroup Reports

Faulty Assumptions Medicaid Workgroup

Lucas Group: Suggest that Illinois should provide meaningful alternatives to nursing home admission.

> **Reality: Meaningful alternatives are already in place. A) Illinois has one of the largest assisted living Medicaid waiver programs in the Nation with 113 participating facilities in rural and metropolitan counties. Approximately 7,500 seniors participate in the program. B) The state Community Care Program, by court decree, must serve anyone requesting services who meets eligibility standards. C) Illinois began augmenting the Older American Act home delivered meal program in FY 98, making Illinois first state in the nation to fund a statewide home delivered meal program. D) Illinois operates an aggressive nursing home diversion program requiring every person requesting nursing home admission to be prescreened by a Community Care Program (Medicaid waiver home and community based services program) care coordinator and offered a package of community based services in lieu of nursing service admission. This is backed up by a hospital diversion program that requires the hospital to notify the appropriate pre-screener 24 hours in advance of the discharge of Medicare beneficiary. Note: DoA has limited the effectiveness of this program by allowing prescreening on short term stays to be completed within 2 weeks of admission.**

Misleading Statements Medicaid Workgroup

Lucas Group: In 2000, income eligibility for aged and disabled populations increased, which resulted in approximately 136,000 new enrollees.

> **Fact: The Lucas Group failed to connect all the dots. The increase in aged enrollees was absorbed by the home and community based services waiver program. Between FY 99 and FY 09, HCBS waiver enrollees increased 42%, while nursing home residents dropped by 13%.**

Lucas Group: Between FY 99 and FY 09, Medicaid liabilities increased by an average rate of 6.9% per year.

> **Fact: The Lucas Group again failed to connect all of the dots. Medicaid liability for nursing homes grew by only 1.6% between FY 99 and FY 09. In round numbers, Medicaid liability increased by $6 billion between FY 99 and FY 09, with nursing home liability accounting for only $400 million of the increase. According to an AARP report, the escalating Medicaid liability is not the result of increased costs for services to those over 65 years of age.**

Lucas Group: Medicaid liabilities will reach $22 billion by 2019 if it continues to grow at an annual rate of 7%. If the growth rate can be reduced to 3% per year, Medicaid liabilities would be only $15 billion in FY 19.

Fact: By lumping all Medicaid programs together, the Lucas Groups allows the reader to come the conclusion that the state will need to reduce liability in all to get spending under control.

Lucas Group: Of the 160,000 seniors in the Medicaid system, many are in nursing homes that with appropriate support services could live in a less costly community setting.

Fact: Only approximately a third of the 160,000 seniors in the Medicaid program. Of the approximately 54,000 to be served in nursing homes in FY 10, less than 32%, according to AARP, are longer term stays. The remaining seniors are receiving post-hospital services.

Lucas Group: AARP research shows that nursing home beds are not needed because seniors would prefer to receive end of life care in their own homes.

Fact: According to AARP, preference is only one factor that must be taken into account in projecting future trends in demand for nursing home beds. They indicate that projecting trends is difficult, because you must also factor in disability trends and life expectancy.

Inaccuracies in Medicaid Workgroup Report

Lucas Group: Between FY 99 and FY 09, Medicaid liabilities increased by an average rate of 6.9% per year.

FY 09. Liability in FY 99 was $4,517.8 million. This increased to $9,206.0 million in FY 09, for a growth of $4,688.2 million or 103.8%.

Lucas Group: Growth in Medicaid expenditures is blamed in part on increasing costs of nursing home care.

Fact: As stated earlier, nursing costs grew by an average of 1.6% each year between FY 99 and FY 09. Less than 10% of the average annual Medicaid increase is attributable to increased nursing home costs. Given that experts acknowledge that nursing home admissions are increasingly frailer, older, and in need of more complex medical treatment, facilities are to be commended for keeping their costs down.

Lucas Group: The Lucas Group reported that an AARP document showed that in 2009 Illinois has a rate of older adults in institutions of 5.0 per thousand.

Fact: AARP reported that in 2007 (report released in 2009) Illinois had a rate 5.0 seniors per 100 in facilities.

Lucas Group: Cutting nursing home admissions by approximately 40% over 5 years is necessary to reduce growth in Medicaid liability to 3%.

Fact: Note that the Lucas Group is not suggesting slowing the growth in nursing home admissions, because they are actually decreasing year due to client preference and decreasing rates of disability and functional limitations. By denying nursing home admissions to individuals who in collaboration with their families and their doctors have chosen this option, the Lucas Group is suggesting that you control Medicaid spending by denying services to the frail elderly. Instead the state needs to isolate the real sources of the escalating Medicaid costs and develop strategies to bring them under control.

Faulty Assumptions in the Human Services Report

Deloitte: Mega-human services agencies, such as the one operating in Ohio; more efficiently and effectively administer human services, including aging services, than Illinois.

Reality: While the Illinois system may not be perfect, it is not broken, as suggested by the Lucas Group. The creation of the Illinois Department of Human Services has not eliminated silos or insured the integration of programs and functions. Instead of separate agencies, there are now simply separate divisions within the same agency. More importantly, consumers lost the transparency that existed prior to the merger.

Deloitte: Court decrees driving the Illinois human service delivery system have created an environment that hampers the state's overall effectiveness.

Reality: Money follows the person in Illinois senior services programming, because of a 1982 court order. For this reason, Illinois does not have wait lists for its Community Care Program.

Deloitte: Outsourcing call centers will save the state money.

Reality: Illinois has outsourced information and reporting lines and brought them back in house over the years. In most instances, lack of quality control drove the decisions to eliminate outsourcing.

Deloitte: The state can achieve significant savings by better coordinating assessment of customer needs.

Reality: The elderly are a very distinct population with very unique communication needs. DoA case managers receive specialized training to work with this population. Potential savings must be weighed against reduced quality and the potential for losing elderly clients through cracks in the system.

Deloitte: "The state must quickly transition from being a provider of generous, uninterrupted, institutionalized care..."

Reality: Care plans for nursing home residents are based on the specific health care needs of each individual resident. The Department of Healthcare and Family Services monitors facilities to make sure care plans are consistent with the needs of the residents and that the resident is receiving the services promised. To characterize this process as driving "generous" care plans suggests that the drafter is advocating for nursing homes to ignore a portion of the care needs of their residents, which would be in conflict with federal regulations.

Deloitte: "The state must quickly transition ..... to a locator of rapid, varied, and sustained pathways to quality community vendors."

Reality: The state "provides" home and community based services in much the same way they "provide" nursing home care. This seems to imply that the drafter is suggesting that the state would simply locate non-public funded services.

Deloitte: "Projections from the aging Baby Boomer generation foresee increasing needs for the state to manage customers' access to Medicaid and other services, while the opportunities and complexities of modern life and their implications on traditional nuclear family structures likely mean an increasing need for dense a matrix of community-based care outlets."

Reality: Increased demand from the baby boomer generation and implications of modern life on the traditional nuclear family structure are as relevant to arguing for the continuing need for nursing home services. In reality, disability and functional limitation rates are decreasing at higher and higher ages for the older population in general, which argues for increasing need for home and community based services. The fact that the fastest growing segment of the state's population is 85 plus, the upswing of two-wage-earner families, and divorce rates among women age 50 plus all argue for a continuing need (although declining) for nursing home beds.

Deloitte: Illinois will need to start from a "standstill" in revamping its long term care system, because the state has not fully embraced the community-based service model.

Reality: Illinois has been incrementally rebalancing the long term care system since 1982, when the Community Care Program began operating as an entitlement program. In 1997, Illinois became the first state to take their home delivered meal program statewide. In 1998, Illinois rolled out its assisted living Medicaid waiver program. In 1999, the state began licensing assisted living and shared housing. In 2000, Illinois expanded its state funded older adult prescription drug program and the Senior Health Assistance Program. In 2001, Illinois became one of only two states to receive a waiver to fund its prescription drug program. In 2004, Illinois implemented a nursing home transition program. In 2007, the state passed a formal money follows the person program. This is to name just a few of the leaps forward the state has made in the last 2 decades.

Deloitte: The availability of nursing beds permits case managers who want to clear their caseloads quickly to place people inappropriately in them.

Reality: Illinois' system does not work this way. Case managers, or as they are called in Illinois, care coordinators, do not place people in nursing homes. They are employed through the Community Care Program. Their primary function is to develop home and community based services care plans. In addition to these duties, they complete prescreens for individuals who have made applications to nursing homes.

Deloitte: It is easier still to leave a client in institutional care, potentially denying that individual the opportunity to lead a more dignified life in a less restrictive setting.

Reality: Although Illinois' care coordination system is set up for care coordinators to follow their clients into the nursing home for short stays and assist them in transitioning back to the community, to date, the state has not funded this component. Therefore, the care coordinator leaves their client at the nursing home door.

Deloitte: Nursing home residents are not leading dignified lives.

Reality: The vast majority of nursing homes in Illinois have embraced many of the "greenhouse" concepts using a concierge type delivery system. Great care is taken to diminish loss of control and allow each resident life with dignity.

Inaccuracies in Human Services Report

Deloitte: DoA, along with DHS and DCFS, operates local service centers.

Fact: DoA does not have local offices. All services, included case management, are provided by contract with community level providers. Case managers operate virtual reality offices, taking their services to clients' homes.

Deloitte: DoA oversees services for 1.3 million older adults.

Fact: An unduplicated count of older Illinois services by programs administrated by the Department on Aging is not available, but 1.3 million older adults represent all Illinois residents age 65 and older. Only a fraction of these individuals receive services. For example, the Community Care Program is projected to serve only 54,000 older adults in FY 10. The home delivered meal program will serve an approximately 50,000, but many are also participants of the CCP program.

Deloitte: The Department on Aging administers the Circuit Breaker Pharmaceutical Assistance Program.

Fact: The Circuit Breaker Program is a grant program that assists low income seniors with property tax relief.

Deloitte: The Community Care Program provides services to low-income older adults.

Fact: The Community Care Program is available to all seniors with assets of $17,500 or under, regardless of income. Approximately 50% of the participants have their care paid for under the state's HCBS Medicaid waiver. The remainder is funded solely by GRF.

Deloitte: The Department of Human Services and the Department on Aging serve the health care needs of the elderly.

Fact: The Department on Aging and the Department of Healthcare and Family Services, not the Department of Human Services serve the health care needs of the elderly.

Deloitte: It costs $36,000 to $140,000 per year to serve a typical client in a nursing home and at these prices only the most in need should be serviced in a nursing home.

Fact: Medicaid, on the average, pays an estimated $36,000 for nursing home care. $140,000 represents very high end, private pay nursing home services.

Deloitte: It costs $8,400 to $17,000 per year to coordinate Medicaid home and community based services.

Fact: Service Maximums for direct care in the Community Care Program range from $2,400 to $19,200 per year, depending on the older adult's Determination of Need (DON) score. This does not include other components in a package of care, such as home delivered meals or money management. These also do not cover the cost of care coordination, which is provided by local Case Coordination Units.

Deloitte: Illinois operates a total of 104,000 nursing home beds with just over 81,000 occupied.

Fact: The state does not "operate" nursing homes. It does certify Medicaid beds to insure that a bed is available when it is needed. The number of certified beds by definition must be greater than the number of occupied beds. The state does not pay based on the number of certified beds; instead reimbursement is based on the care actually provided. The State is not paying for unoccupied beds. Closing unoccupied beds will actually have a negative revenue impact since nursing homes pay a provider assessment on all beds, regardless of occupancy.

Deloitte: Pennsylvania has recently implemented a successful bed reduction program.

Fact: According to officials in Pennsylvania they have not enacted a bed reduction program.

April 21, 2009

To: The Honorable Governor Pat Quinn
The Honorable Members of the General Assembly

From: Pat Comstock, Executive Director

Subject: The Lucas Report & the Response from the Senate Republican Caucus

For nearly two decades, Illinois' revenue has not kept pace with expenditures for the entire continuum of Medicaid services. Exacerbated by the current financial crisis, Illinois policymakers have now been challenged, and rightly so, to carefully examine how the state pays for critical services and to seek cost efficiencies.

On behalf of our 600 facility members, the 60,000 Medicaid residents served and the 80,000 employees who work with our residents every day, the Health Care Council of Illinois stands ready to work in partnership with policymakers to assist in evaluating proposals and recommendations that have been put forward. The following analysis of the Lucas Group Report and the subsequent report issued by the Republican members of the Illinois Senate Committee on Deficit Reduction is the first of these assessments.

In reading the Lucas report and the Senate Republican Caucus response, the General Assembly should be aware of the following general concerns:

- The Lucas Group based their long term care savings on an average cost for facility care that was almost double what Medicaid pays in Illinois.

- The Lucas Group Report contains inaccurate and misleading data, which calls into question conclusions and recommendations contained in the document.

- Global waivers and global budgeting programs suggested by the Lucas Group Report have produced questionable results. The report also includes other recommendations that have already been implemented and other measures that have been tried and scrapped because they failed to produce the promised benefits.

- The inter-relationship between the State's acute care and long term care systems is not fully reflected in the report. As acute stays get shorter and more procedures are handled on an outpatient basis, the demand for rehab, post acute, and post surgery care rises. The demand for this relatively new use for facility beds is strong and growing in Illinois.

- The success of "rebalancing" long term care services in Illinois' has not been accurately presented. Rebalancing is being achieved as a result of new programs and a focus by long term care providers on the needs of the residents. The MDS-based reimbursement program has been a driver of this process.

The remainder of this document addresses the four concerns highlighted above. **The entire long term care profession has consistently demonstrated its priority for working in partnership with the State of Illinois for the benefit of the residents whose care we manage.**

Nursing and rehab centers not only provide vital services to Medicaid residents, we make a significant contribution to the State's economy. Collectively, we employ over 80,000 individuals, contributing over $5 billion to local Illinois communities in payroll, purchases of food, supplies and services, utilities, and local taxes. In many rural communities in Illinois, the nursing and rehab center is the largest employer.

Under the federal stimulus law, which provides the States with an enhanced federal Medicaid matching rate of 60 percent (an increase of more than 10 percent), for every $1 Illinois spends on Medicaid, the federal government will contribute $1.50. Medicaid has a tremendous multiplier effect on the economy – a greater impact than state spending on other programs – because it pulls a large infusion of new dollars – federal dollars – into the economy from outside the state. **One study indicates that each $1 of Medicaid spending generates $2.50 of economic activity in Illinois.**

Finally, and this must be remembered, **the Illinois Medicaid rate for nursing and rehab centers is still 49th in the nation out of 50 states.** The average Medicaid rate of $118 a day is $27 a day below the cost of care and $37 a day below the national average. **After recipient income is taken out of the payment, Illinois actually pays a little over $99.00 per day.**

The Health Care Council of Illinois is available to work with you personally on these issues and to provide the additional information you may need to face the challenges ahead. We respectfully urge you to carefully consider the recommendations made by the Lucas Group and the dramatic impact such changes will have on the services provided across the Medicaid continuum in Illinois.

The Long Term Care Profession Concerns Related to the Lucas Group Report and the Follow-up Report Issued by the Senate Republican Caucus.

Concern 1:
The Lucas Group Report Contains Inaccurate and Misleading Data

Data used to profile Illinois and other states is inaccurate and often apples and oranges are lumped together and compared to grapefruit.

- Cost of a Medicaid Stay. Cost savings promised in the Lucas Group plan are vastly overstated. **Medicaid in Illinois pays only about $36,000 per year** for a nursing and rehab center stay, not the $60,000 included in the report.
- Importance of Care Setting. The report places an over-importance on staying at home. A 2006 survey of Illinois AARP members found that **the issue ranked 11th in a list of issues of extreme interest/concern**. In fact, it TIED with FINDING DEALS AND DISCOUNTS and was well below the top three: health insurance, Medicare, and medication affordability.
- Misleading and Inaccurate data. **Data presented in the report as factual is inaccurate and misleading.** This calls into question their assumptions about savings and their recommendations for changes to our long term care system.

  Misleading
  - Nursing and rehab center expenditure numbers include both long term stays and short term rehab/post acute/post surgery stays. They further confuse the issue by using expenditures for ALL ages, not just the 65 plus population.
  - Home and Community Based Care numbers are also murky. The GRF portion of our Community Care Program is not taken into account. On the other hand, what they portray as home and community based services is really home health and personal care services. All services not provided in a nursing and rehab center are lumped into this category.

  Number Errors
  - Missouri's home health/personal care is inflated by $70 million.

- Illinois' allocation for nursing and rehab centers is 55%, not 60%.
- The national average for home health/personal care is 40.1%, not 52%.
- Illinois' allocation for home health/personal care is 40%, not 33.1%.

Concern 2:
Global Waivers and Global Budgeting Programs Have Not Produced Desired Results

Global waivers, like global budgeting, might provide the state with flexibility to move money between programs. However, global waivers, like global budgeting, may be more advantageous in concept than they prove to be in practical application. These concepts have proven to be contrary to the pro-consumer elements of transparency and accountability. Careful study should be done to determine the long-term implications of such programs.

- Home and Community Services Global Budget. Experience has proven that the Department on Aging's experiment with global budgeting has served only to reduce transparency, diminish advocate oversight, eliminate the legislature's role in making program allocations, and enhance the authority of non-elected officials to make state funding decisions without legislative oversight.

- Global Waivers. Not only is the concept of global waivers relatively untested, it is not without its detractors. In an assessment released by the Kaiser Commission on Medicaid and the Uninsured in March of this year, reservations were raised about both Vermont's and Rhode Island's attempts to restructure their Medicaid programs, gain predictability in Medicaid expenditures, and expand coverage of targeted populations through global waivers. Specifically, the report noted that Vermont's waivers capped expenditures far in excess of their historical spending, which would result in little savings. In contrast to Vermont's generous cap, CMS lowered Rhode Island's cap below the amount requested. Kaiser's report indicated that Rhode Island's cap is significantly lower than spending projections of what will be needed to provide services to the eligible population. Without some adjustments, care and services will need to be rationed.

- The Senior Agenda Coalition in Rhode Island expressed concern about the viability of the state's global waiver and the potential for the rationing of care, including instituting waiting lists for in-home senior services. The Rhode Island legislature concurred, putting in place significant controls and oversight including a 16-member oversight committee and the retention of approval authority for all program changes prior to implementation.

Concern 3:
Relationship between Acute Care and Short Term Stays is Ignored

Understanding the inter-relationship between health care delivery systems – acute and long term care – is essential to achieving cost efficiencies without creating critical gaps in the state's health care delivery system. Likewise, the promised cost savings by the Lucas Group may be unrealistic if cost efficiencies already implemented are not considered.

- Increased emphasis on outpatient procedures may reduce cost on the acute side of the equation, but necessitates renewed support for residential rehab services. In Illinois, residential rehab services for Medicaid participants are provided in licensed nursing and rehab center beds and paid for out of the long term care Medicaid budget line. An increased emphasis on outpatient procedures coupled with a reduction in funding for long term care beds would create a critical gap in the healthcare continuum for Medicaid participants of all ages.

- Nursing and rehab centers are already doing their part to reduce acute care costs by implementing aggressive disease management programs. Illinois' nursing and rehab centers participate in the "Your Healthcare Plus," a medical management program operated by the Illinois Department of Healthcare and Family Services. The program focuses on targeted chronic care populations to prevent costly hospitalizations and maximize cost effective treatment approaches.

- It is unclear if the Lucas Group's savings projections factored in existing prevention and disease management programs.

Concern 4
Federal Stimulus Dollars are Already Allocated

The Lucas report also states that the federal stimulus dollars are a "source of funding without cost to the state taxpayer" and indicates that it is really "simply a matter of how the State wants to use the new Federal match revenue." Yet, in actuality a significant portion of the new revenue is already committed.

Federal regulations require the state to achieve a 30 day payment cycle for certain Medicaid services and to maintain this cycle during the life of the enhanced match. While the State was given 60 days – the months of April and May – to achieve the payment cycle goal, the State will need to borrow over $2 billion to achieve a 30 day payment cycle for nursing and rehab centers, hospitals and other Medicaid providers. Future federal matching funds will then be set aside to meet debt service payments and maintain the 30 day cycle. In reality, a significant portion of the enhanced match has already been spent.

Concern 5:
Illinois On-Going Rebalancing Efforts Ignored

The Lucas report displays a lack of understanding of Illinois long term care system – facility and non-facility based care. A quick review of the numbers demonstrates that the vast majority of seniors are not choosing to receive their long term care in nursing and rehab centers until they need the type of intensive medical care that can only be found in a nursing and rehab center. In reality, the vast majority of Medicaid nursing and

rehab center beds are not being used for long term stays, but rather post-surgical, post acute, and restorative services.

Facts about Rebalancing Long Term Care in Illinois

1. On-Going Rebalancing Efforts

Illinois' long term care and services system has been gradually recalibrating itself since 1982 when the U.S. District Court effectively transformed the Community Care Program into an entitlement program. The Benson vs. Blaser court order prohibits the state from denying services to anyone who meets program eligibility regardless of the amount of money budgeted.

Example: **Between FY99 and FY09, the number of seniors served by the Illinois' Community Care Program increased by 42%, while Medicaid nursing and rehab center residents dropped by 13%. Note: The Community Care Program data does not include state funded home deliver meal clients.**

2. Money Follows the Person

As demand for home services has increased and older Illinoisans have requested to receive their services in their own homes, money has followed them to the Community Care Program.

Example: **Between FY99 and FY09, the state's allocations for the Community Care Program increased a total of 169.2% - nearly 17% a year for each of the ten years. Note: The Community Care Program data does not include increase to the state funded home deliver meal clients.**

3. Bed Reduction Fallacy

As more seniors have opted for home based services, the state has paid for fewer and fewer seniors to receive their care in nursing and rehab centers. Unlike other states that pay nursing and rehab centers for unused beds, Illinois' reimbursement formula only pays for occupied beds. Taking unused Medicaid beds off-line will not reap a huge savings. In actuality, it will decrease revenue because facilities pay excise fees on all licensed beds, regardless of whether they are occupied or whether they still exist.

Example: **In the decade between FY99 and FY09, the state budget for nursing and rehab centers increased by only 16%.**

4. Post Acute Services Driving the Process

Medicaid is paying for more and more rehabilitation beds in nursing and rehab centers and fewer and fewer long term care beds. Long term residents are increasingly older and sicker, demanding more complex medical care than ever before.

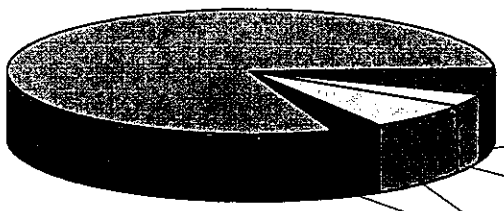
Examples:

- **In FY 08 alone, nearly 48,000 individuals were discharged from nursing and rehab centers in Illinois.**
    - **Over 38,000 returned to their homes.**
    - **Another 3,300 returned or were transferred to assisted living-type facilities.**
- **In FY 08, over half of the residents discharged resided in the nursing and rehab center for less than 32 days.**
- **In FY 08, 80% of the residents discharged stayed for only 84 days.**
- **Today, the average stay of a nursing and rehab center resident is 10 months, down from 19 months 15 years ago.**

All of the numbers presented in Concern 4 were calculated using MDS data provided by the Department of Healthcare and Family Services.

The following chart illustrates the data above.

When Residents Leave a Nursing and Rehab Center?
FY 08 Data



Return Home
38,000 People or 80%

Assisted Living
3,300 People or 7%

Nursing and Rehab Cente
1,500 People or 3%

Other
1,600 People or 3%

Enter a Hospital
3,500 People or 7%

Numbers in the chart based on MDS data provided by the Department of Healthcare and Family Services.

Conclusion:

The Health Care Council of Illinois pledges to continue its Partnership with Illinois to serve the needs of our most vulnerable residents.

The data included here provides clear evidence that nursing and rehab center providers have served as a strong partner with the State of Illinois to provider the best possible services to Medicaid residents in the most appropriate setting possible.

This analysis is intended to provide an additional perspective for consideration as work continues to craft a FY 10 budget. We believe that our analysis demonstrates that the recommendations included in the Lucas Group Report indicate a general lack of understanding of the Medicaid programs in Illinois and how they operate. Further, the report overstates potential cost savings, does not account for the past work of the General Assembly to achieve efficiencies and rebalancing, fails to account for the significant contribution made to communities by Medicaid providers, and, if implemented, may leave Illinois residents across the Medicaid continuum without needed services.

Please accept our pledge to serve as a resource for your deliberations. Our entire membership is available to you as you proceed with your work.