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## JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN SERVICES

### MEDICAID BUDGET - NURSING HOMES

**February 4, 2005**

For the record, I am Rose Hughes, Executive Director of the Montana Health Care Association. I am offering this testimony on behalf of our member nursing homes throughout the state of Montana.

We are here to talk to you about the need for adequate funding of nursing home services for Medicaid beneficiaries. Because Medicaid funds over 60% of all nursing home services, it is the single largest source of revenue to our facilities. This means that our Medicaid rates dictate the quality of services we can provide to the elderly in our care - our Medicaid rates dictate how many staff we can hire, what we can pay them, and how much training we can provide. We can either figure out how to live within our Medicaid rates, with all of the limitations that implies, or we can continue to shift costs to our private pay patients. Of course, the more we shift costs to these people, the sooner they spend down their assets and become eligible for Medicaid.

**Cost vs. Rate.** The Medicaid program pays nursing homes less than the actual allowable costs—as defined by DPHHS—for caring for each Medicaid beneficiary. And, those patients who pay for their own care pay more than the cost of care—to make up for what Medicaid doesn't pay. I have attached a sheet showing cost vs. rate information for the current year and also projected for FY 06 and FY 07. If all of the funding proposed by the Governor – both the 3% provider rate increase and direct care wage funding – are approved, the Medicaid rate for FY 07 will still be almost \$14 per patient day less than the actual cost of providing the care.

**Critical need for Medicaid to pay its fair share of the cost of care.** Montana's nursing homes are struggling to provide good care and keep their doors open. They are facing numerous challenges which make it more important than ever that Medicaid pay the cost of care for Medicaid beneficiaries:

- Acuity—the amount of care needed by patients continues to go up. Lighter care patients are no longer part of the “mix” in our nursing homes. Those requiring minimal care are getting those services in personal care and assisted living

facilities, or at home, leaving only the most difficult-to-care-for residents in our facilities. These sicker patients mean: more staff, more licensed staff, more documentation, more in services and training, more and different kinds of equipment and supplies—in short, higher costs.

- We are facing serious staff shortages and turnover rates that are through the roof.
- Census is down—there are fewer people seeking nursing home care. This means fixed costs are spread over fewer residents.
- The cost of liability insurance has skyrocketed. Facilities with no adverse claims history have seen substantial increases in their liability insurance premiums – because nursing homes have been targeted for litigation nation wide. Our workers' compensation insurance costs are also on the rise again.
- New regulations continue to drive costs up. Two recent examples are: (1) HIPAA privacy and security regulations will mean that some facilities will have to change their physical plant to maintain privacy and equipment changes may also be necessary; and (2) a new life safety code has been adopted which will end up requiring many of our facilities to remove all roller latches from existing doors. The cost per latch for doing this has been estimated at anywhere from \$100 to \$190 per door.
- The regulatory and enforcement process related to quality assurance continues to get tougher. The federal government continues to drive this process toward new, more stringent interpretations. These new interpretations “raise the bar” in terms of the care and services we are expected to provide and raise our costs without regard to whether anyone is willing to pay the costs associated with the care demanded.

These are the major pressures facing nursing homes today. Revenue is down. Care needs and costs are up.

If we are going to be able to provide the quality of care our patients deserve and the regulations demand, the Medicaid program is going to have to pay its fair share of the costs of providing care to Medicaid beneficiaries. Right now, the state of Montana is sending mixed signals to nursing facilities—on one hand, you send out state inspectors to demand only the highest quality of care for nursing home residents. On the other hand, you refuse to pay the costs of providing that high quality care. The role of DPHHS is ironic: One arm of the agency, the Quality Assurance Division, comes into our facilities and tells us we need more staff to meet the needs of our patients; and the other arm of the very same agency, i.e., Senior and Long Term Care Division is forced to tell us they won't pay for it—they must live within the legislative appropriation!

## What are we asking you to do?

1. *Provider rate increase.* We are asking you to appropriate sufficient funds to nursing home rate increases to close the gap between the cost of caring for Medicaid beneficiaries and the amount Medicaid pays for that care. We are asking you to do this because if you don't the quality of care provided to Montana's oldest, most vulnerable citizens will suffer. Medicaid is the primary payer of nursing home services in this state—you set the standard of care provided in nursing homes by your commitment or lack of commitment to pay for these services.

To provide the kind of care our parents and grandparents deserve, nursing homes need to hire more staff of all types (nurses, nurse aides, activities, social services), we need more licensed nurses, we need more and better training for our staff, and we need to pay them more for their hard work. But we can't do these things without your help.

The department changed nursing home reimbursement to a "price-based" system. It was designed to make the reimbursement system less volatile and rates more predictable. This system is basically a flat rate for a day of nursing home care—adjusted only for the acuity level of patients in each facility. MHCA supported the move to a price-based system. However, the new system is not a panacea for the problems our nursing homes face. A price-based system is only as good as the PRICE that is set. This system will not work if the price does not keep up with increases in the cost of providing care.

2. *Intergovernmental transfers (IGT's).* The department requests spending authority to use intergovernmental transfers to increase funding to nursing homes. We support this request.

However, we do not believe the IGT program will continue to generate funding at current levels. Our expectation is that the IGT program may be able to generate "at risk" payments in amounts that are about half of what facilities currently receive. And even this minimal program will be possible only if we stop the practice of using IGT funds to fund other programs. We strongly believe the base funding of \$1 million per year currently going to community services and \$648,000 per year currently going to the nursing home base should be replaced with a different funding source.

3. *The Bed Tax.* Nursing homes pay a nursing home "bed tax" of \$5.30 per patient day, which brings almost \$11 million per year into the general fund and a special revenue account. The nursing homes are currently the only Medicaid provider

that pay a tax to help generate funds to pay their Medicaid rates and have been paying the tax since 1991. When they agreed to pay the tax back in 1991, it was to "catch up" rates that were critically inadequate. Their understanding was that the state would then keep their rates current instead of letting them fall behind again. Unfortunately, that has not been the case.

However, we are once again willing to pay a tax to "catch up" our rates. As part of our effort to generate Medicaid rates that cover the cost of providing care, we are proposing that the legislature approve an increase in the nursing home bed tax. We will ask that the amount of the increase be sufficient to move rates to cost after first applying the rate increase and direct care worker wage increase proposed by the Governor. This will assure that the tax increase is no higher than absolutely necessary to pay for the cost of care.

Some legislators and consumers have raised the issue of the unfairness of this tax on private pay residents in nursing facilities. The tax was designed to help the private pay residents by reducing the cost shift. However, because the difference between our rates and the actual cost of care has crept up again, the private pay resident is asked to pay the cost shift, plus pay the bed tax. If you want to be fair to the private pay residents in nursing homes, the state must pay the cost of care to Medicaid beneficiaries to avoid the large cost shift to the private pay residents.

4. *Bed days.* The department's budget request includes a small increase in utilization of bed days. It appears that occupancy in nursing facilities has stabilized. Other states have watched nursing home bed days go down, stabilize, and start to increase again. We strongly support the modest increases in bed days requested by the department. It would be foolish to underestimate utilization; it is an approach sure to create budget problems in the future.

Thank you for the opportunity to offer testimony of this portion of the budget. I would be pleased to answer any questions you may have and to work with subcommittee members and the department to find solutions to the issues we have raised.