



SKILLED
NURSING CARE
COALITION

**Finance and Financial Institutions Committee
Testimony of the Skilled Nursing Care Coalition
By Robin L. Hillier, LNHA, STNA, CPA
May 19, 2009**

Good morning, Chairman Carey, ranking member Miller and members of the Committee. I am Robin Hillier and I thank you for the opportunity to come before you today representing the almost 85,000 people who are cared for around the clock each day by dedicated staff at our skilled nursing facilities (SNFs) and could not be here to speak for themselves. Specifically, I am here on behalf of the Skilled Nursing Care Coalition (SNCC), whose members include the Association of Ohio Philanthropic Homes Housing and Services for the Aged (AOPHA), the Ohio Academy of Nursing Homes (OANH) and the Ohio Health Care Association (OHCA). As a licensed nursing home administrator and recent SNF owner, a state tested nursing assistant and a certified public accountant; I am in a unique position to talk with you regarding the impact the budget bill as it currently stands will have on the more than 50,000 Medicaid recipients who rely on us all day, every day for care.

Here is what I hope you will take away from my testimony:

- More people in SNFs need more care from staff, but inadequate funding over many years already has forced staff cuts and reduced our ability to care for patients.
- The lack of an increase for SNFs proposed in this budget will hurt patients who choose SNF care.
- The SNCC supports funding for the full continuum of care but that has to include SNFs as well, because we are taking care of patients who need more and higher levels of care as they have remained in other settings longer and come to us with greater care needs.
- SNFs are being asked to pay a large fee increase that could be used to give SNF providers and the Medicaid recipients they care for a much needed increase, and still allow the state to shift more than half of the fee revenue and the accompanying federal matching funds to other purposes.

Last week I worked a shift as a nurse aide at a SNF in Oberlin and I was honored to care for ten residents, many of whom were Medicaid recipients. Today I want to tell you about Jerry Majoras and his parents, who were among those who were in my assigned set.

Jerry grew up in Grafton, Ohio and attended Midview High School, where he was a track star. After graduating, he enrolled in the Columbus College of Art and Design, where he received a scholarship. While home on break from College, he was hit by a car while riding his bicycle. He suffered a traumatic brain injury and became a quadriplegic, paralyzed from the chest down. He required far more care than could possibly be provided by his parents at home, even with available community based services, so he moved to Welcome Nursing Home after he was discharged from the hospital. He has lived at Welcome Nursing Home since November 17, 2003.

Jerry is confined to a wheelchair and is dependent on staff for virtually all of his care. He requires assistance from two nurse aides for most of his activities of daily living, such as bathing, dressing, getting in and out of bed, repositioning himself, and managing his incontinence and his ileostomy. He requires a nurse aide to feed him lunch and dinner; he receives breakfast and several snacks throughout the day and most of his medications through a G-tube in his stomach.

He is prone to seizures because of his head injury, and to skin breakdown due to his inability to shift his weight. He has a history of serious respiratory infections. Because of his traumatic brain injury, he is susceptible to inappropriate behaviors and decline in mood. Although his accident left him with use of his arms and hands, his left shoulder is frozen and his hands and arms are severely contracted so his ability to use them is limited.

When we began our shift, another aide and I went to Jerry's room and changed his adult brief, bathed him and changed him from his pajamas into his clothing for the day. The other aide went on to care for someone else while I shaved him, brushed his teeth, combed his hair, applied the splints to his left hand and right elbow and protective boots to his feet, and repositioned him with various pillows to relieve as much pressure as possible from pressure points on his bottom, knees, ankles, etc. I was with him initially for approximately 40 minutes, requiring the assistance of a coworker for about half of that time. As I was leaving to care for the others on my "set" (I was assigned to care for nine other residents in addition to Jerry), the treatment nurse came in to provide his morning skin treatments.

Because he is at such great risk for pressure ulcers, the treatment nurse applies several protective barriers (similar to large bandages) and medicated cream to his bottom and genital areas. His ostomy and g-tube also require cleaning and changing on a regular basis. His skin must be monitored closely from head to toe for signs of breakdown. This skin care procedure took approximately 20 minutes.

As the treatment nurse was leaving, another nurse entered the room to administer his breakfast and morning medications through the tube in his stomach, and to deliver a breathing

treatment. This took about another 15 minutes. As the nurse was leaving the room, the restorative aide came in to provide passive range of motion exercises to his arms, hands, legs and feet. Even though Jerry cannot move these limbs, it is important that they be exercised daily. This program took almost 30 minutes.

While these other staff members were working with Jerry, I was busy making sure the other residents in my assignment were up, dressed, clean and fed. I made sure they had their glasses, dentures, and that their call lights, tissues, remote controls and telephones were in reach. I shaved the men and helped the women with their makeup. I changed any beds that were soiled, made the other beds and made sure everyone was comfortable.

By now it was time to make the rounds of my assignment and help people who needed to use the bathroom, or needed to be changed. Many of these people require two staff to help them, so teamwork was important as we each tried to help our own residents, yet be available to help our coworkers with those residents who need two people to help. Many patients require the assistance of a mechanical lift in addition to two staff members, so coordinating the use of the shared lifting devices was also important and time consuming.

After a short break, it was noon and it was time to get Jerry out of his bed and into his wheelchair for lunch in the dining room followed by a game of Tripoly – one of his favorite activities. Because his skin is so fragile, Jerry can only sit up for a few hours, so we plan when to get him up around which activities he wants to participate in throughout the day. With the help of another aide and a Hoyer lift, we made sure Jerry was clean and dry and transferred him from his bed into his wheelchair. This took about 20 minutes. Jerry went to the dining room, where I spent 65 minutes feeding him his lunch. He looks forward to his meals, but they are very time consuming from a staffing perspective. While I was feeding Jerry for over an hour, I was not available to help any other patient who needed assistance.

After Jerry finished his lunch, the remainder of my shift was spent with the rest of my assigned patients and helping with others who need assistance of two staff. After lunch, residents needed help using the bathroom and laying down for a nap, or getting comfortable in a chair in the room to watch television, read or receive visitors. At the end of the shift, we documented all that we did that day.

It would not be possible for Jerry to receive the help he needs at home. In fact, Jerry's dad, Frank, and his mother, Betty, were also among the residents I took care of last week. Frank first came to Welcome early in 2008 for rehab and returned home. After a decline, he returned to Welcome last September and now shares a room with Jerry. Betty was been at Welcome for rehabilitation since February.

Jerry is one of four quadriplegic or paraplegic patients who live at Welcome. While their specific care needs vary, they all require the same intensive staff time. Jerry is one of 36 patients at Welcome who require two staff to provide assistance with at least one activity of daily living, most require that much help for most of their care needs. These people rely on Welcome

Nursing Home to provide their care.

Welcome Nursing Home has received virtually no increase in their Medicaid rate since 2004. Costs have continued to increase during that time, so they have lost money for the past several years. Worker's compensation premiums alone increased \$150,000 since 2004 due to the elimination of the 75% credit that providers received for many years (including the year that set the current prices). Additional increases occurred in liability and health insurance, and in food and supply costs due to the high cost of fuel experienced last year. In order to stay in business, they have basically frozen wages since 2004. They have eliminated approximately 5 full time equivalents in the nursing department, and have replaced a number of RNs with LPNs. They have made reductions in housekeeping, dietary, maintenance, and administrative positions. They have reduced their employee benefits and increased the employees' share of health insurance premiums. They have fully used their line of credit and are paying their vendors much more slowly than in the past. They are not alone.

Many - if not most - facilities have frozen wages or given increases far below the Consumer Price Index (CPI). In fact, cost report data shows that the average wage for a nursing assistant rose just 5.5% from 2004 to 2007, while the CPI increased nearly double that amount (10.45%). This means that our hard working employees have less purchasing power now than they did five years ago. (See Attachment 1: Direct Care Staffing: The Link Between Reimbursement and Quality - Page 1.) Like Welcome, many facilities have also had to make the heart-wrenching decision to reduce direct care staff. During that same period, Ohio SNFs were forced to reduce direct care staffing by 2.4 million hours, which is more than 1,100 full time equivalents. While cost report data is not yet available for 2008, our information indicates further wage restrictions and direct care staffing cuts have occurred as a result of yet another year of low rate growth. Additional jobs have also been lost in other departments such as activities, housekeeping, dietary and maintenance.

Welcome Nursing Home's acuity has increased almost 15% since 2004. This is consistent with what has occurred in SNFs throughout the state. The people we take care of have never needed more help. (See Attachment 1: Direct Care Staffing: The Link Between Reimbursement and Quality - Page 2.) We take care of people who are so compromised they depend on us for the most basic personal tasks such as scratching their nose when they have an itch. The number of people in our facilities who need help from two staff members to get dressed increased by more than 18% from 2004 to 2007, as did the number of people needing two aides to help them with personal hygiene. During this same period, 13% more people needed two aides to help them move in bed and there was an increase of 12% who required two aides to take them to the bathroom. Many of these activities occur frequently throughout the day. (See Attachment 2: Increasing Acuity of SNF Patients.) So, while we have been forced to reduce direct care staff, we are facing a huge increase in the number of people who need two nursing assistants to provide their care. We hear about "tough decisions" needed to balance the state budget. My tough decisions come when a call light goes on and I know that two aides are required to help that person, and I don't have a coworker available to help me

deliver the care being requested.

Additional demands are also being placed on nurses. For example, there has been a 34% increase in the number of patients taking 15 or more medications, the number of people requiring daily injections grew by 27% and there was a 26% increase in the number of people receiving IVs. These are all time-consuming nursing tasks.

Over the past five years, SNF rates grew an average of only about 1% per year, while the CPI grew by 19%. This deficiency reduced our ability to purchase goods and services and resulted in the need for difficult operational cuts. (See Attachment 3: SNF Rates Have Not Kept Up With Inflation.)

We appreciate the improvements the House made in funding SNFs – reducing the devastating cuts the Governor proposed and providing additional Medicaid reimbursement to help compensate for the 76% franchise permit fee increase. However, the House budget still leaves the SNF profession as a whole flat funded for the biennium, and even with the reimbursement formula changes in the House budget, 430 out of 925 Medicaid facilities are in a worse position than they are today. Forty-three of those SNFs would lose more than half a million dollars, and 20% of all SNFs would lose \$200,000 or more.

The House plan stretches out the transition to the pricing system for SNFs, makes the price for capital more equitable, and provides other modest increases to the prices. Nonetheless, above-price providers would experience rate cuts in both Fiscal Year 2010 and Fiscal Year 2011, and neither above nor below-price providers would receive full reimbursement for the franchise fee they pay, even for the fees on their Medicaid days. Although the House budget raises SNF prices \$3.00 per day in FY 2010 and an additional \$2.35 per day in FY 2011, these increases do little for above-price providers and do not address the fundamental problem that Ohio's prices for direct care – the most important component of SNF care – are based on the 25th percentile. This is the lowest formula for direct care in the country.

The path we have been on of artificially low rate increases and steadily increasing acuity cannot continue without hurting the quality of care provided in SNFs. Our residents have shared the sacrifice of a challenging economy and difficult state fiscal situation for far too long. In fact, Ohio is already spending \$272 million less in state tax dollars in the current biennium to care for our patients than in the SFY 2004-2005 biennium. (See Attachment 4: Declining State Share of SNF Funding.)

As the State has undertaken its “rebalancing” efforts and additional choices have been made available for long term care services, the number of Medicaid days of care in SNFs has been declining. According to the Department of Aging, the state has saved a billion dollars as a result. We strongly support appropriate placement and consumer choice and consider the declining Medicaid occupancy in SNFs to be a sign that rebalancing efforts are working. It is important, however to provide appropriate funding for each option within the continuum. As more people receive their long term care services through home and community based options,

the acuity of those who seek care in a SNF increases (as is demonstrated above).

In other words, while home and community based services are cheaper on the front end, the cost to care for people when they eventually must choose a SNF for their care increases because they have greater care needs by the time they come to us. To rebalance in a manner that doesn't negatively impact the very consumers the State is trying to help, our rates must continue to increase in order to keep pace with our patients' increasing care needs and the rising cost of delivering care over time. Supporters of rebalancing efforts, such as the Business Roundtable, often cite Oregon, Maine and Washington as "model" states. It is important to note that both Oregon and Maine pay SNF providers higher average rates than the average paid in Ohio.

The SNCC is asking that the Senate make several adjustments to the House budget, which would cost an additional \$36 million in state funds. (See Attachment 5: SNCC Requested SNF Reimbursement Provisions for Am. Sub. H.B. 1). Even with this increase, SNFs will be providing significant dollars for the state to use in other areas of the budget because the franchise permit fee generates far more in revenue than is being returned to providers. The fee increase in the budget bill will require SNFs to pay \$285 million to the state over the coming biennium. That \$285 million will draw down \$684 million in federal match, for a total of \$969 million in additional revenue for the state. Compared to SNFs' current funding level, our request when added to what the House has done would amount to \$412 million in total funds, leaving \$557 million to be used elsewhere in the budget.—

We are frustrated that we are being required to pay a hefty fee out of dollars that otherwise would be used for patient care, but we are sensitive to the fiscal difficulties being faced by the State in the current economic environment and the "tough decisions" that have to be made. We feel it is only right that Ohio's SNF patients receive a portion – not even half – of the revenue we are generating for the state to help cushion the blow of the fee increase, to help protect Ohio jobs, and to help ensure quality care.

Thank you. I would be happy to answer any questions you may have.

Attachment 1

Page 1

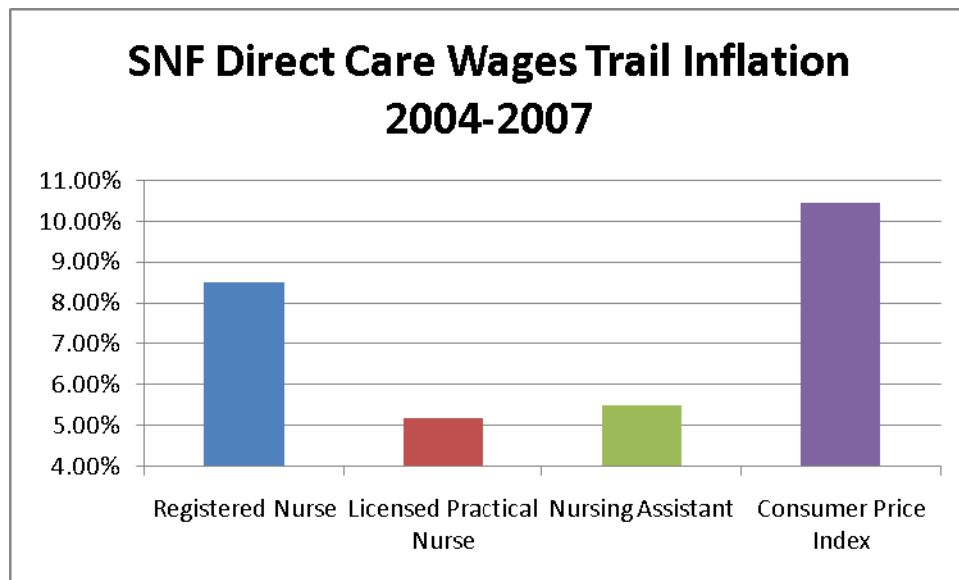
Direct Care Staffing:

The Link Between Reimbursement and Quality

“Staffing is a vital component of quality care for nursing home residents. Associations have been found between higher staffing levels in nursing homes and fewer hospitalizations, fewer infections, fewer pressure ulcers, less skin trauma, less weight loss, decreased resistance to care, and improved functional status.” (U.S. Centers for Medicare and Medicaid Services, June 24, 2008.)

Because of low reimbursement rates over the past five years, Ohio skilled nursing facilities have been forced to reduce cost, which has meant cutting direct care staffing.

SNF direct care wages over the period 2004-2007 have not kept pace with inflation.



A recent survey completed by SNFs that in 2008 provided 55% of the total days of care in Ohio shows that the trend of sub-inflationary average direct care wage increases continued through 2008.

Attachment 1

Page 2

Direct Care Staffing:

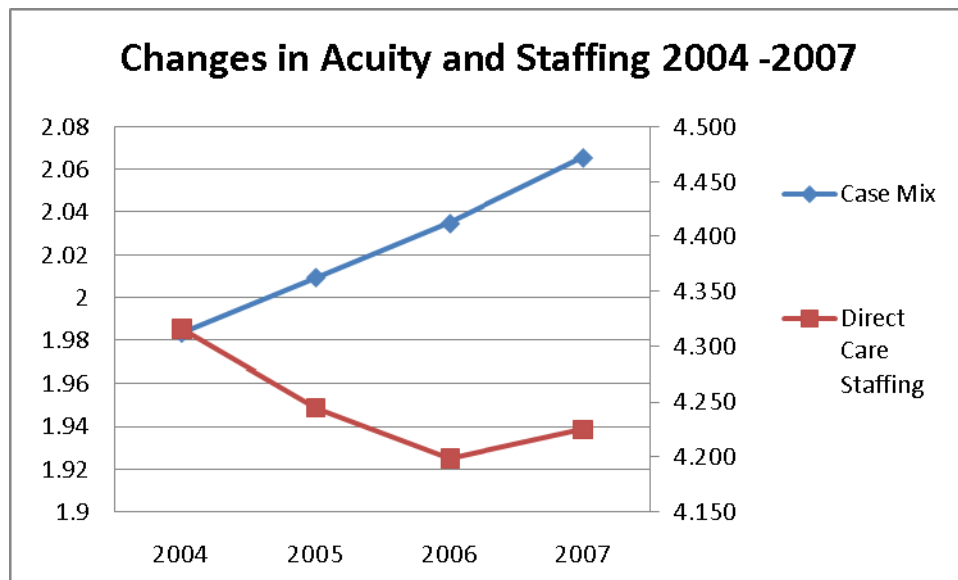
The Link Between Reimbursement and Quality

SNFs in Ohio actually reduced the amount of direct care staffing between 2004 and 2007, despite rising patient acuity – that is, the patients had greater care needs requiring more staff time.

As a result, by 2007, Ohio SNF patients were receiving 2.4 million fewer hours of direct care than in 2004.

When calculated as full-time equivalents (FTEs), Ohio SNFs employed 1,100 fewer direct care FTEs in 2007 than in 2004, even though patients' care needs continued to grow.

According to data from a recent survey of Ohio SNFs, facilities cut direct care staffing even more deeply in 2008.



Further reimbursement cuts and fee increases, as proposed in the Governor's budget, will result in further staffing reductions and job losses.

As there are fewer direct care workers, they will have less time to take care of patients despite their increasing care needs, and patients will experience more negative outcomes.

Attachment 2

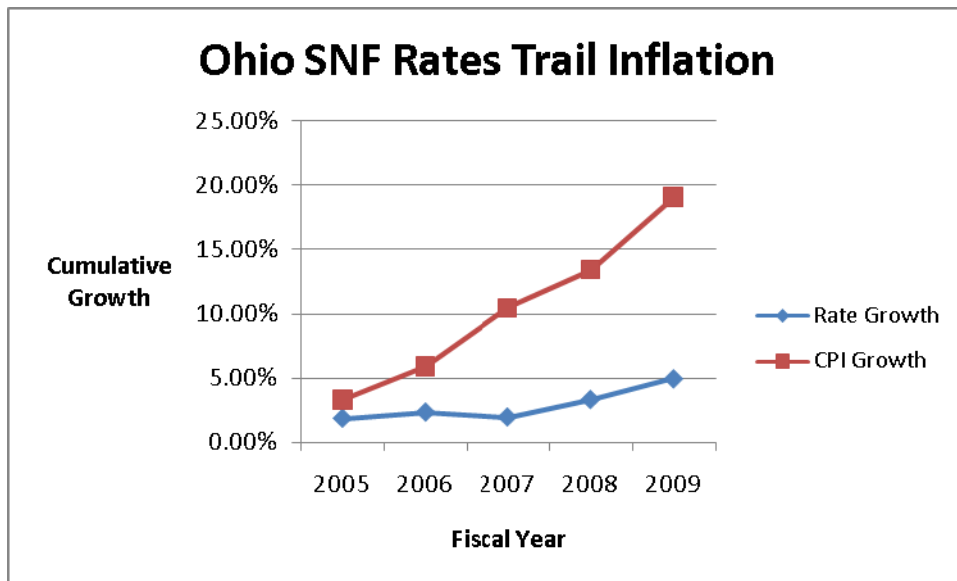
Increasing Acuity of SNF Patients

Attachment 3

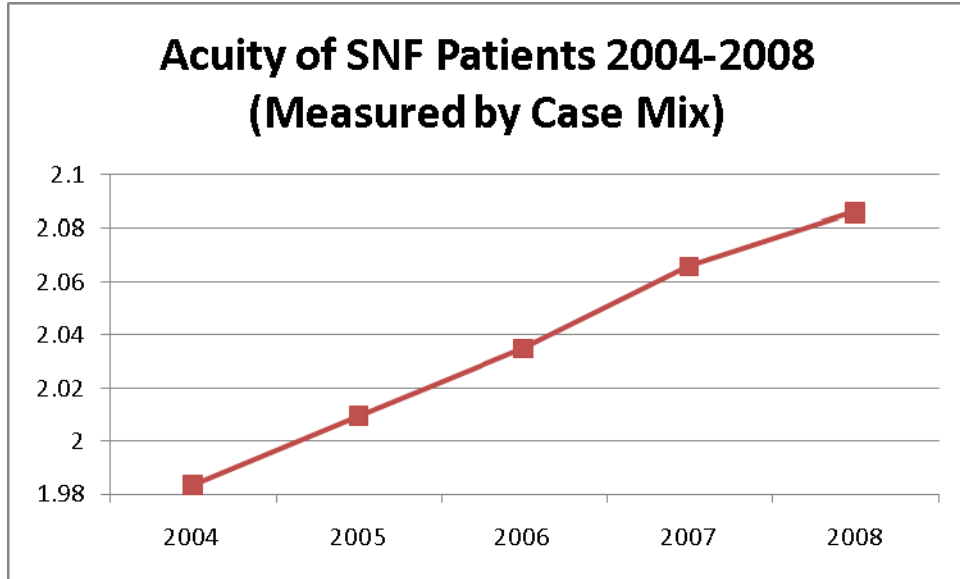
SNF Rates Have Not Kept Pace With Inflation or Patient Acuity

Over the past five years, SNF rates grew an average of only about 1% per year. This was less than one third of the rise in the Consumer Price Index (CPI), which grew 19% over the period.

The compression of rates has reduced the ability for facilities to purchase the same amount of goods and services and forced them to make cuts.



At the same time rates were compressed, the acuity (care needs) of SNF patients rose continuously.



Attachment 4

Declining State Share of SNF Funding

Biennium	Total SNF Spending	Franchise Fee Revenue	Net Spending	State Share @ 40%
FY 2004-2005	\$5,438,190,266	\$541,891,301	\$4,896,298,965	\$1,958,519,586
FY 2006-2007	\$5,240,955,609	\$793,453,774	\$4,447,501,835	\$1,779,000,734
FY 2008-2009	\$5,118,044,689	\$901,688,122	\$4,216,356,567	\$1,686,542,627

Difference 04-05 to 08-09 (\$320,145,577) \$359,796,821 (\$679,942,398) (\$271,976,959)

Attachment 5

Skilled Nursing Care Coalition Requested SNF Reimbursement Provisions for Am. Sub. H.B. 1

1. Transition for Under-Price Providers: Pay Under-Price Providers 50% Price, 50% FY 2009 Rate in FY 2010; 100% Price in FY 2011.
2. Transition for Over-Price Providers: Hold Over-Price Providers Harmless at FY 2009 Rate for Both Years of Biennium.
3. Reimbursement for Franchise Permit Fee Increase During Transition: Add \$4.75 (Amount of Fee Increase) to Base FY 2009 Rate for Over-Price and Under-Price Providers (FY 2010) and for Over-Price Providers Only (FY 2011).
4. Price for Capital: Set Price at Greater of Current Price or June 30, 2005, Capital Rate Plus Capital Compensation Per Diem.
5. Adjustments to Direct Care Price: Increase Direct Care Price from 25th Percentile Plus 7% to Median (FY 2010) and Median Plus 6.5%, 6.75%, or 7.5% (depending on peer group, FY 2011).
6. Pricing in Future: Specify Additional Pricing Adjustments for the Future (Direct Care, Ancillary/Support, Capital).
7. Inflation Factors Used in Price Calculation: Keep the Inflation Factors in Statute but Update Them and Provide Flexibility to Address Future Changes Made at Federal Level.