AN EVALUATION

County Nursing Home Funding

Department of Health and Family Services

00-1

January 2000

1999-2000 Joint Legislative Audit Committee Members

Senate Members:	Assembly Members:
Gary R. George, Co-chairperson	Carol Kelso, Co-chairperson
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State Auditor - Janice Mueller

Editor of Publications - Jeanne Thieme

Audit Prepared by

Paul Stuiber, Director and Contact Person
Kate Wade
James (Joe) Chrisman
Tamarine Cornelius
Sarah Dunning

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State of Wisconsin \ LEGISLATIVE AUDIT BUREAU

JANICE MUELLER
STATE AUDITOR

SUITE 402
131 WEST WILSON STREET
MADISON, WISCONSIN 53703
(608) 266-2818
FAX (608) 267-0410
Leg.Audit.Info@legis.state.wi.us

January 27, 2000

Senator Gary R. George and
Representative Carol Kelso, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator George and Representative Kelso:

We have completed an evaluation of county nursing home funding, as directed by the Joint Legislative Audit Committee. In fiscal year (FY) 1998-99, the State provided $698.1 million in state and federal funds to care for Medical Assistance recipients requiring skilled care in 417 skilled nursing facilities, including 47 that are county-owned.

Administrators of county-owned facilities have expressed concern that current Medical Assistance funding is not sufficient to cover their costs. In FY 1998-99, 44 of the 47 facilities reported deficits, which totaled $66.6 million. County officials argue these deficits were incurred, in part, because their facilities provide care to a disproportionate share of residents who present challenging behaviors in addition to their other medical needs and who are more costly to care for than other nursing home residents.

Based on our analysis, it appears that residents of county-owned facilities generally present more challenging behaviors than residents of privately owned facilities. For example, as part of the most recently completed facility certification survey, the percentage of residents reported to exhibit challenging behaviors was 41.9 percent in county-owned facilities, and 27.1 percent in privately owned facilities.

To address their concerns, county officials have suggested the State increase reimbursement through the Intergovernmental Transfer program, which provides direct supplemental payments to county-owned facilities. County officials believe additional reimbursement is justified because the percentage of county losses funded by this program has declined each year since the program's creation, from 86.1 percent in FY 1993-94 to 55.7 percent in FY 1998-99.

If the Legislature believes additional funding is warranted, it has a number of options for increasing reimbursements to counties and other skilled nursing facilities that serve individuals exhibiting challenging behaviors. However, such increases would require the Legislature to appropriate additional general purpose revenue to fund program costs, may serve as a disincentive to controlling county nursing home costs, and may hamper efforts to increase the amount of care provided in less restrictive, community-based settings.

We appreciate the courtesy and cooperation extended to us by the Department of Health and Family Services and by the county officials and administrators of the nursing facilities we contacted during the course of the audit. The Department's response is Appendix IV.

Respectfully submitted,

Janice Mueller
State Auditor

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SUMMARY

In fiscal year (FY) 1998-99, the State's Medical Assistance budget for skilled nursing care was $698.1 million, including $229.9 million in general purpose revenue (GPR) and $468.2 million in federal funding. The approximately 40,000 residents in skilled nursing facilities received care for their medical, physical, and mental health needs. The Department of Health and Family Services administers both the Medical Assistance nursing home reimbursement formula, which directs state and federal funds to eligible facilities, and an Intergovernmental Transfer (IGT) program, through which the State generates additional federal funds for the cost of nursing home care.

In Wisconsin, 47 of the 417 skilled nursing facilities are county-owned. Administrators of many county-owned facilities have expressed concern that:

- current state and federal reimbursement levels are inadequate to cover costs associated with providing care to individuals who, in addition to their other medical needs, exhibit challenging behaviors, such as wandering or behaving aggressively;

- county property taxes must increasingly be used to cover unreimbursed Medical Assistance expenditures; and

- funds received from the IGT program have not been allocated appropriately by the State.

To address these issues, and at the request of the Joint Legislative Audit Committee, we reviewed recent trends in nursing home expenditures, the State's nursing home reimbursement practices, staff salary and fringe benefit costs, the incidence of residents with behavioral symptoms in nursing facilities, and the Department's allocation of funds generated through the IGT program.

Total funding appropriated for skilled nursing care has increased from $625.4 million in FY 1994-95 to $698.1 million in FY 1998-99, or by 11.6 percent. However, state and federal funding provided to county nursing homes has not kept pace with these facilities' expenditures. As a result, the amount of unreimbursed expenditures reported by county-owned skilled nursing facilities has increased by 54.5 percent, from $43.1 million in FY 1993-94 to $66.6 million in FY 1998-99. In this same period, 44 of 47 county-owned facilities reported deficits.

Viewpoints differ as to why county-owned facilities generate deficits, but county officials assert that the characteristics of facility residents contribute to the deficits incurred by their homes. We analyzed data from the most recently completed survey for skilled nursing facilities, including private facilities in 20 counties and all county-owned facilities. We found that 41.9 percent of all residents in county-owned facilities were reported to exhibit challenging behaviors, regardless of their primary diagnosis, compared to 27.1 percent of residents in privately owned facilities.

To further quantify whether residents in county-owned facilities present challenging behaviors, we used primary diagnoses of mental illness and Alzheimer's disease as proxy measures. Alzheimer's disease was diagnosed among a similar percentage of residents in privately owned and county facilities. However, 35.2 percent of residents in county-owned facilities had primary diagnoses of mental illness, while 22.3 percent of residents in privately owned facilities had this diagnosis. We also reviewed the prevalence of other resident characteristics that might indicate challenging behaviors, including admissions from other nursing homes, and found the differences between private and county-owned homes were not as great.

The Department's initiatives to provide supplemental funding to nursing homes that provide care to individuals with challenging behaviors also suggest differences among resident populations. For example, the Department has administered two supplemental funding programs to direct additional funds to skilled nursing facilities. Between 1994 and 1996, it disbursed $1.1 million through a supplement for residents classified as emotionally disturbed. In addition, since 1990, the Department has provided a supplement of $9 per day for each resident who is diagnosed as mentally ill and determined to need specialized services; these payments amounted to $1.8 million in 1998.

Some observers of county nursing homes argue that causes of the deficits are higher wages, higher fringe benefits, and inefficient operations. We reviewed staffing patterns, wage levels, and other administrative information and found that, on average, county-owned facilities had 6.24 nursing staff per 10 residents, compared to 5.65 staff per 10 residents among privately owned facilities. Of these, most were nursing aides; the county-owned facilities employed 4.42 nursing aides per 10 residents, and the privately owned facilities employed 3.70 nursing aides per 10 residents. We also found that the number of nursing aides in county-owned facilities increased as the percentage of residents with challenging behaviors increased, although the same relationship did not hold for registered nurses or licensed practical nurses in those facilities.

Salaries paid to staff also affect the finances of county-owned facilities. Using 1997 data reported to the Department, we estimate that a full-time registered nurse receiving an average wage and fringe benefits would have received approximately $11,600 more in compensation per year at a county-owned facility than at a privately owned facility; a licensed practical nurse would have earned approximately $7,500 more in a county-owned facility, and an aide would have earned approximately $7,300 more. Although average salaries are higher among county-owned facilities, staff in these facilities also have longer tenure in their positions. For example, in December 1998, 91 percent of the full-time registered nurses in county-owned facilities had tenure of more than one year; the comparable figure in privately owned facilities was 76 percent. Similarly, 91 percent of the full-time aides in county-owned facilities had tenure of more than one year; the comparable figure in privately owned facilities was 66 percent. County officials believe that mandatory participation in the Wisconsin Retirement System is the principal factor contributing to the higher costs of fringe benefits provided to staff of county-owned facilities.

The primary strategy the State uses to mitigate higher county-owned facility expenditures is the IGT program that, since FY 1993-94, has generated additional federal funds based on the unreimbursed Medical Assistance expenditures reported by these facilities. Because counties are created by and derive their authority from the State, their expenditures for Medical Assistance recipients can be claimed as state expenditures, which are eligible for federal matching revenues.

In FY 1998-99, the Department, through its administration of the Medical Assistance program, claimed $66.6 million in unreimbursed expenditures reported by county facilities. That claim allowed the State to earn an additional $95.4 million in federal funding. Of that amount, approximately $37.1 million, or 38.9 percent, was awarded directly to county facilities to fund their Medical Assistance deficits. The remaining $58.3 million, or 61.1 percent, was used to fund a portion of the State's support for nursing home care and was distributed to all facilities, including county facilities, through the nursing home reimbursement formula. The percentage of county losses covered through direct payments to the counties has declined each year since the program's creation, from 86.1 percent in FY 1993-94 to 55.7 percent in FY 1998-99. County Medical Assistance deficits for nursing home care have grown from $43.1 million to $66.6 million over the same period.

County representatives believe that more could be done to increase the amount of federal funding claimed and to enhance the amount of reimbursement provided to fund county losses. As directed by s. 16.0095, Wis. Stats., the Department of Administration contracted with a private firm to determine whether the State could be more aggressive in maximizing the amount of federal funds claimed.

While the firm concluded that the State did not exceed the Medicare upper limit, we include a recommendation that the departments of Administration and Health and Family Services report to the Joint Legislative Audit Committee by May 1, 2000, on the consultant's conclusions and whether aggregate payments made for nursing home services should be adjusted.

The Legislature could consider a number of other options for reimbursement of skilled nursing facilities, including directing the Department of Health and Family Services to provide additional funds to offset county deficits through the IGT program or directing the Department to provide greater reimbursement for the care of residents exhibiting challenging behaviors through the nursing home formula. However, any decision to increase funding to county-owned facilities will require an increase in the amount of GPR appropriated for skilled nursing care. Officials in the Department also note that increasing funding for skilled nursing facility care, regardless of facility ownership, may limit the State's ability to provide care through less restrictive, community-based settings.

Some county officials have suggested that if the State's current reimbursement practices continue, counties may choose to discontinue providing skilled nursing services. Since 1986, six counties have each sold one facility, and one county sold two facilities. However, no county-owned nursing facilities have closed or been sold since 1997. Nonetheless, a number of counties have begun to study whether they should continue to operate their facilities, close them, or sell them.

If a number of the 47 facilities that are currently owned by the counties either closed or were sold, current funding levels would change. First, the State's ability to claim federal IGT funding could be reduced, because IGT revenues are dependent upon deficits incurred by county-owned facilities. If county-owned facilities were closed, fewer federal funds would be available through the IGT program, and the Legislature could be required to appropriate additional GPR to fund nursing home care currently supported with IGT revenues. The closing of county-owned facilities could also have other negative effects, including the disruption of residents and their families as residents are relocated, and the displacement of facility employes. On the other hand, the provision of additional funds to county-owned facilities may serve as a disincentive for county-owned facilities to control their costs.

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INTRODUCTION

The Department of Health and Family Services provides reimbursement for nursing home care.

In fiscal year (FY) 1998-99, the State's Medical Assistance budget for skilled care provided primarily in skilled nursing facilities was $698.1 million: $229.9 million in general purpose revenue (GPR), and $468.2 million in federal funding. The approximately 40,000 residents in these facilities receive care for their medical, physical, and mental health needs. The State provides Medical Assistance funding to all certified nursing homes through the nursing home reimbursement formula, and to county-owned nursing homes directly through an Intergovernmental Transfer (IGT) program. These funds are administered by the Department of Health and Family Services.

There are currently 47 county-owned nursing homes in Wisconsin, and administrators in many have expressed concern that current reimbursement levels are inadequate to cover costs associated with providing care to individuals who, in addition to other health concerns, exhibit serious behavioral problems. Furthermore, some county officials believe that insufficient federal funding has been sought and allocated by the Department to cover county losses incurred in caring for this population, and that as a result, county property taxes must be increased to cover unreimbursed Medical Assistance expenditures. In response to these concerns, and at the request of the Joint Legislative Audit Committee, we reviewed:

- recent trends in federal, state, and county expenditures for county nursing home care;
- the State's nursing home reimbursement practices, to determine the extent to which behavioral issues are considered in setting rates;
- the extent to which residents with behavioral symptoms are disproportionately represented in county-owned homes;
- staff salary and fringe benefit costs associated with care in both county and privately owned nursing homes; and

- how federal funds for reimbursement of nursing home care, including funds and received through the IGT program, are allocated to nursing homes and whether additional federal funds could be redirected to county homes that incur Medical Assistance losses.

In conducting our review, we visited 15 county and privately owned nursing homes and conducted interviews with their administrators. We also conducted telephone interviews with administrators in three other county-owned nursing homes. In addition, we interviewed staff in the Department, county officials, industry representatives, and staff of the Board on Aging and Long-Term Care. Finally, we reviewed reports on the use of federal matching funds in other states and analyzed nursing home data maintained by the Department.

Types of Facilities

Section HFS 132, Wis. Adm. Code, establishes four types of nursing home facilities:

- skilled nursing facilities, which serve individuals whose medical needs, as prescribed by a physician, require either direct professional nursing services or care provided under the supervision of professional nurses;

- intermediate care facilities, which serve individuals under periodic medical supervision, whose long-term illnesses or disabilities have typically stabilized and whose nursing needs are met by registered nurses;

- facilities for the developmentally disabled, which provide specialized care through an array of services designed to enable each individual to attain optimal physical, intellectual, social, and vocational functioning; and

- institutions for mental disease, which are facilities with more than 16 beds that provide diagnosis, treatment, or care for persons with mental diseases, including medical care, nursing care, and related services.

In 1998, Wisconsin's 417 skilled nursing facilities cared for an average of 40,088 individuals per day.

We focused our analysis on skilled nursing facilities because these facilities care for the traditional geriatric nursing home population that was the subject of concern raised by counties. As shown in Table 1, the 417 skilled nursing facilities in Wisconsin in 1998 provided care to an average daily total of 40,088 individuals, representing 92.2 percent of nursing home residents in that year.

Table 1

Types of Nursing Facilities
1998

	Number of Facilities	Average Daily Population	Percentage of Total Average Population
Skilled nursing facilities	417	40,088	92.2%
Facilities for the developmentally disabled	41	3,011	6.9
Intermediate nursing care facilities	4	118	0.3
Institutions for mental disease	3	257	0.6
Total	465	43,474	100.0%

Note: These data exclude the Wisconsin Veterans Home at King and the Trempealeau County Health Care Center. The Veterans Home is owned by the State and provides care only for eligible veterans and their spouses. The Trempealeau County Health Care Center is a highly specialized facility, licensed as both a skilled nursing facility and an institution for mental disease.

As shown in Table 2, the skilled nursing facilities can be characterized as privately owned for-profit facilities, privately owned not-for-profit facilities, county-owned facilities, and municipally owned facilities. Of the 417 facilities, 360 are privately owned and provided care to 82.2 percent of residents in skilled nursing facilities. County governments owned 47 skilled nursing facilities and provided care to 16.3 percent of the residents. Appendix I provides additional information on all county-owned skilled nursing facilities operating in 1998.

Table 2

Skilled Nursing Facilities
1998

Type of Ownership	Number of Skilled Nursing Facilities	Average Daily Population	Percentage of Total Average Population
Private, for-profit	204	18,306	45.6%
Private, not-for-profit	156	14,659	36.6
County-owned	47	6,528	16.3
Municipally owned	10	595	1.5
Total	417	40,088	100.0%

County-Owned Skilled Nursing Facilities

For more than 100 years, a number of Wisconsin counties have operated county homes and other institutions for the mentally ill, the indigent, and individuals with mental or physical disabilities. In contrast to the approach of many other states, which built large facilities to serve thousands of residents, Wisconsin's approach emphasized keeping residents close to their homes and families. In 1974, the Legislature extended statutory nursing home licensing requirements to existing county homes and mental hospitals. As a result of this change, care for medically and financially eligible residents began to be funded through the Medical Assistance program.

In 1976, there were 57 county-owned skilled nursing facilities in Wisconsin. By 1998, that number had decreased to 47. A review of the Department of Health and Family Services' records shows that between 1976 and 1998:

- 12 counties (Chippewa, Dane, Eau Claire, Grant, Jefferson, La Crosse, Marathon, Marinette, Milwaukee, Outagamie, Rock, and Waukesha) ceased operating 12 licensed facilities;

- 2 counties (Douglas and Manitowoc) ceased operating 2 facilities each; and

- 6 counties (Dodge, Juneau, Shawano, Trempealeau, Washington, and Waupaca) each opened 1 skilled nursing facility.

As shown in Table 3, the number of residents in county-owned skilled nursing facilities has decreased each year since 1995, a trend consistent among all skilled nursing facilities, regardless of ownership.

Table 3

County-Owned Skilled Nursing Facilities

Calendar Year	Number of Facilities in Operation	Average Daily Population	Percentage Change
1995	46	7,152	—
1996	46	7,057	-1.3%
1997	46	6,735	-4.6
1998	47	6,528	-3.1

In 1998, 40 counties operated skilled nursing facilities.

As shown in Figure 1, the 47 county-owned skilled nursing facilities currently in operation are located in 40 counties, primarily in the southern two-thirds of the state. Seven of the 40 counties operate two skilled nursing facilities each: Dodge, Fond du Lac, La Crosse, Sheboygan, Washington, Winnebago and Wood.

In addition to the traditional geriatric care counties provide through their skilled nursing facilities, some county-owned facilities have developed specialized care units, such as a traumatic brain injury unit or an Alzheimer's disease unit. Some county facilities provide services to out-of-county residents; for example, the Clark County facility serves as an informal regional center for nursing home care. Other counties, such as Winnebago, choose to limit their services to their own residents.

Figure 1

Counties with County-Owned Skilled Nursing Facilities
1998

Medical Assistance Funding for Skilled Nursing Care

The State and the federal government support nursing home care for medically and economically eligible persons through Medical Assistance reimbursement of allowable costs. As shown in Table 4, the State's FY 1994-95 GPR expenditure of $233.7 million represented 37.4 percent of reimbursed expenditures for skilled nursing care under the Medical Assistance program. The remaining 62.6 percent of total allowable costs reimbursed in that year was paid by the federal government. While the percentage of Medical Assistance expenditures paid by the State has fluctuated since FY 1994-95, the State's share overall declined to 32.9 percent of Medical Assistance nursing home reimbursements in FY 1998-99. The remaining 67.1 percent of Medical Assistance reimbursements will be paid by the federal government. The State's share of expenditures is projected to be 33.4 percent in FY 1999-2000 and 30.7 percent in FY 2000-01.

Table 4

Medical Assistance Expenditures for Skilled Nursing Care*
FY 1994-95 through FY 2000-01

Fiscal Year	GPR	Percentage GPR	Federal Funding	Percentage Federal Funding	Total Reimbursed Expenditures
1994-1995	$233,670,029	37.4%	$391,680,161	62.6%	$625,350,190
1995-1996	231,264,146	34.5	438,920,182	65.5	670,184,327
1996-1997	202,265,712	30.1	470,390,288	69.9	672,656,000
1997-1998	222,789,935	32.8	457,391,443	67.3	680,181,378
1998-1999	229,931,767	32.9	468,201,659	67.1	698,133,426
1999-2000 **	224,080,967	33.4	446,547,142	66.6	670,628,109
2000-2001 **	199,383,543	30.7	449,029,730	69.3	648,413,273

* Projected amounts for all nursing homes, excluding the centers for the developmentally disabled. These expenditures slightly understate total expenditures in skilled nursing facilities. On December 31, 1998, 86.4 percent of the residents in these facilities received skilled or intense skilled nursing care.

** Budgeted amounts as of January 2000.

State funding for Medical Assistance recipients in nursing homes is allocated through a complex formula that provides reimbursement based on projections of allowable nursing home costs for the coming year. This type of reimbursement arrangement, known as a prospective rate system, is set forth in statute and based on each nursing home's expenditures in a prior year for which audited financial statements are available. For example, reimbursement rates for FY 1999-2000 are based on expenditure reports for FY 1997-98.

Nursing home reimbursement is based on costs in seven categories.

Reimbursement rates differ by facility, partly because facility costs differ. In establishing reimbursement rates, the Department considers allowable costs in seven categories, known as cost centers. The seven cost centers are:

- direct care, which includes staff time and medical supplies used to provide direct patient care;
- support services, which include housekeeping, meals, laundry, and security services;
- administrative and general, which includes management and administration expenses not reimbursed through other cost centers;
- fuel and utilities, which include electric, gas, water, and sewer costs;
- property taxes and municipal services;
- capital costs, which include funding for space, furniture, property insurance, and certain types of equipment; and
- over-the-counter medication.

Section 49.45 (6m), Wis. Stats., as amended by 1999 Wisconsin Act 9, directs the Department in the establishment of standards for payment in six of the seven cost centers. The Department is to establish standards for payment that take into account costs for a sample of all facilities in the direct care, support services, administrative and general, and fuel and utilities cost centers. In addition, statutes require that the direct care standard be adjusted for regional labor cost variations and that the fuel and utility standard be adjusted for heating degree day variations. Statutes also require property tax, municipal services, and capital cost payments to be subject to limits determined by the Department and to be based on the actual costs incurred at individual facilities in prior years. The over-the-counter medication cost center is not addressed in statutes.

The behavioral needs of nursing home residents are not directly recognized in the nursing home reimbursement formula.

The nursing home formula does not explicitly recognize behavioral issues in establishing reimbursement rates. However, county nursing home administrators indicate that the costs of caring for residents with behavioral problems are reflected to some extent in the direct care cost center, because it includes the additional staffing costs that would be associated with providing nursing care to residents with behavioral problems.

Since FY 1993-94, county-owned skilled nursing facilities—which are subject to licensing requirements and Medical Assistance reimbursement methodologies identical to those of privately owned facilities—have experienced larger deficits each year. In FY 1998-99, 44 of the 47 county-owned skilled nursing facilities reported deficits related to the care of Medical Assistance recipients. In general, Medical Assistance funds a higher percentage of residents in county-owned skilled nursing facilities than in non-county facilities; 78 percent of the residents in county facilities are funded with Medical Assistance, compared to 66 percent of residents in privately owned skilled nursing facilities.

In FY 1998-99, deficits in county facilities ranged from $10,636 to $8.2 million.

As shown in Table 5, the total of Medical Assistance deficits for government-owned facilities, which includes both county and municipal facilities, has increased by 54.5 percent, from $43.1 million in FY 1993-94 to $66.6 million in FY 1998-99. County-owned facilities account for virtually all of these deficits. For example, in FY 1998-99, county-owned facilities accounted for 99.9 percent of the total deficit of $66.6 million. However, the sizes of county deficits vary widely. For example, FY 1994-95 Medical Assistance deficits in county facilities ranged from $15,467 in Shawano County to $5.2 million in Rock County, and FY 1998-99 Medical Assistance deficits ranged from $10,636 in Calumet County to $8.2 million in Rock County.

Table 5

Medical Assistance Deficits of Government-Owned Nursing Facilities*
(in millions)

State Fiscal Year	Medical Assistance Deficit	Percentage Change
1993-94	$43.1	—
1994-95	48.1	11.6%
1995-96	56.4	17.3
1996-97	61.1	8.3
1997-98	65.8	7.7
1998-99	66.6	1.2

* Includes both county and municipal facilities, but virtually all of these deficits are generated by counties.

Viewpoints differ as to why county-owned facilities generate deficits. Administrators of county-owned facilities assert that these facilities generally care for residents with more challenging behaviors and thereby require higher staffing levels to provide adequate care, and that the lack of attention given to the behavioral characteristics of nursing home residents in setting reimbursement rates has contributed to increasing deficits among most county-owned facilities. On the other hand, some in the nursing home industry assert that higher wages and fringe benefits provided by county-owned facilities, combined with inefficient operations or aging physical plants, are the cause of the deficits. In an attempt to address these issues, we reviewed available data on the characteristics of nursing home residents and analyzed staffing and compensation levels in county and privately owned facilities.

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RESIDENT CHARACTERISTICS

Many county officials assert that their facilities serve a resident population that exhibits more problematic behaviors and requires special attention or services that other populations do not. We attempted to determine if this assertion is supported by the available data on characteristics of facility residents. Although there is no consensus on how current data can best be used to determine if residents exhibit challenging behaviors, such as wandering or aggressive behavior, the available data provide support for the position of county administrators. We found that county-owned skilled nursing facilities reported a higher percentage of residents exhibiting challenging behaviors than did other facilities.

Identifying Behavioral Differences

Surveys of nursing homes include information on their residents' behavioral characteristics.

To determine whether there are differences among residents in county-owned and other facilities, we identified two sources of information that were likely to provide some indication of whether residents exhibit, or are likely to exhibit, challenging behaviors. We had access to two main sources of data relevant to our analysis: 1) surveys of skilled nursing facilities, which include information on the characteristics of facility residents and are conducted by the Department of Health and Family Services at least every 15 months to certify that the facilities are in compliance with federal requirements; and 2) a survey conducted by the Department each year, as part of its responsibility to collect and disseminate information on Wisconsin's health care facilities, which includes information about residents' characteristics and facility utilization and staffing. However, it should be noted that none of the data contained in either of these reports are universally accepted as a definitive means of identifying those residents who require more intensive services as a result of their behavior.

Reported Behavioral Problems

The Department surveys skilled nursing facilities to certify compliance with federal requirements for residents of nursing homes covered by the Medicare and Medical Assistance programs. As part of the survey, nursing home staff complete a Resident Census and Conditions of Residents form, which requires them to provide information on the medical and functional characteristics of current residents. The report includes information on the number of current residents with behavioral

symptoms, which include wandering, resisting care, engaging in verbally or physically abusive behaviors, and exhibiting socially inappropriate or disruptive behaviors.

We analyzed data from the most recently completed survey for all 47 county-owned skilled nursing facilities and all private facilities in 20 counties: Ashland, Bayfield, Brown, Buffalo, Crawford, Eau Claire, Green, Jefferson, Manitowoc, Marathon, Marinette, Marquette, Milwaukee, Outagamie, Polk, Racine, Richland, Taylor, Vilas, and Winnebago. Because surveys are not conducted at the same point in time, the data were reported from November 1997 through March 1999. The facilities in our sample cared for approximately 54 percent of all skilled nursing facility residents in 1998. In analyzing the data for this sample, we made comparisons between the 47 county-owned facilities and 143 privately owned facilities, which include 83 for-profit and 60 nonprofit facilities.

Although the data we analyzed do indicate there are behavioral differences among residents of different types of skilled nursing facilities, the information should be interpreted with caution. Not only were data not collected at the same point in time from facility to facility, but because they are not tied to reimbursement for care provided, the data may include some errors.

In county-owned facilities, 41.9 percent of residents were reported to exhibit challenging behaviors.

As shown in Table 6, we found that county-owned skilled nursing facilities reported a higher percentage of residents exhibiting challenging behaviors, regardless of their primary diagnosis, than did other facilities. In fact, 41.9 percent of residents in county-owned facilities were reported to exhibit challenging behaviors, compared to only 27.1 percent of residents in privately owned facilities.

Table 6

Residents Reported to Present Challenging Behaviors
Skilled Nursing Facilities

	Number of Residents	Number of Residents Presenting Challenging Behaviors	Percentage of Residents Presenting Challenging Behaviors
County-owned facilities	6,517	2,731	41.9%
Privately owned facilities	15,352	4,154	27.1

Other Measures of Residents' Behavior

Some administrators suggested that the primary diagnosis of residents, which is reported in the State's *Annual Survey of Nursing Homes*, would also be useful in analyzing differences among residents at various facilities. We analyzed data reported in December 1998, the most recent year for which data were available, and reviewed the frequency with which a resident's primary diagnosis was mental illness or Alzheimer's disease.

Skilled nursing facility professionals suggested that diagnoses of mental illness and Alzheimer's disease can be used as proxy measures for those individuals presenting challenging behaviors. While not all individuals with mental illness or Alzheimer's disease present challenging behaviors, they may be more likely to present such challenges and to engage in disruptive actions or behaviors that consume staff time. For example, individuals with Alzheimer's disease may enter other residents' rooms and disturb their possessions or pose physical risks to other residents.

Residents of county-owned facilities are more likely to be diagnosed with a mental illness.

As shown in Table 7, 35.2 percent of residents in county-owned facilities had a primary diagnosis of mental illness, while 22.3 percent of residents in privately owned facilities had this diagnosis. However, we found that the incidence of mental illness varies considerably among county-owned facilities. For example, in Brown and Fond du Lac counties, more than three-quarters of the residents in the county-owned facilities had primary diagnoses of mental illness; in contrast, in the county-owned facilities of Samaritan Healthcare Subacute in Washington County and Bloomfield Manor in Iowa County, less than 5 percent of the residents had primary diagnoses of mental illness. There was substantially less variation in the diagnosis of Alzheimer's disease.

Table 7

Prevalence of Mental Illness and Alzheimer's Disease as a Primary Diagnosis in Skilled Nursing Facilities
December 1998

	Percentage of Residents with Primary Diagnosis of Mental Illness	Percentage of Residents with Primary Diagnosis of Alzheimer's Disease
County-owned facilities	35.2%	13.7%
Privately owned facilities	22.3	10.8

Statutes give counties, rather than the State, the primary responsibility for providing mental health services to their residents. Appropriate treatment sites for mentally ill individuals include local community group homes, mental health centers, and nursing homes. Mentally ill individuals may also be admitted to skilled nursing facilities if they have complex medical needs, or if placement in the community is not practical.

The use of skilled nursing facilities in caring for the mentally ill is the subject of much debate. On one hand, because state and federal funds are available to reimburse eligible Medical Assistance recipients who receive care through skilled nursing facilities, some believe that counties have an incentive to place mentally ill patients in skilled nursing facilities rather than in more appropriate community settings. On the other hand, county officials argue that their facilities have a higher proportion of mentally ill residents because private facilities are unable or unwilling to serve this population. They also note that to ensure the fiscal integrity of the Medical Assistance funding system, federal regulations generally limit residents having a primary diagnosis of mental illness to less than 50 percent of the skilled nursing facility population, although other factors are considered. Regardless of the reason for the higher level of diagnosed mental illness among residents of county-owned facilities, county officials contend that this population is more likely to present challenging behaviors and to require additional attention or services.

We also reviewed the prevalence of other resident characteristics that might indicate a higher incidence of behavioral problems. These are not medical diagnoses, but they are descriptive of a resident's care or reason for residency in a skilled nursing facility. These characteristics include:

- wandering behaviors, which may place the resident in dangerous or life-threatening situations, including attempting to leave the facility;

- admission from other nursing homes, which may support the claim of some administrators that individuals with behavioral problems are often transferred from private facilities to county-owned facilities that are better able or more willing to deal with behavioral challenges; and

- placement through a Chapter 51 proceeding under state statutes, which provides for the involuntary commitment of individuals judged to be mentally ill and to present a danger to themselves or others, to receive mental health services in facilities that can include skilled nursing facilities.

As shown in Table 8, residents in county-owned facilities were monitored with electronic devices to prevent wandering to a greater degree than were residents in privately owned facilities. However, the differences were not great; while 12.7 percent of residents in county-owned facilities were monitored for wandering, 11.8 percent of residents in private facilities were monitored. Similarly, a comparison of residents admitted from other skilled nursing facilities differed by only a small amount. Finally, while the overall percentage of individuals admitted through a Chapter 51 proceeding was low for all facilities, it was higher for residents of county-owned facilities than for residents of privately owned facilities.

Table 8

Characteristics of Residents in Skilled Nursing Facilities
December 1998

	Residents Monitored with Formal Wandering Precautions	Residents Admitted from Other Skilled Nursing Facilities	Residents Committed through a Chapter 51 Process
County-owned facilities	12.7%	6.9%	2.0%
Privately owned facilities	11.8	4.6	0.7

Department Recognition of Challenging Behaviors

Some of the Department's initiatives have recognized challenging behaviors as an issue to be addressed.

To support their claim that residents of county-owned facilities exhibit more behavioral problems than do residents of privately owned facilities, county officials point to special initiatives undertaken by the Department. They contend that these initiatives, which include funding supplements and the formation of working groups and a forum to address the behavioral issues of residents, would not have been undertaken if behavioral differences and the funding needs they generate were not justified. However, this view is not shared by officials

in the Department, who have discontinued some funding supplements and reduced other efforts directed at addressing perceived behavioral issues.

Supplement for Residents with Emotional Disturbances

In 1977, the Department created a supplement to direct additional funds to skilled nursing facilities with residents who exhibited certain emotional disturbances, including:

- inappropriate verbal outbursts;
- physical abuse of self or others;
- destruction of property;
- unacceptable sexual or interpersonal contacts;
- severe wandering behavior; and
- social withdrawal or depression.

Between 1994 and 1996, the Department disbursed $1.1 million to care for emotionally disturbed residents.

If residents exhibited these characteristics, they could be classified as emotionally disturbed, allowing the facility to become eligible for a higher level of reimbursement under the nursing home formula. Between 1994 and 1996, the Department disbursed $1.1 million through this supplement; 89 percent of these funds were allocated to county-owned facilities. Not all facilities received funding in each of these three years; however, on average, county facilities received $39,618 annually, and non-county facilities received $9,858 annually.

Officials in the Department indicate that these supplemental payments were discontinued in 1997, in part because of funding issues and a lack of sufficient information to support county assertions that: 1) care for individuals with emotional disturbances was more costly; and 2) additional or special services were being provided to these individuals. This action was supported by a 1989 study conducted by the Department and the University of Wisconsin-Madison, which concluded that residents receiving the supplement were not provided with more services than other residents. The study authors noted, however, that the reason may have been that these residents had less severe health problems. The study also concluded that residents with behavioral problems who needed a high degree of assistance with the activities of daily living consumed more staff resources than did residents who did not have behavioral problems.

In 1998, the Department provided an additional $1.8 million to facilities serving mentally ill residents.

Specialized Services Supplement

In 1990, the Department established another funding supplement for all facilities that serve residents who are mentally ill. This supplement was intended to compensate nursing facilities for federally mandated treatment of these residents. The supplement continues, and facilities are currently paid $9 per day for each resident determined to need specialized services, which amounted to $1.8 million in 1998. On average, facilities received $45,750 through this supplement. Payments to county-owned skilled nursing facilities ranged from a high of $163,890 for Badger Prairie Health Care Center in Dane County to a low of $5,022 for Orchard Manor in Lancaster. Most specialized services funding is provided to county-owned facilities; in 1998, approximately $1.1 million (60.8 percent of funds) was provided to these facilities.

Although additional funding for serving mentally ill residents remains available, administrators of some facilities do not believe it is worthwhile to seek these funds because of what they believe is a cumbersome process. We were told time that could otherwise be directed to providing care to residents must instead be allocated to the completion of detailed assessment forms and reporting requirements. Because the Department tracks funds distributed for specialized services, rather than the number of nursing home residents receiving these services, no data have been collected to determine the extent to which facilities that provide service to eligible mentally ill residents choose not to apply for the funding supplement. Appendix II provides information on the supplemental funds provided to facilities through both the supplement for residents with emotional disturbances and the specialized services supplement.

Other Types of Recognition

The Department, in cooperation with the Board on Aging and Long-Term Care, had previously convened a group of nursing home administrators and long-term care professionals to address concerns related to providing care to residents with challenging behaviors. The work group was active from 1993 through 1996, and it issued four annual reports during this time. While nursing home administrators and professionals familiar with the work group were generally supportive of its efforts, they are uncertain why it has ceased to meet regularly.

Accomplishments of the work group include drawing upon the best practices of facilities related to resident care, and working with an array of public agencies and private health care organizations to develop strategies to ensure quality care. The work group made broad

recommendations to the Department in its first report, issued in August 1993, and acted on each of them during the next three years. Its recommendations included:

- soliciting support from professional and industry associations;
- developing training programs for nursing home staff;
- developing a framework for interagency communications by recognizing the roles staff in many local agencies may take in caring for residents with challenging behaviors; and
- identifying regulation and reimbursement strategies to promote quality care for residents with behavioral symptoms.

Two work groups have formed to identify best practices in caring for residents with challenging behaviors.

The Department has not acted on the work group's recommendations. Officials indicate other priorities were of greater importance, but they believe that the group was beneficial and that its work could continue in some form. To follow up on the efforts of the work group, the Department convened a forum in June 1999 to discuss issues on serving persons with challenging behaviors in nursing homes. The forum was attended by approximately 150 nursing home professionals, including representatives of the major industry associations and administrators from county-owned skilled nursing facilities across the state. Following the June meeting, two new work groups have formed to address the needs of residents with challenging behaviors. The focus of each work group is a medical diagnosis associated with challenging behaviors:

- One work group will identify best practices for providing care to persons with Alzheimer's disease or dementia.
- A second work group will identify best practices for caring for persons with mental illness.

Analyzing Additional Data

Based on our analysis of available data and the Department's actions, it appears that residents of county-owned skilled nursing facilities generally present more challenging behaviors than residents of typical privately owned facilities. Additional data to which the Department has access but we did not may be able to answer these questions more definitively.

These data, known as the Minimum Data Set, have been required to be collected by the federal Health Care Financing Administration (HCFA) since June 1998. They include a detailed medical history, current medical status, and behavioral information on each resident in facilities certified to provide care for persons eligible for Medical Assistance and Medicare. These data are collected and entered into an electronic database at the time of admission, and then quarterly and at any time a resident's condition changes significantly. Federal regulations prohibit their dissemination without prior authorization. In July 1999, we requested access to these data from HCFA. In October 1999, HCFA officials advised us that a special board would be appointed to review our request, that approval by this board was likely one year away, and that there was no guarantee our request would be approved.

The Department has access to data about residents that could be helpful if analyzed.

The Department, however, does have access to these data. It could perform analyses using the Minimum Data Set information, which is likely to be more definitive than the information to which we had access, although it is subject to some of the same limitations. In the future, we encourage the Department to analyze this information because it:

- includes data from all skilled nursing facilities from the same point in time;
- is based on data that support facility reimbursement and, therefore, are likely to be more accurate; and
- provides for a more detailed and comprehensive analysis of specific resident behaviors, such as wandering and resisting care, which were not as completely captured in the data we were able to review.

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The available data generally appear to support county officials' contention that the proportion of residents in county-owned skilled nursing facilities who present challenging behaviors is higher than the proportion in privately owned facilities. To determine whether these differences are associated with the allocation of additional resources, we reviewed staffing patterns, wage levels, and other administrative information. We found higher staffing levels and higher levels of compensation in county-owned facilities.

Staffing Patterns

Staffing costs constitute 63 percent of all skilled nursing facility expenditures.

If differences in resident behaviors have an effect on the costs of county and privately owned skilled nursing facilities, then the challenging behaviors posed by residents of county-owned facilities would require additional staff or the provision of additional services. Staffing costs, including salaries and fringe benefits, constitute approximately 63 percent of all skilled nursing facility expenditures. In reviewing staffing patterns, we found that county-owned facilities do have different staffing patterns than other facilities. However, it is unclear whether these differences are related to inefficiency, as some believe, or to the provision of more resource-intensive services, as the administrators of county-owned facilities claim.

County-owned facilities have higher staffing ratios than privately owned facilities do.

As noted, in establishing reimbursement levels through the nursing home formula, the Department uses data reported annually by skilled nursing facilities certified to participate in the Medical Assistance program. In 1998, these reports included data on staff wages and resident care levels for 397 skilled nursing facilities. We analyzed staffing patterns for nursing staff because administrators indicated it is the nursing staff who provide the daily, time-intensive care for residents with challenging behaviors. As shown in Table 9, with 6.24 nursing staff for every 10 residents, county-owned facilities have higher staffing levels than privately owned facilities do.

Overall, county-owned facilities have higher nurse-to-resident ratios for registered nurses and nursing aides than privately owned facilities do. Because aides provide most of the non-medical and daily assistance care to residents, staffing patterns for nursing aides are most likely to be affected by the number of residents with behavioral problems. In support of the claim of county officials, we found there is a statistical correlation between nursing aide staffing levels and the extent of

Table 9

Nursing Staff Ratios
(Number of Nurses for Every Ten Residents)
December 1998

	Registered Nurses	Licensed Practical Nurses	Nursing Assistants or Aides	Total
County-owned facilities	1.20	0.62	4.42	6.24
Privately owned facilities	1.16	0.79	3.70	5.65

residents' reported behavioral challenges: facilities with the highest levels of nursing aide staffing also tended to report the highest percentage of residents with challenging behaviors.

Staffing levels do not increase consistently with the incidence of challenging behaviors.

Although there are higher staffing levels in county-owned facilities as a group, we found significant variation among these facilities in the percentage of residents with challenging behaviors. Because of this variation, we analyzed staffing patterns according to the incidence of residents with challenging behaviors among county-owned facilities as a group, and among privately owned facilities as a group. We found:

- Although there is a positive relationship in county-owned facilities between nursing aide staffing levels and the incidence of residents with challenging behaviors, the same relationship does not hold for registered nurses or licensed practical nurses in those facilities. That is, the number of nursing aides in county-owned facilities increases as the percentage of residents with challenging behaviors increases, but the number of registered nurses and licensed practical nurses does not.

- Although there is a positive relationship in county-owned facilities between nursing aide staffing levels and the incidence of residents with challenging behaviors, the same relationship does not hold for private facilities. That is, private facilities do not report increased nursing aide hours as the percentage of residents with challenging behaviors increases.

We also analyzed staffing patterns in relationship to the proxy measures of challenging behavior—primary diagnoses of mental illness and Alzheimer's disease. A higher incidence of either mental illness or Alzheimer's disease among a facility's residents might result in higher nursing staff levels. However, we did not find a statistically significant relationship between nursing staff levels and either mental illness or Alzheimer's disease.

Wage Differentials

Although higher expenditures could result from higher staffing levels that might be needed to address behavioral challenges presented by residents, some argue that county-owned facilities' difficulties in covering their costs result primarily from higher employe compensation costs. Higher wages and fringe benefit levels could contribute to the inability of some facilities to cover the costs associated with Medical Assistance recipients, and most nursing home professionals with whom we spoke indicated that wages and fringe benefit levels are higher in county-owned facilities. Some believe that the higher benefit levels in county-owned facilities are the result of union contract negotiations or poor management. Others suggest the higher compensation levels are the result of longer tenure and more demanding working conditions in county facilities. We reviewed financial data the Department uses to develop the nursing home reimbursement formula in order to compare wage and fringe benefit rates among facilities.

On average, nursing staff are compensated at higher levels in county-owned than in private facilities.

As shown in Table 10, nursing wages and fringe benefits reported for 1997, the most recent year for which data were available, are higher, on average, in county-owned facilities. A full-time registered nurse receiving the average county wage and fringe benefit rate would receive compensation worth approximately $11,600 more per year ($2,800 in wages and $8,800 in fringe benefits) than would a registered nurse at privately owned facility. A licensed practical nurse would earn approximately $7,500 more in a county-owned facility ($1,200 in wages and $6,300 in fringe benefits), and an aide would earn approximately $7,300 more ($2,600 in wages and $4,700 in fringe benefits).

Table 10

Average Hourly Nursing Wages and Fringe Benefit Rates
1997

	County-Owned Facilities	Non-County Facilities
Registered Nurses	$18.90	$17.54
Licensed Practical Nurses	13.97	13.38
Nursing aides	9.67	8.42
Fringe benefit rate*	39.9%	19.0%

* Average fringe benefit rate for all facility staff.

Note: On average, wages for registered nurses, licensed practical nurses, and nursing aides constitute 65 percent of the total wages paid by skilled nursing facilities.

The higher compensation levels provided by county-owned facilities may be a factor in the generation of Medical Assistance deficits. As noted, before the passage of 1999 Wisconsin Act 9, the Department established reimbursement of the direct care cost center, which includes reimbursement for nursing staff, at the median for all facilities, with adjustments for regional labor cost variations. The higher compensation levels provided by county-owned facilities, in conjunction with generally higher staffing levels, may result in direct care cost center expenditures that are above the median and unlikely to be fully reimbursed.

As part of 1999 Wisconsin Act 9, the Legislature modified how reimbursement is provided to nursing facilities in an effort to increase nursing compensation in all nursing homes, which is generally lower than in other settings, and thereby address staffing shortages throughout the industry. Beginning July 1, 1999, facilities may increase wages or salaries and fringe benefits for or increase the hours of nursing assistants. Beginning October 1, 1999, the Department will supplement facility payment rates by no more than 5 percent of the total amount of wages reported in 1998 for those facilities applying for the increase.

Nursing staff in county-owned facilities have longer tenure than their counterparts in private facilities.

Because compensation levels are affected by experience and the time nursing staff have worked in the profession, we reviewed available data on staff retention gathered by the Department. Each year, the Department collects some information on staff retention, including the percentage of nurses who have worked at a particular facility for more than one year, for six months to one year, and for less than six months. Although one year's data provide limited information, they do suggest that retention is higher in county-owned facilities. As shown in Table 11, which is based on information collected in 1998, retention rates are higher in county-owned facilities across all classifications of nursing staff for both full-time and part-time staff. Similarly, data collected in 1993 showed consistently higher retention among registered nurses, licensed practical nurses, and nursing aides in county-owned facilities than in other facilities. The data did not allow us to determine definitively whether the higher compensation levels in county facilities are a result or a cause of employment longevity.

Table 11

Percentage of Nursing Staff with Tenure of More Than One Year
December 1998

		County-Owned Facilities	Privately Owned Facilities
Registered Nurses	Full-time	91%	76%
	Part-time	78	73
Licensed Practical Nurses	Full-time	94	80
	Part-time	86	77
Nursing aides	Full-time	91	66
	Part-time	68	60

95 percent of county-owned facilities employ represented staff.

We also reviewed available data related to union representation of staff in skilled nursing facilities. While these data do not indicate either which staff or the percentage of staff represented by labor unions, we did find higher levels of representation in county-owned facilities. Approximately 95 percent of county-owned facilities employ represented staff. In contrast, approximately 63 percent of privately owned facilities employ represented staff. As shown in Table 12, staff in county-owned facilities had higher wages and fringe benefits than staff

in privately owned facilities. In addition, staff in privately owned facilities with union representation reported higher wages and benefits than staff in privately owned institutions with no union representation.

Table 12

Hourly Wage Comparisons Among Skilled Nursing Facilities with Varying Levels of Union Representation
1997

Hourly Wage for:	County-Owned Facilities	Non-County Facilities with Some Represented Staff	Privately Owned Facilities with No Represented Staff
Registered Nurses	$18.90	$17.93	$16.60
Licensed Practical Nurses	13.97	13.67	12.66
Nursing aides	9.67	8.77	7.56
Fringe benefit rate	39.9%	19.6%	17.9%

Administrative Efficiency

Some observers assert county facilities are not efficiently managed.

Officials in the Department and administrators in some private facilities assert that the counties lack incentives to manage efficiently, and inefficient management practices help to generate Medical Assistance deficits. These professionals cite a number of potential causes of inefficiency and note that other nursing facilities operate without the support of county property taxes. Although an analysis of the efficiency of county-owned facilities was beyond the scope of this audit, we did gather anecdotal information on the issue of administrative efficiency.

Some suggest that one potential cause of alleged inefficiency in county-owned facilities is their size and age. Large facilities with floor plans that do not facilitate the efficient placement and use of staff, combined with aging facilities requiring significant capital expenditures, may generate additional costs that other facilities do not incur because they are new and designed to enhance efficiency. County-owned facilities do tend to be larger: 32 of the 47 facilities included in our review, or 68 percent, have 100 or more residents. In contrast, 112 of the non-county facilities, or 30 percent, have 100 or more residents. Table 13 shows the size of the skilled nursing facilities in Wisconsin.

Table 13

Skilled Nursing Facilities and Resident Population
December 31, 1998

Number of Residents	Number of County-Owned Facilities	Percentage of Residents in County-Owned Facilities	Number of Non-County-Owned Facilities	Percentage of Residents in Non-County-Owned Facilities
Fewer than 100	15	17%	258	48%
Between 100 and 199	26	57	95	38
200 or More	6	26	17	14
Total	47	100%	370	100%

In an effort to address these issues, administrators of some county-owned facilities have taken steps to make more effective use of county-owned space. For example, the Jefferson County Board supported local funding for construction of a new facility that will be located within a single building and will be less costly than operating the two buildings currently in use.

Some observers of county-owned facilities also suggest that unreimbursed Medical Assistance expenditures are largely the result of collective bargaining agreements that result in county-owned facilities with high staffing levels, excessive wages, and overly generous benefits. However, county officials note that one of the most costly benefits provided to staff of county-owned facilities is participation in the Wisconsin Retirement System, which is mandatory under s. 40.21(2), Wis. Stats.

In addition, despite the concerns raised about salary levels, administrators we interviewed in both county and privately owned facilities indicated they continue to have difficulty in attracting and retaining nursing staff, especially nursing assistants, at current wage and benefit levels. Industry-wide support for higher wages was reflected in 1999 Wisconsin Act 9's provision of $7.9 million in GPR over the 1999-2001 biennium to increase wages for nursing assistants through the Medical Assistance reimbursement formula.

Generally, officials in the Department and nursing home professionals in the private sector believe that administrators in county facilities have less incentive to reduce costs, and thereby reduce unreimbursed Medical

Assistance expenditures, because they are able to rely on other funding sources, such as funding provided through the IGT program and county property tax revenue. However, administrators of county-owned facilities assert that they do have incentives to manage within the reimbursement provided because there is no assurance that their unreimbursed expenditures will continue to be supported by other sources, and because county boards have become increasingly reluctant to raise property taxes to fund these and other services.

Not all counties choose to operate skilled nursing facilities.

Finally, some believe that there should be no need for counties to levy property taxes to support county-owned skilled nursing facilities. First, they note that some county and municipally owned facilities have not required property tax support in recent years. Second, they note that some counties in Wisconsin choose not to operate skilled nursing facilities, which demonstrates that there are other means of providing care for the persons who would otherwise be served in a county-owned nursing facility. Third, they note that some counties, including Eau Claire and Chippewa, have sold their skilled nursing facilities to private firms that have been able to continue operating them without additional support. Nevertheless, we found some additional support for claims that county-owned facilities' unreimbursed expenditures are the result of caring for residents with challenging behaviors. For example:

- four administrators currently managing county facilities told us that their previous experience in managing private nursing facilities did not include caring for residents with the extent of challenging behaviors exhibited by residents of the county facilities;

- two administrators currently managing private facilities told us that their counties' nursing facilities are relied upon to care for residents with the most challenging behaviors; and

- an administrator of a private facility noted that the former county home, which is now privately owned, is no longer a "dumping ground" for problem residents.

Ultimately, it remains at the discretion of county boards to determine whether their skilled nursing facilities should be closed or sold to private interests if they believe the tax burden on county residents is too great.

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In FY 1998-99, county nursing home losses generated $95.4 million in additional federal funding for the State.

The IGT program was established during the Legislature's 1993-95 biennial budget deliberations to generate additional federal Medical Assistance funds based on the unreimbursed Medical Assistance expenditures reported by skilled nursing facilities owned by local units of government. The expenditures are not reimbursed if Medical Assistance rates are insufficient to cover all costs of providing care. In FY 1998-99, municipally owned and county-owned facilities' unreimbursed Medical Assistance expenditures, or losses, of $66.6 million generated approximately $95.4 million in additional federal funding for Wisconsin.

The State's policy has been to maximize the amount of federal funding received in order to reimburse local governments for a larger percentage of their Medical Assistance expenditures and to offset increasing GPR expenditures for the Medical Assistance program. Over time, counties have funded a growing share of the unreimbursed Medical Assistance expenditures because their total IGT payments have generally remained fixed. However, as the losses of county-owned facilities have increased, so has the federal funding available to the State. In recent years, that funding has been used primarily to offset GPR expenditures that benefit all nursing homes through the nursing home formula. County officials believe that counties should be provided with additional funding through the IGT program. They suggest that this would reflect a return to the original balance and intent in how funds generated by the program should be used: in the initial years of the program, over 75 percent of county losses were reimbursed with direct payments. However, providing additional funds may also serve as a disincentive to controlling county nursing home costs.

Allocating Funds

Wisconsin's current IGT program first provided funding to eligible government-owned skilled nursing facilities in FY 1993-94. Appendix III identifies, for FY 1998-99, Medical Assistance deficits for eligible facilities and the IGT direct care award to each of those facilities.

The methodology for allocating the claimed federal funds is described in the State Medical Assistance Plan, which is subject to federal approval. The Department disburses a portion of the funds directly to those counties that have verified their losses to the Department. Section 49.45(6)(u), Wis. Stats., limits the amount of funding available

to offset county-owned nursing home losses in any given fiscal year to $38.6 million; the Department has disbursed $37.1 million to fund unreimbursed county expenditures in each of the past six years. The remaining funds help provide reimbursement through the nursing home formula for the State's share of eligible Medical Assistance costs claimed by all skilled nursing facilities.

The extent to which the State may use the full amount of unreimbursed expenditures to claim federal matching funds is largely limited by a principle known as the Medicare upper limit. This federal rule limits the amount of reimbursement a state may claim for Medical Assistance costs to what would have been paid for the same services under the Medicare program, which serves older citizens. The Department calculates the upper limit and provides assurance to the federal Health Care Financing Administration (HCFA) that the amount claimed through the IGT program will not violate the upper limit rule.

In FY 1998-99, IGT funds totaling $37.1 million were used to partially fund county losses of $66.6 million.

As shown in Table 14, the Department claimed a total of $66.6 million in unreimbursed Medical Assistance expenditures in FY 1998-99, which allowed the State to earn an additional $95.4 million in federal funding. Of this amount, approximately $37.1 million (38.9 percent) was awarded to county facilities as direct payments. The remaining $58.3 million (61.1 percent) was distributed to facilities through the Medical Assistance reimbursement formula and used to fund a portion of the State's support for nursing home care. In FY 1995-96, although unreimbursed expenditures totaled $56.4 million, the State's claim for federal matching funds totaled $52.2 million because of concerns about potentially exceeding the Medicare upper limit. In every other year, the amount the State claimed was identical to the total amount of certified county nursing facility losses. 1999 Wisconsin Act 9 increased the amount of funds to be directly awarded to counties from $37.1 million to $39.1 million in FY 1999-00, and to $41.1 million in FY 2000-01.

Table 14

Intergovernmental Transfer Program
(in millions)

Fiscal Year	County Losses	IGT Payments to Counties	IGT Funds Used to Offset GPR	Total IGT Funds Allocated
1993-94	$43.1	$37.1	$5.4	$ 42.5
1994-95	48.1	37.1**	30.4	67.5
1995-96	56.4*	37.1**	26.1	63.2
1996-97	61.1	46.1**	72.4	118.5
1997-98	65.8	40.2**	53.9	94.1
1998-99	66.6	37.1	58.3	95.4
1999-00 (budgeted)	73.4	39.1	65.6	104.7
2000-01 (budgeted)	81.9	41.1	77.7	118.8

* The State certified losses of $52.2 million, rather than $56.4 million, in FY 1995-96 because of concerns about potentially exceeding the Medicare upper limit.

** Counties received an additional $17.0 million in FY 1994-95 and $17.6 million in FY 1995-96 as a result of claims for unreimbursed expenditures in prior years. In FY 1996-97 and FY 1997-98, additional direct payments were made because unreimbursed county losses exceeded the amount projected in the state budget but were used to claim additional federal funds.

As shown in Table 15, the percentage of Medical Assistance losses reimbursed by IGT payments has declined each year since the program's creation. The $37.1 million payment counties received in FY 1993-94 covered 86.1 percent of their facilities' certified losses. However, that percentage fell to 55.7 percent in FY 1998-99 because the IGT payment amount remained $37.1 million although certified Medical Assistance losses increased to $66.6 million. Officials in the Department indicated that the $37.1 million was based on levels of funding received in the federal financial participation program that preceded the IGT program, as well as expected increases in unreimbursed expenditures in county-owned facilities.

Table 15

Intergovernmental Transfer Program
Summary of Medical Assistance Deficits and Awards
(in millions)

State Fiscal Year	Overall County Facility Certified Medical Assistance Loss	IGT Payment to Counties	Percentage of Medical Assistance Loss Reimbursed by IGT
1993-94	$43.1	$37.1	86.1%
1994-95	48.1	37.1	77.1
1995-96	56.4	37.1	65.8
1996-97	61.1	46.1	75.5
1997-98	65.8	40.2	61.1
1998-99	66.6	37.1	55.7
1999-00 (budgeted)	73.4	39.1	53.3
2000-01 (budgeted)	81.9	41.1	50.2

Ability to Claim Additional Funds

Some believe more could be done to enhance the amount of federal funds received.

Although the IGT program generates additional federal funds for the State, some believe that more could be done to increase the amount of federal funding claimed and to enhance the amount of reimbursement provided to offset county losses for care provided through skilled nursing facilities. However, officials in the Department maintain that Wisconsin is aggressive in claiming additional federal funding through the IGT program. They are concerned that attempts to increase the amount claimed may not be allowable and note that while HCFA has not questioned the Department's upper limit calculation for skilled nursing facilities, it did review Wisconsin's policies and procedures in an on-site audit in fall 1999.

The State has contracted for a study to determine if additional federal funding can be claimed.

Based on concerns raised by county officials, the Department of Administration, as directed by s. 16.0095, Wis. Stats., contracted with a private firm to study the upper limit calculation and determine whether the State could be more aggressive in maximizing the amount of federal funds claimed. The firm, Myers and Stauffer, Certified Public Accountants, concluded that the State did not exceed the upper payment limit in either 1998 or 1999. In FY 1997-98, the State was under the Medicare upper limit by $6.61 per patient day; in FY 1998-99, the State was under the Medicare upper limit by $3.16 per patient day. The firm

did not, however, recommend aggregate payments that should be made for inpatient nursing home services. In the past, the consulting firm of Susan White and Associates has studied Wisconsin's upper limit calculation on at least three occasions under contract with the Wisconsin Counties Association. This firm's reports have concluded that there is room under the upper limit to claim additional federal funds. The reports estimate the amount available has varied from $50 million in March 1993 to $68 million in October 1994 and $5.5 million in November 1996. Because the issue is the subject of a recently completed independent review required by statutes, we did not duplicate efforts to assess the extent to which additional federal funds could be claimed by the State.

The federal General Accounting Office has studied some state programs in response to congressional concerns, and in 1994 it released findings on its study of IGT programs in Michigan, Tennessee, and Texas. That study found federal funds were used appropriately to finance Medical Assistance programs in Michigan and Texas but were spent inappropriately in Tennessee, where links to the Medical Assistance program could not be found.

Michigan retains almost all of the funds generated through its funding program for skilled nursing facilities.

In 1995, the General Accounting Office conducted follow-up work on Medical Assistance financing arrangements in Michigan, which, like Wisconsin, uses expenditures in county-owned nursing facilities to generate additional federal funds. Michigan obtained additional federal funds by adjusting Medical Assistance payments for 41 of its county nursing facilities and 4 other long-term care facilities owned by local governments from $90 to $269 per day. Despite the increase of almost 200 percent, the General Accounting Office found that Michigan did not violate the Medicare upper limit. Rather than being used to provide supplemental payments to county-nursing facilities, 98 percent of the additional federal funds were retained by the state.

Because the findings of the statutorily required study for which the Department of Administration has contracted are relevant to broad questions the Legislature may consider in the provision of reimbursement to skilled nursing facilities for the care of Medical Assistance recipients, and because the contractor did not recommend aggregate payment levels, as required by the statute, *we recommend the departments of Administration and Health and Family Services report jointly to the Joint Legislative Audit Committee, by May 1, 2000, on the consultant's conclusions and whether the aggregate payments made for nursing home services should be adjusted.*

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If the Legislature is concerned about the adequacy of reimbursement provided to skilled nursing facilities, it may wish to consider options to increase their reimbursement for care provided to Medical Assistance recipients. The Legislature's options include increasing reimbursement specifically to offset the Medical Assistance deficits of county-owned facilities, and directing the Department to recognize the behavioral challenges presented by residents in all skilled nursing facilities as part of the nursing home formula. We reviewed the potential effects of maintaining current reimbursement practices, as well as modifying current practices to enhance the level of funding provided.

Continuing Current Reimbursement Levels

The consequences of continuing current reimbursement practices for skilled nursing facilities are unknown. However, some county officials indicate that their decisions about continuing to provide skilled nursing services may be affected by such a continuation. As noted, 44 of the 47 county-owned facilities reported deficits associated with the care provided to Medical Assistance recipients in FY 1998-99. If a number of these facilities were to close because the amount of local tax revenue needed to support them became unacceptable to local officials, the State's ability to claim federal IGT funding, which is driven by the size of the deficits incurred by county-owned facilities, could be negatively affected.

Federal matching funds would likely decline if county facilities were closed.

What is not known is whether the decline in revenue would have an effect on other facilities. If the decline in revenue represented only the amount that would have been provided to those specific facilities to offset their Medical Assistance deficits, the State's ability to fund other costs would not be affected. However, because only a portion of the revenue received through the IGT program is used to reimburse counties for the deficits they incur, it seems likely that the funds available to the State through the IGT program, which it uses to match federal funds for Medical Assistance services, would decline and that the State would therefore be required to allocate additional GPR to compensate for the reduction in federal funds.

The actual effects on the State would depend on the size of the deficit typically incurred by the county-owned facility that closed. In June 1999, the Legislative Fiscal Bureau estimated that if facilities in three counties—which have a combined 1998 deficit of $8.5 million and have been studying the issue of selling or downsizing their skilled

nursing facilities—were to close, the State's IGT revenues would decline by $12.5 million. Although some residents in county-owned facilities that close might be placed in other county-owned skilled nursing facilities, and potentially continue to generate unreimbursed Medical Assistance expenses that could aid the State in claiming IGT funds, most residents would be more likely to be placed in privately owned facilities, where unreimbursed Medical Assistance expenses would not qualify as state expenditures eligible for federal matching funds.

In addition to the effects on the State's ability to claim IGT funds, the closing of county-owned skilled nursing facilities may have other negative effects. For example, the relocation of residents to other facilities would likely be disruptive both to residents and to their families. The facilities' employes would also be displaced and would need to find other employment.

No county-owned facilities have closed or been sold since 1997.

It is difficult to determine the likelihood that some county-owned skilled nursing facilities would close if the State does not increase its reimbursement for Medical Assistance recipients. Although no such facilities have closed or been sold since 1997, a new county-owned facility was established in 1998. Moreover, a decision by a county board to close or sell its skilled nursing facility may not eliminate county expenditures associated with current residents. A number of residents in county-owned skilled nursing facilities have mental illnesses, and s. 51.42(1)(b), Wis. Stats., states that counties are responsible for providing mental health services. If a county's skilled nursing facility were closed, the county would likely continue to be responsible for providing care for some residents in either community-based settings or alternative facilities capable of providing more extensive services, such as the Winnebago and Mendota Mental Health Institutes. Because Medical Assistance will not provide reimbursement for services provided to individuals in a number of alternative settings, county expenditures for these individuals may actually increase.

Some counties are studying whether to continue to operate their skilled nursing facilities.

On the other hand, there is evidence that counties are moving to limit their support of county-owned skilled nursing facilities. Since 1986, a number of counties have begun to study whether they should continue operating their facilities, as well as the potential of selling their facilities. In the course of conducting our review, for example, we visited four counties that had either hired consultants or developed special study committees to examine fiscal issues associated with continuing to operate their skilled nursing facilities. Since 1986, Chippewa, Manitowoc, Outagamie, Waukesha, Marinette, and Eau Claire counties have each sold one nursing facility, and Douglas county sold two nursing facilities.

Increasing Reimbursement to County-Owned Facilities

Given the potential negative effects that closings would have on skilled nursing facilities' residents, counties, and the State, the Legislature may wish to consider strategies for increasing reimbursement for care of Medical Assistance recipients. As noted, the State's Medical Assistance plan caps IGT funds allocated to offset county-owned facilities' Medical Assistance deficits at $37.1 million. 1999 Wisconsin Act 9, the 1999-2001 Biennial Budget Act, increased this amount to $39.1 million in FY 1999-2000, and $41.1 million in FY 2000-01. However, even with these increases, it is estimated that IGT payments to counties will cover a smaller percentage of county deficits (53.3 percent and 50.2 percent, respectively) than were covered in FY 1998-99 (55.7 percent).

Those facilities with direct care deficits above the average value receive reimbursement equal to the average value, plus a prorated share of any funds remaining within the $37.1 million identified in the State Medical Assistance plan for distribution in FY 1998-99. Some suggest that this methodology puts larger facilities at a disadvantage, because a larger population is likely to generate a larger Medical Assistance deficit when costs are not fully covered through the reimbursement formula.

The Legislature could direct that a fixed percentage of counties' direct care losses be reimbursed.

If the Legislature wishes to provide additional funds to offset county losses directly, it could direct the Department to reimburse a fixed percentage of county losses up to a specified amount. For example, the Department could be directed to reimburse 60 percent of county losses up to a maximum of $50 million. If this policy had been applied in FY 1998-99, reimbursement to counties would have increased $2.9 million, or by 7.8 percent. However, because reimbursement is based on a percentage of county facility losses, not all facilities would receive higher payments. Based on FY 1998-99 expenditures, 13 counties would have benefited from this type of allocation strategy: Brown, Dane, Grant, Jefferson, Manitowoc, Marathon, Milwaukee, Outagamie, Racine, Rock, Vernon, Walworth, and Winnebago. Increases would have ranged from $27,200 in Vernon County to $2.3 million in Rock County. In addition, 27 counties would have experienced a decline in their IGT payments. This decline would have ranged from $4,300 in Calumet County to a total of $800,700 for the three nursing facilities operated by Sheboygan County, of which two are skilled nursing facilities.

Because $37.1 million is no longer adequate to cover the direct care deficits in the county facilities, increased reimbursement could alternatively be tied to counties' direct care deficits, with a higher level of funding authorized by the Legislature for this purpose. This approach may be more appropriate, because county officials assert that their facilities' losses are largely the result of behavioral differences among their residents, and these added costs are incurred in the direct care cost

center. In FY 1998-99, the portion of county deficits represented by the direct care cost center was $52.1 million, or 78.2 percent of the $66.6 million total county unreimbursed Medical Assistance expenditures. In FY 1998-99, 15 county-owned facilities did not receive IGT awards sufficient to cover their direct care deficits. As shown in Table 16, a total of approximately $15.0 million in county direct care deficits was not covered by IGT awards.

Table 16

Direct Care Deficits Not Covered By IGT Awards
FY 1998-99

County	Direct Care Deficit	IGT Award	Amount of Deficit Not Covered	Percentage of Deficit Not Covered
Brown	$ 1,501,194	$ 1,156,245	$ 334,949	23.0%
Dane	3,546,296	1,668,095	1,878,201	53.0
Dodge	1,397,490	1,130,290	267,200	19.1
Jefferson	1,893,052	1,254,320	638,732	33.7
Kenosha	1,248,757	1,093,065	155,692	12.5
La Crosse (Lakeview)	1,044,359	1,041,908	2,451	0.2
Marathon	2,537,108	1,415,515	1,121,593	44.2
Milwaukee	3,520,785	1,661,710	1,859,075	52.8
Outagamie	1,613,136	1,184,262	428,874	26.6
Racine	1,574,382	1,174,563	399,819	25.4
Rock	7,469,156	2,649,912	4,819,244	64.5
Sheboygan (Sunny Ridge)	1,237,900	1,090,348	147,552	11.9
Walworth	3,153,185	1,569,707	1,583,478	50.2
Winnebago (Pleasant Acres)	1,900,594	1,256,207	644,387	33.9
Winnebago (Pavilion)	1,925,752	1,262,504	663,248	34.4
Total	$35,563,146	$20,608,651	$14,954,495	42.1%

Regardless of the manner in which additional IGT reimbursement is provided, the effect on the State would be the same. The State would need to appropriate a comparable amount of GPR in subsequent years to compensate for matching federal funds that would no longer be available under the Medical Assistance program for care provided to residents of skilled nursing facilities. County officials assert that this is justified, because the State would not have access to these supplemental federal funds if not for the losses generated by county-owned skilled nursing facilities. In addition, they assert that the State has made extensive use of these funds to help pay its own Medical Assistance expenditures, while providing inadequate support to counties. However, increasing reimbursement to counties would reduce the amount of funds available to the State to pay for its share of Medical Assistance costs and may also reduce the incentives counties have to control nursing home costs. Officials in the Department also note that increasing funding for skilled nursing facility care, regardless of facility ownership, may limit the State's ability to fund care in less restrictive, more community-based settings.

Enhancing Reimbursement Based on Resident Characteristics

Additional funds could be directed to all facilities, not just county-owned facilities.

Rather than provide increased reimbursement exclusively to government-owned skilled nursing facilities, the Legislature could direct the Department to modify the nursing home formula to provide greater reimbursement to all facilities that care for residents who exhibit challenging behaviors. For example, the Legislature could direct the Department to establish a standard for reimbursement within the direct care cost center that increases in proportion to the percentage of residents reported to exhibit specified challenging behaviors.

This approach may have advantages. For example, administrators of privately owned skilled nursing facilities would likely view it as more equitable, because it would provide the same reimbursement to all facilities regardless of whether they were privately or publicly owned. In addition, this approach would direct reimbursement to what county officials believe is the primary factor that contributes to their inability to cover costs associated with providing care to Medical Assistance recipients.

Providing additional funding through the formula would reduce federal funding the State could claim.

On the other hand, this approach also has significant drawbacks. First, because it would provide reimbursement through the nursing home formula, it would lower county-owned facility Medical Assistance deficits and potentially reduce the amount of federal funding the State could claim through the IGT program. The amount by which it would reduce federal funding would depend on the extent to which additional funds were directed to reimburse facilities for residents who exhibit challenging behaviors, as well as the proportion of these funds that went to publicly owned facilities. Second, it may be difficult for the

Department to develop a valid behavioral measure on which to base reimbursement and to monitor which residents with behavioral challenges are identified accurately. Third, by linking additional funds to institutional care, the State may hamper the development of care options in less restrictive settings.

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APPENDIX I

County-Owned Skilled Nursing Facilities
1998

County	City	Facility Name	Residents
Brown	Green Bay	Brown County Health Care Center	92
Calumet	New Holstein	Calumet Homestead Rehabilitation Center	97
Clark	Owen	Clark County Health Care Center	170
Columbia	Wyocena	Columbia Health Care Center	135
Dane	Verona	Badger Prairie Health Care Center	134
Dodge	Juneau	Clearview North	100
Dodge	Juneau	Clearview South	179
Dunn	Menomonie	Dunn County Health Care Center	141
Fond du Lac	Fond du Lac	Fond du Lac County Health Care Center	94
Fond du Lac	Fond du Lac	Rolling Meadows Nursing/ Rehabilitation Home	115
Grant	Lancaster	Orchard Manor	95
Green	Monroe	Pleasant View Nursing Home	128
Iowa	Dodgeville	Bloomfield Manor Nursing Home	79
Jackson	Black River Falls	Pine View	134
Jefferson	Jefferson	Countryside Home	186
Juneau	New Lisbon	Pleasant Acres	57
Kenosha	Kenosha	Brookside Care Center	153
La Crosse	La Crosse	Hillview Health Care Center	180
La Crosse	West Salem	Lakeview Health Center	160
Lafayette	Darlington	Lafayette Manor	89
Lincoln	Merrill	Pine Crest Nursing Home	175
Manitowoc	Manitowoc	Manitowoc Health Care Center	173
Marathon	Wausau	North Central Health Care Facility	329
Monroe	Sparta	Rolling Hills Rehabilitation Center	126
Outagamie	Appleton	Outagamie County Health Center	241
Ozaukee	Cedarburg	Lasata Care Center	195
Polk	Amery	Golden Age Manor	106
Portage	Stevens Point	Portage County Health Care Center	132
Racine	Racine	Ridgewood Care Center	207
Richland	Richland Center	Pine Valley Health Care/Rehabilitation	101
Rock	Janesville	Rock County Health Care Center	311
Rusk	Ladysmith	Rusk County Memorial Hospital/ Nursing Home	89
Sauk	Reedsburg	Sauk County Health Care Center	131
Shawano	Shawano	Maple Lane Health Care Center	73

County	City	Facility Name	Residents
Sheboygan	Plymouth	Rocky Knoll Health Care Facility	189
Sheboygan	Sheboygan	Sunny Ridge	299
St. Croix	New Richmond	St. Croix Health Center	101
Trempealeau	Pigeon Falls	Pigeon Falls Health Care Facility	36
Vernon	Viroqua	Vernon Manor	109
Walworth	Elkhorn	Lakeland Nursing Home	285
Washington	West Bend	Samaritan Health Center	186
Washington	West Bend	Samaritan Health Care Subacute	9
Waupaca	Weyauwega	Lakeview Manor	62
Winnebago	Winnebago	Park View Health Center – Pleasant Acres	118
Winnebago	Winnebago	Park View Health Center – Rehabilitation Pavilion	102
Wood	Port Edwards	Edgewater Haven Nursing Home	109
Wood	Marshfield	Norwood Health Center	16

APPENDIX II

Emotionally Disturbed and Specialized Services Funds
Skilled Nursing Facilities

County	County-Owned Facilities	FY 1995-96 Emotionally Disturbed Funds	1998 Specialized Services Funds*
Brown	Brown County Health Care Center	$2,355	$47,925
Calumet	Calumet Homestead Rehabilitation Center	0	0
Clark	Clark County Health Care Center	4,840	60,885
Columbia	Columbia Health Care Center	9,530	0
Dane	Badger Prairie Health Care Center	1,072	163,890
Dodge	Clearview	628	97,965
Dodge	Dodge County Community Health Care Center	2,621	**
Dunn	Dunn County Health Care Center	3,781	0
Eau Claire	Center of Care	413	**
Fond du Lac	Fond du Lac County Health Care Center	3,867	57,330
Fond du Lac	Rolling Meadows Nursing/Rehabilitation	0	0
Grant	Orchard Manor	0	3,285
Green	Pleasant View Nursing Home	0	0
Iowa	Bloomfield Manor Nursing Home	0	0
Jackson	Pine View	0	0
Jefferson	Countryside Home	9,963	37,485
Juneau	Pleasant Acres	0	0
Kenosha	Brookside Care Center	0	0
La Crosse	Hillview Health Center	0	0
La Crosse	Lakeview Health Center	12,280	151,263
Lafayette	Lafayette Manor	0	0
Lincoln	Pine Crest Nursing Home	3,400	0
Manitowoc	Manitowoc Health Care Center	537	0
Marathon	North Central Health Care Facility	25,457	33,255
Monroe	Rolling Hills Rehabilitation Center	0	0
Outagamie	Outagamie County Health Center	11,661	146,916
Ozaukee	Lasata Care Center	0	0
Polk	Golden Age Manor	0	0
Portage	Portage County Health Care Center	0	0
Racine	Ridgewood Care Center	25,484	56,367
Richland	Pine Valley Health Care/Rehabilitation	0	0
Rock	Rock County Health Care Center	39,861	129,447
Rusk	Rusk County Memorial Hospital/Nursing Home	0	0
Sauk	Sauk County Health Care Center	3,701	0

County	County-Owned Facilities	FY 1995-96 Emotionally Disturbed Funds	1998 Specialized Services Funds*
Shawano	Maple Lane Health Care Center	4,751	0
Sheboygan	Rocky Knoll Health Care Facility	1,080	5,760
Sheboygan	Sunny Ridge	0	0
St. Croix	St. Croix Health Center	0	24,183
Vernon	Vernon Manor	0	0
Walworth	Lakeland Nursing Home	0	0
Washington	Samaritan Health Center	16,572	0
Waupaca	Lakeview Manor	9,034	25,668
Winnebago	Park View Health Center-Pleasant Acres	0	0
Winnebago	Park View Health Center-Rehabilitation Pavilion	23,812	27,720
Wood	Edgewater Haven Nursing Home	0	0
Wood	Norwood Health Center	7,199	46,638
	Total	$223,899	$1,115,982

County	Non-County-Owned Facilities		
Barron	Heritage Manor	$0	$3,006
Barron	Pioneer Home	0	3,285
Burnett	Capeside Cove Good Samaritan Center	0	15,534
Dane	Four Winds Manor	0	936
Dane	Ingleside Nursing Home	0	3,159
Dane	Oakwood Lutheran Home	0	1,206
Douglas	Southdale Health Center	0	7,893
Douglas	St. Francis Home South	0	5,490
Eau Claire	Dove Health Care	0	3,564
Marquette	Montello Care Center	0	1,197
Milwaukee	Audubon Healthcare Center	0	17,793
Milwaukee	Bel Air Health Care Center	0	19,350
Milwaukee	Kilbourn Care Center	0	21,681
Milwaukee	Lakewood Care Center	0	17,307
Milwaukee	Mt. Carmel Health and Rehabilitation Center	0	18,594
Milwaukee	Plymouth Manor Nursing Home	0	11,043
Milwaukee	Shorewood Heights Health Care Center	0	59,076
	Total	$0	$210,114

* Payments to county-owned institutions for mental disease totaled $508,275 in calendar year 1998.
** No longer in operation.

APPENDIX III

Summary of 1998-1999 Intergovernmental Transfer Program Awards

County	Facility Name	Overall Medical Assistance Deficit	Direct Care IGT Award
Brown	Brown County Health Care Center	$2,293,040	$1,156,245
Calumet	Calumet Homestead Rehabilitation Center	10,636	10,636
Clark	Clark County Health Care Center	1,313,119	1,034,767
Columbia	Columbia Health Care Center	655,149	412,548
Dane	Badger Prairie Health Care Center	3,963,527	1,668,095
Dodge	Clearview South	1,546,335	1,130,290
Dodge	Clearview North	1,459,177	912,435
Dunn	Dunn County Health Care Center	635,418	558,314
Fond du Lac	Fond du Lac County Health Care Center	349,351	172,146
Fond du Lac	Rolling Meadows Nursing/Rehabilitation	687,336	687,336
Grant	Orchard Manor	450,972	136,174
Green	Pleasant View Nursing Home	1,515,306	1,033,562
Iowa	Bloomfield Manor Nursing Home	226,603	226,603
Jackson	Pine View	529,522	451,718
Jefferson	Countryside Home	2,823,191	1,254,320
Juneau	Pleasant Acres	68,010	67,878
Kenosha	Brookside Care Center	1,550,843	1,093,065
La Crosse	Hillview Health Care Center	707,985	707,985
La Crosse	Lakeview Health Center	1,063,049	1,041,908
Lafayette	Lafayette Manor	311,652	262,564
Lincoln	Pine Crest Nursing Home	295,739	268,829
Manitowoc	Manitowoc Health Care Center	1,432,009	784,794
Marathon	North Central Health Care Facility	3,370,176	1,415,515
Milwaukee	Milwaukee County Rehabilitation	6,269,736	1,661,710
Monroe	Rolling Hills Rehabilitation Center	863,280	757,442
Outagamie	Outagamie County Health Center	2,108,592	1,184,262
Ozaukee	Lasata Care Center	793,499	738,989
Polk	Golden Age Manor	100,069	79,817
Portage	Portage County Health Care Center	787,189	695,537
Racine	Ridgewood Care Center	2,123,205	1,174,563
Richland	Pine Valley Health Care/Rehabilitation	413,666	413,666
Rock	Rock County Health Care Center	8,178,418	2,649,912
Rusk	Rusk County Memorial Hospital/Nursing Home	520,567	321,551
Sauk	Sauk County Health Care Center	724,901	482,843
Shawano	Maple Lane Health Care Center	0	0
Sheboygan	Rocky Knoll Health Care Facility	640,181	506,300

County	Facility Name	Overall Medical Assistance Deficit	Direct Care IGT Award
Sheboygan	Sheboygan County Comprehensive Health Center	976,827	916,963
Sheboygan	Sunny Ridge	1,237,900	1,090,348
St. Croix	St. Croix Health Center	434,426	434,426
Trempealeau	Trempealeau County Health Care Center	431,454	431,454
Vernon	Vernon Manor	115,687	42,199
Walworth	Lakeland Nursing Home	4,028,290	1,569,707
Washington	Samaritan Health Center	1,361,296	928,893
Waupaca	Lakeview Manor	902,917	653,905
Winnebago	Park View Health Center-Pleasant Acres	2,448,277	1,256,207
Winnebago	Park View Health Center-Rehabilitation Pavilion	2,089,403	1,262,504
Wood	Edgewater Haven Nursing Home	563,841	471,818
Wood	Norwood Health Center	1,165,068	790,177
	Algoma Memorial Long-Term Care	34,783	34,783
	Heritage of Elmwood	35,237	35,237
	Spring Valley Health Care Center	27,060	27,060
	Total	$66,633,914	$37,100,000

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

January 21, 2000

Janice Mueller, State Auditor
Legislative Audit Bureau
131 West Wilson Street, Suite 402
Madison, WI 53703

Dear Ms. Mueller:

Thank you for the opportunity to respond to the Legislative Audit Bureau report on the funding of county nursing homes. This is a very complex matter, and I would like to recognize the efforts by Audit Bureau staff to understand and analyze these complicated issues. However, I do believe it is necessary for me to clarify and elaborate on a few issues and to better explain the Department of Health and Family Services' perspective.

First, some context is in order. When establishing a mechanism for funding human services such as long-term care, it is important to ensure that the funds are provided in a way that gives service delivery agencies the proper incentives to cost-effectively serve clients in the least restrictive environment. This is a major reason why the Department, with support from the Governor and the State Legislature, has pursued the development of Family Care. Family Care will give service providers the incentives to provide high quality services in the community, when appropriate, while also providing adequate support for needed institutional care.

The audit report suggests that one option for addressing county nursing home deficits is to provide county homes with more funding. However, the Department is well aware that a substantial number of residents in county nursing homes function at a sufficiently high enough level that they are considered excellent candidates for community placement. As a result, if the Legislature considers the option of increasing funding to county nursing homes, we would note our concern that this policy could provide a disincentive to provide community placements for many current residents in nursing homes. This is not the policy direction articulated by the U.S. Supreme Court ruling in the Olmstead case.

Paying more to the county nursing homes would also reduce the losses incurred by these homes, which would decrease the amount of Intergovernmental Transfer (IGT) funding available. This would decrease the funding available for other nursing homes as well as the county homes. Moreover, data indicates that the Medicaid rates in county nursing homes are already significantly higher than those in non-county nursing homes. The average daily rate paid to county and municipal homes in state fiscal years (SFY) 1998 and 1999 was $114.11 and $116.21, which is 24.0 percent and 21.1 percent more in each year respectively than the non-county nursing homes. The Department cannot abandon a "prudent buyer" approach to reimbursement, especially given its commitment to Family Care.

The report's findings do not clearly support claims that clients with behavior problems require more intensive staffing. Although staffing patterns in county nursing homes are higher when caring for people with challenging behaviors, the staffing pattern in other nursing homes with this population is not higher. We have reviewed the staffing patterns for people with challenging behaviors in the past and continue to monitor new studies which were shared with the Legislative Audit Bureau staff. None of these studies indicated that payments should be increased for residents with challenging behaviors.

This view is further confirmed in the latest Medicare Resource Utilization Group (RUG-III) case mix index, which shows that people with behavior problems require 32 percent to 52 percent *less* resources than the average nursing home resident. The RUG-III index, which underlies the new Medicare Prospective Payment System, is in the process of being phased in and will become an integral part of Wisconsin's nursing home reimbursement system in the future.

The report gives the impression that the Medicare upper limit is the only factor in receiving more IGT payments. In fact, the county losses, as well as the Medicare upper limit, are limiting factors. Only in SFY 1995-96 has the Medicare upper limit been a factor in limiting the IGT payment. In all other years, the amount of county nursing home reimbursable expenses has restricted IGT payments. With the change in the Medicare upper limit under Medicare's Prospective Payment System, we do not foresee the requirement limiting nursing home payments to the Medicare upper limit becoming a problem for the IGT program. Moreover, the report states, "As directed by s. 16.0095, Wis. Stats., the Department of Administration has contracted with a private firm to determine whether the state could be more aggressive in maximizing the amount of federal funds claimed." This report has been completed and concurs with the Department's methodology for calculating the Medicare upper limit.

The budget process has always determined the amount of IGT funds distributed directly to counties. The amount of IGT that has been distributed to the counties and the amount of IGT provided to all nursing homes through the nursing home formula has been approved by the Legislature in the budget process in the last three biennial budgets. Current statutory provisions specify that any IGT funds generated by county losses, greater than the amounts allocated in the budget, are to be given to the counties. The county losses in SFY 1999 did not trigger this process.

In conclusion, we concur that the IGT program has been an important source of funding to assist counties in minimizing financial losses. We also want to recognize the challenges county homes have faced in providing cost-effective services to their residents. However, we cannot agree that having a higher proportion of residents with challenging behaviors is a significant reason for higher county nursing home costs, or that funding more county deficits is the answer to this problem.

We are prepared to continue to work with Audit Bureau staff, county nursing home officials, and the Legislature to find solutions that are consistent with the Department's broader objective of providing cost-effective, community-based care, whenever possible.

Sincerely,

Joe Leean
Secretary