Long-Term Care in Illinois

CENTER FOR THE ADVANCEMENT OF ELDER CARE

A Resource Book for LTC CHAMPIONS Long-Term Care in Illinois

CENTER FOR THE ADVANCEMENT OF ELDER CARE

Center for the Advancement of Elder Care

The Center for the Advancement of Elder Care is a 501(c)3 corporation founded by Illinois' three associations dedicated to serving long-term care facilities: The Illinois Council on Long Term Care, the Illinois Health Care Association, and Life Services Network of Illinois.

The Center recognizes that increased attention must be paid to the population of older adults currently or potentially residing in long-term care facilities. It seeks to educate the general public, media, provider representatives, lawmakers and public officials about the care needs of this valuable and growing segment of the general population.

More than 1.4 million people currently live in nearly 16,000 skilled nursing facilities nationwide. **In Illinois, 78,000 residents live in more than 800 skilled nursing facilities.** Those numbers are part of **the entire long-term care profession in Illinois, which encompasses 100,000 residents living in more than 1,200 facilities** that care for the elderly and disabled. **More than 112,000 professionals work in Illinois facilities** and care for these valued residents.

Understanding the long-term care profession is vital as the Baby Boomers enter their 60s and face health-care challenges. After all Baby Boomers have turned 65, more than 71 million senior citizens will be living in the United States, according to the U.S. Census Bureau. People age 65 face at least a 40 percent lifetime potential of entering a skilled nursing facility.

Table of Contents

1. Executive Overview
2. Funding long-term care in Illinois
3. Unfunded regulatory requirements
4. Caregivers in skilled nursing facilities
5. Regulation of skilled nursing facilities
6. Culture change
7. A continuum of care in long-term care
8. Appendix

Executive Overview

Funding long-term care in Illinois

Current Medicaid reimbursement

- The primary source of paying for care in Illinois skilled nursing facilities is Medicaid: **63 percent of all residents – or two-thirds – are on Medicaid.**

- Medicaid reimbursement is composed of three components: **nursing, support, and capital.**

- **Nursing** costs focus on direct care of the resident. State assessment of the clinical needs of residents has been frozen since 1993.

- **Support** costs focus on food, housekeeping, laundry, utilities, insurance, and clerical and administrative staff. **Reimbursement has been frozen at 1999 costs,** with the exception of a liability insurance update to 2002 costs. Lawmakers approved and Gov. Rod Blagojevich signed legislation in 2005 updating liability insurance reimbursement to 2002 costs.

- **Capital** costs make up mortgage, rent, property taxes, facility renovations, remodeling and repairs. **Reimbursement has been frozen at 1999 costs,** with the exception of occasional updating for unusual expenses.

- **Illinois' un-audited 2006 Medicaid rate ranked last when compared to 32 states reported in a June 2006 national survey** conducted by a leading healthcare consulting firm. **See chart on Page 13 and maps on Pages 14 and 15**.

- A lagging payment cycle from the state only exacerbates the inadequate reimbursement. In Fiscal Year 2006, payment cycle was as high as 150 days. This creates a significant hardship for providers to maintain a high level of quality care. Long-term care professionals will monitor payment cycle closely, and will send quarterly updates to lawmakers. At the time of this printing in October 2006, a few providers had received payment 60 days after final monthly date of service. **See chart on Page 7 and map on Page 17.**

MDS-based system will help nursing component

- The **MDS-based reimbursement system** has been approved by all three long-term care associations, state officials and lawmakers, and **will go into effect Jan. 1, 2007.**

- The MDS assessment accurately reflects the care needs of residents, so **an MDS-based reimbursement system directly links resident care and service needs to funding**.

- Lawmakers during the 2006 legislative session approved **the first phase of funding for the MDS in matching state and federal monies totaling $30 million, which will be annualized to $60 million beginning July 1, 2007.**

- Current nursing reimbursement has been based on a measurement of care needs in 1993 – therefore, reimbursement of care needs has been frozen at 1993 costs. Support and capital costs have been frozen at 1999 cost levels. **However, the total average daily cost per resident increased nearly 27 percent from 1999 to 2006, and 88 percent since 1993.**

Unfunded regulatory requirements

Federal and state rules required without appropriation

- Federal and state regulations exist to protect the health and safety of residents. **However, most – if not all – of these regulations come with no funding.**

- A new state law calling for **criminal background checks on all current residents of long-term care facilities, as well as new admissions, is estimated to cost $6.5 million.**

- The **federal Life Safety Code** requires facilities to make building modifications to ensure the safety of residents. **These requirements come with no funding.**

- **New regulations must not be approved unless they come with the necessary funding** to implement them.

Regulation of skilled nursing facilities in Illinois

Federal and state oversight

- Skilled nursing facilities are **licensed by the Illinois Department of Public Health** and **certified by the federal Centers for Medicare and Medicaid Services.**

- IDPH surveyors conduct **at least one on-site licensure inspection each year for every facility**, as well as an inspection following a complaint.

- **Surveys typically last three to four** days and are conducted by a team usually made up of a registered nurse, a nutritionist and an environmental health practitioner. **Surveyors inspect the facility, review medical records and health-care plans, and interview residents, family members and employees.**

- **Fines for cited violations are determined by the severity of the infraction**, but are not less than $5,000 for state violations. **The most common fine imposed by IDPH is $10,000 per violation.** Fines for **violations of federal standards range from $50 to $10,000 per day.**

The survey process

- **Management, administrators and staff are always willing to cooperate** with surveyors and their suggestions for better care for residents.

- More **consistency in the interpretation of regulations** is needed.

- Residents would be best served with **a collaborative effort between surveyors and facility staff.**

- The residents would benefit most if the **official survey report were received by the facility within a specific time frame.**

- **Administrators need to know immediately when a federal or state regulation changes**, so they can serve their residents.

What will it take to accomplish these goals?

Fully fund the system to cover current costs

- **Funding must be in line with today's costs. The current reimbursement system covers only 76 percent of the cost of caring for residents.**

- **Illinois' current Medicaid reimbursement rate is $98.25. The total average daily cost per resident according to facility cost reports filed with the state is $129.85.** However, the current population of higher-cost, medically complex residents being admitted to skilled nursing facilities in Illinois is driving this under-funded gap even wider.

- Full funding for all current costs will take an additional $800 million through the next four fiscal years. **This cost would be shared by both the state and federal governments, with each entity paying an additional $100 million for each of the next four fiscal years.**

The three long-term care associations have recognized the importance of working with state government in solving this crisis, and have proposed a five-year phase-in of funding the MDS. The first phase approved by the Illinois legislature begins Jan. 1, 2007, with a $30 million allocation, which will be annualized to $60 million beginning July 1, 2007. The additional $100 million in state general revenue funds for each of the next four fiscal years will be matched by federal funds and will bring long-term care reimbursement into line with the actual cost of care.

- **A lagging Medicaid payment cycle from the state may be unrelated to reimbursement of care but demands attention on the merits of fundamental reasonableness and governmental priorities.** The length of the payment cycle places undue stress and hardship upon providers. The rising cost of borrowing has had a significant negative impact on the financial viability of facilities that are already under-funded.

  The unintended result of this policy is the creation of criteria of participation in the Medicaid program for those with unlimited access to large lines of credit – as opposed to the true criteria of delivering high quality of care. Other states make Medicaid reimbursement a high priority among their monthly payments. **See chart on Page 7.**

- The convergence of these four factors – inadequate Medicaid reimbursement; unfunded mandates and regulations; inconsistent interpretation of regulations; and a lagging payment cycle – has had a crippling effect on an industry that serves as one of the largest employers in Illinois in its mission of caring for our parents, grand-parents, relatives and friends.

  It is the hope of the three long-term care associations that this resource book will help to clarify and illuminate the challenges facing our industry, as well as serve as a catalyst to unify and energize you. We ask that you lend your strong character and conviction to advocate for the necessary funding and reforms that will allow and encourage the caregivers of Illinois' elderly to focus on providing the best care possible.

Medicaid payment cycle — state-by-state comparison

STATE	PAYMENT CYCLE IN DAYS
Nevada	6-10 days
Ohio	7 days
Kentucky	7 days
Iowa	7 days
Maryland	7 days
North Dakota	7 days
Texas	7 days
Georgia	7 days
Oklahoma	7 days
Utah	7 days
Kansas	8 days
New Jersey	7-10 days
New Mexico	7-10 days
Delaware	7-14 days
North Carolina	7-14 days
Florida	7-15 days
Virginia	7-21 days
Hawaii	14 days
Vermont	14 days
Missouri	14 days
Arkansas	14 days
New York	14 days
Washington	14 days
Maine	14-21 days
South Dakota	14-21 days

STATE	PAYMENT CYCLE IN DAYS
Louisiana	14-21 days
Oregon	14-28 days
Rhode Island	20 days
South Carolina	21 days
California	21-28 days
Massachusetts	30 days
Tennessee	30 days
Alabama	30 days
Minnesota	30 days
Mississippi	30 days
West Virginia	30 days
Nebraska	30 days
Wisconsin	30 days
Michigan	30 days
Pennsylvania	30 days
New Hampshire	30 days
Indiana	35 days
Montana	30-60 days
Connecticut	45 days
Idaho	45-60 days
Alaska	45 days
Wyoming	60 days
Colorado	60-90 days*
Arizona	90 days**
Illinois	**90-150 days**

Note: *A telephone survey of 50 state affiliates of the American Health Care Association was conducted Aug. 14-28, 2006, by the Center for the Advancement of Elder Care. Payment cycle is defined as the time period between submission of a Medicaid claim and payment of that claim.* ***In Fiscal Year 2006, payment cycle in Illinois was as high as 150 days. This creates a significant hardship for providers to maintain a high level of quality care. Long-term care professionals will monitor payment cycle closely, and will send quarterly updates to lawmakers. At the time of this printing in October 2006, a few providers had received payment 60 days after final monthly date of service.***

* *Colorado's Medicaid reimbursement is processed by the individual counties.*

** *Arizona uses managed care for its Medicaid participants, so the individual managed-care plans reimburse skilled nursing facilities. Payment cycle varies, but state law levies penalties if payment takes longer than 90 days.*

Funding long-term care in Illinois

Our changing mission: Much more acute care needed

Ten years ago, a typical resident of a skilled nursing facility would most likely be one of two extremes.

A widowed or single woman in her 70s lived at such a facility because she needed help with activities of daily living such as eating, bathing and monitoring her medication.

At the other end of the spectrum, a resident would come to a skilled nursing facility after a hospital stay of 10 days to two weeks following surgery or a stroke. The surgical wound would already be healed, and the resident would have received some physical, occupational or speech therapy at the hospital.

But if you ask long-term care nurses today how residents have changed during the past 10 years, their answer is quick and synonymous.

"They're coming to us much sicker and quicker," said a long-term care nursing field supervisor.

- Now, surgical or stroke patients come to a skilled nursing facility **after only three or four days in a hospital.**
- Their **surgical wound needs treatment and almost hourly monitoring to heal.** They usually **cannot get out of bed**, and they have not recovered enough to begin any sort of therapy.
- They are often on an **IV drip, catheter, or feeding tube,** and often need **blood drawn for lab tests**.
- These post-surgical, post-stroke residents require **highly trained caregivers to monitor infection control, special diets and complex, multiple medications.**

"The skilled nursing facility has become a med/surgical floor of a hospital, and the hospital has become a free-standing intensive-care unit," said a clinical field nurse for a group of skilled nursing facilities throughout the state.

Hospitals are discharging surgical and stroke patients after only three or four days, instead of the 10 days to two weeks of 10 years ago. Many of these patients have not even stabilized when they are transferred to a skilled nursing facility for recovery and rehabilitation.

A longer life expectancy adds to the challenges. In 1900, people who reached age 65 had a remaining life expectancy of 12 years, according to the U.S. Census Bureau. Statistics for 2000 show 65-year-olds have a remaining life expectancy of 18 years. But this longer life also allows the body to develop chronic medical conditions, such as arthritis, osteoporosis, kidney disease, hypertension, diabetes, and some forms of dementia, including Alzheimer's disease.

"Long-term care is dealing with a variety of medical issues," said the head of a clinical team associated with one of the state's three long-term care organizations.

Dementia – stemming from such diseases as alcoholism, Parkinson's and Alzheimer's – requires special care. A nurse's clinical assessment skills are put to the test, as she or he tries to determine the true condition behind a resident's sometimes irrational behavior. **More than 40 percent of residents living in Illinois nursing homes have Alzheimer's disease or some sort of dementia.**

Paying for long-term care in Illinois

There are three primary sources of paying for long-term care: **private pay with savings or long-term care insurance, Medicare, or Medicaid.**

Medicare pays for the first 20 days after a hospital stay of at least three midnights if the person meets Medicare criteria. It then may partially pay for the next 80 days if Medicare criteria are met.

Two-thirds of residents are on Medicaid

The majority of residents in skilled nursing facilities are on Medicaid – **65 percent nationwide and 63 percent in Illinois,** according to June 2006 data compiled by the American Health Care Association.

Medicaid is the state-federal health insurance created in 1965 for the indigent and disabled. A large percentage of every state's budget is made up of Medicaid costs. States annually appropriate funds to pay for Medicaid residents in skilled nursing facilities, and that funding is then matched by the federal government. Illinois has a 50 percent matching rate, which is the lowest possible state match.

Medicaid funding in Illinois

Illinois' annual appropriation for Medicaid residents in skilled nursing facilities is made up of two sources: general revenue funds – or money from the state's checkbook – and money from the Long-Term Care Provider Fund. Both sources are matched by federal dollars.

The Long-Term Care Provider Fund gets money from two sources: a tax assessed on each licensed bed in a facility and a tax assessed on tobacco products other than cigarettes.

The provider tax was implemented in 1991 and currently stands at $1.50 per licensed bed. The state collects that tax annually, and uses it to get matching federal Medicaid dollars that are funneled back to the facilities in the form of reimbursement rates.

The tax assessed on tobacco products other than cigarettes was implemented in 1993 and currently stands at 18 percent of wholesale price.

The Medicaid system

The Medicaid reimbursement rate for skilled nursing facilities in Illinois is composed of three components: **nursing, support, and capital.**

The total rate is supposed to cover the total average daily cost per resident, which rose from $102.53 in 1999 to $129.85 in 2006 – an increase of nearly 27 percent. The current reimbursement rate is $98.25, covering only 76 percent of costs.

See a state-by-state comparison chart on Page 13 and maps on Pages 14 and 15.

A lagging payment cycle from the state only exacerbates the inadequate reimbursement. **See chart on Page 16 and map on Page 17.**

Nursing component

- **Nursing costs focus on wages and supplies needed for direct care of the resident.** This encompasses the work of nurses, certified nurse assistants, and social workers, as well as most medical and personal-care supplies such as wound care dressings, catheters, and over-the-counter medications.

- Nursing costs currently make up **52 percent of costs in Illinois skilled nursing facilities.**

- **Wages have increased substantially over the past several years, according to data from facilities' annual cost reports.** The average hourly wage for registered nurses working in

Illinois skilled nursing facilities increased 37 percent from 1999 to 2006. During that same time period, the average pay for licensed practical nurses rose 35 percent, while the average wage for certified nurse assistants increased 21 percent.

- **The system for assessing and funding the care needs of residents of skilled nursing facilities has relied on an antiquated system.** State surveys of residents – or the variety of light-care and heavy-care residents – have not been performed since 1993. Moreover, these surveys did not accurately reflect residents' needs, so the Medicaid reimbursement based on the surveys often does not cover the cost of resident care.

- **Medicaid reimbursements to skilled nursing facilities for nursing care have essentially been frozen at 1993 assessment levels.** Although the Illinois legislature has passed cost-of-living-adjustments over the past several years, the COLAs were based on inadequate surveys that are now out-of-date. The result: Many residents receive care that is inadequately funded.

MDS is law in Illinois

However, significant progress toward more adequate funding has been made. The state's three long-term care associations – the Illinois Council on Long Term Care, the Illinois Health Care Association, and Life Services Network of Illinois – joined together in a coalition and worked with Illinois Department of Healthcare and Family Services officials to develop a reimbursement system based on a more accurate evaluation of patient need.

This "minimum data set" assessment – or MDS – is a person-centered clinical assessment program that ensures that a detailed, comprehensive look at the medical needs of today's residents is completed. It also emphasizes restorative and rehabilitative care, specialized Alzheimer's services, ventilator technology, and other highly skilled specialized care found in today's skilled nursing facilities. **The MDS assessment is already required by the federal government for every resident of a skilled nursing facility, and also reflects a facility's variety of patient-care levels**. An MDS-based reimbursement system, therefore, directly links resident care and service needs to funding. Nearly half the states in the nation use an MDS-based reimbursement tool for skilled nursing facilities.

This MDS-based system has been approved by all three associations, Illinois Department of Healthcare and Family Services officials and Illinois lawmakers, and signed into law by Gov. Rod Blagojevich. It will go into effect Jan. 1, 2007. A team made up of long-term care nursing clinicians from all three associations traveled to skilled nursing facilities across the state, auditing more than a 1,000 resident charts to fine-tune the MDS for use in Illinois.

During the 2006 legislative session, lawmakers approved the first phase of funding for the MDS in matching state and federal monies totaling $30 million, which will be annualized to $60 million beginning July 1, 2007.

According to a June 2006 national survey of Medicaid reimbursement rates conducted by leading national health-care consulting firm BDO Seidman, **Illinois's un-audited 2006 Medicaid rate ranked last when compared to the 32 states reporting data for 2006.**

See a state-by-state comparison chart on Page 13 and maps on Pages 14 and 15.

Support component

- **Support costs make up 37 percent of total daily costs** and focus on dietary needs, housekeeping, laundry, utilities, liability insurance, and the wages and benefits for clerical and administrative staff. **Reimbursement for support costs have been frozen at 1999 costs**, with an update to 2002 costs for liability insurance. Lawmakers approved and Gov. Rod Blagojevich signed legislation in 2005 updating liability insurance reimbursement to 2002 costs.

- Food and all dietary expenses compose nearly 25 percent of support costs**. Food costs for skilled nursing facilities rose 11 percent from 1999 to 2005.**

- **The average cost of liability insurance rose 278 percent from 1999 to 2006,** with some areas of the state seeing a 1,000 percent increase in liability insurance premiums.

- **Costs of utilities have increased 30 percent during the same time period**, according to data from facilities' annual cost reports.

Capital component

- **Capital makes up 11 percent of total daily costs** and refers to the actual home for the residents – **the bricks and mortar of the facility, including the land.**

- **Annual property taxes, mortgage, and rent fall under this expense category**. Any facility renovations – such as painting or wall-papering, a new roof, furnace or air-conditioning – also make up capital costs.

- **Property taxes have risen an average of 16 percent from 1999 to 2006**, although higher increases have occurred in such areas as Chicago and Cook County.

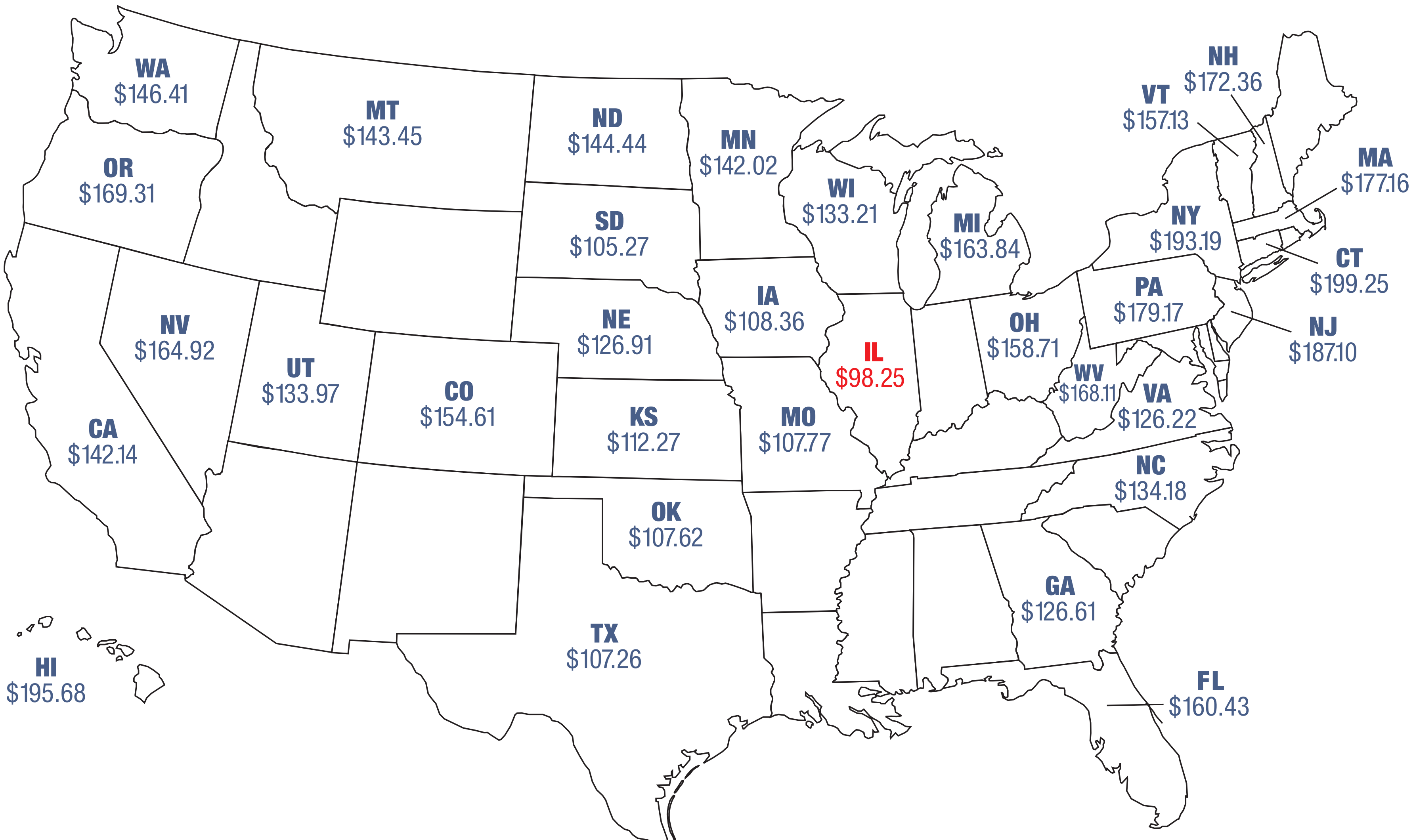
- Medicaid reimbursement for capital costs have been frozen at 1999 costs, with the exception of occasional updating for unusual expenses.

33-State Comparison of '06 Medicaid Reimbursement Rates

STATE	RATE
Connecticut	$199.25
Hawaii	$195.68
New York	$193.19
New Jersey	$187.10
Pennsylvania	$179.17
Massachusetts	$177.16
New Hampshire	$172.36
Oregon	$169.31
West Virginia	$168.11
Nevada	$164.92
Michigan	$163.84
Florida	$160.43
Ohio	$158.71
Vermont	$157.13
Colorado	$154.61
Washington	$146.41
North Dakota	$144.44
Montana	$143.45
California	$142.14
Minnesota	$142.02
North Carolina	$134.18
Utah	$133.97
Wisconsin	$133.21
Nebraska	$126.91
Georgia	$126.61
Virginia	$126.22
Kansas	$112.27
Iowa	$108.36
Missouri	$107.77
Oklahoma	$107.62
Texas	$107.26
South Dakota	$105.27
Illinois	**$98.25***

Source: *June 2006 report by accounting and consulting firm BDO Seidman, using 2006 data from 32 states that submitted rate information by a specified deadline. Illinois missed that deadline.*

***Illinois has an un-audited Medicaid rate for 2006 of $98.25 – which ranks last when compared to the 32 other states reporting data.** That rate covers only 76 percent of the average total daily cost per resident in 2006 of $129.85.



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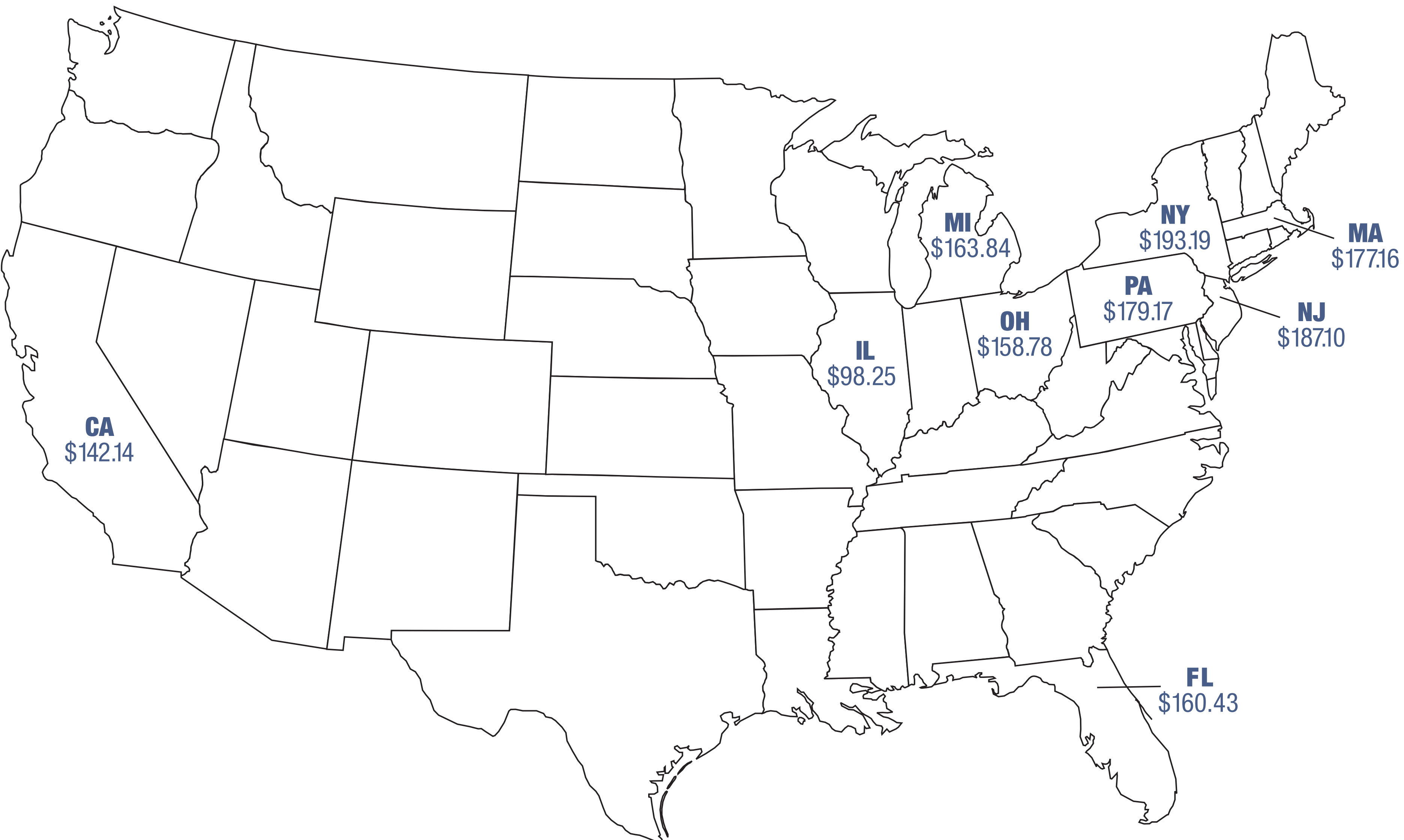


Comparison of Medicaid Rates Among Leading Industrialized States

(Source: June 2006 national survey by BDO Seidman, a leading healthcare consulting firm)

Medicaid payment cycle — state-by-state comparison

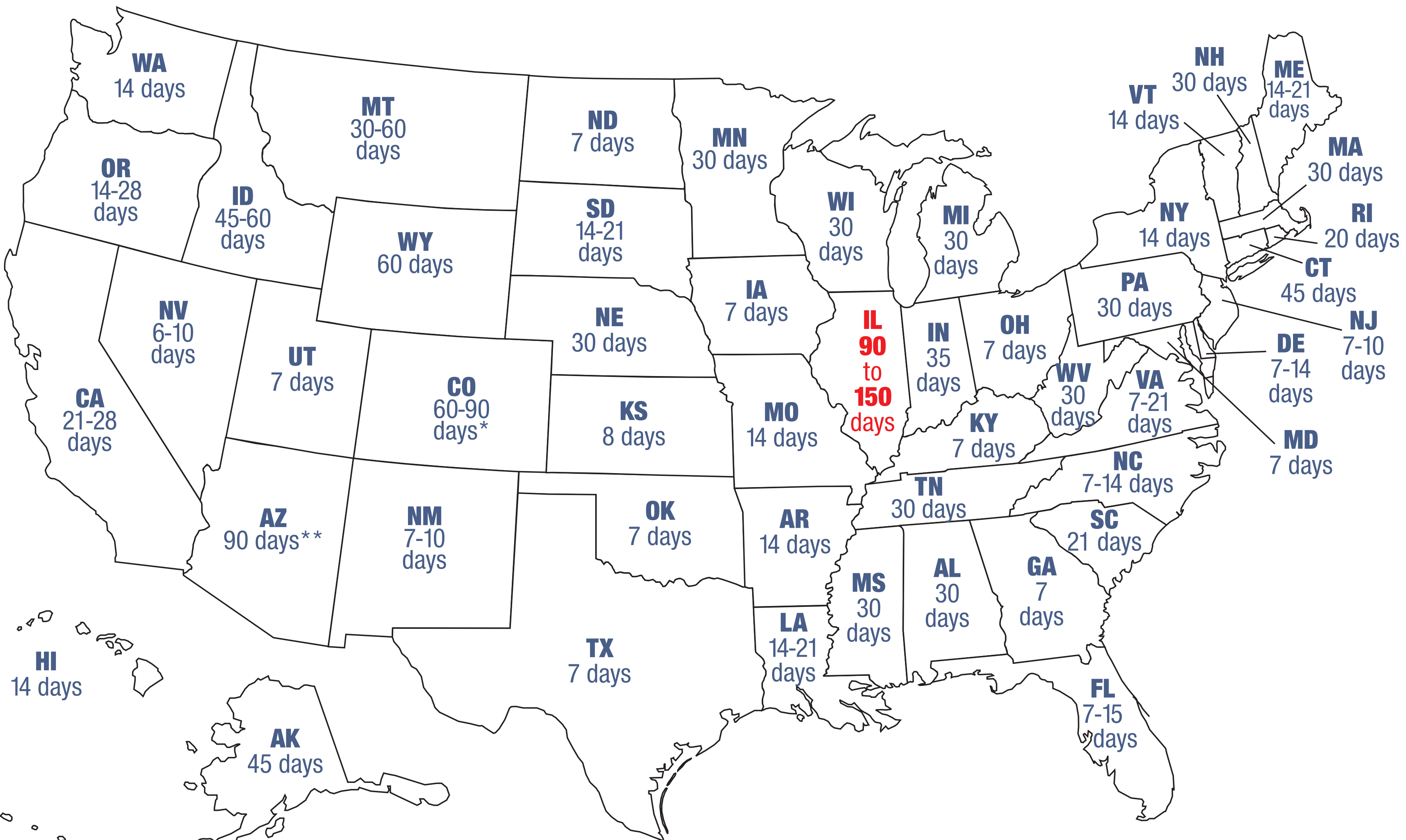
STATE	PAYMENT CYCLE IN DAYS
Nevada	6-10 days
Ohio	7 days
Kentucky	7 days
Iowa	7 days
Maryland	7 days
North Dakota	7 days
Texas	7 days
Georgia	7 days
Oklahoma	7 days
Utah	7 days
Kansas	8 days
New Jersey	7-10 days
New Mexico	7-10 days
Delaware	7-14 days
North Carolina	7-14 days
Florida	7-15 days
Virginia	7-21 days
Hawaii	14 days
Vermont	14 days
Missouri	14 days
Arkansas	14 days
New York	14 days
Washington	14 days
Maine	14-21 days
South Dakota	14-21 days

STATE	PAYMENT CYCLE IN DAYS
Louisiana	14-21 days
Oregon	14-28 days
Rhode Island	20 days
South Carolina	21 days
California	21-28 days
Massachusetts	30 days
Tennessee	30 days
Alabama	30 days
Minnesota	30 days
Mississippi	30 days
West Virginia	30 days
Nebraska	30 days
Wisconsin	30 days
Michigan	30 days
Pennsylvania	30 days
New Hampshire	30 days
Indiana	35 days
Montana	30-60 days
Connecticut	45 days
Idaho	45-60 days
Alaska	45 days
Wyoming	60 days
Colorado	60-90 days*
Arizona	90 days**
Illinois	**90-150 days**

Note: *A telephone survey of 50 state affiliates of the American Health Care Association was conducted Aug. 14-28, 2006, by the Center for the Advancement of Elder Care. Payment cycle is defined as the time period between submission of a Medicaid claim and payment of that claim.* ***In Fiscal Year 2006, payment cycle in Illinois was as high as 150 days. This creates a significant hardship for providers to maintain a high level of quality care. Long-term care professionals will monitor payment cycle closely, and will send quarterly updates to lawmakers. At the time of this printing in October 2006, a few providers had received payment 60 days after final monthly date of service.***

* *Colorado's Medicaid reimbursement is processed by the individual counties.*

** *Arizona uses managed care for its Medicaid participants, so the individual managed-care plans reimburse skilled nursing facilities. Payment cycle varies, but state law levies penalties if payment takes longer than 90 days.*



State-By-State Comparison of Medicaid Payment Cycles

Note: *A telephone survey of 50 state affiliates of the American Health Care Association was conducted Aug. 14-28, 2006, by the Center for the Advancement of Elder Care. Payment cycle is defined as the time period between submission of a Medicaid claim and payment of that claim. I**n Fiscal Year 2006, payment cycle in Illinois was as high as 150 days. This creates a significant hardship for providers to maintain a high level of quality care. Long-term care professionals will monitor payment cycle closely, and will send quarterly updates to lawmakers. At the time of this printing in October 2006, a few providers had received payment 60 days after final monthly date of service.*** **Colorado's Medicaid reimbursement is processed by the individual counties. **Arizona uses managed care for its Medicaid participants, so the individual managed-care plans reimburse skilled nursing facilities. Payment cycle varies, but state law levies penalties if payment takes longer than 90 days.*

Unfunded regulatory requirements

The long-term care profession recognizes that federal and state regulations exist to protect the health and safety of residents. **However, most – if not all – of these regulations come with no funding.** Skilled nursing facilities are left to cope with these unfunded regulations, while struggling with inadequate and often-delayed Medicaid reimbursement.

State unfunded regulatory requirements

Since 1996, skilled nursing facilities have been required to run **criminal background checks** on applicants or existing employees whose duties involve direct care of residents. **No funding was attached to that regulation.**

That requirement was further refined in 2006 to include all employees with duties that may involve contact with residents, access to their living quarters, or access to their financial, medical, or personal records. However, licensed staff members are exempt. **Again, no funding was attached to the regulation**.

Of the 112,000 staff members in all long-term care facilities, about 89,300 fall into the category requiring a background check. Fingerprinting is sometimes required, bringing the estimated cost of this new regulatory requirement to $3.5 million. Annual turnover among staff is estimated at 70 percent, so this is a re-occurring cost.

During the 2006 legislative session, long-term care professionals, senior-citizen advocates and representatives of the Illinois attorney general's office collaborated on **approved legislation intended to protect residents from felony offenders.** This measure helps to ensure the safety of residents.

However, the new law calls for criminal background checks on the existing 100,000 residents in long-term care, as well as new admissions. Special accommodations must be made for residents found to be felony offenders in order to protect other residents. **These accommodations and criminal background checks are estimated to cost $6.5 million – but no funding was attached to the legislation.**

Federal unfunded regulatory requirements

The federal Centers for Medicare and Medicaid Services regularly adopts a Life Safety Code for skilled nursing facilities. **All long-term care facilities are required to make modifications to their buildings to comply with the Life Safety Code – but no funding has been appropriated for the implementation of these changes.**

An example of a required building modification is the **installation of automatic-closure dampers on bathroom vents.** These dampers would prevent any smoke from a fire from spreading throughout the facility by way of the bathroom vents. **However, the cost of these dampers typically totals from $100,000 to $200,000 per facility.**

Another Life Safety Code requirement calls for all exits of a facility to have **sidewalks that lead to a cemented, secure area. For many rural facilities, the cost of this requirement is prohibitive.**

More unfunded regulatory requirements are on the horizon. The National Fire Protection Association's 2006 edition of the Life Safety Code requires the installation of sprinklers in existing long-term care facilities. CMS has yet to adopt rules mandating the use of the 2006 Life Safety Code but is expected to in the future. Currently, any skilled nursing facility that remodels must install sprinklers – without the necessary funding.

The long-term care profession supports the installation of sprinklers in all existing and new facilities – but with the necessary funding.

Caregivers in skilled nursing facilities

Skilled nursing facilities nationwide employ nearly 1.577 million workers, ranging from chief executives to database administrators to physical therapists to head cooks and janitors.

Majority of employees in direct-care positions

However, the bulk of that employment – **57 percent** – can be found in occupations that care directly for the residents: certified nursing aides, licensed practical nurses and registered nurses.

Data from the U.S. Bureau of Labor Statistics for May 2005 (the most recent information available) show that 599,310 nursing aides, orderlies and attendants work in skilled nursing facilities at an average hourly wage of $10.33. The force of licensed practical nurses totals 186,560, earning an average hourly wage of $18.06. Meanwhile, registered nurses tally 120,200 at an average salary of $24.76 an hour.

Skilled nursing facilities in Illinois reflect the national trend, with direct-care workers making up 59 percent of facilities' work force.

According to data listed in facilities' annual cost reports filed with the Illinois Department of Healthcare and Family Services, 28,500 full-time certified nurse aides work in Illinois skilled nursing facilities. The number of licensed practical nurses totals nearly 7,070, while registered nurses tally nearly 7,195. **More than 112,000 professionals work in all Illinois long-term care facilities and care for these valued residents.**

Direct-care workers in Illinois skilled nursing facilities earn more than the national average. The average hourly wage for registered nurses for 2006 is $25.66, an increase of 37 percent from 1999. Licensed practical nurses earn an average of $19.43 an hour, up 35 percent from 1999. Certified nurse aides make an average hourly wage of $10.88, an increase of 21 percent from 1999.

Federal, state staffing levels must be met

Skilled nursing facilities must meet minimum staffing levels set by both the federal and state governments. Federal rules require that a facility must use the services of a registered nurse for at least eight consecutive hours a day, seven days a week. Additionally, a registered nurse should be designated as the director of nursing, while a licensed nurse must be designated as a charge nurse on each shift.

Staff recruitment, retention, and development

The current shortage of registered nurses, licensed practical nurses and certified nurse aides extends across the health-care spectrum, including skilled nursing facilities.

However, most registered nurses working in long-term care find the work more rewarding than work found in other settings. Long-term care nurses are able to take a holistic approach in caring for the residents they see day-to-day. They use their assessment skills to create a personal bond integral to monitoring the residents' health.

Career ladders for staff

Managers of skilled nursing facilities have taken innovative steps to recruit and retain talented direct-care staffers. Some facilities offer employees scholarships so they can continue their education. Certified nurse aides train to become licensed practical nurses, LPNs go on to become registered nurses, and RNs go back to school to get their bachelor's degree in nursing.

Efforts to provide higher-level, in-house training for certified nurse aides are currently under way in Illinois. Lawmakers in 2001 passed legislation calling for a **statewide task force to create a career ladder for CNAs.** Aides would be trained to take on responsibilities greater than their current personal-care duties, such as checking blood glucose levels for diabetic residents or administering oxygen. Such additional training would take a CNA's care of residents to the next level, as well as free up registered and licensed practical nurses for other duties.

The state's three long-term care associations also support the creation of a medication technician program so that nurses in skilled nursing facilities would have more time to assess the health-care needs of the residents and then direct their care.

Profession representatives in 2005 pushed legislation creating a **medication technician program for certified nursing assistants.** At least 16 states have such a training program that enables CNAs to administer certain routine oral and topical medications to residents of skilled

nursing facilities or assisted living facilities. An additional 14 states have medication technician programs for CNAs working only in assisted living facilities.

The proposed legislation allowed certified nurse aides with one year of experience in a skilled nursing facility and a recommendation from a licensed nurse to enter the 100-hour training program. **After completing 60 hours of classroom instruction and 40 hours of clinical supervision, enrollees would then take a certification exam administered by the Illinois Department of Public Health**. These medication technicians would then be required to take 16 hours of continuing education during a two-year period to renew their certification.

The legislation passed the Illinois House of Representatives in April 2005 on a strong 84-29 vote, with three lawmakers voting “present.” However, the measure died when it moved over to the Senate.

Adding a medication technician program to a career ladder for certified nurse aides will create an added dimension to the profession.

Regulation of skilled nursing facilities

Skilled nursing facilities in Illinois fall under the **regulatory umbrellas of the Illinois Department of Public Health and the federal Centers for Medicare and Medicaid Services**.

Public Health ensures that facilities fully comply with state regulations, and serves as CMS's so-called "arm" in Illinois by making sure that facilities accepting Medicare and Medicaid payments meet federal regulations and certification rules.

Licensure and certification surveys

The Illinois Department of Public Health grants one and two-year licenses to operators of skilled nursing facilities for an annual fee of $995. The license is renewed every year and after a Public Health licensure survey. Skilled nursing facilities in Illinois are subject to **at least one regular on-site licensure inspection each year**, as well as an inspection following a complaint filed against the facility with Public Health. All inspections – or surveys – are unannounced.

Certification surveys are completed at the same time as licensure surveys for facilities that participate in the Medicare and/or Medicaid programs. Certification surveys evaluate compliance with federal regulations for these programs.

Licensure and certification surveys are conducted by a team of Public Health officials that usually includes a registered nurse, a nutritionist and an environmental health practitioner. Surveys are conducted over three to four days, and assess compliance with state and federal standards that focus on such areas as resident rights, access to care, activities, resident care plans, dietary services, staffing, housekeeping and physical plant. **Surveyors will inspect the facility, review medical records and health-care plans, and interview residents, family members and employees.**

Surveyors usually discuss deficiencies and violations with administrative staff at the end of the survey. However, the official report on the survey must come from Springfield, and then facility administrators have 10 days to file a plan of correction.

Complaint surveys are generally conducted by one to two surveyors as deemed appropriate by Public Health.

The survey process

Managers of skilled nursing facilities recognize that IDPH surveyors are charged with a tremendous responsibility during a survey. Administrators and staff are always willing to cooperate with surveyors and their suggestions for better care for residents.

Research found the following suggestions for the survey process:

- **More consistency in interpretation of regulations and the survey process itself**
  Surveyors differ widely in their interpretation of regulations, with one citing a facility for a deficiency and another seeing no deficiency. **More consistency is needed in the interpretation of regulations.**

- **A more collaborative attitude between surveyors and facility staff**
  The long-term care profession recognizes that surveyors are charged with providing oversight to ensure the safety and health of residents. Differences of opinion as to what is best for the residents sometimes result in a somewhat confrontational stance by surveyors with facility staff members. The facility's professional caregivers keep their residents' health and safety as their top priority. A more collaborative attitude between surveyors and facility staff would help make this top priority an attainable goal.

- **A specific time frame for receiving the official survey report, so administrators can act more quickly to correct deficiencies**
  Administrators may have a general idea of the results of the survey, or very specific deficiencies cited – it all depends on the surveyors and how much they wish to discuss at the exit interview. Administrators need a specific, quick turn-around time on receiving the official survey report so they can begin correcting deficiencies as soon as possible.

- **Improved communication with facilities on new or changed regulations**
  Facilities and the three state long-term care associations should be immediately informed about new or changed state and federal regulations. Unless a facility belongs to one of the associations, **its administrator and staff often learn of new or changed rules when a surveyor steps through the door.**

- **Eliminate the two-year disqualification of nurse-aide training programs at facilities that are cited with deficiencies**
  This action **only compounds the current shortage of certified nursing aides.** Once deficiencies have been corrected, the training program should be re-instated.

Licensure and certification fines

State fines for cited violations are determined by the severity of the infraction, but are not less than $5,000. **The most common fine imposed by Public Health tallies $10,000 per violation**. Fines for **violations of federal standards range from $50 to $10,000 per day**, but Public Health may only recommend a federal fine – it is up to the federal CMS to impose, change or waive the recommended fine.

Federal and state fines interact in an interesting – and often frustrating – way. The state and federal governments may fine a facility for the same infraction. A facility may request a hearing from both the federal and state governments. However, that facility must pay 100 percent of the levied fine while waiting for the federal hearing, while collection of any state fine will be postponed until after the state hearing. If the state hearing determines the infraction was not valid, no state penalty is collected. But the infraction – and its penalty – stands on the federal front, despite the state finding.

Money collected from federal fines – called civil monetary penalty funds – must be used for programs or initiatives that improve skilled nursing facilities, such as the long-term care ombudsman program. Public Health officials determine how to allocate CMP funds, but must receive federal approval for their use. CMP funds cannot be used for direct care of residents.

Money collected from state fines partly goes toward funding surveys, but the rest is funneled to Public Health's general budget. Data collected from IDPH's Web site was used to create a chart on a history of fines.
See chart on Page 26.

Fines levied against skilled nursing facilities by IDPH

Year Qtr.	1999	2000	2001	2002	2003	2004	2005	2006
1st	$117,000	$110,917	$91,242	$195,000	$260,000	$150,000	$310,000	$840,000
2nd	$108,289	$131,947	$95,034	$115,000	$335,000	$420,000	$270,000	
3rd	$106,751	$154,441	$140,500	$130,000	$155,000	$230,000	$371,500	
4th	$131,750	$66,677	$120,000	$165,000	$235,000	$208,190	$386,000	
Total	$463,790	$463,982	$446,776	$605,000	$985,000	$1,008,190	$1,337,500	

Culture Change

As the general population ages and changes, skilled nursing facilities must evolve too. The Baby Boomers will not be satisfied with the so-called “rest homes” of their grandparents. Skilled nursing facilities are changing to fit the varying health, social, emotional and spiritual needs of this new brand of senior.

This evolution – or perhaps revolution – has already begun. Skilled nursing facilities across the nation are implementing **“culture change”** by focusing on resident-centered care that recognizes the individual needs of human beings.

“Culture change” turns upside-down the traditional hospital-like skilled nursing facility. Decisions on such issues as personal care, activities, food, and décor are returned to the resident as often and as much as possible.

- Wings of the facility are usually transformed into **neighborhoods of residents cared for by a regular team of caregivers.** Residents are often encouraged to bring **personal pieces of furniture** into their room, or pick out the walls’ paint color or wallpaper border. **Buffet-style dining** is introduced, and **breakfast, lunch and dinner hours are extended** to satisfy different appetites. A refrigerator and toaster are sometimes placed in each “neighborhood,” allowing for those late-night snacks.

- Residents are given **the option of when they want to bathe or shower**, and nursing aides’ hours are adjusted to reflect the varying personal-care needs. **“Neighborhoods” sometimes schedule their own activities** against the facility’s regular activity schedule, with residents often taking outings to community parks or shopping centers.

- The **landscaping surrounding the facility often reflects a peaceful garden setting**, with flower beds, ponds or even waterfalls. **Raised gardens may be created** to allow residents to continue their hobby of raising flowers or vegetables.

- **Staff members often bring their pets to work**, as cats and dogs roam the halls like any home. Some facilities even begin **day-care centers for the children of employees**, giving workers peace of mind and the children a houseful of substitute grandparents.

Typical culture change outcomes

Typical outcomes of resident-directed culture change include decreased usage and costs of psychotropic drugs as depression and boredom of residents ease with the more home-like environment. The new dining styles have helped residents gain weight and decrease the use of supplements, while facilities have saved money since less food is wasted. Residents are also generally happier in this environment.

Several organizations exemplify “culture change,” such as **Pioneer Network, Eden Alternative or Wellspring**. But they all share the common goal of the most autonomous, home-like, and resident-centered care possible.

A continuum of care in long-term care

Skilled nursing facilities are no longer viewed as a destination as individuals age. **Instead, such facilities are evolving into a "hub" of senior services, encompassing an interchanging variety of home, community, and facility-based options for care and rehabilitation.**

Illinois leads with the Older Adult Services Act

Illinois policymakers, representatives of the long-term care industry, and senior citizen advocates such as AARP recognize the need for a continuum of care that caters to seniors' desire to live as independently as possible in their own home as long as possible.

In 2004, lawmakers crafted and approved legislation intended to overhaul the state's current service system for older adults. Senate Bill 2880 was signed into law in August 2004 by Gov. Rod Blagojevich, and sets the stage for a re-structuring of the traditional, long-term care industry into a continuum of care for the state's senior citizens.

Known as the Older Adult Services Act, Senate Bill 2880 calls for "the transformation of Illinois' comprehensive system of older adult services from funding primarily a facility-based services delivery system, taking into account the continuing need for 24-hour skilled nursing care and congregate housing with services."

- **The law takes an "age in place" attitude, expanding or implementing services to seniors that allow them to stay in their homes.** These services include adult day care, case management, community re-integration, counseling and education, family caregiver support, home-delivered or congregate meals, homemaker services, personal care, laundry services and medication reminders.

- **Demonstration grants – subject to appropriation – would be made available for innovative "age in place" programs,** such as evening and weekend home-care coverage, assisted living in a supervised apartment, family adult day care or adult family foster care.

- **However, the importance of facility-based care programs is also a key part of the legislation.** Start-up grants – also subject to appropriation – would be allocated to skilled nursing facilities for the **conversion of multi-occupant bedrooms to single-occupant**

rooms or the conversion of all or part of the building to an assisted living facility or an Alzheimer's wing. Participating facilities would have to put up a 20 percent financial match toward the cost of the project.

- **Grants could also be used to convert unused facility space into a "hub" for community-based services such as adult day care, home-delivered meals, outpatient therapy and senior transportation.** All of the medical, nursing, therapy, dietary, activity and environmental resources already exist within the skilled nursing facility – why not use them?

Safeguards for residents of skilled nursing facilities

Senate Bill 2880 is a long-term project that would dramatically overhaul the state's long-term care services. **However, safeguards for maintaining care of current residents of skilled nursing facilities are built into the legislation.**

- Any skilled-nursing-facility conversion grant cannot diminish or reduce the quality of services available to residents or force any resident to involuntarily accept home- or community-based services instead of skilled nursing facility services.
- The grants also cannot diminish or reduce the supply and distribution of skilled nursing facility services in any community below the level of need or cause undue hardship on any person who requires facility-based care.

Advisory panel plans for implementation

The legislation created the **Older Adult Services Advisory Committee** to advise state officials on the implementation of the act. Committee members have been meeting in workgroups since November 2004 to discuss and plan objectives such as understanding the financing system of the state's current long-term care system; expanding adult day service programs by increasing the transportation rate; and expanding home-delivered meals by offering two meals a day 365 days of the year.

Members have established workforce improvement as a priority by calling for health benefits and career ladders for personal care aides, as well as funding respite care for family caregivers in the form of home care, transportation assistance and vouchers.

Conversion of skilled nursing facility space to assisted living or Alzheimer's units should begin by establishing a baseline of the need for facility-based care, and then **updating the bed need formula through work with the Illinois Health Facilities Planning Board.**

Illinois prepares for federal attitude favoring home- and community-based care

The Older Adult Services Act and its trend toward more home- and community-based services mesh with the current federal attitude toward long-term care. President George W. Bush in 2001 announced the New Freedom Initiative, directing federal agencies to develop a government-wide framework to help provide seniors, as well as the disabled, with the assistance necessary to fully participate in community life.

'Money follows the person' grants

The Deficit Reduction Act signed into law in February 2006 further underscores the federal government's commitment to community-based services. According to an April 2006 report by the Kaiser Commission on Medicaid and the Uninsured, **the act calls for a "Money Follows the Person" demonstration program that awards grants to states that increase community-based services over institutional services.** Those states would get an enhanced federal Medicaid match ranging from 75 percent to 90 percent, depending on their current match.

The increased match would last for the first 12 months of an eligible resident's transition from an institution to the community. The states must then maintain access to community services after the demonstration project for as long as the participating individuals need the services and remain eligible for Medicaid.

Residents eligible for the "Money Follows the Person" program must currently reside in facilities such as hospitals, skilled nursing facilities, intermediate care facilities for persons with mental retardation (ICF-MRs, or ICF-DDs as they are known in Illinois) and institutions for mental disease (IMDs).

Representatives of the long-term care industry acknowledge the importance of home-and community-based services – but not at the expense of residents in need of the care provided only by a skilled nursing facility. New programs should not be funded at the expense of proven, needed existing programs.

Skilled nursing facilities are 'hub' of senior services

The nationwide trend is toward home- and community-based services, but the importance of skilled nursing facilities is key in the continuum of care for older adults. Chronically ill or medically fragile individuals in need of continual oversight of a team of professional caregivers will always need the care and services of a skilled nursing facility. Additionally, the skilled nursing facility is the perfect "hub" for community-based services.

Appendix

Levels of care in long-term care

People face varying health challenges as they grow older, so the geriatric long-term care profession offers different levels of care according to facility designation.

Skilled Nursing Facility (SNF)

- These facilities offer continuous, 24-hour nursing care for convalescent, critically ill or chronically ill residents.
- Registered nurses (RN), licensed practical nurses (LPN) and certified nurse assistants (CNA) deliver medical and personal care to residents as prescribed by physicians.
- Social services and activities are scheduled daily to meet the residents' emotional and social well-being.
- Physical, occupational and other therapies are offered as needed.
- A Skilled Nursing Facility also may be certified to participate in the Medicare and/or Medicaid program, in addition to accepting private-pay residents.*

Intermediate Care Facility (ICF)

- These facilities offer less-intensive care than found in a Skilled Nursing Facility.
- Registered nurses, licensed practical nurses, and certified nurse aides deliver medical and personal care as prescribed by a physician on a 24-hour basis.
- Rehabilitative programs, social services and daily activities are provided for residents not capable of full independent living.
- Physical, occupational and other therapies are also offered as needed.

- An Intermediate Care Facility also may be certified to participate in the Medicaid program, in addition to accepting private-pay residents.*

Shelter Care (SC)

- These facilities offer care that is focused on the social needs of the individual rather than their medical needs.

- Residents are people who are functionally independent but need some assistance in daily living. Dietary and housekeeping services, medication monitoring and leisure activities are provided.

- Periodic medical supervision and other medical services are provided as needed.

- Services offered in Shelter Care do not qualify for Medicare or Medicaid.

Assisted Living (AL)

- Assisted Living provides a community-based, yet individual, residential setting for people who are mobile but may need help with one or two activities of daily living.

- Round-the-clock supervision is available.

- Daily meals are prepared by the establishment or an outside contractor. Housekeeping services are available and include vacuuming, dusting and general cleaning of the resident's unit. Laundry and linen services are available.

- Security is usually provided 24-hours-a-day and often includes locked entrances or security guards.

- An emergency communication response system connects each individual residential unit with the community's management or others who can immediately respond with assistance.

- Some nursing services, as well as medication monitoring or supervision of self-administered medications, can also be provided.

- Assisted Living Facilities do not qualify for Medicare or Medicaid.

Supportive Living Facility (SLF)

- Supportive Living Facilities offer the same setting and services of Assisted Living for residents who are eligible for Medicaid.

Shared Housing Establishment

- These facilities are publicly or privately operated free-standing residences for 12 or fewer functionally independent individuals. At least 80 percent of the residents must be 55 or older and unrelated to the owners and one manager of the residence.

- Community-based services – such as housing and personal care assistance – provide support for those individuals requiring support with activities of daily living.

- Shared Housing Establishments operate under a waiver in the Medicaid program, so residents must qualify for Medicaid's income levels.

Continuing Care Retirement Community (CCRC)

- These communities usually offer the entire range of geriatric care levels, allowing residents to stay in the community as their needs change. Independent residential units, assisted living, a skilled nursing facility and Alzheimer's unit are usually offered within the community.

- Most services offered at a Continuing Care Retirement Community do not qualify for Medicare or Medicaid. However, skilled nursing care may qualify for Medicare, and skilled nursing care and Alzheimer's care may qualify for Medicaid if the resident meets the program's income requirements.

*Medicare and Medicaid

- **Medicare** is the federal health insurance program for people aged 65 and older. It will pay for the first 20 qualified days of doctor-ordered, skilled nursing care after a hospital stay of at least three midnights. (The time in a skilled nursing facility must begin within 30 days of leaving the hospital.) The program may then partially pay for the next 80 days if care needs meet Medicare criteria.

- **Medicaid** is the state-federal health insurance program for the indigent and disabled. It will pick up payment of skilled nursing care generally after an individual exhausts his or her savings.

Other long-term care facilities

Senior citizens are not the only ones who need continual care, and other long-term care facilities exist to take care of these residents.

Intermediate Care Facility for the Developmentally Disabled (ICF/DD)

- These facilities offer 24-hour residential programs for developmentally disabled individuals.
- Registered nurses and licensed practical nurses provide medical and personal care.
- Other professionals develop programs to meet social, developmental, behavioral and psychosocial needs of the residents.
- Residents of Intermediate Care Facilities for the Developmentally Disabled are eligible for Medicaid if they meet the program's income requirements.

Skilled Pediatric Facility (SNF/PED)

- These facilities provide 24-hour residential care for infants and children who are chronically ill, medically fragile and usually developmentally disabled.
- Specialized nursing, therapy, social and educational services are provided. The goal of a Skilled Pediatric Facility is to care for and prepare children for an eventual return to their family.
- Residents of Skilled Pediatric Facilities are eligible for Medicaid if they meet the program's income requirements.

Community Integrated Living Arrangement (CILA)

- These living arrangements can be likened to a small group home for developmentally disabled residents who can live independently with community-based supports, such as personal-care assistants.
- Community-based social service agencies provide supervision.
- No more than eight residents can live in a CILA.
- Residents of Community Integrated Living Arrangements are eligible for Medicaid if they meet the program's income requirements.

Institutions for Mental Disease (IMD)*

- These facilities provide 24-hour care for severely mentally ill residents and act as a transition between a locked psychiatric unit and less-supervised living arrangements in the community.

- Registered nurses and licensed practical nurses provide medical and personal care under the supervision of a psychiatrist.
- Regular programs for behavioral and psychosocial development are provided.
- Residents of Institutions for Mental Disease are eligible for Medicaid if they meet the program's income requirements.

* Managers of Institutions for Mental Disease are in the process of forming a distinct association, separate from the three existing geriatric long-term care associations.