ISSUE
AB 40: Medicaid Funding For Nursing Homes

The Governor’s Budget Proposal
Gov. Scott Walker’s proposed 2013-15 state budget (Assembly Bill 40) proposes a 2% increase in Medicaid funding for nursing homes in each year of the biennium. As stated by the Governor upon release of his proposal, the budget “will reduce prior administration revenue transfers by increasing nursing home reimbursement rates.”

Budget-related documents do not portray the Governor’s proposal as a “rate increase” but rather as an “acuity increase” that recognizes the elevated conditions and escalating needs of nursing home residents. To address heightened resident acuity, Gov. Walker has proposed increased funding of $13.1 million in 2013 ($5.4 million GPR) and $25.5 million ($10.5 million GPR) – a two year investment of $38.6 million in much needed additional funding to support resident care.

Budget documents also project that a reduction in nursing home utilization over the next biennium will result in a Medicaid patient day decrease of 4.3% in 2013-14 and 3.1% in 2014-15. These projections are reflective of and consistent with nursing home utilization trends over the past decade.

The Governor’s budget reveals that WHCA/WiCAL and its members’ efforts to secure return of the nursing home bed tax skim has been partially successful. The 2% increase in funding will restore and commit a significant portion of skimmed bed tax revenues to their original purpose – support of resident care.

The following identifies funding generated from nursing home bed tax payments that have been diverted from resident care over the past four years:

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The Governor’s return and rededication of “skimmed” tax revenues to nursing home resident care via the proposed 2% acuity adjustment will reduce the amount “skimmed” bed funds by 43%. To fully eliminate the misuse and abuse of the bed revenues initiated by the prior administration, would require an additional appropriation of approximately $20 million in state funds.

WHCA/WiCAL Position
WHCA/WiCAL applauds the fact Gov. Walker’s 2013-15 budget, like his prior budget, does not seek an increase in the nursing home bed tax as a mechanism to fund nursing home services or other state programs or operations. More significantly AB40 represents the first time a Wisconsin Governor has proactively addressed the
controversial nursing home bed tax skim issue with a focus on restoring the integrity, equity, and mission of the nursing home bed tax.

To that end, WHCA/WiCAL supports the Governor’s proposal and calls upon members of the Legislature to recognize and support the urgency of the need for the 2% nursing home funding increase proposed in AB40. WHCA/WiCAL requests legislators acknowledge the severe financial fragility of Wisconsin’s nursing homes and the critical need for further investment in meeting the ever escalating needs of those who receive and provide services within those facilities. There remains approximately $20 million in bed tax generated funding that can be restored to support that investment. The intensity and immediacy of that need cannot be understated:

- 99% of the 381 skilled nursing facilities in this state do not receive a Medicaid payment that covers the cost of care they provide their residents.

- In the 2011-12 payment year the disparity between the costs of care nursing homes provided their residents and Medicaid payment for that care reached a record high - $355,903,758.

- Wisconsin’s Medicaid nursing home reimbursement system is ranked 4th worst in the United States. Medicaid losses Wisconsin facilities incur are the largest in the Midwest and more than double the national average.

- $200 million of direct nursing services provided by Wisconsin nursing home residents were not reimbursed by Medicaid in 2012. Direct care nursing is the essence of long term care and accounts for 60% of resident care costs.

- Projected inflation of 2.6% and 3% in the next two years will exceed the budget’s proposed increase and further expand the disparity between resident care cost and Medicaid payments.

- Staggering Medicare funding cuts homes will experience this biennium will further compromise their ability to meet the needs of those who receive and provide nursing home care. Payment to facilities was slashed by 12.6% ($83.5 million) in 2011. Cuts in excess of $60 million will occur this year as a result of the Affordable Care Act and prior CMS payment “adjustments”. Under Federal Sequestration, facilities will experience another 2% reduction in Medicare Part A and B payments effective April 1, 2013.

- As a result of the glaring inadequacy of Medicaid funding and continuing cuts in Medicare payments, the vast majority of Long Term Care facilities in this state will ultimately be subject to penalties under the Affordable Care Act in 2014. Facilities simply lack the resources to absorb either the costs of a qualifying health insurance program or the penalties for not offering affordable options.
“BY THE NUMBERS”
The Scope & Impact of Medicaid Payment Shortfalls in Wisconsin

A comprehensive analysis of the nation’s Medicaid nursing home payment systems has ranked Wisconsin’s as the fourth worst in the country. The independent study, “A Report on Shortfalls in Medicaid Funding for Nursing Home Care,” was conducted by the accounting and consulting firm of Eljay, LLP. Released in December 2012, the study reveals that Medicaid deficits sustained by Wisconsin’s nursing facilities are the fourth largest in the country; nearly twice the national average ($22.34 per patient/per day); and far beyond those of facilities in all surrounding states. (See graphic below.)

Wisconsin’s national ranking is not a surprise to the state’s long-term care provider community. The Wisconsin Medical Assistance program’s own data base of 2011-12 nursing home cost/payment information validates the inadequacy and inequity of its Medicaid payment system. The following – extracted from the DHS database – demonstrates the national study has actually understated the nature and scope of the system’s failings:

$355,903,758 – Total Medicaid Losses Sustained by Wisconsin Nursing Homes
In the 2011-12 Medicaid payment year, the disparity between the cost of care that nursing homes provided their Medicaid residents and payment they received was $332,540,494. Nursing homes incurred additional losses of $23,363,264 in providing care to Family Care enrollees.

$200,065,742 – Direct Nursing Costs Not Reimbursed by Medicaid
The hands-on nursing services that residents required and received accounted for 60% of the total care costs that were not reimbursed under Medicaid in 2012.

99% – Wisconsin Nursing Homes Sustaining Medicaid Losses
Virtually all (98.95%) of the 381 skilled nursing facilities in the DHS database received Medicaid payments in 2012 that failed to meet the cost of care they provided. The average loss amounts to $51.96 per patient per day.

67.3% – Nursing Home Residents Reliant on Medicaid
As of July 2012, Medicaid was the source of payment for more than two-thirds of the 30,579 residents receiving care in Wisconsin nursing facilities. Medicare was the source of payment for approximately 12.5% of residents, with private payors representing fewer than 19% of the total population served.
70% – Facility Care Costs Attributable to Labor
Wisconsin nursing homes employ about 52,000 individuals with labor costs accounting for approximately 70% of the total cost of resident care. Nursing (RN, LPN, and Certified Nursing Assistants) represents 60% of total care costs.

$90 – Per Day “Hidden Tax” Medicaid Impose on Private Pay Resident Rates
An inequitable and unavoidable consequence of Medicaid’s failure to pay its fair share of resident care costs is that private pay residents and their families are compelled to pay rates that average approximately $90 per day higher than the nursing home’s Medicaid payment rate. Private pay residents and their families also have had to absorb the $170 per month bed tax. If bed tax payments had been applied as originally intended, private pay subsidies would have been reduced. Budgetary “skimming” of the tax has increased both facility losses and private pay subsidies.

$204,000 – Annual Bed Tax Paid by an Average Wisconsin Nursing Home
Wisconsin’s nursing home bed tax was increased to $170/bed/month on July 1, 2010. The average 100-bed facility now pays $114,000 more per year in bed taxes than in 2009.

$45,000,000 – Annual Bed Tax “Skim”
In 2012, approximately $45 million of revenues derived from nursing home bed tax payments will be used for purposes other than supporting and improving nursing home resident care.

The preceding merely reveals the fiscal impact of Medicaid’s failure to fund the cost of nursing home care in Wisconsin. These numbers do not effectively convey the extent of the personal impact the system’s failings occasion for nursing home residents, caregivers, and their families. Every day the quality of life for a quarter-million state citizens is adversely impacted by the underfunded system’s failure to acknowledge their needs.

1 The states of New Hampshire, New York, New Jersey are respectively ranked first, second and third worst in the nation.
History of Wisconsin’s Nursing Home Bed Tax

Background
Twenty-two years ago the nursing home bed tax was adopted in Wisconsin as a mechanism to generate federal matching funds that would be used exclusively to support and improve resident care. Today, the average nursing home pays $204,000 in nursing home bed taxes per year. The following provides a summary of the genesis of Wisconsin’s nursing home bed tax. It depicts how the tax has been misused and transformed into a budgetary tool to address state fiscal needs at the expense of those who receive and provide nursing home care.

The nursing home bed tax first surfaced in Wisconsin in 1991. The original tax was endorsed by the nursing home community and supported by the Wisconsin Legislature for the exclusive purpose of generating federal matching funds to support and enhance resident care. The initial bed tax was $32 per month and applied to occupied beds. Medicare beds were exempted. Consistent with intended purpose, all nursing home bed tax payments and federal funds generated by those payments were returned to facilities via the Medicaid payment formula to support resident care.

The 2003-05 State Budget
To curb states’ increasing appetite for using provider taxes to leverage federal matching funds, the federal government passed regulations in 2003 that prohibited states from engaging in dollar-for-dollar return of tax payments to providers who were subject to such levies. In part to meet the new federal restriction, Gov. Jim Doyle, in his 2003-05 state budget, proposed raising the tax to $116/per month and extended the reach of the tax from occupied to licensed beds. While the Legislature approved the latter, it reduced the proposed increase to $75 per bed. Federal funding derived from the tax increase supported a 2.6% increase in Medicaid funding for nursing home services.

The 2005-07 State Budget
In his 2005-07 state budget, Gov. Doyle once again proposed increasing the nursing home bed tax. Under the Governor’s proposal, the tax would have increased to $125 and provided a 1.4% funding increase to nursing homes in each year of the biennium. However, Gov. Doyle wanted to siphon off federal monies generated from facility tax payments and apply them to purposes other than resident care. Indeed, he proposed that half of the federal matching funds the state would have derived from the budget’s proposed tax increases were to be “skimmed” to support Medicaid base funding.

The Legislature rejected the proposed bed tax increase and passed a budget that used GPR funding to support the 1.4% increase that the Governor had proposed. Gov. Doyle vetoed the proposed increase because it was funded with state dollars. WHCA/WiCAL actively supported an override of the Governor’s veto. By a mere one-vote margin, the Assembly voted to override the Governor’s veto of nursing home funding – the first time since 1991 any Governor’s veto had been overridden. However, a week later, Senate Republicans were unable to secure the three Democratic votes necessary to achieve the two-thirds majority vote necessary to achieve an override.

Six months following the failed veto override, the Legislature agreed to provide a 0.35% funding increase for nursing homes in the last quarter of the fiscal year, and a 2.8% funding increase in the following year. This marked the first time since the 1993-95 state budget that GPR funds were used to fund a nursing home rate increase.
The 2007-09 State Budget

Once again in his 2007-09 budget, Gov. Doyle proposed a substantial increase in the nursing home bed tax – to $101.10 in 2007-08 and to $125.33 the following year. The Legislature rejected the bed tax increase. It provided no increase in funding for nursing home services in 2007-08, but authorized a 5% increase the following year. The increase was funded with the $13.8 million in bed tax generated federal match funds the state had previously “skimmed” to fund other state operations. As a result of the action taken by the Legislature, the integrity of the tax was restored. All federal matching funds the state derived from nursing home bed tax payments were applied toward the purpose for which the tax was originally conceived – supporting nursing home resident care.

The 2009-11 State Budget

Faced with the largest budget deficit in state history ($5.9 billion), Gov. Doyle, in his 2009-11 state budget, proposed the largest single nursing home bed tax increase in history. He proposed to double the tax from $75/bed/month tax to $150 in 2009-10 and to increase it, once again, in 2010-11 to $170/bed/month. Just a fraction of the funds derived from the massive tax increase were applied to provide nursing homes with a purported 2% Medicaid funding increase. The vast majority of federal funds derived from the massive increase in nursing home tax payments was used to fund Medicaid base expenditures.

With Democrats controlling both houses of the Legislature, Gov. Doyle’s proposed bed tax increases were approved in Act 28. The bed tax increases were imposed on July 1, 2009 and July 1, 2010. However, the 2% nursing home funding increases the taxes were supposed to support never materialized. Post-budget Medicaid cuts imposed by DHS combined to cut nursing home funding by $28 million. As a result, nursing facilities received only a 1.2% increase in FY10 and sustained a 0.7% rate cut in FY11.

As a result of the July 1, 2010 increase in the bed tax, nursing homes paid $40.9 million more in bed taxes than in FY09. Their increased tax payments annually generated approximately $90 million in federal matching funds for the state. (The state received increased federal dollars from nursing home bed payments due to the federal matching fund increase contained in the Economic Stimulus package.) However, of that total, just $11.8 million (13%) was applied to supporting nursing home resident care. The remaining $78.2 million (87%) was diverted from resident care, and “skimmed” to fund the state budget deficit.

The 2011-13 State Budget

The budget proposed and signed into law by Gov. Scott Walker (Act 32) sought no increase in the nursing home bed tax. This was the first time in over a decade that a bed tax increase was not proposed. It advanced a 1% acuity adjustment for nursing homes that would, in part, address the increased care costs facilities were confronting in meeting the elevated medical needs of their residents. More significantly, Gov. Walker’s budget reversed the past administration’s practices of raiding and reallocating state GPR funds used to support the Medical Assistance program. Indeed, it invested more than $1.2 billion in state GPR funding to stabilize the program until reforms could be implemented to make the program fiscally sustainable in the future.

While the Governor’s budget included no bed tax increase, the massive budget deficit confronting the administration prevented inclusion of provisions to address prior misuse of bed tax revenues and rededicate “skimmed” bed tax revenues to their original purpose. As a result, the bed tax skim has continued throughout the current biennium. The following chart identifies the level of bed tax revenues that have been syphoned and applied to purposes other than resident care between 2009-13:

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WHCA/WiCAL endorsed SB27/AB40’s rational and fiscally responsible approach to address the state’s mammoth $1.8 billion Medicaid deficit. However, as respectful as we were of the state’s desperate fiscal condition, the increasingly severe financial situation confronting Wisconsin’s nursing homes remained a primary concern. More than a decade of chronic underfunding of nursing home services combined with the recent abuse and misuse of the nursing home bed tax contributed to Wisconsin’s facilities experiencing Medicaid losses that were the largest in the nation. The medical acuity and complexity of nursing home residents needs continued to rise. Resident needs continued to escalate and facilities’ legal and professional responsibility to meet those needs remained constant. They could not be compromised, adjusted, or ignored to reflect in the state’s depressed fiscal climate.
The 2013-15 State Budget

WHCA/WiCAL applauds the fact that Gov. Walker’s proposed 2013-15 state budget reflects the first conscious attempt to address past abuse of the nursing bed tax and a movement toward utilizing all bed tax revenues to supporting and improving resident care. In his “Budget in Brief” the Governor expressed that his budget “will reduce prior administration revenue transfers” by increasing funding to nursing facilities by 2% in each year of the biennium. While final budget figures have not yet been confirmed by the Legislative Fiscal Bureau, it appears the proposed increase will amount to $38.6 million (All Funds) over the biennium. This re-dedication will restore a significant portion, but not all, of the $45 million in nursing home bed tax payments have been annually syphoned and diverted from their intended purpose – resident care. In the next biennium approximately $20 million in “skimmed” bed tax revenues will continue to be applied to purposes other than nursing home resident care.

WHCA/WiCAL continues to pursue complete restoration of the integrity and equity of the nursing home bed tax. Indeed, the rededication of all nursing home bed payments to their original purpose is needed more now than ever before. The annual disparity between the cost of care facilities provide and the Medicaid program payment they receive for that care is at an all-time high: $355,903,758. These staggering Medicaid losses come on the heels of record-high Medicare cuts, which slashed Medicare payment to Wisconsin facilities by 12.6% ($83.5 million) in 2011-12. Nursing homes will confront another $64.1 million reduction in Medicare payments in federal FY14 due to CMS regulatory “adjustments” and reductions contained in the Affordable Care Act to support federal health care reform. In addition, Medicare payments to facilities will be reduced by another 2% on April 1, 2013 when “Sequestration” takes effect.
ISSUE
Cost of Compliance with Affordable Care Act

Background
Wisconsin’s long-term care direct-care workforce totals nearly 90,000 workers and is larger than any occupational grouping in the state. Disturbingly, over 40% of Wisconsin’s direct-care workers rely on some form of public assistance, including Medicaid, BadgerCare and food stamps.

The wages for workers in human services programs, including nursing and assisted living facilities are typically insufficient to support the payment of deductibles and/or co-pays under currently offered health care insurance options. As a result, a significant portion of nursing home, assisted living and other long-term care workers are currently uninsured, underinsured or enrolled in Wisconsin’s Medicaid program. Most long-term care workers in Wisconsin do not have private health care insurance, primarily because they cannot afford it or they do not work sufficient hours to qualify for the coverage their employers offer.

Due to woefully inadequate Medicaid funding levels, the vast majority of long-term care facilities in Wisconsin may ultimately be subject to penalties under the Affordable Care Act (ACA) beginning in 2014. Long-term care facilities, reliant on Medicaid as the source of payment for resident care, simply have no resources to absorb either the costs of a qualifying health insurance program or the penalties for not offering affordable options.

Medicaid as the primary consumer of long-term care services in Wisconsin has an inherent responsibility to recognize and fund the unavoidable costs facilities will necessarily incur as a result of implementation of the federal Affordable Care Act.

WHCA/WiCAL Position
Wisconsin’s Medical Assistance Program must be prepared to acknowledge and fund its fair share of the additional costs the nursing home and other long-term care providers will necessarily incur as a consequence of compliance with Affordable Care Act mandates.

In anticipation that resources will not be available to permit facility compliance with the expectations of the ACA, WHCA/WiCAL proposes that the following options be explored:

1. Provide a Medical Assistance rate pass-through to cover health insurance costs.
2. Provide a Medical Assistance pass-through for employer penalties under ACA.
3. Create provision in Wisconsin’s health insurance exchange to provide additional subsidies for employees of Medical Assistance long-term care providers.
ISSUE
Assisted Living Issues

ISSUE: Community Based Residential Facility (CBRF): Definition and Licensure Process

Background
Governor Walker’s proposed budget package (Assembly Bill 40) includes two items impacting Community Based Residential Facilities (CBRFs). WHCA/WiCAL endorses both.

CBRF Definition
There exists a measure of ambiguity within the Chapter 50 statutory definition of a CBRF (Wis. Stats. 50.01(1g)). The law defines a CBRF as “a place where 5 or more adults who are not related to the operator or administrator and who do not require care above intermediate level nursing care reside and receive care, treatment or services that are above the level of room and board but that include no more than 3 hours of nursing care per week per resident.” Following the general definition is a series of examples of settings that do not fall within the term. Section 1228 of budget bill adds to that list. It proposes new language to clarify that a CBRF is not “a private residence that is the home to adults who independently arrange for and receive care, treatment, or services for themselves from a person or agency that has no authority to exercise direction or control over the residence.”

The budget’s expanded definition of a CBRF gives a welcome and needed clarification. It preserves the rights of individuals to independently secure services in their home, while also preventing individuals or entities from operating unlicensed CBRFs by establishing an affiliated entity to provide services to residents.

Permanent License Process
Currently, DHS must inspect a CBRF before issuing a permanent license to operate as a CBRF and must also, for certain applicants, conduct a second inspection before issuing the permanent license. Section 1229 of the budget provides DHS some flexibility in the requirement of conducting the second inspection. Under the bill, for those applicants, DHS must still conduct the first inspection, but may then evaluate, rather than re-inspect, the CBRF before issuing a permanent license to operate. This new flexibility afforded DHS in the licensing process will permit more effective use of DHS and provider resources. At the same time it preserves DHS inspection authority to address situations that may require intensified scrutiny before granting a permanent license to operate a CBRF.

WHCA/WiCAL Position
WHCA/WiCAL supports the proposed modifications to Chapter 50 that will provide greater clarity to the definition of a CBRF and will afford DHS discretion in the application and licensure process.

ISSUE: Family Care - Transparency of MCO Rate Setting Process

Background
Over the past several years assisted living and other long-term care providers have become increasingly frustrated with the lack of transparency and stability of the Family Care MCO’s contracting and rate setting process. In response to provider concerns,
DHS recently inserted a new provision within its 2013 contract with Family Care MCOs that placed limits on the circumstances under which residential care providers Family Care rates could be changed. Under the new provision, once a rate is established between an MCO and a residential provider, it may only be changed (1) by their mutual consent; (2) when there has been a change in resident condition; or (3) after the rate has remained in effect for 12 months. WHCA/WiCAL sought, supported and applauded the DHS/MCO contract amendment.

However, there still remains a critical need to establish transparency within the Family Care rate setting process to assure MCO’s accountability for the accuracy and appropriateness of the provider rates they propose. Current policies and practices among the 9 different Family Care MCOs vary widely on whether providers within their respective networks may review the MCO rate calculations to assure a proposed rate represents an accurate assessment of resident needs and proper application of the MCO’s rate-setting methodology. In many cases, providers are denied the ability to review the underlying calculations. In all cases, they are denied a right to contest the appropriateness or accuracy of a proposed rate.

WHCA/WiCAL Position

Providers should be afforded the right to review MCO rate calculations to assure proposed rates represent an accurate assessment of enrollee needs and proper application of the MCO’s payment methodology. To the extent material errors or inaccuracies exist, a provider should be allowed to contest the rate.

To that end, WHCA/WiCAL is requesting that either DHS adopt an MCO contract amendment or legislation be advanced that would embrace the following or similar expectations:

1. Within 10 days of receipt of a notice of a change in a provider’s MCO contract payment rate for a family care enrollee, a provider may request, and the MCO shall provide, any or all of the following:
   a. A copy of the MCO payment methodology that was utilized in calculating the resident’s rate;
   b. A copy of the MCO assessment of resident need that was applied in the rate calculation;
   c. The MCO rate worksheet, reflecting the specific rate calculation;
   d. An explanation of any change to the MCO payment methodology and/or the MCO’s assessment of the resident’s needs that was the basis for the rate change reflected in the MCO notice.

2. An MCO must respond to request filed under paragraph 1 above within 10 days of receipt of the request.

3. The provider has a right to contest and file administrative appeal challenging a proposed MCO on the basis of any of the following:
   a. That the MCO failed to properly apply its payment methodology in calculation of the provider’s payment rate for a specific enrollee;
   b. That the MCO’s rate calculations were inaccurate;
   c. That the MCO assessment of a resident’s needs was materially inaccurate or incomplete.

4. A provider appeal of an MCO rate determination must be filed within 10 days of receipt of the information the MCO provided under subparagraph 2 above. The appeal must be in writing and
   a. identify the general basis for the appeal under subparagraph 1) above, and
   b. identify the specific errors or omissions on which the appeal is founded.

ISSUE: Remote monitoring in Adult Family Home Settings

Background

For persons who seek small congregate care settings, Adult Family Homes (AFHs) are designed to house up to four persons. These homes are licensed under Chapter DHS 88, Wisconsin Administrative Code.

An AFH is defined in Wisconsin law as “a place where three or four adults who are not related to the operator reside and receive care, treatment or services that are above the level of room and board and that may include up to seven hours per week of nursing care per resident.”

Monitoring technology embraces the use of technology to monitor, to supervise, or provide oversight or supports to ensure the health and safety of individuals served in certain settings and support their independence. Monitoring technology could be used in a variety of contexts and settings to enhance the quality of individual’s lives or take the place of current services.

WHCA/WiCAL Position

We support consideration for the use of remote monitoring in limited and appropriate settings, provided adequate safeguards are incorporated. We support the Department of Health Services using its existing authority to provide an Adult Family Home a variance, under specific circumstances, for the use of remote monitoring, provided the AFH demonstrates the remote monitoring is both a safe and effective alternative that will assure client protection.
ISSUE
Therapeutic Alternatives – Nursing Homes Formularies

Background
A formulary is a continually updated list of medications that are deemed the most clinically and financially effective to address the health needs of a given population in a specific setting.

Formularies are established through previously written protocols formally developed through a pharmacy and therapeutic committee which includes physicians, pharmacists, and other health care professionals. Medicare, Medicare Part D, Wisconsin’s Medicaid program, commercial health insurers all utilize formularies to insure that their enrollees have access to the most clinically and cost effective prescription drugs. The use of formularies is required in health care institutions seeking accreditation by the Joint Commission on Accreditation. The American Society of Health Systems Pharmacists considers the presence of a formulary in an institution as a minimum standard. They are perceived as an essential tool for health care organizations to assist in the use of quality medications.

Wisconsin law, written in the 1980s, affords only hospitals, under the leadership of a pharmacy therapeutic committee the ability to develop a formulary for the organization. The law needs to be updated to reflect the dramatic evolution of the state’s health care delivery system and afford nursing homes, their residents, and professional staff the opportunity to realize the improved quality of care, patient safety and cost effectiveness formularies can provide.

The Pharmacy Society of Wisconsin has worked in consultation with WHCA/WiCAL, LeadingAge Wisconsin, the Wisconsin Medical Society and the Wisconsin Department of Health Services to develop a proposal which would permit the development of formularies for use in Wisconsin nursing homes. The proposal would permit nursing homes to utilize formularies provided that are developed and maintained in adherence with the professional standards, protocols, and statutory expectations that currently apply to hospitals. The proposal preserves the right of the resident’s attending physician to direct that any prescription for a nursing home resident be dispensed as written.

WHCA/WiCAL Position
Permitting the use of formularies in Wisconsin’s skilled nursing homes will promote and facilitate all of the following:

- **Improved Resident Care**
  Use of formularies will reduce delays in securing medications for new orders.

- **Improved Resident Safety**
  Use of formularies will facilitate more efficient medication management and reduce the potential for transcription and medication errors.

- **Improved Resident Care**
  Quality will be enhanced by promoting healthcare professionals use and familiarity with preferred medications within a medication class as opposed to expecting familiarity with all medications within a class.
Resident and Facility Cost Savings
There are typically significant cost differences between medication classes that are considered clinically interchangeable. Savings will be generated through developing formularies that reflect the most medically appropriate and cost effective medications.

More Efficient Use of Physician Resources
Absent the presence of pre-approved formulary protocols that authorizes pharmacists to interchange medications, the patient’s personal attending physician will be contacted by pharmacists regarding the need to change orders to preferred medications.

Preservation of Physician Right to Prescribe
The proposal preserves the right of the resident’s attending physician to direct that any prescription for a nursing home resident be dispensed as written.

Legislation reflecting the Pharmacy Society of Wisconsin’s proposal is currently being drafted by the Legislative Reference Bureau. WHCA/WiCAL supports this legislation and encourages Wisconsin legislators to both support the proposed bill and consider signing-on when it is circulated for co-sponsorship.
ISSUE
Transfer of Licensed Nursing Home Beds

Background
Under current law, the maximum number of licensed nursing home beds statewide is 51,795. A skilled nursing home may transfer a licensed bed to another facility only under the following conditions:

- The receiving nursing home is in the same health planning area as the transferring home, or in a county adjoining that area;
- The transferring and receiving home are owned by the same corporations;
- The transferring and receiving homes notify the Department of Health Services of the proposed transfer within 30 days before the transfer; and
- The Department approves the transfer.

In the past several years, over 5,000 nursing home beds have been closed as facilities focus on rehabilitating the elderly and disabled and returning them to home or other community long-term care settings. At the same time, the aging baby boomers are moving, continually shifting the demand for access to long-term care services throughout Wisconsin.

Since the number of licensed nursing home beds has been decreasing, the flexibility for transferring licensed beds to areas that need them must also increase to ensure that beds are available where they are needed. Removing artificial and outdated barriers to bed transfers will permit nursing homes to respond to the shift in need and demand.

WHCA/WiCAL Position
WHCA/WiCAL seeks support of legislation that:

- Reduces the statewide licensed nursing home bed cap to 42,000 beds; and
- Allows a nursing home to transfer licensed beds to another facility located anywhere in Wisconsin if the transferring and receiving nursing homes notify the Department of the proposed transfer within 30 days before the transfer occurs and the Department reviews and approves the transfer.

- Passage of the proposal would eliminate the health planning area boundaries, created in 1985, as a restriction on bed transfers.

Legislation reflecting this proposal is currently being drafted by the Legislative Reference Bureau. WHCA/WiCAL encourages Wisconsin legislators to both support the proposed legislation and consider signing-on when it is circulated for co-sponsorship.