



STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

February 13, 2008

MEMORANDUM

TO: Honorable Josh Green, M.D., Chair
House Committee on Health

Honorable Maile S.L. Shimabukuro, Chair
House Committee on Human Services & Housing

FROM: Lillian B. Koller, Director

SUBJECT: **H.B. 2170, HD1 - RELATING TO HEALTH**
Hearing: Wednesday; February 13, 2008 8:00 a.m.
Conference Room 329, State Capitol

PURPOSE: The purpose of this bill is to provide fair compensation to: 1) acute care hospitals for the services they provide to Medicaid patients who have been treated for acute illnesses and injuries and who have recovered sufficiently so that they should be transferred to long-term care, but for whom long-term care is not available; and 2) long-term care facilities for services provided to patients with medically complex conditions who prior to admission to the long-term care facility were receiving acute care services in an acute care hospital; to ensure that when Quest Expanded is implemented, long term care facilities will receive Medicaid payments that are at least equal to the rates in effect immediately prior to the implementation of Quest Expanded; and to require the Department of Human Services to provide presumptive eligibility to Medicaid or QUEST eligible waitlisted patients.

DEPARTMENT'S POSITION: The Department of Human Services is opposed to this bill for the following reasons:

1) The Department strongly objects to paying acute care rates to hospitals for patients waitlisted for bed space at a non-hospital based long-term care facility.

AN EQUAL OPPORTUNITY AGENCY

000088

This bill is contrary to the methodology currently used to establish these rates. There is clear distinction in the level of routine care between acute services and long-term care services. The difference in these rates is meant to account for this distinction in level of care. The routine acute rate is meant to reimburse for services, equipment usage and supplies that are not necessary as part of the care of a waitlisted or long-term care beneficiary. It is not appropriate for an acute care facility to be reimbursed an acute rate for services it did not provide.

This rate difference would put non-hospital long-term care facilities at a distinct disadvantage for reimbursement of similar services. This inequity could provide incentive for long-term care facilities to demand the same acute care rate an acute care facility would receive for nursing facility level of care services causing an unnecessary and unintended escalation of reimbursement at an extraordinary burden to the State.

This bill also undermines the progress that has been made to achieve equitable reimbursements based on acuity of care for nursing home level of care at hospitals and non-hospital based long-term care facilities. This equitable reimbursement was mandated by Act 294, SLH 1998, which was codified as chapter 346D-1.5, Hawaii Revised Statutes. The Department does not support the reversal of Act 294 inherent in H.B. 2170, H.D. 1.

The lack of distinguishable reimbursement between acute care and waitlisted rates would also put those facilities that are not experiencing full occupancy at a distinct disadvantage for reimbursement of dissimilar services. Those facilities that are not in the position to “turn away” an acute care patient would be receiving the same reimbursement for providing more services to an acute patient than another facility that is providing less service to a waitlisted patient. This inequity could provide incentive for acute care facilities to demand an increasingly higher acute rate when providing care above that of waitlisted services causing an unnecessary and unintended escalation of reimbursement at an extraordinary burden to the State.

Importantly, an acute care facility that is reimbursed the acute care rate for a waitlisted patient does not have the same level of urgency to assist in transitioning the waitlisted patient to the appropriate facility. This could cause a waitlisted patient’s length of stay at an acute care facility to be extended, thus increasing the length of time the patient would suffer from, as this bill indicates, “a diminished quality of life.”

2) The Department also objects to this bill's proposal to provide cost reimbursements to non-hospital based long-term care facilities for services provided to patients with "medically complex" conditions who, prior to admission to the long-term care facility, were receiving acute care services in an acute care hospital.

This bill would authorize that long-term care facilities be reimbursed the actual cost of providing care to "medically complex" beneficiaries that have been transitioned from an acute care facility.

This bill does not clearly define who would be classified as "medically complex". This language could include almost all long-term care patients. While it is clear that this interpretation is not the intent of this bill, further clarification would be required to prevent abuse of this reimbursement methodology.

A sub-acute level of care reimbursement rate methodology is already in place at a number of Hawaii's long-term care facilities. This rate is meant to reimburse for the services provided to those patients who may fall into the bill's definition of "medically complex." This sub-acute rate is significantly higher than the average long-term care rate. Any patients who do not meet this level of care are accounted for in the computation of the acuity based rate of each long-term care facility.

As authorized by this bill, reimbursement would be based on the "actual costs" of services to the medically complex. Cost-based reimbursement is only applied as a reimbursement strategy in Hawaii when specifically indicated as a requirement to receive Federal financial participation from the Centers for Medicare and Medicaid Services (CMS). This has become a typical practice of the vast majority of Medicaid programs around the country. The trend away from cost-based reimbursement was, among other purposes, intended to encourage providers to be increasingly cost-conscious and avoid inflationary business practices. The Department would strongly advise against any cost-based reimbursement strategy.

(3) The Department also submits that this bill's proposal is unnecessary with respect to the long term care facilities receiving Medicaid payments that are at least equal to the rates in effect immediately prior to the implementation of Quest Expanded.

The QUEST Expanded Access (QExA) program, which is slated for implementation on November 1, 2008, already addresses reimbursement rates for nursing facilities in Hawaii. In the contract between the QExA health plans and the Department of Human Services, the following is described for reimbursement for nursing facilities:

AN EQUAL OPPORTUNITY AGENCY

000090

“The health plan shall reimburse nursing facilities utilizing an acuity-based system in accordance with HRS § 346-D-1.5. The health plan shall reimburse nursing facilities the rates as of July 1, 2008 in accordance with HRS § 346-D-1.5.” HRS § 346-D-1.5 is Act 294 which was enacted into law in the 1998 Legislative session.

(4) Finally, the Department strongly opposes this bill's proposed presumptive eligibility.

This bill would authorize that a patient transitioning from acute care to long-term care would be presumed eligible for participation in the Medicaid Fee-For-Service (FFS) or the QUEST program. This bill would also authorize that the Department would reimburse the provider or the plan for the charges incurred during the period of presumptive eligibility for those patients presumed eligible who are later found to not be eligible for Medicaid FFS or QUEST reimbursement.

During this period of presumptive eligibility, State general funds only will be paid to the provider as Federal funds cannot be accessed until a person is Medicaid eligible. The Department does not support providing reimbursement that does not qualify for Federal financial participation nor is it in the Department's budget to do so.

This section is also confusing because it differentiates between the payment rates of persons presumed Medicaid eligible who are later determined eligible and those persons who are presumed Medicaid eligible who are later determined not eligible.

For those who are later determined eligible, the cost per person would be at least \$10,000. This is based on an average rate of \$225 per day for 45 days. During this time, payment made to the provider will be with State funds only.

For those who are later determined ineligible, the cost per person would be at least \$50,625. This is based on an average cost rate of \$1,125 per day (utilizing the Ernst and Young calculation that Medicaid reimburses only 20% of the cost) for 45 days. Again, payment made will be with State funds only.

We do not know how many waitlisted individuals are Medicaid applicants and we should not be subsidizing non-Medicaid waitlisted patients. However, based on the data shared by Healthcare Association of Hawaii (HAH), 25% of the waitlisted individuals are receiving Medicaid services, 6% are receiving HMSA services, 55% are covered by Medicare and the remaining 14% are other, probably uninsured. HAH has also shared that, on any given day, there are between 200 to 275 waitlisted individuals. If we were to take the 55% Medicare covered and the 14% uninsured individuals, we could have

between 138 and 190 individuals potentially qualifying for the presumed eligible status on any given day.

Presumptive eligibility is also not necessary for hospital acute care patients waitlisted for non-hospital based long-term care services because, beginning March 1, 2008, the Department will implement a five-day expedited process of Medicaid applications of hospital waitlisted patients. When a completed application is submitted to the Medicaid Eligibility Branch, the process will be completed within five working days. This is just as fast as the Department already expedites applications for pregnant women, foster children, and other classes of persons needing expedited eligibility determination.

The Department does not have any data as to the number of hospital waitlisted patients being "stymied from placement" exclusively due to their waiting for Medicaid eligibility determinations to be completed. Therefore, the Department will be tracking these patients, for whom we will be doing five-day expedited eligibility determinations, to see if they are actually being discharged from the hospitals into a nursing facility level of care placement, or if, for other reasons unrelated to Medicaid eligibility, they are continuing in hospitals on waitlisted status.

Thank you for this opportunity to testify.



THE QUEEN'S MEDICAL CENTER

1301 Punchbowl Street • Honolulu, Hawaii 96813 • Phone (808) 538-9011 • FAX: (808) 547-4646 • www.queens.org

Representative Josh Green, Chair
Representative John Mizuno, Vice Chair
House Committee on Health

Representative Maile Shimabukuro, Chair
Representative Karl Rhoads, Vice Chair
House Committee on Human Services & Housing

Wednesday, February 13; 8:00 a.m.
State Capitol, Conference Room 329

RE: H.B. 2170, H.D. 1 - Relating to Health

Chairs Green and Shimabukuro, Vice Chairs Mizuno and Rhoads, and Members of the Committees:

My name is Christina Donkervoet. I am the Director of Care Coordination and Patient Flow at The Queen's Medical Center. This position requires that I regularly monitor, strategize and manage the complex challenges involved with timely and appropriate discharges of acute inpatients. As a representative of Queen's, I actively participated in the task force that was convened by the Healthcare Association of Hawaii (HAH) in response to the 2007 Legislature Senate Concurrent Resolution (SCR) 198.

On behalf of The Queen's Medical Center, I thank you for this opportunity to testify in support of this bill.

The Medical Center is greatly impacted by the limited community resources that are available to serve people in need of community-based care, rather than acute hospitalization. We agree that people on the waitlist often have a less-than-optimal quality of life, and their general health may be negatively impacted by a prolonged stay in an acute care hospital. Additionally, when we treat these non-acute patients in the acute hospital bed, we are less able to respond to our community's needs for acute care services. Too often it happens that we have to go on emergency room divert because we simply do not have the bed capacity to admit patients needing hospitalization. In December of 2007, for example, we reached a high for the year, with 66 patients awaiting placement (see Attachment 1). The inability to admit patients impacts the health care system statewide, as we often serve as a higher level of care, transfer center for many of the hospitals in the state and throughout the Pacific.

We support the language in this bill that provides for reimbursement rates for waitlisted patients to be at the level of the acute care bed rate. Since these patients reside in the acute hospital bed while waiting for community placement, the cost of patient care

Founded in 1859 by Queen Emma and King Kamehameha IV

000093

remains the same and the loss of the inpatient capacity continues. As indicated in the bill, the payment currently received for these patients is only 20-30% of the actual cost. The increase to the payment rate for these waitlisted patients is a necessary action in order to sustain our health care system. In FY 2007, Queen's lost approximately \$16.3 million due to uninsured/under insured waitlisted patients. Given the waitlisted numbers experienced thus far in 2008, we expect that this number will be greater by year-end. This type of financial shortfall, at Queen's and other hospitals, significantly weakens our health care system as a whole.

We also support the language in this bill that would ensure that long term care facilities are compensated at the cost of care they provide to these non-acute, yet complex, patients. Appropriate compensation to the long term care facilities would assist the acute care hospitals by increasing the discharge options for the patient care team.

Lastly, Queens supports the presumptive eligibility process for the waitlisted patients as defined in the bill. With the verification of a patient's annual income and the confirmation of waitlist status by the hospitals, the risk of implementation is minimal. And yet, the potential gains could be substantial. This presumptive eligibility process would assist hospitals and community-based programs in admitting patients to long term care facilities and community services in a more timely manner.

In closing, we respectfully request that you consider adjusting the reimbursement rates for waitlisted patients remaining in hospitals and develop a presumptive eligibility process to ease some of the burden that is placed on acute care hospitals due to the limitations in our community services. The fragility of the health care system across the state requires your prompt attention. The longer it takes for action, the more our system is weakened, and the greater the impact to the overall quality of life of our patients.

We continue to value and embrace our role within the community. We understand the need for collaboration and will continue to work with state agencies and community facilities and programs. We recognize that the challenges presented to our state are complex and require multiple actions. The actions in this bill are a few that will help assure quality health care while we build more community options for our aging population. Your favorable review of this bill is appreciated.

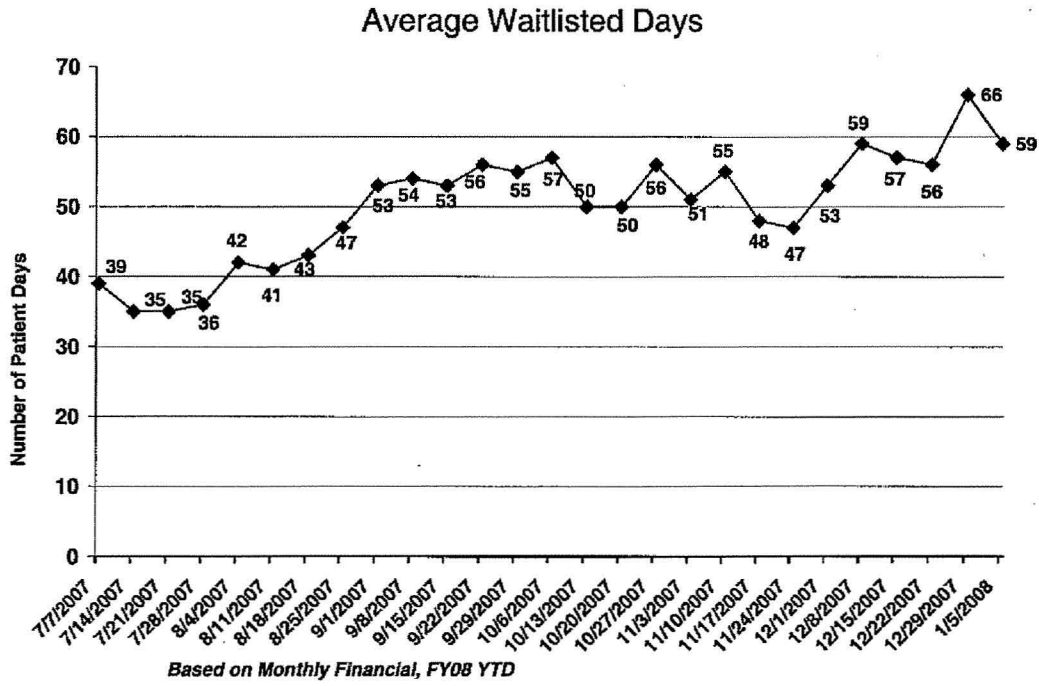
Thank you for the opportunity to testify.

Respectfully Submitted,

Christina M. Donkervoet, RN, MS
Director, Care Coordination & Patient Flow
The Queens Medical Center

000094

Attachment 1: SCR 198
 QMC Waitlisted Patients Data
 July 2007 – January 2008



Hawaii Pacific Health

55 Merchant Street • Honolulu, Hawaii 96813 • hawaiiapacifichealth.org

Wednesday, February 13, 2008 – 8:00am
Conference Room 329

The House Committee on Health

To: The Honorable Joshua Green, M.D., Chair
The Honorable John Mizuno, Vice Chair

The House Committee on Human Services & Housing

To: The Honorable Maile Shimabukuro, Chair
The Honorable Karl Rhoads, Vice Chair

From: Virginia Pressler, MD, MBA
Executive Vice President

Re: Testimony in Strong Support of 2170 HD1 - Relating to Health

Dear Honorable Committee Chairs and Members:

My name is Virginia Pressler, Executive Vice President for Hawaii Pacific Health (HPH). For more than a century, families in Hawaii and the Pacific Region have relied on the hospitals, clinics, physicians and staff of Hawaii Pacific Health as trusted healthcare providers. Our non-profit integrated healthcare system is the state's largest healthcare provider and is committed to improving the health and well-being of the people of Hawaii and the Pacific Region through its four hospitals -- Kapi'olani Medical Center for Women & Children, Kapiolani Medical Center at Pali Momi, Straub Clinic & Hospital and Wilcox Memorial Hospital -- 18 outpatient centers and a team of 1,100 physicians on the islands of Oahu, Kauai and Lanai.

Hawaii Pacific Health is writing in **strong support of HB 2170 HD1**, which takes steps to solve the hospital waitlist problem by: (1) Increasing certain Medicaid payments to hospitals and long term care facilities; and (2) Establishing a process of Medicaid presumptive eligibility for waitlisted patients.

On any given day there are as many as 275 patients in hospitals across Hawaii who have been treated and are now waiting to be transferred to a long term care facility but who must remain "waitlisted" in a hospital because long term care is not available. Discharge timeframes for waitlisted patients range from days to over a year. This represents a poor quality of life option for the patient, presents an often insurmountable dilemma for providers and patients, and creates a serious financial drain on acute care hospitals with ripple effects felt throughout other healthcare service sectors.

HB2170 HD1 would adjust Medicaid payments to improve the flow of patients from acute hospitals to long term care facilities. Payments to long term care facilities would be increased for patients with medically complex conditions that require increased care, as current payments do not cover the actual costs of care.

KAPIOLANI
MEDICAL CENTER
AT PALI MOMI



KAPIOLANI
MEDICAL CENTER
FOR WOMEN & CHILDREN



Straub
CLINIC & HOSPITAL

 **Wilcox Health**

000096

In addition, payments to hospitals for waitlisted patients would be increased so that payments are closer to the actual costs of care incurred by hospitals. The recommended legislation would also establish a Medicaid presumptive eligibility process that is designed to reduce the period of time for determining whether a waitlisted patient qualifies for Medicaid. For financial reasons, Medicaid eligibility is required by many long term care facilities before certain types of patients are admitted.

We ask that you pass **HB 2170 HD 1**. Thank you for your time regarding this measure.



000097



February 13, 2008

To: Chairs Josh Green and Maile Shimabukuro and Members of the
House Committees on Health and Human Services & Housing
From: Bob Ogawa, President
Hawaii Long Term Care Association
Re: H.B. 2170, HD1, Relating to Health

The Hawaii Long Term Care Association (HLTCA) supports H.B. 2170, HD1 as a preliminary step toward addressing Hawaii's current hospital waitlist problem.

We would, however, like to make a few comments:

1. While we fully understand, sympathize with and wish to find a remedy for the financial "bleeding" waitlisted patients cause our hospitals, we (HLTCA) must be cautious of the possibility that the acute-bed reimbursement proposed in this measure does not become some foot-in-the-door erosion of the basic premise of what is commonly know as Act 294, the Medicaid Reimbursement Equity Act of 1998. Act 294 states:

". . . there shall be no distinction between hospital-based and nonhospital-based reimbursement rates for institutionalized long term care under medicaid. Reimbursement for institutionalized intermediate facilities and institutionalized skilled nursing facilities shall be based solely on the level of care rather than the location."

We understand that the bills speaks to long term care patients in acute-licensed, not ICF/SNF-licensed beds, but vigilance in this matter is a responsibility we owe to the long term care provider community.

2. Regarding presumptive eligibility, it is our understanding that, except for pregnant women, the Centers for Medicare and Medicaid Services (CMS) does not endorse the concept. That aside, though, our concerns are: (a) Who becomes the payor in those cases where a resident already taken into a nursing facility is later deemed **not** medicaid-eligible? (b) Further, in such instances, does the State simply absorb the "spent-money" costs, or does it seek reimbursement -- and, if the latter, from whom?

While presumptive eligibility is indeed an option we should entertain, I am not certain that nursing facilities would risk accepting a resident under such uncertain circumstances. The historical "fall through" (eventually-determined non-eligible) rate has been stated as being in the range of 4-6%. With respect to pregnant women, that may amount to a bearable loss, but in a high-cost skilled nursing setting, payment uncertainty in the case of even one resident would be a meaningful financial gamble.

All that said, though, we must move forward and begin to explore all avenues open to us in resolving the waitlist problem. H.B. 2170 is a good beginning, and we urge its passage.

000098

**Testimony Presented Before
The House Committee on Health
The House Committee on Human Services & Housing
Wednesday, February 13, 2008 – 8:00am
Conference Room 329**

HB 2170, HD1 RELATING TO HEALTH

Chairs Green and Shimabukuro, Vice-Chairs Mizuno and Rhoads, and Members of the Committees:

My name is Kathryn Matayoshi, Executive Director of the Hawai'i Business Roundtable. I am testifying in support of House Bill 2170, HD 1 which seeks to address the hospital waitlist problem by: (1) Increasing Medicaid payments to hospitals and long term care facilities; and (2) Establishing a process of Medicaid presumptive eligibility for waitlisted patients.

The Hawaii Healthcare Associations' task force report on the wait list problem included recommendations in four areas to help alleviate the impacts of the wait list issues. This bill is one part of the proposed solutions. The recommended legislation would adjust Medicaid payments to improve the flow of patients from acute hospitals to long term care facilities. Payments to long term care facilities would be increased for patients with medically complex conditions that require increased care, as current payments do not cover the actual costs of care. In addition, payments to hospitals for waitlisted patients would be increased so that payments are closer to the actual costs of care incurred by hospitals. The recommended legislation would also establish a Medicaid presumptive eligibility process that is designed to reduce the period of time for determining whether a waitlisted patient qualifies for Medicaid. For financial reasons, Medicaid eligibility is required by many long term care facilities before certain types of patients are admitted.

The Roundtable sees the wait list issues as impacting our employees, our families and our communities, in terms of quality of life and access to appropriate quality care, as well as a financial burden on healthcare providers. Complex issues require multifaceted solutions, and the task force has recommended first steps in two areas that will hopefully start us moving towards better options for our employees and their family members with medically complex conditions who need long term facilities. As our population ages, these issues will become more and more pressing. The time to start solving them is now.

In summary, the Hawaii Business Roundtable supports passage of HB 2170, HD1. Thank you for your consideration.

000099



HOUSE COMMITTEE ON HEALTH
Rep. Josh Green, M.D., Chair

Conference Room 329
Wednesday, February 13, 2008 at 8:00 a.m.

Testimony in support of HB 2170 HD 1.

I am Coral Andrews, Vice President of the Healthcare Association of Hawaii, which represents the entire spectrum of health care, including acute care hospitals, two-thirds of the long term care beds in Hawaii, as well as home care and hospice providers. Thank you for this opportunity to testify in strong support of HB 2170 HD1, which takes steps to solve the hospital waitlist problem by: (1) Increasing certain Medicaid payments to hospitals and long term care facilities; and (2) Establishing a process of Medicaid presumptive eligibility for waitlisted patients.

The waitlist dilemma is unique to Hawaii, largely because Hawaii has one of the lowest ratios of long term care beds for its population in the United States. Whereas the US average is 47 beds per 1000 people over age 65, Hawaii averages 23 (half of the US average).

On any given day there are 200, and as many as 275, patients in hospitals who have been treated so they are well enough to be transferred to long term care, but who are waitlisted because long term care is not available. Waitlisted patients are defined as "Patients who are deemed medically ready for discharge and no longer in need of acute care services but who cannot be discharged (due to various barriers) and therefore must remain in the higher cost hospital setting."

Discharge timeframes for waitlisted patients range from days to over a year. This represents a poor quality of life option for the patient, presents an often insurmountable dilemma for providers and patients, and creates a serious financial drain on acute care hospitals with ripple effects felt throughout other healthcare service sectors.

Recognizing the waitlist problem, in 2007 the Legislature adopted SCR 198, which requested the Healthcare Association of Hawaii (HAH) to study the problem and propose solutions. HAH subsequently created a task force for that purpose.

The task force has had a number of meetings, and at the request of the task force HAH has contracted with a consultant to gather information. The task force has identified the following four barrier areas that contribute to the waitlisted patient dilemma: (1) Reimbursement; (2) Capacity; (3) Regulatory/Government; and (4) Workforce. The task force has determined that solving the waitlist problem will require actions in all four of the barrier areas, and that focusing on only one area of need will not create a sustainable solution.

At this time the task force has developed specific recommendations for legislation. However, data gathering is still in process, and the task force will make further recommendations after it is completed.

The recommended legislation would adjust Medicaid payments to improve the flow of patients from acute hospitals to long term care facilities. Payments to long term care facilities would be increased for patients with medically complex conditions that require increased care, as current payments do not cover the actual costs of care. In addition, payments to hospitals for waitlisted patients would be increased so that payments are closer to the actual costs of care incurred by hospitals. The recommended legislation would also establish a Medicaid presumptive eligibility process that is designed to reduce the period of time for determining whether a waitlisted patient qualifies for Medicaid. For financial reasons, Medicaid eligibility is required by many long term care facilities before certain types of patients are admitted.

The legislation recommended by the task force represent the first step that must be taken to solve the waitlist problem. The task force intends to recommend further legislation in the 2009 legislative session.

The Healthcare Association suggests several amendments to the bill, as follows:

- (1) For the sake of clarity, Section 2, paragraph 1 should be replaced with the following:

"346D- Medicaid reimbursement for long term care provided in acute care hospitals. Not later than July 1, _____, Medicaid reimbursements to acute care hospitals for patients who are waitlisted for long term care shall be equal to the acute medical services payment rate.

- (2) Section 2, paragraph 2 was found to be unworkable, and should be replaced with the following:

346D- Medicaid reimbursement equity; medically complex conditions. Not later than July 1, 2008, Medicaid reimbursements to long term care facilities for patients with medically complex conditions who, prior to admission to the long term care facility were receiving acute care services in an acute hospital, shall include a separate rate for complex medical patients that shall be 40 percent more than the current rate. As used in this section "medically complex condition" means a combination of chronic physical conditions, illnesses, or other medically related factors that significantly impact an individual's health and manner of living and cause reliance upon technological, pharmacological, and other therapeutic interventions to sustain life.

- (3) Section 2, paragraph 2 should include a date of July 1, 2008.

- (4) Section 5 should contain an appropriation of \$6,500,000.

With the suggested amendment, the Healthcare Association strongly supports HB 2170 HD 1.

TESTIMONY TO THE TWENTY-FOURTH STATE LEGISLATURE, 2008 SESSION

To: House Committee on Health
House Committee on Human Services and Housing

From: Gary L. Smith, President
Hawaii Disability Rights Center

Re: House Bill 2170, HD1
Relating to Health

Hearing: Wednesday, February 13, 2008 8:00 AM
Conference Room 329, State Capitol

Members of the Committee on Health:

Members of the Committee on Human Services and Housing:

Thank you for the opportunity to provide testimony supporting House Bill 2170, HD1, Relating to Health.

I am Gary L. Smith, President of the Hawaii Disability Rights Center, formerly known as the Protection and Advocacy Agency of Hawaii (P&A). As you may know, we are the agency mandated by federal law and designated by Executive Order to protect and advocate for the human, civil and legal rights of Hawaii's estimated 180,000 people with disabilities.

We support this bill because it offers good potential to secure the placement of individuals in community settings. The legislature has seen many examples in the past year or two of the long waitlist for community housing experienced by patients in acute facilities. In addition, a briefing was recently provided by the Healthcare Association on the problems of placing "challenging" patients into community settings. One of the barriers identified has been the low cost of Medicaid reimbursement for these individuals. At the same time, Medicaid payments are made to facilities far in excess of what might otherwise be paid to these home and community based settings. Providing the Department of Human Services with the ability to pay for patient care in a long term care facility based on the actual cost as opposed to an artificially low Medicaid payment schedule should greatly help to facilitate the community placement of such individuals. We need to accept the fact that until the rates for community placements are realistic in

terms of the demands required for the care of the more medically complex patients, this problem will never be solved.

We also support the provision regarding presumptive eligibility. Delays in processing these applications add to the problems of placing these individuals and are an unnecessary source of difficulty. There is no reason to delay these applications. It is our hope that these provisions will help to alleviate the current problem experienced by hospitals as well as their waitlisted patients. Regarding the payment to hospitals of long term care based reimbursement rates, we are certainly sympathetic to the economic plight faced by the hospitals who are not receiving adequate reimbursement for these patients who really do not need to even be in the hospital after a point. They are often torn between the financial realities they face and the general ethic they do possess which directs them to want to treat and care for these individuals. Any assistance the legislature can render will not only help these facilities; it will also make it more likely that these patients will continue to receive adequate care while they are developing an appropriate community placement discharge plan.

Thank you for the opportunity to provide testimony in support of this bill.