NEIL ABERCROMBIE
GOVERNOR

PATRICIA MCMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

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

March 30, 2012

TO: The Honorable Marcus R. Oshiro, Chair
House Committee on Finance

FROM: Patricia McManaman, Director

SUBJECT: **S.B. 2466, S.D.2, H.D. 1 - RELATING TO LONG-TERM CARE FACILITIES**

Hearing: Friday, March 30, 2012; 3:00 p.m.
Conference Room 308, State Capitol

PURPOSE: The purpose of the bill is to establish the Nursing Facility Sustainability Program special fund into which nursing facility sustainability fees shall be deposited and requires the department of human services to charge and collect a provider fee on health care items or services provided by nursing facilities.

DEPARTMENT'S POSITION: The Department of Human Services (DHS) supports increasing the sustainability of the State's service delivery system. We recognize that our long-term care facilities provide needed long term care beds for Medicaid beneficiaries and the community. The DHS continues to work with stakeholders to develop a model so that proposed language may be provided to amend the bill.

For the Legislature's information, the stakeholders, the DHS and their respective consultants will be meeting on Thursday, March 29. The DHS is hopeful that in the very

near future an agreement can be reached on substantive language that can be offered to the Legislature for consideration.

Provider assessments are commonly used to generate revenue for a state by leveraging federal funds through Medicaid. The DHS and stakeholders recognize that the provider fee would provide an opportunity for the State to obtain additional federal matching funds which will reduce the amount of losses incurred by nursing facilities.

There are many methods in which provider fees have been implemented in other states. Under federal law, provider fees must meet three essential tests: the tax must be broad-based; uniformly imposed; and cannot exceed the maximum allowed by federal regulation.

The Department believes that a methodology can be agreed upon that will benefit both the long-term care facilities and DHS. For the long term care facilities they will be fully compensated for their uncompensated or under compensated services to Medicaid patients and the uninsured. For the State and DHS, the funding generated will enable the Department to maintain and provide medical assistance to all of those who need it.

Thank you for the opportunity to testify on this bill.

WRITTEN ONLY

TESTIMONY BY KALBERT K. YOUNG
DIRECTOR, DEPARTMENT OF BUDGET AND FINANCE
STATE OF HAWAII
TO THE HOUSE COMMITTEE ON FINANCE
ON
SENATE BILL NO. 2466, S.D. 2, H.D. 1

March 30, 2012

RELATING TO LONG-TERM CARE FACILITIES

Senate Bill No. 2466, S.D. 2, H.D. 1, establishes a Nursing Facility Sustainability Program Special Fund into which shall be deposited nursing facility provider fees which will be used to match federal Medicaid funds to increase Medicaid payments to nursing facilities.

While the Department of Budget and Finance does not take any position on the policy of establishing a nursing facility sustainability program, as a matter of general policy, the department does not support the creation of special funds which do not meet the requirements of Section 37-52.3, Hawaii Revised Statutes. Special or revolving funds should: 1) reflect a clear nexus between the benefits sought and charges made upon the users or beneficiaries of the program; 2) provide an appropriate means of financing for the program or activity; and 3) demonstrate the capacity to be financially self-sustaining.. In regards to Senate Bill No. 2466, S.D. 2, H.D. 1, it is difficult to determine whether there is a clear nexus between the nursing facilities which are assessed fees and the nursing facilities which receive increased Medicaid payments, and it does not appear that the special fund will be self-sustaining.

I encourage the Legislature to scrutinize the fiscal and operational plan for this program to ensure that it does conform to the requirements of Section 37-52.3, Hawaii Revised Statutes.

Healthcare Association
of Hawaii

HOUSE COMMITTEE ON FINANCE
Rep. Marcus Oshiro, Chair

Conference Room 308
March 30, 2012 at 3:00 p.m. (Agenda #2)

Supporting SB 2466 SD 2 HD 1: Relating to Long-Term Care Facilities

The Healthcare Association of Hawaii advocates for its member organizations that span the entire spectrum of health care, including all acute care hospitals, as well as long term care facilities, home care agencies, and hospices. In addition to providing quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 40,000 people. Thank you for this opportunity to testify in support of SB 2466 SD 2 HD 1, which creates the Nursing Facility Sustainability Program that strengthens the financing of nursing facilities in Hawaii.

Medicaid is a critical component of Hawaii's health care system because it pays for medical care for more than one in five Hawaii residents. However, Hawaii's Medicaid program has serious shortcomings that create a burden for nursing facilities and the entire health care delivery system.

The simple fact is that Medicaid pays nursing facilities less than the actual costs they incur in providing care to Medicaid patients. In other words, a nursing facility that provides the same care to a Medicaid patient and a patient with private funding is paid less by Medicaid than with private funding.

Hawaii's Medicaid program pays nursing facilities, on average, $7 to $8 less than the actual costs of care per patient per day. Exacerbating the situation, Medicaid patients represent 70% of all nursing facility patients.

The federal government has a program that allows nursing facilities to assess themselves a fee and use these funds as a "match" to draw down federal dollars. A total of 47 states have some kind of provider fee program. If Hawaii implements a program as developed by the Healthcare Association of Hawaii, we believe we can substantially reduce the losses due to Medicaid.

Due to the severity of the losses, nursing facilities decided to explore the possibility of developing and implementing a provider fee program. However, they were hesitant because they will have to pay an assessment from unbudgeted revenues and trust that they will be reimbursed. But because the situation today is so dire, nursing facilities decided to pursue a provider fee program.

After this bill was introduced, various stakeholders expressed interest and voiced opinions about it. The nursing facilities have considered the multitude of issues that have been raised and recently agreed to make adjustments, which are contained in the proposed draft of the bill that is attached.

One of the concerns that has been raised is that the special fund created in the bill may not fulfill the requirements for creating a special fund. However, this concern is unfounded because the program's special fund satisfies the requirements specified in Section 37.52.3, Hawaii Revised Statutes, which mandates that any special fund must:

(1) Reflect a clear nexus between the benefits sought and charges made upon the users or beneficiaries of the program;
(2) Provide an appropriate means of financing for the program or activity; and
(3) Demonstrate the capacity to be financially self-sustaining.

First, there is a clear nexus between the benefits and charges because the same organizations that receive the enhanced reimbursements are the ones that are assessed the provider fee. Second, the means of financing is appropriate because, according to federal law, the provider fee is the only possible method of financing this program. Third, the program is self-sustaining because the assessment is based on the revenues of the participating organizations, so the program will continue as long as these organizations are operating. In the unlikely event that the program is terminated because federal matching funds are discontinued, the special fund is automatically terminated.

The process of developing a model that is fair and equitable has been difficult, but we believe that such a model is contained in the attached bill draft. Its major purpose is to use federal funds that are available to help sustain Hawaii's nursing facilities financially. The program assesses a provider fee on Hawaii's private nursing facilities, with 95 percent of the revenue generated used to draw down federal funds. The federal funds and the State match are used to help cover nursing facility losses due to Medicaid funding shortfalls and uncompensated care.

The Centers for Medicare and Medicaid Services prohibits benefits from being distributed to the various nursing facilities in the same proportion that they pay in provider fees, so that some facilities must pay more in provider fees than others, but receive less in benefits. However, the model contained in this proposed bill is broadly acceptable to Hawaii's private nursing facilities.

This model benefits not only Hawaii's private nursing facilities, but also the State. Five percent of the revenue from the provider fee is allocated to the Department of Human Services for administrative expenses and other uses. Those monies may be doubled with a federal match if used for Medicaid services. In addition, this model frees up certified public expenditures that may be used to draw down federal funds for the public hospitals in the Hawaii Health Systems Corporation.

The attached proposed bill draft includes the following amendments:

(1) Includes revenue from Medicare in the total revenue on which the provider fee is assessed;
(2) Excludes facilities in the Hawaii Health Systems Corporation from the program;
(3) Exempts facilities with 28 or fewer beds rather than 46 or fewer beds;
(4) Modifies the timing of payments;
(5) Reduces the penalty for non-payment from 5% to 2%; and
(6) Makes the program retroactive to the effective date of the bill.

For your information, this bill creates a provider fee program for nursing facilities, and another bill being considered by the Legislature creates a separate provider fee program for hospitals.

Thank you for the opportunity to testify in support of SB 2466 SD 2 HD 1.

THE SENATE
TWENTY-SIXTH LEGISLATURE, 2012
STATE OF HAWAII

S.B. NO. 2466 S.D. 2 H.D. 2 Proposed

A BILL FOR AN ACT

RELATING TO LONG-TERM CARE FACILITIES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. Long-term care facilities in the State face major financial challenges in providing quality health care for Hawaii residents. These challenges are largely the result of payments to medicaid enrollees for care that do not cover the actual costs of care. The legislature finds that federal funding to help sustain Hawaii's long-term care facilities financially may be accessed through a provider fee.

Provider fees exist in forty-seven states and the District of Columbia as a means of drawing down federal funds to sustain their medicaid programs due to rising state budget deficits, increasing health care costs, and expanding medicaid rolls. Implementation of a provider fee in Hawaii would help stabilize declining medicaid payments to facilities and slow the erosion of access to care for beneficiaries served by the program.

Medicaid is jointly financed by the federal and state government, but by statutory formula, the federal government pays between fifty per cent and seventy-four percent of medicaid costs incurred by states for care delivered to their medicaid

beneficiaries. Federal medical assistance percentages vary by state, with states that have lower per capita incomes receiving higher federal matching rates. Under federal rules, the state share must be public funds that are not federal funds.

Provider fees, which are collected from specific categories of health care items and services may be assessed on nineteen different classes of health care services, including inpatient and outpatient hospital and nursing facility services. However, there are limitations on the way provider fees are structured. The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, P.L. 102-234, passed by Congress in 1991, imposes the following requirements:

(1) Broad-based. To be considered broad-based, a provider fee must be imposed on all health care items or services furnished by all non-federal, non-public providers in the class in the State. Provider fee programs may exclude public facilities without violating federal law;

(2) Uniformly imposed. In general, a provider fee is uniformly imposed if it is the same amount or rate for each provider in the class; and

(3) Hold harmless prohibition. States may not hold providers harmless. A provider fee is considered to hold the provider harmless if the providers paying the fee receive, directly or indirectly, a non-medicaid

payment from the state or any offset or waiver that guarantees to hold the provider harmless for all or a portion of the fee. A provider fee is also considered to hold the provider harmless if the medicaid payments to the provider vary based only on the amount of the fees paid by the provider.

The maximum provider fee a state may receive is currently six per cent of net patient revenue. A number of proposals have been made, but not implemented, to eliminate medicaid provider fee programs in order to reduce the federal deficit. However, since provider fees are used by so many states, many of those who are knowledgeable about this subject view elimination of provider fees as unlikely due to strong political support for the program. A more realistic expectation is a reduction of the provider fee maximum, as proposed by President Barack Obama's fiscal year 2012 budget, which would reduce the maximum to three and one-half per cent in 2017. This proposal recognizes that provider fees are essential for most states to maintain a stable, functioning medicaid program.

In Hawaii, a provider fee would increase medicaid payments at a time when constraints on the State's budget have forced a reduction in payments and optional benefits. The additional federal funds obtained via the fee program would reduce the amount of losses incurred by nursing facilities. As such, the provider fee would help preserve access to health care for the

medicaid population and sustain the State's entire health care system.

The purpose of this Act is to ensure access to health care for medicaid recipients by establishing a nursing facility sustainability fee and a special fund to receive moneys from the nursing facility sustainability fee in order to receive federal medicaid matching funds under the QUEST Expanded Medicaid Section 1115 Demonstration Waiver.

SECTION 2. The Hawaii Revised Statutes is amended by adding a new chapter to be appropriately designated and to read as follows:

"CHAPTER

NURSING FACILITY SUSTAINABILITY PROGRAM

§ -1 Title. This chapter shall be known and may be cited as the "Nursing Facility Sustainability Program Act" .

§ -2 Findings and declaration of necessity. It is the intent of the legislature to encourage the drawdown of federal medicaid funds by establishing a special fund within the state treasury to receive revenue from the nursing facility sustainability fee to be administered by the department and to use it to receive federal medicaid matching funds under the Section 1115 waiver.

§ -3 Definitions. As used in this chapter:

"Continuing care retirement community" means an entity providing nursing facility services, along with assisted living

or independent living on a contiguous campus with the number of assisted living and independent living beds in the aggregate being at least twice the number of nursing facility beds. For purposes of this definition, "contiguous" means land adjoining or touching other property held by the same or related organization, and includes land divided by a public road.

"Department" means the department of human services.

"Net patient service revenue" means gross inpatient revenues from services provided to nursing facility patients less reductions from gross inpatient revenue resulting from an inability to collect payment of charges. Inpatient service revenue excludes non-patient care revenues, such as revenues from beauty and barber services, vending income, interest and contributions, revenues from the sale of meals, and all outpatient revenues. Reductions from gross revenue include contractual adjustments, uncompensated care, administrative, courtesy, and policy discounts and adjustments, and other revenue deductions.

"Nursing facility" means any facility licensed pursuant to chapter 11-94.1, Hawaii administrative rules.

"QUEST" means the demonstration project developed by the department described in Hawaii's Section 1115 waiver and includes the QUEST, QUEST-Net, and QUEST-Ace components.

"QUEST expanded access" means the demonstration project developed by the department described in Hawaii's Section 1115 waiver.

"Resident day" means a calendar day of care provided to a nursing facility resident, including the day of admission and excluding the day of discharge; provided that one resident day shall be deemed to exist when admission and discharge occur on the same day. A resident day includes a day on which a bed is held for a patient and for which the facility receives compensation for holding the bed.

"Section 1115 waiver" means the QUEST Expanded Medicaid Section 1115 Demonstration Waiver (Number 11-W-00001/9).

§ -4 Nursing facility sustainability program special fund. (a) There is created in the state treasury the nursing facility sustainability program special fund to be administered by the department into which shall be deposited all moneys collected under this chapter.

(b) Moneys in the special fund shall consist of:

(1) All revenues collected or received by the department from the nursing facility sustainability fee required by this chapter;

(2) Any interest or penalties levied in conjunction with the administration of this chapter; and

(3) Any appropriations, federal funds, donations, gifts, or moneys from any other sources.

(c) Revenue from the nursing facility sustainability fee shall be used exclusively as follows:

(1) No less than ninety-five percent of the revenue from the nursing facility sustainability fee shall be used to match federal medicaid funds, with the combined total to be used to enhance capitated rates to the QUEST and QUEST expanded access plans for the purpose of increasing medicaid nursing facility payments to the maximum permitted by federal law; and

(2) Any portion of the revenue not used as set forth in paragraph (c)(1) may be used to support the medicaid program of the department including payment of administrative expenses.

(3) All moneys remaining in the special fund on the last day of the fiscal year shall be distributed to nursing facilities within thirty days in the same proportions as received from the nursing facilities.

§ -5 Nursing facility sustainability fee. (a) Effective July 1, 2012, the department shall charge and collect a provider fee on health care items or services provided by nursing facilities.

(b) The nursing home sustainability fee shall be based on the net patient service revenue of all nursing facilities that are subject to the sustainability fee, as determined by the department.

(c) The nursing facility sustainability fee shall not exceed three per cent of net patient service revenue and shall be calculated and paid on a per resident day basis. The fee shall be the same amount for each affected facility, except as prescribed in subsection (d)(2).

(d) In accordance with the redistribution method set forth in title 42 Code of Federal Regulations section 433.68(e)(1) and (2), the department shall seek a waiver of the broad-based and uniformity provider fee requirements under federal law from which to exclude certain nursing facilities and to permit certain high volume medicaid nursing facilities or facilities with a high number of total annual patient days to pay the sustainability fee at a lesser amount per resident day, as follows:

(1) The department shall exempt the following nursing facility providers from the nursing facility sustainability fee subject to federal approval under title 42 Code of Federal Regulations section 433.68(e)(2):

(A) Nursing facilities with twenty eight or fewer Medicaid licensed beds;

(B) Nursing facilities owned or operated by the Hawaii health systems corporation; and

(C) Continuing care retirement communities; and

(2) The department shall reduce the fee for high volume Medicaid nursing facilities or facilities with high patient volumes that meet the redistributive tests of title 42 Code of Federal Regulations section 433.68(e)(2).

(3) The department, with agreement by the nursing facility trade associations located in Hawaii, may modify, add to or reduce the categories of facilities exempt from the assessment if necessary to obtain and maintain approval of the waiver by the Centers for Medicare and Medicaid Services, if the modification is consistent with the purposes of this chapter.

§ -6 Nursing facility sustainability fee assessment. (a) Nursing facilities shall pay the nursing facility sustainability fee to the nursing facility sustainability program special fund in accordance with this chapter.

(b) The department shall determine, with agreement by the nursing facility trade associations located in Hawaii, the fee rate prospectively for the applicable fiscal year.

(c) The department shall collect, and each nursing facility shall pay in twelve equal installments, the nursing facility sustainability fee in § -5 on a monthly basis, subject to the terms of this section. The fee shall be due within thirty days after the end of each month, with the initial payment due forty-five days after the required federal approvals for the

assessment and any increase in health plan capitation payments have been secured from the Centers for Medicare and Medicaid Services.

§ -7 **Federal approval.** The department shall seek a waiver and other approvals from the Centers for Medicare and Medicaid Services that may be necessary to implement the nursing facility sustainability program, including the approval of the contracts between the State and the QUEST and QUEST expanded access health plans.

§ -8 **Multifacility locations.** If an entity conducts, operates, or maintains more than one nursing facility, the entity shall pay the nursing facility sustainability fee for each nursing facility separately.

§ -9 **Penalties for failure to pay nursing facility sustainability fee.** (a) If a nursing facility fails to pay the full amount of the nursing facility sustainability fee when due, there shall be added to the fee, unless waived by the department for reasonable cause, a penalty equal to two percent of the fee that was not paid when due. Any subsequent payments shall be credited first to unpaid fee amounts rather than to penalty or interest amounts, beginning with the most delinquent installment.

(b) In addition to the penalty identified in this section, the department may seek any of the following remedies for failure of any nursing facility to pay its fee when due:

(1) Withholding any medical assistance reimbursement payments until such time as the fee amount is paid in full;

(2) Suspension or revocation of the nursing facility license; or

(3) Development of a plan that requires the nursing facility to pay any delinquent fee in installments.

§ -10 **Enhanced rates to QUEST and QUEST expanded access plans.** In accordance with title 42 Code of Federal Regulations section 438, the department shall use revenues from the nursing facility sustainability fee and federal matching funds to enhance the capitated rates paid to the QUEST and QUEST expanded access plans for the subject fiscal year consistent with the following objectives:

(1) The rate enhancement shall be used exclusively for increasing nursing facility reimbursements to support the availability of services and to ensure access to care to QUEST and QUEST expanded access enrollees;

(2) The rate enhancement shall be made part of the monthly capitated rates by the department to the QUEST and QUEST expanded access plans, which shall provide documentation to the department and the nursing facility trade associations located in Hawaii certifying that the revenues received under paragraph (1) are used in accordance with this section;

(3) The rate enhancement shall be actuarially sound and approved by the federal government for federal fund participation.

(4) The rate enhancement shall first reimburse the Medicaid share of the assessment to each facility, with the remainder being an equal per diem per Medicaid day to each facility.

§ -11 **Payment of Rate Enhancement.** The rate enhancements referred to in § -10 shall be retroactive to the effective date of this legislation. Retroactive rate enhancements shall be paid within thirty days of notification by the Centers for Medicare and Medicaid Services to the department of the waiver and plan amendment approval.

§ -12 **Termination.** (a) Collection of the nursing facility sustainability fee under § -5 shall be discontinued if:

(1) The waiver in § -7 or the enhanced capitation rates in § -10 have not been approved by the Centers for Medicare and Medicaid Services;

(2) The department reduces funding for nursing facility services below the state appropriation in effect on June 30, 2012;

(3) The department or any other state agency uses the money in the special fund for any use other than the uses permitted pursuant to this chapter; or

(4) Federal financial participation to match the nursing facility sustainability fee becomes unavailable under federal law. In such case, the department shall terminate the collection of the fee beginning on the effective date of the federal statutory, regulatory, or interpretive change.

(b) If collection of the nursing facility sustainability fee is discontinued as provided in this section, all money in the special fund shall be returned to the nursing facilities from which the fee was collected within thirty days in the same proportions as received from the nursing facilities.

§ **-12 Severability.** If any provision of this chapter or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of the chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are severable."

SECTION 3. This Act shall take effect on July 1, 2012, and shall be repealed on June 30, 2013.

HAWAII HEALTH SYSTEMS
CORPORATION
"Touching Lives Everyday"

House Committee on Finance
Representative Marcus Oshiro, Chair
Representative Marilyn B. Lee, Vice Chair

March 30, 2012
Conference Room 308
3:00 p.m.
Hawaii State Capitol

Testimony Supporting Senate Bill 2466, SD2, HD1, Relating to Long-Term Care Facilities Establishes the Nursing Facility Sustainability Program Special fund into which nursing facility sustainability fees shall be deposited. Requires the department of human services to charge and collect a provider fee on health care items or services provided by nursing facilities.

Bruce S. Anderson, Ph.D.
President and Chief Executive Officer
Hawaii Health Systems Corporation

On behalf of the Hawaii Health Systems Corporation (HHSC), thank you for the opportunity to present testimony in support of the concept of SB 2466, SD2, HD1 that establishes the Nursing Facility Sustainability Program Special fund into which nursing facility sustainability fees shall be deposited.

Given that health care provider reimbursements are declining at both the federal and state level, it is imperative that health care providers find innovative ways to generate revenues to offset the decline in reimbursements. We believe that the concept of a provider fee on health care items or services provided by nursing facilities would be a good financing mechanism that could leverage federal funds to increase the reimbursements to nursing facilities from the QUEST and QUEST Expanded Access (QEXA) programs.

As is common in other states that have implemented sustainability fee programs, the public hospitals of the Hawaii Health Systems Corporation are being exempted from the nursing facility sustainability fee. This is being done to maximize both the amount of federal funds that the private nursing facilities will receive through the nursing facility sustainability fee program and the amount of federal matching funds the public hospitals can receive under the State of Hawaii's Section 1115 waiver. As a matter of public policy, the public hospitals should be allowed to utilize their certified public expenditures

March 30, 2012

To: Chair Marcus Oshiro and Members
House Committee on Finance
From: Bob Ogawa, President
Re: SB 2466, SD2, HD1 - Establishing the Nursing Facility Sustainability Program Special Fund

The Hawaii Long Term Care Association (HLTCA) strongly supports SB 2466, SD2, HD1. I will not go into extensive detail on the problems this measure seeks to address. You are all well-familiar with the substantial financial and services challenges that face our State medicaid system. Long term care facilities, in particular, have been falling into increasingly dire straits just as the leading edge of the Baby Boomer Generation has begun to turn 65. We must act now, or we will find ourselves with a decimated senior care infrastructure at precisely the time when the need for a robust one is the greatest in our history.

Very simply, as is employed in some form or fashion in nearly every other state in the country, this measure proposes a provider fee that will be used to draw down additional federal funds to cope with budget shortfalls, rising healthcare costs and ever-expanding medicaid rolls. This will enable increased payments to nursing facilities, thus reducing the losses they are presently incurring, preserving access to care for the medicaid population and helping to ensure sustainability for our long term care system.

Between the HLTCA and the Healthcare Association of Hawaii, we represent all the affiliated nursing facility beds in the State of Hawaii. As such, we present to you a united front in pursuit of the passage of this legislation.

In all candor, this is a work in progress. This is not a simple program to configure or implement. There are a myriad moving parts and variables. However, while the devil may be in the details, we cannot let the details bedevil us into inaction. That is not an option. Part of HLTCA's mission statement says: *How we provide for Hawaii's kupuna, chronically ill and convalescent disabled is a measure of the respect and compassion we have for them . . . a reflection of our dignity as a society.*

Moving this measure forward will indeed reflect our dignity as a society. We cannot let the system fail, because we cannot fail our kupuna. Thank you.

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HALE MAKUA HEALTH SERVICES

COMPASSION COMMITMENT COMMUNITY

March 23, 2012

TO: **Representative Marcus Oshiro, Chair, House Finance Committee**
Friday, March 20, 2012, 3:00 p.m.
Conference Room 308
State Capital

FROM: **Tony Krieg, Chief Executive Officer**

RE: **SUPPORT FOR SB 2466 SD2, HD1 RELATING TO LONG-TERM CARE FACILITIES**

Aloha Chairman Oshiro and members of the House Finance Committee

My name is Tony Krieg, C.E.O. of Hale Makua Health Services. I am writing in strong support of SB 2466 SD2 , HD1 which will provide additional revenues at minimal cost to the State of Hawaii to help make up a significant shortfall for our nursing facilities. For over 65 years Hale Makua Health Services has provided nursing homes, care home, and home and community based services for people needing long term care on Maui. In addition to home health, case management and adult day health services, we operate two nursing homes with a total of 378 beds. Seventy-nine percent (79%) of the patient days in these homes are occupied by Medicaid recipients. The only other nursing home beds on Maui are part of Kula Hospital (a critical access hospital with 100 nursing home beds).

Medicaid does not cover the cost of providing care to our residents, and there have been reimbursement cuts in Medicaid and Medicare reimbursement which will result in a serious budget shortfall totaling $1.7 million for both facilities in 2012.

These cuts come at a time when federal and state regulations are calling for increases in quality, and renovations to provide homelike environments. The residents in Hawaii's nursing homes have some of the highest acuity care needs in the nation. I have illustrated this in the last table below this testimony.

Over 70% of the cost of providing care is for labor costs. As you well know, the cost of energy, food, supplies and other commodities are also on the rise. Due to these budget shortfalls, last year the Hale Makua Health Services Board of Directors was forced to seriously considered closing Hale Makua Wailuku because we could not get the largest labor union to agree to wage concessions. This would have meant that between 50 and 60 nursing home residents would have had to be placed in other facilities on Oahu or in other homes across the State.

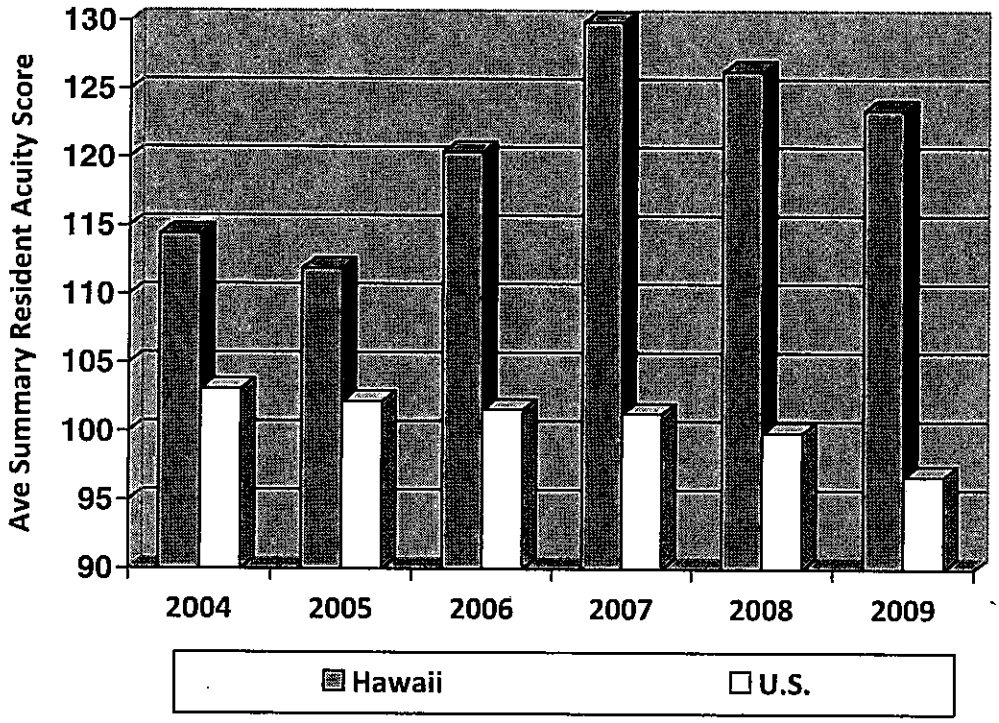
This bill provides a mechanism to draw down additional federal funds to ease this severe budget deficit. Barring an influx of state general funds, this is the one of the few means for nursing facilities to maintain services to our elderly and frail nursing home residents. **I strongly urge you to pass this bill with the original formula as proposed by the Healthcare Association of Hawaii.**

The following table illustrates the patient days and shortfalls due to the current Medicaid reimbursement system for our organization.

HALE MAKUA KAHULUI & WAILUKU
2011 RESULTS

	SHORTFALL = COST > REIMBURSEMENT	TOTAL # OF PATIENT DAYS	% MEDICAID
MEDICAID	-$1,688,821.00	93,821	79%
ALL PAYERS		118,499	

Average Summary Score for Nursing Facility Resident Acuity Using the Management Minute Index



From: Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2004-2009
Charlene Harrington, Ph.D.Helen Carrillo, M.S.Brandee Woleslagle Blank, M.A –
.Department of Social & Behavioral Sciences *University of California San Francisco 2010*

The table above shows the average summary score for resident acuity using the management minute approach. This index is based on a compilation of resident characteristics including being bedfast, needing assistance with ambulation, needing full eating assistance, needing some eating assistance, having an indwelling catheter, being incontinent, having a pressure ulcer receiving bowel or bladder retraining, and receiving special skin care. Each of these characteristics was weighted by the average amount of management minutes or the time needed to provide nursing care.

The average index was 103.10 in 2004 which declined to 96.74 in 2009 for all facilities surveyed in the U.S. **This index allows for comparisons of acuity differences in facilities across states, which ranged from 73.07 in Iowa to 123.49 in Hawaii in 2009**