Athena
Health Care Systems

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Written testimony of Lawrence Santilli, President and CEO, Athena Health Care Systems, and President of the Connecticut Association of Health Care Facilities Concerning the Governor's Recommended FY 2016 and FY 2017 Proposed Budget

Good evening Senator Bye, Representative Walker and to the members of the Appropriations Committee. My name is Lawrence Santilli, President and CEO of Athena Health Care Systems in Farmington, Connecticut and President of the Connecticut Association of Health Care Facilities. Athena Health Care Systems is a Connecticut based longstanding provider of nursing care for over thirty years. We have 18 nursing homes in Connecticut, 20 in Massachusetts and 5 in Rhode Island.. Throughout the Athena network, we employ over 8,000 employees with over 5,000 nursing home beds.

I am very proud that some of my Administrators and other key employees from the Athena Connecticut network of nursing homes are present this evening and testifying. I am proud of our devoted caregivers, from RNs, LPNs, CNAs, Therapists, etc., who all want to deliver the highest quality of care to anyone who comes to the Athena network. These workers are doing an amazing job, and I am so grateful to them and proud of them for everything they are doing.

I know the state is facing many financial challenges in trying to do what is best for the State of Connecticut and the many people it serves. However, please give the proper consideration to the aging and frail residents that we care for on a daily basis. As you are aware, our costs of providing care has risen dramatically from increased costs in food, utilities and drugs, we have remained flat in terms of an increase. With the ongoing financial challenges the state faces today, I am very concerned that our nursing facilities' budget could be cut this session and that would be devastating.

To be part of the solution, please see the attached proposal from CAHCF, Plan to accelerate the transfer of care from nursing facilities to Money Follow the Person. We believe this plan correlates to the state's objective of right sizing of the nursing home industry. We feel this plan can benefit many stakeholders.

Thank you for your time and if you have any questions on the proposal, please contact me.

Sincerely,

Lawrence Santilli
President and CEO

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CAHCF
Connecticut Association of Health Care Facilities

Plan to accelerate the transfer of care from nursing facilities to Money Follows the Person

Efforts to move Medicaid recipients out of costly institutional settings and into more affordable home and community based programs such as Money Follows the Person (MFP) have not achieved anticipated goals. Among other factors, MFP's success has been frustrated by an excess supply of licensed nursing facility beds. However, nursing facilities have been reluctant to de-licensed beds. The reluctance stems from the justifiable notion that if facilities reduce their licensed capacity, the reduction would cause a permanent reduction in the facilities' value. To counter that fear and, at the same time, enhance the success of MFP the Connecticut Association of Health Care Facilities has designed a plan.

In general, the plan would allow a nursing facility to, on a temporary basis, voluntary de-license a sufficient number of beds, including occupied beds, to cause the facility to achieve a normal occupancy rate of at least 99 percent. Residents in de-licensed occupied beds would, if they chose, transition to another nursing facility or to MFP.

An example follows.

A nursing facility with a capacity of 120 beds has maintained an occupancy rate of 90 percent for many months. In other words, of its 120 beds only 108 are occupied. To bring the facility's occupancy rate to 99 percent the facility would reduce its capacity to 109 beds (108/.99). However, under the plan the facility must also de-license occupied beds and give the affected residents a choice to either relocate to another facility or be cared for at home under MFP.

The facility's physical plant configuration suggests that it could efficiently operate at a capacity of 90 beds. Under such a scenario the facility would de-license a complete wing of 30 beds (120-90).

The facility's new capacity of 90 beds would necessitate the relocation of eighteen (18) residents (108-90). It is assumed that, given the choice, approximately one in four residents would qualify for *and* be willing to receive their care in a community setting. Accordingly,

thirteen (13) of the eighteen affected residents in our example would relocate to another nursing facility and five (5) would receive care under MFP.

The net cost to the state for care in a nursing facility is approximately $2,650 per month, whereas the net cost to the state under MFP is only $963. Therefore, with regard to the residents in our example who elect to be care for under MFP, the state would realize an annual savings of $101,220 ($2,650-$963*12*5).

Information published by DSS indicates that there are 200 nursing facilities in the state that are operating at less than 99 percent of capacity. If each of those 200 facilities reduced their capacity by an amount to cause at least five residents to opt for MFP, the state would realize an annual savings of $20.2 million ($101,220*200), and 1,000 (5*200) individuals would realize the benefits of MFP.

While not every nursing facility would agree to reduce its capacity, many others might agree to a reduction in an amount that could cause more than five residents per facility to opt for MFP. Moreover, with the anticipated change to an acuity-based reimbursement system, the incentive to reduce capacity would be even greater and the savings potential would increase as well.

The plan proposed by the Connecticut Association of Health Care Facilities has worked in Rhode Island and Massachusetts (examples follow). Either model would work in Connecticut as well. .

The status quo should not be an option. Our plan will help MFP succeed for the benefit of all stakeholders.

Massachusetts and Rhode Island Options:

Purpose - To accelerate the state's long term care rebalancing goals by rightsizing skilled nursing facility bed capacity and offer possible revenue relief to facilities experiencing financial difficulties due to low occupancy.

Goals-

1)Increase occupancy percentage at requesting facility and the surrounding facilities.

2) Accelerate cost effective home and community based transitions under Money Follows the Person demonstration program and Reduce licensed nursing home beds by removing excess bed capacity.

3) Provide, if applicable based on options below, rate relief for the above. Rate relief would be provided as an adjustment to existing Medicaid rate.

Criteria-

1) Current occupancy percentage at requesting facility below 95%.

2) Must mothball or permanently decertify a wing, minimum of 30 beds. A wing would include vacant and occupied beds.

Options-

1) **Massachusetts option**:

A) Create a business plan proposal for submission to DSS including the amount of proposed facility license decrease. (30 bed minimum)

B) Beds could be closed permanently or mothballed.

C) Residents in occupied beds of the closed wing would be transferred to other facilities within a 15 mile radius or to Money Follows the Person.

D) Facility would achieve a cost savings through the decrease in staffing of the closed unit. No initial Medicaid rate adjustment is given. In future years the facility would rebase lowering the penalty of imputed days.

E) Facility could file, no more than annually, to recertify the mothballed beds.

F) DPH review and response within 60 days of submission.

2) **Rhode Island option:**

A) Create a business plan proposal for submission to DSS including the amount of proposed facility license decrease. (30 bed minimum)

B) Beds could be closed permanently or mothballed.

C) Residents in occupied beds of the closed wing would be transferred to other facilities within a 15 mile radius or to Money Follows the Person.

D) Facility mothballing or permanently closing the wing would receive a Medicaid rate increase calculated as follows:

Determine the capital and other fixed costs of the facility. The Medicaid per diem for these costs would be ratably increased to reflect the lower capacity. The increase would be capped at $7.00 per day. See simplified example below:

Example: Facility ABC's current license is 150 beds. Medicaid per diem is $200. ABC wants to close a 30 bed wing that currently has 15 patients. Medicaid rate increase for ABC is determined as follows:

	Existing	Revised	Increase
Beds	120	90	(30)
Fair Rent	$7.00 per diem	$8.33	$1.33
Capital Costs (1)	$6.00 per diem	$8.00	$2.00
Other Fixed Costs (2)	$10.00 per diem	$13.33	$3.33
Total			$6.66
Cap			$7.00
Lesser of Total or Cap			$6.66

(1) Excludes provider tax/user fees
(2) Includes fixed salaries and expenses

E) Facility could file, no more than annually, to recertify the mothballed beds. The recertification process would require DSS's prior approval.

F) Recertification would be based on bed need within a 15 mile radius of the facility.

G) Current occupancy percentage at existing and all other facilities within 15 mile radius must be minimally at 95% occupancy.

H) No partial recertification. Would have to recertify the entire number of mothballed beds.

I) Any previous rate increase received for mothballed beds would be removed from the Medicaid rate.

J) DSS & DPH review and response for recertifying the beds within 60 days of submission.

For additional information, contact: Matthew V. Barrett, CAHCF at mbarrett@cahcf.org, (860) 290-9424, or (860) 373-4365.