



State of Connecticut

HOUSE OF REPRESENTATIVES STATE CAPITOL

REPRESENTATIVE CHARLES J. FERRARO
ONE HUNDRED SEVENTEENTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4200
300 CAPITOL AVENUE
HARTFORD, CT 06106

CAPITOL: (860) 240-8700
TOLL FREE: (800) 842-1423
Charles.Ferraro@housegop.ct.gov

MEMBER
APPROPRIATIONS COMMITTEE
HUMAN SERVICES COMMITTEE
PUBLIC SAFETY AND SECURITY COMMITTEE

Testimony in support of
HB5589 An Act Concerning Acuity-Based System for Medicaid Reimbursement
Human Services Committee
March 8, 2016

Good day Chairwoman Abercrombie, Chairwoman Moore, Ranking Members Wood and Markley, and distinguished members of the Committee. I want to thank you for raising **HB5589 An Act Concerning Acuity-Based System for Medicaid Reimbursement**, and I offer my full support.

It is no secret that many nursing homes in recent years have had to do more with less and many are facing extremely difficult decisions with regards to their being able to provide quality service in order to keep their doors open. One such home who has had to make the difficult decision to close down is Derby's Marshall Lane Manor, a 120 bed facility that housed 96 residents and over 100 employees. The reason cited for the closure was financial. Marshall Lane's occupancy over the last several years has been at 80% and for a nursing home to be financially viable they generally need to have closer to 95% occupancy. In fact, nearly one third of CT's nursing homes are less than 90% occupied. Overall, CT's nursing home occupancy has tumbled from 93.3%, 3rd highest in the nation in 2003 to 89.8%, the 10th highest in 2013. Only 11 of the 230 licensed nursing homes in the state are at full capacity as of spring of 2013.

Nursing home administrators say vacancy rates have been fueled by a number of factors, including state initiatives to keep more elderly and disabled residents in home and community settings, as well as, the ballooning assisted-living industry loosely regulated in CT. The State is aggressively pursuing home-care options through programs such as, "Money Follows the Person," which seeks to transition thousands of Medicaid eligible residents out of nursing homes and into community settings. State plans anticipate a reduction of 7,000 to 9,000 of the remaining 26,300 licensed nursing-home beds by 2025.

In the short term, many nursing homes have seen their census fall and the illness acuity of their patients rise, at a time of shrinking Medicaid and Medicare funding. While nursing homes understand the state's objectives, there is more than likely going to be a continued strong need for high-quality skilled nursing homes. State reports project that the number of people needing long-term care will rise more than 20 percent by 2025, (silver tsunami).

There remains the question as to whether the survival of nursing homes will be based on quality or, largely on supply and demand. Some of the homes experiencing high vacancy rates have excellent federal quality ratings, while some with high occupancy rates have low quality scores. Kimberly Hall South Center of Windsor for example, has an above average federal rating but is only 62 percent occupied. On the flip side Aurora Senior Living of Cromwell was 93 percent occupied, but has a "much below-average" overall rating.

One solution to this problem is to adjust the reimbursement payments to patients' care needs (acuity-based or case-mix). Several States have long ago implemented such systems for Medicaid reimbursement: Illinois (1969); West Virginia (1976); Ohio (1980); Maryland (1983); Minnesota (1985) and New York (1986). The advantage to the case-mix reimbursement systems are: 1. such systems directly relate dollars paid to resident's needs and functional disabilities and / or to services deemed necessary to meet those needs. 2. state governments can then be better assured that their payments are in line with patients clinical needs. 3. Acuity-based / Case-mix reimbursement systems can improve the overall access of Medicaid patients to need care, particularly for patients with relatively high needs. Improved access may be especially valuable for states with patients 'back-up' in hospitals unable to obtain necessary care. 4. If designed to provide the correct incentives, the reimbursement systems can encourage the provision of the appropriate type and quality of care while saving state government the cost of lengthy hospitalization for high-need patients.

Connecticut currently has a prospective facility-specific, cost-based reimbursement system for Medicaid; Private pay rates are also regulated under this system. This system of reimbursement is not consistent. Not all residents have the same level of need with regards to care. There are considerable differences in the rates Medicaid pay in Connecticut. There is more than \$100 / day difference between the lowest and the highest paid facility. Great variation among per diem Medicaid rates is due to profit status, with average rates in non-profit facilities being reimbursed at significantly higher rates than for profit homes. Unionized homes receive significantly more than non-unionized homes; non-profit unionized receive as much as \$25.00 dollars per day more for each Medicaid resident than for profit unionized homes. Leveling the playing field by adopting an Acuity-based system of Reimbursement for Medicaid is the right thing to do.

I want to thank the committee Committee for giving me the opportunity to submit written testimony on HB 5589 and I respectfully request that the committee consider adopting an acuity-based system for Medicaid reimbursement.

Respectfully submitted,

Representative Charles Ferraro