

February 14, 2017

**Written testimony of Matthew V. Barrett, President and CEO of the Connecticut Association of Health Care Facilities (CAHCF) concerning H.B. No. 7020 (RAISED) AN ACT REQUIRING THE IMPLEMENTATION OF THE RECOMMENDATIONS OF THE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING LONG-TERM CARE.**

Good morning Senator Flexer, Senator Kelly, Representative Serra and to the distinguished members of the Aging Committee. My name is Matthew V. Barrett. I am the President and CEO of the Connecticut Association of Health Care Facilities (CAHCF), our state's trade association and advocacy organization of one-hundred and fifty skilled nursing facilities and rehabilitation centers. Thank you for this opportunity to testify in support of H.B. No. 7020 (RAISED) AN ACT REQUIRING THE IMPLEMENTATION OF THE RECOMMENDATIONS OF THE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING LONG-TERM CARE and to request a substitute version of the bill.

This legislation implements many of the important finding and recommendations of the Program Review and Investigations committee 2016 study.

At the outset, I would like to state CAHCF's ongoing support for Connecticut's 2016 LTSS Plan and the overall effort to utilize Connecticut's scarce state resources in the most cost-effective manner as our state braces up to deliver LTSS to a well-documented and rapid expansion of older adults. Connecticut has been a longstanding leader in developing a strong array of home and community based services as an alternative to care provided in skilled nursing facilities and other facility-based settings. Connecticut has been recognized as having one of the most comprehensive Money Follows the Person initiatives in the nation. Indeed, our state is seeing remarkable progress is shifting a policy emphasis and corresponding resources to home and community based services. Corresponding to these initiatives, there have been ongoing discussions about potential state Medicaid savings associated with accelerating even further this transformation.

In this regard, the 2016 PRI study included the very important component of "examining the costs of care for persons with disabilities and older adults in nursing homes versus home/community care setting." Implementation of PRI findings can serve to inform features the public budgeting aspect of LTSS for the next decade as our state populations continues to age and require LTSS in increasing numbers.

**Main PRI Staff Findings:**

- PRI staff researchers reported, and characterized it as a main finding, that "Some home and community based Medicaid waiver programs are more costly than nursing home care; [and] living in the community may sometimes be a more personal choice and philosophy rather than save CT money."

- PRI staff presented data showing that “many of the Medicaid waivers allow the plan of care to exceed 100 percent of the institutional care and therefore, for some individuals, the costs of community care is likely much higher than institutional care. For more information about this key finding see page 68 and 69 of the full report (attached).

Please remember that the above pertains only to the costs comparison component of the study. The full report delves into many aspects of the policy preference for home and community based services in Connecticut. However, PRI staff did find the following:

- The average annual Medicaid costs for Medicaid nursing home care at \$69,816. Researchers also noted testimony provided by CAHCF indicating the true net annual state costs at \$27,010 when you factor in the 50% federal Medicaid matching rate and deduct the nursing home provider tax.
- PRI researchers presented data on Table 4-1 (page 69) showing the Maximum Annual Cost Limit in 2016 for the Connecticut Home Care for Elders Category 3 and the PCA Waiver Program at \$80,280 (\$10,464 more than the average Medicaid nursing home cost).
- PRI researchers presented data on cost maximums in various other Medicaid financed home and community based waiver programs. For example, Mental Health Wise Program at \$87,270 (\$17,454 more than the average Medicaid nursing home cost); DDS Comprehensive Waiver - \$252,363 maximum annual costs limit (\$182,547 more than the average Medicaid nursing home costs).

The report further provides: “While it is likely that, on average, the costs of care under the waivers is much lower than the cost maximums, this information should be available. The state has already committed to a philosophy of promoting community care for individuals, however, the true costs of those services have never been compared. Therefore, to fully understand the cost to Connecticut of LTSS in the community versus institutions, PRI staff recommends:

**The Department of Social Services should conduct an analysis of the distribution of individuals by costs, grouped into costs ranges, for each Medicaid waiver program. A summary of the department’s findings should be provided to the legislative committees of cognizance, including the Joint Committee on Appropriations, subcommittee on Human Services (page 70).**

**Because this very important and main finding of the PRI study is omitted in HB 7020, CAHCF is asking the Aging Committee to include the recommendation in a substitute version of the bill.**

The ongoing instability of the Connecticut state budget and the potential for comprehensive changes at the federal level in the form of a Medicaid block grant assure that the cost implications of LTSS will remain an area of ongoing focus. This additional information on the costs and savings in the area of LTSS will assist Connecticut policy makers evaluate this important area of policy and the budget. Thank you and I would be happy to answer any questions you may have.

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## Factors Influencing Receipt of Long-Term Care Services and Supports in Home and Community Settings

### Background

For the last several years, Connecticut state governments, with financial and policy encouragement from the federal government, has undertaken several initiatives that have helped increase the proportion of Connecticut's long-term care services and supports (LTSS) that are delivered in home and community settings rather than in nursing homes and other institutions.

It is generally accepted that it is preferable to increase the percent of people receiving LTSS in the community because: 1) people prefer living in their own homes in a community setting rather than in a nursing home or other institutional setting, and 2) it can be less expensive than delivering services in an institution.

There are two major programs administered by the Department of Social Services (DSS) that provide support for community-based care for frail older adults and people with disabilities. The Connecticut Home Care Program (CHCP) is the primary vehicle used by the state to provide home and community-based care to prevent institutionalization. Money Follows the Person Rebalancing Demonstration (MFP) supports Connecticut's efforts to "rebalance" the long-term support system, by providing transition services and supports to enable institutional residents to return to a home and community based setting. There are also prevention measures that may be taken to reduce the need for LTSS in nursing homes or other institutional settings such as respite for caregivers, fall prevention programs, and congregate housing support services.

PRI staff analyzed information contained in MFP and CHCP databases. Staff also obtained through interviews with state agency personnel, provider groups, and other interested parties. PRI staff also toured nursing home, assisted living, and congregate housing facilities.

### Main Staff Findings

- While an increasing percent live in nursing homes as they age, even at 95+ years of age, two-thirds of CT residents still live in the community.
- Although many believe LTSS prevention and diversion programs, such as fall prevention, telemonitoring, and chronic disease self-management, are helpful, outcome data is scarce.
- Some home and community based Medicaid waivers are more costly than nursing home care; living in the community may sometimes be more a personal choice and philosophy rather than save CT money.
- Compared with 2009/2010, nursing home residents in 2014 have become older and sicker, having more health diagnosed illnesses.
- Regarding MFP:
  - DSS made significant improvements in 7 years in both the # of transitions and time to transition for MFP participants.
  - Despite some concerns from the field, transition outcomes for MFP participants with risk agreements are similar to other transitioners.
  - Risk factors such as cardiac/pulmonary and endocrine diagnoses, and also shorter length of time in preparing for transition, were more prevalent for MFP participants who died within 365 days of transition.
- The LTSS rebalancing ratio of home/community based care to nursing home/institutional care needs to be clarified, and costs better understood. Also,
  - If recalculated to include state-funded LTSS programs and MFP transitioners, then the rebalancing ratio becomes 63.1 percent community to 36.9 percent institutional care.

### PRI Staff Recommendations

**Improvements to LTSS data collection.** Clarify how MFP referrals, transitions, and challenges are captured. Report Nursing Home Registry information in a more useful manner, and require outcome data for fall prevention programs.

**Increased efficiencies to MFP program.** Establish maximum time for certain cases, clarify services available for non-demonstration participants, disseminate favorable outcome on MFP risk assessment participants, provide training on ADL/IADL assessment, ensure planning information is shared, and adequate planning occurs for those with particular risks.

**Calculation of rebalancing ratio.** Develop rebalance ratio for state use only, incorporating home health services, state-funded CHCPE participants, and MFP transitioners. Report LTSS costs in greater detail.

**Other improvements.** Expand the CHCPE care transition role currently provided in some hospitals, and monitor Medicaid waiver waitlists.

### Selected Other Medicaid State Plan Long-Term Services and Supports

As noted in Chapter 1, there are other DSS LTSS services and programs available under the regular Medicaid State Plan that were examined by PRI staff. These services or programs would be available to anyone who is Medicaid-eligible and meets the functional criteria for obtaining the service. In addition, as part of the state's LTSS system, a profile of nursing homes and resident characteristics are also described. Issues with comparing cost of care between the various Medicaid waivers that promote community based care and nursing homes is also discussed.

**Home health services.** Any individual who receives Medicaid-waiver services is also eligible for services under the Medicaid state plan, including home health services if needed. These services are not limited to elderly persons, but for example, could be used by any individual who experienced a hospital stay and needed additional at-home services upon discharge.

Medicaid reimburses medically necessary services provided by licensed home health agencies that are delivered in the home. In order to receive services, they must be ordered by a physician or nurse practitioner. The order is sent to a home health agency that will do an assessment of the client and work with the physician or nurse practitioner to complete an appropriate plan of care. Covered services include:

- nursing;
- home health aides;
- physical, occupational, and speech therapy; and
- nursing for high risk pregnancies .

*Service limitations.* DSS covers the services of a home health aide only when the aide is assisting with activities of daily living (ADL). ADLs are bathing, dressing, toileting, transferring, and feeding. The department will not pay for an aide to do housework or other chores, although an aide who is in the home to help with an ADL (for example, feeding) may perform some minor housework at the same time (for example, tidying up the kitchen).

In addition, prior authorization is needed from DSS for:

- all home health aide services in excess of 14 hours per week;
- all nursing in excess of 2 visits per week;
- all nursing in excess of 2 hours per day; and
- other services as described in department regulation.

The request for prior authorization must come from the home health agency that will be providing the service.

DSS does not track the number of individuals who receive home health services on a long-term basis to determine if DSS is providing LTSS through home health care only and in lieu of another LTSS program, or if these services are being leveraged along with other LTSS so that people are able to avoid nursing home or other institutional care. In its annual CHCP report, the department does try to provide a rough estimate of use of home health services by CHCP Medicaid-eligible recipients and attributes 22 percent of total home health costs to CHCP clients in its last report. However, there are many other individuals receiving LTSS in other LTSS programs. The Office of Policy and Management, through the Long-Term Care Planning Committee, also estimates the cost of home health services for all Medicaid programs, including those offered by DDS and DMHAS, at 60 percent of total home health expenditures.

Given that home health services under Medicaid is are another source of LTSS being provided by DSS, PRI staff believes attributing the dollar amount of these services is important because it does impact the cost of services delivered in the community. **Therefore, PRI staff recommends:**

**The Department of Social Services and the Office of Policy and Management should reach a consensus on the percent of home health service expenditures that be attributed to Medicaid state plan, Medicaid waiver, and state-funded recipients.**

**Community First Choice.** A relatively new Medicaid state plan program, introduced in July 2015, is called Community First Choice (CFC). It is an optional state plan service allowed under Section 1915 (k) of the Social Security Act and was established under the Affordable Care Act of 2010. This option provides a six percent increase in federal matching payments to states for service expenditures related to this option, in addition to the 50 percent FMAP. It is a reflection of the federal government's shift to providing individuals on Medicaid with a community option that is not part of a Medicaid waiver. Total expenditures in FFY 15, including federal Medicaid reimbursement of 50 percent, were \$2,857,754.

Medicaid beneficiaries who require nursing facility or other institutional level of care are eligible for CFC. Beneficiaries of this service must self-direct their community-based services using individual budgets, with the support of a fiscal intermediary. Self-direction means the person or someone they appoint makes the decisions regarding services. Program recipients have control over what services they want in their homes, and the responsibility for managing those services. Individual that are enrolled in CFC can hire from pools of qualified staff or they can hire certain family members and friends.

Services available under CFC include personal care assistants and other self-direction supports. These services can include—but are not limited to—help in self-hire personal care attendant; home delivered meals; emergency response system; support and planning coach; and assistive technology. Staff can be used to go out to community activities, and doctors' appointments, and provide help with errands. Family members, with certain exclusions, can provide services to the beneficiary.

As of August 31, 2016, DSS reported:

- 2,197 applications were received;
- 1,003 applicants were referred to an Access Agency;
- 383 service plans were submitted; and
- 313 service plans were approved.

If individuals who are currently on a waiver, but are also Medicaid eligible under the state plan and use self-directed Personal Care Assistants (PCA) on their waiver, they will automatically become CFC participants for the covered services.

### **Long-Term Services and Supports Provided by Nursing Homes in Connecticut**

The Office of Policy and Management maintains a Nursing Home Registry and provides information annually on the characteristics of nursing homes and the residents. According to the OPM registry, as of September 30, 2015, there were 230 nursing homes in the state with a private pay cost of \$407 per day in a semi-private bed, or slightly more than \$148,500 annually.

There were a total of 27,414 beds, a decline of eight percent since September 30, 2004. There were 23,842 residents, 499 fewer than on the same date in 2014 and 3,954 fewer than in 2004. Occupancy rates also continued to gradually decline. The average nursing facility occupancy rate statewide was 87 percent. In addition:

- the majority of residents were white (83 percent);
- female (67 percent);
- without a spouse (80 percent); and
- 65 years old or older (87 percent);
  - Of which 48 percent were age 85 or older.

In the past, OPM collected information on admissions, readmissions and discharges, as well as the number of ADL limitations nursing home residents had. Based on information from September 30, 1999, 73 percent of nursing home admissions and readmissions were from a general hospital, while the majority of discharges were either to home or a general hospital (35 percent and 36 percent respectively). PRI staff believes this type of information is useful to gauge progress on the rebalancing ratio and therefore **PRI staff recommends:**

**The Nursing Home Registry should capture information on admissions, readmissions, and discharges, as well as a summary of the number of activities of daily living limitations by resident. In addition, the Nursing Home Registry should report on individuals separately, counting those are considered short-term and are receiving rehabilitation versus those in the long-term care portion of a nursing home.**

*Significantly lower Medicaid rate paid to nursing homes.* The Medicaid rate paid to nursing homes is significantly lower than the private pay rate. As of July 1, 2015, the statewide average Medicaid rate was \$233 per day or \$85,045 for all non-specialized facilities compared to the private pay rate of \$400 for a semi-private room or slightly more than \$148,500 annually (as of September 30, 2014). The state receives 50 percent reimbursement for Medicaid residents. Based on 2013 data, the payor mix for clients residing in nursing homes was:

- 70.4% Medicaid;
- 13.3% Medicare;
- 10.9% private pay; and
- 5.4% other (e.g., veterans/N.Y. Medicaid).

### **Issues Regarding Comparing Costs of Community versus Nursing Home Care**

There are several differences between receiving LTSS in a home and community-based setting versus in a nursing home or other institutional setting. They are:

- nursing homes are residential facilities, and assume total care of the individuals who are admitted;
- the per diem fee includes include room and board, as well as most other services;
- Medicaid services received under community-based programs are specifically prohibited from including room and board;
- the services received are billed and reimbursed as a single bundled payment rather than on an individual fee-for-service basis; and
- nursing homes must be licensed and certified by the state, according to federal standards and must undergo periodic survey to maintain their certification and license to operate.

Based on testimony provided to the PRI committee at its September 21, 2016 hearing, services provided under the Medicaid program to residents in nursing home facilities on a twenty-four hour/seven days a week basis include:<sup>1</sup>

- skilled nursing care
- routine nursing care
- personal care
- physical therapy
- occupational therapy
- speech pathology
- clinical care supervised by a licensed medical director
- three meals a day
- housekeeping and laundry services
- recreational activities;

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<sup>1</sup> Connecticut Association of Health Care Facilities, Inc. September 21, 2016 PRI public hearing, submitted written testimony.

- social services by licensed personnel
- durable medical equipment
- housing
- supplies and specialized medical equipment
- incontinence care
- 24-hour monitoring
- 24-hour RN care available
- All housing related costs.

Actual net state Medicaid expenditure per day is \$74, once federal matching funds, applied income, and a nursing home provider tax are deducted for a net annual state cost of \$27,010.

Nany of the Medicaid waivers allow the plans of care to exceed 100 percent of institutional care and therefore, for some individuals, the costs of community care is likely much higher than institutional care. Table 4-1 shows the maximum annual cost of care under Medicaid waiver or CHCP programs ranges from \$17,488 to \$798,240. For institutional care, the average annual cost was \$69,816 for nursing home care, \$177,379 for ICF/IID, and \$406,008 for chronic disease hospital care that for some individuals, it can be more expensive to receive LTSS in the community compared to nursing home/institutional care. More detail on each waiver and the state-funded CHCP maximum annual cost limits for an individual's plan of care are shown in Appendix D.

<i>Source of LTSS</i>	<i>Type of Institution</i>			<i>Maximum Annual Cost Limit in 2016</i>
	NH	CD	ICF/IID, Other	
CHCPE Category 1	√			\$17,448
CHCPE Category 2	√			\$34,908
<b>Nursing Home</b>				<b>\$69,816<sup>1</sup></b>
Katie Beckett	√	√	√	\$69,816-\$399,124
CHCPE Category 3	√			\$80,280
PCA	√			\$80,280
Mental Health (WISE)	√			\$87,270
ABI II	√	√	√	\$104,724-\$598,687
ABI I	√	√	√	\$139,632-\$798,240
<b>ICF/IID</b>				<b>\$177,379</b>
DDS Comprehensive			√	\$252,363
<b>Chronic Disease Hospital</b>				<b>\$406,008</b>

<sup>1</sup>This average is lower than the \$85,048 Medicaid reimbursement rate cited above because the average applied income is deducted from the full Medicaid reimbursement rate. (i.e, the amount the applicant must "contribute to the cost of care,").

Source: Department of Social Services



While it is likely that, on average, the costs of care under the waivers is much lower than the cost maximums, this information should be available. The state has already committed to a philosophy of promoting community care for individuals<sup>2</sup>, however, the true costs of those services have never been compared. Therefore, to fully understand the cost to Connecticut of LTSS in the community versus institutions, **PRI staff recommends:**

**The Department of Social Services should conduct an analysis of the distribution of individuals by costs, grouped into cost ranges, for each Medicaid waiver program. A summary of the department's findings should be provided to the legislative committees of cognizance, including the Joint Committee on Appropriations, subcommittee on Human Services.**

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<sup>2</sup> C.G.S. Section 17b-337(a) states: that Connecticut's long-term care "policy and plan shall provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting."