February 27, 2015

Written testimony of Matthew V. Barrett, Executive Vice President of the Connecticut Association of Health Care Facilities (CAHCF), Inc. concerning the Governor's FY 2016 and FY 2017 Budget Recommendation

Good evening Senator Bye, Representative Walker and to the members of the Appropriations Committee. My name is Matthew V. Barrett. I am Executive Vice President of the Connecticut Association of Health Care Facilities (CAHCF).

I am here this evening with a simple message from our one hundred and sixty member association of skilled nursing facilities and rehabilitation centers (SNFs), and on behalf of the residents and their caregivers: *Our nursing facilities need your help.* CAHCF is very mindful and understanding of Connecticut's fiscal challenges, but at a time when we need our state government most to help us maintain the quality of care that we are known for, and required of us, we have to continue to speak up. For example, in the last biennial budget, SNFs were cut $53.4 million in FY 2014 and $81.0 million in FY 2015 from the current services budget. An additional nursing facility funding cut of $11.0 million in FY 2014 and $14.8 million in FY 2015 was only partially restored, leaving a $5 million reduction. Nursing facility rates were cut at a time while operating costs continue to move upwards, such as health insurance, food, property taxes, wages, repairs and utilities.

Unfortunately the FY 2016 and FY 2017 Budget Recommendation now before the Appropriations Committee represents a continued threat to the mission of the SNF sector. Specifically:

"Reduce Medicaid Provider Rates
This proposal reduces Medicaid rates for most providers. The department will have discretion as to the distribution of this reduction. This proposal does not impact federally qualified health centers which are reimbursed under a federally prescribed payment system. To help with access to primary care services, rates for primary care services are not expected to be reduced. Savings figures reflect the state's share of Medicaid expenditures. After factoring in the federal share, this proposal will reduce total Medicaid expenditures by $107.5 million in FY 2016 and $117.5 million in FY 2017.

Remove Statutory or Regulatory Inflation Adjustments

Effective July 1, 2015 and July 1, 2016, recipients of Temporary Family Assistance, State Administered General Assistance, and Aid to the Aged, Blind and Disabled are scheduled to receive a state-funded cost of living adjustment based on the percentage increase in the Consumer Price Index - Urban. This proposal eliminates the standards increases for the biennium. In addition, under current statute or regulation, DSS is required to provide funding for an inflationary increase for nursing homes, intermediate care facilities for individuals with intellectual disabilities and boarding homes. This proposal eliminates these increases over the biennium. Savings figures reflect the state's share of Medicaid expenditures ($6.9 million in FY 2016 and $17.8 million in FY 2017). After factoring in the federal share, this proposal will reduce total Medicaid expenditures by $13.8 million in FY 2016 and $35.6 million in FY 2017."

In response to the biennial budget recommendation, I would like to simply point to the public record and body of evidence collected by the Human Services Committee earlier this session at its February 5, 2015 public

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hearing considering several bills to provide a COLA or other cost adjustments for Connecticut SNFs. At that hearing, the committee heard testimony on Proposed H.B. No. 5586 AN ACT INCREASING NURSING FACILITY RATES; Proposed H.B. No. 5812 AN ACT CONCERNING A COST OF LIVING INCREASE FOR NURSING FACILITIES; and Proposed S.B. No. 231 AN ACT CONCERNING COST-OF-LIVING INCREASES FOR NURSING HOMES. This legislation has been favorably reported by the Human Services Committee to the Appropriations Committee.

The bills address the same issues of the proposed biennial budget. Medicaid Nursing facility rates have been basically flat since 2007, but costs have been dramatically rising. The bills address the fundamental problem of the escalating cost of proving high quality health care by increasing payments based on a cost of living adjustment. Dozens of skilled nursing facilities from all across Connecticut have submitted testimony or have appeared in person at the February 5, 2015 public hearing to express what this dilemma means where the care is actually delivered---at the skilled nursing facility.

The message from the operator's point of view was plainly expressed at the hearing----they need your help. The skilled nursing facilities just can't continue on a path where no help is provided without strapping our employees and jeopardizing quality. Scores of SNFs are also present this evening to communicate a similar message.

In addition, in late 2014 the CAHCF formed a workgroup consisting of individuals in the following disciplines: legal, operational, clinical, finance and reimbursement from the skilled nursing facility sector . Over the course of several weeks the workgroup collaborated to identify and quantify uncontrollable annual cost increases incurred from October 1, 2011 by a typical 120-bed nursing facility located in Connecticut. The date of October 1, 2011 was chosen as it represents periods subsequent to the latest period used to rebase Medicaid rates for the nursing facilities.

Preliminary findings indicate that, with respect to the uncontrollable annual cost increases, the typical 120-bed nursing facility would incur approximately $89,500, consisting of:

- Electricity Rates - $17,000
- Natural Gas Rates – $12,000
- FUTA Credit Reduction - $16,000
- Affordable Care Act - $39,000
- Encryption Software (HIPPA) - $500
- Criminal Background Checks - $5,000

The workgroup has not finished its analysis as of the date of this report. Additional identifiable and quantifiable costs are anticipated which are likely to include those associated with the following:

- PA 13-70 Training staff about fear of retaliation
- PA 14-194 Dementia training
- PA 14-231 Oral health and hygiene training
- PA 13-208 Section 3 Background checks for volunteers

Connecticut nursing facilities remain in a period of ongoing financial distress. Medicare reductions in 2012 were as high as 16% in many Connecticut nursing homes. Further, nursing homes were cut an additional 2% in the Medicare sequestration in 2013. At the state level, the gap under Medicaid between providing care and its costs is widening dramatically. This year nursing home providers will on average be reimbursed $25.43 per patient day less than what it costs to care for our residents. For the typical nursing facility, this represents over $500,000 per year in unfunded costs. There has been no general Medicaid rate increases in the system since 2007, except for increase made possible by raising the user fees paid by nursing homes themselves (again, cut by $5 million in the 2013 legislative session).

This follows a sustained period of nursing facility receiverships, bankruptcies, closures, and Medicaid hardship rate relief requests. Yet there are 1 million baby boomers in Connecticut. There are 600,000 residents in Connecticut over the age of 60. Connecticut's aging population is among the oldest in the Nation, with over 160,000 Connecticut citizens over the age of 80 according to a December 2012 report issued by the U.S. Census Bureau. Much is being asked of our nursing facilities today, and more will be asked in the future, given the dramatic aging of our population. As the state continues in the direction of long term care rebalancing and rightsizing, these changes will mean that the acuity and numbers of nursing facility residents will continue to rise measurably as our population ages, even as more residents choose home and community based environments to receive their care. However, the state's rightsizing initiatives are not keeping pace with their expressed goals.

In this regard, CAHCF is advancing a proposal to accelerate the state's long term care rebalancing goals with a voluntary nursing home bed reduction initiative modelled after successful programs in Massachusetts and Rhode Island. Connecticut can and should include this type of initiative among the various efforts now underway. If adopted, a voluntary bed reduction program with offer increased stability to SNFs experiencing low census as an alternative to closure. At once, limiting bed supply will accelerate home and community based services placements under the Money Follow the Person Program, with resulting savings for the Connecticut state budget. The proposal and details on the models are attached to this testimony. In addition, S.B. 899 AAC VOLUNTARY BED REDUCTIONS AT NURSING HOME FACILITIES is legislation before the Human Services Committee that we hope will be favorably reported to the Appropriations Committee.

I would be happy to answer any questions you may have.

For additional information, contact: Matthew V. Barrett, Executive Vice President, mbarrett@cahcf.org or 860-290-9424.

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.

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