

March 5, 2015

Written testimony of Matthew V. Barrett, Executive Vice President of the Connecticut Association of Health Care Facilities (CAHCF), and Mike Mosier, Chief Financial Officer, Athena Health Care in Support of S.B. No. 899 AAC VOLUNTARY BED REDUCTIONS AT NURSING HOME FACILITIES

Good afternoon Senator Moore, Representative Abercrombie and to the members of the Human Services Committee. My name is Matthew V. Barrett, Executive Vice President of the Connecticut Association of Health Care Facilities (CAHCF), our state's one hundred and sixty (160) member trade association of skilled nursing facilities and rehabilitation centers (SNFs). Thank you for this opportunity to offer testimony this afternoon in support of S.B. 899 AAC VOLUNTARY BED REDUCTIONS AT NURSING HOME FACILITIES. I am pleased to be joined this afternoon by Mike Mosier, the Chief Financial Officer at Athena Health Care. Mike's participation in today's testimony is very important because Athena has considerable experience with the voluntary bed reduction models being advance in SB 899 as they are based on models operated in Rhode Island and Massachusetts where Athena also has SNFs in addition to their corporate home and significant SNF presence in Connecticut.

S.B. 899 offers Connecticut a reasoned and planned approach to the voluntary reduction of licensed SNF beds. Efforts to move Medicaid recipients out of more costly SNF settings and into more affordable home and community based environments in such programs as the state's hallmark Money Follows the Person (MFP) have been very challenged to meet their expressed goals. For example, the MFP Demonstration Grant was to transition some 5200 SNF residents to home and community based settings by 2016. In the MFP program's Quarter 4, 2014 report, 2408 demonstration consumers transitioned. Last week, DSS reported that they anticipated 700 new transitions in 2015 and 850 in 2016 due to a recent reorganization of the MFP program. These ambitious new DSS transition estimates represent a considerable increase from the current transition experience in the program. At once, the remaining SNF population is anticipated to have higher acuity and more complex needs than so far experienced in the MFP program.

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. However, CAHCF wants to be very clear. This is not an argument against the value and importance of the MFP program. This is an argument for the need of a responsible voluntary bed reduction program.

In general, SB 899 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 higher occupancy rate. Residents in de-licensed occupied beds would, if they chose, transition to another nursing facility within a 15 mile radius or to MFP.

Attached to this testimony is a detailed example of how the models would work for a typical 120 bed SNF, including information on the Rhode Island and Massachusetts' models. In summary, 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 increase the facility's occupancy rate, the facility could reduce its capacity to 109 beds (108/.99). However, under this 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 public policy reasons for advancing a long term care rebalancing strategy are well known. 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.

A responsible voluntary SNF bed reduction program can help advance these goals.

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

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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-license 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 higher occupancy rate. Residents in de-licensed occupied beds would, if they chose, transition to another nursing facility within a 15-mile radius 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 increase the facility's occupancy rate, the facility would reduce its capacity to 109 beds ($108/.99$). However, under this 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,

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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.

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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:

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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:

	<u>Existing</u>	<u>Revised</u>	<u>Increase</u>
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	<u>\$3.33</u>
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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(CAHCF SNF Bed Reduction 0223215)