CAHCF/CCAL

Connecticut Association of Health Care Facilities
Connecticut Center for Assisted Living

March 4, 2021

Written testimony of Matthew V. Barrett, President and CEO of the Connecticut Association of Health Care Facilities / Connecticut Center For Assisted Living (CAHCF/CCAL) concerning H.B. No. 6446 AN ACT CONCERNING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES / Section 7

Good afternoon Senator Moore, Representative Abercrombie and to the distinguished members of the Human Services Committee. My name is Matt Barrett. I am President and CEO of the Connecticut Association of Health Care Facilities and the Connecticut Center For Assisted Living (CAHCF/CCAL). CAHCF/CCAL is a one-hundred and sixty member trade association of skilled nursing facilities and assisted living communities. Thank you for this opportunity to offer comments in opposition to the July 1, 2021 initial transition to a Medicaid acuity-based payment system in Section 7 of the bill.

A Budget Neutral Transition to a Medicaid Acuity Based Payment System Won't Achieve Higher Quality, Adequacy of Staffing, and Improved Resident Outcomes

CAHCF is supportive of a transition to a cost-based acuity payment system. However, such a system will not support improvement in quality, adequacy of staffing and resident outcomes unless it is adequately funded and is not based upon budget neutrality as proposed. Therefore, CAHCF recommends that this major reform in the nursing home rates be postponed until SFY 2023. Instead, the focus, attention and resources of the state and our nursing homes must remain on getting to the other side of the COVID-19 pandemic through policies and resources to rebuild nursing home census and financial stability. As background, CAHCF estimates the longstanding Medicaid funding shortfall to nursing homes is now $135 million. Further, CAHCF estimates that to address the unprecedented 14% occupancy decline now being experienced due to the pandemic would require bridge funding in the amount of $177 million.

Moreover, no new state resources are recommended for the acuity-based payment system in the Governor's proposed budget recommendation, let alone resources to address these longstanding and current underlying funding issues. Regrettably, nursing home funding is flat in the Governor's biennial budget recommendation now before the Appropriations Committee.

CAHCF believe that in order for an acuity-based system to improve quality, adequacy of staffing and resident outcomes, it must adequately funded, it must be based upon cost data, census information, and acuity scores reflective of nursing home operations post COVID. It cannot be based upon data trended from 2018. Occupancy in nursing homes is down 14 percentage points from FY19 meaning per diem costs are much higher in FY20 and FY21 than per diem costs from 2018 trended to FY22.

The new case-mix system is currently planned to be "budget neutral" - which we believe automatically means it too will be underfunded, but by what level we do not yet know. Therefore, if we do not increase the current level of funding, the new system will not be allowed to work as designed and will not meet the stated objective of appropriately funding high acuity care. The current funding will just be reallocated within the system, but not at the rate levels needed. As a result, we fear that many quality nursing homes may be negatively affected by a reduction in their rates and others will not receive the funding necessary to cover the cost of caring for higher acuity residents.

Similarly, it will be essential that the performance incentive payments, which are a hallmark feature of the proposed case mix system, be funded with additional resources. Given the demonstrated underfunding now present in the system, we believe it would significantly undermine the very objective of quality improvement if incentive funds were diverted from existing underfunded resources.

Once more, it is imperative to use the most current post-COVID data in acuity-based rate setting. Using outdated cost, census and payer mix information to establish acuity-based payment will result in nursing rates that are not commensurate with facilities' current cost structures and payer mix and is not going to improve quality, adequacy of staffing and resident outcomes.

CAHCF has the following additional recommendations in addition to the delay until SFY 2023:

State Legislative Committees of Cognizance Oversight and Approval Process. The submission and approval of the Connecticut General Assembly's legislative committees of cognizance (Appropriations, Human Services and Public Health Committees) of a case mix Medicaid state plan amendment (SPA) to CMS, and the adoption of state regulations, before the Department of Social Services (DSS) may implement a Medicaid case mix based payment system for Connecticut nursing facilities.

Requirement Components of the Case Mix SPA. A requirement that the SPA submission to the legislative committees and to CMS to include the major components of the case mix system and the assurance that the case mix system is adequately funded to assure access and quality nursing facility care.

For additional and more detailed analysis please see the attached presentation: *CAHCF Recommendations of Transitioning to an Acuity-Based System* (March 1, 2021).

For these reasons, CAHCF recommends the case mix reforms be delayed until SFY 2023

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

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

CAHCF Recommendations on Transitioning to An Acuity-Based System

March 1, 2021

Improving the Process

- CAHCF Suggests Greater Collaboration and Less Formality
  - More Frequent and Collaborative Meetings/Calls to Address Methodology and System Parameters, Alternative Options, Data Requirements, Implementation Timeline, and Phase-in Approaches Similar to That Used in Numerous Other States That Have Redesigned Their System
  - Make the Process Collaborative Rather Than The State Simply Developing a Model With Limited Provider Involvement
  - Allow Discussion And Exchange of Ideas and Options Between State and Industry Consultants Rather Than the More Formal Requirement That All Comments and Questions Must Be In Writing and Provided to the State
  - Develop Models That Will Achieve Goals of Improved Quality, Access, Enhanced Staffing and Resident Outcomes Without Attempting to Fit the Models into a Cost Neutrality Budget. Other States Have Provided Additional Funding and/or Federal Maximization Programs to Help Fund New Methodologies. Seldom are These New Systems Budget Neutral

Requirements for An Acuity-Based System to Improve Quality, Staffing Adequacy and Resident Outcomes

- System Must Be Adequately Funded
- Cannot Be Based Upon Budget Neutrality
- Reflective of Current Nursing Home Operations Relative to Cost, Census, Acuity Scores and Patient Mix
  - Cannot Be Based Upon Old Data (2018 Cost Reports)
- Especially Relevant With Significant Changes in Nursing Home Operations Due to COVID
  - Occupancy Down 14%
  - Costs Per Patient Day Have Increased Dramatically-Higher Costs Spread Over Fewer Days

Requirements for Acuity-Based System to Improve Quality, Staffing Adequacy and Resident Outcomes (Continued)

- Especially Relevant With Significant Changes in Nursing Home Operations Due to COVID (Continued)
  - The Significant Decline in Medicare Patients Materially Impacts the Calculation of Patient Acuity and Would Increase Payment For Medicaid Residents-This Will Not Be Accounted For In A Model Based Upon Pre-COVID Costs and Patient Mix
  - Behavioral Health and other High Acuity Program Add-Ons

Why States Implement Cost-Based Acuity Model

- Greatest Benefit is to Better Identify the Nursing Cost Of Medicaid Patients Rather Than Dividing Nursing Costs Evenly Across All Patients
  - That is the Primary Reason 33 States and DC Have Implemented Case Mix Systems
- Cost-Based Acuity Systems Only Result in Higher Reimbursement For Facilities if:
  - The Facility Has High Medicaid Acuity on Average; and
  - The Facility Has High Cost-Higher Than Maximum Nursing Rates Under a Non-Acuity-Based Model; and
  - The Facility Has Lower than Average Medicare Volume; and
  - The State is Willing to Pay For Quarterly Increases in Acuity Rather Than Imposing Cost Neutrality Limitations on This Adjustment
  - Very Few Facilities Meet These Criteria

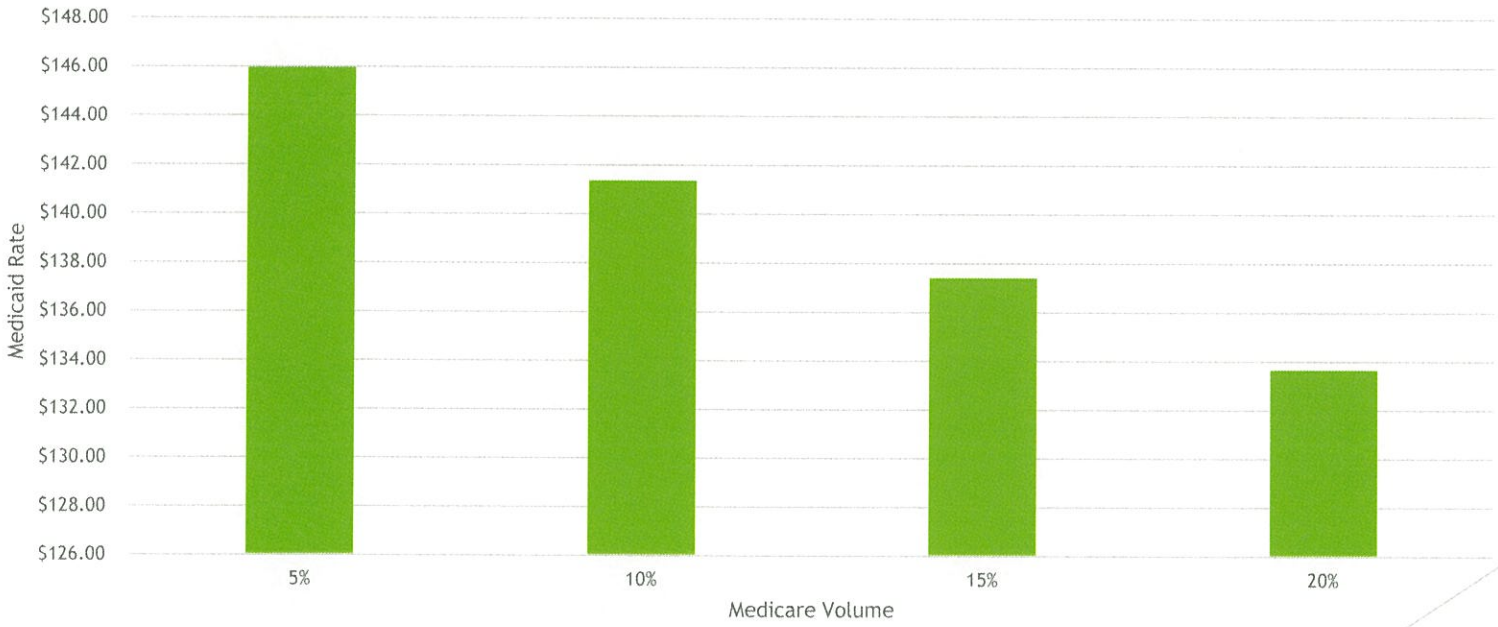
Key Factors Driving Acuity-Based Payment

- The Acuity System Being Used Which Determines the Relative Difference in Nursing Resource Requirements of Patients Based Upon the Patient's Clinical and Functional Deficits
  - The Decades-old System Most Commonly Used Is Being Sunsetted by CMS and Most States Will Adopt the Replacement System Over the Next Few Years
- Facility Nursing Per Diem Cost-Which Has Changed Dramatically since COVID
- Average Medicaid Acuity
- Number of Medicare Patients in the Facility-The Higher the Number of Medicare Patients (Who Typically Have the Highest Acuity Scores), the Lower the Allocation of Nursing Per Diem Cost to Medicaid Patients and the Lower the Medicaid Nursing Component Rate
  - The Number of Medicare Patients in Facilities Has Dropped Significantly Since COVID. Since This Number is So Vital In Allocating Nursing Costs Between Medicaid and Non-Medicaid Patients, Using Current Cost and Census Information in Calculating Nursing Component Rates is Imperative

Impact of Acuity-Based System On Nursing Payment and an Example of a Change In the Number of Medicare Patients

Pre-COVID		Post-COVID	
Nursing Per Diem Cost	$150.00	Nursing Per Diem Cost	$150.00
Average Medicaid Acuity Score	0.9	Average Medicaid Acuity Score	0.9
Average Acuity Score For All Patients-Medicare patients represent 15% of Resident days	.983	Average Acuity Score For All Patients-Medicare patients represent 8% of Resident days	0.944
Ratio of Medicaid Acuity to Total Acuity	0.916	Ratio of Medicaid Acuity to Total Acuity	0.953
Nursing Component Reimbursement	$137.40	Nursing Component Reimbursement	$143.01

Medicaid Rates At Varying Volumes of Medicare Utilization Based Upon a Nursing Per Diem Cost of $150



Patient Classification into Particular Acuity Levels are Changing

- This Will Primarily Impact the Acuity Level and Scores for Medicare Patients, Most Likely Lowering Them
- This Will Increase the Nursing Cost Allocation to Medicaid Patients and Nursing Rates
- Acuity-Based System Implementation Should Be Delayed Until:
  - **Full Transition to the New Classification System to Insure a More Accurate Allocation of Nursing Cost Between Medicaid and non-Medicaid Patients**
  - **Post Pandemic Stabilization.**

CAHCF Recommendations

- CAHCF Supports Implementation of an Acuity-Based System if:
  - It is Based Upon Current Costs, Census, and Payer Mix With Funding Adequacy Based Upon This Data. Using Pre-COVID Cost and Census Data will Materially Understate Both the Cost of the New System and the Allocation of Nursing Cost to Medicaid Patients
  - It Utilizes the New Classification Methodology (Patient-Driven Payment Model) for Nursing Classification and Acuity Scoring Which Will Result in a More Accurate Allocation of Nursing Costs to Medicaid Patients
  - Quarterly Adjustments to Rates Based Upon Changes in Medicaid Patient Acuity are Fully Funded and Not Subject to Budget Neutrality
- State Plan Amendment (SPA) and legislative committees of cognizance review consideration