CAHCF/CCAL
Connecticut Association of Health Care Facilities
Connecticut Center for Assisted Living

**March 5, 2024**

**Testimony of Matt Barrett, President and CEO of the Connecticut Association of Health Care Facilities / Connecticut Center For Assisted Living (CAHCF/CCAL):**

Good afternoon Senator Hochadel, Representative Garibay, and to the members of the Aging Committee. My name is Matthew Barrett. I am President and CEO of the Connecticut Association of Health Care Facilities and the Connecticut Center For Assisted Living (CAHCF/CCAL). Thank you for this opportunity to testify on H.B. No. 5001 An Act Supporting Connecticut Seniors and the Improvement of Nursing and Home-Based Care.

We are grateful that Speaker Ritter and the Aging Committee leadership has put a strong focus on nursing home quality improvement in this comprehensive aging services proposed legislation. This is a common goal that nursing home providers have as well, and we agree that a comprehensive approach creates a real opportunity for advancing meaningful quality improvement measures this session.

**Section 9 (c) - DSS Authority to reduce Medicaid rates when CMS 2 Star or fewer in the three most recent reporting periods and Section 10.**

For this reason, we recommend staying the course on the comprehensive development of the nursing home quality improvement approach, referred to as a Value Based Payment (VBP) component, that is now significantly under development, rather than the Medicaid rate reductions presented in sections 9 and 10.

As background, state Medicaid programs have historically used a Medicaid fee-for-service (FFS) reimbursement model for reimbursing nursing homes, which is a flat fee based on allowable costs, and commonly adjusted for the acuity of the residents. However, these per diem payments have traditionally been made unrelated to the quality of care that is provided. Former DSS and DPH commissioner Deidre Gifford set in motion two major payment reforms in this

area---first, to adjust rates based on the acuity of the resident population, and second, as a means to incentivize quality improve, the development and implementation of quality benchmarks in the rates.

The Connecticut Department of Social Services (DSS) development of a VBP payment component in the rates is now significantly underway The VBP approach, since its inception, has been linked to the now implemented rate reform aligning the acuity of the resident population (acuity-based payments or case mix), now in its second phase of implementation in Connecticut. The goal is straightforward: align facility payments with incentives for better resident outcomes using quality measures that the facilities will be held accountable to achieve.

The currently proposed VBP under development has harsh consequences for lower performing facilities. While we are advocating for broader participation for nursing homes struggling to achieve the quality benchmarks, the current model now excludes the lowest performing facilities (referred to as special focus facilities), and those that experienced a deficiency that qualifies for a CMS finding of abuse. Moreover, the critically-important funding pool for VBP has not yet been identified, and Connecticut nursing homes remain opposed to funding quality improvements achieved by better performing facilities from Medicaid cuts to lower performing facilities.

Nevertheless, the VBP program under development represents a modern and comprehensive approach to rate-setting in that it rewards quality improvement aligned with the acuity-based payment reform in the rates. See also: https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Nursing-Home-Reimbursement/Nursing-Home-Reimbursement-Acuity-Based-Methodology

This type of approach is being implemented in some thirty states now. We are recommending that Connecticut continue to develop the VBP payment model, which also includes a customer satisfaction component in the model (called CoreQ). The model is currently in a testing phase nursing facilities for implementation for potential implementation in the next biennium.

The state legislature has set oversight parameters for the developing VBP program in the prior session under Section 17b-340d (2). This includes a full report to be submitted not later than

June 30, 2025 to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services on the quality metrics program. The report must include information regarding individualized reports and the anticipated impact on nursing homes if the state were to implement a rate withhold on nursing homes that fail to meet certain quality metrics. Since this report may be submitted while the state legislature is not in session in 2025, we recommend that full implementation of a VBP system be authorized no sooner than July 1, 2026 so that the Connecticut General Assembly will have a full legislative session to evaluate the implications of the VBP program, including the adequacy of the funding associated with the program.

Toward clarifying the VBP payment schedules and timelines now in the statute, and including the customer satisfaction component that is now a feature of the developing model, we are recommending the following revisions to this section to section 9 and 10:

**Proposed Substitute for Section 17b-340d (2):**

(2) Beginning July 1, 2022, facilities will be required to comply with collection and reporting of quality metrics as specified by the Department of Social Services, after consultation with the nursing home industry, consumers, employees and the Department of Public Health. Rate adjustments based on performance on quality metrics**, including a customer satisfaction component,** will be phased in, beginning July 1, 2022, with a period of reporting only**, with implementation authorized no sooner than July 1, 2026**. Effective July 1, 2023, the Department of Social Services shall issue individualized reports annually to each nursing home facility showing the impact to the Medicaid rate for such home based on the quality metrics program. A nursing home facility receiving an individualized quality metrics report may use such report to evaluate the impact of the quality metrics program on said facility's Medicaid reimbursement. Not later than June 30, 2025, the department shall submit a report, in accordance with the provisions of section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services on the quality metrics program. Such report shall include information regarding individualized reports and the anticipated impact on nursing homes if the state were to implement a rate withhold on nursing homes that fail to meet certain quality metrics.

**Section 6 and 7 - Department of Social Services and Department of Public Internet web site link to the Medicare online Nursing Home Reporting Tool.**

The provisions of sections 6 and 7 should be adopted as the broader distribution of the CMS Nursing Home Care Compare website found at https://www.medicare.gov/care-compare is

a very important tool for both consumers, providers, advocates, lawmakers and public officials. CAHCF/CCAL includes a link to this on the association website.

In CMS' own words:

> CMS created the Five-Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes more easily and to help identify areas about which you may want to ask questions. The Nursing Home Care Compare web site features a quality rating system that gives each nursing home a rating of between 1 and 5 stars. Nursing homes with 5 stars are considered to have much above average quality and nursing homes with 1 star are considered to have quality much below average. There is one Overall 5-star rating for each nursing home, and separate ratings for health inspections, staffing and quality measures.

**Section 8. – Plan to expand fingerprinting locations in the state for persons requiring state and national criminal history records checks**

A plan to expand fingerprinting locations in the state to facilitate greater access with assist in expediting employer hiring and should be adopted.

**Section 34. – DPH study of current practices used by skilled nursing facilities to diagnose a resident with a cognitive disorder.**

We are recommending substitute language to this section to correctly state that the study be directed to the current practices of physicians and other appropriately qualified and licensed practitioners to diagnose an individual with a cognitive disorder who resides in skilled nursing facilities or whose diagnosis was made prior to admission in a skilled nursing facility because the bill incorrectly provides that skilled nursing facilities diagnose cognitive disorders. Nursing homes are not authorized under the law to diagnose. Moreover, the study should include a review pf the federal law governing these state matters and the role of the state contractor implementing these provisions for the Connecticut Department of Social Services (DSS). Finally, because DSS is responsible under state and federal law for the PASSR process, the study should be implemented by both DPH and DSS.

**CAHCF Recommended Substitute Language for Section 34 of H.B. No. 5001:**

Sec. 34. (*Effective from passage*) The Commissioner of Public Health and the Commissioner of Social Services shall conduct a study regarding current practices of physicians and other appropriately qualified and licensed practitioners to diagnose an individual with a cognitive disorder who resides in a [used by] skilled nursing facilities or whose diagnosis was made prior to admission in a skilled nursing facility [to diagnose a resident with a cognitive disorder]. Such study

shall include, but need not be limited to, (1) identification of the type of health care provider commonly making such diagnoses, (2) an examination of the procedures and assessments used to make such diagnoses and whether such procedures and assessments are consistent with recognized standards for the diagnosis of cognitive disorders, (3) an assessment of whether health care providers are commonly obtaining the resident's informed consent before conducting any cognitive disorder assessment, [and] (4) recommendations to correct any deficiencies in the current practices of physicians and other appropriately qualified and licensed practitioners to diagnose an individual with a cognitive disorder who resides in a skilled nursing facilities or whose diagnosis was made prior to admission in a skilled nursing facility [used skilled nursing facilities to diagnose a resident with a cognitive disorder that were identified pursuant to the study], (5) a review of the federal Preadmission Screening and Resident Review (PASRR) process pursuant to 42 C.F.R. § 483.100 – 483.138., including a review of the policies and procedures of the State of Connecticut and its contractor for PASRR and the determination of medical necessity, and (6) a review of federal law found at 42 C.F.R. § 483.20(b)(1) which requires all nursing homes to engage physicians and other clinical practitioners to perform "a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by the federal Center for Medicare and Medicaid Services.

Thank you.

*For additional information on this testimony, please contact Matt Barrett, President and CEO of CAHCF/CCAL, at mbarrett@cahcf.org.*