



**Testimony of the
Connecticut Association of Not-for-profit Providers For the Aging
Presented to the Human Services Committee
March 11, 2008
Regarding**

Senate Bill 662, An Act Concerning Medicaid Eligibility and Reimbursement

CANPFA members serve thousands of people every day through mission-driven, not-for-profit organizations dedicated to providing the services people need, when they need them, in the place they call home. Our members offer the continuum of aging services: assisted living residences, continuing care retirement communities, residential care homes, nursing homes, home and community-based services, and senior housing.

Good morning Senator Harris, Representative Villano, and members of the Committee. My name is David Houle and I am the Chief Financial Officer of Hebrew Health Care in West Hartford. I am here today to speak on behalf of the Connecticut Association of Not-for-profit Providers for the Aging (CANPFA), regarding the various aspects of **Senate Bill 662, An Act Concerning Medicaid Eligibility and Reimbursement.**

Section 14 – Pending Medicaid Payment Pool

I know that you are all aware of the fact that an increasing number of nursing home residents are being cared for during extending periods of non-payment due to their "Medicaid pending" status. These are residents who have exhausted their private funds and have applied for Medicaid assistance by submitting a Medicaid application to the state. Once the application is submitted, the residents and the nursing homes must wait for the Department of Social Services to review and verify the information. Unfortunately, this is a very complicated and tedious process and the time it takes to complete an eligibility verification – for various reasons - is becoming longer and longer. And as you can imagine, it is causing a severe cash flow crisis for many nursing homes. The extended pending status of just a few Medicaid residents can cause great uncertainty in the daily financial operations of a facility.

While I have testified to this situation in the past, the problem remains and the fact is that both the state and the nursing home are very often at the mercy of the resident, their family, or their responsible party to provide the necessary financial documentation or to carry out the financial transactions necessary to qualify the resident for Medicaid. That is why the concept of creating a pool of funds that could be used to advance payments to nursing homes that are caring for residents with pending applications would be a welcome resolution to the cash flow needs.

Section 1-Medicaid Eligibility

We also support the modifications to the current review and eligibility process proposed in Section 1 (NEW) (k) of this bill which would alleviate another consequence of the pending application problem and that is the lingering “unresolved asset”. We run into this situation in the nursing home setting when an application is reviewed within the 45-day time period and a disqualifying asset is discovered. This can be *any* asset valued at over \$1,600 - such as the \$1,900 whole life policy that was discovered with one of our residents. For every month that a disqualifying asset is not cashed in or spent down by the resident – that is another month of ineligibility for Medicaid. So, as in the case of the whole life policy, if the family or the resident ignores the issue, delays taking action, or is unable to quickly liquidate the asset, the application can go ungranted for months and even years. And the resident accumulates a bill that is owed to the nursing home by the resident, not the state, and the resident does not have the resources to pay it. In the case of the whole life policy, the policy was worth only \$1,900 – but the accumulated outstanding bill owed to the facility was \$63,000.

CANPFA strongly supports this modification to the review and eligibility process that would resolve this issue. If adopted, the nursing home would be eligible to receive payment from the state after the otherwise eligible resident incurred a debt to the nursing home equal to the amount of the disqualifying asset. This would limit the nursing home’s exposure to just the amount of the outstanding asset of under \$10,000.

Section 11-Medicaid Audits

While Section 11 of this bill speaks to modifications to the home care claims audits; we encourage the Committee to make similar modifications to the nursing home cost report audits. Our suggestion would not remove or reduce the auditing oversight of nursing homes, but would require that the audits be done within two years. By requiring that the audit function be done sooner rather than later, the state would actually improve their oversight of nursing homes because any discrepancies in the cost reporting would be identified up to five years sooner than the current practice. We have submitted this same testimony in the past and we continue to encourage you to consider requiring that Department of Social Services perform their audits of nursing homes in a timely fashion.

Currently the Department has up to seven years to perform an audit of the cost report. The providers, and particularly the smaller providers, are at a disadvantage when their cost reports are audited after such a long period of time. The documentation requirements for such an audit are very strict and a late audit may require hard copy financial documentation of invoices and cancelled checks from over ten years ago. The hours of staff time spent researching and retrieving documentation for an overdue audit can be very costly for a facility. As you can imagine, the changes in staffing, software and bookkeeping systems over the years can exacerbate this problem. And most upsetting, when a bookkeeping error is found after ten or so years, the extrapolation of that error can mean thousands of dollars in penalties – not because the error was intentional or egregious, **but just because it happened so long ago**. In fact, there have been cases where the auditor approved a nursing facility’s bookkeeping method– but several years later the next auditor did not agree. The facility was then penalized for

utilizing that previously approved method for the several years that ensued between audits.

We propose that many of these concerns can be alleviated by requiring the Department of Social Services to perform the cost report audits **sooner rather than later**. We suggest that the current statute be amended to require the following when the Department is conducting cost report audits:

- That the cost report audit be completed no later than two years from the date the cost report is filed with the Department.
- That the Department use statistically valid random sampling methodology (which they have currently adopted in practice).
- That the Department not require financial documentation for more than two years prior to the cost year being audited.

Thank you for allowing me the opportunity to comment on this bill and I would be happy to answer any questions.

Respectfully submitted,
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