

5059

Testimony of Deborah Chernoff
Before the Human Services Committee
Public Hearing held February 5, 2009

In Re: House Bill 5059 (AN ACT CONCERNING THE FINANCIAL CONDITION OF NURSING HOMES)

Representative Walker, Senator Doyle and members of the Human Services Committee: My name is Deborah Chernoff. I am an Elected Organizer of the New England Health Care Employees Union, District 1199 and direct the research and communications departments for our union. 1199 represents 7,000 nursing home workers at 65 nursing homes in Connecticut. Our members include nurses, aides, housekeepers, dietary, laundry and maintenance workers. I also serve as a member of the Long Term Care Advisory Committee.

I am here to testify on proposed House Bill 5059 (An Act Concerning the Financial Condition of Nursing Homes). First I want to thank Representative Villano and the other members of this committee for raising this critical issue. As we have all seen, the precarious financial condition of too many Connecticut nursing homes continues to threaten the health and livelihoods of thousands of citizens who rely on those facilities and the caregivers who provide that care. There are currently ten nursing homes in state receivership, another half-dozen in bankruptcy and many teetering on the brink. Layoffs and hours cuts are widespread, causing staffing levels to decline. Hundreds of jobs, healthcare access for the frail elderly and in some cases, lives are on the line if we do not stabilize and supervise this critical industry.

On behalf of the 22,000 health care workers in our union, however, I would like to suggest expanding the scope of this bill. Effective financial oversight can't be accomplished in a vacuum. It is one piece of a complicated system; to make it work right, we have to change the system itself. After all, our mutual goal is not just to prevent nursing home operators from spending money unwisely or fraudulently; it must also be to encourage responsible operators to provide good care by spending money in the right way: on quality patient care.

In Re: House Bill 5059 (AN ACT CONCERNING THE FINANCIAL CONDITION OF NURSING HOMES)

This is a long-standing and complicated issue but fortunately we already have a strong blueprint for reforming the costs of funding and the means of providing care in our skilled nursing care facilities.

In 2001, the General Assembly convened the Ad Hoc Task Force on Nursing Home Costs in Connecticut to address these issues. The Task Force was made up of representatives of all the key stakeholders: legislators, the for-profit and non-profit providers, our union, advocacy organizations, elder law attorneys and academic experts. The Task Force was chaired by Dr. Bruce Vladeck, a nationally-known expert on health care policy who served as Secretary of the Health Care Financing Authority (now known as CMS) under President Clinton.

That Task Force issued its final report in early 2002 with a number of comprehensive recommendations that would significantly improve the quality of care, ensure that state and federal dollars were spent appropriately, protect health care access for those who need it most and strengthen financial oversight. I have attached a complete copy of that report to my testimony, but let me summarize a few key points.

The Task Force determined that nursing home Medicaid reimbursement rates, as currently determined, **do not** reflect the actual costs of providing care. This is a key factor in the financial instability of many nursing homes.

To address that issue, the Task Force recommended that nursing homes should be reimbursed at **95% of actual, allowable costs for Direct Care and Indirect Care.** (Direct Care is, essentially, nursing and medical costs, including CNAs; Indirect Care covers support staff like dietary, laundry and housekeeping, supplies, food, etc.)

In Re: House Bill 5059 (AN ACT CONCERNING THE FINANCIAL CONDITION OF NURSING HOMES)

The 5% “discount” would encourage facilities to contain costs, but would not punish higher-staffed facilities would not be punished financially for their higher labor costs or penalize higher-need facilities for their higher costs.

As in the bill before us today, to ensure that nursing homes are paid only for *actual allowable costs*, the State must strengthen its capacity to conduct detailed and frequent audits of reported costs. Proposed Bill 5059 contains several different strategies for ensuring stricter financial oversight.

To encourage facilities to maintain and improve the physical plant for residents, including critical infrastructure such as sewage, fire safety devices, or wheelchair access at older facilities, those costs should be considered as “Indirect Care” instead of “Administrative and General,” so they will get reimbursed at a higher rate.

At the Griswold Health and Rehabilitation Center, (formerly Haven of Jewett City), physical plant improvements were not made for years, resulting in the current \$5 million estimate to fix the facility. Better reimbursement policies on essential repairs and physical maintenance (along with better enforcement) could have avoided the situation we find ourselves in now and in the past, where the cost of fixing the facility leads to closure. A packed public hearing on Tuesday, February 3 at the facility made it abundantly clear that closure of Griswold’s only skilled nursing facility would be a devastating blow for the residents, their families, the staff and the town.

Any nursing home that is 90% or higher Medicaid should get additional “disproportionate share” reimbursements, modeled after the way the State currently reimburses hospitals, to make up for the fact that Medicaid pays the least of any payor source. Many of our in the bigger cities and distressed municipalities have very high Medicaid populations with no other payor source to

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offset the shortfall between reimbursement rates and the actual cost of care. This would also help maintain access to long-term care for the poor and their families, since they have few other options.

Finally, to ensure quality care, the state should raise staffing standards to those recommended by NCCNHR (4.1 hours per patient day minimum, with ratios of staff-to-residents that vary by shift). The Task Force believed that making the suggested adjustments to the way in which nursing homes are reimbursed as listed above would make nursing home better able and more willing to pay for increased staffing.

In addition to copies of the Task Force report, I have attached to my testimony draft language that would incorporate the Task Force recommendations into a bill that takes a comprehensive, holistic approach to resolving nursing home issues, not as a "quick fix," but as a model for quality care now and in the future. I urge the Committee to take a serious look at the Task Force recommendations before quality care in our state is eroded further.

Thank you for your time today.

In Re: House Bill 5059 (AN ACT CONCERNING THE FINANCIAL CONDITION OF
NURSING HOMES)

DRAFT LANGUAGE

Proposed Bill No. #####

AN ACT PROVIDING QUALITY CARE, FINANCIAL OVERSIGHT AND NURSING HOME FUNDING REFORM IN CONNECTICUT

Be it enacted by the Senate and House of Representatives in General Assembly
convened:

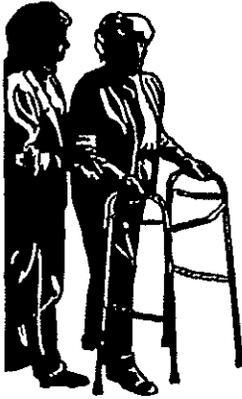
That the general statutes be amended to: (1) Implement the full findings and recommendations of the "Final Report", dated February 15, 2002, by the Ad Hoc Task Force on Nursing Home Costs in Connecticut; (2) Require pre-admission screening of all potential nursing home admissions by appropriately trained professionals independent of the nursing home to ensure that individuals with primarily psychiatric disabilities and/or a history of sexual abuse are not admitted to nursing homes; (3) Require nursing homes to meet or exceed the staffing ratio standards recommended by the National Citizens' Coalition for Nursing Home Reform (NCCNHR); (4) Ensure that quality of care standards in Connecticut's Nursing Homes are determined by the Department of Public Health based on best available clinical evidence and professional judgment, not on the basis of cost; (5) Reimburse nursing homes at 95% of actual costs of "direct care" and "indirect care" cost centers so that Medicaid reimbursements adequately reflect the actual costs of wages, benefits and staffing; (6) Make required reforms to the Medicaid reimbursement system to implement the full findings and recommendations in the Final Report by the Ad Hoc Task Force on Nursing Home Costs in Connecticut including shifting the "plant maintenance costs" to incorporate it into the "indirect care" cost center to encourage improvement and updates in the physical environment of nursing homes; (7) Provide supplemental disproportionate share payments equal to 5% of the total of other allowable costs, except property and capital, to Nursing Homes in which Medicaid patients account for more than 90% of patient days, in recognition of the greater costs to facilities of taking care of low-income persons and the fact that Medicaid rates are lower than those of any other payor; (8) Strengthening the state's audit capabilities to insure that only allowable costs are reimbursed by the state; (9) Increase financial support for training and recruitment of nurses, certified nursing assistants, therapists, and other health care professionals and paraprofessionals in order to address the current shortages in health personnel; (10) Require state-funded secondary and higher education institutions to expand their training programs for nursing and/health services and expand state training programs to focus on creating better career opportunities for nursing aides.

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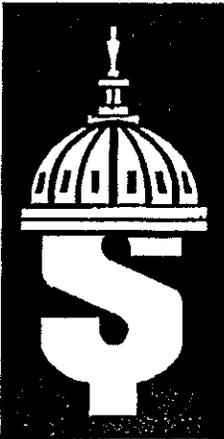
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NURSING HOMES)

Statement of Purpose:

To ensure that Medicaid rates paid by the state to nursing homes adequately reflect the actual costs of providing care including wages, benefits and staffing, and that appropriate reforms are made to modernize staffing standards and the oversight of nursing homes.



Final Report of the



**Ad Hoc Task Force on Nursing
Home Costs in Connecticut**



February 15, 2002

Background and Purpose

The Ad Hoc Task Force on Nursing Home Costs in Connecticut was established in the Fall of 2001 by Senate President Pro Tempore Kevin B. Sullivan and Speaker of the House Moira K. Lyons.

The purpose of the task force was to "investigate whether the Medicaid rates paid by the state to nursing homes appropriately reflect the actual costs of wages, benefits and staffing, including costs of collectively bargained wages and benefits."

In cognizance of the legislative calendar in 2002, the task force was asked to produce a draft report by February 1, and a final report by February 15, and to submit both to the Appropriations, Human Services, Public Health, and Labor and Public Employees Committees.

Members of the Ad Hoc Task Force on Nursing Home Costs in Connecticut:

Chair: Bruce Vladeck, Ph.D., Acting Chair and Professor, Brookdale Department of Geriatrics and Adult Development, and Professor of Health Policy, Mount Sinai School of Medicine

Senator Mary Ann Handley

Senator Toni N. Harp

Senator Edith Prague

Representative William Dyson

Representative Theresa Gerratana

Ramon Castellblanch, Director, Healthcare Administration Programs, Quinnipiac University

Teresa Cusano, State Long Term Care Ombudsman

Marilyn Denny, J.D., Greater Hartford Legal Assistance

Leslie Frane, New England Healthcare Employees Union, District 1199, SEIU

Bonnie Gauthier, Hebrew Health Care

Dr. James Judge, Masonicare

Lawrence Santilli, Athena Health Care Systems

Activities of the Task Force

The task force met four times: December 7, 2001, December 20, 2001, January 16, 2002 and January 30, 2002.

The first meeting was dedicated to procedural decisions and information sharing, as well as to establishing a draft list of criteria by which to evaluate any Medicaid Rate Setting system. The draft criteria are attached in Appendix A.

The second meeting included a presentation by Catherine Conlin and Maryellen Duffy, of the Legislative Program Review and Investigations Committee (LPRIC) staff. Ms. Conlin and Ms. Duffy presented and discussed the findings of the recent LPRIC study of the Nursing Home Medicaid Rate-Setting System in Connecticut. THE LPRIC study evaluated the efficacy and equity of the state's Medicaid rate-setting system for nursing facilities and offered recommendations for modifications to the system. The report is available at www.cga.state.ct.us/pri/PRIweb/2001_Studies.htm.

The third meeting of the task force included two presentations. Gary Richter, Director of the Certificate of Need and Rate Setting Division of the State Department of Social Services, and his colleague Kathy Shaughnessy, provided insight into the rate-setting procedures of the Department. Joan Leavitt, of the Bureau of Regulatory Services of the State Department of Public Health, provided insight into the nursing home survey and quality enforcement processes.

The final meeting of the task force was dedicated to discussing the draft version of this report.

In addition to the meetings of the task force, numerous documents and ideas were shared among the members via e-mail and FAX.

Further questions regarding the activities and accomplishments of the Ad Hoc Task Force on Nursing Home Costs in Connecticut can be directed to Deb Polun of the Senate Democrats Office by phone at (860) 240-8600 or e-mail at Debra.Polun@po.state.ct.us.

Findings and Recommendations

The Task Force agreed on twelve specific findings and recommendations, in all cases by a large majority, and in most cases by consensus. *Findings and recommendations with which individual members disagreed are noted accordingly.* The Task Force also agreed that, while each of its recommendations is worthy of consideration on its own merits, it is necessary to understand the extent to which they are interrelated. Thus, for example, effective implementation of the recommendation about staffing standards depends on changes to the reimbursement system, and also on increases in the availability of health care professionals to work in nursing homes.

The Findings and Recommendations of the Task Force are as follows:

1. Ultimately, members of the Task Force agreed, decisions about Medicaid reimbursement policies for nursing homes should be made in the context of a broader, overarching policy framework for all of long-term care in the State, so that the reimbursement system can promote attainment of those goals. This framework should take into account at least the following:
 - Expected changes in the size and characteristics of the elderly population;
 - The fact that Connecticut, compared to other states, has relatively high use rates for nursing homes, and relatively low use rates for home and community-based long-term care services;

- The preference of most seniors and their families to remain in their homes;
 - The fact that roughly 700 licensed nursing home beds are currently out of service;
 - The inadequacy of Connecticut's existing programs for home and community-based services; and,
 - The needs of special populations, including those with serious and persistent mental illnesses (not including Alzheimer's Disease and related cognitive impairments) who should not be served in conventional nursing homes, and others for whom specialized facilities might be appropriate.
2. In order to foster progress towards the goal of a long-term care system that is more oriented to home and community-based services, the State should require pre-admission screening of all potential nursing home admissions. These screenings should be performed by appropriately-trained professionals independent of the nursing home, and when appropriate, should include recommendations relative to home or community-based services as well as nursing home care. For admissions from the community, this screening should take place in the client's home. This screening process should also insure that individuals with primarily psychiatric disabilities and a history of physical or sexual abuse are not admitted to nursing homes. *Ms. Denny and Mr. Brown, representing Ms. Frane, also felt that nursing homes in Connecticut should be required to admit from a single waiting list, regardless of payment source.*

3. The Task Force agrees that standards for the quality of care in nursing homes should be determined by the State Department of Public Health based on the best available clinical evidence and professional judgement, not on the basis of cost. Acknowledging the view that the quality of nursing home care is not solely - perhaps not even primarily - dependent on nursing and other staff hours worked in the facility, the Task Force still believes that the State should move, as soon as practicable, given the availability of appropriate personnel and other considerations, to the nursing home staffing standards proposed by the National Citizens' Coalition for Nursing Home Reform (about 4.1 total nursing hours [RNs plus aides] per patient per day, or roughly 1/3 more than the current average staffing pattern in Connecticut). *Ms. Gauthier agreed with the principle of increased staffing, but not the specific methodology used by NCCNHR.*

4. The Task Force finds that, while the current Medicaid reimbursement system in Connecticut was soundly conceived when first implemented a decade ago, the cumulative effect of stop-gain/stop-loss ceilings, infrequent rebasing, and a highly discretionary Interim Rate process have undermined the operational effectiveness of that system. Specifically, in terms of the Task Force's charge, it was agreed that the current system does *not* "adequately reflect the actual costs of wages, benefits and staffing." *Mr. Santilli noted, "I disagree with the statement that the current system does not adequately reimburse the cost of wages, benefits and staffing. In addition, I disagree with any system that eliminates stop-gain/stop-loss provisions or one that automatically allows for annual rebasing*

that would allow provider costs to flow through the system unchecked."

5. As an alternative, the Task Force recommends that *actual, allowable* costs in what are now defined as the "direct care" and "indirect care" cost centers be reimbursed at 95% of actual costs. This will permit facilities to staff and operate in a way best-suited to maintain a high quality of care, while continuing to provide an incentive (in the form of a 5% "copayment") for cost containment. *Mr. Santilli noted, "I disagree with the replacement of the current cost caps in direct and indirect care with a 95% reimbursement level. Again, this would, in effect, pass through costs without caps and at virtually no incentive to control costs. In addition, this would inappropriately redistribute monies from current cost-efficient facilities receiving 100% reimbursement, for direct and indirect, to help fund the higher cost facilities. The efficient facility's 5% reduction would help fund those currently over the direct and indirect caps."*
6. In order to make the prior recommendation a viable policy, the Department of Social Services will need a substantial strengthening of its audit capabilities, preferably in-house, to insure that only allowable costs are reimbursed.
7. The other components of the current Medicaid rate system (for administrative costs, property, and capital) should be kept intact, at least until State policy towards the supply and distribution of nursing home beds is formally re-evaluated. However, in order to encourage

improvement in the physical environment of nursing homes, plant maintenance costs should be considered in the "Indirect care" cost center, not "Administration and General."

8. Nursing homes in which Medicaid patients account for more than 90% of patient days should also receive supplemental disproportionate share payments, in recognition of the greater costs to facilities of taking care of low-income persons and the fact that Medicaid rates are lower than those of any other payor. These payments should be equal to 5% of the total of other allowable costs, except for property and capital.

9. According to the December, 2000 Report of the Legislative Program Review and Investigations Committee, full implementation of the NCCNHR staffing standards would cost Medicaid roughly \$78 million a year additional, of which the federal government share would be half. The Task Force also believes that adoption of its recommendations would produce some reduction in reliance on Interim Rates, with concomitant savings that would offset some of these additional costs. *Mr. Santilli noted, "It would cost \$85 million, not \$78 million, to implement the NCCNHR staffing standards per the December 2000 Legislative Program Review and Investigations Committee Report (see page 41). Also, in order to implement the NCCNHR staffing standards and change the system to 95% of actual costs, an additional \$51 million would be needed, per the December 13, 2001 Legislative Program Review and Investigations Committee Report. In summary, a total of \$136 million would actually be*

needed to cover the actual costs and the NCCNHR staffing standards."

10. Changes in regulatory standards and the Medicaid reimbursement system will not be sufficient, by themselves, to insure adequate staffing in Connecticut's nursing homes, if the current shortages in many categories of health personnel persist or worsen, as is widely expected. In other words, State policy needs to address the supply of health care workers as well as the "demand" for them engendered by regulations and payment systems. Increased financial support for training of nurses, therapists, and other health care professionals and paraprofessionals is obviously necessary. So is concerted and systematic attention to these issues from State and local agencies primarily responsible for secondary and higher education, as well as those responsible for health services. State-funded institutions should be required to expand their training programs, and privately-funded institutions given an incentive to do so. In addition, the Legislature should consider legislation that clearly defines crimes, conviction for which should preclude employment in long-term care, subject to appropriate consideration of factors related to rehabilitation and a determination that an employee is not a danger to long-term care clients.

11. Further, the State should explore adoption of mechanisms to fund greatly expanded programs of in-service training and employer-sponsored upgrading and career ladders, including programs like those developed in New York State, through Medicaid rate adjustments, with their automatic draw-down of federal financial

participation. In particular, efforts should focus on creating better career opportunities for nursing aides.

12. While acknowledging the usefulness of at least some parts of the MDS reporting system in tracking and monitoring nursing home quality, the Task Force found no compelling reason to adopt at this time a system of formal case-mix measurement for either reimbursement or staffing standards purposes.

Appendix A

The following criteria were discussed to aid in the evaluation of the reimbursement system in Connecticut. The nursing home payment system must:

1. have adequacy in payment levels, in order to keep providers in business
 - a. must help with capital
 - b. must ensure that there are enough facilities in the right geographic locations (i.e., supply meets demand)
2. provide financial incentives for high quality of care and good services
3. be affordable, in the larger context of the state budget
4. be able to be understood by all the stakeholders (i.e., "transparent")
5. be responsive to changes in circumstances in the outside world (e.g., rapidly increasing insurance costs; new regulatory requirements)
6. minimize the possibilities for "gaming" or manipulation of the system
7. address the adequacy of compensation for workers, including the costs of collective bargaining agreements
8. provide equity between providers and across types of providers
9. provide for differences in case mix/levels of acuity across providers
10. acknowledge the staffing shortage
11. account for case management (i.e., determination of institutionalization vs home health needs)
12. take into account the regulations promulgated by the state Department of Public Health (i.e., the interagency relationship between DPH and DSS, or policy vs funding)
13. not be inconsistent with the Olmstead decision

Digest

Medicaid Rate Setting for Nursing Homes

Rate Variation

Payers and Home Variation: Findings

The average Medicaid per diem rate in Connecticut is considerably less than the other two major payers - about \$100 a day less than Medicare and \$65 less than the average private pay rate.

There is considerable difference in the rates Medicaid pays in Connecticut - there is more than \$100 a day difference between the lowest and highest paid facility.

Great variation among per diem Medicaid rates was due to profit status - with average rates in non-profit facilities \$15.72 higher than for-profit homes.

Unionized homes received \$8.15 a day more than non-unionized homes; non-profit, unionized received \$24.49 more per day for each Medicaid resident than for-profit, unionized homes.

Rate Increases: Findings

The highest paid facilities in FY 01 received the highest dollar increases to their rates over the period but the lowest percentage increase, indicating those facilities started at higher rates in FY 92.

The 77 facilities with the lowest rates in FY 01 received a 36 percent increase over the 10-year period, about average for all facilities.

The 77 facilities in the lowest-paid group received about \$3.00 less per day than the facility average overall and about \$6.00 a day less than the two higher paid groups.

Staffing, Costs, and Rates: Findings

On average, slightly more than half a facility's costs are for direct care - salaries and fringe for nurses and nurse aides.

There is a positive relationship between rates and total direct care -- nursing and aides -- staffing levels (hours per patient day).

Average direct care staffing levels grew from 3.2 to 3.6 hours per patient day from 1999 to 2000, a 12.5 percent increase, indicating the 1999 Wage Enhancement Act targeting funding to increasing staff and benefits has had an impact.

Average non-profit direct care staffing levels are higher than for-profits - 3.9 nurse and aide hours per resident day -- compared to 3.51 hours in for-profit facilities.

Fairfield County direct care salaries are higher than the rest of the state. This difference is expected and is built into the rate system with different cost ceilings placed on certain cost components for Fairfield County facilities than the rest of the state.

Connecticut's rates are fifth highest in the nation and second highest in the Northeast, most of the variation can be

explained by wage differences between Connecticut and the other Northeastern and Mid-Atlantic states

Rate Setting: Overall Impact

Findings

Adoption of flat increases for rate reimbursement has eliminated the relationship between facilities allowed costs and the Medicaid rate ultimately issued.

Application of a flat rate increase has also had an adverse effect on fair reimbursement rates

There is no evidence in the statute that the stop gain provision takes precedence over the statutory requirement that nursing home costs be rebased every two to four years.

Medicaid reimbursement and overall rate increases -- including interim rates and special adjustments - are higher than inflation because of:

- *the Wage Enhancement Act of 1999 raised overall rates but its funding was targeted to wage and staffing increases, but did not address other inflationary increases,*
- *higher percentages based on interim rates and special adjustments drive the overall average increase, but a majority of facilities are not receiving interim rates;*
- *measuring rate increases alone does not account for other factors that also drive costs like bed conversions to a higher license type, and*
- *property costs are readjusted for rates each year.*

Recommendations

For FY 03-04, nursing home Medicaid rates should be calculated according to the statutory system currently in place with the following modifications:

- 1. In years that nursing home costs are not rebased, rates should be adjusted using the Skilled Nursing Facility Market Basket index annual (third quarter to third quarter) increase in inflation.**
- 2. C.G.S. 17b-340(7) shall be amended to repeal the use of the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban) as the inflation index used to inflate nursing home costs. For years in which costs are rebased, the SNF Market-basket Index shall be used to inflate costs for the time period currently required in statute, mid-point of the cost year to mid point of the rate year.**
- 3. C.G.S. 17b-340(8) shall be amended to require nursing home costs be rebased every three years, notwithstanding C.G.S. 17b-340(4) that limits nursing home rate increases to specified percent increases or decreases.**
- 4. A case-mix system, shall be adopted and implemented beginning in the FY 04 rate year (see recommendation 6).**
- 5. The commissioner of DSS shall amend its regulations regarding nursing homes Medicaid reimbursement as described in C.G.S. sec. 17b-340.**

Case Mix and Medicaid Reimbursement

Findings

There is no correlation between facilities' case mix and their

- *Medicaid per diem rates,*
- *direct care costs, and*
- *aide hours per resident day*

A very weak relationship was established between facilities' case mix and their

- *nursing hours per resident day;*
- *total nursing hours (nurse and aide) per resident day*

Not only is there no correlation between facilities' case mix and direct costs, but there is wide variation in direct costs, even when facilities have similar case-mix indices.

Although both the union and industry oppose adoption of a case-mix system, the extent of disconnect between resident acuity and Medicaid reimbursement poses unfairness and inequity that cannot be ignored.

Recommendation

6. A resident case-mix Medicaid reimbursement system shall be adopted by the Department of Social Services beginning in FY 04 for chronic and convalescent nursing homes and rest homes with nursing supervision. The case-mix system shall be implemented as follows:

First, facilities shall be separated into the peer groupings that currently exist - by license type, and by Fairfield county and the rest of the state.

Second, for years in which nursing home costs are rebased to set Medicaid rates, RUG scores shall be calculated by the Department of Social Services, in conjunction with the Department of Public Health, for each Medicaid resident residing in a nursing home. The RUG score shall be based on any full MDS assessments within the last cost report period. The case-mix weights established by the Centers for Medicare and Medicaid appropriate for 34-group RUG-III classification shall be applied to the calculated RUG to establish each facility's average Case Mix Index for the cost report period used to rebase costs. If a Medicaid resident has more than one RUG group for the year, because of a significant change in health or functional status, the case mix weights shall be applied to each group and weighted for the Medicaid days the resident was in each group.

For the purposes of determining allowable direct care costs under the Medicaid reimbursement system, three case-mix peer groups shall be established for each level of nursing care. All facilities' case-mix indices shall be arrayed and the case-mix peer groups shall be as follows:

- **a low case-mix peer group shall be established and comprised of facilities with Case Mix Indices in the lower third of the total index range;**
- **a middle case-mix peer group shall be established and comprised of facilities with Case Mix Indices in the middle third of the total index range; and**
- **a high case-mix peer group shall be established and comprised of those facilities with Case Mix Indices in the top third of the total index range.**

Direct care costs shall be arrayed for each case mix peer group and per diem maximum allowable direct care costs for each group shall be equal to:

- **115 percent of median costs for the low case mix peer group;**
- **120 percent of median for the mid acuity peer group; and**
- **125 percent of median for the high case mix peer group.**

Planning and Financial Oversight

Long-Term Care Planning: Findings

Decisions that drive the nursing home system and its financing, such as approving interim rates, allowing beds to be converted from one licensure level to a higher, more expensive level, transferring beds from one facility to another and closing facilities are being made on a case-by-case basis, rather than within the context of broader policy goals.

Currently, except for the State Health Plan developed by the Department of Public Health, there is no single source of data that projects nursing home bed need.

The intent of the program review committee's 1996 recommendation -- to establish a long-term care planning committee to act as a decision-making body with authority to set long-term care direction and policies -- has not been fulfilled

Recommendation

7. The Office of Policy and Management (OPM), building on the Long-Term Care Planning Committee efforts, and with input from implementing agencies, shall undertake a comprehensive needs assessment of long-term care services. The plan shall assess the three major components of the long-term care system - home and community-based services, assisted living, and nursing home care -- to evaluate need for services, as well as costs of providing them. The plan shall:

- **develop a nursing home bed need methodology, based on demand and alternatives available, as well as demographics;**
- **consider the expected impact of changes in nursing home bed supply;**
- **develop a comprehensive strategy to match supply and need by area of the state;**
- **estimate the costs of the three-component system, and how it will be financed.**

To develop the plan, the Office of Policy and Management must access the data that measures the level of care (resident acuity) of persons currently living in nursing homes to gauge whether Connecticut's nursing home population is being served in the most appropriate, least-restrictive setting. Therefore, the Office of Policy and Management shall seek authorization from Centers for Medicare and Medicaid Services to access and conduct analysis on the Minimum Data Set (MDS). Data from this source shall be integrated with data resulting from facility inspections conducted by the Department of Public Health and nursing home cost data from the Department of Social Services.

The Office of Policy and Management shall analyze the data to track and evaluate:

- **resident acuity by facility;**
- **relationship between facility and costs;**
- **acuity and staffing patterns;**
- **changes in acuity over time; and**
- **adequacy of the admissions assessment tool.**

The requirement that the state Department of Public Health publish a report listing all nursing homes (C.G.S., Sec 19a-538) be repealed.

Financial Stability: Findings

Financial stability in the nursing home industry has worsened, since 1999, 20 percent of facilities have been placed in receivership or bankruptcy

Current CON-Rate-setting staff is responsible for overseeing more than \$2 billion in Medicaid reimbursement and more than 1,100 residential providers; staff is consumed by day-to-day financial crisis in the industry

Recommendation

8. To improve financial stability oversight:

- add six staff persons to DSS CON/Rate-Setting unit as proposed in the governor's FY 2001-2003 budget;
- change the emphasis of the auditing staff to one of examining for financial stability (see recommendation 10);
- assign new staff to:
 - rate-setting, including maintaining, analyzing, and calculating the - case mix indices by facility to adjust its rate in rebasing years;
 - assist certificate of need functions;
 - overseeing audits; and
 - developing information for the interim rate panel to base decisions.
- require the Director of CON/Rate Setting to craft a plan addressing the issue of financial stability within the industry. The director shall use, as a guide, the long-term care plan including nursing home bed need, as proposed (see recommendation 7).

Interim Rates: Findings

The number of facilities receiving interim rate requests and special adjustments has been increasing gradually over the last 10 years.

With more than 60 facilities (or 25 percent) on interim rates or special adjustments - the interim rate process has become an alternative system for rate setting.

Several significant problems identified with the current interim rate-setting process include:

- a lack of criteria for requesting, or granting these rates,
- the inequities in reimbursement that interim rates create - in FY 00, interim rates were more than \$7.50 a day higher than rates set through the regular system, and
- an administratively burdensome and costly system for DSS staff since decisions are made case by case rather than establishing rates for the entire industry

Recommendation

9. A rate review panel shall be established by July 1, 2002, comprised of five members - one from the Office of Policy and Management; one from the Department of Social Services; one from the Department of Public Health; a health care economist or similar health care expert; and a financial management expert. The panel shall meet quarterly to act upon requests from nursing facilities for interim rates or special adjustments. A request for a facility should be acted on within a six-month period.

The panel shall establish its criteria in writing including standards for request. Criteria shall be based solely on financial hardship, and change of ownership would no longer be a criterion on its own. A facility shall provide supporting documentation of financial hardship, including the results of an independent audit.

The panel shall establish criteria to limit the number of interim rates or special adjustments granted to one facility. Decisions shall be made on established criteria, based on the comprehensive plan for long-term care (see recommendation 7) including need for beds in nursing facilities. The panel in the granting of interim rates or special adjustments may impose conditions on the facility's operation.

Change of Ownership: Findings

All but one of the 53 facilities in receivership or bankruptcy is owned by a chain, and all changed ownership at least once between 1994 and 1999

Recommendation

10. Require a CON approval for change of ownership for a nursing facility before the purchase is transacted. DSS should apply the same financial criteria it would on an initial facility CON. Further, DSS must inform the potential purchaser of the current rate-setting system, including limits on property reimbursement, and that change in ownership alone will not be a criterion for establishing interim rates.

Audit: Findings

Low percentage of audit recoupments, and the amounts of facility costs not reimbursable through rate-setting lessen the need for purely financial auditing.

Elements that measure quality of care and financial stability need to receive greater emphasis in audits

Recommendation

11. Audits shall include a verification of nurse and nurse aide hours worked, as submitted by the facility on their cost reports. Secondly, audits shall require a substantiation of any change in case-mix peer grouping tied to rate increases. If necessary, auditors may request a nurse consultation to examine documentation in order to determine whether the change in resident acuity, and case-mix grouping, is justified. Thirdly, audits should be conducted for other than last cost year report, with a focus on early warning signs concerning financial stability.

Return to Year 2001 studies