



The Connecticut Association of Not-for-profit Providers For the Aging

**Testimony to the Human Services Committee
Regarding**

**Senate Bill 1013, An Act Implementing the Governor's Budget Recommendations
Concerning Human Services**

March 15, 2011

**Presented by Stephen McPherson, President and CEO of Masonicare
Chair of CANPFA**

Masonicare is the state's largest provider of healthcare and retirement living communities for seniors. A not-for-profit organization that dates back to 1893, the Masonicare continuum includes geriatric acute and psychiatric acute care, skilled nursing care, long term care, dementia care, assisted living, home health and hospice care, residential care, senior housing and retirement communities.

CANPFA is a membership organization representing over 130 mission-driven and not-for-profit provider organizations serving elderly and disabled individuals across the continuum of care including nursing homes, residential care homes, housing for the elderly, continuing care retirement communities, adult day centers, home health care and assisted living agencies. CANPFA members are sponsored by religious, fraternal, community, and governmental organizations that are committed to providing quality care and services to their residents and clients. Our member organizations, many of which have served their communities for generations, are dedicated to providing the services that people need, when they need them, in the place they call home.

Good afternoon Senator Musto, Representative Tercyak, and Members of the Human Services Committee. My name is Stephen McPherson and I am the President and CEO of Masonicare and the Chairman of the Board of the Connecticut Association of Not-for-profit Providers for the Aging or CANPFA, an association of over 130 not-for-profit providers of aging services. On behalf of CANPFA, I would like to submit testimony regarding *Senate Bill 1013, An Act Implementing the Governor's Budget Recommendations Concerning Human Services* and specifically to speak to the issues of long term care as they are addressed in the budget proposal. I would also like to share with you CANPFA's vision of the future of aging services and our solution to help you achieve it.

We present our testimony with the realistic acceptance of the dire fiscal situation the state is facing and the shared sacrifice we have been asked to accept. We are grateful for the effort that the Governor has made to preserve the safety net that protects so many of the frail, elderly we serve. We know that the services we provide consume a large portion of the Medicaid budget, but we can assure you that these services are vital and serve as a lifeline to our oldest of citizens.

CANPFA maintains a vision in which every community offers an integrated and coordinated continuum of high quality and affordable long term health care, housing and community based services. We encourage the Governor and the Legislature to embrace this larger vision as you construct this difficult and historic budget because now is the time to look toward innovative solutions, invest our resources wisely, and begin to create the future of aging services. The members of CANPFA would like to help you to achieve those goals.

Developing Nursing Home Solutions

We need to move quickly to strengthen our system of long term care, and particularly the nursing home segment. CANPFA proposes that the state accomplish this by allowing nursing home professionals to find solutions and institute change by giving those professionals the latitude to develop their own individual business plans for their existing skilled nursing facilities and campuses. The objective for the state would be to solicit plans of restructuring, diversifying and/or downsizing existing facilities and services to build a better model of care that would strengthen the full continuum and therefore meet current consumer demands, market needs and the goals of the state's long term care plan. Restructuring could be budget neutral or result in savings to the state, both short term and long term, through fewer nursing home Medicaid days, healthier facilities that will not need the costly interim rates that are currently negotiated by the state, and the development of a more robust continuum of diverse long term care services.

The concept would be to give the individual providers the opportunity to transform the state's system of aging services *one solution at a time*. To allow this to work, the state would have to modify the administrative process and regulatory mind set that currently restricts innovative initiatives in the field. The state agencies and their processes would need to become more flexible, objective, coordinated and timely. This change in philosophy and practice would encourage providers to be creative in their thinking and create real solutions to the needs of their communities while bringing innovation and modernization to the residents they serve.

The state's nursing home policy needs to move away from putting out fires and toward looking for and rewarding innovative solutions. For too long we have relied upon a short sighted system of interim rate relief for financially distressed nursing homes and this is draining our resources. An interim rate should be an investment in future long term care services, not a temporary band-aid. Before they are granted rate relief, nursing homes in need of assistance should be required to develop business plans aimed at meeting the long term care needs of their communities and utilizing financially viable business models. The end result will be individual solutions that will make the entire system stronger.

Attached to this submission is a document entitled: "Creating the Future of Aging Services One Solution at a Time" which outlines the goals and recommendations of this policy initiative. We have also attached additional specific comments related to the Governor's budget proposal. Our comments are provided within context of the larger vision of creating an integrated and coordinated continuum of high quality and affordable long term health care and with our offer of help as we all work to achieve this vision.

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

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Creating the Future of Aging Services One Solution at a Time

We have too long relied on interim rates to bail out homes caught in our outdated and stagnant concept of long-term care. It is time to look toward innovative solutions and begin to create the future of aging services.

We propose that the state allow us, the long term care professionals, to initiate those innovative solutions - *one solution at a time.*

Nursing home solutions:

- Allow and encourage the development and implementation of individual business plans for our existing skilled nursing facilities and campuses.
- Voluntarily adjust the supply of beds to meet the skilled bed need and correct the occupancy percentage throughout the entire skilled nursing field.
- Improve and update physical plant and moveable equipment to address the rising level of acuity in our skilled facilities.
- Redesign, transform and/or modernize current physical plants to address future consumer needs, demands and expectations.
- Encourage diversification and the development of full continuums of long term care options for consumers.
- Accomplish all of this in a budget neutral manner and create a system that will save significant dollars in future years.

To allow for these solutions, the regulatory environment needs to:

- Encourage renovation and improvement to physical plant, investment in modern equipment, and adoption of state of the art models of care that will meet the demands of a changing consumer and enhance the work place environment.
- Facilitate a rational process for adjusting the bed supply across the state including the opportunity to mothball beds.
- Encourage the diversification of services and the development of continuums of care.
- Provide budget neutral prospective rate relief to facilities experiencing financial difficulties due to low occupancy rates, *but only* if the nursing home is taking the necessary steps to correct and improve occupancy percentage.
- Most importantly, the regulatory process must be conducted efficiently and timely, and in a coordinated manner between all administrative levels of state government including both the Department of Social Services and the Department of Public Health.

Creating the Future of Aging Services



canpfa

Testimony to the Human Services Committee Regarding the Governor's Proposed Budget March 15, 2011

Supplemental Submitted Testimony

Adequate Rates of Reimbursement

Right now Medicaid is the primary public source of financing for long term care. On the federal level we are optimistic that the CLASS Act program will provide an additional, alternative source of payment, but that is several years away. Today we must deal with the fact that Medicaid rates do not come close to meeting the costs of providing long term care, *either in the nursing home or in the community*. Our goal as a state must be to work toward an efficient, high quality, and cost effective system that can provide adequate rates of reimbursement throughout the long term care continuum.

The state has adopted a long term care plan with a goal of rebalancing the system and providing a choice for individuals seeking long term care. CANPFA supports this goal, but experience shows that while rebalancing can moderate the growth of long term care costs, it does not eliminate the growth. Costs will continue to rise through the entire long term care system – and the state needs to recognize this and invest in it. This is an essential element to the success of a balanced long term care plan and the only way we can maintain the commitment to those who rely upon the Medicaid system for their long term care needs.

Medicaid as a Self-insured Administrative Service Organization (ASO) Form

We optimistically support the plan to move the state's Medicaid program to a self-insured Administrative Services Organization (ASO) format and the effort to obtain federal funding to initiate a demonstration project that would utilize an Integrated Care Organization (ICO) model to implement better care coordination for the dual eligible population. While these are currently just conceptual models, the concepts are in line with our vision of creating a more integrated and coordinated continuum of high quality and affordable long term health care, housing and community based services.

The Expanded Money Follows the Person Initiative

The expanded Money Follows the Person initiative includes at least \$21 million over five years for a strategic nursing home rebalancing plan to "right-size" bed capacity and guide the nursing home field on business diversification, something that CANPFA has been advocating for in our "One Solution at a Time" proposal. It is also our understanding that a specific number of individual nursing homes will have the opportunity to secure grant funding to initiate their own strategic planning process. We would hope to have an opportunity to participate in the planning and implementation process of this initiative.

Nursing Homes

Restructured Nursing Home User Fee Proposal (Section 35)

We understand the administration's desire to maximize on the federal rules for the existing nursing home user fee system and we appreciate the effort to utilize those matching funds to assist the entire nursing home field. It is difficult to comment on the specifics of the proposal as they are not yet available, but it appears that the current nursing home user fee program will be adjusted across the board through an increased tax and a resulting match that is at least partially returned through the rate system. The inherent consequence of any user fee system is

that it does create winners and losers and in the case of a nursing home user fee, a heavy burden does fall on the private pay resident. This is why it is vital to return and equally distribute all of the federal matching funds to the nursing homes.

Freeze Fair Rent for Nursing Homes Proposal (Section 1)

Under current statute, the Department of Social Services is required to incorporate an adjustment to accommodate improvements to real property (referred to as a "fair rent adjustment") when setting annual nursing home rates. Unfortunately, fair rent increases have been frozen for two years and the budget is proposing to continue this freeze over the biennium.

The fair rent rate adjustment option will be critical to our proposed plan to promote diversification and renovation. In addition, this policy is extremely short sighted in this economy. The lack of fair rent funding will restrict the ability of providers to finance improvements to their aging facilities, and it will discourage those with working capital from spending it. Fair rent rate increases are matched by federal funds and are spent in the local economy on construction work, repairs and facility improvements. *We urge the reconsideration of this freeze.*

Small House Nursing Home Proposal (Section 25)

We would hope that the small house nursing home concept and other innovative models of nursing home care will be encouraged as nursing homes are incentivized to transform their facilities and diversify their services.

Strengthen Recovery Efforts and Encourage Use of Private Resources Proposal (Section 40)

We would propose that the state strengthened recovery efforts with regard to nursing home residents and modify regulations that will promote the use of private resources to fund nursing home care rather than encourage a reliance on Medicaid funding, *but we do not agree with the proposed amendment to 17b-261a to address the partial return of a transferred asset.* This specific proposal provides that if a nursing home resident returns the entire amount of a transferred asset, he or she will not be penalized. However, a *partial* return will not result in a reduced penalty period and may in fact extend the period of time during which a nursing home is left providing skilled nursing care without payment. This is the wrong message to send and it will further hurt the financial stability of nursing homes. The state should encourage use of private resources and permit reduction of the penalty period if someone makes a partial return of transferred assets.

There are many areas where the state could strengthen recovery efforts with regard to Medicaid eligibility nursing home residents. Over the last two years, more and more nursing homes have reported instances of resident family members misappropriating resident social security and pension checks and refusing to pay over this "applied income" to the facility – even after Medicaid eligibility is granted with specific instructions to pay applied income. Sometimes nursing homes find that family members have misappropriated resident assets. In these cases, reports and referrals are made to law enforcement, but the facility has no recourse. Because nursing homes may not discharge residents who are Medicaid recipients, the facility must continue to care for the resident without getting paid in full for the services provided.

In addition, now that asset transfer penalties have become stricter, nursing homes shoulder a heavier burden. Most nursing home residents are not admitted to the facility as Medicaid recipients. The typical resident enters as a private pay resident and spends down whatever assets he or she has to the facility to pay for their care before applying for Medicaid. Once a resident spends down and applies for Medicaid, the state reviews their finances back for five

years. If a determination is made that the nursing home resident transferred assets within that five year look back period, a penalty period is imposed on the resident during which no Medicaid is paid for the length of time equal to the transferred asset. During a penalty period, the resident remains in the facility with no source of payment. In these cases, it is impossible for the facility to discharge the resident as no other facility would accept a resident under these circumstances without a source of payment. One or two resident penalty periods can be devastating to the financial health of a nursing home.

Finally, Connecticut has some of the only waiting list regulations in the nation. These laws were designed to require that nursing homes admit residents who have qualified for Medicaid. While this is a laudable policy, it does not provide any incentive for prospective residents to maintain their private financial resources to pay for nursing home care.

We recommend the following additional proposals for the state to strengthen recovery efforts and encourage the use of private resources:

- **Assist in the Collection of Misappropriated Resident “Applied Income” Funds**
- **Address the Issue of Missing or Intentionally Transferred Assets**
 - Rectify current Medicaid eligibility rules that require an ineligibility determination for a nursing home resident who cannot locate a missing asset, even though the resident otherwise meets eligibility criteria. *(Suggested statutory language available.)*
 - Require DSS to adopt regulations governing undue hardship waivers for individuals subject to penalties due to transfers of assets; allow nursing homes to request hardship relief for nursing home residents subject to transfer of asset penalties; authorize DSS and the Attorney General’s Office to legally pursue individuals who receive improperly transferred assets; and permit nursing facilities to receive financial relief, subject to certain conditions, if the facility must continue to care for a resident subject to a transfer of assets penalty period.
- **Encourage the Use of Private Resources to Fund Nursing Home Care by Modifying the Waiting List Requirements (§ 17b-550)**
 - Current state requirements mandate that a nursing home maintain an official waiting list subject to state regulations in a bound book. If a nursing home has a vacancy, it must take the next appropriate resident on the waiting list, unless the home has a private pay census of less than 30%. If the nursing home has a percentage less than 30%, it instead may go to the next *self-pay* person on the waiting list. *Suggestion: Change the current waiting list waiver conditions from 30% self-pay to 49% self-pay. Add to it that regardless of the ratio of payer mix, if at the time of vacancy a nursing home has residents who are either Medicaid pending or in a Medicaid penalty period (and therefore the nursing home is not receiving payment for their care at the time of the vacancy), then the nursing home would be permitted to go to the next self-pay person on the waiting list. This could be scaled to 1 such resident for a home of 120 beds or less and 2 for a home of 121 beds or more.*

Residential Care Homes

Medication Technician Mandate (Section 9)

Residential care homes (RCHs) are a unique and cost effective level of housing for many individuals receiving state assistance. The proposed elimination of a statutory rate increase comes at a time when the state is also mandating that the homes employ medication technicians that will be trained at the RCH's expense (after the current staff is initially trained.) This mandate is intended to save the state money, but is a financial burden on these homes and may result in our losing many of them. *We would request that the state eliminate the medication technician mandate that is currently placed on RCHs.*

Home and Community Based Services

State-Funded Connecticut Home Care Program Proposals (Section 14)

The state has adopted and embraced a long term care plan with a goal of rebalancing the system and providing choice for individuals seeking long term care. The Connecticut Home Care Program for Elders should be the flag ship program for this plan. While our recent emphasis has been on moving people from the nursing home to the community, what will bring true cost savings to the system is having a robust community based system of care that will postpone or prevent nursing home placement. The way to reach that goal is to intervene early in the aging process and provide the community based services and supports. This is what the Home Care Program for Elders seeks to do and rather than seeking cuts in this program, the state would be wise to encourage participation in it.

- **Freeze Intake on Category 1 of the State-Funded Connecticut Home Care Program**

We do not agree with the decision to close the Category 1 segment of the state-funded Connecticut Home Care Program for Elders. Category 1 clients are the very individuals you want to intervene with early to establish the services and supports that will enable them to stay in the community and delay or prevent more costly interventions or nursing home placement.

The budget proposal references a new opportunity under the 1915(i) waiver that will allow the Department of Social Services to transfer dually eligible clients under the state-funded program who do not meet the functional requirements for the home care waiver program to Medicaid and claim reimbursement. While we would be supportive of this effort to capture federal matching funds, we are fearful that it will not capture everyone affected by this cut and *we would urge the state to reconsider.*

- **Increase Cost Sharing under the State-Funded Connecticut Home Care Program**

We know from recent experience that participation in the Connecticut Home Care Program for Elders was hurt by the implementation of a 15% co-payment and continues to be thwarted by the current 6% co-pay. These co-pays are affecting access to care as the elderly who need services may be unable to afford the co-pay expense and are choosing not to take advantage of the necessary services. We also know that the uncertainty of a co-pay obligation that can fluctuate month to month is discouraging participation. *If we cannot eliminate the co-pay altogether, we should work to develop a cost sharing mechanism that is both affordable and specific so that older adults can comfortably budget for the expense.*

Allow Administration of Medication by Unlicensed Certified Providers Proposal (Section 15)

We oppose this mandate to require the training and use of unlicensed home health care medication technicians. Currently there is a mandated medication technician program for residential care homes that is of great concern and is unenforceable because no one has come

forward to perform the training. *We would encourage the repeal of that mandate* and allow the residential care homes to continue to conduct the voluntary medication technician programs that are appropriate for their setting.

We are certainly open to the concept of medication technicians, but such a program needs to be implemented through a well thought out policy that makes sense from a public health and a quality care perspective. The training and educational aspects of the program need to be established in a manner that ensures adequate standards, program consistency, and course availability. The current process mandated for residential care homes and now proposed for home health has been a haphazard approach to implementing a potential cost saving option targeted to the administration of psychiatric medications in the community setting. This is not good public policy. If there is an indentified need for more effective models of care delivery than we should look to find solutions that make good public policy sense and we would be more than willing to participate in finding those solutions.