

March 12, 2013

Written testimony of Matthew V. Barrett, Executive Vice President, Connecticut Association of Health Care Facilities (CAHCF) in opposition to H.B. No. 6609 (RAISED) AN ACT CONCERNING NURSING HOME TRANSPARENCY.

Good afternoon Senator Slossberg, Representative Abercrombie and to the members of the Human Services Committee. My name is Matthew V. Barrett, Executive Vice President of the Connecticut Association of Health Care Facilities (CAHCF), our state's one hundred and sixty-six (166) member trade association of skilled nursing facilities and rehabilitation centers. Thank you for this opportunity to offer testimony this afternoon in opposition to H.B. No. 6609 (RAISED) AN ACT CONCERNING NURSING HOME TRANSPARENCY.

The legislation will require only for-profit nursing homes to include in annual cost reports a profit and loss statement for each related party that the nursing home pays ten thousand dollars or more a year for goods, fees and services and a profit and loss statement for each nursing home transaction with such party. The bill defines "related party" to include, but is not limited to, companies related to such nursing homes through family associations, common ownership, control or business association with any of the owners, operators or officials of the facility. The bill further requires that the profit and loss statement must also include the actual cost of the goods and services, including a detailed account of the goods and services purchased and fees paid, and the mark-up, profit or administrative charges related to such purchase.

This legislation is harmful because it imposes burdensome requirements on all for-profit nursing homes without reason. The requirements are inexplicable. There is no apparent reason for these details to be disclosed. The information has no bearing on the setting of Medicaid rates or relevance to any other component of the rate-setting process, audit process or certificate of need process. The bill also inexplicably targets for-profits nursing homes while nonprofit nursing homes are similarly required to file annual cost reports, without being required to furnish related party financial information. Finally, the bill targets nursing homes when a full range of similarly situated health care and human service providers of services to DSS, DCF, DMHAS and DDS (hospitals, group homes, clinics) that have their payments determined in whole or in part based on cost report filings. Moreover, there are existing cost limitations and caps within the present rate-setting methodology designed to prevent costs unrelated to patient care from being reimbursed in the Medicaid rates.

The longstanding current requirements of the law provide a level of satisfactory detail in this area. The annual cost report already requires disclosure of all payments to related entities and actual costs. With regard to related party transactions federal law states that "...costs applicable to services, facilities, and supplies furnished to the

provider by organizations related to the provider by common ownership or control are includable in the allowable costs of the provider at the cost to the related organization.”, 42 CFR 413.17. Accordingly, page 4 of the cost report requires the provider to identify all related parties with whom there are transactions, and requires the provider to identify the costs reported by the provider AND the “Actual Cost to the Related Party.” Such a requirement in effect discloses whether or not and to what extent there was a profit or loss associated with each related party transaction. Our association is not aware of any problem with proper reporting of related party payments. It should be noted that reports are filed subject to penalty of perjury. Current rules appropriately do not require information unrelated to the governmental purposes of reimbursement, audit or CON.

Further, federal law already requires extensive reporting of ownership and control information by nursing facilities. In addition to already existing requirements for disclosure of ownership and control information under federal regulations, the Accountable Care Act has added additional disclosure requirements to further the goal of transparency which require reporting of any person or entity with any operational, financial or managerial control over a nursing facility or who provides policies and procedures to the facility or who has any financial interest in the real property, whether through direct or indirect ownership or as holder of a mortgage or security interest. Nursing facilities must now disclose all of the following information under federal law (42 USC 1320a-3):

1. Anyone with direct or indirect ownership of 5% or more;
2. Officers, directors, partners;
3. Managing employees;
4. Name of any person/entity owning a mortgage, deed of trust, note, or obligation secured by the facility or property of the facility, if the interest is 5% or more of the total property;
5. Identity of each member of the governing body;
6. The organizational structure of any "additional disclosable party" and relationship to the facility. Additional disclosable party is defined as any person or entity who:
 - a) exercises operational, financial or managerial control over all or part of a facility or provides policies and procedures or financial and cash management services;
 - b) leases or subleases property to the facility or owns a whole or part interest of at least 5% of the value of the real property; or
 - c) provides management or administrative services, management or clinical consulting services or accounting or financial services.

In closing, Connecticut nursing homes remain in a period of ongoing financial distress. Medicare reductions in 2012 were as high as 16% in many Connecticut nursing homes and additional federal cuts are proposed this year. A 2% Medicare sequestration cut, unfortunately, is now set for April 1, 2013. On average, providers are paid today \$14.73 per patient day less than what it costs to care for our residents. For the typical nursing facility, this represents over \$400,000 per year in unfunded costs. There has been no rate increase in the system since 2007, except for increases made possible by increasing the user fees paid by nursing homes themselves (these increase are proposed

for reduction in this budget). More challenges are ahead as the state continues its efforts to rightsize and rebalance Connecticut's long term care system. H.B. No. 6609 is a distraction from efforts to address the important issues nursing homes face in this challenging environment. We urge no action on the bill for these reasons.

I would like to offer our general support for the need for studies provided in the following bills, and our offer to participate with expertise and resources in any study undertaken in these important areas:

S.B. No. 1086 (RAISED) AN ACT CONCERNING LONG-TERM CARE.

H.B. No. 6607 (RAISED) AN ACT CONCERNING NURSING HOMES.

H.B. No. 6608 (RAISED) AN ACT CONCERNING AN INTEGRATED SYSTEM OF CARE.

I would also like to reiterate our request that the issues raised in HB 5106 also be studied, perhaps as part of a more comprehensive review of nursing home issues. I have included once more our testimony on HB 5106 below for your consideration, delivered at the February 19, 2013 Human Services Committee public hearing.

“Proposed H.B. No. 5106 AN ACT CONCERNING CHARGES FOR PATIENT CARE BY NURSING HOMES.

Good afternoon Senator Slossberg, Representative Abercrombie and to the members of the Human Services Committee. My name is Matthew V. Barrett, Executive Vice President of the Connecticut Association of Health Care Facilities (CAHCF), our state's one hundred and sixty-six (166) member trade association of skilled nursing facilities and rehabilitation Centers. Thank you for this opportunity to offer testimony this afternoon on Proposed H.B. No. 5106 AN ACT CONCERNING CHARGES FOR PATIENT CARE BY NURSING HOMES.

This legislation proposes that “the general statutes be amended to change the current flat-rate system used by nursing homes to charge for patient care to a new system that calculates such charges based on each patient's individual health care needs.” According to the proponent, the stated purpose is to reduce the state's overall Medicaid costs. This type of Medicaid nursing facility payment system is commonly called a “case mix” system where payments to providers are made based on the level of care provided to the residents. These payments systems are also referred to as acuity-based or acuity adjusted payment models. The Medicare payment system is an acuity based payment system.

The implications of moving from our current system to a case mix system would be far reaching and complex. A significant change of this type should only be made after careful study. Our association would commit to fully participating in such a study should the state legislature direct a case mix or acuity payment system study.

A review of the current rate setting system is certainly warranted at this time, particularly in light of the impact of the dramatic aging of our population, long term care rebalancing, rightsizing and a range of home and community based service initiatives.

Nursing home operators believe that the acuity of nursing home residents will continue to rise measurably as our population ages, even as more residents choose home and community based environments to receive their care. The existing system has been unable to reflect these changing dynamics. A review of the payment system should include evaluating the implication of moving to an acuity adjusted for this reason.

However, a review should also evaluate the effectiveness of Connecticut's current rate-setting system. It can be said easily that the current payment system is not allowed to function as it was intended. There has been no rate increase in the system since 2007, except for marginal increases made possible by increasing the user fees paid by nursing homes themselves. The Fair Rent component of the rate formula, which incents nursing home quality improvement, was frozen in 2009 and only partially restored last session, with the leadership of the Human Services Committee. This is especially important given that many nursing homes in Connecticut are nearly 40 years old and have the need for ongoing investment in the facility infrastructure, including meeting updated building requirements, and life and safety infrastructure maintenance. On average, providers are paid today \$14.73 per patient day less than what it costs to care for our residents. For the typical nursing facility, this represents over \$400,000 per year in unfunded costs.

The inadequate system has produced a lawsuit file by CAHCF, which is still pending against the state of Connecticut. Our cost-based prospective payment system is not allowed to function, therefore as acuity rises in the nursing home setting, the program today is unable to reflect those costs. When this matter was last reviewed in Connecticut in a 1993 acuity study, researchers found a moderately strong correlation between current Medicaid rates and facility case mix. In their words: "This means that current cost-based rates partly reflect resident care need – higher rates for some facilities with higher resource use (heavy care) and lower rates for some facilities for some facilities with lower resource use (light care) residents." However, this system since 1991 has never been implemented. Instead, the annual Appropriation Act has set nursing rates based on available resources.

In closing, the current system and an acuity based system should be reviewed and our association would gladly participate in such a well-timed evaluation."

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

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