



**Testimony of Deborah Chernoff, Director of Public Policy, District 1199/SEIU
Before the Human Services Committee**

Thursday, February 20, 2014

***Supporting: HB 5051: AN ACT IMPROVING TRANSPARENCY OF NURSING HOME COST
REPORTS and HB 5136, AN ACT CONCERNING NURSING HOME TRANSPARENCY***

***Opposing: HB 5052: AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET
RECOMMENDATIONS FOR HUMAN SERVICES PROGRAMS***

Good morning, Senator Slossberg, Representative Abercrombie, and members of the Human Services Committee. My name is Deborah Chernoff and I am the Director of Public Policy for the New England Health Care Employees Union, District 1199. I also serve on the state's Long Term Care Advisory Committee, representing 25,000 health care members, including our 6,000 nurses, aides and support staff who provide care in Connecticut's skilled nursing homes.

Supporting HB 5051 and HB 5136: The Requirements and Purpose of the Bills

Both 5051, which is the Governor's Bill, and 5136 promote greater transparency in the cost reports filed annually by nursing home operators with the Department of Social Services. Both bills would require the operators of skilled nursing homes that pay significant amounts of money (in excess of \$10,000 per year) to related parties or companies to include profit-and-loss statements for such companies.

More Transparency Required: \$136 Million paid to related parties in one year

Nursing home operators pay out hundreds of millions of dollars to "related parties" for goods and services such as rent or lease payments, management services, pharmaceuticals, medical supplies/equipment, therapy services and temporary personnel. **For Cost Year 2011 (October 1, 2010 to September 30,2011), just the 10 largest nursing home chains operating at that time in Connecticut together paid more than \$136 million, as detailed in the chart below:**

Corporate Entity/Chain	# of facilities	Total payments to related parties, CY 2011
Apple Health Care	24	\$ 36,110,215.00
Athena Health Care Systems	18	\$ 10,333,145.00
Genesis Healthcare	9	\$ 19,988,697.00
HealthBridge Management/Care One	9	\$ 14,123,005.00
iCare Management	9	\$ 12,437,361.00
Ostreicher/National Health	11	\$ 22,625,370.00
Paradigm Healthcare Development	6	\$ 2,867,082.00
Ryders	6	\$ 4,068,623.00
Spectrum Healthcare	6	\$ 2,424,266.00
SunBridge Healthcare	9	\$ 11,057,173.00
TOTALS	107	\$ 136,034,937.00

Table 1: All data from "Annual Report of Long-Term Care Facility" for Cost Year 2011

More recent financial data for Cost Year 2013 from these facilities was just recently submitted to DSS. We plan to review, analyze and report that data to the legislature within the next few weeks.

HealthBridge Management: An Ongoing Object Lesson

The protracted legal and labor dispute involving HealthBridge Management provides clear evidence of the need for greater transparency from nursing home corporations. HealthBridge is one of a group of inter-related companies based in New Jersey that operate, lease and supply eight Connecticut facilities, five of which are unionized.

In July of 2012, after lengthy negotiations did not produce agreement on new contracts, HealthBridge declared that negotiations had reached impasse and unilaterally changed the terms and conditions of their collective bargaining agreements at five union nursing homes, prompting a strike. The National Labor Relations Board issued numerous federal Unfair Labor Practice Complaints against the company for unlawfully declaring impasse and changing the contract terms.

A US District Court Judge subsequently issued an injunction against the Company, ordering them to revoke the contract changes and re-engage in bargaining. After a lengthy legal battle, the Court found the Company in civil contempt for failing to comply with the injunction.

So far, however, HealthBridge has been able to circumvent the Judge's orders by declaring that the facilities are in bankruptcy and getting a New Jersey judge to approve the same destructive contractual cuts and changes that the Labor Board found to be illegal. They have been able to do this because they filed for bankruptcy for each individual facility, **but not for HealthBridge Management itself, nor for any of the other related entities that collect tens of millions of dollars each year from taxpayer dollars towards rent, pharmaceuticals and other goods and services.**

Because all of these related businesses are privately held, no public financial information is available beyond that in the current Cost Reports. Without greater transparency in reporting financial data, no one can make an informed decision regarding the company's claims of financial hardship. Not only do the taxpayers of Connecticut continue to foot the bill, but HealthBridge has been able to evade, at least for now, complying with lawful orders from federal courts.

Nursing Home Closures Put Residents at Risk, Require Financial Scrutiny: The Wethersfield Story

A HealthBridge facility in Wethersfield, which closed in 2013, illustrates another serious public policy interest in greater transparency around nursing home finances.

If a nursing home submits an application with DSS for a Certificate of Need to terminate services, based largely on the facility's assertion that it is not financially viable, DSS does not currently have access to important information necessary to make the right decision on a matter of such deep public concern and serious consequence as closing a nursing home. Many individual nursing homes report significant losses in a given year while expending millions of dollars in payments to other, related businesses.

This is not just a theoretical risk. As reported in 2012 in the *Hartford Courant*, DSS initially rejected a Certificate of Need application from the operator of the Wethersfield Health Care Center after that operator, HealthBridge Management, **refused to supply financial information requested by the Department that would justify the closure**, even though the primary rationale given by the company for closure was the financial condition of the facility. The facility was closed some six months later.

Because that facility was the only skilled nursing home in Wethersfield, those residents not only lost their home, they lost access to their community and their families and friends now have to travel to visit them. Serious consequences flow from nursing home closures; DSS and consumers alike should have access to the information that supports – or doesn't – such a serious decision.

The Haven Healthcare Scandal

Connecticut has had a few other exceptional bad examples of nursing home operators using public funding for their own purposes and gain, instead of for providing care to the frail, elderly or infirm residents living in their facilities. It would be hard to forget or ignore the case of Haven Healthcare, whose CEO, Ray Termini, built one of the larger chains of nursing homes in the state. In 2007, Haven filed for bankruptcy immediately after a series of articles in the *Hartford Courant* exposed a history of poor patient care and dubious financial transactions.

Haven CEO Termini and his company became the subject of federal and state investigations into whether Medicaid and Medicare funds designated for patient care were fraudulently diverted into other personal investments, **including a \$5 million personal loan to the CEO which went to purchase, among other things, three apartment buildings, a yacht and a Nashville recording company**. Mr. Termini subsequently went to prison, but the fraud was exposed by

investigative reporting rather than through DSS. In fact, the DSS Commissioner declined to follow a recommendation from then Attorney-General Richard Blumenthal that the homes be put in state receivership, because "there is nothing that appears to violate any regulations or rate policies." ("Haven Alarm Raised in '06," *Hartford Courant*, December 18, 2007).

Why Cost Reports Matter

The "Annual Report of Long-Term Care Facility," as these reports are formally designated, lack the information and transparency about nursing homes' corporate financial transactions needed to promote good public policy, responsible state expenditures, informed decision-making and consumer rights; this bill addresses that critical information gap.

Cost reports are a key component of the state's rate-setting procedures for Medicaid reimbursement, which is the major source of funding for Connecticut's skilled nursing facilities. About 70% of care provided in our state's nursing homes is paid through Title XIX.

The Cost Reports do give DSS a great deal of the information the state needs to monitor whether precious state resources are being expended appropriate for the care of the 27,626 residents of Connecticut's nursing homes. They also **provide a snapshot of the financial health of individual facilities, which is an important element in state decisions regarding applications to change or terminate services at a skilled nursing facility.**

Essential Data Missing from Cost Reports

However, the kind and level of the financial data now contained in these cost reports is no longer adequate to inform these important public policy decisions. The nature of the nursing home industry has changed radically over the last few decades, moving from a preponderance of small "mom-and-pop" facilities and non-profit operators to more and larger corporate, for-profit regional or national chains. Many of these chains operate on a vertically-integrated business model, where the individual facility, generally incorporated as a Limited Liability Corporation (LLC), purchases many of its major services and supplies from other **related businesses or entities – businesses which are related by family associations, common ownership, common control or business association with the owners, operators or officials of the individual facility.**

However, often all of the related businesses are privately held, making it impossible for DSS to evaluate the real financial situation of the home because **the state has no access to information about whether those related businesses are profitable or not.** Nor is it possible for those families or individuals who pay for nursing home care out of their own pockets to

evaluate if an increase in private-pay rates is justified when the nursing home raises those rates.

To a greater or lesser extent, most for-profit nursing home chains make some payments to related parties for major cost components including rent/lease, management services, pharmaceuticals, medical supplies and equipment, staffing, consultants, and specialty care such as physical, occupational or respiratory therapy. Many of these individual facilities report losses, sometimes very large losses, on their cost reports. While nursing homes are obliged to report the existence and amount of such payments to related entities, **they do not have to supply the detailed information necessary to make a full assessment of the real financial condition of the facility.**

Of course, management services, drugs and temporary staffing are all legitimate costs for a nursing home, but there is no detailed reporting that would show us whether these costs and charges are standard, discounted or inflated.

Given the often-complex vertical integration of these related companies, **it would certainly be possible for the individual nursing home to serve as a kind of "loss leader," where the facility itself loses money while funneling millions of dollars to highly-profitable related businesses.** Is that the case? Never, sometimes, often? Unless we significantly enhance the financial transparency of nursing home cost reports, our state will lack access to the information necessary to make that evaluation.

The State's Interest Requires Transparency of Financial Data

The state has an obvious interest in **making sure that nursing homes are not overcharging by overpaying related entities.** This means if nursing homes want to do business with related entities they can be put to the following choice: either provide from themselves and the third parties documents which demonstrate that the nature of the relationship and that the internal accounting for charges is fair and reflective of the market, or don't do business with related entities.

This is comparable to the rules for charitable boards. A charity can do business with entities that are controlled by its board members, but if it does so, it must be able to demonstrate that such business is not overcharging (thus turning the charity into a tax exempt for-profit), or it must not do that business.

Caps on Reimbursement Rates Don't Resolve Key Issues

Some might argue that the additional cost reporting requirements contained in this legislation are unnecessary because the state controls reimbursement for Medicaid expenses by a variety of mechanisms including caps on the amount of expenditures by nursing homes on different "cost centers." For example, in determining an appropriate daily rate of Medicaid reimbursement, DSS looks at the actual cost of direct nursing care, but caps the allowable amount to be reimbursed at 145% of the median rate for that cost center. Therefore, if a particular nursing home spends significantly more than the median, it will not be reimbursed by the state for the higher amounts.

The caps, however, only address the reimbursement issue, not the expenditure issue and only for those "cost centers" that are capped – there is, for example, no cap on capital expenditures. There are no regulatory limits on how much a nursing home can spend, and such expenditures contribute to the overall financial health of the facility. The losses claimed by the Wethersfield Health Care Center were offered as justification for closure of the facility. Dozens of other nursing homes have done the same in the past and, as a result, hundreds of residents have been evicted and forced to relocate, while hundreds of workers have lost their jobs, and related businesses have suffered loss of revenue.

The State of Connecticut has a critical interest in transparency in order to protect the rights and interests of nursing homes residents and their families, to afford access to information for consumers and to make wise use of the more than \$1.6 billion we expend annually on nursing home care.

This legislation is good public policy. The changes are consumer-friendly and necessary to protect the vital interests of one of the state's most vulnerable populations – as well as our precarious budget. I urge you to support these bills.

Opposing HB 5052: Changes to the Re-basing Statute for Nursing Homes and IDF/DD Facilities

The caregivers in our union strongly oppose the provisions of HB 5052 that would alter the current statutory language regarding re-basing of Medicaid reimbursement rates for skilled nursing homes and ICF/DD facilities.

Medicaid, which pays for about 70% of all the resident care in Connecticut nursing homes, already historically and routinely pays less than the actual cost of care, resulting in inadequate staffing, layoffs, hours cuts and cuts to the compensation for nursing home staff. Now we see legislation proposed that will make a bad situation completely untenable. House Bill 5052, if

enacted, will remove one of the few remaining mechanisms for allowing nursing homes to see their actual costs of providing care reflected in their reimbursement rates by (1) changing the re-basing statute so that rates can go down with lowering costs but not up to reflect higher costs and (2) eliminating any potential adjustments for inflation. Since nursing homes can't turn down the heat or stop serving food – and those costs WILL increase, since we can't legislate away inflation – we will see more hours and jobs cut, even worse staffing ratios and even fewer employees with adequate health benefits, forcing them onto the Medicaid and HUSKY insurance rolls, where we just pay for benefits from a different budget line. Those same changes regarding rebasing and inflation will also impact our direct care staff who work for private DD/ID agencies, where many of our members have not had a wage increase in five years.

Pretending that there is a no-cost solution, or that the problem will go away if we ignore it long enough, or that home care can make everything better if we just clap our hands and believe, but don't invest, is magical thinking. Quality care for people costs money, no matter where or how it's delivered, whether home- or facility-based, and we can't wish – or even legislate – that reality away. So I urge you to think long, carefully and compassionately about the real costs and consequences of continuing to underfund and undermine long-term care for the elderly and people with disabilities – not just about the short-term effects on our budget balance.

Thank you.