February 26, 2015

Written testimony of Matthew V. Barrett, Executive Vice President of the Connecticut Association of Health Care Facilities (CAHCF), concerning

H.B. No. 6846 AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES PROGRAMS.

Good afternoon Senator Moore, 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 (160) member trade association of skilled nursing facilities and rehabilitation centers. Thank you for this opportunity to offer testimony this afternoon concerning H.B. No. 6846 AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES PROGRAMS.

Because this is legislation introduced to implement the Governor's biennial budget recommendations, I would like to begin with our observations about the budget as implicates skilled nursing facilities and rehabilitation centers (SNFs) (Source Governor's FY 16 and FY 17 Budget Recommendation):

"Reduce Medicaid Provider Rates

This proposal reduces Medicaid rates for most providers. The department will have discretion as to the distribution of this reduction. This proposal does not impact federally qualified health centers which are reimbursed under a federally prescribed payment system. To help with access to primary care services, rates for primary care services are not expected to be reduced. Savings figures reflect the state's share of Medicaid expenditures. After factoring in the federal share, thisproposal will reduce total Medicaid expenditures by $107.5 million in FY 2016 and $117.5 million in FY 2017.

Remove Statutory or Regulatory Inflation Adjustments

Effective July 1, 2015 and July 1, 2016, recipients of Temporary Family Assistance, State Administered General Assistance, and Aid to the Aged, Blind and Disabled are scheduled to receive a state-funded cost of living adjustment based on the percentage increase in the Consumer Price Index - Urban. This proposal eliminates the standards increases for the biennium. In addition, under current statute or regulation, DSS is required to provide funding for an inflationary increase for nursing homes, intermediate care facilities for individuals with intellectual disabilities and boarding homes. This proposal eliminates these increases over the biennium. Savings figures reflect the state's share of Medicaid expenditures ($6.9 million in FY 2016 and $17.8 million in FY 2017). After factoring in the federal share, this proposal will reduce total Medicaid expenditures by $13.8 million in FY 2016 and $35.6 million in FY 2017."

111 Founders Plaza • Suite 1002 • East Hartford, CT 06108 • Telephone (860) 290-9424 • Fax (860) 290-9478

I understand that these matters will be addressed in the appropriations process, but I view the Human Services Committee deliberations as so important in informing the appropriations process---in this regard, I would like to simply point to the public record and body of evidence collected by the Human Services Committee earlier this session at its February 5, 2015 public hearing considering several bills to provide a COLA or other cost adjustments for Connecticut SNFs. At that hearing, the committee heard testimony on Proposed H.B. No. 5586 AN ACT INCREASING NURSING FACILITY RATES; Proposed H.B. No. 5812 AN ACT CONCERNING A COST OF LIVING INCREASE FOR NURSING FACILITIES; and Proposed S.B. No. 231 AN ACT CONCERNING COST-OF-LIVING INCREASES FOR NURSING HOMES.

The bills address the same issues of the proposed biennial budget. Medicaid Nursing facility rates have been basically flat since 2007, but costs have been dramatically rising. The bills address the fundamental problem of the escalating cost of proving high quality health care by increasing payments based on a cost of living adjustment. Dozens of skilled nursing facilities from all across Connecticut have submitted testimony or have appeared in person at the February 5, 2015 public hearing to express what this dilemma means where the care is actually delivered---at the skilled nursing facility.

The message from the operator's point of view is simple----they need your help. The skilled nursing facilities just can't continue on a path where no help is provided without strapping our employees and jeopardizing quality.

In late 2014 the CAHCF formed a workgroup consisting of individuals in the following disciplines: legal, operational, clinical, finance and reimbursement from the skilled nursing facility sector . Over the course of several weeks the workgroup collaborated to identify and quantify uncontrollable annual cost increases incurred from October 1, 2011 by a typical 120-bed nursing facility located in Connecticut. The date of October 1, 2011 was chosen as it represents periods subsequent to the latest period used to rebase Medicaid rates for the nursing facilities.

Preliminary findings indicate that, with respect to the uncontrollable annual cost increases, the typical 120-bed nursing facility would incur approximately $89,500, consisting of:

- Electricity Rates - $17,000
- Natural Gas Rates – $12,000
- FUTA Credit Reduction - $16,000
- Affordable Care Act - $39,000
- Encryption Software (HIPPA) - $500

- Criminal Background Checks - $5,000

The workgroup has not finished its analysis as of the date of this report. Additional identifiable and quantifiable costs are anticipated which are likely to include those associated with the following:

- PA 13-70 Training staff about fear of retaliation
- PA 14-194 Dementia training
- PA 14-231 Oral health and hygiene training
- PA 13-208 Section 3 Background checks for volunteers

CAHCF asks of the Human Services Committee is to carry that message forward to your leaders in both caucuses.

As for the legislation before the committee today (HB 6846), I have the following recommendations:

Section 23 and 24. CAHCF recommends that a review of the moratorium and policies governing exceptions to the moratorium be referred to the Nursing Home Finance Advisory Committee (NHFAC) for their careful consideration and recommendation before additional legislation is adopted. In the meantime, the legislature should only extend the nursing home bed moratorium at this time,

As background, Public Act 14-55 (Sec. 2) adopted in the previous legislative session charges the Department of Social Services (DSS) and the Department of Public Health (DPH) with reconvening the long dormant Nursing Home Financial Advisory Committee (NHFAC). Among other things, the NHFAC must evaluate "the overall infrastructure and projected needs" of Connecticut's SNFs. Further, the NHFAC is charged with recommending "appropriate action consistent with the goals, strategies and long term care needs" with the state's long term care strategic rebalancing plan. Additionally, the law requires DSS to provide quarterly reports on the NHFAC to the Human Services Committee and an annual report to the full Connecticut General Assembly. We understand that DSS and DPH intend to convene the NHFAC in March 2015.

For these reasons, the provisions contained in Section 23 and 24 concerning the mechanisms to close a SNF, the interim close down rate requirements, and the provisions allowing the transfer of beds to another facility should be referred and evaluated by the NHFAC, and a recommendation made to the Human Services Committee and the state legislature, as contemplated in Public Act 14-55. There are apparently no corresponding budgetary provisions associated with these two sections, therefore adoption in this session is not imminent.

Section 26. While CAHCF supports the state's long term care rebalancing goals, we urge you to take no action on this provision as drafted. The language provides:

(e) If a nursing facility has reason to know that a resident is likely to become financially eligible for Medicaid benefits within one hundred eighty days, the nursing facility shall notify the resident or the resident's representative and the department. The department may (1) assess any such resident to determine if the resident prefers and is able to live appropriately at home or in some other community-based setting, and (2) develop a care plan and assist the resident in his or her transition to the community.

This language is improper as it requires the SNF to divulge private information to DSS on a nursing home resident that at the time of disclosure has not yet applied for long term care Medicaid assistance. This resident, in fact, has no relationship with the DSS at all at this time. For this reason, it is very likely a violation of the resident's privacy to disclose this information to the government.

Moreover, the SNF is in no position to have a clear "reason to know that a resident is likely" to become eligible for long term care Medicaid. The long term care Medicaid application process is often characterized by long delays as a result of undisclosed information, which leads to periods of ineligibility are commonplace. This provision improperly requires the SNF to make a determination that is in no position to make.

However, a considerable amount of information is currently available to DPH and DSS in the "Section Q" CMS Minimum Date Set (MDS) requirements pertaining to all SNFs:

> "---Section Q has broadened the scope of the traditional boundary of discharge planning for sub-acute residents to encompass long stay residents. In addition to home health and other medical services, discharge planning may include expanded resources such as assistance with locating housing, transportation, employment if desired, and social engagement opportunities.
>
> o Asking the resident and family about whether they want to talk to someone about a return to the community gives the resident voice and respects his or her wishes. This step in no way guarantees discharge but provides an opportunity for the resident to interact with LCA experts.
>
> o The NF is responsible for making referrals to the LCAs under the process that the State has set up. The LCA is responsible for contacting referred residents and assisting with transition services planning. They should work closely together. The LCA is the entity that does the community support planning, (e.g. housing, home modification, setting up a household, transportation, community inclusion planning, etc.). A referral to the LCA may come from the nursing facility by phone, by e-mails or by a state's on-line/website or by other state-approved processes. In most cases, further screening and consultation with the resident, their family and the interdisciplinary team by the nursing home social worker or staff member would likely be an important step in the referral determination process.".

Under these CMS requirements, the LCA stands for the "local contracting agency". In Connecticut, this is the state's Money Follows the Person Program. Accordingly, all SNFs, through the MDS Section Q, currently report whenever a resident or family member indicates they would like to talk to someone about returning to the community. Moreover, the SNF is now required to refer such cases to the MFP program. Given these existing requirements, CAHCF recommends a substitute version of Section 26 to expedite the MFP intervention and care planning.

CAHCF Recommended Substitute language:

(e) Whenever the Department of Social Services receives an application for long term care Medicaid for an individual residing in a nursing home, or has reason to know that a resident is likely to become financially eligible for Medicaid benefits within one hundred eighty days, the Department shall notify the resident or the resident's representative. The department shall (1) assess any such resident to determine if the resident prefers and is able to live appropriately at home or in some other community-based setting within thirty days, and (2) develop a care plan and assist the resident in his or her transition to the community within thirty days.

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

For additional information, contact: Matthew V. Barrett, Connecticut Association of Health Care Facilities, (cell) 860-373-4365 or mbarrett@cahcf.org