September 21, 2016

Written testimony of Matthew V. Barrett, President and CEO of the Connecticut Association of Health Care Facilities (CAHCF) concerning the Program Review and Investigations Committee (PRI) Study of Factors Influencing Receipt of Long-Term Care Services and Supports in Home and Community Settings.

Good morning Senator Fonfara, Representative Carpino, and to the distinguished members of the Program Review and Investigations (PRI) Committee, my name is Matthew V. Barrett. I am the President and CEO of the Connecticut Association of Health Care Facilities (CAHCF), our state's trade association and advocacy organization of one-hundred and fifty skilled nursing facilities and rehabilitation centers. Thank you for this opportunity to testify on the ongoing committee study titled: "Study of Factors Influencing Receipt of Long-Term Care Services and Supports in Home and Community Settings."

The scope and breadth of this important study will examine what differentiates Connecticut residents who receive long-term services and supports (LTSS) in the community versus in nursing homes, and identify ways these findings may be used to increase efficiency and potentially reduce costs. Possible influences include: characteristics of the individuals and the nursing homes; the transition planning/process; services available in the community, including informal family supports; and payer source of LTSS.

At the outset, I would like to state CAHCF's ongoing general support for Connecticut's 2016 LTSS Plan and the overall effort to utilize Connecticut's scarce state resources in the most cost-effective manner as our state braces up to deliver LTSS to a well-documented and rapid expansion of older adults, which Governor Malloy has publicly referred to as the "silver tsunami." Connecticut has been a longstanding leader in developing a strong array of home and community based services as an alternative to care provided in skilled nursing facilities and other facility-based settings. Connecticut has been recognized as having one of the most comprehensive Money Follows the Person initiatives in the nation. Indeed, our state is seeing remarkable progress is shifting a policy emphasis and corresponding resources to home and community based services. Corresponding to these initiatives, there are been remarkable claims outside of state government about state Medicaid savings associated with accelerating even further this transformation.

For this reason, CAHCF is especially interested in the component of the study "examining the costs of care for persons with disabilities and older adults in nursing homes versus home/community care setting. The study has the promise of informing the public budgeting aspect of LTSS for the next decade. This is a welcome and much needed evaluation. During a time of ongoing state budget deficits, it is especially important to as accurately as possible forecast state expenditures and savings initiatives in the areas of LTSS. The ongoing instability of the Connecticut state budget in the area of Medicaid will inevitably be an area of focus. In this regard, it would be very important not to overstate the case for savings in the area of LTSS rebalancing as we might exacerbate the very the problem we are seeking to solve.

At this time, I am happy to provide the following information on the cost-effectiveness of the skilled nursing facility model of care.

Medicaid Expenditures and Care Provided by CT Nursing Facilities

Medicaid expenditures for the typical nursing facility	
Medicaid per diem rate	$233 a
Provider Tax paid by nursing facility to State of Connecticut	$(21) b
Applied income paid by resident from Social Security Benefit	$(43) c
Medicaid expenditure for the typical nursing facility	$ 169
Federal Match funding 50% (Medicaid rate less applied income)	$ (95) d
Net State Medicaid expenditures per day	$ 74

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a – For the purpose of this analysis $233 was used as it equals the average nursing home Medicaid rate effective July 1, 2015 per Connecticut Department of Social Services
b – Source: Connecticut Department of Revenue Services
c – Source: Social Security Administration – Monthly Statistical Report – June 2016
d – Source: Federal Register November 25, 2015.

Against the above costs, it is very important to consider the full array of nursing home services provided in the nursing home setting against the intermittent care being provided in the home care comparison, including the situations when 24/7 care is provided in the community financed by Medicaid. For example:

Services provided under the Medicaid Program to residents in nursing facilities 24/7:
Skilled nursing care
Routine nursing care
Personal care
Physical therapy services
Occupational therapy
Speech pathology services
Clinical care supervised by a licensed medical director
Three meals a day supervised by a licensed dietician
Housekeeping and laundry services
Recreational activities
Social services by licensed personnel
Durable medical equipment
Housing compliant with Life Safety Code
Supplies and specialized medical equipment
Incontinence Care
24 hour monitoring of patients
24 hour RN care availability
Daily Recreational services provided by certified staff
All Housing related costs including utilities, cable TV, snow removal, landscaping and furniture
fuel assistance, non-medical transportation, recreation support services and adult daycare services

As the study moves forward, we hope that the above analysis will offer a valuable perspective when the committee evaluates the cost comparison of skilled nursing facility care versus home and community based care. As an example, the maximum payment now available under the Medicaid-financed Personal Care Assistance (PCA) program is $225 per day, with the net cost to the state after 50% match $112.50 with a 65% match available only in the first year of the benefit for MFP clients. Similarly, under a recently approved federal Medicaid waiver, Connecticut will be able to offer home care benefits under the Connecticut Home Care Program for Elders Program in excess of the cost of skilled nursing facility care. These are not arguments against a policy of providing expanded home and community based services, however hope the committee will carefully considering these cost comparisons when estimating the costs of providing LTSS in Connecticut into the future.

There are several other areas where staff researchers should review to inform the public budgeting aspect of LTSS:

- An evaluation of the dynamic and assumption that all cases where Medicaid financed home care is not provided will incur a skilled nursing facility cost.
- An evaluation of the dynamic that persons who are not in immediate placement to a nursing home facility may become eligible for the home care benefit in increasing numbers.
- An evaluation of whether skilled nursing facility costs may continue to rise with the aging of the population even as more care is provided in the HCBS environment.
- An evaluation of the continuing dynamic of the nursing home population becoming older and requiring more complex care and staffing, as individuals with less care needs are addressed in HCBS environments

- The impact of the incidence of increasing numbers of persons in Connecticut with diabetes, obesity, Alzheimer's disease and dementia, and other areas of complex care and a forecasting of the associated costs
- Other state costs associated with HCBS based care, such as state rental certificates, community based meals on wheels program, fuel assistance, non-medical transportation, recreation support services and adult daycare services.
- A transparent list of those costs that must be paid for by the consumer in the HCBS environment.
- An evaluation of the costs of wage pressure in the HCBS settings as the federal courts have recently decided that certain live-in caregivers must be paid overtime and minimum wage as nursing homes must provide.
- The costs associated with pressure to increase HCBS wages to fully develop a professional HCBS workforce to care for expanded numbers of individuals.

We also hope the committee will review policies to further encourage the voluntary reduction of nursing home beds in the system. CAHCF believes that policies to encourage nursing homes to reduce beds, voluntarily close without the need for a CON, and movement toward a Medicaid acuity based payment system can help to achieve Connecticut's rightsizing and rebalancing goals.

I would like to restate that our recommended areas of further should not be perceived in any way in opposition to the policy direction of building a stronger infrastructure of home and community based services, and that they are recommended for the purpose of accurately estimating the costs of nursing home care versus HCBS.

Finally, I want to thank the committee staff persons assigned to the study, Mariam Kluger and Maryellen Duffy, for their professionalism, intelligence and diligence in their approach to the study. We look forward to continuing to work with the committee staff as the study moves forward.

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

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