CAHCF/CCAL
Connecticut Association of Health Care Facilities
Connecticut Center for Assisted Living

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Written testimony of Matthew V. Barrett, President and CEO of the Connecticut Association of Health Care Facilities / Connecticut Center For Assisted Living (CAHCF/CCAL)

Good afternoon Senator Moore, Representative Abercrombie and to the distinguished members of the Human Services Committee. My name is Matt Barrett. I am President and CEO of the Connecticut Association of Health Care Facilities / Connecticut Center For Assisted Living (CAHCF/CCAL). CAHCF/CCAL is a one-hundred-and-fifty member trade association of skilled nursing facilities and assisted living communities. Thank you for this opportunity to submit testimony on S.B. No. 1057 (RAISED) AN ACT CONCERNING NURSING HOMES.

INCREASED MINIMUM STAFFING REQUIREMENTS

This legislation would on or before January 1, 2022 require the Department of Public Health to establish minimum staffing level requirements for nursing homes of at least four and one-tenth hours of direct care per resident, including seventy-five hundredths hours of care by a registered nurse, fifty-four hundredths hours of care by a licensed practical nurse and two and eighty-one hundredths hours of care by a certified nurse's assistant.

As reported by the Staffing Levels Subcommittee of the Nursing Home and Assisted Living Oversight Work Group (NHALOWG) in January 2021: "Adequate numbers of qualified, trained, appropriately compensated, and caring staff are integral to support the needs of nursing home residents in a holistic and person-centered manner." There is no disagreement from CAHCF/CCAL on the policy goals expressed by the subcommittee. Further, the subcommittee acknowledged that achieving this result necessarily involves diverse strategies, including, but not limited to, establishing a daily minimum staffing ratio of at least 4.1 hours of direct care per resident.

Efforts to increase minimum staffing levels must consider two main implementation challenges. First, having an available workforce to fill the positions. Second, is the financial cost of employing more people. To help inform the implications of increasing staffing in this manner, CAHCF/CCAL obtained the support of the *Center for Health Policy Evaluation in Long Term Care* ("The Center") to provide a framework for estimating the costs of increasing minimum staffing ratios in Connecticut nursing homes. The full report is attached.

In this initial and preliminary framework, the *Center* reviewed creating minimum nurse staffing to resident thresholds in nursing homes (RN = 0.75, LPN = 0.54, and CNA = 2.81) for a Total Nursing Staffing of 4.1. In the report, the Center characterized the facilities currently below this threshold and calculated the number of additional staff and labor costs needed to achieve the proposed minimum staffing. They used staffing levels collected by the Center for Medicare and Medicaid Census (CMS) from nursing home payroll data. To estimate total labor

costs, they used average state labor costs, fringe benefits, and payroll tax rates. Further, the Center observed:

> Based on Q3 2020 staffing data, 181 (88.7%) of nursing homes in Connecticut are below the proposed minimum staffing threshold. The analysis was repeated using pre-COVID Q4 2019 staffing census data. Under pre-COVID conditions, the number of nursing homes below the minimum staffing threshold rose to 199 (97.5%). A big driver for this increase was a higher census pre-COVID. The average Connecticut nursing home census in Q4 2019 was 104 compared to 86 in Q3 2020. This is a 17% decline, which exceeds the national average decline of 14%. On average, Connecticut nursing homes below the staffing threshold are larger and have more Medicaid residents than the others. Their November 2020 Five-Star ratings were on average lower.
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> For Connecticut to implement minimum staffing ratios, we estimate it will require between 1,793-3,364 FTEs and cost $140.9-$273.9 million dollars. The exact figure will depend on resident census. To get the current 181 nursing homes above the proposed minimum staffing threshold, 1,793 FTEs would be needed statewide at a total annual cost of $140.9 million, including fringe benefits and payroll taxes. CNAs make up most of the needed FTEs (1,426) and cost ($95.0 million). This assumes census stays the same as it is now, which is much lower than before the COVID pandemic. To estimate the costs when census increases, our simulation was repeated using pre-COVID-19 Q4 2019 PBJ staffing census data. In this analysis, the number of nursing homes below the minimum threshold rose to 199 (97.5%). Also increasing were the number of needed FTEs (3,364) and costs ($273.9 million) to meet the minimum staffing.

As census returns over the next 18 months, we can anticipate these costs to increase further, necessitating accompanying reimbursement increases.

CAHCF/CCAL supports the effort to ensure adequate staffing at all nursing homes and to compensate all nursing home caregivers and employees at a level that recognizes their value. However, we favor a focus on elevating the status and importance of long-term care staff through recruitment and retention strategies and providing long underfunded nursing homes with the financial resources needed to address these staffing issues. A significant state and federal investment will be required to increase staffing requirements, minimum staffing ratios, or minimum wages during or after the pandemic when there are limited trained individuals to fill the positions and not enough resources to cover additional, unfunded costs.

We do not support a recommendation to establish a minimum percentage of reimbursement to be spent on staffing without further study of the issue in the context of planned shifts in reimbursement structure to an acuity-based system and more thorough consideration of potential impacts of such a requirement. Moreover, nursing homes currently must comply with state and federal rules requiring staffing to meet the needs of residents. Finally, nursing homes should be given the flexibility on where to direct the percentage of

staffing resources to RNs, LPNs and CNAs to address the specific care needs of the individual nursing homes.

A DIRECT CARE MINIMUM PERCENTAGE OF MEDICAID REIMBURSEMENT

The proposed bill also directs the Commissioner of Social Services, in consultation with the Commissioner of Public Health, to establish a minimum percentage of Medicaid reimbursement to nursing homes for the provision of direct care to nursing home residents. Establishing a direct care Medicaid reimbursement ratio to Connecticut nursing homes can only lead to reduced overall funding to nursing homes unless adequate funding for all direct care costs is provided in addition to addressing all the underlying underfunded costs in Connecticut's Medicaid rates for nursing homes, and addressing the increased costs associated with the pandemic-caused occupancy decline now being experienced. Moreover, nursing home expenditures are publicly transparent, costs are capped and have been found to be on average $25 below the actual cost of providing care.

Pre-COVID Connecticut Nursing Home Underfunding of $135 Million

As we have expressed to the Appropriations Committee, the pandemic has once more exposed the longstanding Medicaid underfunding of Connecticut nursing homes. If nursing home were funded in accordance with the rate setting formula, the allowable calculated rates per day would equate to $270.52 per day. Instead, for state budgetary reasons, the average issued rate to nursing homes of $239.96 (as of 06/30/2019) has represented an annual underfunding of otherwise reimbursable costs of $30.56 per patient day which, equates to and underfunding of $135,159,193. A 9.2 percent Medicaid increase is required to address this longstanding issue.

A Precipitous and Unprecedented Occupancy Decline Equates to a 14% Increase in Costs Requiring a 14% Medicaid rate increase ($177 Million)

The average occupancy rate in September 2019 was 88%. A year later it was 74% where it hovers. This means occupied beds have gone down from 22,197 to 18,402. The financial impact is worsened as the percentage of occupied nursing facility beds funded by Medicaid, where the cost of care is not fully reimbursed, has increased from 70% to 83% in SFY 2020. Moreover, the average monthly number of non-Medicaid residents in a nursing home has precipitously dropped from 6,688 in SFY 2019 to $3216 in SFY 2020. This 14% decline in occupancy essentially equates to a per resident increase to a commensurate increase in per resident costs of 14%. Addressing the increased costs in equally higher Medicaid rates would appropriately require a 14% increase in Medicaid rates amounting to $177 million increased Medicaid appropriation annually.

Transparency: Nursing Home Costs Have Allowable Cost Maximums, Public Cost Reporting and Audits.

Presently, nursing home financial information such as expenditures, revenue and balance sheet data are submitted annually to the Department of Social Services for per diem rate-setting purposes. DSS conducts annual audits of nursing homes. Facility costs, calculated on a per diem basis by category, are limited to maximums established as percentages of median costs in the Direct, Indirect and Administrative/General categories. *There are five costs categories with allowable cost maximums:*

1. **Direct** - Nursing and nurse aide personnel salaries, related fringe benefits and nursing pool costs.
2. **Indirect** - Professional fees, dietary, housekeeping, laundry personnel costs and expenses and supplies related to patient care.
3. **Administrative and General** - Maintenance and plant operation expenses, and salaries and related fringe benefits for administrative and maintenance personnel.
4. **Property (Fair Rent)** - A fair rental value allowance is calculated to yield a constant amount each year in lieu of interest and depreciation costs.
5. **Capital Related** - Property taxes, insurance expenses, moveable equipment leases and moveable equipment depreciation.

Transparency: Related Party Profit and Loss Statements

All for for-profit nursing homes must also include in their annual reports to DSS a profit and loss statement from each related party that receives from the nursing home fifty thousand dollars or more per year for goods, fees and services.

In conclusion, for these reasons, we urge the committee to take no further action on establishing a direct care Medicaid reimbursement ratio for Connecticut nursing homes.

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

For additional information, contact: Matthew V. Barrett, mbarrett@cahcf.org or 860-290-9424.

(c) The Commissioner of Public Health, in consultation with the Commissioner of Social Services, shall (1) review the current definition of the term "direct care" in the

regulations of Connecticut state agencies and consider redefining the term for purposes of minimum staffing level requirements, (2) review and implement best practices for establishing and maintaining minimum staffing levels at nursing homes, (3) encourage nursing homes to adopt payment incentives for staff to work in a single nursing home, and (4) prohibit the hiring of any person subject to a consent order issued by the Department of Public Health for violations of health and safety regulations pertaining to nursing homes from working at a nursing home in any capacity.

(e) The Commissioner of Public Health shall adopt regulations in accordance with chapter 54 of the general statutes to implement the provisions of this section.