Testimony to the Appropriations Committee

Presented by David Lawlor, Chair of LeadingAge Connecticut & Mag Morelli, President

February 19, 2020

HB 5005, An Act Adjusting the State Budget for the Biennium Ending June 30, 2021

Regarding the Governor's Budget Adjustment Proposals Related to the Department of Social Services

Good evening Senator Osten, Representative Walker and members of the Appropriations Committee. My name is David Lawlor and I am the President and CEO of United Methodist Homes in Shelton and the Chair of LeadingAge Connecticut, a statewide membership association representing not-for-profit provider organizations serving older adults across the continuum of aging services, including skilled nursing facilities, residential care homes, home health care and hospice agencies, adult day centers, assisted living communities, senior housing and life plan communities. I am joined by Mag Morelli, the President of LeadingAge Connecticut.

We thank you for this opportunity to testify on the Governor's budget adjustment proposals. While we have submitted written testimony with comments on the Medicaid program, the rebalancing of our system of long-term services and supports, and the Medicaid rates of reimbursement; I would like to focus my testimony this evening on the State's plan to transition to a new nursing home reimbursement system and then Mag will comment briefly on the Medicaid rates for home and community-based services.

Transitioning to a Case-Mix Rate Nursing Home Reimbursement System

As you know, the Department of Social Services is currently developing a case-mix rate nursing home reimbursement system designed to replace our current cost-based system. The new case-mix system will add an acuity-based component and one or more value-based performance incentives to the payment rates – and our association has been supportive of these concepts. The State has a target implementation date of July 1, 2020 and we have been pleased to be working with the Department and their consultants as they develop the new system.

While we support the idea of a case-mix system, we also recognize that this will be a major change in the reimbursement system – a change that has the potential of significantly impacting the financial landscape of the entire nursing home sector. It will therefore be extremely important for us to work together to ensure that quality, well-staffed nursing home care is not disrupted in this transition. Toward that goal, we have two priority requests of this Committee.

First, we request that the Committee include additional funding in the budget to meet the anticipated funding needs of the new system. We ask for this because the new system will only meet its intended objectives if it is fully funded. Otherwise, the current funding, which is woefully inadequate, will

merely be moved around and reallocated within the new rate system. We fear that quality nursing homes will be negatively affected by a resulting reduction in their rates while others will not receive nearly enough funding to cover the cost of caring for higher acuity residents.

The problem is that the transition to the new system is currently intended to be budget neutral, and since the current system is estimated to be underfunded by as much as $120 million, we can assume that the new system will also be underfunded – but to what extent we will not know until the financial modeling becomes available in late March or April – and possibly not until after the legislative session has ended.

In addition, it will be essential that the performance incentive payments, which are a hallmark feature of the proposed case mix system, be funded with additional resources. This is why we are asking you to anticipate the need and provide additional funding in the budget for the next fiscal year.

Second, we request that the Legislature remain apprised of the details involved in the development of the new system. The implementation is on a fast track with an anticipated July 1 start date and yet, we may not know the details of the new system until after the legislative session has adjourned. We are hopeful that your attention to the process will help to ensure that the final system design will deliver the resources needed to provide consumer access to quality nursing home care, to retain and recruit our workforce, and to meet the quality of life and physical environment expectations of consumers and regulators.

In our written testimony we have outlined several items that we would like to see incorporated into the new system, including an opportunity for nursing homes to proactively request a reduction in licensed bed capacity by July 1 so that the smaller bed count can be applied to their calculated base rate in the new system. Since a low census can be detrimental to a home's rate calculation, we see offering an opportunity to reduce beds as a chance to incentivize voluntary bed reduction for homes with excess bed capacity.

Requesting Annual Increases in Rates of Reimbursement for Home and Community-Based Services

We view the development of a new nursing home rate system through the lens of the rebalancing initiative. And while we need to address the changing demand for nursing home care on one end of the aging continuum, we also need to address the growing demand for home and community-based services on the other end. We believe we can address that growing demand by building and strengthening the home and community-based provider network.

And so, with a goal toward strengthening the home and community-based provider network, we respectfully request that the Committee consider instituting an *annual increase* to the rates for home and community-based services provided within both the Medicaid and the waiver programs. An annual investment in these rates will strengthen the community-based provider network, enable a successful rebalancing of the long-term services and supports system, and ultimately save the state money. Even if this increase is a small percentage, it will gradually build up the rate structure for this crucial network of providers.

We would like to express our appreciation for the recent 2% and 1% rate increases provided last year for the providers in the Connecticut Home Care Program for Elders (CTHCPE). The recent increases were helpful and demonstrate the benefit of a general rate increase. Unfortunately, a gap remains

between the rates of reimbursement and the costs of providing care for both these providers and for the licensed home health care providers who have not seen an increase in the Medicaid rates for skilled home care in years. We ask for your help and support in addressing this funding need.

We have provided more detailed written testimony, but our closing message is this. Please stay committed to the vision and progress we have made in the area of aging services and let us work together to provide a strong and balanced system of long-term services and supports.

Thank you for the opportunity to testify this evening and we would be happy to answer any questions.

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Managed Fee for Service Medicaid and the Changing Landscape of Aging Services and Supports

The aging services and health care delivery systems in Connecticut and across the country are in the midst of positive transformational change. This change is being driven by the move to coordinate and integrate care, as well as by the Affordable Care Act's triple aim of improving care quality and outcomes, and achieving positive patient experiences for all. The idea is that by providing better, more efficient and effective care, it will, in turn, slow the future growth of healthcare costs.

In Connecticut, this change is being implemented through several Medicaid initiatives, including a managed fee-for-service system and a strategic rebalancing plan that will allow more people the opportunity to receive aging services and supports in community-based settings. And it is working.

Nursing homes, home and community-based providers, physicians and hospitals are working hard on these Medicaid initiatives and it is making a difference in peoples' lives. *We agree with the Governor's continued support the of current Medicaid initiatives that are providing effective care, slowing the growth of Medicaid spending, and rebalancing the system of long-term services and supports.*

Increasing the Rates of Reimbursement for the Continuum of Long-Term Services, Supports and Health Care

Quality aging services – whether they are provided in the community or in the nursing home – cannot be sustained without rates of reimbursement that cover the cost of care. Medicaid providers are struggling to serve the older adult Medicaid client under the current reimbursement system and many providers are finding it increasingly difficult to stay in the program altogether. To maintain a strong network of providers, the rates of reimbursement must be increased to sufficient levels. If not, we risk losing ground on the strides that have been made in transforming our Medicaid program and our system of aging services and supports. We ask that the State stay committed to that transformational effort as our work intensifies and the older adult we serve becomes frailer, older, and in need of more care, not less.

Current rates of reimbursement are much lower than the actual cost of providing long-term services and supports and while the recent small rate increases were greatly appreciated, there is still a long way to catch up to the current cost of providing services. *We urge the Committee to develop a plan to adequately reimburse providers of aging services as we prepare for the aging of the state's population.*

Impact of a Minimum Wage Increase and the Workforce Crisis

The minimum wage phase in to $15 an hour is having an impact on all providers of aging services. As the minimum wage is increased, it raises the entire wage scale and increases the cost of corresponding benefits. As a result, we anticipate a continued and significant increase in our labor costs. Doing our best to assess the impact on our membership of non-profit nursing homes, we estimate the impact of the increase to the new minimum wage with 20% benefits for just these homes to be approximately $8 to 9 million. Our home health care members also report a significant impact, as do our community-based provider members.

The impact is also becoming evident in the competition for a steady workforce. As other employment sectors increase their wage scale, the ability to recruit and retain employees within the aging services sector has become more difficult, causing more pressure on our wage scales and the growing demand for employees. The workforce demand within aging services is reaching a crisis level. We urge the State to include this sector in their workforce efforts.

Nursing Home Rate History and the Transition to an Acuity-based, Case-Mix System

Connecticut's Medicaid program is aggressively pursuing a strategic rebalancing plan for long term services and supports and nursing homes are at the center. The state's rebalancing plan calls for nursing homes to realign their structures, redesign their environments and reduce their bed capacity while intensifying their work as those they care for become frailer, older, and in need of more care. But the state must recognize that while they anticipate the need for fewer nursing homes, *they must invest in the nursing homes that will still be desperately needed by those who cannot be cared for at home.*

Medicaid is the single most important public source of funding for nursing home care, but the fact is that current Medicaid rates do not meet the cost of providing this care. 74% of residents living in nursing homes count on Medicaid to pay for their care, but the average daily Medicaid rate that is paid to a nursing home is significantly lower than the cost of providing that care. Connecticut's current Medicaid rate structure is outlined in statute and is based on a calculation of the allowable costs of providing daily nursing home care – but the actual per diem rates paid are much lower than the calculated rates due to years of legislated rate freezes. In fact, recent rate analysis data available from DSS shows that the paid per diem rates in total fall an estimated $91 to 120 million short of the actual calculated rates. Individually, LeadingAge Connecticut nursing home members are experiencing large gaps between what the current rate system calculates and what the Medicaid rate system actually pays. (*Link to overview of Medicaid rate setting for nursing homes)*

Nursing homes have not had a *general* nursing home rate increase since 2012. That increase was the direct result of an increase to their nursing home provider tax (which is now $21.02 a day), and the following year nursing homes received a rate cut. The subsequent rate increases that were given in 2015, 2016, 2018 and 2019 were specifically directed to wage enhancement and while 70% of nursing home costs are related to human resources, there are other cost centers such as heat, utilities, food and medical supplies. All the costs related to resident care increase year after year and beyond the control of the nursing home providers, but only those related to direct labor costs have been recognized by the most recent rate increases. *We ask that the Committee address the overall needs of our state's nursing homes by recommending the full funding of the new acuity/case-mix nursing home reimbursement system so that it is able to operate as intended. (Link to overview of new acuity-based system development.)*

Medicaid Nursing Facility Rate History

Rate Period	*Increase/Decrease*	*Cost Report Year*
1/1/05-6/30/05	1.0%	2000
7/1/05-6/30/06	14.0% (4.0% net - Rebase with Tax)	2003
7/1/06-6/30/07	3.0%	2003
7/1/07-6/30/08	2.9%	2003
7/1/08-6/30/09	0%	2003
7/1/09-6/30/10	0%	2007
7/1/10-6/30/11	0%	2007
7/1/11-6/30/12	3.7% (1.25% net w/Tax Increase)	2007
7/1/12-6/30/13	0.33% (.17% net w/Tax Increase)	2007
7/1/13-6/30/14	-0.273 (Decrease)	2011
7/1/14-6/30/15	0%	2011
7/1/15-6/30/16	$26 + 9 million wage/benefit enhancement	2011
7/1/16-6/30/17	0%	2011
1/1/17-6/30/17	6 month loss of fair rent component for some homes due to policy change	
7/1/17-6/30/18	0% (Rebasing of rates with 1.6% stop loss)	2016
11/1/18-6/30/19	2% (Directed toward wage & benefits)	2016
7/1/19-6/30/20	2% (Directed toward wage & benefits)	2018
10/1/20 scheduled	1% (Directed toward wage & benefits)	2018
1/1/21 scheduled	1% (Directed toward wage & benefits)	2018

Nursing Home Provider Tax

It is important to keep in mind that nursing homes are required to pay a nursing home bed tax at a rate of $21.02 per bed per day. The proceeds of this tax go toward funding of the entire Medicaid system of long-term services and supports, not just nursing home care, and must be paid even if the resident's Medicaid application is pending and there is no payer source for the bed. This is one more cost burden placed on nursing home providers.

Transitioning to an Acuity-based Case-mix Rate Reimbursement System

Public Act 15-5 (Section 394) allowed for the implementation of an acuity-based reimbursement system and the statute requires the Department of Social Services to consider recommendations from the nursing home industry when developing the methodology. The State is now developing the new system with a target implementation date of July 1, 2020. It will replace the current cost-based system.

Our association supports the concept of a case-mix nursing home reimbursement rate system that will add an acuity-based component and value-based performance incentives to the payment rates and we have been working with the Department of Social Services and their consultants as they develop the new system. *But we also realize that this will be a major change to the reimbursement system and will potentially have a significant financial impact on the nursing home sector*. It is therefore vital that we work together to ensure that quality, well-staffed nursing home care is not disrupted in this transition and we have two priority requests of this Committee.

First, we would like the Committee to reserve funding in the budget to meet the anticipated funding needs of the new system when it is implemented in July. The new reimbursement system will only meet its intended objectives if it is fully funded. Otherwise, the current funding, which is woefully inadequate, will just be moved around and we fear that many quality nursing homes may be negatively affected by a reduction in their rates while others will not receive the funding necessary to cover the cost of caring for higher acuity residents.

Second, this implementation is on a fast track with the anticipated July 1 start date and yet, we may not know the details of the new system until after the legislative session has adjourned. We therefore request that the Legislature remain involved in the process so as to ensure that the system design will deliver the resources needed to provide consumer access to quality nursing home care, to retain and recruit our workforce, and to meet the quality of life and physical environment expectations of consumers and regulators.

1) **This new reimbursement system will only meet its intended objectives if it is fully funded**.
   - The current cost-based system has an annual funding shortfall estimated to be as high as $120 million. This estimate is based on the State's own calculation of the rates utilizing what the State considers to be the allowable costs of providing care. This is because of the freezes and limited rate increases placed on the statutory rate structure over the years. While nursing homes have recently received rate increases for labor costs, they had not had a general rate increase since 2012. That increase was the direct result of an increase to the nursing home provider tax, and then the following year the rates were cut.

   - This new case-mix system is currently planned to be "budget neutral" - which automatically means it too will be underfunded, but by what level we do not yet know. Therefore, if we do not increase the current level of funding, the new system will not be allowed to work as designed and will not meet the stated objective of appropriately funding high acuity care. The current funding will just be reallocated within the system, but not at the rate levels needed. As a result, we fear that many quality nursing homes may be negatively affected by a reduction in their rates and others will not receive the funding necessary to cover the cost of caring for higher acuity residents.

- Similarly, it will be essential that the performance incentive payments, which are a hallmark feature of the proposed case mix system, be funded with additional resources. Given the demonstrated underfunding now present in the system, we believe it would significantly undermine the very objective of quality improvement if incentive funds were diverted from existing underfunded resources.

2) **With a July 1, 2020 implementation date, the development of the new system is on a fast track, but we may not know details until later this year.** While the DSS consultants are working aggressively, we still will not be able to see financial models of the new system until late March or April – and so we will not begin to have knowledge of the financial impact (or potential impact) of the system until that time. Because of this uncertainty, we all must be prepared with the information necessary to design the right system in this limited time period and we must agree to certain principles to be included in the final system.

   We are requesting the following information be available and utilized to ensure that the system design will deliver the resources needed to provide consumer access to quality nursing home care, an ability to retain and recruit our workforce, and to meet the quality of life and physical environment expectations of consumers and regulators:

   1) A fiscal evaluation that identifies the level of funding needed to fully fund the final case-mix rate system model.
   2) A facility-by-facility impact analysis.
   3) An access to care analysis to assure a sufficient supply of nursing facility beds and services, including specialty services.

   We are requesting that the new system include:

   1) A provision to adequately reimburse for the costs of providing specialty long-term care for diagnoses or behaviors that may not be captured by traditional acuity measures.
   2) A provision for value-based performance incentives funded through the allocation of new financial resources.
   3) A rate differential for nursing facilities within Fairfield County.
   4) Timely inflationary adjustments and periodic rebasing of the base rates.
   5) A phased-in implementation schedule, including a stop-loss provision.
   6) To incentivize voluntary bed reduction, the ability for nursing homes to proactively request a reduction in licensed bed size prior to the implementation of the new rate system and have the new smaller bed count be applied to their calculated base rate.
   7) Training on this new system for nursing facility staff.

   Reducing Bed Capacity

   As you see, one element of what we are asking for is the ability for nursing homes to reduce their bed capacity prior to the implementation of the new rate system. Nursing home with low census are penalized in the base rate calculation and we are hoping that the ability for homes to right size their facilities before the new system is initiated, a fresh start of sorts, will bring about thoughtful bed reduction. A bed reduction will not only facilitate the rebalancing effort, but we believe that a thoughtful reduction of the bed supply will also help bring financial stability to the nursing home sector; allowing it to maintain a stable workforce and

provide quality resident care. We will be better positioned to implement the new acuity-based rate system for nursing home reimbursement.

We want to take this opportunity to thank Commissioner Gifford and her staff for including us in the planning process and to acknowledge the expertise provided by their consultant, Meyers and Stauffer. We look forward to receiving the draft case mix model options and backup materials as we continue to work together to develop this new reimbursement system and to ensure that quality nursing home care is not disrupted in the transition.

Residential Care Homes

The residential care home setting is both supportive and affordable and is a setting of choice for many older adults. It can be a valuable community-based housing choice for those choosing to receive Medicaid funded home and community-based services and supports and therefore we are currently working with the state agencies to ensure that residential care homes can choose to qualify as a community-based setting for the purpose of Medicaid funding.

Residential care homes last received a 1% rate increase on July 1, 2018 which was to be directed toward wages and benefits.

The Governor has proposed new method of structuring the reimbursement rates for Residential Care Homes. As a representative of non-profit Residential Care Homes (RCH) serving older, we are optimistic about this proposal which will recognize and separate out the personal care services provided to RCH residents from the current daily rate and establish them as Medicaid covered services. This will allow the state to receive federal matching funds on that service portion of the reimbursement. Traditionally funded through State Supplemental funds, this will be the first time the State will receive any federal funding on these expenditures and a portion of the State's savings (25%) is promised to be reinvested into the RCHs.

This policy change shows a confidence in this model of community-based living and reaffirms its crucial role in the continuum of aging services. We are hopeful that the ability to access federal funding for the RCH sector will encourage its growth and help existing providers maintain and improve their physical plant as well as keep up with the costs of providing room, board and services.

We are, however, cautious in our optimism as we do not yet know the details of this new rate structure or what the impact will be on the current reimbursement for existing homes. We therefore ask that safeguards, such as a stop-loss provisions, be put in place if necessary, so that residential care homes are not negatively impacted in the transition.

We will want to know if there will be just one base rate for the services and if additional rates will be offered for individual services such as medication administration. We are also interested in the reinvestment plan for the additional funding and hope to provide input into that decision-making process. And finally, we are aware that many of the providers are small and unfamiliar with the Medicaid billing process and therefore assistance and training in this area would be welcomed.

We ask that the state legislature remain involved in the transition so as to advocate for the residential care home residents and providers. These homes are an important part of the long-term services and supports continuum and we are hopeful that this new rate structure will provide the additional resources needed to support and expand this affordable community based residential option.

Home and Community Based Services

The Connecticut Home Care Program for Elders (CHCPE) is the heart and soul of our state's rebalancing plan when it comes to providing home and community-based aging services. It is this program that helps eligible clients over the age of 65 who are in need of long-term services and supports remain at home. It is also the program that assists many older adults who return to home through the Money Follows the Person Program. *That is why it is vital that we continue to invest in this program and in the provider network that delivers the services and supports.*

Many providers are finding it more and more difficult to serve clients enrolled in this Medicaid waiver program. The rate structure for these services is not sufficient to meet the costs of providing the services and so many providers must restrict the number of waiver clients they serve. On January 1, 2019, the providers in the Connecticut Home Care Program for Elders received a 2% rate increase that was to be directed toward employee wages. On October 1, 2019 they received a 1% increase, again directed toward wages and benefits. Prior to this, the last increase was 1% in 2015.

While appreciative of these recent rate increases, many providers are still finding it to be financially difficult to care for these clients. Adult day centers alone have reported that the gap between the reimbursement rate ($73.06) and the actual cost of providing the service (which includes transportation) is between $7.50 and $63, depending on their location within the state. Adult family living is one of the newest community-based services and they unfortunately did not receive the most recent increase.

Unlike the unlicensed providers in the Connecticut Home Care Program for Elders, licensed home health agencies have not received an increase in rates for skilled services in several years. The inability of the rate structure to keep up with the cost of provider services is causing many agencies to consider limiting their Medicaid case load and this is not the outcome we want to see. As a state that is working vigorously to balance our system of long-term care, we must invest in our licensed home health care network so that older adults can maintain the ability to choose to live and receive skilled nursing services in their home.

*To meet these growing challenges, we propose that the state initiate an annual rate increase for home and community-based providers***.** Even if this increase is a small percentage, it will gradually build up the rate structure for this crucial network of providers. This annual investment will also work to build a strong network of home and community-based providers that will be needed to achieve a successfully rebalanced system of long-term services and supports.

Community based providers are meeting the growing needs of Connecticut's older adults and their caregivers while preventing or delaying placements in skilled nursing facilities and helping to prevent the need for more expensive health care settings such as emergency rooms and acute care hospitals. The latest available annual report of the Connecticut Home Care Program for Elders describes the

savings that are generated by use of the program as an alternative to nursing home care. These community-based services should be encouraged and we ask for your continued support.

The rebalancing process is working. More of our elderly are being cared for in the community. We must not stop now. This systems change is not only the right thing to do, but it is slowing the growth in Medicaid expenditures for long term services and supports. We urge the state to work with us and the other dedicated stakeholders to continue this progress.

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