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) concerning the Governor's FY 2022 and FY 2023 Budget Recommendation to the Connecticut General Assembly

Good evening Senator Osten, Representative Walker and to the distinguished members of the Appropriations Committee. My name is Matthew V. 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 sixty member trade association of skilled nursing facilities and assisted living communities.

Flat Nursing Home Funding is an Unresponsive and Inadequate Response to the Public Health Emergency

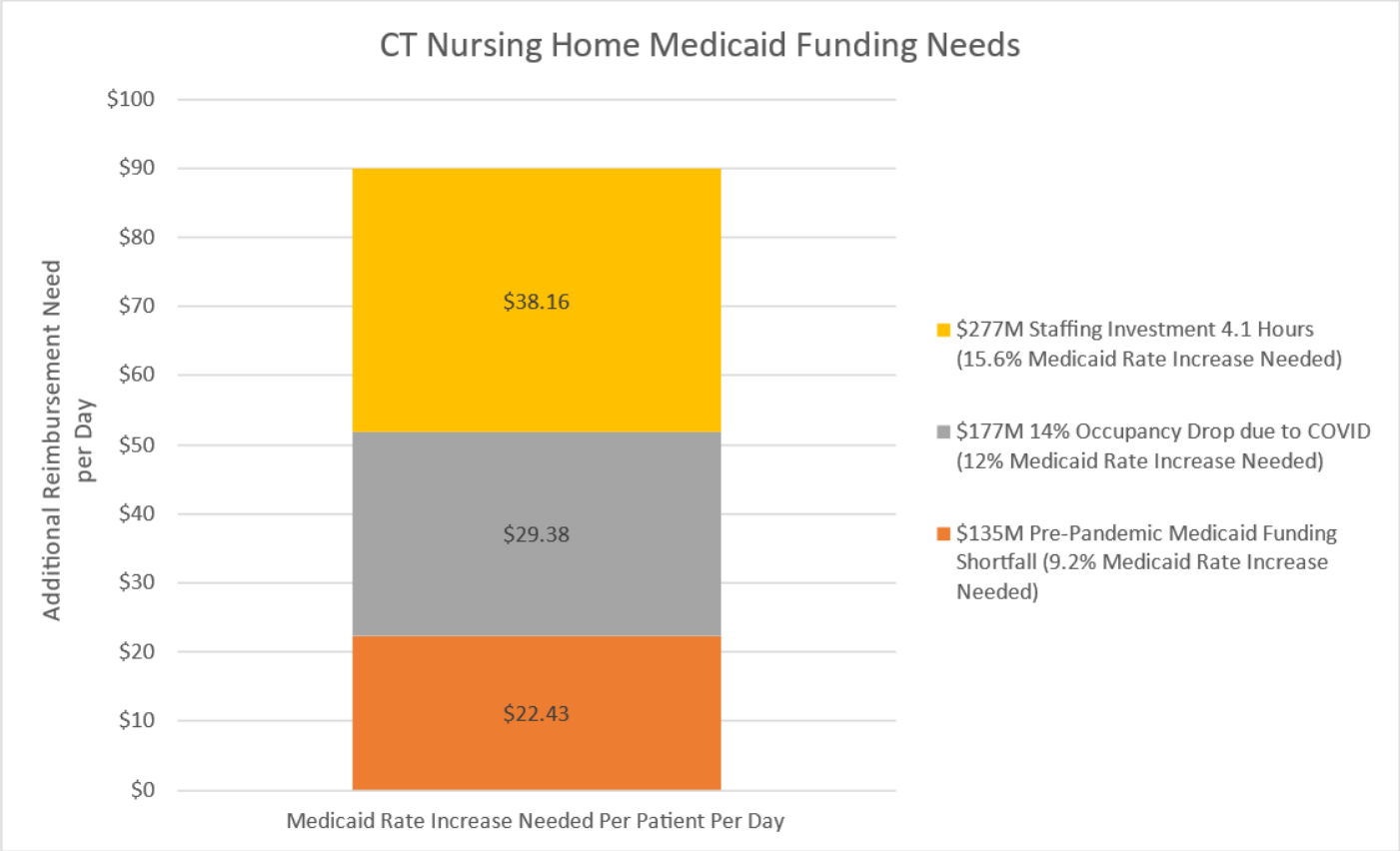
This year marks another two years of flat nursing home funding in a proposed Connecticut state budget. Regrettably, the proposed biennial budget removes all Medicaid statutory and regulatory inflationary increases for nursing homes in a year where this help is essential. This amounts to $36.1 million reduction for nursing homes during this biennial budget period ($11.8 million in FY 22 and $24.3 million in FY 23). Level funding for Connecticut nursing homes is an inadequate response to the financial instability being experienced in the sector as providers seek recover from the epic COVID-19 public health emergency.

Our nursing homes, the residents they serve, and their employees, have been challenged like in no other time during the epic and ongoing COVID-19 public health emergency. The highly contagious virus preyed on older people with underlying health conditions, especially in congregate settings like nursing homes and assisted living communities. The consequences were severe and heartbreaking for nursing home operators, residents and families, and the staff who provide nursing home care.

What is especially heartbreaking and tragic is that nursing home staff did all that was in their power to protect their residents. They implemented all the CDC and DPH protocols. Nursing homes implemented rigorous resident and staff testing when testing became available in the early summer. They secured needed PPE and overcame the supply shortages that were present early in the pandemic. Heroic work was done against a virus spreading through persons showing no symptoms and in a state that was impacted with challenging rates of community spread of the virus. The sector faced unprecedented staffing challenges while providers adapted to the severe and emotionally devastating visitor restrictions by facilitating visitation through outdoor, indoor when allowed, compassionate care and virtual visits. The sustained vigilance of our staff and the COVID-19 vaccine roll-out are now showing us the pathway to the end of this pandemic for our nursing home. Our resident vaccination percentage rate is over 90%. Over 65 percent of staff have been vaccinated.

However, the nursing home occupancy decline experienced due to ongoing pandemic has created unprecedented financial consequences to our already underfunded nursing home. The federal and state funding received this far has been a critical lifeline, but much more help will be needed in the state budget Connecticut adopts this session. The level funding and severely underfunded acuity-based payment system in the

Governor's proposed budget for nursing homes must not be approved. At this critical juncture, a substantial funding increase to our nursing homes is imperative so nursing homes can deliver the high-quality care we know everyone wants as they recover from this epic pandemic that has caused so much heartbreak and tragedy for this hard-hit community.



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.

Pre-COVID Connecticut Nursing Home Underfunding of $135 Million

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.

An Investment in Nursing Home Staffing Is Estimated to Minimally Cost $277 Million

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 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, composed of: ▪ .75 hours Registered Nurse ▪ .54 hours Licensed Practical Nurse ▪ 2.81 hours Certified Nurse Assistant. To help inform the implications of increasing staffing in this manner, CAHCF 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.

If the total cost were $277 million, a 15.6 percent Medicaid increase to nursing homes is needed to address this issue.

A Budget Neutral Transition to a Medicaid Acuity Based Payment System Won't Achieve Higher Quality

CAHCF is supportive of a transition to a cost-based acuity payment system. However, such a system will not support improvement in quality, adequacy of staffing and resident outcomes unless it is adequately funded and is not based upon budget neutrality as proposed. For the reasons that follow, CAHCF recommends that this major reform in the nursing home rates be postponed until SFY 2023.

For an acuity-based system to improve quality, adequacy of staffing and resident outcomes, it must be based upon cost data, census information, and acuity scores reflective of nursing home operations post COVID. It cannot be based upon data trended from 2018. Occupancy in nursing homes is down 14 percentage points from FY19 meaning per diem costs are much higher in FY20 and FY21 than per diem costs from 2018 trended to FY22.

As importantly, payer mix has changed dramatically. The substantial decline in non-Medicaid days will dramatically increase the per diem cost allocated to Medicaid patients. This can only be recognized in an acuity system if the cost report base year used to set rates represents the current payer mix situation. This cannot be accomplished using 2018 cost report census data.

One benefit of a cost-based acuity system is to better identify the nursing cost of a Medicaid patient by using the Medicaid case mix index as the basis of nursing payment rather than determining Medicaid nursing cost based upon an average per diem. A cost-based acuity system only results in higher nursing reimbursement for a facility if the facility's Medicaid acuity is much higher than industry norms, and the facility has high nursing costs that would exceed the reimbursement ceiling in the nursing cost center under the existing non acuity-based methodology. This is a small minority of facilities in Connecticut.

In fact, most facilities will see less nursing reimbursement under a cost-based acuity-based methodology than a non-acuity system. They receive no benefit from a higher acuity-adjusted payment ceiling if their nursing costs are already below the nursing cost ceiling under the existing non acuity-based methodology. Their payment drops because reimbursement is not based upon their average nursing per diem cost, but their average nursing per diem cost adjusted by a ratio of Medicaid acuity to total facility acuity, which for almost all facilities is a ratio less than 1.0. The reason is that the denominator (total facility acuity) includes the acuity scores of Medicare patients who typically have the highest acuity scores. A significant change in payer mix, due to a decline in Medicare volume will significantly increase this ratio as Medicare volume decreases, resulting in higher Medicaid nursing per diem rates.

However, as that ratio changes, as it has significantly in the last year, nursing rates change based upon that new ratio only if the cost report period used to set rates is reflective of that same payer mix time period. This again demonstrates that it is imperative to use the most current post-COVID data in acuity-based rate setting. Using outdated cost, census and payer mix information to establish acuity-based payment will result in nursing rates that are not commensurate with facilities' current cost structures and payer mix and is not going to improve quality, adequacy of staffing and resident outcomes.

Also, the allocation ratio referenced above for determining the nursing cost of a Medicaid patient in relation to non-Medicaid patients will change considerably with the changeover to the new PDPM acuity model. Initial indications are that the nursing cost allocation to Medicaid patients under PDPM will be greater than that using RUGs, which would be the acuity model used if the system is implemented July 1, 2021. Using a post-pandemic base year cost report to establish initial rates under the new acuity system allows for the use of the more accurate PDPM case mix classification and indices for a time period that perfectly matches up with the cost report time period. It makes no sense to transition now to RUGs as the allocation methodology knowing that will soon changeover to PDPM and that the nursing cost allocation to a Medicaid patient will materially differ under PDPM versus RUGs.

The state must commit to funding quarterly increases in acuity rather than the rate adjustment being cost neutral. If the adjustment is cost neutral, the only facilities that receive some quarterly increase in payment are those with acuity increases exceeding the statewide average quarterly increase in acuity. Those with acuity increases less than the statewide average receives a rate decrease and those with acuity decreases see a greater

decrease in rates than the decrease they should have received. For these reasons, CAHCF recommends the case mix reforms be delayed until SFY 2023.

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

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