Testimony before the Human Services Committee
Kathleen Brennan, Deputy Commissioner
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Good morning Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Kathleen Brennan, and I am the Deputy Commissioner of the Department of Social Services (DSS).

I am pleased to appear before you today to testify in support of **HOUSE BILL 7164 -** ***AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES.*** I would like to take this opportunity to speak on various sections of the bill.

This bill makes the following changes:

Sections 1 and 2 eliminate the cost of living adjustments for recipients of the Temporary Family Assistance, State Administered General Assistance and State Supplement for the Aged, Blind and Disabled programs. It should be noted that Connecticut is one of the few states that allows TFA recipients to retain their full cash assistance benefit if their employment earnings are less than or equal to the federal poverty level. State savings of $2.6 million in FY 2020 and $4.8 million in FY 2021 are anticipated.

Under current statute, DSS is required to determine rates annually for various boarding homes. **Sections 3 through 6** remove rate increases for boarding homes over the biennium. In accordance with DSS' regulations, boarding home rate increases are based on actual cost reports submitted by facilities, barring any legislation to remove rate increases for a particular fiscal year. This bill also maintains the minimum flat rate at current levels for boarding homes that choose not to submit annual cost reports. State savings of $1.7 million in FY 2020 and $3.7 million in FY 2021 are anticipated.

Under DSS' regulations, an inflationary adjustment is required for intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs). **Section 7** removes rate increases for these facilities for the biennium. State savings of $790,000 in FY 2020 and $1.7 million in FY 2021 are anticipated.

Sections 8 through 11 implement a number of provisions included in the Governor's budget related to nursing homes.

Section 8 eliminates statutorily required inflationary increases over the biennium. State savings of $14.4 million in FY 2020 and $30.6 million in FY 2021 are anticipated. **Section 8** also revises the calculation for nursing home rates to encourage higher quality and occupancy levels. Long-term care rebalancing efforts have left the state with a significant surplus of empty licensed nursing home beds despite the closure of 26 nursing homes within the past eight years. While optimal occupancy rates are typically around 95%, Connecticut's current statewide occupancy rate is approximately

86%, which equates to over 3,000 empty beds. To achieve an occupancy rate of 95%, the closure of approximately 2,200 beds statewide would be necessary.

To improve occupancy rates statewide, **section 8** implements a rate rebasing effort in FY 2020. Typically, when rates are rebased, rate reductions are limited through a "stop loss" – a mechanism that limits financial instability to nursing homes that would otherwise experience a significant reduction in their Medicaid rates.

Through this bill a "stop loss" of up to 2% is available for those nursing homes with a high occupancy level or high quality measures. However, to address the significant oversupply of nursing home beds while maintaining a focus on quality, the stop loss provision is eliminated for any nursing home with an occupancy level of less than 70% or an overall rating of one star on Medicare's Nursing Home Compare website. State savings of $2.4 million in FY 2020 and $2.9 million in FY 2021 are anticipated.

Section 9 of the bill strengthens provisions related to nursing home receiverships and clarifies the timing of certain actions. Specifically, the changes:

- Allow a receiver to spend up to $10,000 (an increase from $3,000) to correct a physical plant or furnishings deficiency without court authorization;
- Require that the receiver's viability determination be completed and reported to the court within the first 45 days;
- Require that the receiver seek facility purchase proposals only for facilities for which the receiver has already reported to the court a finding of viability and that this be done within six months of the viability report; and
- Require that the receiver immediately commence the closure process for facilities with less than 70% occupancy without performing a viability determination when the closure of the facility is consistent with the strategic rebalancing plan for long-term services and supports.

With a focus on rebalancing long-term services and supports and reducing the over-reliance on institutional care, **sections 10 and 11** of the bill include language to streamline the process for nursing home operators of financially distressed homes that are voluntarily seeking closure and meet certain criteria. The expedited process outlined reflects a narrow exception to the current process. It allows DSS to authorize the closure of a facility only if: (1) the facility is not viable given actual and projected operating losses; (2) occupancy is less than 70%; (3) closing is consistent with DSS' long-term services and supports strategic rebalancing plan, which includes a review of regional nursing home bed capacity; and (4) the facility is not providing special services that would go unmet if closed.

While the bill waives the requirement for a public hearing prior to closure, it retains the full range of resident rights protections, including written notice to residents and responsible parties, rules for discharge, and the Long-Term Care Ombudsman and Money Follows the Person provisions – essentially all resident protections elsewhere afforded under state and federal law remain unchanged.

Section 12 establishes in statute that a "covenant not to compete" is against public policy and shall be void and unenforceable. This ensures freedom of choice and freedom of movement between caregivers and clients and, by doing so, helps to protect the health, safety and well-being of individuals. A Medicaid provider in the home care program has non-compete language in their employment contracts. This agency continues to pursue legal action against caregivers that have

left their employ but have continued to work for individual clients or another agency. They have also instituted or threatened legal action against other agencies that may hire their caregivers to continue caring for individual clients, thereby disrupting continuity of care and putting the health, safety and welfare of frail elderly and younger adults with disabilities at risk. This statutory change is not, however, restricted to Medicaid. As a matter of public policy, the health and safety of frail elders or persons with disabilities should not be disrupted by homemaker-companion or home health agencies that seek to protect their business interests at the cost of those they serve.

Section 13 institutes an asset test under the Medicare Savings Program. The Medicare Savings Program (MSP) is a Medicaid-funded program that helps Medicare recipients with income up to 246% of the federal poverty level (FPL) pay their cost sharing obligations. Depending on their income levels, individuals with income up to 211% FPL may be eligible for the Qualified Medicare Beneficiary (QMB) program, which provides coverage of Medicare Part A and Part B premiums, deductibles, coinsurance, and copayments or they may be eligible for the Specified Low-Income Medicare Beneficiary (SLMB) or the Qualifying Individual (QI, also known as Additional Low-Income Medicare Beneficiary (ALMB)) programs, which provide coverage of Medicare Part B premiums.

Connecticut is one of only eight states that does not have an asset test under MSP. There are 40 states with an asset test equal to the federal minimum (currently, $7,730 for singles and $11,600 for couples), two states with limits that are higher than the federal minimum (Maine and Minnesota) and eight states that have no asset test (Alabama, Arizona, Connecticut, Delaware, Mississippi, New York, Oregon, and Vermont). Prior to FY 2010, Connecticut's income levels were in line with other states and, similarly, an asset test was in place.

This bill aligns Connecticut with the vast majority of other states by instituting an asset test equal to the federal minimum. Consistent with federal rules, countable resources would include money in a checking or savings account, stocks and bonds. An individual's home, one car, a burial plot, up to $1,500 in a burial account, and household and personal items would be excluded. To avoid excessive administrative costs, the asset test will be effective July 1, 2020, in order that the asset verification system under ImpaCT be in place prior to implementation.

It is projected that this bill will reduce MSP expenditures by approximately 10%. State Medicaid expenditures related to the costs of deductibles, coinsurance and copayments under the QMB program are expected to be reduced by $10.5 million in FY 2021. In addition, because Medicare premiums are covered through the diversion of Medicaid revenue, less revenue will need to be diverted to cover these costs, resulting in additional revenue to the state of $16.0 million in FY 2021. In total, after factoring in the personnel and systems costs, this proposal will result in net savings to the state of $25.6 million in FY 2021.

Note: A technical correction is required on line 1111 of the bill – the effective date should be July 1, 2020.

Sections 14 and 15 reduce the state's ever-increasing potential exposure to unbudgeted expenditures, while ensuring that providers with individually calculated rates based on cost report information continue to have an opportunity for those rates to be reviewed and corrected. Current law gives specific provider types (namely, hospitals, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities) an opportunity to seek rate-setting corrections and additional review based on cost report information to ensure the provider-specific rate is accurate. This bill preserves that purpose, while reducing excessive appeals of broad, statewide

rates that continue to expose the state to substantial unbudgeted liability, as well as impose an excessive administrative burden for DSS.

Specifically, many hospitals have filed rehearing requests for most payment methodologies issued or amended in recent years, including reimbursement methodologies that apply to all acute care general hospitals. Collectively, hospitals are seeking various retroactive payment increases in the currently pending rate rehearing proceedings. If hospitals were to receive the full amount of requested retroactive increases, the collective result could potentially expose the state to as much as $2.5 billion or more in new unbudgeted expenditures. Unless this statute is revised, that potential exposure is likely to continue increasing as the hospitals may continue to request rate rehearing proceedings for statewide rates issued in future years.

In addition, in order to align with the changes to section 17b-238, this bill removes the rate appeal language from the home health rate statute. The removal of this language will ensure that DSS is able to set rates in accordance with both federal requirements and available state appropriations without the risk of exposure to unbudgeted increased expenditures.

Furthermore, with the state modernizing hospital reimbursement to uniform rate methodologies and increased federal oversight of Medicaid rates, it is neither necessary nor appropriate for providers to challenge the sufficiency of statewide rates. Federal Medicaid law already requires the state to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan…as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A). Federal Medicaid access regulations further require state Medicaid programs to ensure that payments are sufficient to ensure access to services for Medicaid members. See 42 C.F.R. §§ 447.203(b) and 447.204.

Section 16 links hospital payments to readmission rates. With Medicare and commercial payers increasingly moving towards more value-based payments, this section is a small step towards similar value-based payments. It is intended to encourage better quality and outcomes by instituting a readmission payment adjustment of 15% for readmissions within 30 days after discharge for a related diagnosis. Based on calendar year 2017 data, readmission rates under HUSKY Health were above 10%, with 8,275 readmissions identified. State savings of $2.0 million in FY 2020 and $2.4 million in FY 2021 are anticipated.

Section 16 also ensures that Medicaid payments to hospitals are only made in compliance with federal law. This new language is necessary because Medicaid payments to hospitals and various other providers must comply with the federal Upper Payment Limit (UPL) and other federal requirements. The UPL is a federal rule that certain Medicaid payments cannot be more than the state's reasonable estimate of Medicare payment, calculated based on federal rules and guidance. Payments above the UPL are not eligible for federal matching funds. Current hospital payment levels are now very close to the UPL, so this language is necessary to ensure that the state is not required to make any Medicaid payments that would not be eligible for federal matching funds.

The Governor's budget provides over $453.3 million in supplemental payments for hospitals in each year of the biennium. **Section 17** requires that, of this amount, $15.0 million in FY 2020 and $45.0 million in FY 2021 be distributed based on certain quality performance measures. This will encourage hospitals to improve outcomes, resulting in better care for HUSKY Health members.

In total, the above initiatives will result in state savings of $21.2 million in FY 2020 and $54.7 million in FY 2021, as well as additional revenue of $1.4 million in FY 2020 and $16.9 million in FY 2021.

The Department respectfully requests that the Committee take favorable action on HOUSE BILL 7164 - *AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES.*