Testimony before the Aging and Human Services Committees
Commissioner Andrea Barton Reeves
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Good morning, Senators Hochadel and Lesser, Representatives Garibay and Gilchrest, and distinguished members of the Aging and Human Services Committees. My name is Andrea Barton Reeves, Commissioner of the Department of Social Services (DSS).

I am pleased to appear before you today to offer remarks on three of the bills on today's agenda.

SB-989 AN ACT CONCERNING NURSING HOMES

DSS supports aspects of this bill but has concerns with certain sections of the bill as noted.

Section 1 establishes a requirement for air conditioning in all resident rooms while Section 2 establishes a loan-based financing mechanism through the Connecticut Health and Education Facilities Authority to support the additional costs that would result. For facility improvements, additional debt service costs are acknowledged when determining facility reimbursement. Therefore, this new mandate would result in additional costs to the state which are not budgeted.

Section 4 of the bill establishes, subject to available appropriations, a grant to support nonemergency transportation for nursing home residents to the homes of residents' family members, provided: (1) the family members live within fifteen miles of the nursing home facility, and (2) such transportation is approved not less than five business days in advance by a physician or physician's assistant. This new grant program is not currently supported by the state budget, would not be eligible for Medicaid reimbursement, and would result in additional unbudgeted costs. Additional Department staff will also be required to support the administration of the grant, which is also currently not accounted for in the budget.

The Department is opposed to Section 6 of this bill as this work is already performed by DSS and it would limit the Department's ability to make future adjustments to Medicaid provider cost reporting.

Section 9 of this bill will result in an estimated unbudgeted increased cost of over $30 million, subject to federal Medicaid reimbursement. This bill calls for increased minimum staffing level requirements for nursing home facilities of at least four and one-tenth hours of direct care per resident, including three-quarter hours of care by a registered nurse, fifty-four hundredth hours of care by a licensed practical nurse and two and eighty-one hundredth hours of care by a certified nurse's assistant, and modifies staffing level requirements for social work and recreational staff. While the Department supports the intent of increased staffing ratios which increase the quality

of care provided to nursing home residents, the Department cannot support the bill as written given the significant unbudgeted cost increase.

DSS fully supports transparency regarding Medicaid expenditures and how providers use Medicaid funding in the support and care of our members. DSS has always made Medicaid cost reports publicly available and, in 2015, started to post reports to the DSS webpage. Further, DSS provides additional transparency in public reporting on data and analysis regarding nursing home spend and provider costs. The nursing home cost report, as submitted annually to the Department by nursing homes, provides a detailed analysis of costs that are allowable for Medicaid reimbursement.

Nursing homes submit annual Medicaid cost reports to DSS which are posted publicly on the DSS webpage, and copies of cost reports are also made available to the public upon request. Section 6 (a) requires that cost reports show the five cost categories that are reimbursable under the approved Medicaid state plan, but this information is contained within the cost report and therefore this requirement is redundant and not needed.

For example, cost reports feature extensive information on nursing home operations including, but not limited to, total expenditures, total revenue, profit/loss statements, related party transactions, staffing costs, salaries, ownership interest, and more. Cost reports also categorize costs into five cost groups for Medicaid rate setting purposes. Categorization of costs featured on the cost report include:

- Direct Care Costs such as nursing and nurse aide personnel salaries, related fringe benefits and nursing pool costs.
- Indirect Costs such as professional fees, dietary, housekeeping, and laundry personnel costs, and expenses and supplies related to patient care.
- Administrative and General Costs such as maintenance and plant operation expenses, salaries and related fringe benefits for administrative and maintenance personnel.
- Property Costs or Fair Rent which is reimbursed to nursing homes in lieu of interest and depreciation costs for non-moveable equipment.
- Capital Related Costs such as property taxes, insurance expenses, moveable equipment, leases and depreciation.

DSS also updates the cost report and makes revisions based on changes in the industry and for required data needed for Medicaid rate setting purposes. Cost reports are also used for audit purposes and the desk review process, as well as acuity reimbursement modeling. This data is also publicly posted to the DSS webpage. This bill would require specific data points, which are already included in today's cost report, but by establishing statutory requirements it may limit the Department's ability to make future revisions to the cost report as needed.

For reference, cost reports are currently available at the following DSS webpage: https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Nursing-Home-Reimbursement/Nursing-Facility-Cost-Reports/Cost-Report

Section 6 (b) also seeks a comparison of expenditures between nursing homes. This information is already available at the DSS website under the rate computation reports featured on this DSS webpage: https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Nursing-Home-Reimbursement/Medicaid-Nursing-Home-Reimbursement/Nursing-Facility-Rates

Acuity modeling and nursing home comparisons are available at the DSS webpage: https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Nursing-Home-Reimbursement/Nursing-Home-Reimbursement-Acuity-Based-Methodology

The Department does not support this bill as written.

HB-6386 AN ACT CONCERNING SAFEGUARDING THE RIGHTS, HEALTH, FINANCES AND QUALITY OF LIFE OF NURSING HOME RESIDENTS

Section 1 of this bill requires the Commissioner of Social Services to "ensure that the Department of Social Services (1) renders a final decision on a Medicaid applicant's eligibility promptly and without undue delay in accordance with section 17b-80 of the general statutes, and (2) provides written notice to such applicant of the department's final decision not later than fifteen calendar days after such decision is rendered."

Federal law already stipulates the time in which the Department must render an eligibility decision on a Medicaid application. Specifically, 42 C.F.R. § 435.912(c)(3) requires the Department to make a determination within "[n]inety days for applicants who apply for Medicaid on the basis of disability" and within "[f]orty-five days for all other applicants." The Department is explicitly prohibited from using these timeliness standards "[a]s a waiting period before determining eligibility," 45 C.F.R. § 435.912(g)(1), and does not do so in practice. Furthermore, Connecticut has been and continues to be a state leader in application processing timeliness (see Governor Lamont Applauds Federal Report Ranking Connecticut a National Leader in Medicaid Application and Eligibility Processing Speed; magi-app-process-time-snapshot-rpt-jan-mar-2022.pdf (medicaid.gov)).

Federal law does not allow the Department to rush to an eligibility determination (for instance, by denying an application) at the end of the applicable 45 or 90-day time limit if the Department has not received all necessary information to make an eligibility determination, provided the applicant continues to cooperate by attempting to obtain necessary information. In these instances, federal law prohibits the Department from using the timeliness standards "[a]s a reason for denying eligibility (because it has not determined eligibility within the time standards)," 45 C.F.R. § 435.912(g)(2), and instead requires it to continue to develop the application and "document the reasons for delay in the applicant's case record." 45 C.F.R. § 435.912(f). In particular, this may occur in cases where the applicant is requesting long-term services and supports, such as nursing home care or home and community-based services, because, in these cases, federal law requires the applicant to obtain and submit to the Department a substantial amount of information, including medical information, five years of financial records, and copies of any trusts or annuities relevant to the eligibility determination. Gathering and submitting this information is often a time-consuming process, and records submitted may

obligate the Department to request additional information to, for instance, document unexplained transfers of assets, causing further delay.

When the Department can make a final eligibility determination, federal law also requires the Department to "promptly and without undue delay consistent with timeliness standards established under § 435.912, furnish Medicaid to each such individual" if the determination is favorable. Federal law similarly requires prompt notice where the eligibility determination is unfavorable. *See generally* 45 C.F.R. § 435.917(a) (stating that "the agency must provide all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility, including an approval, denial, termination or suspension of eligibility, or a denial or change in benefits and services."). As a practical matter, when an eligibility determination has been completed, notices are automatically generated through the Department's eligibility systems and mailed to applicants, well before the expiration of the 15-day window contemplated by this bill.

In short, existing law already requires the Department to make prompt eligibility determinations in the Medicaid program within federally prescribed time limits, and to promptly notify applicants of those determinations. The Department therefore opposes passage of section 1 of this bill, as it is unnecessary and could cause conflicts with existing federal law.

HB-6626 AN ACT CONCERNING LONG-TERM CARE

Section 1 of this bill would permit DSS to submit a Medicaid state plan amendment to add the Program of All-Inclusive Care for the Elderly (PACE) in the Medicaid state plan, as well as establish participation criteria for individual eligibility.

PACE is a program that integrates Medicare and Medicaid-funded services to help people meet their health care needs in the community instead of going to a nursing home or other care facility. With PACE, there is a team of health care professionals working to deliver care through a coordinated model. In many states, the PACE model provides an additional community-based option which plays an integral role in the long-term services and support continuum.

The Department supports the concept and intent of this bill, however it is unclear at this time what the fiscal and operational implications would be. Were PACE to be implemented, DSS would need additional staff to administer and oversee the program and to develop fiscal impact modeling on the overall Medicaid budget. We are available to work with the committees to define the cost and benefits to the state of adding PACE to our Medicaid program but cannot. support this bill at this time.