Governor Ned Lamont
State of Connecticut

FACT SHEET
2019 Legislative Session

HOUSE BILL 7164
AN ACT CONCERNING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HUMAN SERVICES

Summary of Proposal:

This bill makes the following changes:

Sections 1 and 2. Eliminate Cost of Living Adjustments under Public Assistance Programs. Current statute provides recipients of Temporary Family Assistance, State Administered General Assistance and State Supplement for the Aged, Blind and Disabled a state-funded cost of living adjustment on July 1 of each year. Sections 1 and 2 of the bill maintain the existing assistance levels. 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. Savings of $2.6 million in FY 2020 and $4.8 million in FY 2021 are anticipated.

Sections 3 – 6. Remove Rate Increases for Boarding Homes. Under current statute, DSS is required to annually determine rates for various boarding homes. Per 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 eliminates these rate increases over the biennium and, for boarding homes that choose not to submit annual cost reports, maintains the minimum flat rate at current levels. Savings of $1.7 million in FY 2020 and $3.7 million in FY 2021 are anticipated.

Section 7. Remove Rate Increases for Intermediate Care Facilities. To comply with DSS' regulations, the baseline budget includes an inflationary adjustment in each year of the biennium for intermediate care facilities for individuals with intellectual disabilities. This bill eliminates these increases over the biennium. Savings of $790,000 in FY 2020 and $1.7 million in FY 2021 ($1.6 million in FY 2020 and $3.4 million in FY 2021 after factoring in the federal share) are anticipated.

Sections 8 - 11. These sections of the bill implement several provisions included in the Governor's budget related to nursing homes:

1. Remove Rate Increases for Nursing Homes. Under current statute and regulation, DSS is required to rebase nursing home costs no more than once every two years, but no less than once every four years, and provide funding for an inflationary increase for years in which rebasing is not occurring. Section 8 of this bill eliminates these increases over the

biennium. Savings of $14.4 million in FY 2020 and $30.6 million in FY 2021 ($28.8 million in FY 2020 and $61.2 million in FY 2021 after factoring in the federal share) are anticipated.

2. Revise 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. The optimal occupancy rate is typically around 95%, but Connecticut's current statewide occupancy rate is approximately 86%, which equates to over 3,000 empty beds. Achieving an occupancy rate of 95% requires the closure of approximately 2,200 beds statewide. To improve occupancy rates statewide, section 8 of this bill 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 drastic reduction in their Medicaid rates. Since Connecticut has a significant over supply of nursing home beds, this bill eliminates the stop loss provision for any nursing home with remarkably low occupancy or very low federal quality measure scores; any nursing home with high occupancy and high quality measures that has an issued rate higher than its calculated rate will be afforded a stop loss of 2%. Under this bill, any home with an occupancy level of less than 70% or an overall rating of one star on Medicare's Nursing Home Compare website will not be afforded a stop loss. Savings of $2.4 million in FY 2020 and $2.9 million in FY 2021 ($4.9 million in FY 2020 and $5.8 million in FY 2021 after factoring in the federal share) are anticipated.

3. Revise Nursing Home Receivership Provisions. Section 9 of the bill strengthens receivership provisions and clarifies the timing of certain actions. It includes the following changes:

    - Allows a receiver to spend up to $10,000 (an increase from $3,000) to correct a physical plant or furnishings deficiency without court authorization;
    - Requires that the receiver's viability determination be completed and reported to the court within the first 45 days;
    - Requires 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
    - Requires 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.

4. Expedite Financially Distressed Nursing Home's Voluntary Request To Close. With a focus on rebalancing long-term services and supports and reducing the over-reliance on institutional care, the Governor's bill includes 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 in sections 10 and 11 of the bill reflects a narrow exception to the current process. It allows DSS to authorize the closure of a facility only if certain conditions are met: the facility is not viable given actual

and projected operating losses; occupancy is less than 70%; closing is consistent with DSS' long-term services and supports strategic rebalancing plan, which includes a review of regional nursing home bed capacity; and 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 does retain 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 are not changed and will remain.

Section 12. Establish Non-Compete Language. This bill 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. One homemaker-companion agency that has a contract with DSS continues to pursue legal action against caregivers that have violated the non-compete language in their contracts by continuing to work for individual clients outside of their employment with the agency, as well as 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 language is not restricted to Medicaid, however. 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. Institute 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, $7,560 for singles and $11,340 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 is in place prior to implementation. This bill will reduce state Medicaid expenditures related to the costs of deductibles, coinsurance and copayments under the QMB program by $10.5 million in FY 2021 ($21.0 million after factoring in the federal share). 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.

Sections 14 and 15. Clarify Rate Appeal Language. The purpose of the rate-rehearing provision in section 17b-238(b) is to give 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.

In addition, 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 statute 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.

This bill reduces the state's ever-increasing potential exposure to unbudgeted expenditures, while still ensuring that providers with individually calculated rates based on cost report information will continue to have an opportunity for those rates to be reviewed and corrected.

Sections 16 and 17. These sections of the bill implement several provisions included in the Governor's budget related to value-based payments for hospitals.

1. Link Hospital Payments to Readmission Rates. Based on calendar year 2017 data, readmission rates under HUSKY Health were above 10%, with 8,275 readmissions identified. With Medicare and commercial payers increasingly moving towards more

value-based payments, the provisions in section 16 of this bill represent a small step towards similar value-based payments and 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. Savings of $2.0 million in FY 2020 and $2.4 million in FY 2021 ($6.1 million in FY 2020 and $7.3 million in FY 2021 after factoring in the federal share) are anticipated.

2. Update Hospital Supplemental Payment Language. The Governors' 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 providers to improve outcomes, resulting in better care for HUSKY Health members.

Reason for Proposal:

Legislation is required to implement the Governor's Budget.

Significant Impacts:

In total, the above initiatives will result in savings of $21.2 million in FY 2020 and $54.7 million in FY 2021 ($45.7 million in FY 2020 and $105.3 million in FY 2021 after factoring in the federal share), as well as additional revenue of $1.4 million in FY 2020 and $16.9 million in FY 2021.