Nursing Home Medicaid Reimbursement 101

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Nursing Home Sector Overview

- 205 Licensed Skilled Nursing Facilities (aka Nursing Homes) in Connecticut
  - 10 of which do not take Medicaid, 40 which are non-profit
  - 24,295 licensed bed capacity
  - Homes range in size from 25 to 360 beds
- Statewide nursing home census in December of 2022 was 83.67%
  - 87.6% pre-pandemic
- Between 1995-2022, 82 homes have closed (7,858 beds), 1 was converted from a chronic disease hospital to a skilled nursing facility (125 beds)
- Operating homes have reduced their bed capacity by 438 beds in the last two years
- Workforce we estimate to be approximately 30,000

(Source: DSS)

Long Term Services, Supports and Care Continuum

- Home and Community Based Services (HCBS) such as Homemaker Companion, Personal Care Assistant, Adult Day Services, Meals on Wheels, etc.
- Residential Care Home
- Assisted Living Community
- Continuing Care Retirement Community
- Home Health Care Agency
- Hospice Agency
- Skilled Nursing Facility (Nursing Home) for long-term care and short term post-acute rehab care

Nursing Home Overview: Who Pays for the Care?

- Medicaid is the source of payment for **72%** of nursing home residents
  - Average Medicaid per diem rate (including applied income) is **$280** (per DSS)
  - 50% of that rate is paid for by the federal government (non-PHE)
  - The nursing home pays the state back **$21.02 a day** in a nursing home user fee or provider tax
- Private pay accounts for 9% of residents payment source.
  - Average private pay rate in 2021 was **$462** for semi-private room due to need to shift the cost to this source
- Medicare only pays for short-term, post-acute rehab stays
  - Medicare advantage on average pays much lower than traditional Medicare

(Source: OPM Nursing Home Census Report September 2021)

Nursing Home Overview: Why the Dependence on Medicaid?

- The federal government has no system of paying for long-term care other than Medicaid.
- Historically, nursing home care was one of the only long-term care service covered under the Medicaid program.
- We now have many other options of covered long term services and supports (LTSS) provided in the home and community, including the Connecticut Home Care Program for the Elderly Medicaid waiver program.
- Today, many residents arrive at the nursing home with limited private funds and quickly qualify for Medicaid.

Qualifying for Medicaid Coverage for a Nursing Home Stay

- Federal rules dictate Medicaid eligibility for long term care and services.
- A nursing home resident must spend down to **$1,600 in assets** to qualify for Medicaid to pay for their long term care nursing home stay.
- The state looks back at **5 years of finances** and penalizes the applicant for any inappropriate transfer of assets that occurred during that 5 year look back period.
- The application for long term care Medicaid (or Husky C) is very long and detailed.
- There are protections in place to maintain a portion of the financial assets for the community spouse.
- The nursing home resident's eligibility is redetermined every year.

State's Medicaid Spend on Long Term Services and Supports

- SFY 2022 Total Long Term Care Medicaid Expenditure $3.5 billion
  - **42%** of the spend was on Institutional Care
  - **58%** of the spend was on Home & Community Based Services (HCBS)
  - **69%** of CT's Medicaid long term care clients are HCBS recipients

- *Note: In SFY 2003, 31% of the spend was on HCBS and 46% of the recipients were served in the community*

(Source: LTC Planning Committee's 2023 Annual Report)

State's Moratorium on Building New Nursing Homes

- Nursing home moratorium enacted in 1991 by the state legislature.
- No new nursing home has been able to be built outside of a few exceptions.
- Rigorous Certificate of Need (CON) process put into place to regulate renovation, replacement or investment into the existing buildings.
- CON process for nursing homes is overseen by the Department of Social Services (DSS).
- "Rightsizing" efforts, bed location, building conditions impacted by this moratorium.

How Nursing Home Medicaid Rates are Determined by DSS

- CT Medicaid calculates per diem nursing home rates using a “cost-based” methodology
- To do this:
  - Nursing homes submit cost reports each year to DSS.
  - State uses these cost reports during a “rebase” year to calculate the per diem Medicaid rate for each individual home.
  - Cost reports categorize costs into 5 buckets (direct, indirect, fair rent, capital, administrative and general).
  - The state only recognizes the *allowable costs* and they *cap* the costs allowed in the rates direct, indirect, and administrative/general buckets before calculating the rate.

How Nursing Home Medicaid Rates are Determined

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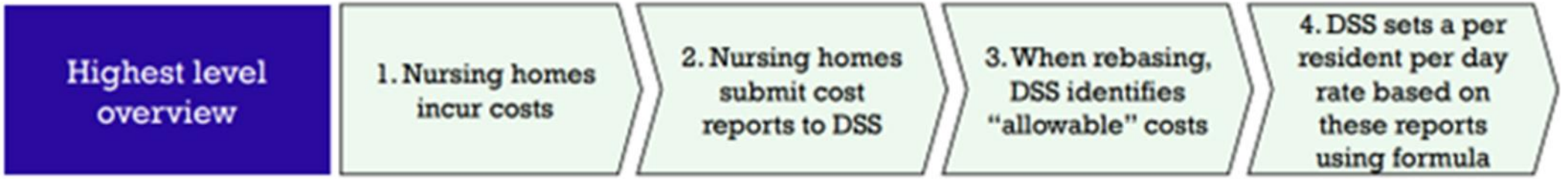


CT Department of Social Services

To be a good fiscal steward and follow CMS guidance, DSS identifies "allowable" and "not allowable" costs

Categorizing spending

Allowable Costs:

1. **Direct** - Nursing & nurse aide salaries, related fringe benefits and nursing pool costs.
2. **Indirect** - Recreation, social worker, dietary, housekeeping, laundry, and supplies related to patient care.
3. **Administrative and General** - Maintenance and plant operation expenses, salaries and related fringe benefits for administrative and maintenance personnel.
4. **Property (Fair Rent)**
5. **Capital Related** - Property taxes, insurance expenses, moveable equipment leases and depreciation.

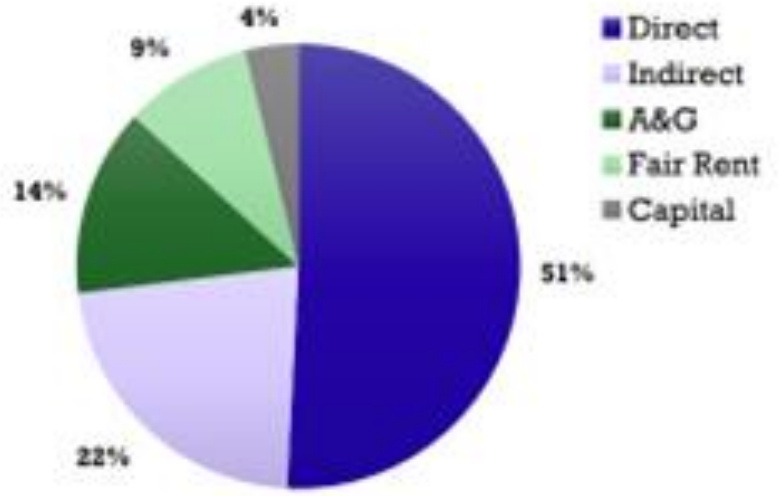
Unallowable Costs:

i. Disallowed salaries and fees and those over reasonable cost caps
ii. Disallowed managerial administrative compensation over reasonable cost caps
iii. Disallowed rent
iv. Building interest, depreciation, amortization
v. Physical therapy, speech therapy, and occupational therapy expenses (paid by Medicare)
vi. Miscellaneous desk review disallowances not related to patient care (advertising, bad debt etc.)

Breakdown of "allowable costs: in CT

In FY 2018, 23% of costs included on Connecticut nursing facility cost reports were unallowable.

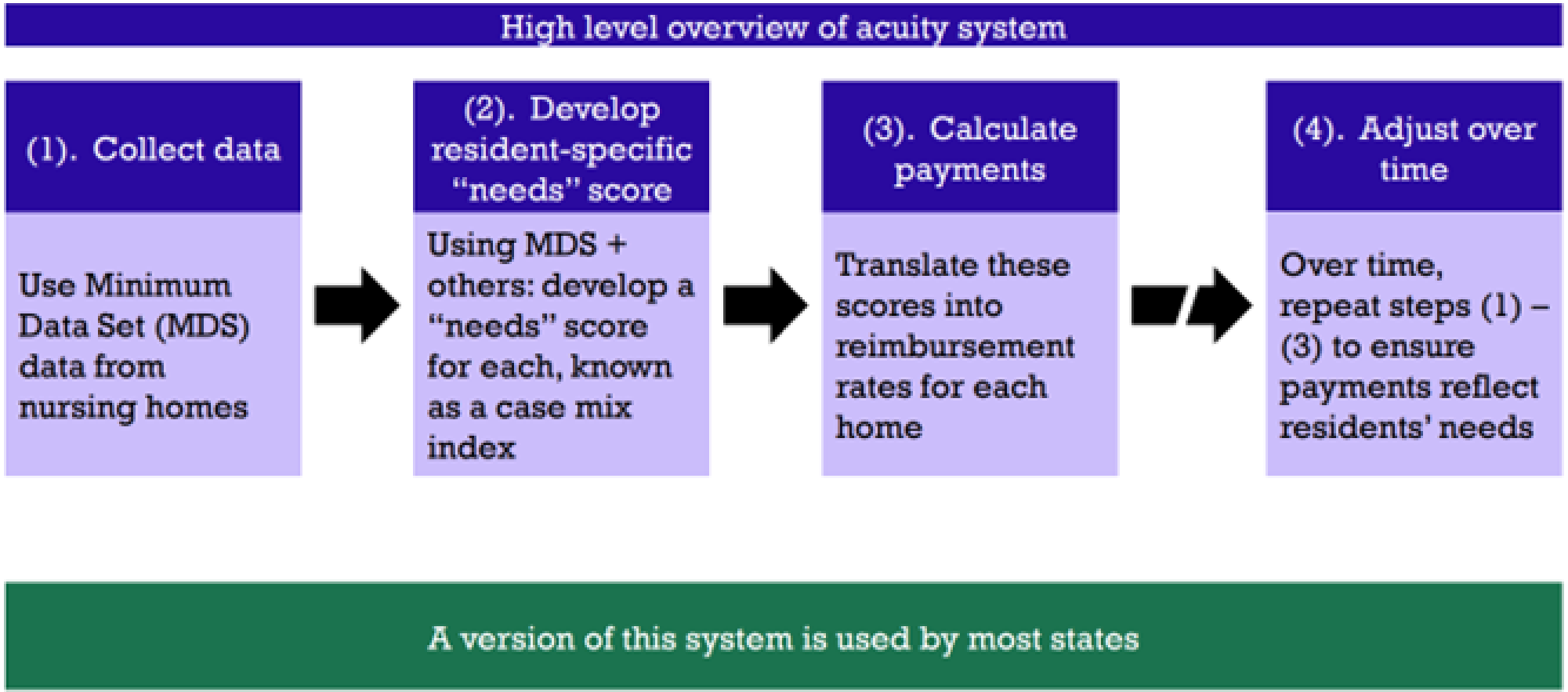
That year, 51% of allowable costs went to "direct" care.



How Nursing Home Medicaid Rates are Determined: Changes Occurring Now - *Acuity*

- In 2019, CT redesigned the cost-based reimbursement to add a quarterly adjustment to the rate to recognize the acuity level of residents.
- July 2022: The new rate system with the acuity adjustment was initiated with year one of a planned 3 year phase-in of the new rates.
- The new acuity system will adjust payments based on health needs/expected costs of the Medicaid residents living in that nursing home using resident data currently collected by the nursing home and submitted to both the state and federal government (Minimum Data Set, MDS).
- **The cost reports are still used to calculate the base rates for this new acuity adjusted rate system.**
    - Some base costs remain the same regardless of the acuity level of residents: Food, utilities, housekeeping, administration, etc.
    - Direct care is the most widely adjusted cost variable within an acuity adjusted system

Acuity matches payments to residents' estimated need



How Nursing Home Medicaid Rates are Determined: Changes Occurring Now - *Acuity*

- Acuity adjusted systems are used in most states.
- It incentivizes nursing homes to serve the highest needs residents.
- Ensures the Medicaid dollars are flowing to homes based on their level of resident needs.
- Very high levels of care, such as ventilator care, can also be addressed through such a system.
  - This is an issue the associations are studying with the hospitals and DSS
  - Seeking appropriate discharge, level of care and setting

How Nursing Home Medicaid Rates are Determined: Changes Occurring Now - *Acuity*

- The base rates for this new acuity system were rebased using the 2019 cost reports and DSS asked for a three year phase of these rates.
- DSS placed stop gain/stop loss on the 3 year rate phase-in:

Selected Parameters	SFY 2023	SFY 2024	SFY 2025
Cost report year	2019	2019	2019
Case mix neutrality limit	0.75%	1.51%	2.27%
Stop gain	$6.50	$20	None
Stop loss	$0	$5	None

- Note that the second year stop gain is an additional **$13.50** from the year one rate – *not* an additional $20.

How Nursing Home Medicaid Rates are Determined: Changes Occurring Now – *Quality*

- The redesign of the rate system also added a ***quality payment system*** which is being designed right now and which is expected to go into effect on July 1, 2023.
- Nursing homes will have an opportunity to earn a quality payment based on achieving certain predetermined quality measures.
- The quality measures chosen will be done with intention to achieve specific quality outcomes and are expected to change over time.
- Quality measure payments (or value based payments) are used throughout the health care system.

Remaining steps to implement policy in July 1, 2023…and beyond

1. Finalize metrics
2. Finalize financial calculations
3. Begin payment adjustments 7/1/23
4. Revise / test and learn

Finalize **initial list of quality measures + adjustments** (e.g. risk adjustment / numerator / denominators)

Determine **exact calculations** linking higher / lower quality to change in nursing home reimbursements

Example of policy decisions:

- Stop gain?
- Only allow homes that are not under CMS / state investigation to quality?
- Size and scope of program

- DSS and the industry are **working collaboratively**
- Reimbursement adjusted for quality will begin 7/1/23

Note: CMS state plan amendment (SPA) approval required

Implement consumer satisfaction survey. Reporting only starting 7/1/23. Consumer satisfaction survey results will be incorporated into reimbursement impacts once a baseline is established.

Quality measures will be monitored and adjusted over time, reflecting desired outcomes for resident care.

DSS Audits of Nursing Home Medicaid Payments

- Periodic audits of cost reports conducted by DSS.
- Profit and loss statements of related parties receiving over $50,000 must be submitted to DSS with cost report.
- Specific audits of rate increases intended for wages are currently being conducted.
  - In addition, PA 22-145 allows DSS to assess a civil penalty on a nursing home that receives a rate increase to enhance its employees' wages but fails to use it for that purpose. The civil penalty is in addition to any applicable recoupment or rate decrease the law otherwise allows.
- DSS is auditing the MDS data that is being used to measure acuity.
- All cost reports and rate letters are posted on the DSS website.

Regulatory Oversight of Quality and Care by the Department of Public Health (DPH)

- Nursing home quality standards are regulated on both the state and federal levels and are one of the most highly regulated entities in the state.
- Nursing homes are licensed by the state's Department of Public Health (DPH) and regulated by the Public Health Code and state statute.
- The U.S. Centers for Medicare and Medicaid Services (CMS) also have extensive regulations for nursing homes on the federal level.
- DPH enforces both the state and the federal regulations through an annual, unannounced inspection process and through complaint investigations.
- Nursing home violations result in a range of penalties including deficiencies, citations, civil monetary penalties, restrictions on admissions, and even closure.
- Violations must be corrected by the nursing home within prescribed timelines in order to be placed back into compliance.

Regulatory Oversight of Quality and Care by the Department of Public Health (DPH)

- DPH oversees changes in ownership, changes in licensure, closures.
- DPH oversees and inspects physical plant operations.
- DPH oversees CON approved renovations and construction projects.
- DPH is a partner in the Long Term Care Mutual Aid Plan (LTC-MAP).

- Note: The Long Term Care Ombudsman is an independent entity that serves as an advocate for the nursing home resident.

Nursing Home Staffing

- In the last legislative session, the state legislature directed DPH to implement a 3.0 minimum direct care staffing level.
- The federal staffing requirement is that you must staff at a level sufficient to meet nursing needs of their residents and DPH also enforces this standard.
- CMS is in the process of studying and developing the implementation of a more specific staffing ratio on the federal level, with the possibility of issuing a rule as early as May of this year.

Workforce Crisis

- The health care sector in general is facing a severe workforce shortage.
- On a national level, nursing homes experienced the worst job loss within the larger health care sector during the pandemic.
- Workforce levels are the lowest they have been since 1994.
- The crisis is impacting not only direct care, but also housekeeping, maintenance, dining, social work, recreation therapy, and administrative services.
- Many nursing homes are limiting admissions due to staffing shortages and/or utilizing costly temporary nurse agencies.

(Source: American Health Care Associations)

Our Commitment

CAHCF/CCAL and LeadingAge Connecticut stand ready to collaborate with the State Legislature and the Administration on behalf of our members, and look forward to continuing the ongoing discussion of how to ensure quality nursing home care in Connecticut.

Publicly Available Information

- DSS Nursing Home Reimbursement website https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Nursing-Home-Reimbursement/Medicaid-Nursing-Home-Reimbursement
  - Annual Cost Reports, Rates, Census, Rate System Methodology, etc.

- CMS Care Compare website https://www.medicare.gov/care-compare/?providerType=NursingHome
  - Five star rating, inspection results, staffing information, ownership information, vaccination data and quality measures

Other Resources

- Long-Term Care Planning Committee's 2023 Report to the Aging and Human Services Committees on the Number of Individuals Receiving Long-Term Services and Supports in the Community and in Institutions: https://portal.ct.gov/-/media/OPM/HHS/LTC_Planning_Committee/CT-Rebalancing-Summary-2022_Submittal.pdf
- DSS 2022 Annual Rebalancing Presentation: https://portal.ct.gov/-/media/OPM/HHS/LTC_Planning_Committee/DSS-LTC-Committee-Presentation-92022-Final.pptx
- DSS October 2022 Presentation to MAPOC on Nursing Home Reimbursement: https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20221014/DSS%20Report.pdf
- OPM Annual Nursing Facility Census September 2021: https://portal.ct.gov/-/media/OPM/HHS/LTC/NF-Fact-Sheet-2021.pdf
- Annual Report of the Nursing Home Financial Advisory Committee January 2023: https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/Facility-Licensing--Investigations/Nursing-Home-Advisory/Annual-Report-Nursing-Home-Financial-Advisory-Committee-CY-2022_Submitted.pdf

Acronyms

- DSS: Department of Social Services (State)
- DPH: Department of Public Health (State)
- CMS: Centers for Medicare and Medicaid Services (Federal)
- HCBS: Home and Community Based Services
- SNF: Skilled Nursing Facility
- CON: Certificate of Need
- MDS: Minimum Data Set (nursing home resident assessment tool)

Thank you

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