Nursing Home Reimbursement Overview

Under the Connecticut Medicaid program, nursing home payment rates are set on a cost-based prospective basis in accordance with Section 17b-340 of the Connecticut General Statutes and Section 17-311-52 of the Regulations of Connecticut State Agencies. Centers for Medicare and Medicaid Services (CMS) have approved the Medicaid State Plan Amendment (SPA) which is a governing authority for the calculation of nursing home reimbursement and to ensure federal matching funds.

The Department of Social Services (DSS) conducts a review of annual cost reports submitted by nursing homes to determine which costs are allowable and which are unallowable. Section 1903(a)(7) of the federal Social Security Act requires Medicaid reimbursement to be "economic and efficient" and in accordance with patient care. Medicaid may only reimburse for allowable costs, which are determined in accordance with the Medicaid State Plan, as well as state and federal regulations.

Under 17b-340 Connecticut General Statute allowable nursing home costs are:

1. **Direct** - Nursing and nurse aide personnel salaries, related fringe benefits and nursing pool costs.
2. **Indirect** - Professional fees, dietary, housekeeping, laundry personnel costs and expenses and supplies related to patient care.
3. **Administrative and General** - Maintenance and plant operation expenses, and salaries and related fringe benefits for administrative and maintenance personnel.
4. **Property (Fair Rent)** - A fair rental value allowance is calculated to yield a constant amount each year in lieu of interest and depreciation costs. The allowance for the use of real property (non-moveable equipment) other than land is determined by amortizing the base value of property over its remaining useful life and applying a rate of return (ROR) on the base value. The ROR is linked to the Medicare borrowing rate and is currently 2.766% for assets placed in service in 2016. Under state statute the maximum ROR is 11%. Non-profit facilities receive the lower of the fair rental value allowance or actual interest and depreciation plus certain other disallowed costs.
5. **Capital Related** - Property taxes, insurance expenses, moveable equipment leases and moveable equipment depreciation.
6. In FY 2018, 51% of allowable costs went towards direct resident care.

In FY 2018, 23% of costs included on Connecticut nursing facility cost reports were unallowable. In FY 2018 of the costs that were allowable (77%), 51% of allowable costs were related to direct care.

Examples of Unallowable Costs:

- Disallowed salaries and fees and those over reasonable cost caps
- Disallowed Managerial Administrative Compensation over reasonable cost caps

- Disallowed Rent
- Building Interest, Depreciation, Amortization
- Physical Therapy, Speech Therapy, and Occupational Therapy Expenses (paid by Medicare)
- Miscellaneous disallowances not related to patient care (advertising, bad debt etc.)

Reasonable cost is a basic Medicaid reimbursement principle that guides states in the development of rate-setting methods and to ensure only allowable costs are reimbursed for services provided to residents. Reasonable cost reimbursement methods help states to:

- control cost
- maintain quality
- allow for patient access to care
- support state and federal policy goals

Nursing Facility Payment Modernization – Acuity Based Reimbursement

On July 1, 2021, DSS will transition nursing home reimbursement to an **acuity-based system** which will aid DSS in its goals of moving toward a data driven system designed to increase transparency and improve patient health outcomes.

Acuity reimbursement or Case Mix recognizes the relationship between reimbursement and the quality of care and positive care experience that residents need and deserve. By transitioning reimbursement, Connecticut is following the lead of approximately 30 other state Medicaid programs that have already transitioned to case mix reimbursement.

Case Mix systems recognize the need to:

- provide incentives for nursing homes to admit people with high-acuity, complex needs
- structure reimbursement to promote direct care costs like staffing
- enhance quality of care through value-based purchasing (quality)

Case Mix supports the Department's rebalancing agenda, which utilizes diverse strategies to ensure that Medicaid members have meaningful choice in the means and setting in which they receive LTSS. Case mix also:

- Supports budget neutrality.
- Align reimbursement with the anticipated resource needs of each provider based on the acuity of their specific residents.
- Provide incentive for nursing homes to admit and provide care to persons in need of comparatively greater care.
- Periodic adjustments to reimbursement to account for changes in the acuity mix of each provider's residents.
- Evaluation of rate-setting methodology for special populations.

- Aligns with rebalancing efforts by incentivizing care for high need residents and creating less incentive for accepting low need residents in the nursing facility setting.

Additional Information

On February 6, 2020, the Department presented to the Committees of Cognizance Nursing Home Forum: Modernization of Connecticut Medicaid Nursing Facility Reimbursement: An Essential Component of Long-Term Services and Supports "Rebalancing"

https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Medicaid-Nursing-Home-Reimbursement/Nursing-Home-Forum-for-the-Committees-of-Cognizance-2620.pdf

DSS case mix website:
https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Nursing-Home-Reimbursement/Nursing-Home-Reimbursement-Acuity-Based-Methodology