February 24, 2026

Testimony of the Connecticut Association of Health Care Facilities / Connecticut Center For Assisted Living (CAHCF/CCAL):

On behalf of the Connecticut Association of Health Care Facilities / Connecticut Center For Assisted Living (CAHCF/CCAL), a trade association of skilled nursing facilities and assisted living communities, my name is Matt Barrett, the association's President and CEO. Thank you for this opportunity to present testimony in opposition to (as drafted), and with recommended revisions, to S.B. No. 288 (RAISED) AN ACT CONCERNING THE DEPARTMENT OF SOCIAL SERVICES' RECOMMENDATIONS REGARDING EXCEPTIONS TO THE NURSING HOME BED MORATORIUM, NURSING HOME RESIDENT DATA AND NURSING HOME REIMBURSEMENT RATE CAPS FOR RELATED PARTY EMPLOYEES.

Sections 1 and 2 – Exceptions to the Nursing Home Bed Moratorium / CAHCF Recommends Additional Provisions to Implement Multi-faceted Access and Bed Need Strategy

Connecticut state policy makers should develop and implement a multi-faceted, policy oriented, and targeted strategy addressing the current issue nursing home bed shortages now present and expected to increase with rising nursing home occupancy percentages caused by nursing home licensed bed reductions and closures, and increased demand for care of higher acuity nursing homes residents. At 89.5% occupancy, Connecticut nursing homes are now near capacity with some areas of the state experiencing supply shortages and access to nursing home care challenges. With the ongoing increased demand for long term care associated with the dramatically increasing aging population of Connecticut, it is essential that Connecticut move to address these issues in the 2026 session of the Connecticut General Assembly, and this can be accomplished with incremental, but important, policy changes that are consistent with Connecticut's longstanding strategic long term care planning objectives.

No single policy change can address the complicated issues of nursing home occupancy and access to care, therefore this multi-faceted approach is recommended. The proposal includes the following components:

1. Establishing a narrow exception to the 1991 nursing home bed moratorium to allow and encourage the development of small house nursing homes and also increase number of single (one bed) nursing home rooms;

2. Authorizing the transfer of nursing home licensed beds from a from one nursing home to other existing nursing homes, especially when the purpose is to achieve single rooms to promoted infection prevention best practices or to facilitate the transition to a nursing home room configuration of no more than two beds per rooms;

3. The proposal also modifies the CON bed need threshold to 92% from 97.5% for facility projects.

4. In alignment with these policy objectives, this proposal also includes provisions that set forth a process by which nursing homes will apply to the Department of Social Services and the Department of Public Health simultaneously so that Medicaid reimbursement issues can be aligned with public health policy goals, including any waivers necessary and appropriate to implement the objectives of a comprehensively increasing access to nursing home care. The proposal identifies the various categories of costs that will be experienced to implement the policy goals so that the agencies will receive applications in a uniform format in a prescribed manner; and

5. Finally, the proposal includes a revised timeframe to transitioning nursing home room configurations to no more than two beds from July 1, 2026 to July 1, 2029. Related to this, the proposal restates the consensus objective of convening a legislative working group to address the consequences for residents and providers when implementing the requirements to limit nursing home rooms to no more than two beds and other related considerations adopted in Public Act No. 24-141. Regrettably, while leadership appointment were made, this critically important work group never convened.

A detailed proposal is included as an addendum to this testimony.

Section 3 – Opposed to MDS Extrapolation Audit and Related Provisions

This section would authorize DSS to conduct audits of minimum data set information used in the calculation of Medicaid acuity-based per diem rates paid to licensed nursing homes. The bill defines "extrapolation" to mean “the determination of an unknown value by projecting the results of the review of a sample to the universe from which the sample was drawn…”. The bill broadly authorizes an exception to DSS 17b-99a auditing requirements and instead authorizes “any commissioner's request for, or a nursing home's production of, documentation to support the minimum data set audit need not be conducted in accordance with the provisions of this section.”

The bill requires nursing homes to provide all documentation requested pursuant to the minimum data set audit not later than ten days after the date on which the commissioner requests such documentation. The commissioner shall not accept any documentation provided by a nursing home after the completion of the exit conference portion of the audit unless the commissioner and the nursing home agree.

CAHCF is opposed to these provisions because nursing homes assert that underlying DSS MDS policies and audit practices now include major defects and flaws and extrapolation methodologies would continue these flawed practices with serious financial consequences to the providers. This testimony includes a detailed analysis in support of our claims that the state routinely is inconsistent in audit interpretation and routinely lacks standardization in MDS policies and audits. Imposing extrapolation auditing on top of these flaws guarantees unfair and inequitable consequences for the providers. Further, it would be detrimental to impose new extrapolation auditing methods where a significant revision to the acuity based payment system is now scheduled for July 1, 2026 and will include a three year phase-in due to the complexity of the new PDPM policies and the changes in nursing homes practices that will be required within just four months. Nursing home also assert that these proposed provisions have due process and regulatory conflict concerns and a range of other compliance challenges. For more information, see Addendum No. 2, Memorandum from Maureen McCarthy, RN, President and CEO of Celtic Consulting titled: "Connecticut Medicaid CMI Audit Practices & Extrapolation Risk in S.B. No. 288 AN ACT CONCERNING THE DEPARTMENT OF SOCIAL SERVICES' RECOMMENDATIONS REGARDING EXCEPTIONS TO THE NURSING HOME BED MORATORIUM, NURSING HOME RESIDENT DATA AND NURSING HOME REIMBURSEMENT RATE CAPS FOR RELATED PARTY EMPLOYEES."

Connecticut's skilled nursing facilities are caring for increasingly complex residents. Acuity-based reimbursement can be an appropriate mechanism when implemented consistently and transparently. However, audit interpretation variability and extrapolation risk introduce fiscal instability into an already under-resourced system. Audit systems are an important safeguard to ensure Medicaid payment integrity. However, oversight must be consistent, standardized, and aligned with CMS intent. When reimbursement reductions are driven by subjective or non-uniform interpretation rather than demonstrable clinical inaccuracy, funding instability is layered onto an already under-resourced system. Audit practices should protect public funds while remaining grounded in clinical reality and the care actually delivered to Connecticut's most vulnerable residents.

For these reasons, CAHCF is opposed to Section 3 of the bill.

Section 4 – Opposed to Proposed Exclusion of Reasonable Costs Mandated by Collective Bargaining Agreements When Employees are Members of the Bargaining Unit and also Related Parties

CAHCF remains concerned that the related party salary disallowances proposed here, as drafted, are specifically directed and undermining of bona fide and negotiated collecting bargaining agreements between nursing home operators and the unions representing certain

nursing home employees. In this regard, the proposal seems to run counter to the well-established principal that the salary costs associated with nursing home collective bargaining agreements are inherently reasonable and should be recognized and honored because they are the result of a negotiated process.

Here is the language of concern in the bill: "Cost of such services shall include reasonable costs mandated by collective bargaining agreements with certified collective bargaining agents or other agreements between the employer and employees, provided "employees" shall not include persons who are a related party or employed as managers or chief administrators or required to be licensed as nursing home administrators, and compensation for services rendered by proprietors at prevailing wage rates, as determined by application of principles of accounting as prescribed by said commissioner."

Even as today's DSS testimony asserts that "…[this] proposal will clarify that salary above the union-negotiated rates will not be reimbursed through Medicaid and will need to be paid for by the nursing home owner separately," we remain concerned the proposed statutory language is not aligned with the expressed intent.

Thank you for this opportunity to submit testimony.

For additional information on this testimony, please contact Matthew Barrett, President and CEO of CAHCF/CCAL, at mbarrett@cahcf.org.

ADDENDUM No. 1:

AN ACT CONCERNING NURSING HOME OCCUPANCY, ACCESS TO CARE, ENCOURAGING SMALL HOUSE NURSING HOMES, SINGLE RESIDENT ROOMS, THE RELOCATION OF EXISTING NURSING HOME BEDS AND FACILITATING THE TRANSITION TO TWO BED NURSING HOME ROOM LIMITATION.

Summary:

Connecticut state policy makers should develop and implement a multi-faceted, policy oriented, and targeted strategy addressing the current issue nursing home bed shortages now present and expected to increase with rising nursing home occupancy percentages caused by nursing home licensed bed reductions and closures, and increased demand for care of higher acuity nursing homes residents. At 89.5% occupancy, Connecticut nursing homes are now near capacity with some areas of the state experiencing supply shortages and access to nursing home care challenges. With the ongoing increased demand for long term care associated with the dramatically increasing aging population of Connecticut, it is essential that Connecticut move to address these issues in the 2026 session of the Connecticut General Assembly, and this can be accomplished with incremental, but important, policy changes that are consistent with Connecticut's longstanding strategic long term care planning objectives.

No single policy change can address the complicated issues of nursing home occupancy and access to care, therefore this multi-faceted approach is recommended. The proposal includes the following components:

1. Establishing a narrow exception to the 1991 nursing home bed moratorium to allow and encourage the development of small house nursing homes and also increase number of single (one bed) nursing home rooms;

2. Authorizing the transfer of nursing home licensed beds from a from one nursing home to other existing nursing homes, especially when the purpose is to achieve single rooms to promoted infection prevention best practices or to facilitate the transition to a nursing home room configuration of no more than two beds per rooms;

3. The proposal also modifies the CON bed need threshold to 92% from 97.5% to facility projects.

4. In alignment with these policy objectives, this proposal also includes provisions that set forth a process by which nursing homes will apply to the Department of Social Services and the Department of Public Health simultaneously so that Medicaid reimbursement issues can be aligned with public health policy goals, including any waivers necessary and appropriate to implement the objectives of a comprehensively increasing access to nursing home care. The proposal identifies the various categories of costs that will be experienced to implement the policy goals so that the agencies will receive applications in a uniform format in a prescribed manner; and

5. Finally, the proposal includes a revised timeframe to transitioning nursing home room configurations to no more than two beds from July 1, 2026 to July 1, 2029. Related to this, the proposal restates the consensus objective of convening a legislative working group to address the consequences for residents and providers when implementing the requirements to limit nursing home rooms to no more than two beds and other related considerations adopted in Public Act No. 24-141. Regrettably, while leadership appointment were made, this critically important work group, never convened. This proposal also adds to the issues that must be addressed by the work group in its report to the state legislature, as follows:

- The restructuring of Medicaid rates paid to the nursing home in the event that a reduction in licensed bed capacity is required to achieve room configurations of no more than two beds per room,
- Reimbursement for the costs of planning and architectural designs when a renovation is needed,
- Accelerated depreciation in property-fair rent component of the Medicaid rate.
- State bond fund grants to cover required up-front capital costs,
- an interim adjustment to rates to reflect the costs of temporarily discharging residents or limiting admissions during a construction and renovation process

- An expedited and streamlined certificate of need process for proposals submitted in accordance with the policy objective of rooms configurations of no more than two beds per room,
- a three-year transition period to ensure that such facilities are able to comply with the transition to two-bed rooms,
- a uniform application process for nursing homes to follow when submitting proposals seeking approvals from the Department of Social Services and the Department of Public Health of compliance plans, and
- a waiver of deadlines for facilities demonstrating progress or awaiting municipal or other government approval in transitioning to the two bed room configurations.

The working draft statutory language recommended to be introduced in the 2026 session to implement this multi-faceted plan-of-action begins on the following page:

AN ACT CONCERNING NURSING HOME OCCUPANCY, ACCESS TO CARE, ENCOURAGING SMALL HOUSE NURSING HOMES, SINGLE RESIDENT ROOMS, THE RELOCATION OF EXISTING NURSING HOME BEDS AND FACILITATING THE TRANSITION TO TWO BED NURSING HOME ROOM LIMITATION.

Be it enacted by the Senate and House of Representatives in general assembly convened:

Section 1. Subsection (a) of section 17b-354 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Department of Social Services shall not accept or approve any requests for additional nursing home beds, except (1) beds restricted to use by patients with acquired immune deficiency syndrome or by patients requiring neurological rehabilitation; (2) beds associated with a continuing care facility, as described in section 17b-520, provided such beds are not used in the Medicaid program; **[**. For the purpose of this subsection, beds associated with a continuing care facility are not subject to the certificate of need provisions pursuant to sections 17b-352 and 17b-353;**]** (3) Medicaid certified beds either to be relocated from one licensed nursing facility to another licensed nursing facility to meet a priority need identified in the strategic plan developed pursuant to subsection (c) of section 17b-369 or new beds added to an existing facility or a new facility, or relocated from a nursing home to one or more existing nursing homes, with preference given to a nontraditional, small-house-style nursing home facility that incorporates the goals for nursing facilities referenced in the department's strategic plan for long-term care, as outlined in section 17b-355, as amended by this act, or single resident rooms to enhance facility infection prevention control best practices, or to facilitate the transition to nursing home room configurations of no more than two beds, or to address priority needs reflected by area census trends; (4) licensed Medicaid nursing facility beds to be relocated from one or more existing nursing facilities to a new

nursing facility, including a replacement facility, provided (A) no new Medicaid certified beds are added, (B) at least one currently licensed facility is closed in the transaction as a result of the relocation, (C) the relocation is done within available appropriations, (D) the facility participates in the Money Follows the Person demonstration project pursuant to section 17b-369, (E) the availability of beds in the area of need will not be adversely affected, (F) the certificate of need approval for such new facility or facility relocation and the associated capital expenditures are obtained pursuant to sections 17b-352 and 17b-353, and (G) the facilities included in the bed relocation and closure shall be in accordance with the strategic plan developed pursuant to subsection (c) of section 17b-369; and (5) proposals to build a nontraditional, small-house style nursing home designed to enhance the quality of life for nursing facility residents, provided that the nursing facility agrees to reduce its total number of licensed beds by a percentage determined by the Commissioner of Social Services in accordance with the department's strategic plan for long-term care. For the purposes of this subsection, beds associated with a continuing care facility are not subject to the certificate of need provisions pursuant to sections 17b-352 and 17b-353.

Section 2. Subsection (b) of section 17b-352 is amended and the following substituted in lieu thereof:

(b) Any facility which intends to (1) transfer all or part of its ownership or control prior to being initially licensed; (2) introduce any additional function or service into its program of care or expand an existing function or service; (3) terminate a service or decrease substantially its total licensed bed capacity; or (4) relocate all or a portion of such facility's licensed beds, to a new facility or replacement facility, or to request to relocate and transfer licensed nursing facility beds from an existing facility to one or more licensed nursing facilities, shall submit a complete request for permission to implement such transfer, addition, expansion, increase, termination, decrease or relocation of facility beds to the Department of Social Services with such information as the department requires, provided no permission or request for permission is required (A) to close a facility when a facility in receivership is closed by order of the Superior Court pursuant to section 19a-545, or (B) to change a facility's licensure as a rest home with nursing supervision to licensure as a chronic and convalescent nursing home. The Commissioner of Social Services shall consider the criteria in subdivisions (3) and (4) of subsection (a) of section 17b-354 when evaluating a certificate of need request to relocate licensed nursing facility beds from an existing facility to another licensed nursing facility or to a new facility or replacement facility. The Office of the Long-Term Care Ombudsman, or, in the case of a residential facility for persons with intellectual disability licensed pursuant to section 17a-277, as described in subsection (a) of this section, the Office of the Developmental Services Ombudsperson shall be notified by the facility of any proposed actions pursuant to this subsection at the same time the request for permission is submitted to the department and when a facility in receivership is closed by order of the Superior Court pursuant to section 19a-545.

Section 3. Section 17b-355 of the general statutes is repealed and the following is substituted in lieu thereof:

In determining whether a request submitted pursuant to sections 17b-352 to 17b-354, inclusive, will be granted, modified or denied, the Commissioner of Social Services shall consider the following: The financial feasibility of the request and its impact on the applicant's rates and financial condition, the contribution of the request to the quality, accessibility and cost-effectiveness of the delivery of long-term care in the region, whether there is clear public need for the request, the relationship of any proposed change to the applicant's current utilization statistics and the effect of the proposal on the utilization statistics of other facilities in the applicant's service area, the business interests of all owners, partners, associates, incorporators, directors, sponsors, stockholders and operators and the personal background of such persons, and any other factor which the Department of Social Services deems relevant. In considering whether there is clear public need for any request for the relocation of beds to a replacement facility, the commissioner shall consider whether there is a demonstrated bed need in the towns within a fifteen-mile radius of the town in which the beds are proposed to be located and whether the availability of beds in the applicant's service area will be adversely affected. Any proposal to relocate nursing home beds from an existing facility to a new facility shall not increase the number of Medicaid certified beds and shall result in the closure of at least one currently licensed facility. The commissioner may request that any applicant seeking to replace an existing facility reduce the number of beds in the new facility by a percentage that is consistent with the department's strategic plan for long-term care. If an applicant seeking to replace an existing facility with a new facility owns or operates more than one nursing facility, the commissioner may request that the applicant close two or more facilities before approving the proposal to build a new facility. The commissioner shall also consider whether an application to establish a new or replacement nursing facility proposes a nontraditional, small-house style nursing facility and incorporates goals for nursing facilities referenced in the department's strategic plan for long-term care, including, but not limited to, (1) promoting person-centered care, (2) providing enhanced quality of care, (3) creating community space for all nursing facility residents, and (4) developing stronger connections between the nursing facility residents and the surrounding community. The commissioner shall also consider whether an application proposes single resident rooms to enhance facility infection prevention control best practices, or whether an application proposes to facilitate the transition to nursing home room configurations of no more than two beds, or to address priority needs reflected by area census trends. Bed need shall be based on the recent occupancy percentage of area nursing facilities and the projected bed need for no more than five years into the future at [ninety-seven and one-half] ninety-two per cent occupancy using the latest official population projections by town and age as published by the Office of Policy and Management and the latest available state-wide nursing facility utilization statistics by age cohort from the Department of Public Health. The commissioner may also consider area specific utilization and reductions in utilization rates to account for the increased use of less institutional alternatives.

Section 4. Section 19a-521b of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Each licensed chronic and convalescent nursing home, chronic disease hospital associated with a chronic and convalescent nursing home, rest home with nursing supervision and residential care home shall position beds in a manner that promotes resident care and that provides at least a three-foot clearance at the sides and foot of each bed. Such bed position shall (1) not act as a restraint to the resident, (2) not create a hazardous situation, including, but not limited to, an entrapment possibility, or obstacle to evacuation or being close to or blocking a heat source, and (3) allow for infection control.

(b) On and after [July 1, 2026] July 1, 2029, no licensed chronic and convalescent nursing home or rest h1ome with nursing supervision shall place a newly admitted resident in a room containing more than two beds. A violation of the requirements of this subsection shall constitute a Class B violation under section 19a-527, except no licensed chronic and convalescent nursing home or rest home with nursing supervision shall incur more than one violation per newly admitted resident in one calendar year.

(c) The Commissioner of Social Services [may] shall recalculate a licensed chronic and convalescent nursing home or rest home with nursing supervision's Medicaid rate established for the fiscal year ending June 30, 2026, and for the fiscal years thereafter, reflecting any licensed bed reductions associated with the elimination of three and four-bed rooms. Allowable fair rent shall reflect costs for building modifications or other additions incurred for fiscal year 2025, and for the fiscal years thereafter, that are associated with the elimination of three and four-bed rooms.

Section 5. Section 13 of Public Act No. 24-141 is repealed and the following is substituted in lieu thereof:

Sec. 13. (*Effective from passage*) (a) There is established a working group to study the impact of prohibiting licensed chronic and convalescent nursing homes and rest homes with nursing supervision from placing newly admitted residents in rooms containing more than two beds without consent pursuant to the provisions of subsection (b) of section 19a-521b of the general statutes, as amended by this act. The working group shall examine methods to (1) assist such facilities affected by the provisions of said subsection, including identifying opportunities to support the financial sustainability of such facilities, such as (A) the restructuring of Medicaid rates paid to the nursing home in the event that a reduction in licensed bed capacity is required to achieve room configurations of no more than two beds per room, (B) to reimburse the nursing home for planning and architectural designs when a renovation is needed, (C) an interim adjustment to rates to reflect the costs of temporarily discharging or limiting admissions of residents during a construction and renovation, [and] (2) an expedited certificate of need process for proposals submitted in accordance with the policy objective of rooms configurations of no more than two beds per room, (3) a three year transition period to ensure that such facilities are able to comply with the provisions of said subsection, (4) a uniform application process for nursing homes to follow when submitting proposals seeking approvals from the Department of Social Services and the Department of Public Health of compliance plans, (5) a waiver of deadlines for facilities demonstrating progress or seeking municipal or other government approval in

transitioning to the two bed room configurations, (6) the establishment of a capital funding pool authorized by state bonds to provide grants to nursing homes to cover up-front capital costs, and (7) accelerated depreciation in the property-fair rent component of the Medicaid rates.

(b) The working group shall consist of the following members:

(1) One appointed by the speaker of the House of Representatives;

(2) One appointed by the president pro tempore of the Senate;

(3) One appointed by the majority leader of the House of Representatives;

(4) One appointed by the majority leader of the Senate;

(5) One appointed by the minority leader of the House of Representatives;

(6) One appointed by the minority leader of the Senate;

(7) The Secretary of the Office of Policy and Management, or the secretary's designee;

(8) The Commissioner of Social Services, or the commissioner's designee;

(9) The Commissioner of Public Health, or the commissioner's designee;

(10) The chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to aging; and

(11) The ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to aging.

(c) Any member of the working group appointed under subdivision (1), (2), (3), (4), (5) or (6) of subsection (b) of this section may be a member of the General Assembly.

(d) All initial appointments to the working group shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(e) The House chairperson and House ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to aging shall be the chairpersons of the working group. Such chairpersons shall schedule the first meeting of the working group, which shall be held not later than sixty days after the effective date of this section.

(f) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to aging shall serve as administrative staff of the working group.

(g) Not later than January 1, [2026] 2027, the working group shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to aging, in accordance with the provisions of section 11-4a of the general statutes. The working group shall terminate on the date that it submits such report or January 1, [2026] 2027, whichever is later.

ADDENDUM No. 2

MEMORANDUM

To: Matthew V. Barrett, MPA, JD, President and CEO, CAHCF/CCAL

From: Maureen McCarthy, RN, President/CEO, Celtic Consulting

Re: Connecticut Medicaid CMI Audit Practices & Extrapolation Risk in S.B. No. 288 AN ACT CONCERNING THE DEPARTMENT OF SOCIAL SERVICES' RECOMMENDATIONS REGARDING EXCEPTIONS TO THE NURSING HOME BED MORATORIUM, NURSING HOME RESIDENT DATA AND NURSING HOME REIMBURSEMENT RATE CAPS FOR RELATED PARTY EMPLOYEES.

Date February 24, 2026

My name is Maureen McCarthy, RN, and I am the Founder and CEO of Celtic Consulting, LLC, a Connecticut-based health care consulting firm specializing in skilled nursing facility operations, Medicare and Medicaid reimbursement systems, and regulatory compliance for over 24 years. I serve as a certified Master Teacher and Chair of the Board of the American Association of Post-Acute Care Nursing and have over 40 years of experience in long-term care clinical practice, documentation systems, and reimbursement compliance.

This memorandum to addresses two interrelated issues that directly affect patient care and the fiscal stability of Connecticut’s nursing home system:

1. The operational and financial impact of current Medicaid Case Mix Index (CMI) audit practices; and

2. The potential use of extrapolation on audit findings.

These issues are not abstract policy concerns. They materially affect Medicaid expenditures, provider solvency, workforce stability, and access to care for Connecticut's most medically complex residents.

I. Operational and Financial Impact of Current CMI Audit Practices

Connecticut nursing facilities are serving residents with increasingly complex medical and behavioral health needs, including advanced neurological conditions, chronic respiratory illness, active oncology treatment, advanced pressure injuries, post-hospital rehabilitation, and behavioral health disorders. The PDPM payment model was developed as a post-hospital index payment system that does not account for custodial care. The Centers for Medicare and Medicaid Services, or CMS, does not believe nursing homes have the capacity to provide behavioral or psychiatric skilled care and therefore did not structure the acuity assignment for this population into the calculation. This is a significant portion of the residents in our long-term care nursing homes now.

Connecticut's Medicaid reimbursement system for nursing facilities is directly tied to resident acuity as measured through the Minimum Data Set (MDS). Since full implementation of acuity-based reimbursement in July 2024, the Department has conducted MDS audits and reported that approximately 30 percent of submitted documentation was deemed 'questionable.'

It is critical for appropriations deliberations to understand that these audit findings do not represent demonstrated fraud or systemic overbilling. Rather, providers report that many disallowances stem from narrow interpretation of documentation standards, inconsistent application of lookback rules, and subjective auditor judgment.

Inconsistent Audit Interpretation & Lack of Standardization

Recent audit findings demonstrate that chronic diagnoses such as Parkinson's disease and Multiple Sclerosis have been rejected for lack of documentation within a rigid 7-day lookback window, even when functional decline and treatment interventions clearly demonstrate active disease. Cancer lesions under ongoing oncology treatment have been rejected due to timing technicalities. Stage 3 and Stage 4 pressure injuries have been disallowed despite daily treatment documentation, because narrative descriptions were not entered during the precise lookback period.

Audit results reveal inconsistent interpretation of documentation standards. APRN notes have been rejected due to next-day electronic signatures despite no dispute regarding clinical accuracy. Isolation documentation has been rejected for not explicitly stating "private room," in the nurses' notes, even in facilities comprised entirely of private rooms. Respiratory therapy has been accepted for one resident and rejected for another under similar circumstances.

Facilities report that care plans and Treatment Administration Records (TARs), both required interdisciplinary documents, are not consistently accepted as supporting documentation. CNA documentation practices have also been questioned in ways that introduce subjectivity rather than focusing on actual care delivered. Similar documentation has been accepted in some audits and rejected in others, raising inter-rater reliability concerns.

When audit downgrades based on technical documentation interpretations rather than clinical care provided reduce CMI scores at the same time that rates fail to reflect inflation, the financial pressure compounds. In other words, when coded acuity is reduced through audit reinterpretation, reimbursement is retroactively reduced—even though care was delivered. Acuity-based payments are capped, and downward reclassification of acuity due to an audit reclassification further reduce reimbursement. Because base Medicaid rates are already constrained and inflation adjustments have not kept pace with operating costs, audit downgrades compound existing financial strain. This directly impacts staffing investments and access to high-acuity admissions.

The 7-Day Lookback and Regulatory Conflict

Rigid interpretation of the 7-day lookback window creates regulatory conflict. Facilities face a "no-win" scenario: code based on clinical continuity and risk audit downgrade, or refrain from coding and risk survey deficiency. This misalignment promotes defensive documentation and inaccurate coding rather than improved resident care.

Due Process and Audit Timing Concerns

Although nursing homes are federally required to complete MDS assessments in accordance with timeframes specified by CMS, not all software systems have the same capabilities, and may not have the ability to produce required supportive documentation immediately, as was suggested. The current process that documentation be collected and submitted within a 10-day timeframe, after notification of the audit, is sufficient to produce both electronic and paper documents needed to support CMI audit. In some cases, documentation may not be immediately produced during an audit because auditors are requesting records or formats beyond what state surveyors, Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), or other oversight entities traditionally accept as sufficient supportive documentation. This creates a disconnect between established regulatory expectations and evolving audit demands.

Facilities report auditors completing reviews before response windows expire, limiting meaningful opportunity for clarification. Lack of standardized guidance and inconsistent auditor calibration create unpredictability in reimbursement outcomes.

The Department has also reported a 7 percent increase in coded resident acuity since the launch of acuity reimbursement, whereas mature acuity-based systems typically experience only a 1 to 2 percent increase. Resident clinical complexity in Connecticut has not increased by 7 percent during this period. While characterized as "upcoding," this variance may more accurately reflect changes in audit interpretation of the CMS Resident Assessment Instrument (RAI) guidelines for MDS coding and completion—interpretations that may exceed or narrow the original intent of the manual—rather than intentional inflation of acuity by providers. Facilities indicate they have not changed their coding practices; rather, the standard for what auditors will accept as supportive documentation appears to have shifted.

Fiscal Impact Analysis for Appropriations Consideration

Based on facility-level modeling across multiple Connecticut operators, a 3–5 percent reduction in CMI attributable to audit downgrades can translate into annual Medicaid revenue losses ranging from $250,000 to over $1 million per facility, depending on census and acuity mix.

If extrapolation were applied to a statistically small audit sample and projected across multiple assessment periods, aggregate recoupments could escalate into multi-million-dollar liabilities for mid-sized providers. At a statewide level, even a 2 percent downward acuity adjustment across the Medicaid nursing facility base could represent tens of millions of dollars in revenue compression system-wide.

For appropriations purposes, this creates a paradox: short-term recoupments may appear as savings, but destabilization of providers increases the risk of closures, receiverships, and higher-cost hospital utilization—ultimately shifting expenditures elsewhere in the Medicaid budget.

Commented [MM1]: Not sure if you want me to leave this in, or have someone else address this section

Commented [MM2R1]: Celtic is an Independent Review Org for the feds, so this is the way we use extrapolation at the federal level for MDS audit recoupments

II. Potential Use of Extrapolation on Audit Findings

Connecticut's skilled nursing facilities are admitting residents with increasingly complex medical, behavioral, and functional needs. Medicaid nursing home payment is based on the Minimum Data Set (MDS) data reported by facilities, and the Department appropriately audits this information to ensure payments are accurate and used for their intended purpose—resident care. As stated earlier, since July of 2024, the Department has conducted MDS audits and reported that approximately 30 percent of documentation submitted during the audit process has been deemed "questionable."

However, this 30 percent figure must be understood in context. Facilities are federally required to complete MDS assessments within strict CMS timeframes and to maintain supporting documentation. That documentation exists and reflects care delivered. The adjustments cited in audit findings are not indicative of widespread fraud or intentional gaming of the system. Rather, providers report that a significant portion of the disallowances stem from subjective interpretation by individual auditors and inconsistent application of MDS documentation guidelines. Similar documentation has been accepted in some reviews and rejected in others, raising concerns about inter-rater reliability and standardization.

The potential application of statistical extrapolation in CMI audits significantly increases fiscal risk. Extrapolation applies findings from a limited sample of reviewed MDS assessments across a broader universe of assessments, magnifying repayment obligations beyond the specific records reviewed.

In mature Medicare audit systems, extrapolation is reserved for cases involving demonstrated systemic error patterns and statistically valid methodologies. Such

methodologies require clearly defined sampling frames, minimum sample sizes, defined confidence intervals (typically 90–95%), precision thresholds, margin-of-error calculations, and full transparency of statistical assumptions.

Absent these safeguards, extrapolated findings can produce financial liabilities that exceed the actual aggregate error rate. In acuity-based reimbursement systems, where many disputes involve documentation interpretation rather than clinical miscoding, extrapolation can disproportionately amplify technical disagreements into large-scale fiscal penalties.

For appropriations planning, extrapolation introduces volatility and unpredictability into Medicaid long-term care budgeting. It shifts facilities from stable prospective payment expectations into retroactive risk exposure, undermining capital planning, staffing investments, and workforce recruitment.

Legislative & Appropriations Considerations

As the Committee evaluates Medicaid long-term care appropriations for SFY 2027, consideration should be given to ensuring that audit integrity is preserved while financial predictability is maintained.

Policy options may include:

- Clear statewide audit standards defining acceptable documentation released 60-90 days prior to the impact on MDS assessment completion
- Statutorily defined audit documentation standards aligned with CMS RAI guidance
- Recognition of chronic diagnoses without repetitive 7-day re-documentation
- Acceptance of interdisciplinary documentation (care plans, TARs, MARs, consults)
- Mandatory required full-record review prior to disallowance with a clear structured

appeals process by an independent auditing entity prior to financial recoupment

- Auditor calibration and inter-rater reliability oversight
- Alignment between audit and survey standards
- Adequate inflation adjustments and removal of artificial acuity caps or neutrality

factors

- Independent statistical validation requirements prior to extrapolation
- Minimum confidence thresholds and sample size requirements codified in regulation
- Prospective inflation adjustments to mitigate compounded financial strain

Commented [MM3]: If financial consultants are taking the subject of statistically valid sample, they would need these 2 points as well for their recommendations. We can delete them from this document if not needed.

Conclusion

Connecticut's skilled nursing facilities are caring for increasingly complex residents. Acuity-based reimbursement can be an appropriate mechanism when implemented consistently and transparently. However, audit interpretation variability and extrapolation risk introduce fiscal instability into an already under-resourced system.

Audit systems are an important safeguard to ensure Medicaid payment integrity. However, oversight must be consistent, standardized, and aligned with CMS intent. When reimbursement reductions are driven by subjective or non-uniform interpretation rather than demonstrable clinical inaccuracy, funding instability is layered onto an already under-resourced system. Audit practices should protect public funds while remaining grounded in clinical reality and the care actually delivered to Connecticut's most vulnerable residents.

For appropriations purposes, protecting both Medicaid integrity and provider solvency must be viewed as complementary—not competing—goals. Oversight mechanisms should ensure accountability while preserving the financial stability necessary to sustain resident care and avoid higher downstream Medicaid costs.

Thank you.