CAHCF/CCAL
Connecticut Association of Health Care Facilities
Connecticut Center for Assisted Living

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Testimony of Matt Barrett, President and CEO of the Connecticut Association of Health Care Facilities / Connecticut Center For Assisted Living (CAHCF/CCAL).

THE GOVERNOR'S MIDTERM BUDGET RECOMMENDATIONS FOR HEALTH AND HUMAN SERVICES FOR SFY 2027

Senator Osten, Representative Walker and Members of the Appropriations Committee, my name is Matt Barrett. I am President and CEO of the Connecticut Association of Health Care Facilities and the Connecticut Center for Assisted Living (CAHCF/CCAL). As the committee carefully evaluates the needs all of our state's constituencies and communities in the SFY 27 proposed budget adjustment, we once more ask you to also consider the needs of Connecticut's skilled nursing homes in your deliberations.

I would like to begin by acknowledging the critically important investment in nursing home workforce development, recruitment and retention advanced by the leadership of the Appropriations Committee, further developed by Governor Lamont and adopted by the full Connecticut General Assembly last session, noting that the midterm budget proposal fully funds the second year wage nursing home and group home staff wage enhancements in the amount of $46.7 million. ed

Next, though a long awaited inflation adjustment for nursing homes didn't achieve final passage in Connecticut state budget adopted last session, it was enormously

important to us that in the Appropriations Committee in its earlier version of the budget last session, did, in fact, reverse the proposed elimination of statutory inflationary increases, and funded an inflation adjustment, which would have been the first since 2019. In the final adopted biennial budget, we generally understand that the committee inflation adjustment for nursing homes was eliminated or transferred to fund the important wage enhancements that were adopted last session. However, we feel the committee made an enormously important policy statement about the need to recognize inflation, and ask that this matter be again considered in this year's budget adjustment.

I also want to acknowledge that in anticipation of the administration's proposal to rebase nursing home rates effective July 1, 2026 (SFY 27) and to make federally-prescribed revisions to the acuity payment component of the rates, state social commissioner Barton Reeves did initiate a collaborative nursing home and agency stakeholder input process that began in earnest last July in monthly meetings with the two nursing home associations. Noting there hasn't been a stakeholder meeting since November and also that DSS has pledged to resume these meetings, and to share a detailed model of the proposed SFY 27 rates, now that the Governor's budget adjustments have been announced, our goal is that resurrecting this collaboration holds at least the possibility that we may be able to make recommended revisions to the proposed budget adjustment within the next four to six weeks to the Appropriations Committee.

And we believe important revisions are needed, even as the Governor's proposal does employ some measures to mitigate the potential for de-stabilizing and significant rates cuts in the proposed acuity reforms and the rate rebasing where our association estimates some nursing homes could see rate reductions exceeding 5% and amounting to as much as $482,000 in reduced revenue.

Specifically:

- **A Revised Three-Year Phase-In With Adjusted Corridors (Stop-Gain / Stop-Loss)**

- **Inflation From Cost Report Year to Rate Year**

- **Rate Add-Ons, i.e., Behavior and Cognitive Impairment Add-On**

- **Reforms to the Medicaid CMI Growth Cap and Neutrality Factor Reduction**

- **Rebasing and Minimum Occupancy Revisions**

- **The Importance of Specific Statutory Implementation Language in a Budget Implementation Bill Implementing SFY 27 Nursing Home Rates**

For significantly more detailed analysis in support of these recommendations, please see the following excerpt from a Memorandum sent to the Department of Social Services from CAHCF/CCAL on December 23, 2025:

"Thank you again for allowing input from Nursing Facility stakeholders as Connecticut Medicaid transitions to a PDPM case-mix methodology, and for considering related rate-setting policies necessary to better align reimbursement with resident-specific conditions beginning July 1, 2026.

1. **General Commentary**

   Connecticut's transition to an acuity-based Medicaid system has not yet produced the equitable and targeted outcomes originally envisioned. The state appropriately sought a methodology that would better identify the cost of serving Medicaid residents, compensate facilities caring for higher-acuity populations, and strengthen access for clinically complex individuals. Those goals remain valid; however, several structural constraints have limited their realization.

   Now in its fourth year, Connecticut's case-mix framework continues to reflect distortions carried forward from the RUG system, where overweighted therapy categories obscured underlying nursing burden. While PDPM removes the therapy emphasis, it does not address policy mechanisms that continue to suppress recognition of the true cost of caring for medically fragile long-term residents. Stakeholder data indicate that the acuity gap between Medicaid and full-house populations has narrowed substantially. Nevertheless, growth caps, neutrality factor reductions, unreimbursed inflation, and the absence of targeted adjustments for high-cost resident cohorts (particularly those with behavioral health needs) have prevented the system from functioning as intended.

   The recommendations below are designed to correct these structural gaps as Connecticut prepares for the PDPM transition and development of the July 1, 2026 rates.

2. **Rate Add-Ons**

   As Medicaid aligns with PDPM, several resident categories generate predictable and material nursing and operational costs that are not captured in the current rate structure. These pressures disproportionately affect high-Medicaid facilities, destabilize staffing, and create ongoing care and safety challenges.

To address these gaps, CAHCF recommends four narrowly targeted Medicaid add-ons. Each applies to clearly defined qualifying days and avoids the imprecision that results when discrete costs are averaged into the Direct Care component. Note that we have proposed qualifiers and reimbursement rates for each condition as baselines. We welcome the opportunity to review the underlying logic and methodologies. Primary among these concerns is the cost of caring for residents with complex behavioral needs.

A. Behavior and Cognitive Impairment

CAHCF proposes a supplemental payment for each Medicaid day in which a resident meets PDPM behavior-related criteria, regardless of whether the resident is ultimately placed in a different Nursing group due to higher acuity.

Triggering criteria (one or more of the following):

- Cognitive impairment (BIMS ≤ 9 or CPS ≥ 3)
- Hallucinations/delusions (E0100)
- Physical or other behavioral symptoms (E0200A-C, E0800, E0900)
- Substance Use Disorder indicators

Our modeling demonstrates that lowering the imputed occupancy minimum in the Direct Care component would not accurately, proportionally, or equitably fund behavioral-related costs. Occupancy distribution data show that facilities with the highest Medicaid share are least likely to benefit from imputation relief. Specifically, 86 SNFs reported occupancy of at least 90% in the most recent reporting year; this cohort averaged a 68% Medicaid share. Medicaid share declines to 64% for facilities reporting 80–90% occupancy, and to 60% for facilities below 80% occupancy.

Using real-time data from CMI-Connect, only 9.6% of Medicaid PDPM Nursing scores are currently captured in Behavior nursing groups. This significantly understates incidence because PDPM's Nursing component is index-maximizing rather than accretive; once a higher-scoring condition is captured, behavior drivers no longer affect reimbursement. When qualifying traits are evaluated independently of PDPM score assignment, approximately 37–42% of Medicaid days meet Behavior criteria.

Behavior-related expenses persist regardless of whether the PDPM Nursing grouper recognizes them. This is precisely the type of measurable, resident-specific cost that PDPM fails to capture and that Medicaid rate construction should address. Importantly, behaviors are not evenly distributed across facilities; targeted add-on payments ensure appropriate relief.

A. Bariatric Add-On

Purpose: Offset additional labor, equipment, and supply costs associated with caring for residents with severe obesity who require specialized beds, lifts, reinforced wheelchairs, and multi-person assistance.

Eligibility: BMI $\geq$ 35 with documented need for bariatric equipment or enhanced staffing. CMI-Connect modeling: 8% of Medicaid days qualify. $35 per qualifying day.

These residents consistently require additional labor and equipment, yet PDPM and Medicaid rates do not reflect these costs.

B. High Medicaid-Share / Medicare-Only Add-On

Purpose: Support providers treating a high proportion of Medicaid residents or medically complex residents who do not qualify for Medicare benefits and rely solely on Medicaid despite elevated acuity.

Eligibility: Facilities with greater than 70% Medicaid share, or targeted non-dual Medicaid residents during the stay.

Assumption: 9% - 11% of Medicaid days qualify.

Add-on: $20 per qualifying day.

This add-on recognizes the resource intensity of residents who generate no offsetting Medicare reimbursement.

C. Medicaid Private Room Differential (Infection Control & Dignity)

Purpose: Improve infection control by offsetting the structural cost of placing Medicaid residents in private rooms for clinical or cohorting purposes and removing financial disincentives for clinically appropriate room placement, and to ensure every resident, no matter their ability to pay, is afforded the dignity of private accommodations in a financially responsible manner.

Eligibility: Medicaid resident housed in a private room for documented infection control or clinical necessity.

Assumption: 7% of Medicaid days qualify.

Add-on: $25 per qualifying day.

This differential removes a financial barrier to using private rooms as an infection-control tool and directly supports public health priorities.

Collectively, these targeted add-ons modernize Medicaid rate construction by recognizing discrete, verifiable care needs not captured in PDPM. Eligibility criteria are straightforward, documentation requirements are minimal, and fiscal impacts are predictable. Anticipated costs are itemized below. The Association respectfully recommends adoption of all four add-ons as part of the July 1, 2026 PDPM transition.

Inflation From Cost Report Year to Rate Year

As discussed in stakeholder meetings, the 2019 cost report year was used as the base for FY 23 rates, with no recognition of inflation since 2022. This gap should be corrected. Going forward, inflation should be based on the most recently published CPI forecasts available at the start of each rate year and applied prospectively.

Medicaid CMI Growth Cap and Neutrality Factor Reduction

Continued use of Medicaid CMI growth caps and neutrality factor reductions undermines the integrity of a case-mix system by ignoring the services and conditions that drive PDPM scoring. When statewide average Medicaid CMI exceeds the growth limit, all facility CMIs are uniformly reduced, regardless of actual resident acuity.

Data presented by Myers and Stauffer compared RUG-based CMI differences between Medicaid and full-house residents. That spread was driven largely by mispriced rehabilitation categories, which masked underlying nursing acuity.

Real-time CMI-Connect data from nearly half of Connecticut providers show that, absent therapy distortion, the acuity difference between Medicaid and short-term residents is substantially compressed. In high-Medicaid facilities, Medicaid acuity often equals or exceeds full-house acuity. Growth caps and neutrality reductions negate the purpose of PDPM by suppressing measurable acuity rather than correcting overpayment.
This is not a macro-funding argument. It is a verifiable issue fundamental to the integrity of PDPM rate construction.

Rebasing and Minimum Occupancy

Rates for FY 23–FY 26 are based on 2019 cost reports and include a minimum occupancy penalty below 90%. The July 1, 2026 rebasing should utilize the most current audited or desk-reviewed cost reports, which will be 2024. Rebasing should then occur no less frequently than every two to four years.
Consideration should also be given to eliminating the minimum occupancy penalty within the nursing cost center.

Phase-In With Corridors (Stop-Gain / Stop-Loss)
Budget-neutral transitions inherently produce rate increases for some providers and reductions for others. In a constrained SNF economy with limited operational flexibility, abrupt reductions risk destabilizing the post-acute safety net.
CAHCF may request a phased PDPM implementation with corridors. A stop-loss floor paired with open-ended gains is the most equitable approach, as increases reflect correction of historical underpayment rather than overpayment elsewhere.
Illustrative framework (subject to modeling):

- **Stop-loss:** 0% Year 1; 5% Year 2; Unlimited Year 3
- **Stop-gain:** 5% Year 1; 10% Year 2; Unlimited Year 3

  Subject to rate modeling.

We look forward to continued discussion at an upcoming stakeholder meeting. Please do not hesitate to reach out with any questions or comments.

Sincerely,

Matt Barrett”

Thank you for your consideration, and I would be happy to answer any questions you may have.

For additional information, please contact Matthew Barrett at mbarrett@cahcf.org