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

July 28, 2022

Connecticut Department of Social Service
Medical Policy Unit
55 Farmington Ave, 9th Floor
Hartford, CT 06105

Re: SPA 22-Z: "Nursing Facility Reimbursement – Transition to Acuity Based Reimbursement System"

To Whom it May Concern at the Department of Social Services:

On behalf of the Connecticut Association of Health Care Facilities and the Connecticut Center for Assisted Living ("CAHCF/CCAL"), thank you for this opportunity to submit comments concerning SPA 22-Z: "Nursing Facility Reimbursement – Transition to Acuity Based Reimbursement System". CAHCF/CCAL is a trade association of one hundred and fifty skilled nursing facilities and assisted living community members located at 213 Court Street, Suite 1002, Middletown, CT 06457.

RECOMMENDED REVISIONS TO SPA 22-Z: Nursing Facility Reimbursement – Transition to Acuity Based Reimbursement System".

For the reasons expressed in this comment letter, SPA 22-Z should be revised as follows:

1. The nursing facility reimbursement rate maximum gain for fiscal year ending June 30, 2023 will be a minimum of $6.50 or a higher amount to reflect more accurate and current inflationary projections and cost increases funded within available state and federal resources and fiscal year ending June 30, 2024 will be at a minimum $20.00 or a higher amount to reflect a more accurate and current inflationary projection funded within available state and federal resources; and
2. The nursing facility reimbursement rate will not be subject to any Medicaid case mix growth limits for the fiscal years ending June 30, 2023, June 30, 2024, and June 30, 2025.

Introduction

In general, CAHCF/CCAL supports the transition to an acuity-based reimbursement system where payment for nursing costs is based upon the acuity of the Medicaid residents rather than the average nursing cost of all residents, noting that the "new"

payment model utilizes the methodology and parameters of the prior system (without stop gains and losses) except for the payment of the nursing costs component. CAHCF/CCAL applauds the comprehensive stakeholder input process provided by the Connecticut Department of Social Services ("DSS") in the development and proposed implementation of the acuity-based reimbursement system, including a three-year transition period, which also included a shadow rate period as Connecticut skilled nursing facilities began the transition to the new acuity-based rates. The comments expressed here identify issues and concerns with the new Medicaid case mix reimbursement model implemented on July 1, 2022 and provides recommendations that will result in more equitable payment for the costs of serving Medicaid residents, namely in the following areas: necessary revisions in the accurate treatment of inflation, maximum rate increase limitations, rebasing of the rates, and the elimination of Medicaid CMI growth limits.

Inflation From Cost Report Year to Rate Year and Recommendations Relative to Inflation

The 2019 cost report year was used as the base year in setting FY 23 rates. As such, the 2019 costs should have been inflated from the midpoint of the cost report year (March 31, 2019) to the midpoint of the FY23 rate year (December 31, 2022), a time period of 45 months. Instead, costs were only inflated to the midpoint of FY22 (December 31, 2021) or 33 months, shortchanging providers a full year of inflation. The state only applied a 4.5% wage adjustment to the calculated rates for FY23. Making matters worse, the CPI inflation table used to calculate inflation for the 33 months through December 31, 2021, was an older CPI forecast model; one that at the time the CPI projections were prepared, assumed inflation was transitory and, as a result, substantially understated CPI inflation for the 33-month period.

RECOMMENDATION: With the use of unspent federal American Rescue Plan Act (ARPA) funding, or other state or federal resources, the cost reports should be properly inflated from the midpoint of the cost report year (March 31, 2019) to the midpoint of the FY23 rate year (December 31, 2022). Based upon the published CPI data for the Northeast through June 30, 2022, inflation from March 31, 2019 to June 30, 2022 was 14.3%. Conservatively extrapolating that another six months to December 31, 2022, using half the CPI annual growth rate from June 2021 to June 2022 CPI (3.8%) as an estimate, results in projected inflation of 18.7%. This is the appropriate inflation factor that should be applied to 2019 cost reports to inflate them to the FY23 rate year in lieu of the 5.5% inflation factor that was applied in FY23 rate setting. For future rate setting periods, including FY24 and FY25, inflation should be based upon the most recently published CPI forecasts available as of the start of the rate year and inflation applied for each rate year based upon that forecast. The model currently does not apply any inflationary adjustments for FY24 and FY25.

Maximum Rate Increases for FY23 and FY24 and Recommendations Relative to Maximum Rate Increases

The maximum rate increases for FY23 and FY24 are $6.50 and $20 per patient day respectively. That represents a maximum increase of only 2.5% on average in FY23 and another 5% in FY24, nowhere near current inflationary levels. The rate model reflects 55% of providers having rate increases limited to the maximum increase in year one of the phase-in; 38% in year 2. Those percentages would climb dramatically if accurate inflation projections were applied in the model.

RECOMMENDATION: Again, using unspent ARPA dollars, or other state or federal resources, the maximum rate increase in FY23 and FY24 needs to be substantially increased. The maximum rate increase in FY23 should, at a minimum, double to 5% of average FY22 rates (about $13 per patient day), and in addition, by the average per diem impact of any inflation correction made to the FY23 rates using ARPA dollars. The FY24 per diem maximum of $20 also needs to be increased by the per diem amount of any increase in the maximum for FY23 as well as the average per diem impact of any inflation increase provided for in FY24.

Further, SPA 22-Z: Nursing Facility Reimbursement – Transition to Acuity Based Reimbursement System", as expressed above, should be revised as follows:

1. The nursing facility reimbursement rate maximum gain for fiscal year ending June 30, 2023 will be a minimum of $6.50 or a higher amount to reflect more accurate and current inflationary projections and cost increases funded within available state and federal resources and fiscal year ending June 30, 2024 will be at a minimum $20.00 or a higher amount to reflect a more accurate and current inflationary projection funded within available state and federal resources; and
2. The nursing facility reimbursement rate will not be subject to any Medicaid case mix growth limits for the fiscal years ending June 30, 2023, June 30, 2024, and June 30, 2025.

Rebasing and Minimum Occupancy and Recommendations Relative to Rebasing and Minimum Occupancy

The rates for FY23-FY25 are based upon the 2019 cost reports with a minimum occupancy penalty for providers with less than 90% occupancy. There is no provision to rebase the rates utilizing more current cost reports or to adjust the occupancy penalty threshold given changes in facility cost structures and occupancy since the pandemic.

RECOMMENDATION: Nursing home per diem costs have changed dramatically since 2019 due to many factors including, by not limited to, the pandemic, labor shortages,

rampant inflation, economic uncertainty, and supply chain issues. It is therefore practical and equitable to rebase rates within a reasonable time frame utilizing more current cost reports to account for these factors. Based upon the phase-in provisions of the system, a rebasing in FY25 is currently proposed, the first year of full system implementation. However, the state policy should provide an authority to rebase at an earlier date, including FY23, for the reasons expressed above. Future rebasing should utilize the most currently available audited or desk-reviewed cost reports and inflated by the CPI. Thereafter, rebasing should occur no less frequently than every two to four years, again based upon the most recently available cost reports.

Elimination of the 90% Minimum Occupancy Standard

Consideration should also be given to elimination of the minimum occupancy penalty relative to the nursing cost center. The implications of this 90% occupancy standard in nursing are that a nursing facility with occupancy below that threshold has excess staff and that any increase in occupancy in the nursing facility from its current level until it reaches 90% could be managed with existing staff. Given today's labor shortages and competitive market conditions, one would be hard pressed to argue that nursing homes, regardless of occupancy, have too much nursing staff or that existing staff could handle a greater patient load.

Medicaid Case Mix Increase Limitation

It is inequitable to cap Medicaid case mix increases once the system is implemented. The state indicated it wants a case mix system to better identify the cost of Medicaid patients; to better compensate for higher Medicaid acuity patients and to incentivize facilities to take more complex care Medicaid patients. So, while the new system reaps the benefit of an acuity system by carving out the cost of high acuity non-Medicaid patients (Medicare carve-out), it fails to properly compensate providers for increasing Medicaid acuity; a key goal of the system and one of the few benefits to providers of moving to a case mix system.

Implementing a case mix system and basing nursing cost reimbursement on the average per diem nursing cost of Medicaid patients rather than the average per diem cost of all patients, generated over $26 million in savings to the state, almost $5 per Medicaid patient day. Yet, the new system fails to fully compensate providers for increasing Medicaid acuity going forward by capping statewide Medicaid CMI increases to .75% per year.

One concern on the state's part may be that Medicaid acuity may rise, based upon improved coding, rather than increasing acuity. That argument has little merit. First, the

providers have had the benefit of receiving quarterly CMI scores since 2020. As such, they have had at least two years to put systems and processes in place to insure accurate coding and documentation. This means that, for most providers, any increases in acuity based upon improved coding measures are already "baked in" the acuity score that is to be used to set the 07/01/22 rate. Therefore, Medicaid CMI increases for future quarters most likely represent increased acuity of Medicaid residents or admission of higher acuity patients, which is exactly what the state wants to accomplish with a case mix system.

Even if some of the future acuity growth represents better coding and documentation systems, the result is simply a more accurate acuity score for Medicaid patients, and more accurate reimbursement for Medicaid nursing costs. Finally, if another reason for capping Medicaid CMI growth is the concern that nursing costs are not increasing commensurate with increased acuity scores, then more frequent rebasing, as recommended previously, solves that problem if it exists.

Providers Subject to Maximum Rate Increases During Phase-in Receive No Rate Adjustments for Increases in Medicaid Case Mix

55% of providers have rate increases limited to the maximum increase in year one of the phase-in; 38% in year 2. These providers will receive no increase in their rate if Medicaid case mix increases in future quarters. However, if their Medicaid CMI score decreases, they will receive a rate decrease if the resulting impact of the CMI decrease lowers their rate increase below the maximum increase. This inequity is further compounded in that their Medicaid CMI score is included in the computation of the statewide average CMI growth limit, even though they receive no rate benefit from any increase in Medicaid CMI.

Recommendations Relative to Medicaid CMI Growth and Adjusting Maximum Rate Increases for Case Mix Increases

RECOMMENDATION: There should be no limitation on Medicaid CMI growth. It is inequitable for the Department to reap their full benefit from implementation of a case mix system yet cap the benefit accruing to providers. If the Department is concerned that nursing costs are not climbing commensurate with Medicaid CMI increases, then rebase more frequently.

Also, the maximum rate increase limitations in FY23 and FY24, respectively should be increased by the per diem impact of Medicaid CMI increases experienced by providers affected by these rate increase limitations. Otherwise, a high percentage of providers

gain no benefit from admitting and serving higher acuity Medicaid residents during the phase in period.

Further, SPA 22-Z: Nursing Facility Reimbursement – Transition to Acuity Based Reimbursement System", as expressed above, should be revised as follows:

3. The nursing facility reimbursement rate maximum gain for fiscal year ending June 30, 2023 will be a minimum of $6.50 or a higher amount to reflect more accurate and current inflationary projections and cost increases funded within available state and federal resources and fiscal year ending June 30, 2024 will be at a minimum $20.00 or a higher amount to reflect more accurate and current inflationary projections and cost increases funded within available state and federal resources; and
4. The nursing facility reimbursement rate will not be subject to any Medicaid case mix growth limits for the fiscal years ending June 30, 2023, June 30, 2024, and June 30, 2025.

Transition to PDPM and Recommendation Relative to PDPM

One of the primary reasons Medicare patients have higher nursing CMI scores resulting in a greater allocation of nursing cost to these patients is that, under RUGs, they classify into a rehab group based upon therapy minutes provided. These rehab groups have relatively higher nursing CMI scores as well even though the classification is driven by therapy minutes provided, not nursing time spent with the patient. That all changed under the Patient Driven Payment Model (PDPM) with the nursing CMI score for every patient solely based upon medical and functional needs, not the amount of therapy provided. As such, under PDPM, the average nursing CMI score for a Medicare patient may decline relative to the average acuity score of non-Medicare patients.

RECOMMENDATION: Nursing CMI scores for all payers should be calculated on a quarterly basis under the PDPM model and shared with the Associations and their providers. If the relationship between average Medicaid and facility wide CMI is significantly different using PDPM compared to RUGs, then consideration should be given to using the PDPM classification model effective with the first rebasing. This will result in a more accurate and equitable allocation of nursing cost between Medicaid and non-Medicaid patients.

Conclusion

As stated previously, the new system simply transitions the nursing component to a case mix methodology. Funding has been increased by over $68 million, phased in over 3 years, excluding the impact of future CMI changes. The majority of new funding is the result of rebasing using 2019 cost reports without stop gain or loss limitations rather

than due to transition to case mix. There are many areas where the system needs improvement especially relative to inflation, maximum rate increase limitations, rebasing, and elimination of Medicaid CMI growth limits. Finally, SPA 22-Z: Nursing Facility Reimbursement – Transition to Acuity Based Reimbursement System", as expressed above, should be revised as follows as expressed earlier in these comments:

1. The nursing facility reimbursement rate maximum gain for fiscal year ending June 30, 2023 will be a minimum of $6.50 or a higher amount to reflect more accurate and current inflationary projections and cost increases funded within available state and federal resources and fiscal year ending June 30, 2024 will be at a minimum $20.00 or a higher amount to reflect a more accurate and current inflationary projection and funded within available state and federal resources; and
2. The nursing facility reimbursement rate will not be subject to any Medicaid case mix growth limits for the fiscal years ending June 30, 2023, June 30, 2024, and June 30, 2025.

Once more, CAHCF/CCAL appreciates the opportunity to submit these comments and would welcome the opportunity to answer any questions you may have or provide additional information.

Sincerely,

Matthew V. Barrett

Matthew V. Barrett
President and CEO, CAHCF/CCAL