Department of Social Services
Office of Certificate of Need and Rate Setting

Overview of Nursing Facility Rate Setting
(September 2008)

Background

There are 240 nursing homes in Connecticut caring for approximately 28,000 residents. These facilities have total revenues of approximately $2.5 billion and employ over 30,000 people. The care for about 85% of nursing home residents is paid for by government programs including Medicaid, Medicare and Veterans Administration.

Connecticut Nursing Facility Payor Mix

Medicaid	68%
Private Pay	15%
Medicare	14%
Other (Veterans/N.Y. Medicaid)	3%

Under the Connecticut Medicaid program, payment rates for nursing facilities 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. The federal government provides states discretion in determining the method used to pay for nursing facility services. The state method, however, must be approved by the Centers for Medicare and Medicaid Services (CMS) within the federal Department of Health and Human Services.

The annual rate period is July 1 through June 30, unless modified by the legislature and, the cost report period is October 1 through September 30. Cost reports are due from facilities by December 31 of each year. The annual cost report is a thirty-nine page document and includes detailed cost, statistical (e.g. residents days, therapy service volume, nursing hours) and ownership/related party transaction information.

In the current rate period, July 1, 2008 through June 30, 2009, the average Medicaid rate is $215.37 per day and rates range from $123.36 to $270.40 per day. In SFY 2008, Medicaid expenditures for nursing facility services were approximately $1.3 billion.

Cost Basis of Rates

Prior to the adoption of PA 91-8 (June Session), rates were "rebased" each year. That is, the most recently completed annual cost report was used to set rates each July 1 (1989 report used for 7/1/90 rates).

PA 91-8 (June Session) revised the prior method by prescribing those cost years that would be used for the rate years beginning July 1, 1991 through July 1, 1993. Beginning with rate year July 1, 1994, the Commissioner was required to rebase no more than once every two years and no less than once every four years. The 1992 cost report was first used for the rate year beginning July 1, 1994 and was used for the fourth and final time

for the rate year beginning July 1, 1997. Rates for the period beginning July 1, 1998 was based on 1996 filing which was also used for July 1, 1999 and July 1, 2000 rate setting.

Under 17b-340 CGS, the Commissioner is permitted, to use the most recent cost reports for determining the property component of each facility rate to reflect capital improvements. In this way, facilities receive additional revenue through their rates to account for debt service and related costs associated with major property improvements. For example, the 2005 cost report was used to determine the property component of July 1, 2006 rates while the 2003 cost report was used for all other costs.

Categorization of Costs

Reported expenditures are categorized into five cost groups as follows:

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 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 was 7.203% for assets placed in service in 2006. 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, equipment leases and equipment depreciation.

Allowable Cost Maximums

Facility costs, calculated on a per diem basis by category, are limited to maximums established as percentages of median costs in the Direct, Indirect and Administrative/General categories. The allowable cost maximums are specified by year under the statute as reflected in the following table.

Allowable Cost Maximum Percentages By Category (% of median)

	Direct	Indirect	Admin./Gen.
7/1/91	140%	130%	125%
7/1/92	140%	125%	115%
7/1/93	135%	120%	110%
7/1/94	135%	120%	105%
7/1/95 to 7/1/98	135%	115%	100%
7/1/99 to 7/1/00	135%	125%	100%
7/1/01 Forward	135%	115%	100%

Under the statute, there are separate "peer groupings" by licensure type within the Direct category and for facilities in Fairfield County in recognition of higher wages in that area.

Cost Component Limit Amounts (July 1, 2008- June 30, 2009)

	Direct	Indirect	Admin./General
Fairfield County			
CCNH Licensure	$174.25	$55.00	$27.68
RHNS Licensure	$104.11	$55.00	$27.68
Non-Fairfield County			
CCNH Licensure	$154.17	$55.00	$27.68
RHNS Licensure	$90.98	$55.00	$27.68

Wage, Benefit and Staffing Enhancement Program

A Wage, Benefit and Staffing Enhancement Program (PA 99-279) was established effective April 1, 1999 to provide nursing facilities with special funding for wage, benefit and direct and indirect care staffing increases. The program provided for Medicaid rate increases targeted to wage, benefit and staffing enhancements amounting to $75 million on an annual basis.

A facility's allocation of the enhancement funding is based on its 1998 direct and indirect cost component salary, wage and benefit costs and Medicaid utilization as a percent of the total of all facilities.

Rate add-ons for wage, benefit and staffing increases must to be applied toward costs associated with hourly wage increases, additional employee benefit costs such as health insurance and pension and added direct and indirect care staffing hours. Adjustment funding may be applied towards wage and benefit increases for any employees except administrators, assistant administrators, owners or related party employees. Enhancement payments may also be used for necessary and reasonable nursing pool costs. The average Medicaid rate increase under the Wage, Benefit and Staffing Enhancement program was approximately $10.00 per day.

The additional payments were included in rates from April 1, 1999 through June 30, 2001 and have effectively been incorporated into prospective rates for subsequent periods due to application of annual rate increases mandated in legislation.

Inflation Update

The Regional Consumer Price Index and the projected value of that index (by Data Resources Inc.) are employed to inflate costs from the cost year to the rate year. Reductions to the inflation update have been included in statute for certain rate periods to promote efficiency and to limit the update to meet necessary cost increases. Allowable cost year 2003 costs have been inflated by 18.3% for the July 1, 2008 rate period representing actual and estimated inflation between the cost period and rate period.

Incentives/Efficiency Allowances

The system provides a rate increase adjustment or "efficiency allowance" to facilities having lower costs in the Indirect and Administrative cost categories. The incentive is 25% of the difference between the facility's cost per day and the state-wide median cost per day in the component category.

Minimum Occupancy for Rate Setting

For rate computation purposes, allowable costs are divided by the higher of reported total resident days for the year or facility occupancy at 95% of licensed capacity.

Limits on Year-to-Year Rate Changes

The statute limits a nursing facility's rate increase from year to year. Rates may exceed the increase limits only to account for additional allowable property costs. The following is a summary of the annual rate increase limits.

July 1, 1992	6.0%	July 1, 2000	2.0%
July 1, 1993	6.0%	July 1, 2001	2.5%
July 1, 1994	6.0%	Jan. 1, 2003	2.0%
July 1, 1995	3.0%	Jan. 1, 2005	1.0%
July 1, 1996	3.0%	July 1, 2005	15%/Net 4.5% See Below
July 1, 1997	2.0%	July 1, 2006	3.0%
July 1, 1998	3.0%	July 1, 2007	2.9%
July 1, 1999	1.0%*	July 1, 2008	0%

* Plus an average increase of 7.5% under Wage Program add-on.

Effective July 1, 2005 (Pubic Act 05-251)- Medicaid rates effective July 1, 2005 were based upon a multi-step formula. For facilities with prospective rates in effect as of June 30, 2005, the Act provides that prospective Medicaid rates effective July 1, 2005 will be based upon 2003 cost report filings, subject to the standard rate setting formula, with the addition of an $11.80 per day rate increase. No rates increased by more than $32.00 per day and June 30, 2005 rates equal to or greater than $195.00 could not increase by more than 11.5%. Any June 30, 2005 rate below $195.00 may not exceed $217.43 effective July 1, 2005. Rate increases were implemented in conjunction with a Nursing Facility Resident Day User Fee.

Interim Rates

Under state statute and regulations, the Commissioner may grant an interim rate when a facility changes ownership, has a significant change in licensed bed capacity or faces a financial distress. In these cases, there is a cost settlement process for the interim rate periods subject to rate setting provisions (e.g. component maximums) and any conditions related to the interim rate (e.g. management fee limit). It is typical for the Department to issue 30 to 50 interim rates annually related to major capital projects, ownership changes and hardship situations.

Resident Day User Fee

Public Acts 05-251 and 05-280 established a nursing facility resident day user fee to be imposed effective for calendar quarters commencing on or after July 1, 2005 and calculated by multiplying a nursing home's total non-Medicare resident days during the calendar quarter by the user fee. The current User Fees ($15.90 per non-Medicare resident day/$12.20 for facilities with over 230 beds or owned by municipality) have not been increased since July 1, 2005. The current user fees generate approximately $128 million annually.

The resident day user fee is paid to the Department of Revenue Services by electronic funds transfer on or before the last day of October, January, April and July for the calendar quarter ending on the last day of the preceding month.

Resident days mean each resident service day and include the day a resident is admitted and any day for which the facility is eligible for payment for reserving a resident's bed due to hospitalization or temporary leave or death. *Resident days* do not include the day a resident is discharged or days for which a resident is eligible for payment, in full or with a coinsurance requirement, under the Medicare program.

The User Fee legislation required that DSS apply to the Federal government for a waiver of tax uniformity rules to exempt nursing homes owned by entities registered as Continuing Care Retirement Communities (CCRCs) from the resident day user fee. The Department's waiver request was approved in October 2005 retroactive to July 1, 2005. There are 16 nursing homes associated with CCRCs and 13 are exempt from the resident day user fee under the Federal waiver.

In order to meet Federal waiver requirements, the Act provided that a reduced resident day user fee be applied to those nursing facilities that are licensed for more than 230 beds or that are municipally owned. The User Fee was reduced to $12.20 for the affected facilities.