

MEDICAID RATE SETTING FOR NURSING HOMES

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LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

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**CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE**

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LEGISLATIVE PROGRAM REVIEW
& INVESTIGATIONS COMMITTEE

**Medicaid Rate Setting
for Nursing Homes**

DECEMBER 2001

Digest

Medicaid Rate Setting for Nursing Homes

Rate Variation

Payers and Home Variation: Findings

The average Medicaid per diem rate in Connecticut is considerably less than the other two major payers – about \$100 a day less than Medicare and \$65 less than the average private pay rate.

There is considerable difference in the rates Medicaid pays in Connecticut – there is more than \$100 a day difference between the lowest and highest paid facility.

Great variation among per diem Medicaid rates was due to profit status – with average rates in non-profit facilities \$15.72 higher than for-profit homes.

Unionized homes received \$8.15 a day more than non-unionized homes; non-profit, unionized received \$24.49 more per day for each Medicaid resident than for-profit, unionized homes.

Rate Increases: Findings

The highest paid facilities in FY 01 received the highest dollar increases to their rates over the period but the lowest percentage increase, indicating those facilities started at higher rates in FY 92.

The 77 facilities with the lowest rates in FY 01 received a 36 percent increase over the 10-year period, about average for all facilities.

The 77 facilities in the lowest-paid group received about \$3.00 less per day than the facility average overall and about \$6.00 a day less than the two higher paid groups.

Staffing, Costs, and Rates: Findings

On average, slightly more than half a facility's costs are for direct care – salaries and fringe for nurses and nurse aides.

There is a positive relationship between rates and total direct care -- nursing and aides -- staffing levels (hours per patient day).

Average direct care staffing levels grew from 3.2 to 3.6 hours per patient day from 1999 to 2000, a 12.5 percent increase, indicating the 1999 Wage Enhancement Act targeting funding to increasing staff and benefits has had an impact.

Average non-profit direct care staffing levels are higher than for-profits – 3.9 nurse and aide hours per resident day -- compared to 3.51 hours in for-profit facilities.

Fairfield County direct care salaries are higher than the rest of the state. This difference is expected and is built into the rate system with different cost ceilings placed on certain cost components for Fairfield County facilities than the rest of the state.

Connecticut's rates are fifth highest in the nation and second highest in the Northeast; most of the variation can be explained by wage differences between Connecticut and the other Northeastern and Mid-Atlantic states.

Rate Setting: Overall Impact

Findings

Adoption of flat increases for rate reimbursement has eliminated the relationship between facilities allowed costs and the Medicaid rate ultimately issued.

Application of a flat rate increase has also had an adverse effect on fair reimbursement rates.

There is no evidence in the statute that the stop gain provision takes precedence over the statutory requirement that nursing home costs be rebased very two to four years.

Medicaid reimbursement and overall rate increases -- including interim rates and special adjustments -- are higher than inflation because of:

- the Wage Enhancement Act of 1999 raised overall rates but its funding was targeted to wage and staffing increases, but did not address other inflationary increases;*
- higher percentages based on interim rates and special adjustments drive the overall average increase, but a majority of facilities are not receiving interim rates;*
- measuring rate increases alone does not account for other factors that also drive costs like bed conversions to a higher license type; and*
- property costs are readjusted for rates each year.*

Recommendations

For FY 03-04, nursing home Medicaid rates should be calculated according to the statutory system currently in place with the following modifications:

- 1. In years that nursing home costs are not rebased, rates should be adjusted using the Skilled Nursing Facility Market Basket index annual (third quarter to third quarter) increase in inflation.**
 - 2. C.G.S. 17b-340(7) shall be amended to repeal the use of the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban) as the inflation index used to inflate nursing home costs. For years in which costs are rebased, the SNF Market-basket Index shall be used to inflate costs**
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for the time period currently required in statute, mid-point of the cost year to mid point of the rate year.

3. C.G.S. 17b-340(8) shall be amended to require nursing home costs be rebased every three years, notwithstanding C.G.S. 17b-340(4) that limits nursing home rate increases to specified percent increases or decreases.
4. A case-mix system shall be adopted and implemented beginning in the FY 04 rate year (see recommendation 6).
5. The commissioner of DSS shall amend its regulations regarding nursing homes Medicaid reimbursement as described in C.G.S. sec. 17b-340.

Case Mix and Medicaid Reimbursement

Findings

There is no correlation between facilities' case mix and their:

- *Medicaid per diem rates;*
- *direct care costs; and*
- *aide hours per resident day.*

A very weak relationship was established between facilities' case mix and their:

- *nursing hours per resident day;*
- *total nursing hours (nurse and aide) per resident day.*

Not only is there no correlation between facilities' case mix and direct costs, but there is wide variation in direct costs, even when facilities have similar case-mix indices.

Although both the union and industry oppose adoption of a case-mix system, the extent of disconnect between resident acuity and Medicaid reimbursement poses unfairness and inequity that cannot be ignored.

Recommendation

6. **A resident case-mix Medicaid reimbursement system shall be adopted by the Department of Social Services beginning in FY 04 for chronic and convalescent nursing homes and rest homes with nursing supervision. The case-mix system shall be implemented as follows:**

First, facilities shall be separated into the peer groupings that currently exist – by license type, and by Fairfield county and the rest of the state.

Second, for years in which nursing home costs are rebased to set Medicaid rates, RUG scores shall be calculated by the Department of Social Services, in conjunction with the Department of Public Health, for each Medicaid resident residing in a nursing home. The RUG score shall be based on any full MDS assessments within the last cost report period. The case-mix weights established by the Centers for Medicare and Medicaid appropriate for 34-group RUG-III classification shall be applied to the calculated RUG to establish each facility's average Case-Mix Index for the cost report period used to rebase costs. If a Medicaid resident has more than one RUG group for the year, because of a significant change in health or functional status, the case-mix weights shall be applied to each group and weighted for the Medicaid days the resident was in each group.

For the purposes of determining allowable direct care costs under the Medicaid reimbursement system, three case-mix peer groups shall be established for each level of nursing care. All facilities' case-mix indices shall be arrayed and the case-mix peer groups shall be as follows:

- a low case-mix peer group shall be established and comprised of facilities with Case-Mix Indices in the lower third of the total index range;
- a middle case-mix peer group shall be established and comprised of facilities with Case-Mix Indices in the middle third of the total index range; and
- a high case-mix peer group shall be established and comprised of those facilities with Case-Mix Indices in the top third of the total index range.

Direct care costs shall be arrayed for each case-mix peer group and per diem maximum allowable direct care costs for each group shall be equal to:

- 115 percent of median costs for the low case-mix peer group;
- 120 percent of median for the mid acuity peer group; and
- 125 percent of median for the high case-mix peer group.

Planning and Financial Oversight

Long-Term Care Planning: Findings

Decisions that drive the nursing home system and its financing, such as approving interim rates, allowing beds to be converted from one licensure level to a higher, more expensive level, transferring beds from one facility to another and closing facilities are being made on a case-by-case basis, rather than within the context of broader policy goals.

Currently, except for the State Health Plan developed by the Department of Public Health, there is no single source of data that projects nursing home bed need.

The intent of the program review committee's 1996 recommendation -- to establish a long-term care planning committee to act as a decision-making body with authority to set long-term care direction and policies -- has not been fulfilled.

Recommendation

7. The Office of Policy and Management (OPM), building on the Long-Term Care Planning Committee efforts, and with input from implementing agencies, shall undertake a comprehensive needs assessment of long-term care services. The plan shall assess the three major components of the long-term care system – home and community-based services, assisted living, and nursing home care -- to evaluate need for services, as well as costs of providing them. The plan shall:

- **develop a nursing home bed need methodology, based on demand and alternatives available, as well as demographics;**
- **consider the expected impact of changes in nursing home bed supply;**
- **develop a comprehensive strategy to match supply and need by area of the state;**
- **estimate the costs of the three-component system, and how it will be financed.**

To develop the plan, the Office of Policy and Management must access the data that measures the level of care (resident acuity) of persons currently living in nursing homes to gauge whether Connecticut's nursing home population is being served in the most appropriate, least-restrictive setting. Therefore, the Office of Policy and Management shall seek authorization from Centers for Medicare and Medicaid Services to access and conduct analysis on the Minimum Data Set (MDS). Data from this source shall be integrated with data resulting from facility inspections conducted by the Department of Public Health and nursing home cost data from the Department of Social Services.

The Office of Policy and Management shall analyze the data to track and evaluate:

- **resident acuity by facility;**
- **relationship between facility and costs;**
- **acuity and staffing patterns;**
- **changes in acuity over time; and**
- **adequacy of the admissions assessment tool.**

The requirement that the state Department of Public Health publish a report listing all nursing homes (C.G.S., Sec 19a-538) be repealed.

Financial Stability: Findings

Financial stability in the nursing home industry has worsened; since 1999, 20 percent of facilities have been placed in receivership or bankruptcy.

Current CON-Rate-setting staff is responsible for overseeing more than \$2 billion in Medicaid reimbursement and more than 1,100 residential providers; staff is consumed by day-to-day financial crisis in the industry.

Recommendation

8. To improve financial stability oversight:

- **add six staff persons to DSS CON/Rate-Setting unit as proposed in the governor's FY 2001-2003 budget;**
- **change the emphasis of the auditing staff to one of examining for financial stability (see recommendation 10);**
- **assign new staff to:**
 - **rate-setting, including maintaining, analyzing, and calculating the – case-mix indices by facility to adjust its rate in rebasing years;**
 - **assist certificate of need functions;**
 - **overseeing audits; and**
 - **developing information for the interim rate panel to base decisions.**
- **require the Director of CON/Rate Setting to craft a plan addressing the issue of financial stability within the industry. The director shall use, as a guide, the long-term care plan including nursing home bed need, as proposed (see recommendation 7).**

Interim Rates: Findings

The number of facilities receiving interim rate requests and special adjustments has been increasing gradually over the last 10 years.

With more than 60 facilities (or 25 percent) on interim rates or special adjustments – the interim rate process has become an alternative system for rate setting.

Several significant problems identified with the current interim rate-setting process include:

- *a lack of criteria for requesting, or granting these rates;*
 - *the inequities in reimbursement that interim rates create – in FY 00, interim rates were more than \$7.50 a day higher than rates set through the regular system; and*
 - *an administratively burdensome and costly system for DSS staff since decisions are made case-by-case rather than establishing rates for the entire industry.*
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Recommendation

- 9. A rate review panel shall be established by July 1, 2002, comprised of five members – one from the Office of Policy and Management; one from the Department of Social Services; one from the Department of Public Health; a health care economist or similar health care expert; and a financial management expert. The panel shall meet quarterly to act upon requests from nursing facilities for interim rates or special adjustments. A request for a facility should be acted on within a six-month period.**

The panel shall establish its criteria in writing including standards for request. Criteria shall be based solely on financial hardship, and change of ownership would no longer be a criterion on its own. A facility shall provide supporting documentation of financial hardship, including the results of an independent audit.

The panel shall establish criteria to limit the number of interim rates or special adjustments granted to one facility. Decisions shall be made on established criteria, based on the comprehensive plan for long-term care (see recommendation 7) including need for beds in nursing facilities. The panel in the granting of interim rates or special adjustments may impose conditions on the facility's operation.

Change of Ownership: Findings

All but one of the 53 facilities in receivership or bankruptcy is owned by a chain, and all changed ownership at least once between 1994 and 1999.

Recommendation

- 10. Require a CON approval for change of ownership for a nursing facility before the purchase is transacted. DSS should apply the same financial criteria it would on an initial facility CON. Further, DSS must inform the potential purchaser of the current rate-setting system, including limits on property reimbursement, and that change in ownership alone will not be a criterion for establishing interim rates.**

Audit: Findings

Low percentage of audit recoupments, and the amounts of facility costs not reimbursable through rate-setting lessen the need for purely financial auditing.

Elements that measure quality of care and financial stability need to receive greater emphasis in audits.

Recommendation

- 11. Audits shall include a verification of nurse and nurse aide hours worked, as submitted by the facility on their cost reports. Secondly, audits shall require a substantiation of any change in case-mix peer grouping tied to rate increases. If necessary, auditors may**
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request a nurse consultation to examine documentation in order to determine whether the change in resident acuity, and case-mix grouping, is justified. Thirdly, audits should be conducted for other than last cost year report, with a focus on early warning signs concerning financial stability.

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Medicaid Rate Setting for Nursing Homes

In March 2001, the Legislative Program Review and Investigations committee authorized the study of Connecticut's Medicaid rate-setting system for nursing homes, with a focus on examining the efficacy and equity of the current system. The study also explores whether other rate-setting methods, such as a case-mix system, might provide a better approach.

Nursing homes, nursing home care, and nursing home funding have been issues of recent study and debate here and nationwide. The call for this study came as legislation resulting from the committee's December 2000 study on *Staffing in Nursing Homes* was being discussed, as the effects of the legislative Wage Enhancement Act of 1999 were being evaluated, and as a highly publicized nursing home strike occurred here in Connecticut.

Industry experience nationwide. Nationally, the nursing home industry is facing difficult financial times. A study sponsored by the American Health Care Association¹ -- a national organization operating in 50 states, representing more than 10,000 for-profit and nonprofit facilities involved in providing long-term care -- found that nationwide (36 states) the average shortfall between reimbursement and expenses allowed under the Medicaid program for its nursing home residents exceeded \$9.00 a day for each Medicaid resident.

The study indicates nursing homes have historically been able to shift their costs to other payers (Medicare and private pay) to subsidize low Medicaid per diems, but this is becoming increasingly difficult as:

- nursing home populations are primarily Medicaid (70 percent) and that ratio continues to grow;
- Medicare has reduced payments by changing from a cost-based to a price-based, case-mix system, and, on average, only 10 percent of nursing home populations are being reimbursed by Medicare; and
- private pay patients are decreasing because of other long-term care options (home care or assisted living) to nursing home care. Efforts at encouraging consumers to purchase private insurance to pay for long-term care have only been somewhat successful.

At the same time as revenue sources -- in addition to Medicaid -- tightened, other financial problems have affected nursing home operations. First, most states are facing budget problems causing them to reduce growth in their long-term care Medicaid expenditures.

Second, no laws or regulations mandate that nursing home reimbursement be based on costs. In 1997, the federal Balanced Budget Act (BBA) repealed a federal law known as the Boren amendment, which had been in existence since 1980 and required states to set rates that were "reasonable and adequate to meet the costs that must be incurred by efficiently and

¹ "A Briefing Chartbook on Shortfalls in Medicaid Funding for Nursing Home Care", Prepared by BDO Seidman, LLP, for the American Health Care Association, August 2001.

economically operated facilities.” The BBA replaced the “reasonable and adequate” requirement with an opportunity for public comment on rates and methodologies. Thus, in Connecticut and many states, budget pressures are driving nursing home reimbursement rather than facilities’ costs to provide the service.

Third, while revenues have slowed or experienced actual declines, nursing home costs have been increasing for a number of reasons:

- salaries and benefits increased beyond inflation, due to labor shortages especially in the health care fields;
- heightened emphasis on quality and measuring patient outcomes, with pressure from families, advocates and government to increase direct care staffing;
- sharp increases in costs other than labor – such as liability insurance and utilities; and
- for the above reasons, lenders and financial markets reluctant to lend and invest in the nursing home industry.

Also, most states use cost-containment features to limit nursing home rate increases such as: using cost inflators that are not reflective of nursing home cost increases; subtracting a percentage from the inflation index; using outdated cost data; or capping rate increases from year to year. These cost containment features appear to be paramount, and are impacting states reimbursement systems regardless of whether they are based on price or costs or whether they use a case-mix approach (consider patient acuity) or not.

Connecticut experience. Since 1991, Connecticut has employed several cost-containment measures to limit nursing home reimbursement. Like other states, these features have driven Connecticut’s rate-setting system. For example, just one component of cost containment alone -- the use of caps on rates – reduced state nursing homes payments for FY 02 by about \$27.5 million over what they otherwise would have been. Further, because actual costs exceeded inflation, nursing homes were not reimbursed for \$51 million for cost year 2000, a gap of \$7.65 a day for every Medicaid resident. The Seidman study noted above estimates Connecticut’s Medicaid reimbursement gap at \$8.94 per day. Nursing facilities report a gap of total expenses over revenues (from all sources) of about \$50 million in their cost reports for 2000.

The situation has worsened since FY 00, when flat rate increases were begun as the sole factor in adjusting facilities’ rates. Once the stop gain provision -- adopted in FY 93 -- and its replacement, across-the-board, flat percentage increases (FY 00) are applied year after year, the cumulative loss effect becomes greater, and the relationship between costs and rates is weakened. This resulted in more facilities requesting special adjustments or interim rates, increasing numbers of homes being granted such adjustments, and, since 1999, a considerable percentage (20 percent) of nursing facilities facing bankruptcy.

The committee finds that cost containment in Connecticut, and more recently the flat rate increases, have contributed to Connecticut nursing facilities’ financial problems. The committee

believes a periodic adjustment in rates using actual facility costs, with cost ceilings in place, is crucial. In the interim years, when costs are not rebased, the committee recommends applying the skilled nursing facility inflation factor, the index developed for the Centers for Medicare and Medicaid Services² (CMS), and used to inflate Medicare nursing home rates. The committee also recommends a simple case-mix system be adopted that would adjust direct care costs based on a facility's case-mix index of its Medicaid residents' acuity or needs level.

Adjusting the rate-system alone will not return all facilities to financial health. The committee believes a process must be developed that considers all long-term care needs, including nursing home bed requirements, to serve as a guide to fund nursing home facilities in the future. Bed closures may be necessary, including the elimination of bed transfers, as long-term care consumers experience more choices.

The committee recommends Department of Social Services (DSS) Certificate of Need (CON)/Rate Review regulators use the comprehensive plan on long-term care to develop a strategy to deal with financial stability in the nursing home industry in Connecticut. The committee recommends an additional six staff members be added to the DSS unit, as proposed in the governor's FY 01-03 budget. Auditors under contract with DSS should change their auditing focus to include verification of direct care staff hours in nursing homes and examination of a facility's cost reports and financial documents for financial stability concerns.

The committee found current regulations governing rate-setting are almost 20 years old, so outdated they do not even describe aspects of the present system. These should be replaced with new ones that accurately reflect the current approach. A panel consisting of state agency representatives and two persons outside state government with expertise in nursing home economics and financial management should make interim rate and special adjustments decisions. Criteria for requesting and determinations of such adjustments need to be developed and, again, the long-term care plan should be used for establishing these criteria.

Report organization. The report is comprised of five chapters. The first provides an overview of why rates are set for nursing home care, the types of reimbursement systems used, as well as a chronology of Connecticut's rate-setting system. Chapter Two contains an industry profile, trends in Medicaid expenditures, and an analysis of rates, including factors contributing to Medicaid rate variation. Chapter Three describes Connecticut's rate-setting process, analyzes the system's impact on reimbursement rates to Connecticut facilities, and recommends system modifications that more closely tie reimbursement to facility costs. The fourth chapter measures case mix among facilities based on resident acuity or care-need level, using the federal Resource Utilization Groups (RUGs III), and recommends a simplified case-mix component to setting rates. Chapter Five discusses the need for a long-term care plan in order to set policy for delivering and funding services at the most appropriate level, and for providing the foundation for overseeing financial stability of the nursing home industry.

The report includes four appendices. Appendices A and B contain the responses from the Department of Social Services and the Office of Policy and Management, respectively.

² CMS was formerly known as the Health Care Financing Administration (HCFA). Its name was changed in June 2001.

Appendix C provides a glossary of rate-setting terms, and Appendix D describes the major resource utilization groups and lists the case-mix indices for the 34 RUGs categories.

Agency Response

It is the policy of the Legislative Program Review and Investigations Committee to provide state agencies subject to a study with an opportunity to review and comment on the recommendations prior to the publication of the final report. The response from the Department of Social Services is in Appendix A and the one from the Office of Policy and Management is in Appendix B.

Reimbursement Systems

Both federal and state government heavily regulate nursing homes. Facilities are required to be licensed before they are allowed to operate, and in Connecticut, as with most states, homes must first obtain approval that a need exists for the services (i.e., beds) it will provide. This creates a market that is based on factors other than supply and demand, with costs most often paid by a government payer like Medicare or Medicaid, and not the consumer of the service. Thus, rate-setting systems become necessary for the following reasons:

- as a payment method for a third party like insurance or government payer—when other than consumers are paying;
- as a way of controlling costs—especially with rates set for the future, rather than reimbursement for expenses;
- to establish a price or maximum payment for a certain facility or type of facility or a certain category of patient; and
- to ensure a minimum level of service is provided.

Rate-Setting Approaches

There are a number of methods used to establish rates for nursing home costs. These are summarized below:

1. **RETROSPECTIVE:** Facilities are reimbursed based on a facility's reasonable costs (similar to being paid a fee for service) and after-the-fact reporting on costs is used. Under this system, there is no incentive to operate efficiently, and there could be tremendous variation in costs among facilities. Medicare used this system until 1998.
2. **PROSPECTIVE PRICE-BASED:** Rates are set prospectively based on a set price -- usually a per-diem—for a particular type of facility or more commonly, a particular category of patient. The rate is typically increased annually using some type of inflation index. Medicare sets its rates this way, varied geographically using a wage index, for 44 different categories of patients. Rates are increased annually, using the skilled nursing facility inflation index, established by the federal Centers for Medicare and Medicaid Services (CMS) – formerly the Health Care Financing Administration.
3. **PROSPECTIVE COST-BASED:** Rates are established in advance but are based on reported costs. New rates can be set each year using actual costs from the prior year, known as annual rebasing (adjusting for inflation because of the lag time between costs and new rates); or rates may be set each year based on a certain cost year and inflated forward annually. Cost-based systems usually establish costs components, and ceilings

or caps for some or all of the categories, to arrive at a per diem rate. There are two sub-categories to the prospective cost-based approach:

- A. One system accounts for case mix or patient acuity in some way, often by adjusting the direct care cost component by multiplying one or more weighting factors -- depending on the levels of care needed by the patients in that facility. To determine resident acuity, a uniform assessment tool is used, and payment levels are assigned using the results.
- B. The other prospective cost-based approach does not consider the acuity of the resident in setting rates. The cost of running facilities is the basis for rates, although such factors as: percent of facility's resident population on Medicaid; peer groupings; and occupancy rates can impact what a facility is paid.

Medicaid Rate-Setting Systems Used By States

All states set rates for Medicaid nursing home services. The vast majority of states employ a prospective approach to setting rates, which as outlined above, is a more successful way of containing costs. In addition, a slight majority of states use some type of case-mix or acuity-adjusted system to set rates, as Table I-1 indicates. Four of the six New England states use a case-mix approach to rate setting; as the table indicates, Connecticut does not use a case-mix approach to establish rates.

Table I-1. Types of Reimbursement Systems Used in Which States.		
<i>Type of System</i>	<i>Number of States</i>	<i>States That Use</i>
Prospective – Cost-based (no case-mix)	22	AL, AK, CA, CO, CT, DE, GA, HI, ID, IA, LA, MI, MO, NM, NC, OK, OR, RI, TN, UT, WA, WY
Retrospective	1	NE (with a case –mix adjustment)
Prospective – Case-Mix or Acuity Adjusted	27	AR, AZ, FL, IL, IN, KS, KY, ME, MA, MD, MN, MS, MT, NV, NH, NJ, NY, ND, OH, PA, SC, SD, TX, VT, VA, WV, WI
Source: 1998 State Data Book On Long-Term Care Program and Market Characteristics, US Health Care Financing Administration, January 2000		

Connecticut’s Rate-Setting System -- A Chronological Summary

Connecticut began setting rates for nursing homes in the 1950s. Over the decades, changes have occurred in the administering agency responsible for setting the rates as well in the rate-setting process itself. Table I-2 provides a summary of rate-setting history in Connecticut.

<i>Table I-2. Summary Overview of Nursing Home Rate Setting in Connecticut.</i>	
<p><i>1950s and early 1960s:</i></p> <p><i>Licensure and rate setting begun for nursing homes in Connecticut; Rates set by Hospital Cost Commission – rates set each July 1st, based on costs for cost year ending previous September 30.</i></p>	<p><i>1970s and 1980s:</i></p> <p><i>Federal legislation requiring state Medicaid plans set nursing home rates reasonable for efficiently and economically run facilities. In CT, state social services agency given nursing home rate-setting authority; Growth in industry continues; Great impact on state and federal Medicaid budgets</i></p>
<p><i>1965 – Medicare/Medicaid begun – nursing facilities reimbursed on a retrospective, reasonable cost basis</i></p> <p><i>Late 1960s- Federal monies promote growth in nursing home industry. CT’s number of nursing homes grows from 35 in 1965 to 121 by 1975.</i></p>	<p><i>1990s: Cost containment measures are priority in state budget; Connecticut introduces (P.A. 91-8) key cost control features for Medicaid (see Table I-3); Medicare imposes price-based rates tied to acuity of patients; federal Balanced Budget Act of 1997 eliminates requirement that states set rates that are “reasonable and adequate for efficiently and economically operated facilities”; CT Legislature passes Wage Enhancement Act (1999) which targets \$75 million to increased staffing, wages and benefits; curtails other rate increases.</i></p>

Milestone legislation occurred in the early 1990s that shaped Connecticut’s current rate-setting system. In 1991, the state was experiencing a financial crisis, facing large budget deficits. The state initiated an income tax, but other budget-cutting solutions were also employed. Because Medicaid was a large part of the state’s budget, the entire program’s funding was reduced. Medicaid nursing home costs, which had been growing at about 15 percent a year, were especially targeted for cuts. Public Act 91-8 initiated a number of cost containment features – outlined in Table I-3 -- to the nursing home rate-setting system in order to implement the cost reductions.

Table I-3. Key Changes To Connecticut's Rate-Setting System Resulting from P.A. 91-8

Pre P.A. 91-8:

- Rates set prospectively beginning July 1st each year;
- Annual rebasing of costs --- costs are evaluated and adjusted annually;
- Occupancy level for rate-setting at 90%; and
- Inflation index was Gross National Product Price Deflator.

Post P.A. 91-8

- Limited rebasing costs to every two to four years to establish rates, beginning with 1994 rates;
- Adopted the Consumer Price Index (CPI) in health care costs for Northeast, developed by Data Resources Incorporated, as inflation index to adjust costs from last year of rebased costs to current rate year;
- Developed five cost components and developed ceilings on allowable costs;
- Established two peer groupings – Fairfield County and rest of the state for two types of licensure: 1) chronic and convalescent nursing homes (CCNH); and 2) rest homes with nursing supervision – to set ceilings for direct care cost ceilings;
- Set the occupancy level for rate-setting at 95%;
- Imposed a moratorium on new nursing home beds, except under certain circumstances;
- Imposed a stop gain/stop loss provision margin against a facility's prior year rate; and
- Abolished rate setting for private-pay patients and established rules for admitting residents from waiting lists.

Industry Profile

Currently, there are approximately 260 licensed nursing facilities and 31,545 beds in Connecticut. The majority of homes are operated by for-profit organizations (76 percent), and about 25 percent are unionized. Geographically, nursing homes are located throughout the state – with facilities located in 105 of 169 towns in Connecticut. Most homes in Connecticut were built before 1980. Nursing homes vary tremendously in size, from 30 beds to well over 300, with approximately 120 beds being the average size.

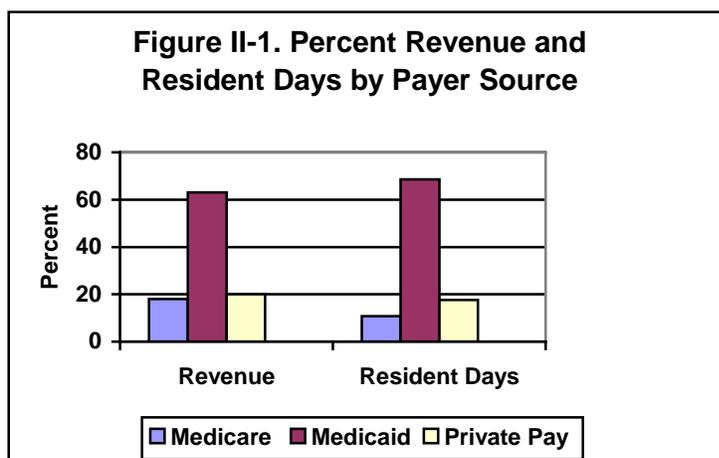
There are two levels of licensed nursing home beds:

- rest home with nursing supervision (RHNS), the lower license level, which covers 1,970 or only 6 percent of the state’s licensed beds;
- chronic and convalescent nursing homes (CCNH) the higher type, which covers the vast majority (29,575) of beds.

Financing

Nursing homes are supported by the following three major sources of revenue:

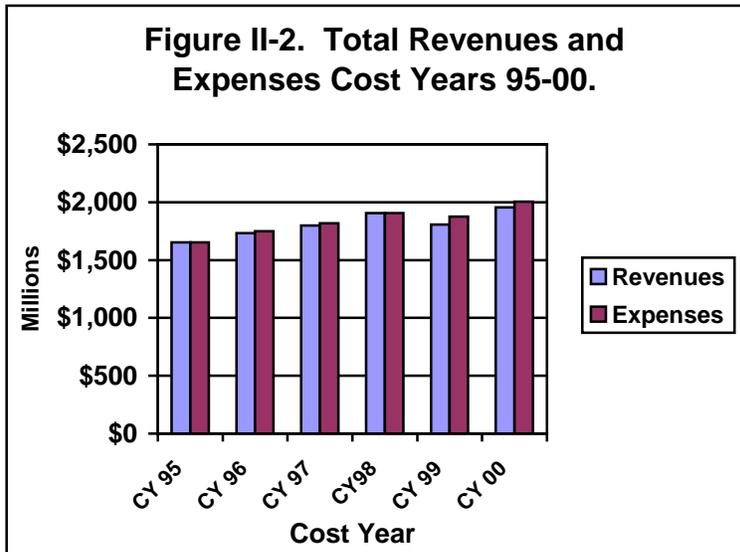
- **Medicaid** – the combined federal and state health care program that supports long-term care for poor elderly in nursing homes. Connecticut is reimbursed 50 percent by the federal government for its Medicaid expenditures.
- **Medicare** – the totally federal-funded health care program for elderly and disabled. Under some circumstances Medicare pays for nursing home care for relatively short-term, rehabilitative and sub-acute services.
- **Private-pay** – residents themselves, or their private insurance, pay for nursing home care.



In Connecticut, as in most states, the bulk of nursing home revenues come from Medicaid. Annually, each nursing facility must file its Medicaid cost report with the Department of Social Services. The reports, which cover the period from October 1 to September 30, provide information on revenues and expenses for the cost year.

For the cost year ending September 30, 2000, about 63 percent of nursing home revenue came from that program, as illustrated in Figure II-1. Almost 20 percent was generated from private pay patients and about 18 percent came from Medicare.

However, as Figure II-1 shows, Medicaid also pays for the largest portion of residents. Almost 70 percent of nursing home patients are on Medicaid while less than 20 percent are private pay residents, and about 10 percent are Medicare.



Facility revenues from all sources and facility expenses for cost years 1995 through 2000 are shown in Figure II-2. According to those reports, except for cost year 1995, expenses have exceeded revenues in each year shown. In cost year 2000, the reported gap between expenses and revenues was about \$50 million.

Expenditures

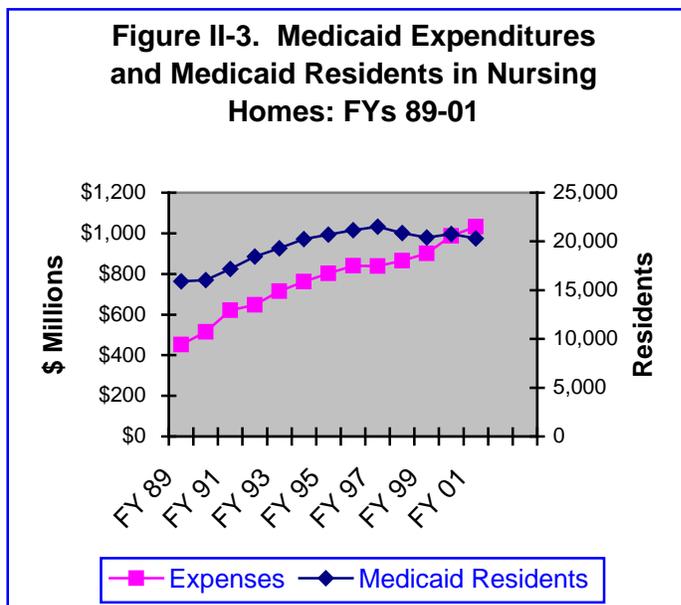


Figure II-3 shows the growth in Medicaid expenditures annually and the number of Medicaid recipients in nursing homes since FY 89. In FY 89, Medicaid paid \$452.7 million for slightly fewer than 16,000 clients; by FY 01, Medicaid spent \$1.031 billion for 20,315 residents. Medicaid expenditures have more than doubled over the period, but the number of residents has increased by 27.8 percent, and has actually leveled off since FY 98.

Thus, Medicaid cost increases are due more to greater expenses than to increasing volume. Likely factors contributing to greater expenses are: more frail and sicker residents; conversion of facility beds from the lower license type – rest home with nursing supervision (RHNS) -- to the higher, more costly, license type – chronic and convalescent nursing home (CCNH); and increased labor and benefit costs.

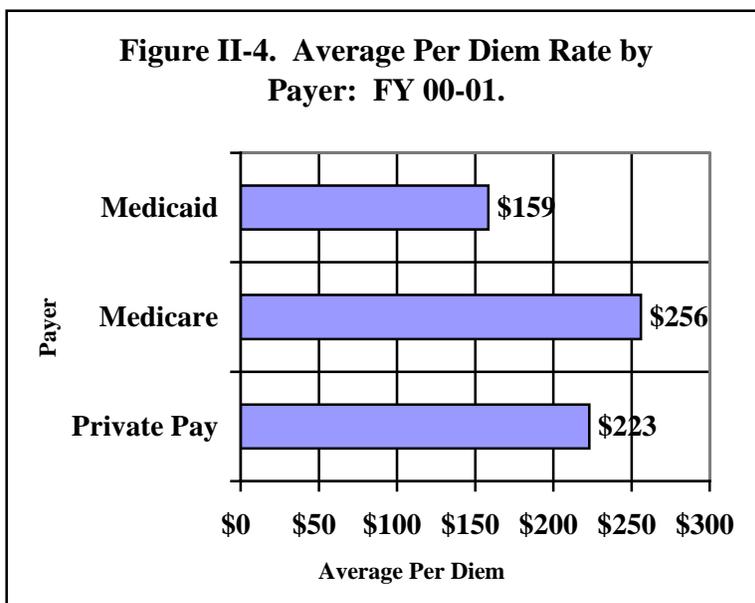
Another large Medicaid expenditure for nursing home care, which is not covered under the per diem rate, is the cost of prescription drugs for Medicaid residents. In calendar year 2000, those totaled \$60 million.

Rates and Rate Variation

Daily Rates

Medicaid is the largest source of revenue for nursing homes in Connecticut, but as discussed above, it also pays for the largest segment of the nursing home population.

On a daily basis, however, Medicaid pays less than the other two payer sources. Figure II-4 illustrates the latest per diem rates. Medicaid paid \$158.51 a day in FY 01, while Medicare's per diem was about \$100 more -- at \$256. The average private pay rate was \$223; \$65 more than Medicaid.



Growth in Per Diem Rates in Connecticut

Table II-1 presents the growth in Medicaid rates for nursing homes compared to the other two payers – private residents and Medicare. The growth in the average daily Medicaid rate (including interim and special rate adjustments) was about 22 percent from FY 96 to FY 01, similar to the percentage growth in private pay. However, in actual dollar amounts, the \$29 per-day increase in Medicaid was well behind the private-pay increase of more than \$40.

Growth in Medicare daily payments for board and care (not including therapies) outpaced the other two rates, rising more than \$70 (or 39 percent) between FY 96 and FY 00. Medicare changed its reimbursement system in FFY 98 to prospective payment rather than fee for service; since then, yearly increases have slowed considerably.

Variation in Medicaid Rates

In addition to variation in rates by payer source, the committee also found considerable disparity among Medicaid rates paid to facilities – there is more than a \$100 per day difference in the lowest paid and the highest paid Medicaid rate. One explanation for the disparity is that Connecticut has always had a cost-based, facility-specific rate-setting system, rather than one

based on price. Thus, costs differences, for many reasons, were recognized and built into the rates.

<i>Fiscal Year</i>	<i>Medicaid</i>	<i>% Inc.</i>	<i>Private Pay</i>	<i>% Inc.</i>	<i>Medicare</i>	<i>% Increase</i>
1996	\$129.62		\$182.23		\$184.21	
1997	\$133.82	3.2	\$193.17	6.0	\$204.51	11.02
1998	\$137.06	2.4	\$201.88	4.5	\$234.25	14.54
1999	\$147.97	7.9	\$207.40	2.7	\$237.43	1.36
2000	\$154.37	4.3	\$213.92	3.1	\$256.00	7.82
2001	\$158.51	2.61	\$223.	4.2	N/A	
Total inc. FY 96-01	\$28.89	22.2%	\$40.77	22.3%	\$71.79 (through FY 00)	38.9%

Table II-2 compares average Medicaid rates using several variables for comparison – county, union, and profit status. These are weighted Medicaid averages using cost-year 2000 Medicaid patient days. All data are based on cost-year reports for 2000, and are for the chronic and convalescent nursing homes (CCNH), which account for 95 percent of licensed nursing home beds.

<i>Region</i>			
	<i>Weighted Average*</i>	<i>Low</i>	<i>High</i>
Statewide	\$158.94	\$106.52	\$211.27
Fairfield County	\$172.39	\$136.73	\$211.27
Non-Fairfield County	\$156.87	\$106.52	\$208.44
<i>Profit Status</i>			
For-Profit	\$156.53	\$106.52	\$211.27
Non-Profit	\$172.25	\$115.96	\$208.44
<i>Union Status</i>			
Union	\$165.53	\$113.89	\$205.47
Non-Union	\$157.38	\$106.52	\$211.27
*Because a straight average would result in an overall mean by facility, and not consider the number of Medicaid clients in each facility, a weighted average was used. A weighted average adjusts the average Medicaid rate by volume to account for the difference in Medicaid days among facilities.			

Committee analysis of Medicaid per diem rates finds:

- *great variation among per diem Medicaid rates was due to profit status – with average rates in non-profit facilities \$15.72 higher than for-profit homes;*
- *Fairfield County facilities were, on average, \$15.52 higher than facilities in the rest of the state;*
- *unionized homes received \$8.15 a day more than non-unionized homes; non-profit, unionized received \$24.49 more per day for each Medicaid resident than for-profit, unionized homes;*
- *for facilities with lower occupancy (below 80 percent), the average rate was higher (\$171) than facilities with high occupancy (95 percent or higher) at \$159.21; and*
- *in general, the newer the facility the higher the rate – those built after 1990 had an average rate of \$176.68, while those in operation before 1970 had an average rate of \$151.89, almost \$25 a day higher. Newer facilities that began operating after 1992 would likely have had interim rates, typically higher than those for existing facilities whose rates were established based on cost year 1992.*

Rate increase variation. Part of the criticism of the rate-setting methodology adopted under P.A. 91-8 was that facilities with high costs at that time received high rates. The charge is also made that the system continues to short-change the lower-paid facilities and reward historically high-cost facilities with higher rate increases.

To examine this, the committee staff grouped facilities into three categories by current per diem rate levels – 1) those with FY 01 rates of \$175 or higher; 2) those homes with rates between \$150 and \$175; and 3) homes with rates less than \$150. Table II-3 compares the average increases – both in dollar amounts and percentages – for each category for the 10-year period. (There were 62 facilities with FY 01 rates that had no rate for FY 92; the vast majority because they became operational after FY 92).

<i>FY 01 Rate Category</i>	<i>Number of facilities in Category in FY 01</i>	<i>\$ Increase Between FY 92 and FY 01</i>	<i>% Increase Between FY 92 and FY 01</i>
FY 01 Rates \$175+	34	\$41.77	32%
FY 01 Rates \$150 - \$175	67	\$41.18	37%
FY 01 Rates Less than \$150	77	\$35.06	36%
All Facilities	178	\$38.64	36%

Results of the rate increase analysis shows:

- *the highest-paid facilities in FY 01 received the highest dollar increases to their rates over the period but the lowest percentage increase, indicating those facilities started at higher rates in FY 92;*
- *the 77 facilities with the lowest rates in FY 01 received a 36 percent increase over the 10-year period, about average for all facilities; but*
- *the 77 facilities in the lowest-paid group received about \$3.00 less per day than the facility average overall and about \$6.00 a day less than the two higher paid groups.*

Costs. To establish rates, facilities' costs are categorized into five major components:

direct care - salaries for nurses, nurse aides, and nursing pools, and related fringe benefits;

indirect care - professional fees, dietary and housekeeping staff and fringe benefits and supplies related to patient care;

administrative and general – maintenance and plant operations, including utilities, and administrative and maintenance personnel salaries and fringe;

capital – includes property taxes, insurance, equipment leases, etc.; and

property – fair rent calculated each year based on amortizing base value over remaining useful life and applying a rate of return.

Table II-4 provides a breakdown of the five cost components used in rate setting and shows the percentage of costs allocated to each of the five categories to all facilities and compares the allocation percentages by profit status and by unionized and non-unionized homes. (These are unweighted averages.)

Table II-4. Comparison of Component Percentage of Facility Costs.					
<i>Nursing Home Category</i>	<i>Direct Care %</i>	<i>Indirect %</i>	<i>A&G %</i>	<i>Capital %</i>	<i>Property %</i>
All Facilities N=228	50.4	25.3	15.2	2.6	6.7
Profit Status					
Profit N=174	51.1	25.3	14.6	2.9	6.3
Non-profit N=52	47.8	25.7	17.0	1.9	7.6
Government N=2	55.2	24.4	14.6	1.0	4.7
Union Status					
Union N=62	52.6	24.9	14.0	2.8	5.6
Non-union N=166	49.5	25.6	15.5	2.5	6.7

One of the major questions concerning rates is the relationship between rates and staffing levels. As the table shows, overall, more than 50 percent of all facilities' costs in Connecticut pay for direct care staffing -- nurses and aides -- salaries and benefits. When indirect care (i.e., housekeeping and dietary) staff salaries and benefits are added, those two components account for more than 75 percent of facilities' costs.

Staffing. The committee examined staffing and rates and found the following:

- *There is a positive relationship³ (.51) between rates and total direct care - - nursing and aides -- staffing levels (hours per patient day).*
- *Average direct care staffing levels grew from 3.2 to 3.6 hours per patient day from 1999 to 2000, a 12.5 percent increase, indicating the 1999 Wage Enhancement Act targeting funding to increasing staff and benefits has had an impact.*
- *Average non-profit direct care staffing levels are higher than for-profits – 3.9 nurse and aide hours per resident day -- compared to 3.51 hours in for-profit facilities.*
- *Total direct care staffing is higher in non-unionized homes than unionized facilities – the average is 3.66 hours in non-unionized and 3.46 in unionized homes.*

Salaries. Nursing home care is labor intensive, with direct and indirect care staffing accounting for 75 percent of facility costs in Connecticut. Thus, differences in salaries account for substantial variation in facility rates. The committee found the following concerning salaries:

- *Table II-5 shows Fairfield County direct care salaries are higher than the rest of the state. This difference is expected and is built into the rate system with different cost ceilings placed on certain cost components for Fairfield County facilities than the rest of the state.*
- *The difference is greatest— \$1.65 per hour—in the average salary for registered nurses.*

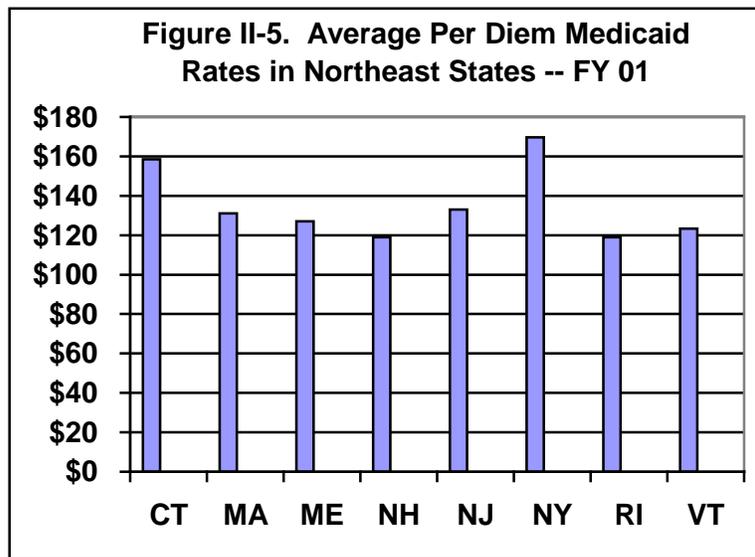
Table II-5. Comparison of Hourly Wages in Nursing Facilities: By Region.		
<i>Job Class</i>	<i>Fairfield County</i>	<i>Other Counties</i>
Registered Nurse	\$27.14	\$25.49
Licensed Practical Nurse	\$21.81	\$21.04
Nurse Aide	\$13.15	\$12.51

³ The committee staff correlated rates and direct care staffing among facilities. Possible Correlation can range from -1.0 showing a strong negative correlation to +1.0 showing a strong positive correlation. A strong correlation, either negative or positive means there is a close relationship between the two measures analyzed, but the cause of the relationship is not identified. In this case, a .51 indicates a relatively strong positive relationship between rates and direct care staffing.

- *The difference in salaries is greater between union and non-unionized homes (Table II-6) than it is in the regional comparison (Table II-5).*
- *The differences in wages between unionized and non-unionized homes was greatest in the licensed practical nurse category – unionized homes paid an average of \$2.49 more per hour than non-unionized facilities.*

<i>Job Class</i>	<i>Union</i>	<i>Non-Union</i>
Registered Nurse	\$27.15	\$24.87
Licensed Practical Nurse	\$22.16	\$19.67
Nurse Aide	\$13.51	\$12.11

Connecticut and Northeast states. While considerable variation exists in Medicaid rates in Connecticut, *the committee found that the average Medicaid rate in Connecticut is high compared to other states. Connecticut's Medicaid rates are the fifth highest in the nation and the second highest in the Northeast (as illustrated in Figure II-5). The committee concluded most of the variation can be explained by wage differences between Connecticut and the other Northeastern and Mid-Atlantic States.*



Two recent studies⁴ indicate that wages paid to staff in the direct care area (i.e., nurses and aides) are higher in Connecticut than any other state in the Northeast. For example, nurse aide salaries are at least \$1.00 an hour higher in Connecticut than Massachusetts (the next highest wage state) and New Jersey, and \$2.00 to \$3.00 per hour higher than New York, Maine and Vermont. Registered nurses annual salaries are at least \$5,000 more per year than in Massachusetts, and licensed practical nurses earn more than \$2.00 an hour more in Connecticut than Massachusetts.

Based on these wage differences, direct care salaries alone (not benefits) make Connecticut facilities \$57 million a year more expensive than Massachusetts' homes. This does

⁴ 1999 salary comparison from GAO report (May 2001) on nursing shortages; and survey of American Association of Homes and Services for the Aging (2001-2002).

not compare the added costs of wages paid for indirect care, like housekeeping and dietary workers (which the AAHSA survey indicates are also higher in Connecticut).

The committee believes one reason New York rates are higher than Connecticut's (since their average wages are not) is because the daily rate in New York includes prescription costs, while Connecticut's rate does not. If Connecticut's \$60 million in nursing home prescription costs were added to the rate, it would raise the per diem amount \$8.21, almost closing the gap between Connecticut's and New York's rate.

Chapter Three

Rate Setting Process and Impact on Reimbursement

A major focus of the program review committee's study on nursing home Medicaid reimbursement is whether Connecticut's current rate-setting system adequately recognizes costs incurred by nursing homes in providing care to Medicaid beneficiaries. As noted in Chapter One, high increases in average Medicaid nursing home payments during the late 1980s and early 1990s led to significant changes in Connecticut's reimbursement methodology in 1991. The revised methodology included several cost containment components in order to limit growth of Medicaid expenditures. This chapter describes the rate-setting process, analyzes the impact of the cost containment provisions on nursing home rates, and presents findings and recommendations related to they system.

Under Connecticut's Medicaid program, payment rates for nursing facilities are set on a cost-based, prospective basis and determined annually. By December 31 of each year, facilities are required to submit detailed cost reports for the preceding period of October 1 through September 30. Although reports are submitted annually, DSS is only required to rebase⁵ costs every two to four years. Thus, costs reported in a year selected for rebasing costs are used to establish rates for multiple years (except for annual reimbursement amounts for fair rent). However, the department is not required to use the most recently submitted cost report when it rebases costs. Figure III-1 identifies the cost report years used to rebase costs and the subsequent rate years affected.

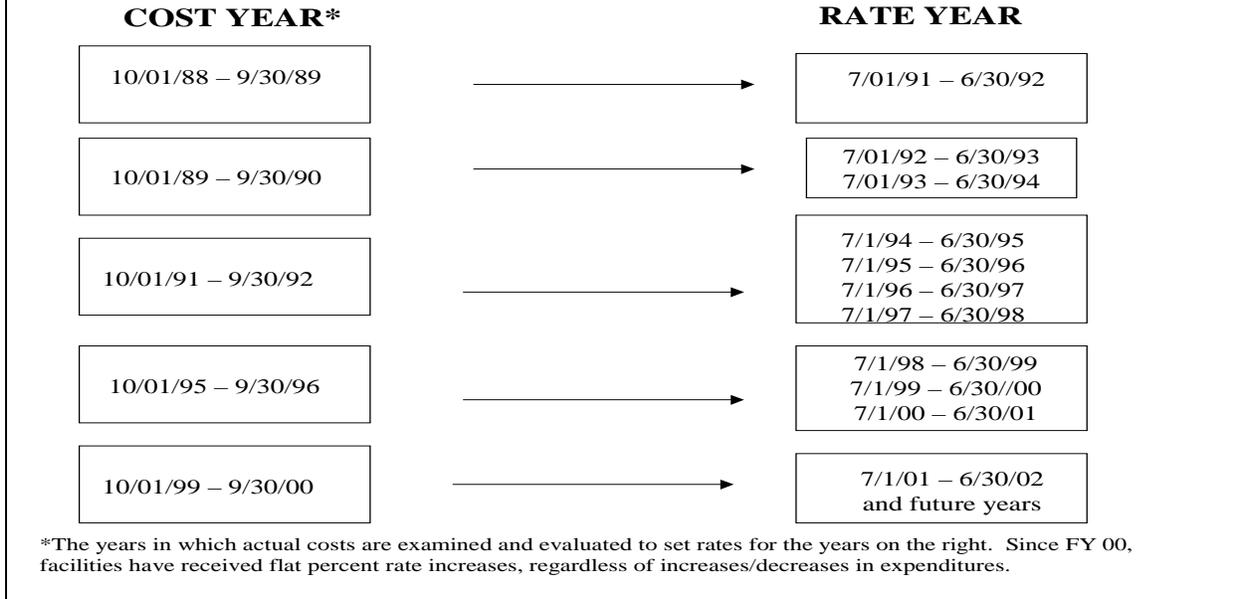
Nursing home rates are set by DSS, in conjunction with a subcontractor, for the period from July 1 through June 30. Figure III-2 illustrates the rate-setting process used to establish Medicaid per-diem rates. Only expenses allowed under federal and state regulations are considered in setting Medicaid rates.

Built into the rate-setting process are several cost containment features that promote efficiency and protect against uncontrolled Medicaid expenditures. Major rate-setting system components include:

- rebasing nursing home costs to set Medicaid rates every two to four years rather than annually;
- arraying nursing home expenditures into five categories;
- limiting allowable costs to a certain percentage of median costs in three of the cost categories;
- providing an efficiency allowance to facilities with low costs in the indirect and administrative categories;

⁵ Rebasing is an element of the reimbursement system that periodically assesses and updates the actual costs of operating a nursing home and reflects those costs in computation of the NH's Medicaid rate. A cost year is selected as a base year and allowable costs are established; those costs are inflated forward from that base cost year to the appropriate rate year(s). See Figure III-1.

Figure III-1. Medicaid Rebasing Schedule



- using an occupancy standard of 95 percent to calculate rates;
- applying an inflation index - the Regional Consumer Price Index (CPI) in Health Care Costs and its projected value to inflate costs from the cost year to the rate year (although in some years the legislature has lowered the index by requiring specific percentages be subtracted from it); and
- the dominant provision, that supercedes all others, caps facilities' per-diem Medicaid rate increases from year to year to specified statutory percentages (i.e., applying a stop gain/stop loss percent to the prior year's rate).

A description of the five cost categories considered in the rate calculation is shown in Table III-1.

Cost Component	Description
<i>Direct Care</i>	salaries for nurses and nurse aides, nursing pools, and related fringe benefits
<i>Indirect Care</i>	professional fees, dietary, housekeeping, laundry personnel costs and expenses and supplies related to patient care
<i>Administration & General</i>	maintenance and plant operations, salaries and related fringe benefits for administrative and maintenance personnel
<i>Capital Related</i>	Property taxes, insurance expenses, equipment leases and depreciation
<i>Property (fair rent)</i>	a fair rent value allowance calculated to yield a constant amount each year instead of interest and depreciation costs; the allowance for buildings is set by amortizing the base value over its remaining useful life and applying a rate of return (cannot be more than 11 percent) on the base value. Nonprofit facilities receive the lesser of the fair rental allowance or actual interest and depreciation except that any cost component limits or certain other allowances may be added back but cannot exceed allowable fair rent.

Source: C.G.S. Sec. 17b-340.

Insert Figure III-2

Allowable Cost Maximums

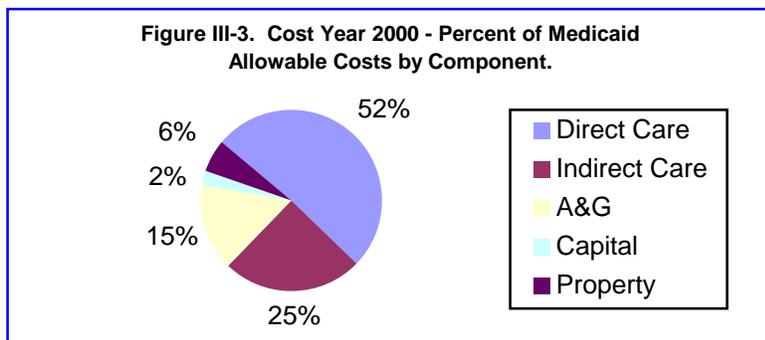
Costs for all residents are arrayed into the five categories shown in Table III-1 and allowable costs for each category - as defined by statute and regulation - are determined. Facilities' allowable costs are then limited to maximums established as percentages at or above median costs in the direct, indirect, and administrative and general categories. Cost ceilings for each category are specified by year under the statute as shown in Table III-2.

The reimbursement system contains costs by establishing cost ceilings -- expenditures that fall above the maximums are disallowed and those costs are excluded from the rate calculation. There is no limit on capital costs, and fair rent is calculated using the most recent cost report and a different formula.

<i>Year</i>	<i>Direct</i>	<i>Indirect</i>	<i>Admin & General</i>
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 – 7/1/98	135%	115%	100%
7/1/99 – 7/1/00	135%	115%	100%
7/1/01	135%	115%	100%

Source: C.G.S. 17b-340.

Figure III-3 shows the percent each cost component accounted toward total Medicaid allowable expenses (\$1,777,589,503) in Cost Year 2000. The Direct care category comprised 52 percent of total expenses, while Indirect Care accounted for 25 percent.



These two components, which are mostly staffing costs, make up more than 75 percent of the total allowed costs. Property costs accounted for about 6 percent of total allowable expenses, and capital costs only about 2 percent.

Analysis of Effects of Allowable Cost Maximums

Based on cost reports submitted by facilities for 1996 and 2000 (years in which costs were rebased), and applying the allowable cost ceilings identified in the table above, Table III-3 shows almost all facilities would have had direct care costs fully allowed if a stop gain provision were not applied. Over three-quarters of facilities would have indirect care costs fully allowed. Since the administrative and general cost category is set at the median, half of the facilities have costs allowed, while half are disallowed. *However, not all facilities with allowable costs are actually reimbursed based on those costs because the overriding feature of the rate-setting system is the stop gain/stop loss on the prior year's rate. Thus, even though facilities may be below the maximum ceilings in any of the cost categories, once the stop gain provision is applied to the computed rate, allowable costs may not be reimbursed if those costs grew at a faster rate than the stop gain.*

Table III-3. Facilities with Allowable/Disallowed Costs				
Cost Component	# Facilities with Allowed/Disallowed Costs		Percent	
	1996	2000	1996	2000
Direct	271/18	291/16	93.77%	94.79%
Indirect	219/70	241/53	75.78%	81.97%
A&G	144/144	147/147	50%	50%

Source: DSS (1996) and LPR&IC Analysis (2000).

Stop Gain/Stop Loss Provisions in Statute

The stop gain/stop loss provision limits rate changes to statutorily specified percentages (shown in Table III-4), even when facilities' costs are below the maximum allowed. In the mid-

Table III-4. Stop Gain/Stop Loss.	
Fiscal Year	Percent
92-93	6% maximum
93-94	6% maximum
94-95	6% maximum increase – 5% maximum decrease
95-96	3% maximum increase - open decrease
96-97	3% maximum increase - open decrease
97-98	2% maximum increase - open decrease
98-99	3% maximum increase – 1% maximum decrease
99-00	1% maximum increase (7.5% Staffing, Wage, and Benefit Enhancement Act)
00-01	2%
01-02	2.5%
02-03	2%

Source: C.G.S. 17b-340(4) and P.A. 01-2 (June Special Session).

1990s the stop gain was high, but since FY 00 a flat percent increase has been given to all facilities regardless of their reported costs.

Thus, as shown in Figure III-4, the rate computed based on the major components of the system (i.e., allowable cost ceilings, efficiency incentives, occupancy standards, CPI inflation, and fair rent) can differ from the actual rate

issued to a facility because of stop gain/stop loss limits that are applied. *Once the stop gain is applied to a facility's rate for multiple years, the cumulative effect of the loss is even greater, weakening the relationship between a facility's costs and the rate it receives.*

What is the Effect of the Stop Gain/Stop Loss?

To develop rates for FY 99, DSS used the 1996 cost report with allowable costs inflated forward with stop gain applied. Committee staff used the calculated rate (i.e., no stop gain applied) for FY 99 and compared it to the actual rate issued by DSS to analyze the impact of the stop gain provision on reimbursement.

The actual rate issued to facilities for FY 99 multiplied by Medicaid days totaled \$901.1 million - \$28.7 million more would have been paid by the department if the stop gain of 1 percent were not applied and the system-computed rate were given. Table III-5 shows based on the 314 licenses issued to facilities, 188 facilities (60 percent) fared worse because of the stop gain - the annual loss in Medicaid revenue ranged from \$1,200 to over \$1 million. Fifty-two licensed facilities fared better because of the stop gain provision and 34 showed no impact.

Figure III-4. Effect of Stop Gain/Stop Loss Provision for Rate Year 01-02.

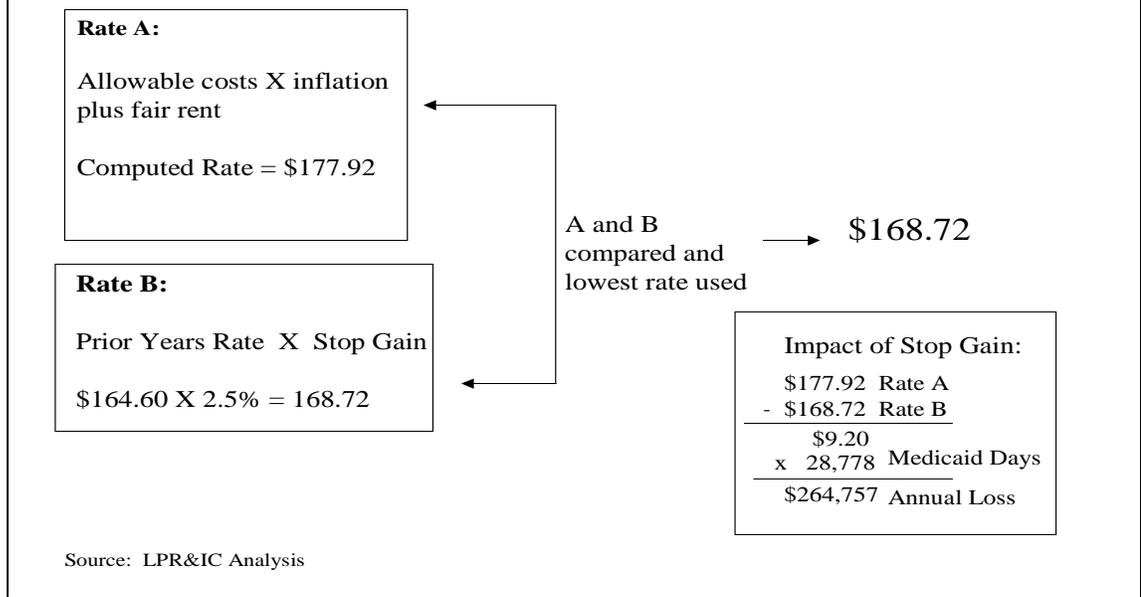


Table III-5. Comparison of Actual Medicaid Rate to Computed Medicaid Rate: RY 99.

Rate Year	Actual Rate Less Than Computed Rate				Actual Rate Greater Than Computed Rate				Total Net Effect*
	# licensed Fac	Average Annual Loss	Range	Total Annual Revenue Loss	# licensed Fac	Average Annual Gain	Range	Annual Revenue Increase	
RY 99	188	(\$183,451)	(\$1,200 - \$1,532,826)	(\$34,488,734)	51	\$111,076	\$1,042 - \$839,156	\$5,775,970	(\$28,713,807)

*35 Facilities – no budget impact, 21 facilities identified as being on an interim rate and were not included in the analysis, and 19 facilities had no information available in data file.
Source: LPR&IC Analysis – CY 96 & CY 99 Resident Days – RY 99.

The same comparison was also done for rates issued for FY 02 based on 2000 Cost Reports (shown in Table III-6). Based on 314 licenses issued to facilities, 152 facilities fared worse because of the stop gain - the annual loss in revenue ranged from \$5,871 to almost \$1.3 million. Fifty-eight facilities fared better because of the stop gain – the annual gain in revenue ranged from \$9,743 – \$2,097,189. Total net loss for facilities is \$27.5 million.

Table III-6. Comparison of Actual Medicaid Rate to Computed Medicaid Rate: RY 02.

Rate Year	Actual Rate Less Than Computed Rate				Actual Rate Greater Than Computed Rate				Total Net Effect*
	# licensed Fac	Average Annual Loss	Range	Annual Loss of Revenue	# licensed Fac	Average Annual Gain	Range	Annual Gain of Revenue	
RY 02	152	(\$257,095)	(\$5,871 - \$1,297,573)	(\$39,078,438)	58	\$199,352	\$9,743 - \$2,097,189	\$11,562,404	(\$27,516,035)

104 facilities showed no impact because of special adjustments, interim rates, or rates were not issued.
Source: LPR&IC Analysis – CY 96 & CY 99 Resident Days – RY 99.

What Would the Impact Be if Costs Were Rebased Annually?

The committee also compared the effect on reimbursement if nursing home costs were rebased annually, rather than adjusting cost ceilings using the inflation index. As noted above, rebasing of costs occurs only every two to four years, and the effects of rebasing are muted because of stop gain/stop loss.

Table III-7 compares actual per diem cost ceilings to hypothetical rebased ceilings. Actual ceilings for FY 99 are based on Cost Year 96 and inflated forward using the CPI inflation factor used by DSS. Hypothetical rebased ceilings recalculate the upper limits using reported costs for Cost Year 99. Actual cost ceilings for FY 00 are based on actual FY 99 ceilings inflated forward using the 1 percent increase facilities were given for FY 00. Hypothetical rebased ceilings were calculated using reported costs for Cost Year 2000.

Table III-7. Comparison of Actual Inflated Ceiling to Ceilings if Costs were Rebased.				
Cost Component	FY 99		FY 00	
	Actual¹ Ceilings FY 99	Hypothetical Rebased CY 99	Actual² Ceilings FY 00	Rebased CY 00
Fairfield – Direct	\$111.97	\$115.60	\$116.61	\$121.99
Other – Direct	\$101.23	\$104.50	\$105.76	\$112.18
Indirect	\$41.36	\$41.28	\$42.83	\$43.59
A&G	\$20.80	\$21.81	\$21.43	\$22.21
Total Fairfield	\$174.13	\$178.69	\$180.87	\$187.79
Total Other	\$163.39	\$167.59	\$170.02	\$177.98
¹ Costs from the 1996 cost report are inflated forward to Rate Year 1999 using CPI of 6.27% and \$5 of Wage Enhancement funds apportioned as follows: direct care 70%, indirect care 21%, and A&G 8%). ² Costs inflated forward from FY 99 using 1% legislative increase and apportioning remaining \$5 of Wage Enhancement funds. Source: LPR&IC Analysis.				

Table III-7 shows per diem allowable costs would be much higher if costs were rebased more frequently – for example, if all facilities were at the ceilings and there were an average of 20,000 Medicaid residents, rebasing costs would have about a \$51 million dollar impact in FY 00.

Findings and Recommendations

Although the committee believes cost-containment features should play a major role in the rate-setting process, homes also must be adequately reimbursed based on reasonable costs. In recent years, the rate-setting system has been superceded by a single system component -- the stop gain provision. Furthermore, since FY 99, the stop gain provision has evolved into a flat percent increase with specific percent increases established through the state budget process and applied to all facilities' prior year's rates.

The program review committee finds adoption of flat percent increases for rate reimbursement has eliminated the relationship between facilities' allowed costs and the

Medicaid rate ultimately issued. Under Connecticut's rate-setting system, facilities submit cost reports, and a two-step process determines allowable costs to compute rates. First, DSS excludes costs not allowed under the Medicaid program, and then disallows costs above the cost ceilings in three of the five categories (direct care, indirect care, and administrative and general) in which costs are arrayed. The costs are then used to calculate per diem Medicaid rates. However, since FY 00, the stop gain provision has made this calculation pointless, since a flat rate increase percentage is merely applied to the prior year's rate to yield the new per diem issued to a facility. In other words, the rate ultimately established has no connection to the costs submitted by the facility.

As noted earlier in this chapter, nursing home costs have risen due to increases in expenses, not because nursing home admissions are increasing. Under the current system of flat rate increases, these expenses are not being examined and linked to rate reimbursement. In the opinion of the committee, flat rate increases have had a negative financial impact on facilities. That is evidenced by:

- committee findings indicating a shortfall of \$27.5 million between the computed rate and the issued rate for FY 02;
- the existence of a shadow rate system – 45 percent of facilities received approval of interim rates requests since 1998, and 20 percent are on an interim rate at any given time; and
- findings in a national study showing the average disparity between Medicaid rates and allowable Medicaid per-resident-day costs is almost \$9.00.

The committee finds application of a flat increase has also had an adverse effect on fair reimbursement rates. Further, the flat percentage increases are fundamentally unfair because:

- facilities with higher rates in 1992 receive higher increases because the cumulative effect of year-to-year percentage increases is applied to a higher base each year; and
- as was pointed out earlier in this chapter, lower-cost facilities have received \$6.00 less in per diem rate increases since FY 92 than higher paid facilities.

However, in any discussion involving adequate Medicaid reimbursement in Connecticut, it is important to remember interim rate increases have become so common, that case-by-case review has replaced a systemic approach to rate setting (see Chapter Five). Further, the impact of interim rate approvals on costs shows rates have actually risen more than the stop gain percent increases, even in the last year. For example, the average weighted daily Medicaid rate in FY 01 was \$158.64 and grew to \$164.64 in FY 02 – an increase of 3.8 percent, although the stop gain percent was 2.5 percent. Thus, cost containment approaches intended for the entire system lose their effectiveness when the measures are waived for the high percentage of facilities on interim rates or special adjustments.

Inflation

The committee finds comparing nursing home cost and rate increases to measures of inflation produce rather confusing, and often conflicting, results. First, as discussed in Chapter Two, Medicaid costs have more than doubled between FY 89 and FY 01. At the same time, the number of Medicaid residents increased only about 28 percent during the same time period, and, since FY 98, the number has actually dropped slightly. Thus, the committee finds recent increases in nursing home Medicaid expenditures have more to do with rising costs than greater volume of Medicaid residents.

Recent increases in Medicaid reimbursement to nursing homes have been higher than inflation -- since FY 96, they have risen from \$841 million to \$1.03 billion – a total increase of 22.5 percent, or an average of 4.6 percent a year, while inflation by most measures, has been less 3 percent per year. In addition, average overall rates, including interim rates, also increased (by 22.2 percent) since FY 96, or an average of 4.4 percent a year.

Table III-8 shows increases in several categories related to nursing home financing and illustrates the variation in percentage growth depending on which measure is examined. For example, nursing home costs between 1999 and 2000 grew more than 7 percent; Medicaid reimbursement for FY 2001 increased by 4.7 percent, both higher than the 3.2 percent inflation rate⁶. However, the flat rate increase established through the budget process for FY 01 was 2 percent, lower than inflation. Thus, because of interim and special rate adjustments, rates actually increased more than provided for by the budget, however the increase still didn't match inflation.

<i>Measure</i>	<i>Percent Increase</i>
Nursing Home Costs Allowed under Medicaid Regulations	7.6%
Medicaid Reimbursement to Nursing Homes	4.7%
Rates for FY 01 (including interim rates and special adjustments)	2.6%
Flat rate increase for FY 01 through budget process	2%
Inflation – SNF Market Basket	3.2%

The committee concludes that Medicaid reimbursement, and overall rate increases including adjustments, are higher than inflation due to several factors.

- First, the Wage Enhancement Act funding, which added 7.5 percent to FY 00 rates over FY 99, is included in the increases above. However, the legislation targeted funds to increase staffing, wages and benefits, and not on other expenses at a facility, like utilities or insurance. Further, because the enhancement formula was based on a facility's FY 98 wage and benefit costs, those facilities already paying higher wages received a greater enhancement allotment. Thus, facilities indicate that the Enhancement Act further widened

⁶ Inflation index used is the SNF market basket index used by Medicare to set prospective payments for nursing homes as forecasted for FFY 2001, published in the Federal Register, July 31, 2000.

the gap between higher-rate and lower-rate facilities, and secondly, added to all facilities wage costs rather than helping to address inflation.

- Secondly, a great number of facilities had rates adjusted through interim rates or special adjustments -- about 50 facilities a year (20 percent) have their rates adjusted. These adjustments raise only some facilities' rates, but drive the statewide average rates higher. However, facilities without special rates are not receiving the high percentage increases.
- Thirdly, measuring rate increases alone does not account for other system factors that also drive costs. For example, between 1995 and 2001, there have been about 3,800 bed conversions from the lower-cost RHNS beds to the higher-cost CCNH level. This increases costs to the system more than would be attributable to rate increases alone.
- Lastly, facilities' property costs are readjusted each year to establish their rates. Those increases can be greater than the flat percentage increase in overall rates.

The committee also finds that *if facility costs were adjusted annually using inflation increases⁷, many facilities would have received higher reimbursement amounts.* For example, the committee found for Cost Year 2000, 33 facilities were not reimbursed for \$8.1 million in direct care costs (nurses and aides) that would have been paid if facilities' costs had been adjusted for inflation. Lack of inflation adjustments on administrative and general costs (A&G) had an even greater impact -- 189 facilities incurred about \$32.6 million in A&G costs that were not reimbursed, because no inflation index was applied.

The committee does not suggest a return to a system where facilities are reimbursed for all their costs each year. That system, in effect prior to 1991, yielded annual increases of about 15 percent a year. However, the committee believes with more frequent rebasing and a simpler and more appropriate inflation index applied annually (without statutory subtractions from the index) for years between rebasing costs should more adequately pay facilities for their expenses.

Rebasing nursing home costs. Rebasing nursing home costs assesses and updates the actual costs of operating a nursing home and reflects those costs in computing the nursing home's Medicaid rate. Currently, the DSS commissioner is given discretion in determining when to rebase nursing home costs, with the statute requiring only that this occur no more frequently than every two years and no less frequently than every four years. In addition, the statute does not require the most recently submitted cost report to be used by DSS in years that costs are rebased.

A primary reason for recalculating nursing home rates is to update facilities' allowable costs with their expenses. Thus, infrequent rebasing limits costs by preventing facilities with low

⁷ The committee used the inflation adjustment that is hypothetically built into the rate system to adjust rates-- the CPI increases in health care costs for the Northeast inflated forward from the last year in which costs were rebased (1996) to the current rate year (2000)

reimbursement rates from making significant improvements in staffing or operations, by capping rates at the prior year's rate plus some inflation factor – even if costs remain below established cost ceilings. In addition, inflating costs forward for too many years ignores valid reasons for cost increases -- such as increasing direct care staffing in response to changes in resident acuity.

The statute currently requires costs to be rebased between every two to four years. The Department of Social Services rebased in 1996 and although, in theory DSS used 2000 cost reports to rebase nursing home rates for FY 02, in actuality, facilities received the same flat rate increase. *Furthermore, after a review of the statute, the committee finds no evidence the stop gain provision (C.G.S. Sec. 17b-340(4)) takes precedence over C.G.S. 17b-340(8) which requires rebasing every two or four years.*

In addition, the committee believes rebasing should be done according to an established schedule so the link between nursing home costs and Medicaid reimbursement is maintained. The statute also needs to be clarified to ensure the most recently submitted cost report is used in the rebasing calculation.

As will be discussed in Chapter Five, the key to containing nursing home costs is not to erode the industry's reimbursement rates, but to determine the adequate number of beds by area, and fund only that number. Inflationary pressures affect the costs of operating nursing homes. Providing inadequate inflationary increases and rebasing costs less frequently impact the industry's ability to attract qualified staff, and, without reducing the size of the industry, will eventually pose a serious threat to the quality of resident care as inflation forces homes to reduce spending on critical needs.

The program review committee believes several fundamental changes to the Medicaid reimbursement system are warranted -- eliminating the trend of providing flat rate increases that are not related to facilities' costs; using a more appropriate inflation index to adjust costs and rates; establishing a fixed schedule for rebasing nursing home costs; and adopting a simplified case-mix approach linking case-mix levels to direct care costs -- will all serve to improve the system. Therefore the committee recommends:

For FY 03-04, nursing home Medicaid rates should be calculated according to the statutory system currently in place with the following modifications:

- 1. In years that nursing home costs are not rebased, rates should be adjusted using the Skilled Nursing Facility (SNF) Market Basket index annual (third quarter to third quarter) increase in inflation;**
- 2. C.G.S. 17b-340(7) shall be amended to repeal the use of the *Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban) – All Items* as the inflation index used to adjust nursing home costs. For years in which costs are rebased, the SNF Market basket index shall be used to inflate costs for the time period currently required in statute, mid-point of the cost year to mid-point of the rate year.**

3. **C.G.S. 17b-340(8) shall be amended to require nursing home costs be rebased every three years, notwithstanding C.G.S. 17b-340(4) that limits nursing home rate increases to specified percent increases or decreases.**
4. **A case-mix system shall be adopted and implemented beginning in the FY 04 rate year. (See Chapter Four).**

*In addition, a review by the committee finds the regulations used by the Department of Social Services to establish Medicaid nursing home rates have never been modified to reflect revisions to the reimbursement methodology under Public Act 91-8. The existing regulations were adopted in 1983 and have little relationship to the current system, including its financial reporting or auditing requirements. To remedy this, **the program review committee recommends:***

The commissioner of DSS shall amend its regulations regarding nursing homes Medicaid reimbursement as described in C.G.S. sec. 17b-340.

The committee believes the modifications to the rate-setting system will improve Medicaid rate reimbursement to nursing homes in several ways. It will link the stop gain or capping provision to an inflation index that most accurately reflects annual increases in costs to the nursing home industry. It begins to reestablish a connection between facilities' actual costs and their fair reimbursement through rebasing every three years. Further, the recommendation weights a facility's direct care costs by its case-mix index (in Chapter Four), and reimbursement is based on the association of staffing costs and the needs of the facility's residents.

The recommendation clearly recognizes the need for cost containment, with rate increases linked to inflation and lowered cost ceilings based on case mix. The committee believes these measures promote a more adequate and equitable system for spending finite resources by more appropriately funding facilities that need it based on the level of care their residents require. Updating nursing home costs on a predictable schedule and employing realistic caps on costs should alleviate some of the financial pressures experienced by nursing homes while maintaining valid cost containment features.

Case Mix and Medicaid Reimbursement

The program review committee examined the relationship between Medicaid resident case mix, aggregated by facility, Medicaid reimbursement rates, and each facility's allowable direct care costs for the year ending September 30, 2000. The allowable direct care cost category is one of five components used in calculating Medicaid rates and includes salaries and related fringe benefits for nurses and nurse aides, and nursing pools.

Time measurement studies done by the federal Centers for Medicare and Medicaid Services (CMS) show that resident acuity (health and functional status) has a major impact on facility resource requirements, particularly in the varying amount of nurse and nurse aide time consumed by residents. Because of this relationship, Medicare, and Medicaid programs in 26 states, reimburse nursing homes based on some type of resident case-mix system. Most Medicaid case-mix reimbursement systems recognize higher costs that result from caring for residents with higher needs, typically by applying a case-mix index to a facility's direct care costs.

Uniform resident assessments. Federal law requires that nursing homes conduct a "comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity," within 14 days of admission, upon a significant change in health status, and annually. Facilities use a standardized resident assessment instrument, mandated by CMS, which includes the Minimum Data Set (MDS). The MDS is a core set of screening and assessment elements that forms the foundation of comprehensive assessments for all residents of long-term care facilities. It establishes common definitions and coding categories, and ensures uniformity in resident assessment across facilities.

Information from the MDS can be used to group residents into Resource Utilization Groups-Version III (RUGs-III), a resident classification system developed by CMS. The RUGs-III is based on three nursing staff time measurement studies conducted by CMS. Using the RUGs-III, residents can be first classified into one of seven broad categories (shown in descending order of their relative cost of nurse and nurse aide use). These categories are:

- Extensive services;
- Special rehabilitation;
- Special care;
- Clinically complex;
- Impaired cognition;
- Behavior problems; and
- Reduced physical function.

The resident's functional status or ability to perform activities of daily (ADLs) living further subdivides these groups into one of 34 categories for Medicaid residents.⁸

To evaluate facility case mix, each of the 34 RUG categories is assigned a case-mix index (CMI), also called a "weight". The weights quantify the differences among groups in the relative costliness of their care needs provided by direct care nursing staff. Overall, the CMI increases as more care is needed because of: poorer ADL functioning; need of nursing rehabilitation services; or signs of depression. The Medicaid weights are based on nursing staff times found in large multi-state research studies conducted in 1995 and 1997 and range from 0.59 for the lowest RUG classification to 2.10 for the highest group. (For a description of the seven broad categories identified above, as well as the associated CMI for each RUG category see Appendix D).

Methodology. Program review committee staff obtained authorization from CMS to access MDS information on all individuals who were in Connecticut nursing homes on September 30, 2000. There were 261 licensed nursing homes with 32,745 beds -- 29,949 chronic and convalescent nursing home (CCNH) beds and 2,796 rest homes with nursing supervision (RHNS) beds. Records were obtained on 31,476 nursing home residents from the Connecticut Department of Public Health. However, since the MDS does not capture payer source (i.e., Medicaid, Medicare, or private pay), or the level of nursing care (chronic and convalescent care or the lower care level provided in rest homes with nursing services), information on Medicaid-eligible residents and level of care had to be obtained from DSS and merged with the DPH data.

Analysis

Payer source. A total of 31,476 nursing home residents were contained in the database analyzed by the program review committee staff. Of these, Medicaid paid for 19,719 residents of either CCNH or RHNS facilities. The payer sources for the remaining 11,757 residents included: Medicare; private pay; or other source. The committee staff further subdivided the Medicaid residents by the type of facility providing care -- 18,350 residents (93 percent) lived in a home licensed as a CCNH and 1,369 (7 percent) resided in an RHNS facility. The committee staff focused on the CCNH Medicaid resident population for most of its analysis, because this group accounts for the vast majority of Medicaid residents, and CCNH facilities receive higher Medicaid reimbursement.

RUG categories. Table IV-1 categorizes Medicaid residents and other residents (includes Medicare, private pay or other payment source) into one of the seven broad RUG categories. The majority (45 percent) of Medicaid residents fall into the "reduced physical function" category, followed by "clinically complex". The largest category for non-Medicaid residents is also "reduced physical function" (23 percent), followed by those in need of special rehabilitation. It is likely that the 2,563 residents in the "special rehabilitation" category are primarily Medicare residents, since Medicare requires a high level of rehabilitative services in order to be eligible for nursing home care.

⁸Medicare uses a 44-group RUG-III version to account for the greater use of rehabilitation services.

<i>Classification Category</i>	<i>CCNH Medicaid Residents</i>	<i>% of Total Medicaid Residents</i>	<i>Non-Medicaid Residents</i>	<i>% of Total Residents</i>
Special Rehabilitation	961	5.2%	2,563	22%
Extensive Services	649	3.5%	1,463	12%
Special Care	1,595	8.7%	1,740	15%
Clinically Complex	3,671	20%	2,140	18%
Impaired Cognition	3,027	16.5%	1,121	10%
Behavior Problems	217	1.2%	63	1%
Reduced Physical Function	8,230	44.8%	2,667	23%
TOTAL	18,350		11,757	

1,369 Medicaid residents in RHNS facilities are not included in the above analysis. The majority fell into the reduced physical function category, followed by the impaired cognition group.
Source: MDS DPH September 30, 2000.

Facility case mix. Using the MDS data, the committee staff calculated RUG scores for each nursing home resident, applied the Medicaid RUG weights established by CMS, and aggregated these by facility to determine each facility’s case mix. It should be noted that in any population, 1.0 would not represent the average case-mix index. The reason for this is that the studies to develop the weights were biased to heavier care residents because of the greater resources used, relative to other categories. Therefore, groups that require little nursing time are weighted below 1.0.

Table IV-2 arrays the number of facilities by three measures – facilities’ case-mix index, direct care costs, and Medicaid per diem rate – and shows the number of facilities falling within each quartile (shown on the right). For example, 60 facilities (the bottom 25 percent) have direct care costs at or below \$75.65 per day, while the top 25 percent are at or above \$93.11 – a difference of \$17.46 per day.

<i>Percentile</i>	<i>Case Mix Index N=236</i>	<i>Direct Costs N=235</i>	<i>Medicaid Rate n=240</i>
25 th Percentile	.926 / 59	\$75.65 / 59	\$143.39 / 60
50 th Percentile	.957 / 118	\$84.17 / 118	\$157.04 / 120
75 th Percentile	.996 / 177	\$93.11 / 176	\$173.97 / 180
100 th Percentile	1.272 / 236	\$128.08 / 235	\$211.27 / 240

Source: LPR&IC Analysis.

Next, the committee staff correlated facilities’ case-mix index with a variety of other nursing home measures. Possible correlation can range from –1.0 showing a strong negative correlation to 1.0 showing a strong positive correlation. A strong correlation (either negative or positive) means there is a close relationship between the two measures analyzed, but the cause of that relationship is not identified.

The committee staff selected five measures to correlate with facilities' case-mix index. Shown in Table IV-3 are the average, the minimum, and maximum ranges for each measure. Case-mix indices, based on Medicaid residents' RUG scores ranged from .77333 to 1.27214. On average, allowable direct care costs in CCNH facilities were \$84.69. This is the cost component that is typically adjusted in Medicaid case-mix reimbursement systems because it includes nurse and aide costs, the category that research has found is most impacted by resident acuity.

Table IV-3. Analysis Variables used in Correlation.			
<i>Category</i>	<i>Average</i>	<i>Minimum</i>	<i>Maximum</i>
Medicaid Rate	\$158.66	\$106.52	\$211.27
Direct Costs	\$84.69	\$48.67	\$128.08
Case Mix Index	.961	.773	1.27
<i>Direct Care Staffing hours per Resident Day</i>			
Aide	2.35	1.59	3.82
Nurse	1.27	.81	2.20
Total Direct Care Staff ¹	3.62	2.60	6.02
¹ Total direct care staff hours per day cannot be calculated by adding the columns because the numbers relate to different facilities.			
Source: DSS, MDS, and Legislative Program Review and Investigations Committee analysis.			

Based on correlation analysis conducted, the committee finds:

- *no relationship exists between facilities' case mix and their:*
 - *Medicaid per diem rates (.19);*
 - *direct care costs (.15);*
 - *aide hours per resident day (.15); and*
- *a very weak relationship was established between facilities' case mix and their:*
 - *nursing hours per resident day (.24);*
 - *total nursing hours (nurse and aide) per resident day (.22).*

Furthermore, the committee finds not only is there no correlation between facilities' case mix and direct costs, but there is wide variation in direct costs, even when facilities have similar case-mix indices.

To examine the relationship between case mix and direct care costs more closely, the committee staff arrayed facilities' direct care costs and classified them into thirds. The bottom third was designated as low-cost facilities; the middle third as mid-cost; and the top third as high-cost. Facilities' case-mix indices were similarly arrayed and assigned to low, mid, and high case-mix categories. The analysis shows that of the 75 facilities with high costs, fully 25 percent had low case-mix indices, while another 40 percent had mid case-mix indices. Only about one-third had a high case-mix index to match the high costs. Conversely, of the 77 facilities classified as low-cost, a full 26 percent had a high case-mix index. Table IV-4 presents the full results of the analysis.

Table IV-4. Comparison of Case Mix and Direct Costs by Category.				
Direct Costs	Case-Mix Index			Total
	Low Mix	Mid-Mix	High Mix	
Low Cost	33	24	20	77
Mid-Cost	25	24	26	75
High Cost	19	30	26	75
Total	77	78	72	227

Source: LPR&IC Analysis.

Based on the above analysis, the committee concludes there is no relationship between acuity and cost. The reason for this is Connecticut’s Medicaid reimbursement system has never examined acuity as a factor in assigning costs. The only factor in evaluating costs has been a facility’s past cost experience. Thus, high direct care costs are recognized by Connecticut’s reimbursement system (up to 135 percent of median costs), but the basis for those costs are a result of: high historical costs that were built into the rate structure in 1992; interim rate approvals based on financial hardship but not on case mix since it is not a factor in the approval process, profit status; and union status. Another limitation of the system is that quality of care is not considered into the rate calculation, so there is no way to assess if facilities with high direct care costs, in reality, provide higher quality care.

The committee recognizes there are several impediments to adopting a case-mix reimbursement system. These include a number of different issues.

- Case-mix systems can be complex and costly to administer because they require:
 - a strong audit function, including nurse evaluation to ensure facilities code residents into the appropriate case-mix category;
 - hardware/software be developed and/or revised by the implementing agency to factor in facility case-mix;
 - increased facility documentation;
 - facilities with high direct care costs but low case mix will have to become more efficient, and therefore may have to reduce staff.
- Case-mix approaches to funding do not address inadequacies in overall system financing as:
 - representatives of labor unions, and for-profit and non-profit nursing home providers during interviews conducted by committee staff indicated the Medicaid reimbursement system is inadequately funded, and therefore changes to the system that do not address funding needs would not address the fundamental problem; and
 - concerns were expressed that redistributing funding based on case mix, without holding facilities’ current rates harmless, would diminish quality in those facilities.
- Ensuring any reimbursement increases related to high case mix are spent on direct care staffing is essential.

However, although both the union and industry oppose adoption of a case-mix system, the committee believes the extent of disconnect between resident acuity and Medicaid reimbursement poses unfairness and inequity that cannot be ignored. For example:

- under the current system, facilities with similar CMIs are reimbursed very differently which impacts the level of direct care staffing available to provide resident care; and
- since almost 70 percent of the nursing home costs are paid for through the Medicaid population, maintaining a publicly funded system with such wide variation – unrelated to resident care needs -- is unfair and inequitable.

The committee concludes there are too many barriers to implement a complex, full-scale case-mix system using all 34 RUG-III categories to adjust direct care costs at this time. However, the committee recommends a simple case-mix reimbursement system be adopted that will begin to establish a link between allowable direct care costs, facilities' case mix, and the ultimate Medicaid per diem rate received.

Therefore, the committee recommends the following reimbursement approach:

A resident case-mix Medicaid reimbursement system shall be adopted by the Department of Social Services beginning in FY 04 for chronic and convalescent nursing homes and rest homes with nursing supervision. The case-mix system shall be implemented in the following manner:

First, facilities shall be separated into the peer groupings that currently exist – by license type, and by Fairfield county and the rest of the state.

Second, for years in which nursing home costs are rebased to set Medicaid rates, RUG scores shall be calculated by the Department of Social Services, in conjunction with the Department of Public Health, for each Medicaid resident in a nursing home. The RUG score shall be based on any full MDS assessments within the last cost-report period. The case-mix weights established by the Centers for Medicare and Medicaid Services appropriate for the 34-group RUG-III classification shall be applied to the calculated RUG to establish each facility's average Case Mix Index for the cost-report period used to rebase costs. If a Medicaid resident has more than one RUG group for the year, because of a significant change in health or functional status, the case-mix weights shall be applied to each group and weighted for the Medicaid days the resident was in each group.

For the purposes of determining allowable direct care costs under the Medicaid reimbursement system, three case-mix peer groups shall be established for each level of nursing care. All facilities' case-mix indices shall be arrayed and the case-mix peer groups shall be as follows:

- **a low case-mix peer group shall be established and comprised of facilities with Case Mix Indices in the lower third of the total index range;**

- **a middle case-mix peer group shall be established and comprised of facilities with Case Mix Indices in the middle third of the total index range; and**
- **a high case-mix peer group shall be established and comprised of those facilities with Case Mix Indices in the top third of the total index range.**

Direct care costs shall be arrayed for each case-mix peer group and per diem maximum allowable direct care costs for each group shall be equal to:

- **115 percent of median costs for the low case-mix peer group;**
- **120 percent of median for the middle case-mix peer group; and**
- **125 percent of median for the high case-mix peer group.**

As discussed in the Chapter Three, establishing cost ceilings on various categories of nursing home expenditures is one way the rate-setting system contains costs. Under the current system, allowable direct care costs are arrayed first by peer group (Fairfield county nursing homes are separated from facilities located in other counties) and cost ceilings are then established at 135 percent of median direct care costs for each licensure category. Costs a facility incurs above the ceilings are not included in the rate calculation.

The committee believes including case mix as a peer group to calculate allowable direct costs will begin to address some of the inequities present under the current system. In addition, allowing higher direct care cost ceilings for facilities that serve the neediest residents provides an incentive to care for those residents, and recognizes that higher direct care staffing ratios are needed.

In addition, the recommendation will ensure the reimbursement system bases a portion of a facility's rates on what research has shown to be more legitimate reasons for cost variations. The committee believes verification of case-mix groupings can be done through the current auditing function as recommended in Chapter Five, and therefore, should not add administrative costs to the system.

Furthermore, the program review committee believes tracking of resident acuity is necessary to develop the state's long-term care plan and formulate a methodology to determine bed need and evaluate the admissions assessment tools. This information will help gauge how well the state is meeting its objectives to promote community-based alternatives and service people in the least restrictive settings. Integrating cost and acuity data helps policymakers and regulators better understand the industry and the population being served, so that planning, oversight, and reimbursement methodologies can be improved.

Chapter Five

Planning and Financial Oversight

Connecticut spends more than \$1.2 billion on long-term care services, with over \$1 billion for funding nursing home facilities. Yet, the committee finds no guiding document exists to make informed policy decisions on a number of long-term care issues, including nursing home bed adequacy, or reductions and transfers of nursing home beds. The absence of a plan, coupled with budget pressures in the state, have contributed to a nursing home industry that is expensive yet financially unstable.

Long-Term Care Planning and Bed Need

During the 2001 legislative session, the General Assembly extended the moratorium on new nursing home beds until 2007. The purpose of the moratorium, established in 1991, was to lower overall costs of long-term care and to encourage creation of less costly alternatives. The committee believes the moratorium extension is appropriate given that: nursing home reimbursement comprises about half the state's entire Medicaid budget; reimbursement rates in Connecticut are among the highest in the nation; current occupancy rates are slightly less than 95 percent; and Connecticut has a higher nursing home bed supply than most other states and the national average (see Table V-1).

Table V-1. Nursing Home Profile: A State Comparison (1999).				
<i>State</i>	<i># Beds per 1000 Age 65+</i>	<i>% of 65+ in Nursing Homes</i>	<i>% Occupancy Rate in Homes</i>	<i>ADL Level</i>
CT	68.8	5.9	95	3.55
MA	65.4	5.9	93	3.84
MD	50.7	4.2	92	3.97
ME	51.6	5.3	87	4.25
NH	56.6	5.4	95	3.57
NJ	43.1	3.8	90	3.72
NY	46.2	4.6	97	3.97
RI	70.5	6.2	90	3.49
VA	38.1	4.2	91	4.32
VT	51.6	6.2	92	3.95
US (avg)	53	4.6	88	3.75

Sources: Facts and Trends 2001, a publication of American Health Care Association; Guide to Nursing Home Industry 2000 by Arthur Andersen; Data on assistance with Activities of Daily Living (ADLs) scores are from the HCFA (now CMS) inspection survey, September 2000, based on 1999 data and committee staff calculations.

However, since the 1991 passage of the state's moratorium on nursing home beds, the state has stymied the moratorium's impact in several ways. First, 1,500 additional nursing home beds were added to the system after the moratorium went into effect because the certificates of need (CON) were approved prior to the moratorium. Second, Connecticut has been slower than other states to eliminate beds from the system because of the state's bed transfer law. That law, passed in 1995, allows a facility that is closing or reducing beds to sell a number of those beds to other facilities. The transfer transactions, which must be approved by DSS, have resulted in a transfer of 814 beds, and a reduction of 312. There are another 1,042 beds available for transfer or closure, and DSS indicated 220 of those beds would be reduced; the other 812 will be available for transfer. Maine and Connecticut are the only states in the Northeast that offset moratorium laws by allowing the sale and purchase of beds when one facility closes or reduces beds, although, according to agency staff in Maine, only about 200 to 300 beds have been transferred in that state.

Third, Connecticut has been later than other states in developing alternatives to nursing home care. An analysis by the program review committee shows states with a low ratio of beds per elderly have funded community-based alternatives to a much greater level than Connecticut, as shown in Table V-2. For example, 33 percent of long-term care expenditures in Maine are for community-based care, while only 5 percent of Connecticut's expenditures were for community-based services. Maine's greater expenditures may be one reason why there are only 56.1 nursing home beds for its elderly population while Connecticut had 68.8. The states with lower bed ratios have more developed bed-need methodologies to determine adequate supply as part of broader long-term care planning efforts, and to promote the provision of care in the least-restrictive, often less-costly, setting.

Table V-2 Medicaid Spending on Long Term Care (FY 00).

<i>State</i>	<i>Community-Based Spending¹</i>	<i>Institutional LTC Spending</i>	<i>Total</i>	<i>Institutional Spending as Percent of total</i>
CT	\$63.3	\$1,099.6	\$1,163.9	95%
MA	\$326.8	\$1,405.4	\$1,732.2	81%
ME	\$163.3	\$336.5	\$499.8	67%
NH	\$140.0	\$185.0	\$325.0	57%
RI	\$12.3	\$308	\$320.3	96%
VT	\$14.6	\$89.4	\$104.0	86%

¹Funds spent on Home and Community-Based Alternatives. Expenditures reflect community-based services provided not home health services (e.g., therapies and skilled nursing) that are provided to all Medicaid recipients if needed.
Source: National Association of State Budget Officers, Fiscal Survey of States, June 2001.

The committee also compared nursing home bed supply by Connecticut counties, and the results are shown in Table V-3. The table shows there is wide variability in the number of beds per 1,000 elderly, with Hartford County having the greatest supply at 74.2 beds per 1,000 elderly and Tolland County having only 44.5 beds. A possible reason for the variation may be that other long-term care alternatives are available in counties with lower bed supplies, but no analysis at the state level is being done to determine why such variation exists.

Table V-3. Nursing home Beds by County: Rates per 1,000 Population 65 and Older.			
<i>County</i>	<i>Beds per 1,000 Age 65+</i>	<i>County</i>	<i>Beds per 1,000 Age 65+</i>
Fairfield	56.3	New Haven	69.3
Hartford	74.2	New London	65.7
Litchfield	65.9	Tolland	44.5
Middlesex	71.4	Windham	70.6

Source: LPR&IC Analysis of 2000 Census Population and Bed Numbers by County.

Further, generally the fewer nursing home beds by population in a state, the higher the dependence level of residents with their daily living activities. Table V-1, presented earlier in the chapter, shows the Activities of Daily Living (ADL) rating for each of the states compared. The rating measures the level of assistance needed with the five ADLs -- eating, toileting, transferring (i.e., mobility), dressing and bathing. These are measured by the state surveys (i.e., inspections) conducted of all 15,000 nursing facilities nationwide; the higher the ADL rating the more assistance the resident population needs.

Connecticut's rating of 3.55 was the second lowest of the states compared, and considerably lower than the national average of 3.75. Only Rhode Island's rating of 3.49 was lower than Connecticut's, and it has a higher number of nursing home beds. These ratings suggest that with alternatives to nursing home care, it is possible that some of Connecticut's current nursing home population could be served in less restrictive settings. In fact, Medicaid policy in Virginia requires that all community-based care alternatives have been exhausted before a Medicaid recipient can be admitted to a nursing home.

The committee finds decisions that drive the nursing home system and its financing, such as approving interim rates, allowing beds to be converted from one licensure level to a higher, more expensive level, transferring beds from one facility to another and closing facilities are being made on a case-by-case basis, rather than within the context of broader policy goals. In order to allocate resources, there needs to be better information on the needs of the entire long-term care system, the demands of consumers, and resulting funding implications.

Currently, except for the State Health Plan developed by the Department of Public Health, there is no single source of data that projects nursing home bed need. Program review the committee believes the State Health Plan is an inappropriate place for these projections for the following reasons.

- The focus of the plan is on public health and need projections are merely looking at current bed use and developing bed need projections based on increases in the elderly population, not on consideration of health improvements among the elderly, nor on fast-expanding long-term care choices.
- The plan does not analyze long-term care services in the context of the continuum of care available, including the availability of home-care and assisted living, as well as consider both cost and quality-of-life factors among those settings.

- Neither the Department of Public Health nor the Department of Social Services has the resources or the authority to set statewide policy for bed need, nor prioritize funding for other alternatives.
- A broad long-term care plan recognizing the least-restrictive setting for elderly and people with disabilities will need to be developed for the state to comply with the U.S. Supreme Court's Olmstead decision.

In its 1996 report, *Services for the Elderly to Support Daily Living*, the program review committee found

a fragmented governmental structure responsible for planning, funding, and overseeing home and community-based care, supportive housing arrangements, and care provided in nursing homes. Long-term care options have often been developed with separate and distinct policies established [for each alternative] with no agency overseeing the entire long-term care system and integrating the various components. The allocation of resources for one component in turn impacts the availability and funding of each of the other components.

The committee recommended a long-term care planning committee be established to develop a plan to be used in policy formulation. A committee was created and has provided a forum for public input into the range of long-term care issues but it lacks staff resources to conduct program analysis and the authority to develop long-term care policies. As a consequence, the committee finds the intent of the program review committee's previous recommendation -- to establish a decision-making body with authority to set long-term care direction and policies -- has not been fulfilled. Therefore, the program review committee recommends:

The Office of Policy and Management (OPM), building on the Long-Term Care Planning Committee efforts, and with input from implementing agencies, shall undertake a comprehensive needs assessment of long-term care services. The plan shall assess the three major components of the long-term care system – home and community-based services, assisted living, and nursing home care -- to evaluate need for services, as well as costs of providing them. The plan shall:

- **develop a nursing home bed need methodology, based on demand and alternatives available, as well as demographics;**
- **consider the expected impact of changes in nursing home bed supply;**
- **develop a comprehensive strategy to match supply and need by area of the state; and**
- **estimate the costs of the three-component system, and how it will be financed.**

To develop the plan, the Office of Policy and Management must access the data that measures the level of care (resident acuity) of persons currently living in nursing homes to gauge whether Connecticut's nursing home population is being served in the most appropriate, least-restrictive setting. Therefore, the Office of Policy and Management shall

seek authorization from Centers for Medicare and Medicaid Services to access and conduct analysis on the Minimum Data Set (MDS). Data from this source shall be integrated with data resulting from facility inspections conducted by the Department of Public Health and nursing home cost data from the Department of Social Services.

The Office of Policy and Management shall analyze the data to track and evaluate:

- **resident acuity by facility;**
- **relationship between facility and costs;**
- **acuity and staffing patterns;**
- **changes in acuity over time; and**
- **adequacy of the admissions assessment tool.**

The requirement that the state Department of Public Health publish a report listing all nursing homes (C.G.S., Sec 19a-538) be repealed.

The logical place for such long-term care planning is the Office of Policy and Management. With OPM as the lead, the plan should have the commitment of the Governor's Office behind it, and the authority to link the plan and its implementation to the budget development process, and signal to implementing agencies (DSS and DPH) the direction in which the state wants to move. The governor's 2001-2003 budget already has made policy decisions and funding alternatives, including assisted living projects, that will impact nursing facilities and beds. A planning document that identifies the variety, availability, and costs of various long-term care options needs, and establishes the policy direction the state will take over the next several years will provide a more reasoned foundation for financing and overseeing services for the state's most frail populations. With this comprehensive plan in place, the committee believes there will no longer be a need for DPH to develop a nursing homes registry. That listing is limited, not often current, and offers no guide to planners or regulators in overseeing the system.

Financial Oversight

Financial stability of the nursing home industry has been a concern in Connecticut for some time. In 1998, the General Assembly passed P.A. 98-239, which dealt with a broad range of issues concerning DSS expenditures. One provision in the act was creation of the Nursing Home Financial Advisory Committee to examine nursing homes' financial solvency on a continuing basis, and to support DSS's and DPH's mission to provide oversight to the nursing home industry in a way that promotes financial solvency and quality of care.

The advisory committee convened and proposed legislation for the 2000 session, but it did not pass. Subsequently, because committee membership could not agree on how to proceed, and lacked staff to develop information for the full committee, the advisory group has not met in over 18 months.

As indicated in the Introduction, the precarious financial situation of nursing homes is not unique to Connecticut. Changes in Medicare reimbursement, a decreasing private-pay

population, unrealistic financial prospects established for the industry in the early and mid-1990s, expanding alternatives to nursing home care, concomitant labor shortages and high wage increases, and low Medicaid reimbursement have all contributed to nursing homes' financial problems.

Since the passage of P.A. 98-239 the financial stability in the nursing home industry in Connecticut has worsened. Table V-4 shows the number of facilities that have been placed in receivership or become bankrupt since 1999, and the number of beds impacted. Currently, 37 of these facilities are in bankruptcy court proceedings, 12 have been sold or transferred, and four have closed.

<i>Year</i>	<i># of Facilities</i>	<i># of Beds</i>
1999	29	4,013
2000	17	2,468
2001	7	1,137
Total	53	7,618
Source: DSS CON/Rate Setting Division		

The 53 nursing homes account for 20 percent of nursing homes in Connecticut. Yet decisions on bed transfers, closures, and hardship rate approvals all continue to be made without a plan or strategy on industry financial stability. While the state is the largest payer source for nursing home residents, because of the frailty of that population, it cannot allow inefficient facilities to close without a well laid out plan. The committee believes the DSS CON/Rate Setting Unit currently has insufficient staff to adequately oversee the nursing home industry or to develop a financial stability plan.

The governor's proposed budget for FY 01-03 called for six additional people in the Department of Social Services, at a cost of \$695,000, to review the financial condition of certain facilities and to ensure the nursing home industry will remain fiscally stable. The proposal was not included in the budget adopted by the General Assembly.

Financial stability, with a well-crafted plan to return the industry to financial viability, must be a priority. The committee believes the additional staff is necessary in the DSS CON/Rate-Setting Unit. The current staff of the unit -- the director, an assistant and five professional staff -- oversee not only nursing homes, but more than 1,100 residential providers, with Medicaid expenditures of more than \$2 billion in FY 01. While a subcontractor supplements the DSS staff's functions, assisting with rate setting and auditing, the committee believes the current staff are consumed by day-to-day financial crises in the industry.

To address this, the committee recommends:

- **adding six staff persons to DSS CON/Rate-Setting unit as proposed in the governor's FY 2001-2003 budget;**
- **changing the emphasis of the auditing staff to one of examining for financial stability (as recommended in the Auditing section of this chapter);**
- **assigning new staff to:**

- **rate-setting, including maintaining, analyzing, and calculating the case mix indices by facility to adjust its rate in rebasing years;**
- **assist certificate of need functions;**
- **overseeing audits; and**
- **developing information for the interim rate panel to base decisions; and**
- **requiring the Director of CON/Rate Setting to craft a plan addressing the issue of financial stability within the industry. The director shall use, as a guide, the long-term care plan including nursing home bed need as proposed in the recommendation discussed earlier in this chapter.**

The plan, as earlier recommended, must include a number of nursing home beds needed by area of the state, and form the basis for crafting a strategy dealing with the industry's financial weakness, including whether bed closures are warranted, and if the bed transfer law is necessary.

Interim Rates

In addition to setting rates for all facilities, the statutes (C.G.S., Sec. 17b-340(a)(2) and Sec. 17b-340f(8)) allow the commissioner broad authority to adjust an individual facility's rates if:

- the facility incurs extraordinary or anticipated costs necessary to avoid a negative impact on public health and safety of its residents;
- licensed beds increase or decrease by 10 or more;
- there is a conversion from one type of licensed bed to another; or
- there is new ownership.

Beyond the statutes, DSS regulations are somewhat more specific, allowing the granting of 1) *interim rates* for a two-year duration for newly established or newly acquired homes or 2) based on *hardship* (regulations specify death or disability of owner or inability to pay employee pension plan).

The committee finds neither the statutory nor regulatory criteria give clear guidance on: reasons a facility may apply for rate adjustments; how frequently adjustments may be requested; or the time frame or the basis for rendering such decisions. The committee also considers the regulatory provision allowing change of ownership as a criterion for establishing interim rates – permitting rate increases solely because a new owner purchases a facility -- to conflict with approaches to both cost containment and industry stability.

The committee considers change of ownership cases to be very different from new facilities where there is no cost experience. With ownership changes, cost reports filed by the previous owner to establish Medicaid rates are in existence. If a facility's rate were inadequate to operate under one proprietor, an increase cannot be justified solely because the facility changes owners. A system that provides the incentive of higher interim rates for new owners promotes instability in the industry, with more selling, purchasing, and frequent interim rates.

Conversely, the financial hardship standards on death or disability of a facility's owner or inability to pay employees' pension funds appear to the committee to be much too restrictive, and, in practice, not recognized in actual hardships cases.

Process. The manner for approving interim rates is a negotiated process. According to DSS staff, until January 2001, facilities always received some increase, although less than requested. However, in January 2001, the governor's proposed budget summary indicated no monies would be available for interim rate increases associated with low census and other financial hardship issues. Although interim rate increases had been funded through Medicaid deficit spending, the budget statement indicates that funding will be terminated or at least slowed. At the same time, (early 2001) the process for approving requests was expanded to include the Deputy Commissioner and the Secretary of Office and Policy and Management. Because of the indicated changes in funding and the interim rate decision-making process, the number of facilities with decisions pending has increased, but it is unclear to date whether more denials will ultimately result, and what the overall financial impact will be.

Activity. The committee found that 45 percent of facilities either received or requested an interim rate or special adjustment during the four-year period from FY 98 to FY 01. During that time period, an average of 50 facilities (20 percent) a year was on an interim rate or special adjustment. During interviews, staff were told the frequency of interim rate requests and approvals increased considerably. To verify, the committee examined the trend of interim rates and special adjustments for an 11-year period, (FY 91-- FY 01) and the results are shown in Table V-5. This shows the number of facilities receiving adjustment each year (not the number of unique facilities) receiving interim rates and adjustments.

<i>Fiscal Year</i>	<i>Total CCNHs</i>	<i># Facilities on Interim or Adjusted Rates</i>	<i>Percent</i>
91	190	23	12
92	190	23	12
93	219	19	8.6
94	235	29	12.3
95	245	38	15.5
96	247	43	17.4
97	245	52	16.3
98	245	48	19.5
99	244	39	15.9
00	243	61	25.1
01*	243	68	28

* An additional nine requests (affecting 18 facilities) received during FY 01 remained pending. Another three requests, affecting seven homes, were received since the beginning of FY 02.

As Table V-5 shows, the number of facilities receiving interim rate requests and special adjustments has been increasing gradually over the last 11 years. Further, in each of the last two fiscal years – 00 and 01 -- more than 60 facilities were receiving a special adjustment or an interim rate.

Table V-6. Comparison of Prospective And Adjusted Rates.		
<i>Year</i>	<i>Average Prospective Rate</i>	<i>Average Interim/Special Rate</i>
FY 00	\$152.23	\$159.79
FY 01	\$158.32	\$161.32

Analysis conducted on interim rates also shows they add costs to the system. As Table V-6 shows, the difference between the average rate set through the regular system and the

average interim rate was \$7.56 in FY 00 and about \$3.00 in FY 01. One plausible reason for the reduced difference in FY 01 is that there were a high number of facilities with interim requests pending for which rate data were not entered in the system. Thus, if a higher interim rate was granted it was not part of the average interim rate calculation for FY 01 and likely reduced the gap between the two rate categories.

The program review committee finds that – with more than 60 facilities (or 25 percent) on interim rates or special adjustments – the interim rate process has become an alternative system for rate setting. There are several significant problems with this process including:

- *a lack of criteria for requesting or granting these rates;*
- *interim rates are higher than rates set through the regular system, therefore creating and perpetuating reimbursement inequities in the system; and*
- *it is an administratively burdensome and costly system for DSS staff since decisions are made case by case rather than establishing rates for the entire industry.*

The committee concludes that, since the interim and special rate process has become so important in establishing operating rates for facilities, adding millions of dollars to the state’s Medicaid expenditures, the process needs to be formalized. Clear standards on requests need to be developed, including a decision-making process that is timely, and approvals or denials should be made by a panel of experts both from state agencies and outside state government.

Therefore, the committee recommends a rate review panel be established by July 1, 2002, comprised of five members – one from the Office of Policy and Management; one from the Department of Social Services; one from the Department of Public Health; a health care economist or similar health care expert; and a financial management expert. The panel shall meet quarterly to act upon requests from nursing facilities for interim rates or special adjustments. A request for a facility should be acted on within a six-month period.

The panel shall establish its criteria in writing including standards for request. Criteria shall be based solely on financial hardship, and change of ownership would no longer be a criterion on its own. A facility shall provide supporting documentation of financial hardship, including the results of an independent audit.

The panel shall establish criteria to limit the number of interim rates or special adjustments granted to one facility. Decisions shall be made on established criteria, based on the comprehensive plan for long-term care (see recommendation on pages 44-45) including need for beds in nursing facilities. The panel in the granting of interim rates or special adjustments may impose conditions on the facility's operation.

The program review committee believes this recommendation will clarify the process for interim rates and special adjustments; update the criteria to establish reasonable grounds for accepting requests and granting such adjustments; and put facilities on notice that interim rates and special adjustment will be strictly examined. Further, adoption of the long-term care plan with appropriate bed-need numbers will give the panel a foundation for ensuring Medicaid dollars are not funding inefficient facilities. In addition, resident acuity information collected under the case-mix recommendation will allow the panel to evaluate a facility's adjustment request in light of the costs of providing care to its residents' needs.

Change of Ownership

As discussed above, the program review committee believes change of nursing facility ownership should not be an automatic criterion for interim rate adjustment. Given that all facilities currently in bankruptcy or receivership changed ownership at least once between 1994 and 1999, the committee also believes change of facility ownership should be submitted for CON approval to the Department of Social Services.

Bankruptcies in Connecticut have become a major problem with more than 20 percent of facilities bankrupt or in receivership since 1999. All but one of the 53 facilities was owned by a chain. These chains bought the facilities in the 1990s, when financial prospects for nursing homes seemed more promising, with high Medicare revenues based on fee for service. However, Medicare changed its reimbursement to a price-based system, severely impacting much of the revenues to nursing homes.

A more rigorous CON review prior to change of ownership may have avoided some of these bankruptcies. For this, and for the following several reasons, the committee believes CON approval for change of ownership should be employed.

- 1) Nursing facilities do not operate in an open market, where only the interests of the buyers and the sellers are of concern. Most of the revenue to nursing facilities comes from government payers – 80 percent of nursing facilities revenues comes from Medicare or Medicaid. Government oversight is needed to ensure patients' interests are addressed and that rates and the rate system are clearly understood by the purchasing party before the transaction occurs.
- 2) CON is needed for other transactions: upgrades or equipment purchases of more than \$2 million; conversion of beds, bed transfers, and even facility closure. It stands to reason a facility purchase of more than \$2 million should go through the same process.

- 3) Of the states in the Northeast, all except New York and Connecticut require change of ownership to undergo the CON process. While New York does not require CON approval, it prohibits publicly owned chains from operating nursing facilities.
- 4) Given Connecticut's moratorium on new nursing homes and nursing home beds, without the original facility's CON, the new facility would not be granted an initial CON. In effect the new purchaser is buying the license to operate, thus, it makes sense to require purchase of facilities to go through CON.
- 5) A CON review would bring more financial stability to the nursing home industry by adding an extra review to ensure the new operators could meet the financial requirements to operate the facility *under current rates*. This, coupled with the recommendation to eliminate change of ownership as an automatic interim rate criterion, should add stability to the financing of the industry.

Therefore, the committee recommends that change of ownership of nursing facilities require a CON approval before the facility purchase is transacted. DSS should apply the same financial criteria it would on an initial facility CON. Further, DSS must inform the potential purchaser of the current rate-setting system, including limits on property reimbursement, and that a change in ownership will not be a criterion for establishing interim rates.

Audits

Requirement. There is no state statutory requirement for auditing the financial records of nursing facilities. However, federal Centers for Medicare and Medicaid Services regulations (42 CFR 447.253) require the state Medicaid agency to provide for the filing of uniform cost reports from each participating provider and periodic audits of the financial and statistical records of participating providers. Each state indicates generally in its Medicaid state plan how it intends to audit providers.

Connecticut state regulations (Sec. 17-311-53) that per diem rates will be based on desk review of the submitted annual cost reports, "which shall be subsequently verified and authenticated by field audit procedures approved by the U.S. Department of Health and Human Services" (approval of the state plan). Regulations further specify that facilities shall generally be audited on a biennial basis although the audit cycle may be changed based upon the audit experience.

If a recomputation of the rate is necessary based on field audit adjustments, this is made retroactive to the applicable period, and replaces the originally determined Medicaid rate for that facility only. When an audit determines funds are owed to DSS, the department usually collects the amount by reducing future Medicaid payments to the facility. A copy of each audit report is sent to the Medicaid fraud unit within the department.

Activity. Audit responsibility is split between DSS, Office of Quality Assurance, and a consulting firm under contract with DSS for rate setting and auditing. Both entities audit other residential and health care providers as well as nursing homes. Auditing activity of nursing

facilities performed by each entity appears in Table V-7. As indicated, 85 facilities were audited over the past two years and about \$24 million was recouped.

<i>DSS</i>				<i>Private Contractor</i>		
Fiscal Year	Number Completed	Dollars Reviewed	Total Recouped	Number Completed	Dollars Reviewed	Total Recouped
FY 00	12	\$91.2 m	\$5.0 m	37	\$194.2 m	\$7.4 m
FY 01	6	\$72.4 m	\$10.3 m	30	\$231.6 m	\$1 m
Total	18	\$163.6 m	\$15.3 m	67	\$425.8 m	\$8.4 m

Sources: Based on reports from DSS and private contractor

As discussed in Chapter Three, the DSS regulations governing Medicaid rate setting for nursing homes were promulgated in 1983 and are outdated. The requirements for auditing outlined in those regulations apply to an old rate-setting system and do not reflect any of the major changes made to the system in 1991 (P.A. 91-8). Beginning with Cost Year 1992, annual rebasing was replaced with readjusting rates using actual costs only every two to four years. The last year for rebasing actual costs in order to set current rates was 1996; thus, 1996 is generally the last fully audited cost year. For more recent cost years, more limited audits of property costs are also being conducted, since property expenses are annually considered to adjust rates. In addition, full audits may be conducted of facilities on interim rates, where a more recent cost year than 1996 has been used to set rates.

Detecting expenses that should have been disallowed is the focus of the nursing home audit. But, the committee concludes that, because of more infrequent rebasing (i.e., setting rates based on actual costs), the *financial* auditing function and resulting findings have become less important in determining or adjusting rates. For the last two fiscal years, recoupments have been about \$24 million of a total of \$588 million audited, or less than 5 percent.

According to the subcontractor, audits do not include auditing of time records or hours worked. The committee believes there should be at least a verification of direct care staff hours worked, since, on average, direct care staffing accounts for 50 percent of facility costs. Since most studies found a link between direct care staffing and quality of patient care, the committee believes there should be as much verification of hours worked as there would be for equipment purchase invoices and the like.

Further, with an adjustment to the rate-setting system to include peer groupings based on facility case mix, auditors will also have to ensure patient acuity assessments can be reproduced by the facility. Further, where there has been a change in a facility's case-mix category impacting its rate, assessment documentation supporting the change will have to be verified.

Currently requirements call for desk and field audits to occur, but federal regulatory requirements, the State Medicaid Plan, and state regulations all appear to be flexible on what the audits may include. The committee believes a change in focus from conducting strictly financial audits is necessary, especially given that annual cost reports are no longer used to establish rates each year.

The committee recommends audits include a verification of nurse and nurse aide hours worked, as submitted by the facility on its cost report. Secondly, audits shall require a substantiation of any change in case-mix peer grouping tied to rate increases. If necessary, auditors may request a nurse consultation to examine documentation in order to determine whether the change in resident acuity, and case-mix grouping, is justified. Thirdly, audits should be conducted for other than the last cost-year report, with a focus on early warning signs concerning financial stability.

The low percentage of audit recoupments, and the number of facilities incurring great costs that are not reimbursed, indicate that purely financial audits for setting or readjusting rates has lessened. While it is clear financial audits -- with detection of unallowable expenditures, and more significantly abuse and fraud -- are still crucial, the committee believes a change in auditing emphasis is necessary. Audits need to address the concerns of the system as it currently exists, not as the nearly 20-year-old regulations describe. For example, issues of quality of care and financial stability are a high priority with resident advocates, public health surveyors, and regulators. With a change in focus, auditors could provide valuable information that would assist regulators in overseeing the industry and advocates and families with audited information that measures quality.

APPENDICES

APPENDIX A

Department of Social Services Response

APPENDIX B

Office of Policy and Management Response



APPENDIX A

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

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February 21, 2002

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Mr. Michael L. Nauer, Director
Legislative Program Review and
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State Capitol, Room 506
Hartford, CT 06106

Dear Mr. Nauer:

Thank you for the opportunity to comment on the Committee's Medicaid Rate Setting for Nursing Homes Report. I congratulate your staff and the Committee for developing a thorough review and assessment of the current rate setting system and a proposed blueprint for change. The Committee Report provides a valuable foundation for additional analysis and policy decisions in the area of nursing home rate setting.

We feel it is important to identify our major concern before addressing each recommendation included in the report. Most importantly, the proposed system will be extremely expensive to implement and is not assured to improve the quality of nursing home care. The proposal to remove year-to-year controls on rate increases is a major factor in the cost increase. Whether the proposed system provides sufficient alignment of funding and staffing with acuity remains to be seen. If significant new funding is directed towards increased Medicaid rates, then we must assure that scarce dollars are used where most critically required.

The following provides comments on the specific recommendations contained in the report:

Case Mix Rate Setting

The report recommends adoption of a three category case mix rate setting method effective July 1, 2003 (SFY 2004). In addition, it is recommended that rates be fully recalculated every three years without application of any rate increase limits and that base year allowable costs be inflated to the rate period using the Skilled Nursing Facility (SNF) Market Basket Index. The proposal would maintain all other aspects of the current system including indirect (food, laundry) and administrative cost category limits.

Cost Impact Estimate and Agency Response:

Program Review provided us with facility case mix scores for CCNH licensed facilities representing over 90% of nursing home beds. Case mix data was not supplied for RHNS licensed facilities. Low, mid and high case mix peer groupings were developed per the proposed reimbursement method. Using the peer groupings and 2000 cost report data, the Department recomputed facility rates using the three case mix category limits and applied the new inflation updates. The revised rates were compared with Medicaid rates under the

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current system. Based on this analysis, it is estimated that adoption of the rate setting proposal would increase Medicaid program costs by at least \$44.1 million. Additional cost analysis is necessary for RHNS licensed facilities.

While we believe that changes to the current system should be considered, additional study, analysis and discussion are necessary by policy makers to set forth goals and expected outcomes of system changes, particularly before the commitment of \$44.1 million in additional state spending. Also, there has not been an adequate assessment of the administrative costs associated with implementing a case mix system including MDS verification and appeal processing. Additional research must be conducted to review the costs that other states incur in the administration of case mix systems. These additional tasks cannot be absorbed within current resources.

Most importantly, however, since the recommendation only partially introducing case mix into the rate setting system, it does not achieve the purpose of case mix systems- to link Medicaid payments to the staffing/resource needs of facilities. Under this proposal, low cost facilities that serve a high case mix residents would not receive additional Medicaid payments and only four facilities with high costs and low case mix would have Medicaid rates adjusted downward. The recommendation goes part way by establishing new direct care cost limits based on case mix category.

Our analysis indicates that the effect of the report recommendations is to almost fully reimburse facility costs without attempting to determine reasonable and adequate rates for efficiently operated facilities taking into account resident acuity and care needs. The \$44.1 million estimated cost is fully attributable to elimination of the rate increase limit and application of a higher inflation update. The case mix provisions actually reduce allowable direct care costs for 27 facilities, however, all but all but six of these would receive rate increases due to full cost rebasing.

We believe it is advisable to determine payment levels for case mix groupings before adjusting the current system. Tying increased payments to acuity along with follow-up reviews to assure that added payments are applied to direct care would have a positive effect on services. In our opinion, the report proposal adds costs without assuring improved services.

Additional Review Comments:

As reflected in the following chart, the cost of the proposed rate changes can be mainly attributed to the elimination of the year-to-year rate increase limit. In fact, the case mix component limits actually reduce allowable Medicaid costs in the direct care category.

<u>Rate Change Cost Increase Analysis</u>	
Elimination of Rate Increase Limit	\$27.1
Higher Inflation Update (+2%)	\$21.0
Case Mix Groups	<u>(\$6.0)</u>
Estimated Net Cost Increase	\$44.1

The following presents the direct care component limits that were calculated based upon the report recommendations.

Direct Care Component Limits
(Per Day 2000 Cost Year)

<u>Case Mix</u>	<u>% of Median</u>	<u>Fairfield</u>	<u>Non-Fairfield</u>
Low	115%	\$104.73	\$91.08
Mid	120%	\$109.47	\$99.71
High	125%	\$115.90	\$105.95
Current Limit	135%	\$121.99	\$112.18

As indicated, the new limits would be lower than current direct care allowable cost ceilings set at 135% of the median cost per day. As the report points out, however, due to rate increase limits in the current system, allowable direct care costs are not always fully reflected in facility Medicaid rates. Under the proposal, allowable direct care costs would be fully recognized in rates since the rate increase limit would be abolished.

The recommendation to link allowable direct care cost limits to facility case mix is logical but as previously indicated may not go far enough to accomplish the objectives of a case mix system. Presently, both low and high case mix facilities are subject to the same 135% of median limit. The 135% limit is very high and effectively allows all direct care costs as only four CCNH facilities have any disallowance due to the ceiling (\$121.99 Fairfield County and \$112.18 Non-Fairfield).

The effect of the proposal is to reduce allowable costs for 27 facilities of which four have disallowances under the current system. This equates to a reduction of approximately \$6.0 million in allowable costs. Eleven facilities in the low case mix category would have reduced allowable direct care costs. Under the proposal, twelve facilities in the mid category would be reduced and only four in the high peer would be effected.

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However, since the proposal calls for full cost rebasing of rates, of the 27 facilities that would have new and/or greater direct care cost disallowances, only six facilities would experience a reduction to their current Medicaid rate.

As previously indicated, the department believes that partial implementation of case mix will not accomplish the assumed goal of a revised system – that is linking payment rates to staffing/resource requirements for resident care.

Long Term Care Planning and Bed Need

The report recommends an expanded role for OPM in planning and coordinating long term care services including the development of a strategy to match nursing home bed supply and need by area of the state. We agree that additional analysis and planning capabilities are needed.

Two positions were provided to the department from the former Commission on Hospitals and Health Care when certificate of need (CON) responsibilities for nursing homes were transferred in 1993. These two staff are fully occupied with CON reviews for capital projects, licensure changes (CCNH to RHNS) and bed transfers as well as Medicare Distinct Part approvals.

Within the last month, OPM has authorized the department to reclassify six existing vacant positions to enhance the staffing in the CON and Rate Setting unit. We believe these resources could build upon current data systems and greatly enhance the functionality of the unit. The department is presently identifying the vacancies and the potential appropriate classes.

The Governor's Recommended Budget revisions for SFY 2003 include the transfer of the Office of Health Care Access staff and functions to the Department of Public Health. During SFY 2003 OPM, DPH and DSS will develop a plan for review, coordination, and planning for healthcare needs and services for all populations including the elderly and their nursing home needs. OPM will be assuming the lead responsibility in coordination of these efforts and development/implementation of this plan eliminating existing fragmentation.

The report suggests that Connecticut has an excess of nursing home bed capacity even though there has been a moratorium on new facilities since 1991. We agree that there is some surplus capacity and due to this fact, we have been exercising more extensive reviews of applications to expand facilities or acquire additional unfilled beds. In fact, during 2001 the department approved CON's for the closure of five facilities with a total of 590 beds. However, additional analysis related to the experience of other states with fewer nursing home beds is needed to determine if there are negative consequences such

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as hospital discharge delays, assisted living care issues and Medicaid recipient placement problems.

Financial Oversight

The department agrees with the report recommendations concerning expanded financial oversight of nursing homes. The addition of six staff in the CON and Rate Setting unit will assist the department with the collection and review of data and the expansion of this oversight. In addition, the department recommends that the audited financial report and debt service CON review requirements included in HB 6702 of the 2001 Session be adopted.

Interim Rates

The report recommends the establishment of five member rate review committee to act upon interim rate requests. In addition, it is recommended that formal criteria for interim rates and rate adjustments be established.

We believe that the interim rate and rate adjustment decisions that have been made evidence department consideration of bed need, fiscal viability and physical plant condition issues. Certainly, resident acuity information could also be used as a resource in the future. However, the addition of staff resources and not the establishment of a new committee offers the best option for ore informed and coordinated decision making.

Change of Ownership

The department agrees with the report recommendations concerning CON review of facility ownership changes.

Audits

The report recommends three changes to current audit activities- verification of reported direct care staffing hours, case mix/MDS reviews and greater focus on the financial viability of homes. An assessment is needed to determine whether and to what extent these additional activities can be absorbed within existing resources. As previously mentioned, further review and analysis of case mix administrative costs in other states is essential.

Comment on Committee "Stop Gain" Finding

The department would like to go on record concerning a Committee finding that there is no evidence that the rate increase limit (stop gain) provision of statute (Section 17b-340(f)(4) CGS) takes precedence over the rebasing provision (Section 17b-340(f)(8) CGS). This finding is inaccurate. Legislative intent as demonstrated through the budget passed each year since 1992 clearly indicates that the rate increase limit provision supercedes rebasing.

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My staff and I greatly appreciated the courtesy and cooperation extended by your staff in conducting this study. We look forward to continuing the important work set forth in this report.

Sincerely,

A handwritten signature in black ink, appearing to read "M. Starkowski", with a long horizontal flourish extending to the right.

Michael P. Starkowski
Deputy Commissioner

MPS:GR

Cc: Patricia A. Wilson-Coker, Commissioner
Marc Ryan, Secretary Office of Policy and Management
David Parrella, Director Medical Care Administration
Gary M. Richter, Director CON and Rate Setting



APPENDIX B
STATE OF CONNECTICUT
OFFICE OF POLICY AND MANAGEMENT

February 21, 2002

Michael L. Nauer, Director
Legislative Program Review and
Investigations Committee
State Capitol, Room 506
Hartford, CT 06106

Dear Mr. Nauer:

Thank you for the opportunity to provide comments on the Program Review Committee's Medicaid Rate Setting for Nursing Homes Report. I appreciate all the effort your staff has put into developing the report and its recommendations.

As you are only too well aware, establishing rates for nursing homes is a complicated issue. While I applaud your staff's efforts in examining the issue, I believe additional analysis is necessary before we make any significant changes to our current system. It is critical to understand the impact that such changes are likely to have on both the quality and cost of care.

Before we embark on wholesale revisions to our system that will ultimately increase the rates for most nursing homes, we need to have a better understanding of whether Medicaid funds are being appropriately spent. While the annual cost reports the Department of Social Services (DSS) receives from each facility are quite detailed, they don't tell the entire story. I hope that the Office of Policy and Management (OPM), in conjunction with DSS, can work with the Committee to explore additional studies and analyses that will provide us with a more complete picture of how our Medicaid nursing home dollar is being spent.

Below are some additional comments on some of the recommendations found in the report.

Rate Setting and Case Mix Recommendations:

It is my understanding that DSS will be providing you with detailed comments regarding the rate setting and case mix recommendations included in the report.

A case-mix based reimbursement system has had significant theoretical appeal for quite some time. However, the introduction of such a system may well have unintended consequences unless we are extremely careful. Obviously, the current financial circumstances require that I guard against changes that could have unintended consequences for our financial stability. I am equally concerned about unintended diminution in the quality of care.

The case mix approach relies solely on the Minimum Data Set (MDS) that each facility must report to the Centers for Medicare and Medicaid Services (CMS). This data is not audited by either the State or CMS. Therefore, to base rates on case mix would require an extensive auditing function, beyond what the Committee report proposes in its auditing recommendations, to ensure that patient acuity is accurately reflected. The introduction of a case mix approach will create an incentive to overestimate the level of acuity for a resident. To insure a system that is fair and equitable, extensive oversight and auditing capabilities will be required to verify the accuracy of the acuity levels reported. Adoption of an acuity-based reimbursement system presumes that the higher rate for higher acuity levels will be directly translated into improved staffing. In most facilities, I believe that increased staffing will occur, but I think the risk is significant that some homes will use the funds for other areas and only sufficient auditing and oversight will be able to ascertain those situations.

Planning and Financial Oversight Recommendations:

I agree with the report's observation that coordinated planning for future long-term care needs is of vital importance, especially with an aging baby boom population presenting unique challenges to our state over the next 20 to 30 years. The Long-Term Care Planning Committee had made similar observations in its Long-Term Care Plan issued in January 2001 when it recommended that a comprehensive needs assessment be performed.

I would, however, question the recommendation that the planning responsibility be shifted to the Office of Policy and Management (OPM). As you know, the Long-Term Care Planning Committee was created by the General Assembly in 1998 with the overall goal of enhancing the coordination between those State agencies involved in long-term care planning. It is my belief that the Planning Committee has done just that over the past three years as evidenced by the numerous cross-agency long-term care initiatives, such as our assisted living pilots, that have been successfully implemented.

The Long Term Care Planning Committee has acknowledged the need for additional analyses for long range planning purposes, including a comprehensive needs assessment. I believe the Planning Committee, with the leadership provided by OPM as the Chair of the Committee, is the appropriate body to carry out your planning mandate. All the relevant agencies are represented on the Planning Committee, leaving it well positioned to coordinate and oversee the activities undertaken by individual agencies. DSS would be the lead agency to take responsibility for the implementation of many of the activities recommended in the report, working in conjunction with OPM and the other agencies.

The report recommends adding six staff people to the DSS CON/Rate-Setting unit. As the report notes, the addition of the six staff is consistent with the Governor's proposal from last year. However, I believe DSS should be given flexibility in how they use these six new staff and I believe the focus should be on financial audits and oversight and not on the case mix indices. Please note that our recommendation was made without the significant expansion in responsibility that is suggested in your report. I suspect that a more detailed analysis of the skills and workload would suggest the need for even more staff to appropriately carry out the functions necessary to implement your recommendations.

I also feel compelled to note that financial audits cannot simply be turned into reviews of the financial stability of our nursing facilities. As noted in my earlier comments, significant financial and acuity audits will be required to implement a fair case-mix system. While we clearly must be cognizant of the financial stability of the industry, it is not the responsibility of the Department of Social Services to insure the financial stability of each and every home.

Regarding the report's recommendation to create a rate review panel for interim rate requests, I support the idea of formalizing the interim rate review process and I believe setting clear criteria would help both the State and the nursing home industry. I also believe it makes sense to eliminate change of ownership as a criteria for asking for an interim rate, as is recommended in the report. I support the report's recommendation that change of ownership of nursing facilities require a CON approval before the facility purchase is transacted.

I must disagree, however, with your apparent recommendation that the final authority for interim or special adjustments be charged to this group. Instead, I would suggest that body be advisory to the Commissioner. Clearly, clear ethical guidelines should be adopted to assure that no member of the panel has a conflict of interest.

My staff and I greatly appreciate the courtesy and cooperation extended by your staff in conducting this study and for allowing us the opportunity to provide these comments.

Sincerely,



Marc S. Ryan
Secretary

cc: Commissioner Patricia A. Wilson-Coker, DSS
Deputy Commissioner Michael Starkowski, DSS

Appendix C

Glossary

Acuity – the intensity of care needed by nursing home residents based on a comprehensive physical, mental, and psychosocial assessment. Acuity levels largely determine the amount of resources (in terms of nurse and therapist staff time) a particular resident or a class of residents will need.

Allowable Costs – items or elements of a facility’s costs which are reimbursable. Costs that are not allowed may include uncovered services, costs that are not deemed unreasonable, and luxury accommodations.

Case Mix – numbers and types of residents served by a facility. Residents can be classified according to diagnosis, severity of illness or other characteristics.

Chronic and Convalescent Nursing Home (CCNH) – licensed by CT Department of Public Health to provide 24-hour skilled nursing care under medical supervision and direction. Requires a higher nursing-staff-to-resident ratio than rest homes with nursing supervision.

Cost Reports – prescribed forms by CT Department of Social Services certifying nursing home provider’s costs and charges.

Per Diem Costs – institutional costs for one day of care per resident. Per diem costs represent averages and do not reflect the true cost of care for each resident.

Rate Year – the time period that CT issues nursing home Medicaid per diem rates is from July 1 through June 30, the same period as the state fiscal year.

Rebasing Costs – A component of the reimbursement system that periodically assess and updates the actual costs of operating a nursing home. A cost year is selected as a base year and allowable costs are established; those costs are inflated forward from that base cost year to the applicable rate year(s).

Rest Homes with Nursing Supervision (RHNS) – licensed by CT Department of Public Health to provide health-related services to individual whose mental or physical condition required services above the level of room and board but below CCNH care. Requires a lower nursing-staff-to resident ratio than CCHN licensure.

Stop Gain/Stop Loss – caps nursing home Medicaid rate increases from year to year to a specific percent that is specified in CT statute.

APPENDIX D

Description of Major RUG Categories

Extensive Services - residents receiving heavy nursing care, including respirator/ventilator care, parenteral feeding, suctioning, or with a tracheostomy. These residents are some of the costliest in nursing care.

Rehabilitation - residents receiving frequent nursing rehabilitation, including range of motion and training activities aimed at restoring or maintaining resident function.

Special Care - heavy care residents with particular serious conditions, such as coma or quadriplegia, serious burns, septicemia and radiation therapy that primarily determine their care needs.

Clinically Complex - residents with particular medical or skilled nursing problems (dehydration, dialysis, lung aspirations, aphasia, and pneumonia). These residents are less debilitated than the special care category because they have more functional capability.

Impaired Cognition – residents with short-term memory loss and impaired decision-making who may or may not have behavior problems.

Behavior Only – residents with high frequency and severe levels of at least one behavioral problem, such as physical aggression, verbal abuse or hallucinations.

Reduced Physical Function - all residents who do not qualify for any of the above categories; they are principally characterized by reduced levels of ADL functioning.

Case-Mix Indices for Medicaid 34-Group Resource Utilization Group.	
<i>Resource Utilization Group</i>	<i>Case Mix Index</i>
<i>Extensive Services</i>	
SE3	2.10
SE2	1.79
SE1	1.54
<i>Rehabilitation</i>	
RAD	1.66
RAC	1.31
RAB	1.24
RAA	1.97
<i>Special Care</i>	
SSC	1.44
SSB	1.33
SSA	1.28
<i>Clinically Complex</i>	
CC2	1.42
CC1	1.25
CB2	1.15
CB1	1.07
CA2	1.06
CA1	0.95
<i>Impaired Cognition</i>	
IB2	0.88
IB1	0.82
IA2	0.71
IA1	0.60
<i>Behavior Only</i>	
BB2	0.86
BB1	0.82
BA2	0.71
BA1	0.60
<i>Physical Function Reduced</i>	
PE2	1.00
PE1	0.97
PD2	0.91
PD1	0.89
PC2	0.83
PC1	0.81
PB2	0.65
PB1	0.63
PA2	0.62
PA1	0.59

Source: Center for Medicare and Medicaid Services, Case Mix Index Set B01: Medicaid 34 Group Nursing Only, for use with Version 5.12 of M3PI.