DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

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

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS).

Changes to Medicaid State Plan

Effective on or after July 1, 2022, SPA 22-Z will amend Attachment 4.19-D of the Medicaid State Plan to implement an acuity-based reimbursement methodology for nursing facilities as detailed below, in accordance with state statute in section 17b-340b of the Connecticut General Statutes, as amended by section 319 of Public Act 21-2 of the June special session.

The acuity-based reimbursement system will make quarterly case-mix adjustments to the direct care component of the per diem rate, which will be based on Minimum Data Set resident assessment data, all of which is described in more detail in the draft SPA pages. This process includes rebasing nursing home costs to the fiscal year ending September 30, 2019.

The transition to the full implementation of the acuity-based reimbursement system will span a three-year period, which will include stop-loss and stop-gain provisions in each of the first two years. The year one, State Fiscal Year (SFY) 2023 stop gain will limit the per diem rate increases to $6.50 and the stop-loss will be $0.00, meaning no provider will experience a rate decrease due to the quarterly case-mix adjustments during year one. The stop-gain in year two (SFY 2024) will limit the per diem rate increases to $20.00, and the stop-loss is increased to $5.00. There will be no stop-gain or stop-loss provisions in year three (SFY 2025).

Additionally, Medicaid reimbursement rates will be subject to a case mix growth limitation set forth below. The statewide average Medicaid case mix index for the July 1, 2022 reimbursement rates will serve as the baseline to determine growth. The statewide average Medicaid case mix index will be subject to the following maximum growth limits: 0.75% for SFY 2023, 1.51% for SFY 2024, and 2.27% for SFY 2025. Any calendar quarter in which the statewide average Medicaid case mix index exceeds the allowed maximum growth limit will result in all facility Medicaid case mix indices being reduced by a uniform percentage until the statewide average Medicaid case mix index is equal to the maximum growth limit.

The purpose of this SPA is to comply with section 17b-340d of the Connecticut General Statutes, as amended, and to modernize the nursing facility reimbursement methodology.

Fiscal Impact

DSS estimates the transition to acuity-based reimbursement will increase annual aggregate expenditures by approximately $25.6 million in SFY 2023 and $59.2 million in SFY 2024.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-State-Plan-Amendments. The proposed SPA may also be obtained at any DSS field office, at the Town of Vernon Social Services Department, or upon request from DSS (see below).

To request a copy of the SPA from DSS or to send comments about the SPA, please email: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference "SPA 22-Z: Nursing Facility Reimbursement – Transition to Acuity Based Reimbursement System".

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than July 28, 2022.

State: **Connecticut**
Methods and Standards for Establishing Payment Rates for Nursing Facilities

Nursing Facility Reimbursement – Acuity-Based Methodology for Direct Cost Component of Per Diem Rate

Effective July 1, 2022, for fiscal years ending June 30, 2023 and beyond, the Direct cost component of each nursing facility's per diem rate will incorporate an acuity-based component as detailed below. An inflation multiplier will be applied to total Direct costs. Inflated Direct cost will be divided by actual and imputed days, resulting in a per diem direct care cost. Direct costs will be subject to a cost normalization process. Per Diem Direct costs will be divided by the all-payer total facility cost report period case mix index average, which corresponds to the base cost reporting period utilized for calculating reimbursement rates. The normalized Direct costs will be compared to the established direct cost maximum. The lesser of each facility's normalized Direct costs or the applicable peer grouping direct cost maximum will be multiplied by the facility's Medicaid case mix index in effect for the applicable rate quarter to establish Medicaid direct cost for the reimbursement rate. Medicaid reimbursement rates will be updated quarterly to account for changes in each facility's quarterly Medicaid case mix index.

The Resource Utilization Group-IV (RUG-IV) 48 grouper nursing-only weight resident classification system (or its successor) will be utilized to calculate the all-payer total facility cost report period case mix index average applied to the base cost reporting period for cost normalization purposes, as well as the quarterly Medicaid case mix index. Each index is a calendar day weighted average, carried to four decimal places, of all indices for MDS assessments transmitted and accepted by CMS that are considered active within the applicable time period.

Effective July 1, 2022, for fiscal years ending June 30, 2023 and beyond, for direct costs, the maximum shall be equal one hundred thirty-five percent of the median allowable normalized direct costs of that peer grouping.

State: **Connecticut**
Methods and Standards for Establishing Payment Rates for Nursing Facilities

Nursing Facility Reimbursement – Acuity-Based Methodology for Direct Cost Component of Per Diem Rate (cont'd)

Effective from July 1, 2022 through June 30, 2025, tor fiscal years ending June 30, 2023 through June 30, 2025, a phase-in of reimbursement rates will be applied as detailed immediately below. Specifically, facility reimbursement rates will be subject to a corridor relating to the allowed maximum gain or maximum loss from each facility's reimbursement rate for June 30, 2022.

Fiscal Year End	June 30, 2023	June 30, 2024	June 30, 2025
Maximum Gain	$6.50	$20.00	None
Maximum Loss	$0.00	$5.00	None

Additionally, Medicaid reimbursement rates will be subject to a case mix growth limitation set forth below. The statewide average Medicaid case mix index for the July 1, 2022 reimbursement rates will serve as the baseline to determine growth. The statewide average Medicaid case mix index will be subject to the following maximum growth limits:

Fiscal Year End	June 30, 2023	June 30, 2024	June 30, 2025
Maximum Gain	0.75%	1.51%	2.27%

Any calendar quarter in which the statewide average Medicaid case mix index exceeds the allowed maximum growth limit will result in all facility Medicaid case mix indices being reduced by a uniform percentage until the statewide average Medicaid case mix index is equal to the maximum growth limit.