



REPORT TO THE JOINT STANDING COMMITTEES OF THE GENERAL ASSEMBLY
On Human Services and Public Health

Public Act 23-204, Section 298
Reviewing and Evaluating the Incidence and Implications of Excess Licensed Bed
Capacity and Any Space Not Presently in Use at Skilled Nursing Facilities

June 2024

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FINAL REPORT

Activities from December 2023 – May 2024

I. Background

This working group was established in accordance with section 298 of Public Act 23-204 and was charged with reviewing and evaluating the incidence and implications of excess licensed bed capacity and any space not presently in use at skilled nursing facilities. The Commissioner of Social Services was required to appoint and convene a ten-member working group to review and evaluate excess licensed bed capacity at skilled nursing facilities and recommend Medicaid rate adjustments to address excess capacity. The working group is required to file both an interim report and a final report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to human services in accordance with the provisions of section 11-4a of the general statutes.

Specifically, subsection (a) of section 298 of Public Act 23-204 required the working group to review and evaluate the incidence and implications of excess licensed bed capacity and any space not presently in use at skilled nursing facilities, with such review and evaluation to include:

(1) A survey of excess licensed bed capacity and any space not presently in use that identifies (A) licensed bed capacity, occupancy percentages and the identification and location within the facility of licensed beds not presently in operation in a closed facility wing or elsewhere in the facility, (B) beds voluntarily taken out of service in an open portion of the facility but where the beds remain counted in the facility licensed beds capacity, (C) any other space not presently in use that was formerly used for nursing facility care and services, and operations, and (D) beds made unavailable due to inability to staff at minimum staffing levels, in accordance with section 19a-563h of the general statutes, or operator-preferred staffing levels; (2) a review and evaluation of the efficiency and effectiveness of Medicaid payment policies that support right-sizing and rebalancing efforts, including, but not limited to (A) minimum occupancy rate-setting requirements, and (B) a price-based component for the administrative and general component of reimbursement based on the median of the peer group spending in the administrative and general component of the rates; (3) a review and evaluation of the mitigating implications of staffing shortages as an impediment to skilled nursing facility admissions and occupancy; and (4) consideration of the physical plant conditions of the existing skilled nursing facilities.

II: Working Group Activities

The working group (“Work Group”) convened on September 13, 2023, and concluded their work on June 12, 2024. In total, the Work Group met 15 times to discuss excess licensed bed capacity at skilled nursing facilities, challenges experienced by the nursing homes in filling empty beds, barriers in hiring staff, and reports from the Department of Public Health (DPH) regarding available space in nursing homes.

In accordance with Public Act 23-204, the Department of Social Services (DSS or “Department”) issued a survey to nursing homes to evaluate the capacity of licensed beds in each facility. The survey was used to evaluate the following:

1. Licensed bed capacity of each nursing home, its occupancy percentages, and the location within each nursing facility of licensed beds not presently in operation in a closed facility wing or elsewhere in the facility.
2. Licensed beds voluntarily taken out of service in an open portion of the facility but included by the nursing facility in their count of the unused beds in the facility's licensed bed count.
3. Any other space identified by the nursing facility that is not presently in use but was formerly used for nursing facility care, services, and operations.
4. Licensed beds made unavailable due to the inability of the nursing facility to staff at minimum staffing levels in accordance with section 19a-563h of the general statutes or operator-preferred staffing levels.

The survey findings became the basis for Work Group discussions about the costs of excess beds under the various circumstances where excess beds are present, and the degree to which a reduction in excess beds might achieve, to various degrees, state Medicaid savings.

The survey also was the impetus for the Work Group's discussions in the following areas:

- Nursing home business diversification models that can achieve multifaceted state policy goals in the area of long-term services and supports right-sizing and rebalancing objectives and address other state policy goals, including the further development of residential care homes to address housing needs in the system for older adults and persons with disabilities.
- State Medicaid provider payment policies that are present in the current rate setting system that provide both incentives and disincentives to reduce excess capacity, and additional rate-setting policies that could further incentivize the reduction in excess beds.

The Work Group also observed the importance of policies and state resources recommended by the Governor and adopted in previous sessions of the Connecticut General Assembly, including \$4 million in funds for nursing home capital improvements to advance specialized services and, related to this, a statutory provision authorizing rate increases for nursing homes providing specialized services, especially those that advance quality and address impediments to hospital discharges.

As part of the DSS survey issued to nursing homes, Anthony Bruno, the Building Construction & Fire Safety Unit Supervisor from DPH conducted visits to nursing homes to follow-up on information reported in the survey. Mr. Bruno conducted several inspections of nursing homes that reported empty space or vacant beds to determine how homes were either using the space or to confirm the space was indeed vacant. Mr. Bruno was able to report to the Work Group important information regarding how homes were actually using vacant space or excess building capacity. This information greatly benefitted the discussions and helped to provide options for the Work Group to explore.

At the time the DSS survey was issued, Connecticut had 192 nursing homes participating in the Medicaid program. In total, 152 nursing homes or 79% returned completed surveys to the Department by August 2, 2023. The Department compiled survey data and presented to the Work Group for the first meeting held on September 13, 2023. Survey data showed the following:

- 10 nursing homes (6.6% of responses) indicated they had licensed beds that are currently “mothballed.” This is defined as a nursing home that took a bed out of use but did not delicense the bed so that the bed is still factored into the licensed bed count. In total, nursing homes reported 237 licensed beds in a “mothballed” status.
- 15 nursing homes (9.9% of responses) indicated the facility currently has square footage not in use. Of these homes, 12 indicated having a closed or partially closed wing of the facility. Note: 3 of the 15 facilities that reported unused square footage also reported having mothballed beds.
 - The average square footage not in use among the 15 facilities was 6,876 square feet; this results in approximately 479 licensed beds being unavailable for use.
- 16 nursing homes (10.5% of responses) indicated having 3- and 4-bed room configurations for a total of 227 rooms with 3 and 4 beds.
 - This equates to approximately 761 total licensed beds, of which 307 would need to be relocated or delicensed to eliminate these configurations in the 16 facilities.
 - An additional 8 facilities reported the removal of licensed beds from 3- and 4-bed configurations. The total beds removed from service was 69 licensed beds.
- 11 nursing homes (7.2% of responses) reported an inability to staff at the minimum staffing levels, which has impacted the ability to increase census.

On March 13, 2024, the Work Group reviewed the nursing home survey results related to closed wings and unused or excess space within the facilities. The Work Group discussed the repurposing of unused space to diversify services offered at the facility, future development of statutory language that provides an exception to the current nursing home bed moratorium to allow for expansion of needed services, and defining minimum occupancy and the role it plays in ensuring Medicaid funds are directed towards patient care.

On May 9, 2024, the Work Group discussed a draft report of their activities and recommendations. The Work Group discussed incorporating into the final draft various recommendations made during prior meetings. Each component of the draft report was reviewed in detail and discussion centered on the importance of minimum occupancy in setting Medicaid reimbursement rates. There were also discussions about the current rebasing policy which is required every two to four years in accordance with statute.

On May 29, 2024, the Work Group met to review the impact of a price-based administrative and general (A&G) rate on each individual nursing home. This included a review of the peer groupings which are based on geographic location (i.e., Fairfield County vs non-Fairfield counties). The Work Group then reviewed a comparison of the calculated price-based A&G rate to the current A&G rate.

The meeting on June 6, 2024, was used to walk through the final draft of the report. The group openly discussed and incorporated edits into each section of the report.

III. Final Recommendations

The Work Group's interim report recommended further exploration of Medicaid payment policies that advance the state's goal in right-sizing nursing homes while increasing quality. After release of the interim report, the Work Group developed recommendations that support: increasing nursing home occupancy percentages; ensuring nursing homes are efficiently using physical space for resident care; encouraging nursing homes to use the Certificate of Need (CON) process to repurpose and create environments that are

desirable for both consumers and staff; and examining the need for major capital and infrastructure improvements. In support of the recommendation to assist nursing homes in repurposing space to meet the needs of residents, Public Act 23-204 allocated \$4.0 million in federal American Rescue Plan Act of 2021 (ARPA) funding to establish a Nursing Home Specialized Unit Infrastructure Fund. The focus of this funding is to support new infrastructure of in-state nursing home specialized units into the facility's program of care. The Department received 21 applications and awarded funds to 10 different projects. Once complete, nursing home residents will have access to a specialized unit to care for patients with Huntington's disease, access to a cardiac care unit, supports for bariatric residents, and treatment options for residents needing complex dialysis treatment. The offering of these services also serves to support hospital discharges by ensuring residents can be safely and timely discharged from the hospital to a nursing home that is able to treat their complex medical conditions.

In accordance with Public Act 23-204, the Work Group offers the following recommendations:

1. Supporting Nursing Homes that Voluntarily Delicense Beds

PA 23-204, Section 298(a)(2)(A): Review and evaluation of the efficiency and effectiveness of Medicaid payment policies that support right-sizing and rebalancing efforts, including ... minimum occupancy rate-setting requirements.

In accordance with section 17b-340d of the general statutes and section 17-311-52 of the regulations of Connecticut state agencies, the Medicaid rate calculation uses a threshold known as minimum occupancy. Minimum occupancy standards are important rate setting tools used by state Medicaid programs to adjust Medicaid rates for nursing homes below the standard. Occupancy percentages are calculated by dividing the number of residents in the building by the number of licensed beds by allowable costs. This is an important function of the Medicaid rate calculation to ensure funds are directed to patient care and to limit the amount of Medicaid funding spent on activities not related to patient care. The Medicaid and CHIP Payment and Access Commission (MACPAC) defines occupancy rate minimums as "a minimum percentage of occupied beds per facility at which payment will be based for one or more cost centers. The state generally pays the facility based on the higher of that occupancy threshold or the facility's actual occupancy level" (2019). According to MACPAC, 27 states use minimum occupancy percentages in their Medicaid rate setting formulas with percentages ranging between 80% to 96%.¹ In Connecticut, statute and the Medicaid state plan allow for 90% minimum occupancy. Moreover, minimum occupancy requirements further support state right-sizing goals by providing an incentive for facilities with significant excess capacity to reduce the excess supply of beds to both become more efficient and to avoid the imputation of the Medicaid rate. A nursing home's per diem rate is determined by dividing the allowable costs by the total resident days, which can include imputed days if a facility is not at least 90% occupied. Imputed days are determined by calculating the licensed bed number by 365 days, then by 90%. If actual resident days are not at least this result, the imputed days figure is used as the divisor for the per diem Medicaid rate. If the actual total resident days are over the 90% minimum days determined, then actual days are used.

The Work Group explored the 90% standard to determine whether this was the correct threshold or if it should be adjusted. Historically, Connecticut's occupancy standard was 95% until fiscal year 2014 when

¹ <https://www.macpac.gov/wp-content/uploads/2019/12/Nursing-Facility-Fee-for-Service-Payment-Policy.pdf>

state legislation changed it to 90%. Upon a review of the historical trend of statewide nursing home occupancy, the impact of the COVID-19 public health emergency has shifted consumer preferences with an increasing number of residents wishing to remain at home and in community-based settings. This has resulted in a decline of the statewide occupancy percentage in nursing homes. Connecticut's statewide occupancy was better than the national average of 75% in July 2023, however, and it continues to improve.² For Medicaid rate setting purposes, when occupancy falls below the 90% threshold, the Medicaid rate may be decreased to support right-sizing and targeting of the Medicaid dollar on resident care.

Statewide occupancy as of March 2024 was 87.16% compared to 84.12% a year prior in March 2023. This represents a statewide increase in nursing home utilization of 3.04%. During the same period, 104 nursing homes were at 90% occupancy, compared to 93 nursing homes a year prior. This marks an important shift with 11 more nursing homes reaching the 90% occupancy threshold. For perspective, in March 2024 statewide occupancy was less than 3% away from the goal of 90% minimum occupancy, which represents 630 beds that either need to be filled with a resident or delicensed to ensure efficient spend of the Medicaid dollar.

Recommendation: Given the statewide increases in nursing home occupancy and progress towards a return to 90% minimum occupancy, the Work Group is not recommending any changes to the occupancy percentage but is recommending a change to the date at which the licensed bed capacity is determined for rate setting purposes as described below.

The Work Group is recommending a change for nursing homes that voluntarily delicense beds. Currently, bed delicensures are only recognized when nursing home costs are rebased in accordance with statute which is every two to four years. In order to encourage and support right-sizing and rebalancing efforts, the Work Group proposes an adjustment to a nursing home's Medicaid rate when a nursing home performs a significant bed reduction. This would be defined as 10 beds or 10% of licensed nursing facility beds, whichever is greater. The Work Group recommends that the Department develop a process where voluntary bed terminations may be factored into the annual rate calculation which takes place on July 1 of every year. This process would recognize changes in bed terminations that took place in the preceding state fiscal year for consideration in the annual rate calculation at the start of the state fiscal year. This change would ensure that the Medicaid rate: (1) reflects changes in costs that resulted from the decrease in the bed count; (2) reflects reductions in the associated costs of those beds; (3) reflects the correct occupancy percentage of the facility ; and (4) better targets resources to resident care. Further, in accordance with section 17b-340d(a)(14) of the general statutes, the Commissioner of Social Services may authorize an interim rate for a facility demonstrating circumstances particular to that individual facility impacting facility finances or costs not reflected in the underlying rate. Nursing homes may wish to work with the Department when experiencing a change to its bed count due to delicensure when appropriate. In accordance with statute, nursing homes may apply for interim rates, which would be revised after the period, if they are seeking support for temporary, short-term changes.

² <https://www.kff.org/other/state-indicator/nursing-facility-occupancy-rates/?activeTab=graph¤tTimeframe=0&startTimeframe=8&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

The Work Group does recognize that Connecticut's population is aging and there will always be a need for nursing home care. The Work Group recommends that to continue to ensure access for residents needing nursing home services, the Department should explore an exception to the current moratorium in statute. Currently, the statutory moratorium prevents any new licensed beds from entering the system (with exceptions for beds restricted to use by patients with acquired immune deficiency syndrome or neurological rehabilitation); this policy was initiated in 1991 and has been maintained to support the state's right-sizing and rebalancing efforts. Given the state's aging population,³ the impact of the pandemic on the industry, and efforts by the industry to delicense beds, it is recommended that a statutory exception to the moratorium be implemented to support access to care should nursing home services need to be expanded. This would be an exception based on geographic or area needs should a section of the state begin to see a shortage in available beds or if there is an unmet need for certain cohorts of patients having similar diagnoses and increased demand for hospital discharge. While further review by DSS is needed, development of statutory language is recommended.

Finally, the Work Group noted that nursing home recovery in the area of occupancy percentages is also moving in the direction of pre-pandemic occupancy levels (almost 88% as of March 2024) due in part to bed reductions and closures in combination with increased demand. Work Group discussions included the observation that a reduction of less than 700 licensed beds from the system would result in a Connecticut occupancy percentage of 90%, which would be among the highest occupancy percentages in the nation, and almost 10 points above the current national average. In this regard, the Work Group recommended continued monitoring of the improving occupancy percentages both statewide and in particular regions of the state where high occupancy percentages may signal potential access to care issues in the system, resulting in delays in hospital discharges for individuals no longer needing acute care in a hospital setting. For vulnerable populations, there is good evidence that "unnecessary days in hospital may lead to increased hospital-acquired patient complications (e.g., healthcare-associated infections, falls) and increased costs for patients and healthcare systems."⁴

2. Administrative & General Component of Rate Setting

PA 23-204, Section 298(a)(2)(B): Review and evaluation of the efficiency and effectiveness of Medicaid payment policies that support right-sizing and rebalancing efforts, including ... a price-based component for the administrative and general component of reimbursement based on the median of the peer group spending in the administrative and general component of the rates

The Work Group performed an analysis of the fiscal impact of a price-based methodology for the A&G portion of the Medicaid rate. Connecticut Medicaid uses an individual cost-related prospective system to determine nursing home reimbursement rates. Rates are determined on an annual basis and issued at the start of every state fiscal year starting July 1. In accordance with statute and regulation, the per diem rate is calculated using cost-based information reported on annual cost reports to the Department. Cost report information is bucketed into one of five approved cost categories which are outlined in statute and under

³ Between 2010 and 2040, Connecticut's population of people age 65 and older is projected to grow by 57%. CT Commission on Aging. <http://aging.ctdata.org/>

⁴ Tipton K, Leas BF, Mull NK, et al. Interventions To Decrease Hospital Length of Stay [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2021 Sep. (Technical Brief, No. 40.) Introduction. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK574438/>

the Medicaid state plan. The five approved cost categories for Medicaid reimbursement are: (1) Direct Care; (2) Indirect Care; (3) Administrative & General; (4) Capital; and (5) Fair Rent. More information on the rate setting process can be found on the Department's [website](#).

The Work Group evaluated the A&G component of the Medicaid rate which is currently limited in two ways. Allowable costs and median costs are first limited by certain limits imposed on individual expense categories. The result of these limits are then subject to a maximum of 100% of the limited median or \$40.72; this means that no nursing home can receive more than \$40.72 for the A&G component of the rate, although a home may receive less if their costs are lower.

In accordance with Public Act 23-204, the Work Group developed peer groups for Fairfield County and non-Fairfield County and set the price at 100% of the median for each county to evaluate the impact of a price-based component. Price-based simply means the amount is “fixed” no matter what the actual cost of providing the service. The Work Group developed medians calculated based on current 2019 data for the two peer groupings and the result was a fixed price calculated at 100% of median: \$42.58 for Fairfield County and \$40.43 for non-Fairfield County. Both of these peer groupings are higher than the current calculation which limits or caps at 100% of the statewide median.

A price-based approach requires that all nursing homes receive the same price – even if the actual costs for a nursing home is lower. The Work Group applied the price-based amounts (\$42.58 for Fairfield County and \$40.43 for non-Fairfield County) to each nursing home to see the total impact. This approach would result in a rate increase for all nursing homes, with 58% of nursing homes receiving a rate that is more than their actual costs, and additional Medicaid expenditures of \$10.6 million (gross).

Recommendation: Given that over half of the homes would be receiving a rate that exceeds their actual costs, a change in rate methodology for the Administrative and General cost center is not recommended at this time. This change in methodology may be reconsidered in the future once there is an opportunity to fully assess the impact of the complete transition to case mix reimbursement, which goes into effect July 1, 2024, and after implementation of a nursing home quality payment program, which does not have a date certain but an initial report on the anticipated impact if the state were to implement a rate withhold on nursing homes that fail to meet certain quality metrics is to be completed by June 30, 2025.

3. Impact of Staffing Shortages on Admissions and Occupancy

PA 23-204, Section 298(a)(3): Review and evaluation of the mitigating implications of staffing shortages as an impediment to skilled nursing facility admissions and occupancy

In order to assess the impact of staffing shortages on skilled nursing facility admissions and occupancy, the Department issued a survey to evaluate the capacity of licensed beds in each facility. One of the survey questions required nursing homes to report if they had licensed beds made unavailable due to the inability of the nursing facility to staff at minimum staffing levels in accordance with section 19a-563h of the general statutes or operator-preferred staffing levels. A total of 11 nursing homes (7.2% of responses) reported an inability to staff at the minimum staffing levels. This directly impacted their ability to increase their census because they have been limiting admissions or have temporarily closed wings due to staffing challenges.

The pandemic negatively impacted the supply of direct care workers, especially in the nursing home industry, causing nursing homes to increase their dependence on temporary staffing agencies to fill vacancies. The industry has indicated the direct care staffing shortage has improved, but the workforce has not fully recovered from the impacts of the pandemic. While nursing homes have been able to reduce their dependence on the temporary staffing agencies and have been able to directly hire more staff, challenges remain.

Recently, the U.S. Department of Health and Human Services (HHS) issued a final rule to improve the safety and quality of care in nursing homes. The final rule⁵ established, for the first time, a national minimum staffing requirement for nursing homes. Within three years, nursing homes participating in Medicare and Medicaid will be required to:

- Provide residents with a minimum total of 3.48 hours of nursing care per day, which includes at least 0.55 hours of care from a registered nurse per resident per day, and 2.45 hours of care from a nurse aide per resident per day.
- Have a registered nurse on site 24 hours per day, seven days per week to help mitigate against preventable safety events and deliver critical care to residents at any time.⁶
- Conduct a stronger annual facility assessment than is currently required to improve the planning and identification of the resources and supports that are needed to care for residents based on their acuity.
- Develop a staffing plan to maximize recruitment and retention.

The HHS final rule is intended to support resident care and improve quality, but questions remain in identifying staff needed to meet the current shortage and the new federal rule which will be in effect within three years. There remain significant questions as to whether the nursing facility industry will be able to meet the rule⁷ and further analysis will be needed to understand the financial and staffing impact.

Recommendation: The Work Group identified staffing challenges, which resulted in 7.2% of Connecticut nursing homes limiting admissions or temporarily closing wings. Future challenges are unknown given the recent announcement of the federal staffing requirements and additional time is needed to understand the percentage of Connecticut homes that will need to increase their workforce to meet the new federal rule. The Work Group supports efforts that attract workers into the field of healthcare and, in particular, support efforts and funding to attract workers into the field of nursing home care.

The Work Group recommends the Department work with industry and labor to understand any potential challenges nursing homes may face in meeting the new federal rule. This recommendation is further supported in the September 2023 report released by the Department titled “Report Concerning Temporary Nursing Service Agencies for Connecticut Nursing Homes,” which identified the need for workforce development efforts that attract workers who are representative of nursing home residents for improved

⁵ <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-takes-historic-action-increase-access-quality-care-and-support-families>

⁶ The registered nurse on-site for 24 hours a day has been a long-standing requirement in Connecticut.

⁷ <https://www.kff.org/policy-watch/nursing-facilities-staffing-levels-standards-final-rule/>

quality of care outcomes, recommended education programs that attract students into healthcare professions, and reviewed the financial impact of temporary staffing agencies as nursing homes often depend on agency staff to fill vacancies.

The September 2023 report showed staffing agencies were charging 73% to 86% more than employees' hourly wages. This cost is often passed to the state through the Medicaid rate. The Work Group recommends efforts that support nursing homes in hiring permanent, full-time, and regular part-time employees to reduce the financial burden on nursing homes by lowering operational expenses through better control of labor costs. In addition to the potential savings in hourly wage costs by hiring permanent staff, full-time and regular part time employees also reduce overtime expenses since employees are more likely to have stable schedules, reduced turnover rates and lower reliance on state public assistance programs. Better workforce planning also creates a sense of belonging and employee loyalty, increased job satisfaction and improved employee morale. Dedicated employees also establish relationships with nursing home residents, enhancing resident well-being, reducing medical errors, and improving overall resident satisfaction. Improved resident satisfaction can also increase the financial position of a nursing home by positively impacting the home's reputation and attracting potential new consumers.

4. Physical Plant Conditions

PA 23-204, Section 298(a)(4): Consideration of the physical plant conditions of the existing skilled nursing facilities

In considering the physical plant conditions of the existing skilled nursing facilities, the Work Group thought it was relevant to reference the work that was already done on this issue by the Nursing Home and Assisted Living Oversight Working Group (NHALOWG) in 2021.⁸ The Infrastructure and Capital Improvement Subcommittee of NHALOWG noted several important and relevant factors regarding nursing home physical plant and infrastructure status, including the age of the buildings, the older medical model configurations of many of the buildings, and the high cost of renovations. NHALOWG issued recommendations related to assisting the industry in seeking the funding necessary to initiate and complete infrastructure improvements which could include any renovations necessary to repurpose existing nursing home space.⁹ The Work Group did not feel it necessary to repeat the findings and recommendations of [NHALOWG](#), but instead chose to reference the subcommittee's [findings and recommendations](#) for the purpose of this report.

Through its own survey of the industry, the Work Group identified space within the system that could be repurposed to support resident need. As noted above, there are at least 10 nursing homes and a total of 237 licensed beds currently "mothballed" (i.e., out of circulation but not delicensed) and 15 nursing homes with square footage not in use (6,876 square feet in total or approximately 479 licensed beds being unavailable for use) with 12 of the 15 nursing homes stating they had a closed or partially closed wing of the facility. Of the 15 facilities that reported unused square footage, 3 also reported having mothballed beds.

⁸https://www.cga.ct.gov/app/taskforce.asp?TF=20201109_Nursing%20Home%20and%20Assisted%20Living%20Oversight%20Working%20Group

⁹https://www.cga.ct.gov/app/tfs/20201109_Nursing%20Home%20and%20Assisted%20Living%20Oversight%20Working%20Group/Working%20Group/20210114/Infrastructure%20and%20Capital%20Improvement%20Subcommittee%20Recommendations%20Draft.pdf

Also as noted above, Public Act 23-204 allocated \$4.0 million in ARPA funding to support nursing homes in the development of specialized units to keep residents in-state for special needs such as neuro-rehab services, bariatric care, and other enhanced levels of care. Each application for funding was reviewed by DSS and DPH to evaluate the need for the service and the physical plant condition of each nursing home. In total, 10 projects were selected: one Huntington's Disease unit, one cardiac care unit, six dialysis units, and two bariatric units. Selected nursing homes are required to file a CON and have until December 31, 2026, to complete their projects. While this funding was a step in supporting expansion of services for nursing home residents, additional work is needed in this area to ensure residents who need care stay in-state when there is a need for specialized care.

Recommendation: The Work Group recommends nursing facilities utilize the Certificate of Need process when renovating or making capital improvements in their buildings and for needed resident equipment. Pursuant to section 17b-353 of the general statutes, nursing homes are subject to CON requirements for capital expenditures exceeding either \$2.0 million or \$1.0 million if a facility's square footage is to be increased by more than 5,000 square feet or 5% of the existing square footage, whichever is greater. Applications are evaluated for factors including public need; quality, accessibility, and cost effectiveness; and financial feasibility. The Work Group observed that Medicaid rate setting policies could help address many state policy goals at once, such as advancing right-sizing goals and assuring greater efficiency and financial stability in the nursing home industry, while also advancing public health best practices, including bed configurations of no more than two beds per room.

The CON process recognizes the costs of these projects and reimburses nursing homes for the Medicaid portion of the costs. This financial support incentivizes homes to provide care to residents and deliver much needed services that often require residents having to travel out of state for care.

Further, the CON process supports nursing homes that wish to transition or make changes in physical plant conditions that support patient care by repurposing space into specialized units. The Department can further support nursing homes in the development of Medicaid rates of reimbursement that support increased levels of care. An example of an opportunity for the industry to repurpose space was further supported during the 2024 legislative session with [Public Act 24-141](#), *An Act Promoting Nursing Home Resident Quality of Life*. Section 1 of the legislation prohibits nursing homes from placing newly admitted residents in a room with more than two beds starting on July 1, 2026, and allows the Department to recalculate Medicaid rates to reflect any associated bed reductions and reimburse costs to comply with this requirement through the Fair Rent portion of the reimbursement system described above. The CON process or Fair Rent system can also support nursing homes that wish to repurpose or realign space as a result of the legislation. For example, if a home wishes to reconfigure its physical plant space to accommodate, or if a nursing home wishes to diversify services as a result of a bed change, the Department will recognize the Medicaid portion of these costs through the CON process for rate consideration or through the Fair Rent system.

It is, however, important to note that while the Fair Rent system reimburses a nursing home through a rate increase distributed over the useful life of the completed infrastructure improvement or addition, it does not provide the initial capital or funding to pay for those improvements up front and that is where the

recommendations of the NHALOWG Infrastructure and Capital Improvement Subcommittee may be helpful.