Tennessee Case Mix Reimbursement System

Frequently Asked Questions

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General Questions

1. Q: When will the Case-Mix Rate Setting system be implemented?
   A: Case Mix Reimbursement will be effective for rates July 1, 2018. The implementation date may be after July 1, 2018 due to the finalization process for the rule.

2. Q: How often will rates be issued?
   A: The rates will be issued semi-annually, at July 1 and January 1.

3. Q: How will the reimbursement rates be sent to the providers?
   A: The reimbursement rates will be sent to providers via email. Myers and Stauffer maintains a master listing of provider email addresses. Should a provider wish to include or remove an individual from their facility listing for rate sheet dissemination, please contact Myers and Stauffer at TNCaseMix@mslc.com.

4. Q: Are there training materials available to assist with different components of the Case Mix Reimbursement System?
   A: Yes, there are pre-recorded narrated webinars that offer information on a variety of topics relating to Case Mix Reimbursement Rates available at the following website address: http://www.mslc.com/tennessee/TN_ProviderTraining.aspx. This information is available for you to review at your convenience.

Cost Reports

1. Q: Will filing the Level 1 & Level 2 Cost Reports still be required?
   A: No, filing Level 1 & Level 2 Cost Reports will no longer be necessary. Instead providers will be required to file their Medicare cost report and the Medicaid supplemental cost reporting form as designated by the department. The Medicaid supplemental cost reporting form can be found at the following website address: http://www.mslc.com/tennessee/TN_Downloads.aspx

2. Q: What level of review will be assigned to the Cost Reports filed with the State?
   A: The level of review will be at the discretion of the Comptroller.
3. Q: Will the state use a cost report more recent than 2015 to set the initial 7/1/18 rate?

A: No, 2015 cost reporting period information will be utilized for the 7/1/2018 reimbursement rates. These cost reports will continue to be the base period information used for reimbursement purposes until the next reimbursement system rebase period (no more than 3 years after the 7/1/2018 implementation period). The direct care spending floor will be updated for more current reviewed provider cost reports at each July 1 beginning with the 7/1/2018 rate period, and will continue until the first system rebase, at which point the base year cost reports will be utilized for the spending floor calculation.

Rate Components

Direct Care Component

1. Q: Is the direct care price (both case mix adjusted and non-case mix adjusted) the same for all providers regardless of size, acuity, and geography?

A: Yes, the direct care price (both case mix adjusted and non-case mix adjusted) is the same for all providers regardless of size, acuity, or geography.

2. Q: What happens if the actual spending for nursing is less than the case mix adjusted price?

A: The Tennessee case mix reimbursement system has a built in mechanism to reduce a provider’s reimbursement rate if the provider’s base year Medicaid CMI adjusted direct care (case mix adjusted and non-case mix adjusted) spending does not exceed the calculated individual provider spending floor threshold. Should this scenario occur, the providers total direct care reimbursement rate will be reduced by the difference between the calculated individual provider spending floor threshold and the Medicaid CMI adjusted direct care spending floor requirement.

3. Q: What are the direct care case mix adjusted cost component expenses?

A: (1) Nursing salaries/wages and contract labor expense for:

- Registered Nurse (RN)
- Licensed Practical/Vocational Nurse (LPN/LVN)
- Certified Nurse Aide (CNA)/Orderlies.

(2) Directly assigned employee benefits and payroll taxes

(3) Applicable allocation of pooled employee benefits and payroll taxes
4. Q: What are the direct care non-case mix adjusted cost component expenses?

A: (1) Salaries/wages and contract labor for:
   - Director of Nursing (DON)
   - Assistant Director of Nursing (ADON)
   - Social Services
   - Recreational (Patient) Activities

(2) Directly assigned employee benefits and payroll taxes

(3) Applicable allocation of pooled employee benefits and payroll taxes

(4) Raw food
   - Includes special dietary supplements
   - Includes those dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even when prescribed by a physician as defined by CMS Publication # 15-1, Section 2203.1

Admin and Operating Component

1. Q: Is the Admin & Operating rate the same for all providers regardless of size and geography?

   A: Yes, the administrative and operating cost component price and rate will be the same for all providers regardless of size, geography, or any other factors. The administrative and operating rate is determined by multiplying the administrative and operating cost component annualized Medicaid resident-day-weighted median cost by 101% to determine the statewide price. Every nursing facility provider will receive the statewide administrative and operating rate as reimbursement in full for their administrative and operating expenditures.

2. Q: What are the Administrative & Operating cost component expenses?

   A: (1) Medicare cost report Worksheet A general service (overhead) cost centers, and applicable subscripted cost centers, with the exception of the following:
      - Capital costs (which is excluded as appraisal data is used for the capital component of the rate)
      - Portion of pooled employee benefits (which can be allocated to other cost components)
      - Nursing and Allied Health education cost centers
      - ParaMed Education cost centers
      - Interns and Residents cost centers
(2) The following Medicaid supplemental cost report schedule C Expenses:

- MDS Coordinator
- Quality Assurance (Infection Control) Coordinator
- Inservice (Training) Coordinator
- Ward Clerk (Unit Secretary)
- Property Insurance

(3) Directly assigned employee benefits and payroll taxes on schedule C of the Medicaid supplemental cost report

(4) Applicable allocation of pooled employee benefits and payroll taxes

3. Q: What costs are specifically excluded from the Administrative and Operating component?

A: (1) Nursing and Allied Health cost centers, Interns and Resident cost centers, ParaMed Education program cost centers, and the direct costs of all non-overhead (general service) cost center and non-routine SNF/NF cost centers

(2) General service (overhead) cost center expense allocation to non-SNF/NF routine cost centers, outpatient cost center, special purpose cost centers, and non-reimbursable cost centers, as determined by TennCare

(3) For hospital-based SNF/NF providers, overhead cost allocation to cost centers other than the routine SNF/NF cost centers

Capital Component (FRV)

1. Q: If a provider has 100 licensed beds, but not all are occupied, does the $1,000 per bed threshold requirement for Capital Improvement Update Requests apply to the total licensed beds or the number of beds occupied?

A: The $1,000 per bed threshold applies to the total licensed beds at the facility, even if all are not occupied.

2. Q: If the renovation I am submitting through a Capital Improvement Update Request adds licensed beds to the facility, do I calculate the $1,000 per bed threshold using the old licensed beds or the new licensed beds total?

A: The $1,000 per bed threshold should be calculated using the old licensed beds total. Licensed beds are updated each July 1 rate period using active licensed beds at the April 1 immediately before July 1, and the new licensed beds will be reflected at that time.
3. Q: If I am submitting a Capital Improvement Update Request, do the items have to be placed into service within the 12 months prior to the submission date, or the Capital Improvement Update Request due date?

A: Items reported on the Capital Improvement Update Request (CIUR) form must be placed into service within the 12 months prior to the date of submission of the CIUR form. For example, if an item was placed into service on July 1, 2017, and the CIUR form was submitted on June 2, 2018, the item will be considered during review of the CIUR. If the same item (placed into service on July 1, 2017) is included on a CIUR form submitted on September 30, 2018, the item will not be considered during review of the CIUR.

4. Q: What types of items/cost should be reported in the “non-nursing facility related” section of the Capital Improvement Update Request Form?

A: If your facility provides services for non-nursing facility levels of care, such as assisted living or hospital related services, the cost related to renovations impacting nursing and non-nursing facility levels of care must be segregated and separately identified and reported on the form, including the costs associated with shared or common areas. Should this segregation of cost require an allocation, a reasonable allocation method (square footage, census, etc.) must be selected and applied. Supporting documentation for any selected allocation method must be supplied with the filing of the CIUR form.

5. Q: If I have administrative or general areas in my facility that have undergone improvements, should these improvements be placed in the “non-nursing facility related” section of the Capital Improvement Update Request Form?

A: If your facility only provides nursing facility services, all of the cost related to these improvements should be reported as nursing facility related cost.

If your facility provides nursing facility and non-nursing facility levels of care services, the cost should be reasonably allocated between nursing facility and non-nursing facility levels of care, and support for this allocation must be provided.

6. Q: My facility just constructed a new building. What information do I need to send, and how is the cost of the new building treated for the capital component of the rate?

A: To reflect the value of any new building the Fair Rental Value (FRV) component of the reimbursement rate, the provider has two different opportunities.

First, if your facility meets certain reimbursement rule requirements, you may request a voluntary re-appraisal by sending a letter on official facility letterhead, which has been signed by the administrator or owner of the facility. The letter should also state how the facility meets the conditions for voluntary re-appraisal, and support showing that the facility meets the conditions for
voluntary re-appraisal should be submitted along with the request. The letter and supporting documentation should be sent to TNCasemix@mslc.com. The facility is responsible for the cost of any voluntary re-appraisal, and the new appraisal values will be subject to maximum land and facility value constraints.

Second, in lieu of a voluntary re-appraisal, a facility may submit the capitalized cost of the new building through a Capital Improvement Update Request (CIUR) form. The facility must meet certain reimbursement rule criteria for their CIUR submission to be deemed acceptable. Once accepted the cost from the CIUR will be included in the FRV rate calculation, with land and building maximum value constraints applied.

7. Q: Why is the land value listed on my rate sheet less than the land value determined during my facility’s appraisal?

A: In addition to the maximum allowable facility value, the provider is subject to a maximum allowable land value. This value is $7,500 per licensed bed. If the appraisal value for land falls below this maximum value, the appraisal will be utilized. If the appraisal value for land is higher than the maximum allowable land value, the maximum allowable land value will be utilized in determining the FRV (capital) component of the rate.

8. Q: I disagree with the results of my appraisal. How can I modify the appraisal values?

A: After the conclusion of the appraisal, you will receive the results from the TennCare Certified Appraisal Contractor. Once you have received these results, there is an appraisal or informal reconsideration time period of thirty (30) days, during which, you may file an appeal or informal reconsideration. Once this time has elapsed, you may not appeal the appraisal results.

There are two other mechanisms to update or alter the Fair Rental Value (FRV) rate for the facility. If you meet certain reimbursement rule requirements, your facility may be eligible to complete a voluntary re-appraisal process, with the new appraisal information being utilized in rate setting. The cost of the voluntary reappraisal is the responsibility of the provider. The other mechanism to adjust the FRV rate is for the facility to submit a Capital Improvement Update Request (CIUR) form. The submitted CIUR must meet certain criteria specified in the reimbursement rule to qualify as an acceptable submission.

Cost-Based Component

1. Q: Will the provider assessment continue with the Case-Mix Reimbursement System?

   A: Yes, the provider assessment process will continue with the Case-Mix Reimbursement System.
2. Q: Can I include tax assessed on equipment as property tax on my Supplemental Cost Report?
   A: No, tax assessed on equipment should not be included in the property tax amount on the Supplemental Cost Report. The property tax reported on the Cost Report shall only related to real estate tax associated with nursing facility functions.

**Quality Incentive Payment Per Diem**

1. Q: How much money is allocated each year for the quality incentive payment?
   A: Funding will be valued at no less than the greater of $40 million or 4% of the total projected fiscal year expenditures for nursing facilities. The quality incentive pool will increase at two times (2x) the rate of index factor inflation until the quality-based component is 10% of the total projected nursing facility expenditures and will remain at 10% thereafter.

**Budget Adjustment Factor (BAF)**

1. Q: What is the BAF?
   A: The Budget Adjustment Factor or BAF is a calculation applied to provider reimbursement rates in order to keep the expenditures of the nursing facility reimbursement system in line with the annual State budgetary appropriation. The BAF may increase or decrease overall provider reimbursement depending on the nursing facility budget target and the expected cost of the rate system.

   For the beginning of each State rate year effective July 1st, TennCare will establish a NF program budget target and compare that to the annual expected Medicaid expenditures of the reimbursement system for the upcoming rate year. TennCare will establish the BAF to adjust the annual expected Medicaid expenditures to meet the program’s NF budget target.

   - NF Budget Target / Rate System Expected Cost = BAF %

**Corridor Phase-In Adjustment**

1. Q: What does the corridor phase-in adjustment do?
   A: For rate setting periods from July 1, 2018 to June 30, 2020, a phase-in of provider reimbursement rates will occur. The phase-in adjustment will beestablished in an effort to ease the transition for providers to the case mix reimbursement system. The phase-in adjustment will utilize a corridor approach that will cap a facility’s loss/gain from the previous reimbursement system, in order to prevent providers from being impacted by large reimbursement swings due to the changing reimbursement system.
2. Q: How is the prior system rate calculated on the new Case-Mix Reimbursement rate sheets?
   A: Based on reimbursement rates in effect on July 1, 2017 as determined on January 1, 2018.
   - Weighted Average NF1/NF2 per diem (weighted based on CRYE 2016 NF1/NF2 cost report days)
   - PLUS: Quarterly Quality Bridge Payment estimated per diem
   - PLUS: Quarterly Acuity Bridge Payment estimated per diem
   - EQUALS: Total base reimbursement rate
   - MULTIPLY: Index factor (midpoint base year to midpoint rate year)
   - EQUALS: Total rate year base reimbursement rate for corridor

3. Q: What periods are included in the quarterly bridge payments used in the calculation of the prior system reimbursement rates?
   A: Quarter 1 and 2 were calculated from actual SFY 2018 data while quarters 3 and 4 were estimated based on the quarter 2 amount.

**Change of Ownership (CHOW)**

1. Q: What is the provisional spending floor adjustment waiver for CHOW’s and how do I obtain the waiver?
   A: For providers that have gone through a change of ownership process, a request for a provisional waiver of the direct care spending floor may be granted. In order to qualify for the provisional waiver the new ownership group must have been created through an arm’s length non-related party change of ownership transaction. The provider must then submit to Myers and Stauffer, at TNCaseMix@mslc.com, a signed letter from the nursing facility’s new ownership group requesting the provisional direct care spending floor waiver, and attesting that the change of ownership (CHOW) was as a result of a non-related party transaction. Please note that being granted a waiver of the direct care spending floor application is only provisional in nature. After submission of cost reports for the new ownership group, and a review by the Office of the Comptroller of the Treasury, the new ownership cost will be used to retroactively settle the direct care spending floor.

**Case Mix Index (CMI)**

1. Q: Is the CMI calculation based on weighted days or snap shot?
   A: The Tennessee case mix reimbursement system will utilize a Time Weighted CMI value calculation approach. The resident MDS assessments are weighted based on the number of calendar days that the assessment is active within a given semi-annual rate period.
2. Q: Is the State grouper RUGS 34 or RUGS 48?
A: The Tennessee case mix reimbursement system will utilize the RUG-IV 48 grouper for Medicaid rate setting purposes.

3. Q: How is the cost report period case mix index calculated?
A: Rate period CMIs that occur during portions of the cost reporting period will be weighted by the amount of time that they occur during the cost report year. For example, a NF provider with a 1/1/2016 to 12/31/2016 cost reporting period would have a nursing facility cost report period case mix index calculated by the following: 
\[
\frac{(7/1/2016 – 12/31/2016 \text{ Rate Period CMI} \times 91 \text{ days}) + (1/1/2017 – 6/30/2017 \text{ Rate Period CMI} \times 183 \text{ days}) + (7/1/2017 – 12/31/2017 \text{ Rate Period CMI} \times 92 \text{ days})}{366 \text{ days}}, \text{ rounded to 4 decimals.}
\]

<table>
<thead>
<tr>
<th>Portion of Cost Report Year</th>
<th>CMI Period</th>
<th>Rate Period Utilizing CMI</th>
<th>Days for Weighted Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2016 through 3/31/2016</td>
<td>10/1/2015 through 3/31/2016</td>
<td>7/1/2016 through 12/31/2016</td>
<td>91 (includes leap day)</td>
</tr>
<tr>
<td>4/1/2016 through 9/30/2016</td>
<td>4/1/2016 through 9/30/2016</td>
<td>1/1/2017 through 06/30/2017</td>
<td>183</td>
</tr>
<tr>
<td>10/1/2016 through 12/31/2016</td>
<td>10/1/2016 through 3/31/2017</td>
<td>7/1/2017 through 12/31/2017</td>
<td>92</td>
</tr>
</tbody>
</table>

4. Q: Will there be a change in the MDS process?
A: Providers should now be familiar with the MDS calculation process that Myers and Stauffer will utilize going forward. The quarterly clean-up process and End-of-Therapy date reconciliation process will continue to occur and be utilized for reimbursement under the new case mix reimbursement system.

Please refer to the Myers and Stauffer Tennessee website (www.mslc.com/Tennessee) for further information and training concerning the MDS assessment and Case Mix Index (CMI) calculation process.
1. Q: Which QuILTSS period will be utilized in the reimbursement rates beginning July 1, 2018?

A: For the rate year beginning July 1, 2018, QuILTSS periods 9 and 10 will be utilized for scoring and reimbursement purposes.

For the rate year beginning July 1, 2019, QuILTSS periods 10 and 11 will be utilized for scoring and reimbursement purposes.

For rate years beginning July 1, 2020 and beyond, QuILTSS scoring be based on the submitted information for the previous calendar year. For example, the July 1, 2020 rate year will utilized submitted QuILTSS information for January 1, 2019 through December 31, 2019.