

# Frequently Asked Questions (FAQ) Revised as of 11/12/19

**Note:** All questions and comments related to the expected budget and changes to the timeframe for implementation are outside the scope and intent of this document. Therefore, these questions/comments should be addressed directly through DSS or through communication with your provider association.

**Q1: What is the expected timeframe for implementation of an acuity-based reimbursement system?**

**A:** An acuity-based rate methodology is currently scheduled for an implementation date of 7/1/2020.

**Q2: Will the MDS assessments “clean-up” review only be utilized for modeling purposes?**

**A:** The MDS assessment information available for a “clean-up” period will be used for both modeling and rate setting. The formal “clean-up” process of assessment records will be for active MDS assessments (for all payer types) during the 10/1/2017 – 9/30/2018 time period, to align with the base year cost reports that will be utilized for the new acuity-based reimbursement system. These records will be used in the “cost normalization” process, which removes the effects of acuity from allowable base year direct care cost (see 9/3/2019 presentation slide #19 for an example calculation). The “clean-up” period is designed to allow providers an opportunity to review and revise missing or misstated MDS assessment records in order to have the most accurate historical information available for the “cost normalization” process.

**Q3: Why are the 2018 year-end cost reports being used as the base year cost report for the acuity-based reimbursement system, rather than 2019 year-end cost reports which are more recent?**

**A:** The 2018 year-end cost reports will be the most recent desk reviewed cost reports available for the 7/1/2020 rate setting. There will not be time for the 2019 year-end cost reports to complete the desk review cycle prior to the 7/1/2020 rate-setting and, therefore, can not be used.

**Q4: With the new acuity-based reimbursement system scheduled for implementation at 7/1/2020, what MDS assessment records will be used for the 7/1/2020 rate setting?**

**A:** It is anticipated that periodic (quarterly) updates to provider reimbursement rates will be made under the new reimbursement system in order to account for changes in provider resident acuity over time. The MDS assessments information used for these periodic rate adjustments will be for active assessment beginning six (6) months prior and ending three (3) months prior to the rate effective date. For the 7/1/2020 reimbursement rate, active Medicaid payer source MDS assessments from 1/1/2020 – 3/31/2020 would be used for rate setting purposes.

**Q5: When should providers begin preparing for the transition to the new acuity-based reimbursement system?**

**A:** Providers should begin preparing now for the transition. This would begin with ensuring that all transmitted MDS assessments (regardless of payer type) are complete and accurate. Additional communications and training will be made available in the upcoming months to assist providers in the transition process.

**Q6: What payer source will Medicaid-pending residents be classified as for reimbursement purposes?**

**A:** Medicaid-pending residents will be considered as part of the Medicaid payer source for reimbursement purposes. The MDS 3.0 RAI manual specifies that in the A0700 field of the MDS assessment a “+” sign can be used to indicate Medicaid-pending status, which Myers and Stauffer uses to categorize the Medicaid-pending residents into the Medicaid payer source. More detailed information and training relating to Medicaid payer source determination and other related MDS and RUG-IV classification information will be forthcoming.

**Q7: Why has DSS made the determination to proceed with a RUG-IV implementation now, when the Patient-Driven Payment Model (PDPM) classification system will be available beginning 10/1/2019?**

**A:** While the PDPM classification system will be available for the Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS) on 10/1/2019, there is not sufficient information available on the MDS assessments for non-Medicare (i.e., Medicaid, commercial payers, etc.) residents to classify into PDPM categories. The Centers for Medicare & Medicaid Services (CMS)

has not committed to a date when all elements for PDPM categorization will be available for non-Medicare resident assessment intervals.

Given the uncertainty of when PDPM information will become available for non-Medicare residents and the focus on NF reimbursement modernization and LTSS rebalancing efforts, DSS has chosen to proceed with the acuity-based categorization system (RUG-IV) that is currently available for the Medicaid population. It is expected that the transition from a RUG-IV model to a PDPM model will be a smooth and simple transition, given the similarities in calculation between RUG-IV and the PDPM nursing component.

**Q8: During the September 3<sup>rd</sup> provider presentation the modeling of various phase-in methods was discussed, will providers be able to choose which method would individually apply to them?**

**A:** No, while multiple phase-in approaches will be part of the modeling process, ultimately DSS will select a single phase-in methodology that would apply to all facilities state-wide.

**Q9: Has a fiscal impact been completed regarding the expected cost increase of MDS staffing due to the new rate methodology?**

**A:** It is not anticipated that a material increase in MDS staff time will be experienced by the provider community due to the transition to an acuity-based reimbursement system.

**Q10: Will the transition to an acuity-based reimbursement system require any changes to the current MDS assessment schedule?**

**A:** No, the federally-required MDS assessment schedule and completion intervals will remain unchanged.

**Q11: Will a fee schedule rate for each RUG category be calculated and posted?**

**A:** No, the new acuity-based reimbursement system will not mimic the Medicare SNF PPS payment methodology. Instead, a single facility-specific rate will be calculated and communicated to each provider. Each provider's rate will be updated four (4) times per year and fluctuate based on the Medicaid acuity (Medicaid case mix index) of their specific residents.

The methodology demonstrated on Slide 19 of the 9/3/2019 Myers and Stauffer presentation can be used by providers to assist with creating their own facility-specific rate estimates. We will evaluate the need for potential rate add-ons to support specific conditions or care needs. There will be future discussions with DSS and industry representatives to determine implementation and fiscal impact communication strategies that will be most helpful to providers.

**Q12: For the secure MDS web portal that is being developed by Myers and Stauffer, will corporate staff be allowed access to the web portal, or will only local facility staff be granted access?**

**A:** Access for both corporate and local facility staff to the secure MDS web portal access will be allowable.

**Q13: Will the new acuity-based reimbursement system incorporate certain current reimbursement system mechanics like, the geographic rate adjustment for Fairfield county and limitations on certain provider expenditures?**

**A:** A final determination on the parameters and variables of the new reimbursement system has not been made by DSS. A detailed modeling process will be performed to assist DSS in establishing appropriate reimbursement policy for the new system. The current reimbursement system geographic adjustment, cost limitations, and other current system variables (amongst other items) will be taken into consideration in the modeling process.

**Q14: Will the new acuity-based reimbursement system include “efficiency incentives” or other mechanisms to promote efficient care?**

**A:** Many rate system options and variables, including efficiency incentives, will be considered during the modeling process. The modeling process will be designed to assist DSS in obtaining sufficient information to make informed reimbursement policy decisions when finalizing rate system parameters.

**Q15: Effective 10/1/19, CMS will only allow for MDS assessment corrections up to two (2) years past the MDS target date, rather than the current three (3) year period. How will this shortened timeframe impact the “clean-up” period for the 10/1/17-9/30/18 MDS submissions?**

**A:** DSS and Myers and Stauffer are aware of the change in the MDS correction window instituted by CMS and will communicate a solution and an associated update to the FAQ in the near future.

**Q16: Will a listing of the CMS RUG-IV 48 grouper CMI values be provided?**

**A:** DSS is in the process of making several decisions with respect to the case mix grouper. Once these decisions have been finalized a listing of RUG-IV 48 grouper CMI values will be provided.

**Q17: Are providers required to set up their software systems to include a State Medicaid Grouper and Alternate State Medicaid Grouper.**

**A:** The State Medicaid Grouper or Alternate State Medicaid Grouper field information is not used by Myers and Stauffer during the case mix index calculation process and therefore is not required. Providers may set up their software systems at their own discretion.

**Q18: Under the current reimbursement system, only the Medicaid portion of physical therapy, speech language pathology (therapy), and respiratory therapy are considered to be allowable expenses, with occupational therapy being excluded. Will the new acuity-based reimbursement system change what is considered to be allowable therapy?**

**A:** No, the acuity-based reimbursement system does not change the definitions of allowable cost for therapy expenditures. Additionally the RUG-IV 48 CMI grouper uses the nursing-only case mix weights and therefore does not adjust reimbursement rates for the estimated resource use of therapy staff. In other words, by using the nursing-only weights, expense for therapy provision is not considered twice in the reimbursement process.

**Q19: How often will new base-year cost report information be incorporated into the new acuity-based rate system?**

**A:** It is anticipated that new, more recent cost reporting information will be included in the rate setting system (i.e. a rebase) every 2-4 years.

**Q20: Should providers anticipate a change in the review/audit cycle of cost reporting information with the transition to the new acuity-based reimbursement system?**

**A:** No, there are not any anticipated changes to the cost report submission or audit/review process.

**Q21: Does the state foresee any changes to reimbursement methodology for capital, fair rental value, or the provider user fee (PUF) during the initial implementation of the acuity-based reimbursement system?**

**A:** It is not anticipated that the reimbursement methodology for capital, fair rental value, and the PUF will be modified for the initial implementation of the acuity-based reimbursement system at 7/1/2020. However, future phases of the reimbursement modernization process may consider these areas.