Frequently Asked Questions (FAQ) 5/26/2022

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: Staffing costs have increased in cost years subsequent to cost year 2019. Is there any consideration about this for the case mix?

A: Legislative rate increases were provided to increase wage rates for nursing home employees on 7/1/2019, 10/1/2020, 1/1/2021 and 7/1/2021. These increases will continued to be included in case mix rates issued on 7/1/2022 in the form of a wage add-ons. Additionally, a 4.5% increase will also be made effective for 7/1/2022, and will be calculated based on reimbursement rates after 7/1/2022 phase-in considerations have been applied.

Q2: Can you provide, prior to implementation, the positive or negative impact relative to the new payment system versus the change in the selected cost year. Providers would like to see if the rate change was substantially due to a structural shift in cost with the next year selected or the acuity in the building?

A: Providers can compare their 9/30/2018 Rate Computation Reports and current issued rates to the provided cost year 2019 shadow rate reports to determine their estimated change in allowable cost and reimbursement rates related to implementation of the case mix reimbursement system. A review of these reports and rates will provide the information needed to determine the portion of the rate change attributable to the change in base year and portion attributable to acuity.

Q3: What are the benefit enhancements that were discussed during the Industry call on April 15, 2022?

A: Special Act 21-5 appropriated $15 million to the department of Social Services, for Medicaid, for the fiscal year ending June 30, 2023 for the purpose of adjusting nursing home rates for facilities that provide enhanced health care and pension benefits for facility employees. These appropriated funds will be integrated into case mix reimbursement rates as of 7/1/2022 for all qualifying providers. For additional information regarding this program, please visit the following link: https://portal.ct.gov/dss/Health-And-Home-Care/Medicaid-Nursing-Home-Reimbursement/Medicaid-Nursing-Home-Reimbursement

Q4: Are the Stop Loss ($0.00 limit in SFY 2023) and Stop Gain ($6.50 limit in 2SFY 023), related only to the direct care cost change? If your rate goes up or down in other categories, wage index etc. will the facility still receive the total $6.50 gain?

A: The $6.50 Stop Gain for SFY 2023 is determined on each provider's total reimbursement rate. The Stop Loss/Stop Gain will be reevaluated each calendar quarter to account for changes in provider case mix. A provider's case mix reimbursement rate from July 1, 2022 and beyond will be compared to the current reimbursement system's rate ("Issued Rate") in effect immediately preceding the 7/1/2022 rate period. If the providers rate under the case mix reimbursement system is more than $6.50/day greater than the providers issued rate under the current system, the facility will receive the maximum $6.50/day gain in SFY 2023.

There is are two exception to the Stop Loss/Stop Gain phase-in process. Those exceptions are as follows:

1. The 7/1/2022 4.5% wage index add-on will be calculated on the providers total reimbursement rate after application of the Stop Loss/Stop Gain rate phase-in considerations (excludes the benefits enhancement).

2. The benefits enhancement (as described in the response to Q3 above), will be calculated separately for the case mix reimbursement rate and phase-in considerations, and will be an additional add-on to qualifying provider's reimbursement rates.

Q5: How are the case mix growth/neutrality factors calculated? Will the case mix growth/neutrality factors be calculated and applied to all providers, or just those that have not reached the Stop Loss/Stop Gain limitations.

A: All providers and their associated case mix index values will be utilized in calculation of the case mix growth/neutrality factors each quarter. The base line value for comparison will be the Medicaid day-weighted statewide average Medicaid CMI values utilized for the July 1, 2022 reimbursement rates. This is based on MDS assessment records from January 1, 2022 – March 31, 2022.

Q6: How will base year 2019 medians be adjusted to account for inflation?

A: Medians are based on 2019 year end costs inflated to the mid-point of SFY 2022. The inflated costs and the associated inflation index values are available for view in the shadow rate sheet that were prepared and sent to providers for the 10/1/2021, 1/1/2022, and 4/1/2022 periods.

Q7: How long will the 2019 cost reports be utilized as the base year for the case mix reimbursement system rates?

A: It is anticipated that the 2019 cost reports will be utilized as the base year allowable costs, at a minimum, through the phase-in period of the case mix reimbursement system. However, a formal determination of the next base year for provider allowable costs has not yet been determined.

Q8: How will specialized patient populations be reimbursed under the Case Mix reimbursement system?

A: Provider Ventilator and AIDS units will continue to be reimbursed under their current cost based per diem methodology, which is separate and distinct from the case mix reimbursement system. DSS will not be incorporating separate or enhanced reimbursement for any other specialized resident population at the current time. However, providers should continue to contact DSS with issues or concerns related to access or payment for specific resident populations for future consideration.

Q9: Should a provider note issues with a resident's MDS record or classification on a Myers and Stauffer's Resident Roster Report, does the MDS need to be modified? How would providers make those modifications?

A: For modification/correction of MDS records, providers should follow the guidelines in chapter 5 of RAI manual. All modification/correction of MDS records must be transmitted and accepted by CMS system prior to the published Myers and Stauffer cut-off date for inclusion in the Connecticut case mix reimbursement system. There is no Connecticut specific MDS acceptance/correction system or portal. The 2022 Connecticut Department of Social Services Time-Weighted Monthly Report Calendar and the **Time-**weighted CMI Resident Roster User Guide published by Myers and Stauffer (pg. 15 offers provider's helpful tips for their review of the quarterly preliminary Resident Rosters) can be found at the following website link:

https://myersandstauffer.com/client-portal/connecticut/connecticut-case-mix/

Q10: Will Myers and Stauffer be issuing any guidance to supplement the RAI manual regarding what type of documentation is acceptable to code certain items on the MDS?

A: At the current time no additional RAI manual supporting documentation requirements or guidelines have been issued by DSS. However, it is expected that providers continue to follow RAI manual requirements for maintenance of appropriate documentation to support required care planning processes and MDS submissions. DSS is evaluating their oversight processes relating to the case mix reimbursement system, and as such, further information on this and other important topics will be provided where appropriate.

Q11: For questions relating to the MDS, resident insurer payer status, or published resident rosters who should I contact?

A: Providers should contact the Connecticut MDS Help Desk at 800.763.2278 or by email at CTHelpDesk@mslc.com for specific questions and concerns. Additionally, helpful information regarding resident roster calculation and classification can be found in the Time-weighted CMI Resident Roster User Guide which is available at the following website link:

https://myersandstauffer.com/client-portal/connecticut/connecticut-case-mix/

Q12: Are there any plans to use the PDPM resident classification system for case mix index values as opposed to RUGs based classification system currently proposed?

A: DSS will be evaluating the Patient-Driven Payment Model (PDPM) as a future enhancements to the case mix reimbursement system. However, the RUG-IV 48 grouper resident classification system will be utilized as the basis for the case mix reimbursement system as of 7/1/2022.