STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

IMPORTANT MEMO

DATE: March 7, 2013

TO: TennCare Nursing Facility (NF) Providers

FROM: Patti Killingsworth, Assistant Commissioner
Chief of Long Term Services and Supports (LTSS)

CC: TennCare Managed Care Organizations
Casey Dungan, Chief Financial Officer
Jay Taylor, Acting Deputy, LTSS Audit & Compliance
Gregg Hawkins, Assistant Director, Division of State Audit, Office of the Comptroller of the Treasury

SUBJECT: Non–Recurring Acuity-Based Rate Adjustments for FY 2013

As you know, the FY 2013 budget recommended by the Governor and passed by the General Assembly included $8 million ($23.6 million state and federal) for non-recurring acuity rate adjustments for NF services provided the current fiscal year. This non-recurring appropriation allows us to modify the rate methodology for services provided in this fiscal year in order to help account for the higher acuity of residents served as a result of level of care changes that became effective July 1, 2012.

The approach by which those rate adjustments will be made has been developed in consultation with the Tennessee Health Care Association (THCA), LeadingAge Tennessee, individual NF provider representatives, and other LTSS stakeholder groups.

Relying primarily on data sources provided by the facility, i.e., the facility's cost reports and Minimum Data Set submitted to CMS, per diem direct care costs for each facility are neutralized based on the facility's overall facility Case Mix Index (acuity of all residents served in the facility), capped at the 90th percentile, and then adjusted based on the acuity of Medicaid residents and the number of Medicaid days provided by the facility. This is consistent with the principles that have guided this process, primarily:

- Acuity adjustments should help to account for increased direct care costs associated with serving persons with higher acuity of need.
- Acuity adjustments should reflect the volume of Medicaid residents served in the facilities.
- Leverage cost reports and existing data sources to simplify and streamline the process.

A summary of the methodology, including the guiding principles and the process by which payments will be made is attached.

Please note that these adjustments which help to complete the reimbursement rates for NF services during FY 2013 are non-recurring. It is our hope to work with stakeholders to finalize by July 1, a new approach to reimbursing NFs that recognizes varying acuity levels of residents served in the facilities, emphasizes overall quality of care, and encourages a focus on improved patient centered outcomes.

Methodology for Non-Recurring Acuity-Based Rate Adjustments for Nursing Facilities

Principles:

The entire FY 2013 $23.6 million appropriation will be distributed to Medicaid NFs for non-recurring acuity-based rate adjustments.

Payments will not exceed the total appropriation.

Acuity adjustments should help to account for increased direct care costs associated with serving persons with higher acuity of need.

Acuity adjustments should reflect the volume of Medicaid residents served in the facilities.

Cost reports and existing data sources should be leveraged to simplify and streamline the process.

Facilities that do not participate in the Medicaid program (i.e., have withdrawn but continue to receive payment for residents remaining in the facility) are not eligible for an acuity adjustment.

Facilities that have been decertified, including facilities that are decertified between now and the distribution of payments by TennCare in each payment cycle, are not eligible for an acuity adjustment.

If a facility is not eligible for an acuity adjustment, the amount of the payment will be returned to the total pool and distributed among remaining facilities pursuant to the methodology defined herein.

Approach:

Step 1: Determine each facility's annualized total direct care costs. This will be the total medical and nursing cost line item on each facility's cost reports. If the costs are not reflective of a 12-month reporting period, the costs will be annualized. This amount will **not** include other related costs such as dietary, laundry, employee benefits, etc. The cost report that will be utilized is the most recently filed complete cost report reviewed by the Comptroller's Office.

Step 2: Determine the overall Case Mix Index (CMI) and the Medicaid CMI (i.e., Medicaid residents *only*) for each facility. This will be calculated by Myers & Stauffer by taking the most recent (i.e., within the applicable quarter) MDS score for each resident (or in the case of the Medicaid CMI, each Medicaid resident) served in the facility during a particular quarter, and then averaging the most recent MDS scores for all residents (or all Medicaid residents, as applicable) served in the facility during that quarter. The facility's CMI for four consecutive quarters will be averaged to determine their CMI for the adjustment cycle.

In order to ensure that the Medicaid population is properly accounted for in the Medicaid CMI, Myers & Stauffer will submit the entire MDS file to TennCare. TennCare will match the files to persons enrolled in the CHOICES program during any of the four quarters included in the adjustment cycle and will provide a list of all persons whose MDS scores should be included in calculating the Medicaid CMI.

Step 3: Determine the number of total patient days for each facility. This will be taken from the facility's cost reports as described in Step 1.

Step 4: Determine the total number of Medicaid Level 1 and Level 2 days for each facility. This will be taken from the facility's cost reports as described in Step 1 and TennCare data sources used for rate setting purposes.

Step 5: Determine each facility's unweighted (i.e., not adjusted by acuity) per diem direct care costs. This will be the facility's total direct care costs (Step 1 above) divided by total patient days (Step 3 above).

Step 6: Determine each facility's case mix neutral per diem direct care costs. This will be calculated by dividing each facility's unweighted per diem direct care costs (Step 5 above) by the facility's average overall CMI (Step 2 above).

Step 7: Apply a 90th percentile cap to the case mix-neutral per diem direct care costs for each facility.

Step 8: Determine the capped Medicaid acuity-adjusted per diem direct care costs for each facility. This will be calculated by multiplying each facility's case mix neutral per diem direct care costs (Step 6 above limited to the 90th percentile in Step 7 above) by the facility's average Medicaid CMI (Step 2 above).

Step 9: Determine the total capped Medicaid acuity-adjusted direct care costs for each facility. This will be calculated by multiplying each facility's capped Medicaid acuity-adjusted per diem direct care costs (Step 8 above) by the total of the facility's Medicaid Level 1 and Level 2 bed days (Step 4 above).

Step 10: Determine each facility's percentage of the total capped Medicaid acuity-adjusted direct care costs across all facilities. This will be calculated by dividing the total capped Medicaid acuity-adjusted direct care costs for each facility (Step 9 above) by the total of all facilities' capped Medicaid acuity-adjusted direct care costs.

Step 11: Determine each facility's distribution of the total non-recurring acuity adjustment amount. This will be calculated by multiplying each facility's percentage of the total capped Medicaid acuity-adjusted direct care costs across all facilities (Step 10 above) by the total amount of the non-recurring acuity adjustment to be disbursed.

Implementation of the Proposed Approach:

Complete one non-recurring acuity adjustment cycle, subject to the principles defined above. Each facility will receive two payments for the cycle (one from each MCO), inclusive of all acuity adjustments for NF services. For ease of administration, individual claims will **not** be reprocessed.

The acuity adjustment cycle will include the last 2 quarters of FY 2012 MDS data and the first 2 quarters of FY 2013 MDS data (i.e., ending December 31, 2012). This payment will be targeted for late Spring 2013, allowing all funds to be disbursed by the end of the fiscal year.

All calculations will be reviewed with THCA prior to their distribution.

Payments will be made to the MCOs, who will in turn pay the facilities the full payment amount as determined pursuant to the methodology defined herein.

Payments will be made by the MCO within the next monthly payment cycle, i.e., no more than 30 days after disbursement by TennCare.