

Medicaid Only Case Mix and Semiannual Scores
Questions and Answers

Q1. Is the semiannual score calculated as a simple average of two quarterly scores?

A1. Yes. For example, the semiannual facility average medicaid case mix score for the payment period beginning July 1 for a given fiscal year shall be the average of the quarterly facility average medicaid case mix score from the preceding December and March reporting quarters.

Q2. Will the median annual score for the peer group be used as a replacement score for a missing quarterly score in determining the semiannual score?

A2. No. The quarterly scores specified in proposed OAC 5101:3-3-43.3 for use in the semiannual score must be available for each payment period. Situations in which quarterly scores may not be available are the following:

- For the nursing facility new to the Medicaid program, the direct care rate shall be determined in accordance with proposed OAC 5101:3-3-65 . The initial direct care rate shall be determined by using the median annual case mix score from the base year for the nursing facility's peer group.
- For the nursing facilities that change provider agreements, the direct care rate shall be determined in accordance with proposed OAC 5101:3-3-65.1. The initial direct care rate for the entering operator shall be the rate the exiting operator would have received. The direct care rate will not be subject to case mix adjustment until the next fiscal year.
- For the nursing facility that fails to submit MDS data or insufficient MDS data to determine a facility case mix score, a penalty score shall be assigned for that particular quarter. The penalty score, as specified in proposed OAC 5101:3-3-43.3, shall then be used in calculating the semiannual score.
- For the nursing facility that does not have any Medicaid records for a particular quarter the median annual case mix score from the base year for the facility's peer group shall be assigned as the semiannual score.

Q3. Would the rate reconsideration process be appropriate if a facility thinks a resident should have been included in the Medicaid score?

A3. The rate reconsideration process would be appropriate if an error was made in the calculation of the quarterly facility average medicaid case mix score for the following reason:

- The resident was eligible for Medicaid on the assessment reference date (ARD) and eligibility had been determined on or before the deadline for processing the semiannual facility average case mix score, but the resident's case mix score was not included in the final quarterly calculation.

Q4. Could there be another final check for Medicaid eligibility prior to calculating the semiannual score?

A4. Yes. An extra step will be added to the semiannual process to recheck the eligibility status of the record selected for the quarterly score prior to the calculation of the semiannual score. For the semiannual score effective July 1, this extra step would most likely only have an impact for the December quarter due to the short time frame between the deadline for calculating the case mix score for the March quarter and the deadline for calculating of the semiannual score. For the semiannual score effective January 1, this extra step would most likely only have an impact for the June quarter due to the short time frame between the deadline for calculating the case mix score for the September quarter and the deadline for calculating of the semiannual score.

Q5. What if the resident is dual eligible and the Medicare assessment is combined with the initial or quarterly assessment. Will the record be included as a Medicaid assessment? If not included, what does the facility do to get the record included?

A5. No. JFS will not include the Medicare assessments (AA8b = 1, 2, 3, 4, 5, 7, 8) in the mix of Medicaid assessments. The facility may complete another assessment after the resident is no longer in a Medicare Part A stay.

Q6. If the resident assessment schedule indicates that both a Medicare assessment and an OBRA assessment are due should two separate assessments be done; one as the Medicare and another with a different ARD for the OBRA assessment in order to have the resident's record identified as a Medicaid record?

A6. No. When a resident is in a Medicare Part A stay and the OBRA assessment time frame coincides with the Medicare assessment time frame, it is appropriate to complete one assessment. Completing two separate assessments for the purpose of including a resident in a Medicare Part A stay as a Medicaid record is not permitted and may constitute Medicaid fraud.

Q7. What if the record is coded Medicare at the end of the quarter but had a non-Medicare assessment earlier in the quarter. Will a record be included as Medicaid?

A7. No. There is no change in the process for selecting records in effect on the reporting period end date. If the most recent record for the quarter is a record coded as Medicare, the record will not be included in the Medicaid score.

Q8. Could the CDJFS be made aware that updates to CRISE for those residents with a pending Medicaid status are critical to the NF rate setting process?

A8. Yes. The Bureau will work with the Bureau of Consumer and Program Support and the Medical Assistance Coordinators to ensure that the county case workers are aware of the rate setting issues for NF residents in a Medicaid pending status.

Q9. Will we no longer have the quarterly case mix score affecting the quarterly rate? What is the semiannual rate if Medicaid Only becomes effective 7/1/06? It is our understanding that the rate was frozen per statute through 6/30/06, and therefore any earlier case mix scores can not be used. Is this correct?

A9. HB66 changed the nursing facility direct care rate adjustment from a quarterly to a semiannual adjustment. The quarterly case mix scores as specified in OAC 5101:3-3-43.3 will be used to determine the semiannual case mix scores. The quarterly scores from calendar year 2005 will not be used for fiscal year 2006 (7/1/05 – 6/30/06). CY2005 annual case mix score will be used only for quality incentive payments pursuant to ORC Section 5111.244. The December 2005 score will be used for fiscal year 2007 case mix adjustment. In order to determine a semiannual score for 7/1/06, the December 2005 and March 2006 scores will be used.

Case mix scores will be adjusted twice a year, July 1 and January 1 of the fiscal year, instead of four times a year.

Q10. What criteria will determine an assessment's inclusion in the facility's case mix score calculation under the new Medicaid Only case mix methodology?

A10. The method for selecting Medicaid records for the new reimbursement system was shared with nursing home associations on 2/27/06. To qualify as a Medicaid record, the SSN on the MDS must match a SSN on Medicaid's recipient master file (RMF) and the assessment reference date (ARD) must fall within the recipient's Medicaid eligibility span. Medicare assessments will be excluded. (See Attachments 1 and 2)

Q11. If we have a quarterly MDS with Medicaid pending status during the quarter, if Medicaid eligibility comes through before the end of the quarter, will we have to complete another MDS with the Medicaid recipient number coded?

A11. No additional MDS assessment or modification will be required. A non-Medicare record's SSN must match the SSN of a resident in the Medicaid RMF and the ARD must be contained within the Medicaid eligibility span. This matching process will be routinely done for weekly, preliminary, and final reports every quarter. (Also see answer to Q4)

Q12. If there are no other quarterlies in a quarter, just an initial assessment combined with the Medicare 5-day assessment, and if you don't do another quarterly before the end of the quarter, then this resident's record wouldn't be used in the facility case mix score calculation. Is this correct? Or would a Medicaid resident at the end of the quarter, with the only assessment during the quarter being a Medicare assessment, be assigned the default score or would the record not count at all?

A12. The RUGs score assigned to a Medicaid selected record will be determined by the same method since the inception of the MDS 2.0. A resident whose most recent

assessment is a Medicare one will not be flagged as a Medicaid record on the reporting period end date (see also A15). In this case, the resident's record would not be used when determining the quarterly facility average medicaid case mix score.

Q13. Will Ohio be providing more detailed information for software vendors about Medicaid Only?

A13. There are no programming requirements for software vendors. HIPAA precludes vendors having access to the Medicaid RMF. However, the Medicaid record determination criteria will be posted on the ODJFS and ODH websites. Nursing facilities will need to contact their vendors if they desire a software program that will **approximate** the quarterly facility average medicaid case mix score.

Q14. When stating that the ARD must be within the Medicaid eligibility span, does it also mean the ARD must be within the time frame for which Medicaid payment is in effect? For example: If a long term patient is currently in a Medicare stay, and a quarterly is due and completed but without a Medicare reason in AA8b - will it apply to the Medicaid only case mix for the quarter, or will another assessment be required after the Medicare stay has ended?

A14. When a resident is in a Medicare Part A stay and the OBRA assessment time frame coincides with the Medicare assessment time frame, it is appropriate to complete one assessment. Completing two separate assessments for the purpose of including a resident in a Medicare Part A stay as a Medicaid record is not permitted and may constitute Medicaid fraud. If the timing requirements for the Medicare assessments and the OBRA assessments do not coincide, it may be appropriate to complete separate assessments. There is no change in the method for selecting records for a particular quarter. The software program looks for the last assessment of the quarter for each resident in the facility (or discharged return anticipated) on the reporting period end date. In determining the quarterly facility average medicaid case mix score only those records selected for the quarter that have been flagged as Medicaid will be used in the calculation. In the example given, if the last record for the quarter was the quarterly assessment (OBRA only) it would be included when calculating the quarterly facility average medicaid case mix score.

Q15. If patient X has an OBRA assessment on 1/10 and Medicare assessments on 3/10 and 3/15, is the software programmed to look for the last assessment of the quarter and then quit because the 3/15 assessment is Medicare or will it continue to go back in time and determine if there is any OBRA assessment in the quarter that qualifies?

A15. There is no change in the method for selecting records for a particular quarter. The software program looks for the last assessment of the quarter for each resident in the facility (or discharged return anticipated) on the reporting period end date. In the example given, the record with the ARD of 3/15 would be selected for the March

reporting period end date. However, only those records flagged as Medicaid records will be used to calculate the quarterly facility average medicaid case mix score. (Also see answer to Q7)

Attachment 1

Medicaid-Only Record Selection

Step 1

- ❖ Medicare assessments are coded in items AA8b or A8b as 1 (Medicare 5 day assessment), 2 (Medicare 30 day assessment), 3 (Medicare 60 day assessment), 4 (Medicare 90 day assessment), 5 (Medicare readmission/return assessment), 7 (Medicare 14 day assessment), or 8 (Other Medicare required assessment).
- ❖ If a Medicare assessment, then flag the record as MCARE for Medicare assessment.
- ❖ If record is not flagged as MCARE, then go to Step 2.

Step 2

- ❖ If not a Medicare assessment, then check for a SSN match on the Recipient Master File (RMF). If there is no SSN match, then flag record as NSSN for no SSN match.
- ❖ If record coded 08 on discharge tracking form (resident discharged prior to completing initial assessment) and grouped as CC1, then check for SSN match on RMF. If there is no SSN match, then flag record as NSSN for no SSN match.
- ❖ If the SSN is a match, then go to Step 3.

Step 3

- ❖ If the assessment reference date (ARD is Item A3a) is not within the Medicaid eligibility span, then flag record as “NELIG” for not Medicaid eligible.
- ❖ If the assessment date is within the eligibility span, then go to Step 4.
- ❖ If the resident discharged, and if the resident coded 08 and groups as CC1, then if R4 (discharge date on the discharge tracking form) within the eligibility span, then go to Step 4.

Step 4

- ❖ Flag the record as “MCAID” for Medicaid record.

ATTACHMENT 2

MEDICAID-ONLY RECORD DETERMINATION

