Ohio Administrative Code

Rule 5160-3-43.1 Nursing facilities (NFs): case mix assessment instrument - minimum data set version 3.0 (MDS 3.0).

Effective: March 1, 2016

(A) As used in this rule:

(1) "Annual facility average case mix score" is the score used to calculate the facility's cost per case-mix unit.

(2) "Assessment reference date (ARD)" is the last day of the observation (or "look back") period that the MDS 3.0 assessment covers for the resident.

(3) "Case mix report" is a report generated by the Ohio department of medicaid (ODM) and distributed to the provider on the status of all MDS 3.0 assessment data that pertains to the calculation of a quarterly, semiannual, or annual facility average case mix score.

(4) "Comprehensive assessment" means an assessment that includes completion of the appropriate MDS 3.0 assessment type listed in paragraph (B)(2) of this rule.

(5) "Critical elements" are data items from a resident's MDS 3.0 that ODM verifies prior to determining a resident's resource utilization group (RUG) classification.

(6) "Critical errors" are errors in the MDS 3.0 critical elements that prevent ODM from determining the resident's RUG classification.

(7) "Default group" is the case mix group assigned to residents with MDS 3.0 records with inconsistent date fields, missing, incomplete, out of range, or inaccurate data, including inaccurate resident identifiers, any of which precludes grouping the record into non-default RUG groups.

(8) "Encoded," when used with reference to a record, means that the record has been recorded in electronic format. The record must be encoded in accordance with MDS 3.0 data submission specifications version 1.15.0.

(9) "Filing date" is the deadline for submission of the NF's MDS 3.0 assessment data that will be used to calculate the preliminary facility quarterly average case mix score. The filing date is the fifteenth calendar day following the reporting period end date (RPED).

(10) "MDS 3.0" is the uniform resident assessment instrument specified for use in Ohio pursuant to 42 C.F.R. 483.20 (October 1, 2014) for implementing standardized resident assessments and for facilitating care management in nursing facilities. The MDS 3.0 provides the core data elements used to group residents into case mix categories. It also includes Ohio-specific data elements, designated as section S. A copy of the section S requirements is available at http://medicaid.ohio.gov/PROVIDERS/ProviderTypes/LongTerm CareFacilities.aspx.

(11) "Medicare required assessment" means the MDS 3.0 that is required only for facilities participating in the medicare prospective payment system.

(12) "Other medicare required assessment (OMRA)" is an unscheduled MDS 3.0 prospective payment system (PPS) assessment required to be completed during a resident's medicare "Part A" SNF covered stay based on the start or cessation of rehabilitation services.

(13) "PPS assessment" is the MDS 3.0 that skilled nursing facilities (SNFs) use to assess the clinical condition for each medicare resident receiving "Part A" SNF level care for reimbursement under the SNF PPS.

(14) "Quarterly facility average total case mix score" is the facility average case mix score based on both medicaid and non-medicaid resident data submitted for one reporting quarter and calculated pursuant to paragraph (B)(1) of rule 5160-3-43.3 of the Administrative Code.

(15) "Quarterly facility average medicaid case mix score" is the facility average case mix score based on only medicaid resident data submitted for one reporting quarter and calculated pursuant to paragraph (B)(2) of rule 5160-3-43.3 of the Administrative Code.

(16) "Quarterly review assessment" means an assessment that is normally conducted no less than once every three months using the MDS 3.0.

(17) "Record" means a resident's encoded MDS 3.0 assessment as described in paragraphs (B)(1) to (B)(4) of this rule.

(18) "Relative resource weight" is the measure of the relative costliness of caring for residents in one case mix group versus another, indicating the relative amount and cost of staff time required on average for defined worker classifications to care for residents in a single case mix group. The methodology for calculating relative resource weights is described in paragraph (E) of rule 5160-3-43.2 of the Administrative Code.

(19) "Reporting period end date" (RPED) is the last day of each calendar quarter.

(20) "Reporting quarter" is the calendar quarter in which the MDS 3.0 is completed, as indicated by the assessment reference date in MDS 3.0 section A, item A2300, except as specified in paragraphs (C)(7) and (C)(8) of this rule.

(21) "Resident Assessment Instrument (RAI)" is the MDS 3.0 used by NFs in Ohio to comply with regulations in 42 C.F.R. 483.20.

(22) "Resident case mix score" is the relative resource weight for the RUG group to which the resident is assigned based on data elements from the resident's MDS 3.0 assessment.

(23) "Resident identifier code" is an alternative resident identifier if the resident does not have a social security number. The resident identifier code shall be reported in MDS 3.0 section S, item S0150. The following method must be used to construct the identifier code:

(a) In the first three boxes, enter the first three letters of the resident's last name.

(b) In the next six boxes, enter the six digits of the resident's date of birth.

(c) Omit the century in the birth date.

(24) "RUG" is the resource utilization groups system of classifying NF residents described in

paragraph (B) of rule 5160-3-43.2 of the Administrative Code. Resource utilization groups are clusters of NF residents defined by resident characteristics that correlate with resource use.

(a) For rates paid for services provided before July 1, 2016, the RUG version used in Ohio is version III (RUG III).

(b) For rates paid for services provided July 1, 2016 and thereafter, the RUG version used in Ohio shall be version IV (RUG IV).

(25) "Semiannual facility average medicaid case mix score" is the average of a facility's two quarterly facility average medicaid case mix scores. It is used to establish the direct care rate and is calculated pursuant to paragraph (E) of rule 5160-3-43.3 of the Administrative Code.

(B) For the purpose of assigning a RUG classification for determining medicaid payment rates for NFs, ODM shall utilize the data from the MDS 3.0. Each NF shall assess all residents of medicaid-certified beds using the appropriate MDS 3.0. When the assessment coincides with medicare assessment time frames, one assessment shall be used to satisfy both assessments. Admission assessments must be combined with either the medicare five day or medicare fourteen day assessment. For a resident who is not a new admission to the facility, the quarterly, annual, and significant change in status assessments must be combined with any medicare assessment if the assessment reference date (ARD) is within the assigned medicare observation period. When combining the assessments, the most stringent requirement for MDS completion must be met. ODM may not utilize the data in the other medicare required assessments (OMRAs) for calculating case mix scores or determining medicaid payment rates.

(1) Comprehensive assessments, medicare-required assessments, quarterly review assessments, and significant corrections of quarterly assessments must be conducted in accordance with the requirements and frequency schedule found at 42 C.F.R. 483.20.

(2) For a comprehensive assessment, NFs must use the MDS 3.0, including section S. The comprehensive assessment is completed as specified in the MDS 3.0 RAI manual. NFs must use the quarterly MDS 3.0, including section S, for the quarterly review assessment or a significant correction to a prior quarterly assessment. The nursing home PPS assessment must be used for all

medicare required assessments.

(3) NFs must use the MDS 3.0 discharge item set for any residents who transfer or are discharged, and the MDS 3.0 tracking record for any residents entering or reentering or who died in the facility in accordance with 42 C.F.R. 483.20.

(4) NFs must use the MDS correction request in section X of the MDS 3.0 for modification or inactivation of MDS records that have been accepted into the CMS database.

(C) All NFs must submit to the CMS database encoded, accurate, and complete MDS 3.0 data for all residents of medicaid certified NF beds, regardless of pay source or anticipated length of stay.

(1) MDS 3.0 data completed in accordance with paragraphs (B)(1) to (B)(4) of this rule must be encoded in accordance with MDS 3.0 data submission specifications version 1.15.0.

(2) MDS 3.0 data must be encoded. The data may be submitted at any time during the reporting quarter that is permitted by instructions in the MDS 3.0 RAI manual. Except as provided in paragraph (D) of this rule, all records used in determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score must be submitted by the filing date.

(3) If a NF submits MDS 3.0 data needed for determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score after the forty-fifth day after the RPED, ODM may assign a quarterly facility average total case mix score as set forth in paragraph (C)(3) of rule 5160-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as set forth in paragraph (D)(4) of rule 5160-3-43.3 of the Administrative Code.

(4) MDS 3.0 data submitted by a provider that can not be timely extracted by ODM from the CMS data server may result in assignment of a quarterly facility average total case mix score as set forth in paragraph (C)(3) of rule 5160-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as set forth in paragraph (D)(4) of rule 5160-3-43.3 of the Administrative Code.

(5) The annual facility average case mix score, quarterly facility average total case mix score, and quarterly and semiannual facility average medicaid case mix scores will be calculated using the MDS 3.0 record in effect on the RPED for:

(a) Residents who were admitted to the medicaid certified NF prior to the RPED and continue to be physically present in the NF on the RPED; and

(b) Residents who were admitted to the medicaid certified NF on the RPED; and

(c) Residents who were temporarily absent on the RPED but are considered residents and for whom a return is anticipated from hospital stays, visits with friends or relatives, or participation in therapeutic programs outside the facility.

(6) Records for residents who were permanently discharged from the NF, transferred to another NF, or expired prior to or on the RPED will not be used for determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score.

(7) For a resident admitted within fourteen days prior to the RPED, and whose initial assessment is not due until after the RPED, both of the following shall apply:

(a) The NF shall submit the appropriate initial assessment as specified in 42 C.F.R. 483.20 and in the MDS 3.0 RAI manual.

(b) The initial assessment, if completed and submitted timely in accordance with paragraphs (C)(1) and (C)(2) of this rule, shall be used for determining the quarterly facility average total case mix score and may be used for determining the quarterly facility average medicaid case mix score in the quarter the resident entered the facility even if the assessment reference date is after the RPED provided the record is identified as a medicaid record pursuant to the calculation methodology in rule 5160-3-43.3 of the Administrative Code.

(8) For a resident who had at least one MDS 3.0 assessment completed before being transferred to a hospital, then reenters the NF within fourteen days prior to the RPED, and has experienced a significant change in status that requires a comprehensive assessment upon reentry, the following

shall apply:

(a) The NF shall submit a significant change assessment within fourteen days of reentry, as indicated by the MDS 3.0 assessment reference date (MDS 3.0, item A2300).

(b) The significant change assessment shall be used for determining the quarterly facility average total case mix score and may be used for determining the quarterly facility average medicaid case mix score for the quarter in which the resident reentered the facility even if the assessment reference date is after the RPED provided the record is identified as a medicaid record pursuant to the calculation methodology in rule 5160-3-43.3 of the Administrative Code.

(D) Corrections to MDS 3.0 data must be made in accordance with the requirements in the MDS 3.0 RAI manual.

(1) For use in determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score, the facility must transmit the corrections to the CMS database no later than forty-five days after the RPED.

(2) For use in determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score, all significant correction assessments must contain an assessment reference date within the reporting quarter.

(3) The provider shall submit an accurate, encoded MDS 3.0 record for each resident in a medicaid certified bed on the RPED.

(a) The provider shall transmit MDS assessments that were completed timely but omitted from the previous transmissions and ODM shall use the resident case mix scores from the assessments for determining the quarterly facility average total case mix score, and may use them for determining the quarterly facility average medicaid case mix score if the assessments are transmitted no later than forty-five days after the RPED provided the record is identified as a medicaid record pursuant to the calculation methodology in rule 5160-3-43.3 of the Administrative Code. If the assessments are not transmitted within forty-five days after the RPED, ODM may assign a default group for those records.

(b) The provider shall notify ODM within forty-five days of the RPED of any records for residents in medicaid certified beds on the RPED that were not completed timely and were not transmitted to the CMS database. ODM may assign default scores to those records.

(c) The provider has forty-five days after the RPED to transmit the appropriate discharge assessment to the CMS database if more residents are determined to be in the facility on the RPED than the number of medicaid certified beds in the facility on that same date. If the facility does not correct the error within forty-five days after the RPED, ODM may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5160-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5160-3-43.3 of the Administrative Code.

(d) The provider shall notify ODM within forty-five days of the RPED of any residents who were reported to be residents of the facility on the RPED, but who had actually been discharged prior to the RPED. If the provider fails to correct the error within forty-five days after the RPED, ODM may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5160-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5160-3-43.3 of the Administrative Code.

(e) The provider has forty-five days after the RPED to submit appropriate modifications or discharge assessments to rectify any discrepancy between the records selected for determining the quarterly facility average total case mix score and the facility census on the RPED. If the facility does not correct the error(s) within forty-five days after the RPED, ODM may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5160-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5160-3-43.3 of the Administrative Code.

(4) If the provider's number of records assigned to the default group in accordance with paragraphs (D)(3)(a) and (D)(3)(b) of this rule is greater than ten per cent, ODM may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5160-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5160-3-43.3 of the Administrative Code.