Medicaid State Plan - Nursing Facilities

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Rules used solely for state plan purposes

State plan sections contained in 'non-institutional' state plan attachments processed through the Regional CMS Office in Chicago

* As referenced on the CMS-179 form. CMS approved the move of 5111.33.001 (5101:3-3-16.4) to Attachment 4.19C on 04/10/08

** Consider both locations when updating state plan

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TN # New Effective Date 10/16/09

Medicaid State Plan - Nursing Facilities
Attachment 4.19D - NF Supplement 1

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Sec. 5111.232. Medicaid Only Case-Mix

(A) (1) The department of job and family services shall determine semiannual and annual average case-mix scores for nursing facilities by using all of the following:

(a) Data from a resident assessment instrument specified in rules adopted under section 5111.02 of the Revised Code pursuant to section 1919(e)(5) of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1396r(e)(5), as amended, for the following residents:

(i) When determining semiannual case-mix scores, each resident who is a medicaid recipient;

(ii) When determining annual average case-mix scores, each resident regardless of payment source.

(b) Except as provided in rules authorized by divisions (A)(2)(a) and (b) of this section, the case-mix values established by the United States department of health and human services;

(c) Except as modified in rules authorized by division (A)(2)(c) of this section, the grouper methodology used on June 30, 1999, by the United States department of health and human services for prospective payment of skilled nursing facilities under the Medicare program established by Title XVIII.

(2) The director of job and family services may adopt rules under section 5111.02 of the Revised Code that do any of the following:

(a) Adjust the case-mix values specified in division (A)(1)(b) of this section to reflect changes in relative wage differentials that are specific to this state;

(b) Express all of those case-mix values in numeric terms that are different from the terms specified by the United States department of health and human services but that do not alter the relationship of the case-mix values to one another;

(c) Modify the grouper methodology specified in division (A)(1)(c) of this section as follows:

(i) Establish a different hierarchy for assigning residents to case-mix categories under the methodology;

(ii) Prohibit the use of the index maximizer element of the methodology;

(iii) Incorporate changes to the methodology the United States department of health and human services makes after June 30, 1999.

(B) The department shall determine case-mix scores for intermediate care facilities for the mentally retarded using data for each resident, regardless of payment source, from a resident assessment instrument and grouper methodology prescribed in rules adopted under section 5111.02 of the Revised Code and expressed in case-mix values established by the department in those rules.

(C) Each calendar quarter, each provider shall compile complete assessment data, from the resident assessment instrument specified in rules authorized by division (A) or (B) of this section, for each resident of each of the provider's facilities, regardless of payment source, who was in the facility or on hospital or therapeutic leave from the facility on the last day of the quarter. Providers of a nursing facility shall submit the data to the department of health and, if required by rules, the department of job and family services. Providers of an intermediate care facility for the mentally retarded shall submit the data to the department of job and family services. The data shall be submitted not later than fifteen days after the end of the calendar quarter for which the data is compiled. Except as provided in division (D) of this section, the department, every six months and after the end of each calendar year shall calculate a semiannual and annual average case-mix score for each nursing facility using the facility's quarterly case-mix scores for that six-month period or calendar year. Also except as provided in division (D) of this section, the department, after the end of each calendar year, shall calculate an annual average case-mix score for each intermediate care facility for the mentally retarded using the facility's quarterly case-mix scores for that calendar year. The department shall make the calculations pursuant to procedures specified in rules adopted under section 5111.02 of the Revised Code.

(D) (1) If a provider does not timely submit information for a calendar quarter necessary to calculate a facility's case-mix score, or submits incomplete or inaccurate information for a calendar quarter, the department may assign the facility a quarterly average case-mix score that is five per cent less than the facility's quarterly average case-mix score for the preceding calendar quarter. If the facility was subject to an exception review under

division (C) of section 5111.27 of the Revised Code for the preceding calendar quarter, the department may assign a quarterly average case-mix score that is five per cent less than the score determined by the exception review. If the facility was assigned a quarterly average case-mix score for the preceding quarter, the department may assign a quarterly average case-mix score that is five per cent less than that score assigned for the preceding quarter. The department may use a quarterly average case-mix score assigned under division (D)(1) of this section, instead of a quarterly average case-mix score calculated based on the provider's submitted information, to calculate the facility's rate for direct care costs being established under section 5111.23 or 5111.231 of the Revised Code for one or more months, as specified in rules authorized by division (E) of this section, of the quarter for which the rate established under section 5111.23 or 5111.231 of the Revised Code will be paid. Before taking action under division (D)(1) of this section, the department shall permit the provider a reasonable period of time, specified in rules authorized by division (E) of this section, to correct the information. In the case of an intermediate care facility for the mentally retarded, the department shall not assign a quarterly average case-mix score due to late submission of corrections to assessment information unless the provider fails to submit corrected information prior to the eighty-first day after the end of the calendar quarter to which the information pertains. In the case of a nursing facility, the department shall not assign a quarterly average case-mix score due to late submission of corrections to assessment information unless the provider fails to submit corrected information prior to the earlier of the forty-sixth day after the end of the calendar quarter to which the information pertains or the deadline for submission of such corrections established by regulations adopted by the United States department of health and human services under Titles XVIII and XIX.

(2) If a provider is paid a rate for a facility calculated using a quarterly average case-mix score assigned under division (D)(1) of this section for more than six months in a calendar year, the department may assign the facility a cost per case-mix unit that is five per cent less than the facility's actual or assigned cost per case-mix unit for the preceding calendar year. The department may use the assigned cost per case-mix unit, instead of calculating the facility's actual cost per case-mix unit in accordance with section 5111.23 or 5111.231 of the Revised Code, to establish the facility's rate for direct care costs for the following fiscal year.

(3) The department shall take action under division (D)(1) or (2) of this section only in accordance with rules authorized by division (E) of this section. The department shall not take an action that affects rates for prior

payment periods except in accordance with sections 5111.27 and 5111.28 of the Revised Code.

(E) The director shall adopt rules under section 5111.02 of the Revised Code that do all of the following:

(1) Specify whether providers of a nursing facility must submit the assessment data to the department of job and family services;

(2) Specify the medium or media through which the completed assessment data shall be submitted;

(3) Establish procedures under which the assessment data shall be reviewed for accuracy and providers shall be notified of any data that requires correction;

(4) Establish procedures for providers to correct assessment data and specify a reasonable period of time by which providers shall submit the corrections. The procedures may limit the content of corrections by providers of nursing facilities in the manner required by regulations adopted by the United States department of health and human services under Titles XVIII and XIX;

(5) Specify when and how the department will assign case-mix scores or costs per case-mix unit under division (D) of this section if information necessary to calculate the facility's case-mix score is not provided or corrected in accordance with the procedures established by the rules. Notwithstanding any other provision of sections 5111.20 to 5111.33 of the Revised Code, the rules also may provide for the following:

(a) Exclusion of case-mix scores assigned under division (D) of this section from calculation of an intermediate care facility for the mentally retarded's annual average case-mix score and the maximum cost per case-mix unit for the facility's peer group;

(b) Exclusion of case-mix scores assigned under division (D) of this section from calculation of a nursing facility's semiannual or annual average case-mix score and the cost per case-mix unit for the facility's peer group.

5101:3-3-43.1 Nursing facility (NF) case mix assessment instrument: minimum data set version 2.0 (MDS 2.0).

(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) "Case mix report" is a report generated by the Ohio department of job and family services (ODJFS) and distributed to the provider on the status of all MDS 2.0 assessment data that pertains to the calculation of a quarterly, semiannual or annual facility average case mix score.

(3) "Comprehensive assessment" means an assessment that includes completion of not only the MDS 2.0 designated for use in Ohio but also completion of the resident assessment triggers, the resident assessment protocols (RAPs), and the resident assessment protocols summary form.

(4) "Critical elements" are data items from a resident's MDS 2.0 that ODJFS verifies prior to determining a resident's resource utilization group, version III (RUG III) class.

(5) "Critical errors" are errors in the MDS 2.0 critical elements that prevent ODJFS from determining the resident's RUG III classification.

(6) "Default group" is RUG III group forty-five, the case mix group assigned to residents with MDS 2.0 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 RUG III groups one through forty-four.

(7) "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 the United States centers for medicare and medicaid services (CMS) uniform data submission document and state specifications.

(8) "Filing date" is the deadline for submission of the NF's MDS 2.0 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).

(9) "Locked" means a record has been accepted into the state database.

(10) "MDS 2.0 correction request form" (CRF) is the mechanism used to request correction of error(s), to identify the inaccurate record and to attest to the correction request. A correction request can be made to either modify or inactivate an MDS 2.0 assessment record or an MDS 2.0 discharge or reentry tracking form that has been previously accepted into the state MDS 2.0 database.

(11) "Medicare required assessment" means the MDS 2.0 specified for use in Ohio that is required only for facilities participating in the medicare prospective payment system but does not include the triggers, RAPs, and RAP summary form.

(12) "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 5101:3-3-43.3 of the Administrative Code.

(13) "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 5101:3-3-43.3 of the Administrative Code.

(14) "Quarterly review assessment" means an assessment that is normally conducted no less than once every three months using the MDS 2.0 designated for use in Ohio that does not include the triggers, RAPs, and RAP summary form.

(15) "Record" means a resident's encoded MDS 2.0 assessment as described in paragraphs (B)(1) to (B)(5) of this rule.

(16) "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 (H) of rule 5101:3-3-43.2 of the Administrative Code.

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

(18) "Reporting quarter" is the calendar quarter in which the MDS 2.0 is

completed, as indicated by the assessment reference date in MDS 2.0 section A, item 3a, except as specified in paragraphs (C)(7) and (C)(9) of this rule.

(19) "Resident Assessment Instrument (RAI)" is the instrument used by NFs in Ohio to comply with 42 code of federal regulations (CFR) section 483.20 (10-1-04 edition http://www.gpoaccess.gov/cfr/index.html) and provides a comprehensive, accurate, standardized, reproducible assessment of each long term care facility resident's functional capabilities and identifies medical problems. The Ohio specified and federally approved instrument is composed of the MDS 2.0, triggers, RAPs and the RAP summary form.

(20) "Resident case mix score" is the relative resource weight for the RUG III group to which the resident is assigned based on data elements from the resident's MDS 2.0 assessment.

(21) "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 2.0 item S12. Refer to instructions in the section S state of Ohio supplement located at http://www.odh.ohio.gov/odhprograms/io/mds/mds_btins.aspx

(22) "RUG III" is the resource utilization groups, version III system of classifying NF residents into case mix groups described in paragraph (B) of rule 5101:3-3-43.2 of the Administrative Code. Resource utilization groups are clusters of NF residents, defined by resident characteristics, that correlate with resource use.

(23) "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 calculated pursuant to paragraph (E) of rule 5101:3-3-43.3 of the Administrative Code.

(B) For the purpose of determining medicaid payment rates for NFs effective October 1, 2000 and thereafter, ODJFS shall accept the RAI specified by the state and approved by CMS. Each NF shall assess all residents of medicaid-certified beds as defined in this rule, using the MDS 2.0 as set forth in appendix A or appendix E of this rule.

(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 CFR section 483.20 (10-1-04 edition

http://www.gpoaccess.gov/cfr/index.html).

(2) NFs must use the Ohio specified MDS 2.0, as set forth in appendix A of this rule, including sections S, T, and W for all comprehensive assessments, significant change assessments, and significant correction assessments. NFs may use the Ohio specified MDS 2.0 as set forth in appendix A of this rule including sections S, T, and W for the quarterly review assessment.

(3) NFs must use the MDS 2.0 discharge tracking form as set forth in appendix B of this rule for any residents who transfer, are discharged or expire, and the MDS 2.0 reentry tracking form as set forth in appendix C of this rule for any residents reentering the facility in accordance with 42 CFR section 483.20.

(4) NFs must use the MDS correction request form as set forth in appendix D of this rule for modification or inactivation of MDS records that have been accepted into the state MDS database.

(5) NFs may use the MDS medicare PPS (prospective payment system) assessment form (MPAF) (http://www.odh.ohio.gov/odhprograms/io/mds/mds_vendor.aspx) as set forth in appendix E of this rule for all medicare required assessments. When the assessment reference date (ARD) is subsequent to the RPED, the date of entry (MDS 2.0 item AB1) must also be submitted for medicaid rate setting purposes as delineated in the "CMS Revised Long-Term Care Resident Assessment Instrument User's Manual version 2.0" (December 2002, http://www.cms.hhs.gov/nursinghomequalityinits/20_nhqimds20.asp). NFs may use the MPAF as set forth in appendix E of this rule for quarterly review assessments.

(C) Effective July 1, 1998, all NFs must submit to the state encoded, accurate, and complete MDS 2.0 data for all residents of medicaid certified NF beds, regardless of pay source or anticipated length of stay.

(1) MDS 2.0 data completed in accordance with paragraphs (B)(1) to (B)(5) of this rule must be encoded in accordance with 42 CFR section 483.20, CMS' uniform data submission document, and state record layout specifications.

(2) MDS 2.0 data must be submitted in an electronic format and in accordance with the frequency schedule found in 42 CFR section 483.20. The data

may be submitted at any time during the reporting quarter that is permitted by instructions issued by the state, except as provided in paragraphs (D) and (E) 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 2.0 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, ODJFS may assign a quarterly facility average total case mix score as set forth in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as set forth in paragraph (D)(3) of rule 5101:3-3-43.3 of the Administrative Code.

(4) MDS 2.0 data submitted by a provider that can not be timely extracted by ODJFS 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 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as set forth in paragraph (D)(3) of rule 5101:3-3-43.3 of the Administrative Code.

(5) The annual, semiannual, and quarterly facility average total case mix score and quarterly facility average medicaid case mix score will be calculated using the MDS 2.0 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 the MDS 2.0 manual (December 2005 http://www.cms.hhs.gov/nursinghomequalityinits/20_nhqimds20.asp) and in 42 CFR 483.20.

(b) The initial assessment, if completed and submitted timely in accordance with paragraph (C)(6)(a) of this rule, shall be used for determining the quarterly facility average total case mix score and 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.

(8) For a resident discharged prior to the completion of an initial assessment, all of the following shall apply:

(a) The NF shall submit a discharge tracking form with the reason for assessment (MDS 2.0, item AA8a) coded as "08" (zero eight), discharged prior to completing initial assessment.

(b) The discharge status (MDS 2.0 item R3) shall be coded "1" through "9" as appropriate.

(c) The resident specific case mix score for clinically complex category, group twenty-two, class "CC1" shall be assigned for a resident of the facility on the RPED who was either:

(i) Admitted in the final fourteen days of the calendar quarter and whose initial assessment was not completed because the resident was discharged or expired.

(ii) Admitted in the final thirty days of the calendar quarter and was admitted to the hospital prior to the completion of the initial assessment, and is still in the hospital on the RPED.

(9) For a resident who had at least one MDS 2.0 assessment completed before being transferred to a hospital, who 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 2.0 assessment reference date (MDS 2.0, item A3).

(b) The significant change assessment shall be used for determining the quarterly facility average total case mix score and 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.

(D) Corrections to MDS 2.0 data must be made in accordance with the requirements in the "CMS Revised Long Term Care Resident Assessment Instrument User's Manual version 2.0", and the "State Operations Manual" issued by CMS (http://new.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage) and,

(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 state 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 2.0 record for each resident in a medicaid certified bed on the RPED.

(a) The provider shall transmit MDS 2.0 assessments that were completed timely but omitted from the previous transmissions and ODJFS shall use the resident case mix scores from the assessments for determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score, if the assessments are transmitted no later than forty-five days after the RPED. If the assessments are not transmitted within forty-five days after the RPED, ODJFS may assign a default group for those records.

(b) The provider shall notify ODJFS 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 state. ODJFS may assign default scores to those records as described in paragraph (F) of rule 5101:3-3-43.2 of the

Administrative Code.

(c) The provider has forty-five days after the RPED to transmit the appropriate discharge tracking form to the state, if more residents are determined as being in the facility on the RPED than the number of its medicaid certified beds. If the facility does not correct the error within forty-five days after the RPED, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(3) of rule 5101:3-3-43.3 of the Administrative Code.

(d) The provider shall notify ODJFS 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, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(3) of rule 5101:3-3-43.3 of the Administrative Code.

(e) The provider has forty-five days after the RPED to submit appropriate modifications or discharge tracking records 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, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(3) of rule 5101:3-3-43.3 of the Administrative Code.

(4) If the provider's number of records assigned to the default group in accordance with paragraphs (D)(4)(a) and (D)(4)(b) of this rule is greater than ten per cent, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(3) of rule 5101:3-3-43.3 of the Administrative Code.

OS Notification

State/Title/Plan Number:	**Ohio 09-024**	
Type of Action:	**SPA Approval**	
Required Date for State Notification:	**March 31, 2010**	
Fiscal Impact:	**FY 2010**	**$ 0**
	FY 2011	**$ 0**

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: **Effective for services on or after October 16, 2009, this amendment contains a revision to the correction period for minimum data set (MDS) version 2.0 submissions from nursing facilities (NF). Specifically, this amendment shortens the time period, from 80 to 45 days, in which a provider must make corrections.**

Other Considerations:

This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

Recovery Act Impact:

The Regional office has reviewed this state plan amendment in conjunction with the Recovery Act and, based on the available information provided by the State regarding 1) MOE; 2) local match; 3) prompt pay; 4) rainy day funds, and 5) eligible expenditures, the Regional Office believes that the State is not in violation of the Recovery Act requirements noted above.

CMS Contact:

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