Washington State Department of Social and Health Services

Transforming Lives

HOW TO READ THE FACILITY RUG REPORT

Purpose of Report

The Nursing Facility RUG Report shows the RUG-IV case mix group and weight for each resident and calculates the Medicaid Average Case Mix Index and Facility Average Case Mix Index. The case mix indices are used to calculate the direct care component of the total nursing facility rate.

Description of the Report

The RUG report is divided into four sections: the page header, column headings, detail, and report footer:

The Page Header

The report title identifies 1) the source of the report, Washington State – Aging and Disabilities Services Administration, 2) the type of report, a "Facility RUG Report for:", and 3) the name of the nursing facility. Below this is the For Dates:, which are the dates the report covers.

The upper right-hand corner of the report identifies date information including: 1) the Report Run Date: MM/DD/YYYY, and 2) Assessments Received as of: MM/DD/YYYY. Below this are the page numbers of the report.

The left hand corner gives the Case Mix quarter or semi-annual and whether it is a Preliminary, Revised Preliminary (Second and Fourth Quarters are 'finalized' but will also be included in the next semi-annual so the 'finalized' quarterly report is called a Revised Preliminary since you can still make corrections up to the Final RUG Report) or Final RUG Report. Below this information is the name of the Rate Analyst assigned to the nursing facility.

Column Headings	Definition:
Facility Id	The CMS internal Facility ID
Resident Name	The resident's last and first name

Resident ID This is a unique identifier that is assigned by CMS the very first time data for a particular resident is transmitted to CMS.

Assess. Ref. Date (A2300) This is the last day of the MDS observation period for the assessment. A blank in this column indicates that there is no assessment and the resident has been classified into a default group.

Stay Day Periods -

Start Date - Start Dates denote the opening of a case mix specific time period. The start date initiates the counting of the number of stay days assigned to a case. It will be the beginning of the quarter (example 10/1/10), the admission date or re-entry date (if the resident was admitted or readmitted after the start of the quarter), the ARD (A2300) date of a new assessment, or the due date for an assessment (default condition).

End Date - denote the closing to a case mix specific time period. The end date terminates the counting of the number of stay days assigned to a case. It will either be the end of the quarter (example: 12/31/10), the discharge date (if the resident was discharged before the end of the quarter), the date prior to a new assessment ARD (A2300) date, or the date prior to the due date for an assessment (default condition).

Payor - The resident can have one of two payor designations: Medicaid or Other. These are determined based on A0700 of the MDS or default status. A resident with a valid client ID number or "+" in A0700 will receive the "Medicaid" designation. A stay period in default will receive the "Medicaid" designation. All others will be labeled Other.

Number of Stay Days - The number of stay days is calculated by subtracting the start date from the end date and adding one day. The maximum number of stay days is the number of days in the quarter or six month semi-annual period. Note that days of discharge are not paid for and are deducted from the maximum number of stay days.

Case Mix Group (Index Maximizing Grouper):

RUG Description - This is the RUG-IV classification description into which the resident groups. There are 57 possible classifications plus the default group. If a facility discharges a resident before completing an initial assessment, the resident dies or is discharged to the hospital prior to completing an initial assessment, or misses a quarterly assessment, it will be coded as "default" for the non-compliant portion of their stay and counted as "Medicaid" for all reports and rate purposes. For residents without an assessment who are discharged with A2100 = 03 Acute hospital or 08 Deceased, the RUG description will be Special h 11-14D^. For all other defaults the Rug Description will be Default.

RUG - This is the RUG-IV code that corresponds to the RUG-IV classification above. Special h 11-14D^ = HD2. Default = BC1.

Case Mix Weight - This is the RUG-IV case mix weight that corre-sponds to the RUG-IV classification into which the resident groups. Note that the case mix weights are specific to Washington State.

The Detail

The detail section of the report lists each resident with resident identifiers, related assessment information, the number of stay days that are used in computing the weighted average case mix indices, the corresponding RUG-IV classification and case mix weight. The detail information is sorted by Resident name and then chronologically sorted by the Start Date.

The Report Footer

The report footer identifies:

Total Number of Stay Days - This is a total of all of the stay days for all of the residents for this facility for this reporting period.

Medicaid Average Case Mix Index The Medicaid average case mix index (MACMI) is calculated by multiplying the Medicaid resident's
number of stay days by their case mix weight.

$$\frac{\sum i\ (\text{Stay Days}_i \bullet \text{CMI}_i)}{\sum i\ \text{Stay Days}_i}$$

- The results of this multiplication are summed and divided by the total number of Medicaid stay days. The MACMI is calculated both with and without defaults. The Medicaid payor type and residents that default are both identified in the payor column.

Facility Average Case Mix Index The facility average case mix index (FACMI) is calculated by multiplying the number of stay days by the case mix weights. The results of this multiplication are summed and divided by the total number of stay days for all residents. The FACMI is calculated without default cases.

Legend - The Legend defines the following items used in the RUG Description column:

Special h 11-14D^ = Died/Discharged to hospital prior to completing initial assessment.

Default = Discharged prior to day 14 without transmitting an initial assessment OR no timely assessment.

Residents Excluded - This is a list of residents for which we were unable to determine stay days so they are not included in the CMI calculations.

Important items to check on your RUG report:

1. Resident ID: If a resident has more than one number please contact the MDS Automation Coordinator.

2. Stay Period End Date: If the resident is not in the facility on the End Date, please check to see if there has been a Discharge successfully submitted and if so, that the A1600 Entry Date is the correct date.

3. Payor: If the resident is listed as Other and should be Medicaid, check MDS A0700. This item must contain a 9-digit Medicaid number or a + to be listed as Medicaid. The Medicaid number is found in the lower right corner of the Award Letter. Note: Defaults will show up as Payor Medicaid.

4. Residents Excluded: This list is residents for which the computer got confused. This is usually caused by two entries in a row without an intervening discharge or two discharges in a row without an intervening entry. Frequently this is caused by an incorrect A1600 Entry Date.

Who to Contact:

MDS Help Desk: MDSHelpdesk@dshs.wa.gov

For copies of prior RUG reports no longer posted to the MDS 3.0 server or questions about how a RUG report item affects rates: Bobbie Howard 360-725-2474
Bobbie.Howard@dshs.wa.gov