The Default Primer Nursing Home Medicaid Payment System, Washington State

What is 'default' in nursing home payment?

Default, as used in the Washington State Medicaid Payment System, is actually a 'default case.'

"Default case" in RCW 74.46.020 (14) means no initial assessment has been completed for a resident and transmitted to the department by the cut-off date, or an assessment is otherwise past due for the resident, under state and federal requirements.

A default case presents the following problem: ALTSA (Aging and Long-Term Support Administration) cannot assign a Resource Utilization Group (RUG) because of no Minimum Data Set (MDS) assessment for the time period in question.

RUG scores are important to nursing facilities because they are used to calculate a final case mix score, which determines the *direct care portion* of the facility Medicaid rate. Since Washington State Medicaid rates are by facility rather than by resident, default cases can have fiscal impact.

What are the 'default groups'?

When a RUG score cannot be calculated, the resident is assigned one of two "default" groups, BC1 or HD2.

BC1- An initial/scheduled assessment or discharge is untimely or not completed. The lowest score of .87 is assigned.

HD2 - The RUG score is calculated at a higher level (3.596 as of June 24, 2015) and is assigned when a resident:

Expires during the first 14 days of a stay prior to completion of an initial MDS assessment;
or
Is discharged to an acute care hospital prior to completion of an initial MDS assessment.

How many default cases does it take to affect the nursing home rate?

It is possible that even one default may affect the final casemix score, which, in turn, may affect the facility rate. All records transmitted (for any payment source of Medicare, Medicaid, or private pay) are, to some extent, factored into the Medicaid rate. A complex weighted average is mathematically derived based on a number of factors such as the size of the facility, RUG group, the length of stay for a particular resident, location, and the total number of residents.

How is a casemix rate determined?

Washington State casemix is determined using two indexes along with allowable costs to establish the **direct care** Medicaid rate:

1. Medicaid Average CaseMix Index - (MACMI) which is **with defaults** – This index is used to set the rate semiannually and includes 1) all Medicaid days and rug weights and 2) all defaults, regardless of funding source. Rates are affected by the MACMI results of a semi-annual period. E*xample: the July rate uses October/March MACMI and the January rate uses April/September MACMI.*

2. Facility Average CaseMix Index - (FACMI) which is **without defaults** - This index is used only when rebasing (see item 3) to calculate the cost per case mix unit. The FACMI used in a rebase is a weighted average calculation, using all 4 quarters of a designated year. The FACMI uses all payer types, e.g., Medicaid, Medicare, private, etc.

3. The term "rebasing*" refers to the following department definition: **Rebased rate** or **cost-rebased rate** means a facility-specific component rate assigned to a nursing home for a particular rate period established on desk-reviewed, adjusted costs reported for that facility covering at least six months of the calendar year. That year is designated to be used for cost-rebasing payment rate allocations under the provisions of RCW 74.46.

4. How the rate calculation works - The direct care rebase allocation (3 above) which uses the adjusted allowable cost is divided by the four quarter FACMI (2 above). This is now called the 'cost per casemix unit.' The cost per casemix unit is then compared to the facility's Peer Group Median cost per casemix unit. If the facility's cost per casemix unit is greater than the Peer Group Median cost per casemix unit, the facility's cost per casemix unit will now be the Peer Group Median cost per casemix unit. If the facility's cost per casemix unit is equal to or less than the Peer Group Median, the facility will keep its own cost per casemix unit. Finally the resulting cost per casemix unit is multiplied by the MACMI (1 above) to determine the direct care payment rate allocation. The direct care payment rate allocation is calculated on a semi-annual basis using this methodology. On a facility specific basis, the higher the MACMI, the higher the rate. In general, reducing defaults is a good way to increase the MACMI.

What kinds of assessments are used for rate setting?

OBRA (except discharge assessments) and Scheduled Medicare Assessments are factored into the Medicaid rate.

With **Facility Average CaseMix Index**, ALTSA looks at all of the assessments used for rate setting, EXCEPT those in default.

With **Medicaid Average CaseMix Index**, ALTSA considers ALL assessments used for rate setting to see:
If the assessment is a Medicaid assessment; or
If any assessment is in default. If either or both criteria apply, the assessment is included in the calculations.
Assessments are counted based on:

1. The A2300 assessment reference date;
2. If a transmitted record is not a discharge or an entry (A0310F 01, 10, 11 or 12);
3. If a transmitted record is not an unscheduled PPS (A0310B 07)

Note: PPS assessments for anything other than direct Medicare are not to be submitted to CMS. Therefore, if a Managed Care (or private insurance) resident is in the facility less than 14 days, the only way to prevent a default is to complete an early Admission Assessment. Admission Assessments must have the whole process completed, included the CAA's.

How much time elapses, after MDS transmittal, before a nursing home knows of any default scores and other resident RUG scores?

A facility does not know the semi-annual RUG scores until ALTSA produces the Final RUG report. They should, however, review their Validation Reports and other reports for errors that give indications of errors and problems that will result in defaults. A preliminary RUG report is posted on the MDS 2.0 Submission website under State Reports for 2nd and 4th quarters and 1st and 2nd Semi-annual periods as a courtesy to facilities and to give a last chance for error corrections. Later the final RUG report is produced and posted on the MDS 2.0 Submission website. State law only requires a final semi-annual RUG report.

RUG Report Run Schedule:

1st semi-annual runs 10/1 through 3/31. The preliminary RUG is run in April around the 15th and posted as soon as possible. The final RUG cutoff date is one month and one day after the end of the semi-annual period.

2nd quarter runs 4/1 through 6/30. The preliminary RUG report will be run in July around the 15th and posted as soon as possible. The Revised RUG cutoff date is one month and one day after the end of the quarter.

2nd semi-annual runs from 4/1 to 9/30. The preliminary RUG report will be run in October around the 15th and posted as soon as possible. The final RUG cutoff date is one month and one day after the end of the quarter.

4th quarter runs 10/1 through 12/31. The preliminary RUG report will be run in January around the 15th and posted as soon as possible. The Revised RUG cutoff date is one month and one day after the end of the quarter.

Note: If the Cut-off date falls on a weekend or Holiday, the next business day will be the final cut-off. Occasionally, due to exceptional circumstances, the cut-off date will be extended.

2020 RUG Report Run Schedule – see link on webpage

2021 RUG Report Run Schedule – see link on webpage

What reports, other than the RUG report, can help prevent defaults?

The Final Validation Report is the most important tool available to help you avoid default cases. Additionally, several other online reports can give you clues of potential problems. Look in CASPER for these reports. You need to have an MDS login to access CASPER and access is obtained through a link on the MDS Welcome page.

Final Validation Report - This report is found in CASPER under Folders. There will be a folder with your facility ID and ending with VR. Regularly review the Final Validation Report warnings/errors. These are system messages regarding items that could result in defaults. If you are perplexed by a message, please investigate and, if need be, contact ALTSA (360-725-2620) or the iQIES Help Line (1-800-339-9313).

Also, reconcile each transmission with the Validation Report. This will help you find assessments that were in a batch but either were rejected or did not transmit at all.

MDS Missing Assessment Report - lists the last assessment received (except for discharges) for any resident who has not had another MDS within the past 138 days. Anyone on this list should have either a discharge or an assessment that needs to be transmitted.

Roster Report - lists all the residents currently in the facility. If there is someone listed who is no longer there, check to see if a discharge has been successfully submitted. Also check to see if someone is listed twice. If the computer thinks they are two people, one of the 'people' will eventually default.

Residents Discharged - lists all discharges submitted during the time period requested. Check to see if all the people who discharged during this time period are on the list.

MDS Activity Report - lists all MDS successfully submitted within the date range specified. This report is a good double-check to see if everything you thought you had submitted was successfully submitted.

Common Reasons for NH Payment Default

Initial Assessment Not Timely - A facility fails to set the ARD (Assessment Reference Date) in a timely manner.

Example: A Medicaid resident was admitted to a nursing home and an initial assessment is not completed with an ARD on or before day 14. The resident remains in the facility.

An assessment with an ARD on or after day 15 will result in a **BC1** default.

Scheduled Assessment Not Timely - When a facility fails to set the ARD for a scheduled quarterly assessment in a timely manner, a BC1 default occurs.

Example: A Medicaid resident in a nursing home has had an initial OBRA assessment completed. The resident remains in the facility and the first quarterly review is due and the ARD is set late, resulting in a default grouping of BC1.

A default occurs where no assessment is completed by the end of 92 days plus the 5-day grace period. The default is calculated back to the due date of the new assessment. The date used for measurement is the ARD in A2300.

Lacking Assessment at Discharge -

Scenario #1 – Discharge With No Assessment Ever - When a resident is discharged with no assessment completed with an ARD on or before the 14th day (the date of entry plus 13 additional days) a default occurs**.** The Discharge Status disposition in field A2100 determines the default:

BC1 - Discharge status codes **01, 02, 04, 05, 06, 07, 09**or **99** give a BC1 default.
HD2 - Discharge status code **03** (**Acute care hospital**) or **08** (**Deceased**) gives a HD2 default except in the circumstance of status code 5 followed by a return to the nursing home during the quarter.

Scenario #2 – Discharge With Assessment Due - When a resident has had at least one assessment completed and then is discharged with a discharge status code of 05 (Acute care hospital) or 08 (Deceased) at the time another assessment is due, a default occurs. Timing determines the default:

BC1 – Discharged to the hospital or deceased after the current assessment expires but during the 5-day grace period.

HD2 – Discharged to the hospital or deceased after not only the current assessment expires, but also beyond the 5-day grace period. The exception to this rule occurs when status code 05 is followed by a return to the nursing home during the quarter.

Resident Wrongly Identified - Through data input error in one or more of the fields related to the resident identification (Name, DOB, SSN, and Gender), a new Resident ID is erroneously created and, as a result, an individual has more than one Resident ID. This causes default since each Resident ID contains only part of the assessment data. A default of 'BC1'** will eventually appear for one or both of the Resident ID's.

No Discharge - If a resident leaves the facility and a discharge assessment or tracking form is not successfully submitted there will eventually be a BC1 default.

A1600 = A2000 - If a resident left the same day they entered a facility, that is fine. However, if there is a prior entry date without a discharge for this client, the computer will assume the resident discharged then returned on the same day and will show the person as still in the facility. Even if the discharge was a death in facility tracker.

Contact Information

MDS Technical Questions / MDS Clinical Questions / NH Rates		
MDS Help Desk	MDS Helpdesk@dshs.wa.gov	
Federal QIES Help Line	800-339-9313	
MDS Technical Questions	**Betty Metz** MDS Automation Coordinator	360-725-3432 Betty.Metz@dshs.wa.gov
MDS Clinical Questions	**Donna Zaglin** RAI Coordinator / Case Mix Accuracy Review Program Manager	360-725-2487 Donna.Zaglin@dshs.wa.gov
NH Rates Questions:	**Bobbie Howard** Rates Analyst	360-725-2474 Bobbie.Howard@dshs.wa.gov

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