Rule 15. Nursing Facilities; Electronic Transmission of Minimum Data Set

405 IAC 1-15-1 Scope

Sec. 1. (a) Nursing facilities certified to provide nursing facility care to Medicaid members are required to electronically transmit minimum data set (MDS) information for all nursing facility residents to the office. Such MDS information shall include the resident's room number on all comprehensive or quarterly MDS assessments and tracking forms. The MDS data is used to establish and maintain a case mix system for Medicaid reimbursement to nursing facilities and other Medicaid program management purposes.

(b) Nursing facilities certified to provide nursing facility care to Medicaid members are required to electronically transmit the end of therapy date for physical, occupational and speech therapy services provided to a resident in a format specified by the Office.

405 IAC 1-15-2 Definitions

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "Case mix reimbursement" means a system of paying nursing facilities according to the mix of residents in each facility as measured by resident characteristics and service needs. Its function is to provide payment for resources needed to serve different types of residents.

(c) “End of therapy date” means the date each therapy regimen ended for physical therapy, occupational therapy, or speech therapy, which is the last date the resident received therapy treatment.

(d) "Minimum data set" or "MDS" means a core set of screening and assessment elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicaid. The items in the MDS standardize communication about resident problems, strengths, and conditions within the facilities, between facilities, and between facilities and outside agencies. The Indiana system will employ the MDS 3.0 or subsequent revisions as approved by CMS.

405 IAC 1-15-4 MDS supporting documentation requirements

Sec. 4. (a) The office shall publish supporting documentation **requirements** for all MDS data elements that are utilized to classify nursing facility residents in accordance with the RUG **IV** resident classification system. The **requirements** shall be published as a provider bulletin and may be updated by the office as needed. Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(b) Nursing facilities shall maintain supporting documentation in the resident's medical chart for all MDS data elements that are utilized to classify nursing facility residents in accordance with the RUG **IV** resident classification system. Such supporting documentation shall be maintained by the nursing facility for all residents in a manner that is accessible and conducive to **review**.

405 IAC 1-15-5 MDS review requirements

Sec. 5. (a) The office shall periodically review the MDS supporting documentation and end of therapy date data maintained by nursing facilities for all residents, regardless of payer type. The reviews shall be conducted as frequently as deemed necessary by the office, and each nursing facility shall be reviewed no less frequently than every thirty-six (36) months. Advance notification of up to seventy-two (72) hours shall be provided by the office for all MDS reviews, except for follow-up reviews that are intended to ensure compliance with validation improvement plans. Advance notification for follow-up reviews shall not be required.

(b) All MDS assessments and end of therapy date data, regardless of payer type, are subject to an MDS review.

(c) When conducting the MDS reviews, the office shall consider all MDS supporting documentation and end of therapy date data that is provided by the nursing facility and is available to the reviewers prior to the exit conference. MDS supporting documentation and end of therapy date data that is provided by the nursing facility after the exit conference begins shall not be considered by the office.

(d) The nursing facility shall be required to produce, upon request by the office, a computer generated copy of the MDS assessment that is transmitted in accordance with section 1 of this rule, which shall be the basis for the MDS review.

(e) Suspected intentional alteration of clinical documentation, or creation of documentation after MDS assessments or end of therapy date data have been transmitted, shall be referred to the IMFCU for investigation of possible fraud. Such an investigation could result in a felony or misdemeanor criminal conviction.

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In addition to the uniform Medicaid rates for nursing facilities, any nursing facility that is owned or operated by a non-state governmental entity and that has entered into an agreement with the Office to participate in the nursing facility supplemental payment program shall receive an additional Medicaid payment adjustment, which shall not exceed its upper payment limit pursuant to 42 CFR 447.272.

This Medicaid supplemental payment adjustment will be calculated as follows:

The Office of Medicaid Policy and Planning (Office) shall calculate a supplemental payment according to the methodology below. The supplemental payment is created to increase Medicaid reimbursement to participating nursing facilities that are owned or operated by a non-state governmental entity. The supplemental payment is subject to the Medicaid upper payment limits found at 42 CFR 447.272.

For each state fiscal year (SFY), the Medicaid supplemental payment shall be calculated as the difference between:

1) the amount that the Office reasonably estimates would have been paid to nursing facilities that are owned or operated by a non-state governmental entity using the Medicare Resource Utilization Group (RUGs) prospective payment system. For each Medicaid resident that is in a nursing facility on the last day of a calendar quarter, the MDS assessment that is in effect on that date is classified using the Medicare RUG system. The Medicare rate applicable to the Medicare RUG, adjusted by the Medicare geographic wage index, equals the Medicaid resident's estimated Medicare rate. A simple average Medicare rate is determined for each nursing facility by summing the estimated Medicare rate for each Medicaid residents in the facility and dividing by total Medicaid residents in the facility, and
2) the Medicaid per diem rate for nursing facilities that are owned or operated by a non-state governmental entity. The Medicaid rate shall be adjusted to include laboratory, radiology, and pharmacy services to account for program differences in services between Medicaid and Medicare. The statewide average of laboratory, radiology, and pharmacy services is calculated using Medicaid cost report data.

Each participating non-state government owned or operated nursing facility's upper payment limit (UPL) gap shall be determined as the difference between the estimated Medicare rate calculated in 1 above and the adjusted Medicaid rate calculated in 2 above. Each facility's UPL gap is multiplied by Medicaid days to arrive at its supplemental payment amount. Medicaid days are taken from the Medicaid cost report.

For each calendar quarter, an estimated interim supplemental payment will be calculated as described above utilizing the latest Medicare RUGs and payment rates and Medicaid cost reports and payment rates available. Payments will be made to each nursing facility that is owned or operated by a non-state governmental entity and that has entered into an agreement with the Office to participate in the supplemental payment program.

Following the completion of the state's fiscal year, the final supplemental payment amount for the state fiscal year just ended will be calculated. These calculations will be based on the final Medicare RUGs and payment rates and the most recently reviewed Medicaid cost reports and payment rates that cover the just ended state fiscal year period. The final supplemental payment calculations will be compared to the estimated interim supplemental payments and the difference if positive will be paid to the non-state governmental entity, and if negative collected from the non-state governmental entity.

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