District of Columbia

Case Mix **#4**

Medicaid

RUG-IV 48-Grouper

Effective 2.1.18

Metric	Components
RUG Grouper	**RUG-IV** Version 5.20 **48** group, index maximizer model
Payment Method	The Medicaid reimbursable patient specific per diem rate is equal to the sum of: • The RUG group weight per RUG-IV 48 grouper and the facility specific per diem for nursing and patient care price • The facility specific per diem for routine and support price • The facility specific per diem for capital cost • Add-ons as per add-on section Each facility is assigned to one of 3 peer groups: • Peer Group One: All freestanding nursing facilities with more than 75 Medicaid certified beds • Peer Group Two: All freestanding nursing facilities with 75 or fewer Medicaid certified beds • Peer Group Three: All hospital-based nursing facilities Once classified into a group, the nursing facility price applies to all facilities in the peer group until rebasing (every 4 years at least with option to rebase if needed between those 4 years). Nursing and resident care costs, routine and support costs and capital related costs as well as OT, PT and ST costs are factored into the rate.
Snap Shot Date(s)	No snap shot dates, rate dependent on RUG category, nursing and resident care costs and therapy services based on the most recent completed fiscal year and a day-weighted average of resident acuity is determined for each facility based on the covered days and the acuity of each Medicaid resident during the fiscal year. All payer case mix is used to fairly calculate District-wide costs of nursing facility care during rebasing.
Based on Daily Weighted Average	Each facility is reimbursed by Medicaid for a patient specific per diem rate for each resident in accordance with the formula in the SPA (State Plan Amendment). The rate shall be prospective and only include allowable cost described in the SPA.
Medicaid Audit	Not stated.
MDS Selection	Resident specific assessments during the claim processing.
Calculation Method	The nursing and resident care cost per diem is adjusted for case mix using the daily-weighted average case mix of the preceding federal fiscal year for each facility based on the case mix of final paid claims for the facility for

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	nursing facility services. Routine and support costs as well as capital related costs are factored into the calculation. The CMI for each submitted RUG category is used to adjust the nursing and resident care portion of the facility specific per diem during claims adjudication.
Default	Not used.
Corrections	Not stated.
Clinical Add-Ons	**Vent Care:** Billable at additional $380.00/day. Defined as requiring at least 16 hours per day of mechanically assisted respiration to maintain a stable respiratory status. **Bariatric Care:** Billable at additional $39.00/day. Defined as BMI over 40 (morbidly obese) and one who needs assistance with 3 or more ADLs that require two or more staff to provide routine care. **Behaviorally Complex Care:** Billable at additional $82.00/day if meets criteria below 4 or more times per week: • Injures self: Head banging, self-biting, hitting self, throwing self to floor • Demonstrate Physical Aggression: Assaultive to other residents, staff or property with or without injury to other residents or staff • Verbal aggression: Disruptive sounds, noises, screaming that disturbs roommate, staff or other residents • Demonstrates regressive behaviors: Sexual behaviors, disrobing, throwing, smearing food, feces, stealing, hoarding, going through other residents'/staff belongings, elopement attempts • Consistently rejects medical care Add-on payments are not paid for leave days.
Clinical Performance Incentive Add-Ons	Nursing facility Quality Improvement Program beginning February 1, 2018. a. Nursing Facility Quality Improvement Reporting Track: Facility reports performance measures for Quality Measures and does not provide a supplemental Medicaid payment OR b. Nursing Facility Quality Improvement Incentive Track: Provides a supplemental Medicaid payment for participating nursing facilities that report performance measures set forth in the SPA and provide services that result in better care and higher quality of life for residents. Measures are NQF endorsed and include many of the CMS Long Stay Measures in addition to DHCF measures such as Resident/Family satisfaction, End of Life Program, Low-Acuity non-emergent ER visits.

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