Avoiding Defaults and Lost Residents in Illinois rate System

Several steps must be taken by facility staff to avoid getting defaults or having residents not appear in the case mix that sets Illinois Nursing component rates.

Such steps relate to:
- Proper IDs
- Untimely R2b dates
- Missing or Untimely Assessments
- Sending to the state Test files instead of Production files
- Bed-hold reporting both dates of departure and return
- Processing Discharges

This paper will detail steps to take to address each of the above issues. However, before we describe how to address the above problem areas some fundamental understanding of the Illinois Reimbursement system must be understood.

Reimbursement Time Line

This addresses one of the three rate components of the Illinois rate system called the Nursing Component. 89 Illinois Administrative Code, Section 147.150 establishes the rate setting process for the Nursing component. Illinois Medicaid pays the same single rate to every Medicaid resident during any given rate period. The system selects a population (set of Medicaid Residents) at a period in the past to calculate the average rate for a period in the future. In a typical fiscal year there will be four rate periods where the MDS data is used based upon the Medicaid population for a single day, this day is referred to as the snapshot date. The important elements of the rate setting process are included in the time lines below. Thus the first time line below shows a rate period starting on January 1. Then the other lines show the rate periods 4/1, 7/1 and 10/1 respectively.

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<tr>
<th>Snap Shot</th>
<th>Pull Data</th>
<th>Rate Period</th>
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<tr>
<td>92 day reference period</td>
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<td>9/30 &lt; corrections &gt;</td>
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<td>HFS RRR</td>
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HFS RRR

Note: The above pertains only to the MDS Nursing component Medicaid rate

**Time Line Headings**

**RATE PERIOD**
The right end of the time line shows the rate period, and the first line shows the rate period starting on 1/1 of the year. The period is an entire quarter where all Medicaid residents will be paid the same Nursing component rate.

**SNAPSHOT**
All of the Medicaid residents enrolled and present in the facility on the snapshot date will have their MDS data used (per the reference period rules below) to set an average rate for the corresponding rate period. Medicaid eligible residents include those who are also dually Medicare eligible. Thus a dually eligible resident may be paid by Medicare and possibly never paid by Medicaid yet can be included in the snapshot population that determines the Medicaid average rate. This is also true of a true Hospice resident being cared for by a hospice agency. The Medicaid rate does not pay for the hospice resident (HFS will send a payment to the hospice agency) but the hospice resident MDS data is used to set the rate.
REFERENCE PERIOD

- Generally, the MDS data used will be the latest OBRA assessment completed during the 92 days prior to the snapshot date. That is, assessments where the MDS item AA8a = 01 Admission assessment, 02 Annual assessments, 03 Significant Change in status assessment, 04 Significant correction of prior full assessment, or 05 Quarterly review assessment.

Note: For the above 92 reference period the Department will be using the assessment completion date, MDS item R2b. However, there are additional special situations:
- For those persons admitted to the facility less than 14 days before the end of the quarter, the reference period will include the 14 days after the snapshot date.
- If the last MDS submission in a quarter is aa8a=08 (Discharge prior to completing initial assessment) and AB1 (Date of Entry) is less than 14 days prior to the snapshot, then the resident is excluded from the rate setting population.

Notice the next three criteria involve bed holds as the source of information to set the population of residents who determine the average nursing rate. Thus it will be very important for facilities to complete bed holds whether they are payable bed holds or non-payable bed holds.
- If within 92 days from their last assessment the resident is sent to the hospital (hospital bed hold), and a resident returns to the facility less than 14 days before the end of the snapshot date, the reference period will include the 14 days after the re-admit date (Note, this is not an MDS readmit data item but the return date on the bed-hold report).
- If within the 92 days from their last assessment they are in the hospital (hospital bed hold), and a resident remains in the hospital through the quarter end, the resident is excluded from the rate setting population.
- If the residents are on bed hold the whole quarter, they are excluded from the rate setting population.

PULL DATA
Sixty (60) days after the snapshot date (12/1 on the 1st example time line) the Department of Healthcare and Family Services will pull the MDS data and match this to the Department’s eligibility enrollment file using the Resident Identification Number (AA7 of the MDS) or the Social Security Number (SSN, AA5a of the MDS). [Note: HFS use the eligibility enrollment file, not the MDS data to determine who is in the rate setting population and adjusted by bed-hold reports]

Thus a correction submitted prior to the pull date will be included in the rate setting but a correction after 60 days after the snapshot date will not be recognized.
If eligibility had not been determined by 60 days after the snapshot the resident will not be included in the rate setting population. However, they may be included in future rate periods.

Facility staff will need to be very familiar with all of these steps in the rate setting process in order that they can appropriately manage the MDS assessments and receive the rate that is due the facilities. So if there is a default or a missing resident staff must apply the rate setting policies above to answer the question why are they missing from the rate setting population or why is this resident a receiving a default rate.

**Missing Resident**

If a resident who was admitted prior to a snapshot date but was not determined eligible by the time of the pull date then the resident would not be in the population that sets the rate for that rate period. If a bed-hold was sent out with a beginning date prior to the snapshot and a return date after the snapshot or a return date of 999999 then the resident would not be in the population that sets the rate for that rate period.

**Dealing with Defaults**

What is a default?

A default is the low rate assigned to residents who appear in the HFS eligibility files at the time of the snapshot but there is no corresponding MDS assessment available for that resident. Without an MDS a rate cannot be calculated so the HFS assigns a very low rate to the resident. Thus the easiest default to find is the one where no OBRA assessment was sent to the state within 92 days prior to the snapshot date.

**Proper IDs:**

The HFS had found in a recent snapshot that of the 851 defaults, 126 lacked the Medicaid number or Social Security number needed to identify the MDS assessment. The Medicaid number or Recipient Identification Number (RIN) and the Social Security Number (SSN) are used to match MDS assessments to HFS eligibility files. This is done to determine if the MDS assessment is for a Medicaid eligible resident at the time of the snapshot. If the HFS eligibility files show a Medicaid resident ID with no corresponding MDS assessment ID (RIN or SSN) from the pulled assessment files then a default rate is assigned.

It only takes a single digit typo to cause a miss match with these IDs. These errors will happen. But facilities have tools to catch these mistakes. The Casper Reports are available to all facilities. The Casper Reports are available at the state MDS transmission site. The reports can be accessed similar to the Validation Reports. One of these reports is called the duplicate resident report another is the Resident Roster Report. These can be very useful in catching mistakes on IDs.
CareWatch® subscribers have several tools that are even more useful in finding ID problems. However, no tool is helpful if it is not used.

- CareWatch® provides logic check warnings called flags to alert staff of any changes in RIN or SSN.

- CareWatch® also provides under the Illinois Watch a page called Residents with Invalid Medicaid Number which lists residents with RIN problems.

- Under Operations there are pages called Resolve Duplicate residents and Separate Merged residents that show residents with identification issues.

- In Illinois watch under Medicaid Inconsistency Alerts a section lists residents with problems with the RIN or SSN.

The toughest defaults may be where the caseworker enrolls the resident after the Resident Roster Report is sent out but before the end of the data collection period (pull date), when the MDS assessments legitimately does not have a RIN in AA7. If the caseworker enters a SSN that is different from what the facility sent to the caseworker then no match will be made and it appears to HFS that no MDS was sent. Some mechanism is needed to track those residents who have had MDS data sent as pending (+ on AA7 of the MDS). For these assessments it is critical that the SSN be correct and that it matches what the eligibility enrollments file.  

*CareWatch® lists the pending separately on the first menu item under the Illinois Watch page.*

**Timely Assessments and R2b**

An MDS must of course be sent to the state. If it is sent to only Care Watch and not to the state then it would obviously end in a default rate.

An even more frequent default than the ID problem is the situation where the latest transmitted MDS had an Assessment Reference Date (ARD) within the 92 days prior to the March 31, 2007 snapshot date but the completion date (MDS item R2b) was not within the 92 days prior to the snapshot date. The Resident Assessment User’s Manual (RAI) Chapter 2 requires OBRA assessments to be done no less than every 92 days. The 92 days is from R2b date to R2b date, not the ARD. The HFS uses the R2b date and not the ARD in selecting the rate setting population.

The R2b date must be with 14 days of the return date reported on the bed-hold the same way the R2b date must be within 14 days of an initial assessment.

A less common problem causing a default would occur if a business office failed to discharge a resident. HFS would be looking for an assessment and not find one. This would lead to a default rate.  

*CareWatch® lists under Illinois Watch a page called Discharged Medicaid Residents for the date range requested.*
Test Transmissions

One final cause of defaults is worthy of discussion. This problem could be the easiest problem to correct. For several years the state has not accepted test transmissions into the MDS database. If assessments are transmitted under test mode the assessments will receive a fatal error reported on the Validation Report. If there is not a production transmission during a rate period then the MDS data will not have assessments for the resident and the resident will get the default rate. Please refer to RAI Chapter 5.3 the section “Validation Edits.” Under Fatal File Errors it reports: “The facility will be informed of the file submission status in the Initial Feedback Report indicating that the batch was ‘accepted,’ ‘received’ (for a test file) or that it was ‘rejected’.”

If an MDS coordinator inadvertently sent a test file, she may make the mistakes of seeing the word “received” and think this is ok. However, the Initial Feedback report must say “accepted.” Please note, since the data was never accepted for a test transmission a subsequent production submission of the assessment does not need to be treated as a correction, see RAI Chapter 5-6.

Facilities may want to take advantage of a new CareWatch® feature called Transmission Watch which streamlines your work processes and integrates CareWatch® into your daily work flow by submitting your assessments directly to CMS through CareWatch®.

MDS Transmission Watch. Now you can submit to CMS through CareWatch®, retrieve you feedback and validation reports, and get your CASPAR reports all in one place.

What should Facilities do?

Above we have shown you how to be rigorous on being accurate on IDs, proper timing of assessment and avoiding test transmissions. But like any important process a review or self audit is very important.

HFS Resident Roster Report

Begin with a review of the HFS resident Roster Report. These are sent out shortly after the snapshot date.

- Compare the HFS Resident Roster Report (RRR) to the CareWatch® DON report found on the right side of the Operations Menu. Users must have either Admin or Management authority to have the DON report. The DON Report includes information such as a breakdown of payer sources, admissions, discharges, and a variety of clinical data such as QI/QMs and occurrences reported for the time period selected. Determine why the RRR includes residents that are not in the DON report and why the DON report has residents the HFS has missing. These will usually be person recently discharged prior to the snapshot date or recently admitted. If the HFS RRR does not show residents then these residents should be tracked for Medicaid eligibility determination.
- Identify residents discharged prior to the snapshot date using the DON report. Any discharged resident on the HFS Roster Report is a potential problem.
Be sure the HFS 1156 has been sent to the local office or reported through REV.
Be sure the HFS 1156 has been received by the local office and that the caseworker has processed it. Keep any documentation as printings of “transmission Received” faxes.

- Check to make sure that all residents on the roster have had an OBRA MDS completed within the quarter and that it has been transmitted to the state. For assessment being completed near the snapshot date, make sure that an MDS transmitted in the quarter has been completed (R2B date) at least within 92 days from the last completed assessment (R2b date).
- Review all residents “MDS discharged” or released to the hospital. The facility may have completed an MDS discharge but HFS will still have these individuals as residents of the facility. For these residents there may not be an OBRA assessment completed within the quarter. If there is no completed OBRA assessment within the quarter the resident will be assigned a default rate unless a bed hold is completed. Be sure all bed holds, HFS 2234s, have been completed (or use REV) on residents released to the hospital whether it is a payable or non payable bed hold. Keep documentation of transmittals. Remember a HFS 2234 can be completed prior to the return of a resident or formal discharge of a resident. A single resident who is in the hospital for a long time could have a HFS 2234 completed every month they are out of the facility. If a bed-hold was submitted with a return date of 999999 then another bed-hold report needs to be completed to report the return date.
- And finally, remember the rate time line; Resident Roster Reports will come out just after the snapshot date (such as early October just after the 9/30 snapshot). During your review if you discover an MDS should be corrected you still have 60 days after the snapshot date to make corrections that will count in calculating the rate from that snapshot data.

**HFS Verification Roster Report**

The HFS Verification report comes out at the same time that the rate sheet and the rate worksheet are sent out which is after the rates have been set for the quarter. It will be too late to make corrections for the rate period quoted in the rate sheet but this can be a valuable tool to learn from mistakes made. The format of the important elements of the Verification report is listed below:

[55 rate items listed staring with “ILLADL” ending with “ACTIV”]

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R A A  L N NW T
I A D
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T T T T T
The report shows the RIN which is the Medicaid number as it is from the HFS eligibility file. AA1 which is the resident name and the R2b date come from the MDS. When there is a Medicaid number (RIN) reported and no name or R2b date then this shows that the state is missing the MDS which is a default. With the name missing you must use the RIN to look up the resident name and then review the residents MDS to determine why the assessment was missing.

Compare HFS Reports to eHDS CareWatch®

The rate setting population is determined based upon the MDS data sent to eHDS CareWatch®. This differs from the state that uses the eligibility enrollment file and bed-hold reports as its source of information. This difference can be very useful for staffs who are investing rate data problems. With each HFS Resident Roster Report and with the HFS Verification report residents lists should be compared to those listed in CareWatch® (remember, set the date period to the snapshot date and not the rate period date). When there is a difference, check:

- Improper IDs
- Untimely R2b dates
- Missing or Untimely Assessments
- Sending to the state Test files instead of Production files
- Missing Bed-hold reporting both dates of departure and return
- Unprocessed Discharges