

NORTH DAKOTA CASE-MIX PAYMENT SYSTEM

Overview of the System

- The payment system has 34 case mix classifications.
- Classifications are based on the resident assessment instrument (MDS) required in all nursing facilities.
- Rates by classification are facility-specific based on historical costs of the facility.
- Residents in high classifications pay more than residents in low classifications at the same facility.
- Facility rates change annually on January 1. Rate changes may occur during the year to adjust rates as a result of audits or special circumstances.
- Facility revenues are influenced throughout the year based on the resident classifications.
- The rate for a self-pay resident can be no more than the established rate for a Medicaid resident in the same classification. Private room charges and special services are excluded and may be billed separately.
- The rate for an individual will change whenever the facility's rates change (30 day notice is required) or when the individual's classification changes (No notice required, rate is retroactive to effect date of classification).
- Resident is reviewed within 14 days of admission or reentry from hospital and then every 3 months.
- Resident's classification can change only at the scheduled 3 month time or if hospitalization occurs.

The Classification and Weighting System

The best indicator of the amount of nursing staff time provided to a resident is the degree to which a resident needs assistance with activities of daily living (eating, toileting, transferring, and bed mobility). In addition, measured behavioral needs, certain medical conditions and treatments, and therapies are also used to determine the nursing staff time provided to a resident. The information on activities of daily living, medical conditions and treatments, therapies, and behavioral needs is obtained from the Minimum Data Set which is part of the resident assessment instrument required for all residents of a nursing facility. The methodology used to classify or group the MDS is available in the Department's "Step by Step Guide to Assigning a Classification."

Review Points for Case-Mix Classifications

The determination of a case-mix classification for a resident is dependent upon the data included in the Minimum Data Set. A facility is required to complete an MDS at specified intervals in order to have a classification assigned to a resident.

If a facility does not adhere to the MDS schedule for an individual the classification for that individual will be the default rate which results in payment being at the lowest rate for any classification in that facility. A resident's classification is determined shortly after admission or reentry from the hospital and then is redetermined every three months thereafter. A change in a resident's condition or treatments, regardless if it is an improvement or a decline, will not impact the current classification but may impact the next classification period if those changes persist. The facility review points for purposes of determining a payment classification are:

- > An MDS must be completed within the first 14 days following admission to the facility.
- > An MDS must be completed within the first 14 days following any return from a hospital stay for a resident who was residing in the facility prior to the hospitalization.
- > An MDS must be completed no later than 3 months to the day following an admission or return from the hospital but no sooner than 7 days prior to that date and then every 3 months using the same days.
- > An MDS completed outside of the required time frames may not be used for classification for payment purposes.

Example: A resident admitted on January 14 must have an MDS completed by January 27 and then must have an MDS completed by April 14 but no sooner than April 7. The next MDS must be completed from July 7 through July 14, then October 7 through October 14, then January 7 through January 14. This schedule will continue until a resident is hospitalized or discharged from the facility.

Rate Equalization

The Case-Mix classification determined using the MDS is applicable to any resident in the facility regardless of payment source for funding of the resident's care. The rate payable for a given classification covers all nursing facilities services required to be provided and is based on semiprivate accommodations. Residents may be charged separately for services and items that are not part of this daily rate. These services and items may include private rooms, cable TV, transportation outside of the facility's medical community, telephones or long distance calls, requested brand name supplies or items, or other nonroutine services that are supplied at the resident's request or for their personal comfort.