

CHANGE NOTICE FOR MANUAL NO. 01-05, CASE MIX

DATE: JUNE 17, 2004

Manual: Family and Children's Medicaid
Change No: 01-05
To: County Directors of Social Services
Effective: July 1, 2004

I. BACKGROUND

Effective May 1, 2004, the rates for long term care facilities changed to a case mix payment system following the Medicare payment system model. Case mix is a payment system where the facility payment rate is based on the medical needs of all the patients rather than the current system of facility costs. Nursing facility providers were informed of this change in the June 2004 Medicaid Provider Bulletin.

This payment system for the facility depends upon the individual medical needs of the current patients, Medicare, Medicaid or private, within the facility during the previous quarter. The patient's assessment is put through a "grouper" to categorize each patient. The category sets the case mix index for that patient. All patients' case mix indexes are calculated to determine the facility's case mix index. The facility's reimbursement rate is established from this case mix index. The nursing facility's reimbursement rate will change quarterly.

The "case mix" change is a result of a review of how Medicaid reimburses for long term care needs. It is anticipated that this change will encourage quality improvement and provide an incentive for more accurate medical needs accounting.

Long term intermediate and skilled levels of care have been replaced with one skilled level of care classified as "nursing facility resident". This change includes nursing facility Hospice care levels. The living arrangement code 50, skilled, will be used. Living arrangement code 58, Intermediate Care Facility (ICF), will not be used. The FL2 will be completed at the initial application. Minimum Medicaid reimbursement rates will change yearly.

The admission criteria do not change and no changes occur in the prior approval system. There is also no change in the patient monthly liability computation process. The reimbursement systems for CAP programs, ICF-MR facilities, ventilator, and swing beds do not change.

II. CONTENT OF CHANGE

MA-3325, Long Term Care Budgeting, is changed to:

- A. Delete reference to intermediate care,
- B. Clarify the requirement for a DMA-5045 to be completed and retained in the case record for an individual under 21 receiving care and treatment in a group home or other non-certified facility for 12 months or more, and
- C. Update the DMA Medicaid Eligibility and Hearing Unit's addresses.

III. EFFECTIVE DATE AND IMPLEMENTATION

The change is effective July 1, 2004. Apply the new rates to all applications taken and redeterminations begun on or after July 1, 2004. If during redetermination the patient who had been eligible based on the minimum Medicaid reimbursement rate has an income higher than the new minimum rate, follow the budgeting steps in Step I in MA-2270, Long Term Care Need and Budgeting, to determine ongoing eligibility.

We looked at a number of cases in EIS and it appears no one should be ineligible. Use living code 50 for new applications after July 1, 2004. Change living code 58 to living code 50 at redetermination.

IV. MAINTENANCE OF MANUAL

Remove: MA-3325, Long Term Care Budgeting, pages 1 through 9.
Insert: [MA-3325, Long Term Care Budgeting](#), pages 1 through 10, which is effective July 1, 2004.

If you have any questions, please contact your Medicaid Program Representative.

Gary H. Fuquay
Director

(This material was researched and written by Susan Ryan, Medicaid Policy Consultant, Medicaid Eligibility Unit.)