Cognitively Impaired Determination

for Colorado Medicaid Supplemental Payments

Applicable Regulations

8.443 Nursing Facility Reimbursement

8.443.1.B For class I nursing facilities, a payment rate for each participating nursing facility shall be determined on the basis of information on the MED-13, the Minimum Data Set (MDS) resident assessment information and information obtained by the Department or its designee retained for the purpose of cost auditing. The nursing facility prospective per diem rate includes the following components:

1. Health Care.
2. Administrative and General.
3. Fair Rental Allowance for Capital-Related Assets.

The Health Care, Administrative and General and Fair Rental Allowance for Capital-Related Assets components are referred to as "Core Components".

In addition to the above per diem reimbursement for core components, a nursing facility prospective supplemental payment shall be made for:

1. Residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury.

8.443.10 Supplemental Payments for Facilities with Cognitive Impaired and PASRR II Residents, Provider Fee and Quality Performance for Class I Nursing Facilities

8.443.10.A In addition to the reimbursement components…the state department shall pay a supplemental payment to nursing facility providers who have residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury. To reimburse the nursing facility providers who serve residents with severe cognitive dementia or acquired brain injury, the state department shall pay a supplemental payment based upon the resident's score on the Cognitive Performance Scale (CPS) used in the RUG-III Classification system and reported on the MDS form. Resident CPS scores range from zero (intact) to six (very sever impairment).

1. *Annually the Department will identify those Medicaid residents with a CPS score of 4, 5, or 6 for each nursing facility. They will then calculate the percent of Medicaid residents with a CPS score of 4, 5, or 6 as a percentage of all Medicaid residents for the facility. This amount is the facility's CPS percentage. The MDS for residents on the April roster will be the source data used in these calculations.*

2. *The state-wide mean (average) CPS percentage will be determined, along with the standard deviation from the mean.*

3. *Those facilities with a CPS percentage greater than the mean plus one, two or three standard deviations will receive an add-on rate for their Medicaid residents with a CPS score of 4, 5, or 6 in accordance with the following table:*

   Mean plus one standard deviation $1.00

   Mean plus two standard deviations $2.00

   Mean plus three or more standard deviations $3.00

4. *If the expected average payment for those residents receiving a supplemental payment is less than one percent of the average nursing facility rate (prior to supplemental payments), the above table rates will be proportionately increased or decreased in order to have an expected average Medicaid supplemental payment equal to one percent of the average nursing facility rate prior to supplemental payments.*

5. *These calculations will be performed annually to coincide with the July 1st rate setting process. Each facility's aggregate CPS add-on will be calculated by taking the add-on rate times Medicaid days with a CPS score of 4, 5 or 6.*

6. *The CPS supplemental payment will be calculated by dividing the facility aggregate CPS amount determined above by the facility's expected Medicaid case load (Medicaid patient days). Medicaid case load for each facility will be determined using Medicaid paid claims data for the calendar year ending prior the July 1st rate setting. Providers with less than a full year of paid claims data will have their case load annualized.*

MDS 3.0 Data

The above regulations were written under MDS 2.0, utilizing the RUG-III 34 Grouper. Under MDS 2.0, there was a single mechanism to evaluate cognitive performance (CPS) and each resident received a CPS score. Subsequent to the inception of the above regulations, MDS 3.0 was implemented. MDS 3.0 changed the evaluation of cognitive performance, as follows:

1. Each resident is evaluated under BIMS and, if possible, assigned a BIMS score.
2. If a BIMS score cannot be assigned (e.g. the resident is not interviewable), then the resident is evaluated under CPS. However, a CPS score is no longer calculated by MDS 3.0.

RUG-III 34 Grouper Cross-Walk

CMS created a cross-walk to tie the MDS 3.0 assessment forms utilized by all nursing facilities (which is intended for the RUG IV 48 and 66 Grouper systems) to the RUG-III 34 Grouper system utilized by the state. To determine if a resident is cognitively impaired, the cross-walk performs the following two step process:

1. Evaluate the BIMS score. If BIMS <= 9 the resident is considered cognitively impaired.
2. If the BIMS score is skipped, the cross walk then evaluates the CPS results. The cross walk assigns a CPS score based on the CPS evaluation. If the assigned CPS >= 4 the resident is considered cognitively impaired.

Calculating the Add-On

The goal of the supplemental payment add-on is to identify those residents who have "moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury". The CMS cross-walk is utilized to calculate the number of cognitively impaired residents.