TIME-WEIGHTED CMI RESIDENT ROSTER USER GUIDE 48-GROUPER

Myers and Stauffer LC

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1 REGULATORY REQUIREMENTS

INTRODUCTION

Connecticut Department of Social Services contracted with Myers and Stauffer LC to develop a case mix reimbursement system for Connecticut's Medicaid nursing facilities.

The source of the case mix rate element is the Minimum Data Set (MDS) which is transmitted electronically to the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) System. This Time- Weighted CMI Resident Roster User Guide describes the process in which these MDS records are used to develop the case mix measure used in the reimbursement rate.

TIME-WEIGHTED CMI RESIDENT ROSTERS

A Resident Roster is a list of residents for each Medicaid certified nursing facility, displaying each resident who resided in the nursing facility during the Resident Roster quarter based on MDS assessments and tracking forms transmitted to the QIES ASAP System and accepted by that system. Each MDS assessment and tracking form dated during the quarter is assigned a case mix index for the period of the quarter the assessment and tracking form apply. From this information, a day weighted case mix index is calculated for all residents in the facility and Medicaid residents in the facility.

2 TIME-WEIGHTED CMI RESIDENT ROSTER ELEMENTS

RUG-IV 48-GROUP CLASSIFICATION MODEL, VERSION 1.03

The system for grouping a nursing facility's residents according to their clinical and functional status identified from MDS data is the Resource Utilization Group, version IV (RUG-IV), 1.03. This grouper uses certain MDS data elements to place assessments into one of the RUG groups based on similar resource needs. The responsibility for calculating the RUG-IV category rests with the Connecticut Department of Social Services or its designated contractor. The Medicaid nursing facility is not required to transmit the state RUG-IV category on the MDS record.

CASE MIX INDEX

The Case Mix Index (CMI) set is the standard nursing-only CMI set published by CMS for RUG-IV 1.03, 48-Group identified as F01.

The days attributable to expired (inactive) assessments or tracking forms are categorized as BC1. Index maximization is used to assign each resident to the final RUG-IV classification.

RUG-IV Classification		CMI-48
ES3	Extensive Service	3.00
ES2	Extensive Service	2.23
ES1	Extensive Service	2.22
RAE	Rehabilitation	1.65
RAD	Rehabilitation	1.58
RAC	Rehabilitation	1.36
RAB	Rehabilitation	1.10
RAA	Rehabilitation	0.82

RUG-IV Classification		CMI-48
HE2	Special Care-High	1.88
HE1	Special Care-High	1.47
HD2	Special Care-High	1.69
HD1	Special Care-High	1.33
HC2	Special Care-High	1.57
HC1	Special Care-High	1.23
HB2	Special Care-High	1.55
HB1	Special Care-High	1.22
LE2	Special Care-Low	1.61
LE1	Special Care-Low	1.26
LD2	Special Care-Low	1.54
LD1	Special Care-Low	1.21
LC2	Special Care-Low	1.30
LC1	Special Care-Low	1.02
LB2	Special Care-Low	1.21
LB1	Special Care-Low	0.95
CE2	Clinically Complex	1.39
CE1	Clinically Complex	1.25
CD2	Clinically Complex	1.29
CD1	Clinically Complex	1.15
CC2	Clinically Complex	1.08
CC1	Clinically Complex	0.96
CB2	Clinically Complex	0.95
CB1	Clinically Complex	0.85
CA2	Clinically Complex	0.73
CA1	Clinically Complex	0.65
BB2	Behavioral Symptoms & Cognitive Performance	0.81
BB1	Behavioral Symptoms & Cognitive Performance	0.75
BA2	Behavioral Symptoms & Cognitive Performance	0.58
BA1	Behavioral Symptoms & Cognitive Performance	0.53

RUG-IV Classification		CMI-48
PE2	Reduced Physical Function	1.25
PE1	Reduced Physical Function	1.17
PD2	Reduced Physical Function	1.15
PD1	Reduced Physical Function	1.06
PC2	Reduced Physical Function	0.91
PC1	Reduced Physical Function	0.85
PB2	Reduced Physical Function	0.70
PB1	Reduced Physical Function	0.65
PA2	Reduced Physical Function	0.49
PA1	Reduced Physical Function	0.45
BC1	Inactive / Expired	0.45

IDENTIFICATION OF MDS ASSESSMENTS/RECORDS

The identification of the MDS assessments on the Resident Roster depends on the assessment coding at A0310 as shown in the following tables.

OBRA Assessments (A0310A)	MDS 3.0 Item Set Code (ISC)	MDS 3.0 (A0310A)	MDS 3.0 (A0310B)	MDS 3.0 (A0310F)
Admission assessment	NC	01	99	99
Quarterly assessment	NQ	02	99	99
Annual assessment	NC	03	99	99
Significant change in status assessment	NC	04	99	99
Significant correction to prior comprehensive assessment	NC	05	99	99
Significant correction to prior quarterly assessment	NQ	06	99	99

PPS (Medicare) Scheduled Assessments (A0310B)	MDS 3.0 Item Set Code (ISC)	MDS 3.0 (A0310A)	MDS 3.0 (A0310B)	MDS 3.0 (A0310F)
5-day assessment	NP	99	01	99

Discharge Assessments (A0310F)	MDS 3.0 Item Set Code (ISC)	MDS 3.0 (A0310A)	MDS 3.0 (A0310B)	MDS 3.0 (A0310F)
Discharge – return not anticipated assessment	ND	99	99	10
Discharge – return anticipated assessment	ND	99	99	11

MDS Tracking Forms (A0310F)	MDS 3.0 Item Set Code (ISC)	MDS 3.0 (A0310A)	MDS 3.0 (A0310B)	MDS 3.0 (A0310F)
Entry/Re-entry tracking	NT	99	99	01
Discharge – death in facility tracking	NT	99	99	12

In many instances, facilities combine reasons for assessment. The MDS assessments/records are identified on the Roster Report using the item set code followed by the submitted values in A0310A, A0310B and A0310F. A complete list of the Item Set Codes can be found in the RAI Manual in Chapter 2.

For example, the record type shown on the Roster Report as NT/99/99/0/01 indicates the Entry Tracking Form and NQ/02/99/99 indicates an OBRA Quarterly not combined with a PPS or Discharge assessment.

The record type NC/01/01/99 indicates a combined OBRA Admission with a 5-day PPS assessment.

3 TIME-WEIGHTED CMI RESIDENT ROSTER DETAILS

DISTRIBUTION SCHEDULE

The Connecticut MDS Web Portal system is utilized to distribute Preliminary and Final Time-Weighted Resident Rosters for each quarter to each Medicaid certified nursing facility. The Resident Rosters are copied to the MDS Web Portal identified with file names indicating the Resident Roster quarter and the status of "Preliminary" or "Final." The following schedule is utilized.

Resident Roster Report Schedule	12/31	03/31	06/30	9/30
Preliminary Report Cutoff Date	01/15	04/15	07/15	10/15
Preliminary Report Posting Date	Last Day of Month of January	Last Day of Month of April	Last Day of Month of July	Last Day of Month of October
Final Report Cutoff Date	02/15	05/15	08/15	11/15
Final Report Posting Date	10th Day of March	10th Day of June	10th Day of September	10th Day of December

SELECTION OF RESIDENTS AND ASSESSMENTS/RECORDS

All residents that have been discharged prior to or on the first day of the Resident Roster quarter will not be listed on the Resident Roster. For example, if the resident is discharged prior to or on the first day of the quarter, and does not return to the nursing facility before the end of the quarter, the resident will not be listed on the Resident Roster. All residents admitted during the quarter will be included.

For each resident listed, assessment and tracking forms are displayed in sequential date order. These records include the assessments and tracking forms that are active during the quarter and are completed, transmitted, and accepted by the QIES ASAP System on or prior to the cutoff dates listed above

RESIDENT ROSTER FORMAT

MDS Resident Identifiers

CMS identifies residents in the QIES ASAP system based on the identifiers listed below. The Resident ID is assigned by the QIES ASAP System based on Social Security Number, gender, date of birth, first name and last name of the resident and is identical to the Resident ID displayed on the Facility Final Validation Report from CMS. Residents identified on the Roster Report, using the information coded on the MDS assessment at the record location in the following table, are uniquely identified by the Resident ID.

MDS 3.0 Location	Description
A0500A	First name
A0500C	Last name
A0600	Social Security Number
A0800	Gender
A0900	Birth Date
Assigned by QIES ASAP System	Resident ID

Resident Roster Elements

Assessments and tracking forms are identified on the Resident Roster at the record location in the following table.

MDS 3.0 Location	Description
Record Type	Determined from values at A0310 A, B, F.
Target Date	Assessment Reference Date (A2300) or Discharge Date (A2000) or Entry/Reentry Date (A1600).
RUG-IV Classification	An assessment assigned one of the 48 RUG-IV groups.
Start Date	Calculated from: a date within the record, or a date within the preceding record, or start of the quarter.
Start Date Field	The MDS item location where the Start Date was obtained, if the date was obtained from the displayed MDS assessment.
End Date	Calculated from: a date within the record, or a date within the following record, or the last date the record is active, or the end of the quarter.
Days	Calculated as the number of days between the Start Date and End Date, if any.
Case Mix Index	A numerical score assigned to each of the RUG-IV classifications.
Payment Source	Determination of Payment Source; Medicaid, Medicare, and Other.

Resident Roster Summary Page

The last page of the Resident Roster includes a summary of the total number of days at each RUG-IV classification, the calculated number of CMI points for Medicaid and All Residents and the day weighted CMI average for Medicaid, Medicare, Other and All residents.

CALCULATION OF DAYS

The following general rules determine the days counted for each resident. Transmission of appropriate assessments in expected sequential order and coded with accurate dates will result in an accurate count of days.

General Resident Roster Rules

A. Inactivated records (A0050 = 3) are not considered in the creation of the Resident Roster.

B. Modified records (A0050 = 2), only the record with the highest Correction Number (X0800) as of the cutoff date is considered.

C. For the purpose of the Resident Roster process, the following types of assessment combinations are used only to obtain discharge dates and discharge status.

(ISC)	(A0310A)	(A0310B)	(A0310F)
ND	99	99	10, 11
NT	99	99	12

D. The calculation of days includes the day of admission. The day of discharge is not included.

E. Days are counted from the first day of the quarter until either the assessment reference date (A2300) of the next assessment, the end of the quarter or until discharged (day of discharge not included), whichever comes first, unless the maximum number of days for the assessment has been reached.

F. Days covered by temporary home visits, temporary therapeutic leave and hospital observational stays less than 24 hours where the hospital does not admit the resident are included in the count of days since CMS does not require a discharge assessment to be completed.

Inactive (Expired) Assessment

G. CMS requirements allow no more than 92 days between assessments. Consistent with CMS, for purposes of Connecticut Medicaid reimbursement, each assessment is considered active for a maximum of 92 days, measured from the assessment reference date (A2300). An assessment that is not followed by any other assessment or Discharge assessment or Death in Facility tracking form within 92 days of the preceding record's assessment reference date will have additional inactive days counted for that assessment after day 92. The assessment is then considered an expired assessment (or inactive). During the inactive period following an expired assessment (starting on day 93) until the start of the next assessment (A2300), the end of the quarter, or a discharge assessment, days are counted at the inactive RUG-IV classification BC1.

In this example, the Quarterly assessment was transmitted with the following:

- Assessment reference date (A2300) 10/14/2017

The subsequent Quarterly assessment was transmitted with the following:

- Assessment reference date (A2300) 03/15/2018

Record Type	Target Date	RUG Class	Start Date	Start Date Field	End Date	Days	Case Mix Index	Payment Source
NQ/02/99/99	10/14/17	CB1	01/01/18		01/13/18	13	0.85	Medicaid
NQ/02/99/99	10/14/17	BC1	01/14/18		03/14/18	60	0.45	Medicaid
NQ/02/99/99	03/15/18	CB1	03/15/18	A2300	03/31/18	17	0.85	Medicaid
					Total Days	90		

Counting 92 days from the A2300 date (10/14/2017) of the first Quarterly assessment results in 01/13/2018, meaning the active days covered by the first Quarterly assessment end on this date. From the 93rd day (01/14/2018) until the day prior to the A2300 date of the next Quarterly assessment (03/15/2018), the days are counted at the inactive RUG-IV classification BC1. The days from the second Quarterly assessment count from the ARD (03/15/2018) until the end of the quarter.

Late Admission Assessment

H. CMS requirements allow no more than 14 days between the admission entry date (A1600 when A1700=1, Admission) and the Admission assessment reference date (A2300). For purposes of Connecticut Medicaid reimbursement, when there are more than 14 days, the admission entry date is used to begin counting days for the Admission assessment up to a maximum of 14 days. Any remaining days beginning on day 15 through the day prior to the assessment reference date (A2300) of the Admission assessment will result in the inactive RUG-IV classification BC1.

In this example, Entry Tracking Form was transmitted with the following:

- Entry date (A1600) 04/12/2017

The Admission assessment was transmitted with the following:

- Assessment reference date (A2300) 01/24/2018
- Entry date (A1600) on Admission assessment 04/12/2017

A Discharge assessment was transmitted with the following:

- Discharge date (A2000) 03/02/2018

Record Type	Target Date	RUG Class	Start Date	Start Date Field	End Date	Days	Case Mix Index	Payment Source
NT/99/99/01	04/12/17	BC1	01/01/18		01/23/18	23	0.45	Medicaid
NC/01/99/99	01/24/18	CC2	01/24/18	A2300	03/01/18	37	1.08	Medicaid
ND/99/99/11	03/02/18		03/02/18	A2000	03/02/18			
					Total days	60		

Inactive days begin on the start of the quarter (01/01/2018) because the entry date of 04/12/2017 is greater than 14 days prior to the assessment reference date of 01/24/2018 of the Admission assessment. Days begin counting on the assessment reference date of 01/24/2018 of the Admission assessment through the day prior to the discharge date of 03/02/2018.

Sequential Discharge Assessments

I. When a series of Discharge assessments is submitted with no assessment in between, the earliest discharge date in the series stops the count of days.

In this example, a Quarterly assessment precedes the start of the quarter followed by a Discharge assessment (return anticipated) and then followed by a Discharge assessment (return not anticipated) transmitted with the following:

Quarterly assessment:

- Assessment reference date (A2300) 12/10/2017

First Discharge assessment:

- Discharge date (A2000) 01/15/2018

Second Discharge assessment:

- Discharge date (A2000) 02/01/2018

Record Type	Target Date	RUG Class	Start Date	Start Date Field	End Date	Days	Case Mix Index	Payment Source
NQ/02/99/99	12/10/17	PB1	01/01/18		01/14/18	14	0.65	Medicaid
ND/99/99/11	01/15/18		01/15/18	A2000	01/15/18			
ND/99/99/10	02/01/18		02/01/18	A2000	02/01/18			
					Total Days	14		

The first discharge dated of 01/15/2018 stops the count of days for the Quarterly assessment on the day before the discharge date.

Entry Tracking Form

J. If an Entry Tracking Form is not preceded by an active assessment for a new stay in the facility and is followed by a Discharge assessment or Death in Facility Tracking Form, the RUG-IV classification will automatically be assigned as follows for the days starting from the entry date (A1600 when A1700=1) to the day prior to the discharge date (A2000) up to a maximum of 14 days:

- **LC2** – when discharge status was deceased (A2100 = 08) or discharged to the hospital (A2100 = 03, 05, or 09).
- **RAB** – when discharge status was other than death or discharge to the hospital (A2100 = 01, 02, 04, 06, 07, or 99).

In this example, the Entry Tracking Form was transmitted with the following:

- Entry date (A1600) 12/25/2017 with A1700 = 1, Admission

The Discharge assessment was transmitted with the following:

- Discharge date (A2000) 01/07/2018
- Discharge status was deceased (A2100 = 08, deceased)

Record Type	Target Date	RUG Class	Start Date	Start Date Field	End Date	Days	Case Mix Index	Payment Source
NT/99/99/01	12/25/17	LC2	01/01/18		01/06/18	6	1.30	Medicaid
NT/99/99/12	01/07/18		01/07/18	A2000	01/07/18			
					Total Days	6		

When an Entry Tracking Form is the first and only record for a new resident that is followed by a Discharge assessment, the RUG-IV classification and associated CMI are based on the discharge status (A2100); either LC2 or RAB. In this case the discharge status is deceased (08); resulting in a RUG classification of LC2. The Entry Tracking Form must be coded A1700 = 1, Admission.

K. Entry Tracking Forms are required to be submitted for each entry or reentry into the nursing facility. The entry date (A1600) indicates the exact date of entry and is used to begin the counting of days. However, the Entry Tracking Form is not an assessment and therefore is unable to be classified.

In this example, a Quarterly assessment prior to the start of the quarter was followed by a Discharge assessment (return anticipated). Later, an Entry Tracking Form was submitted followed by an Admission/5-day PPS assessment with the following:

Quarterly assessment:

- Assessment Reference Date (A2300) 11/15/2017

Discharge assessment:

- Discharge date (A2000) 01/06/2018

Entry Tracking Form:

- Entry Date (A1600) 03/01/2018 with A1700 = 1, Admission

Admission/5-day PPS assessment:

- Assessment Reference Date (A2300) 03/13/2018 and the entry date (A1600) 03/01/2018

Record Type	Target Date	RUG Class	Start Date	Start Date Field	End Date	Days	Case Mix Index	Payment Source
NQ/02/03/99	11/15/17	ES2	01/01/18		01/05/18	5	2.23	Medicare
ND/99/99/11	01/06/18		01/06/18	A2000	01/06/18			
NT/99/99/01	03/01/18		03/01/18	A1600	03/01/18			
NC/01/01/99	03/13/18	ES3	03/01/18	A1600	03/31/18	31	3.00	Medicare
					Total Days	36		

Days begin counting for the Quarterly assessment on the first day of the quarter through the day prior to the discharge date (A2000) 01/06/2018. The Entry Tracking Form is transmitted followed by an Admission/5-day assessment which begins counting at the entry date, (A1600) 03/01/2018, through the end of the quarter. The Entry Tracking Form must be coded A1700 = 1, Admission. Note that no days are assigned to the Entry Tracking Form but instead the entry date A1600 (03/01/2018) is assigned to the days counted for the Admission/5-day assessment as noted in the "Start Date Field" column.

L. If the Entry Tracking Form is not followed by an assessment, but is preceded by an assessment that has not expired, the remainder of the active days from the preceding assessment is used for the count of days starting at the entry date (A1600).

In this example, a Quarterly assessment completed prior to the quarter was following by a Discharge assessment (return anticipated). Later, an Entry Tracking Form was submitted but was not followed by an assessment. Assessments/tracking forms were transmitted with the following:

Quarterly assessment:

- Assessment Reference Date (A2300) 12/30/2017

Discharge assessment:

- Discharge date (A2000) 01/06/2018

Entry Tracking Form:

- Entry Date (A1600) 01/15/2018 with A1700 = 2, Reentry

Record Type	Target Date	RUG Class	Start Date	Start Date Field	End Date	Days	Case Mix Index	Payment Source
NQ/02/07/99	12/30/17	RAC	01/01/18		01/05/18	5	1.36	Medicare
ND/99/99/11	01/06/18		01/06/18	A2000	01/06/18			
NT/99/99/01	01/15/18	RAC	01/15/18	A1600	03/31/18	76	1.36	Medicare
					Total Days	81		

The Entry Tracking Form is transmitted but is not followed by an assessment. Since there is no new assessment within 14 days from the reentry date A1600 (01/15/2018), the RUG-IV classification is taken from the preceding active assessment and applied to the Entry Tracking Form. The Entry Tracking form must be coded A1700 = 2, Reentry.

Missing or Out of Order Assessments

M. When an Admission assessment is preceded by an assessment, the days counted for the Admission assessment begin from the assessment reference date (A2300) on the Admission and not the entry date (A1600).

In this example, a Quarterly assessment was followed by an Admission assessment with the following:

Quarterly assessment:

- Assessment Reference Date (A2300) 12/15/2017

Admission/5-day Medicare assessment:

- Assessment Reference Date (A2300) 02/21/2018 including an entry date (A1600) 02/10/2018

Record Type	Target Date	RUG Class	Start Date	Start Date Field	End Date	Days	Case Mix Index	Payment Source
NQ/02/99/99	12/15/17	LD1	01/01/18		02/20/18	51	1.21	Medicaid
NC/01/01/99	02/21/18	ES1	02/21/18	A2300	03/31/18	39	2.22	Medicare
					Total Days	90		

An Admission assessment should only be completed on admission and should not immediately follow another RUGgable assessment. This is considered "Out of Sequence".

DETERMINATION OF PAYMENT SOURCE

The payment source (Medicaid, Medicare or Other) identified on the Resident Roster is determined from the assessment as follows:

- All assessments with a PPS reason for assessment in MDS item A0310B (01) are identified as Medicare payment source.
- A non-PPS assessment or tracking form (A0310B=99) where MDS item A0700 Medicaid Number is submitted with a valid recipient Medicaid number are counted as Medicaid payment source. A valid recipient Medicaid number is a nine digit non-repeating number that begins with 00 or 10.
- Medicaid pending coded with the "+" (plus) symbol in MDS item A0700 Medicaid Number, are counted as Medicaid payment source, unless the assessment in MDS item A0310B are identified with a PPS reason (01); then Medicare payment source is assigned.
- Any assessments not identified as Medicare or Medicaid are assigned as Other payment source on the detail pages of the Resident Roster

REVIEW OF PRELIMINARY RESIDENT ROSTER

The Preliminary Resident Roster is provided as a tool for use by the facility in determining whether any missing or incorrect records are noted and allows the facility a review period to evaluate records displayed on the roster. All corrections to the Preliminary Resident Roster must be made through the modification, inactivation and transmission process for MDS assessments and tracking forms in accordance with the RAI manual (Chapter 5) and CMS correction policy on or before the cutoff date of the Final Resident Roster CMI report; no manual alterations of the Resident Roster are considered.

In reviewing the Preliminary Resident Roster, the following steps are suggested but not limited to:

- Determine if all residents in the facility at any time during the quarter are listed on the Resident Roster.
- Determine if each resident is identified only once. If the same resident appears as if they were two separate residents, contact the RAI Coordinator to merge resident assessments.
- Review the listed assessments and tracking forms for each listed resident to determine if each assessment/tracking form is accounted for on the Resident Roster.
- Determine if each Medicaid resident is correctly identified as Medicaid for any non-PPS assessment days by reviewing MDS item A0700 Medicaid Number.
- Review any BC1 RUG classifications and, if appropriate, submit any completed missing assessments or tracking forms or complete any modifications of previously transmitted records, when applicable, to correct the reason causing the BC1 RUG classification assignment. Additionally, keep in mind that assessments may have already been transmitted after the cut-off date of the Preliminary Resident Roster and will automatically be listed on the Final Resident Roster including the associated RUG and CMI.
- Review the RUG-IV classification attributed to Entry Tracking Forms followed by a Discharge assessment for accuracy of the discharge status (A2100).
- Keep in mind, missing or corrected (if applicable) assessments that have been transmitted and accepted after the cut-off date(s) will not be reflected on the Time-Weighted CMI Resident Roster Report (both preliminary and final).
- Review for missing or corrected (if applicable) assessments that may have been transmitted and **not** accepted by the QIES ASAP system. Review errors; make corrections and retransmit, if applicable.
- Review for accuracy of dates and or reasons for assessment by following the RAI manual instructions for modifications and inactivation’s in Chapter 5.
- Review the type of Entry Tracking form (A1700=1, Admission or A1700=2, Reentry) to ensure that the reason fits the expected order of assessments/tracking forms displayed.

Any corrections including transmissions must be completed by the predetermined cutoff date for the quarterly Final CMI Resident Roster report.

SUMMARY RESIDENT ROSTER CMI CALCULATION

The day weighted calculations are completed for the facility on the summary page of the Resident Roster. The CMI averages are calculated for Medicaid, Medicare, Other and All Residents quarterly.

The calculated days from the detail pages of the Resident Roster for each source of payment are summed by RUG-IV classification. For each RUG-IV classification, the assigned CMI is multiplied by the total number of days to arrive at CMI points. The sum of all of the CMI points divided by the sum of all days is the day weighted average for the payment source.

4 RESOURCES

The Connecticut Medicaid facility's Time-Weighted CMI Resident Roster is linked to the federal requirements for completion and submission of the MDS. The following list of resources may be beneficial to aid in the correct completion and submission of the MDS to fulfill federal requirements. However, these resources do change over time; it's recommended that facilities view the websites periodically to determine if any updates to the listed manuals and question and answer documents have been made.

Every effort is made to assure that the information provided in this manual is accurate; however, the MDS is an assessment instrument implemented by the federal government. If later guidance is released by the CMS that contradicts or augments guidance provided in this manual, this more current information from the CMS becomes the acceptable standard.

WEBSITES

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html - This site is maintained by the CMS and provides extensive information about the MDS, data submission, Medicare PPS RUG-IV 66-Group classification, etc.

- https://qtso.cms.gov/ - This site is maintained by Telligen (formerly Iowa Foundation for Medical Care). This firm provides support for submissions to the QIES ASAP System and maintains a provider helpdesk for users of jRAVEN and is referred to by the CMS as their Quality Improvement and Evaluation System (QIES) Technical Support contractor. Their website contains information on the MDS submission process, manuals, etc.

- https://www.mslc.com/Connecticut/- This site is maintained by Myers and Stauffer LC and is the location in which materials applicable to the Connecticut Case Mix Reimbursement system are located.

MANUALS

- MDS 3.0 RAI Manual - This manual provides information about the completion of the MDS and is available from various publishers and the CMS and QTSO websites. Changes to this manual are released periodically by CMS and may be viewed by monitoring: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html for the latest information. The applicable portions are incorporated in this document.

- MDS 3.0 Provider User's Guide - This manual provides information about the electronic submission of MDS 3.0 from the facility to the QIES ASAP System and is available on the QTSO website at the following link-https://qtso.cms.gov/providers/nursing-home-mdsswing-bed-providers/reference-manuals

- MDS 3.0 Data Specifications - These specifications describe item-by-item edits for each element of the MDS 3.0 as well as describing sequencing, timing, date consistency and record types and is available on the CMS website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html

HELP DESK

- ***Myers and Stauffer Help Desk*** *– Myers and Stauffer is a contractor to the Connecticut Department of* Social Services and provides the Roster Reports as well as technical assistance. The phone number of the Myers and Stauffer Help Desk is 1-800-763-2278 and is also provided on the Time-Weighted CMI Resident Roster Report.

- **CMSNet** - Providers Phone Number: 888-238-2122
  This relates to problems/assistance relating to providers being able to connect to the private internet (CMSNET). See Overview 2-2 at: https://qtso.cms.gov/system/files/qtso/Users_Sec2_2.pdf

- **QTSO Help Desk** - Providers Phone Number 800-339-9313
  This relates to problems/assistance relating to Casper User IDs or the jRAVEN Application.

5 GLOSSARY

COMMON TERMS AND ABBREVIATIONS

This user guide section provides definitions of terms and abbreviations that a user may hear not only while reviewing the Roster Report, but also within the larger MDS environment.

Term/Abbreviation	Definition
Admission Entry Date	The date the resident began his/her current stay; denoted at MDS item A1600, Entry date and A1700 = 1 (Admission).
Assessment Reference Date (ARD)	The last day of the MDS observation period; denoted at MDS item A2300.
Assessment Submission and Processing System (ASAP)	The CMS system that receives submissions of MDS 3.0 data files, validates records for accuracy and appropriateness, and stores validated records in the CMS database.
Case Mix	The mix of residents being cared for in a nursing facility at any given time.
Case Mix Index (CMI)	A weight or numeric score assigned to each Resources Utilization Group (RUG-IV) that reflects the relative resources predicted to provide care to a resident. The higher the case mix weight, the greater the resource requirements for the resident.
Case Mix Reimbursement System	For a nursing facility, a payment system that measures the intensity of care and services required for each resident and translates these measures into the amount of reimbursement given to the facility for care of a resident. Payment is linked to the intensity of resource use.
Centers for Medicare and Medicaid Services, The (CMS)	The federal agency that is located in the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs.
CMSNet	The communication system used to electronically submit data to the QIES ASAP System. Each staff personnel at the NF who is submitting data must have an individual password.
Discharge Date	The date a resident is discharged from the facility; denoted at MDS item A2000.
Discharge	The act of leaving a facility, regardless of intent to return.
Episode	A series of one or more stays that may be separated by brief interruptions in the facility.
Inactivation	A type of correction allowed under the MDS Correction Policy (Chapter 5 of the RAI manual). A NF may electronically request that an invalid record that was accepted into the database be inactivated.
Inactive period	For Connecticut Medicaid purposes only, the period following an expired assessment beginning with Day 93 until the start of the next assessment (A2300 or A1600 date) or the end of the Resident Roster quarter. OR the period greater than 14 days between the Admission date and the Admission assessment reference date beginning Day 15.
Index Maximization	The term used to define the process by which “Each assessment shall be assigned the RUG-IV category with the highest numeric CMI for which the assessment qualifies.”
Internal Resident ID	See Resident Internal ID

Term/Abbreviation	Definition
Item Set Code (ISC)	A code based upon combinations of reasons for assessment (A0310 items A, B, F) that determines which items are active on a particular type of MDS assessment or tracking record.
Minimum Data Set (MDS)	A core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare and/or Medicaid.
Modification	A type of assessment correction allowed under the MDS Correction Policy (Chapter 5 of RAI Manual). A modification is requested when an accepted MDS assessment is in the QIES ASAP System database but the information in the assessment contains errors. Each modification results in an increase in the Correction Number at MDS item X0800.
OBRA Assessments	A term used when referring to federally required MDS assessments based on the resident's condition and clinical requirements (A0310A = 01–06) as required by the RAI manual.
Omnibus Budget Reconciliation Act (OBRA '87)	Law that enacted reforms in nursing facility care and provides the statutory authority for the MDS. The goal is to ensure that residents of nursing facilities receive quality care that will help them to attain or maintain the highest practicable, physical, mental, and psychosocial well-being.
Prospective Payment System (PPS)	A payment system, developed for Medicare skilled nursing facilities, which pays facilities an all-inclusive rate for all Medicare Part A beneficiary services. Payment is determined by a case mix classification system that categories residents by the type and intensity of resources used.
PPS Assessment	A term used when referring to MDS assessments completed for Medicare PPS requirements/reimbursement (A0310B = 01 or 08).
QIES Technical Support Office (QTSO)	A CMS contractor that provides technical support to the state agencies housing the QIES ASAP System. The QIES Technical Support Office function is provided by Telligen (formerly Iowa Foundation for Medical Care).
Quality Improvement and Evaluation System (QIES)	The "umbrella" system that encompasses MDS, OASIS, ASPEN and OSCAR.
RAI Manual	The Long-Term Care Facility Resident Assessment Instrument User's Manual, issued by the CMS covering the Minimum Data Set and Care Area Assessments.
Reentry Date	The date the resident returns to the facility and continues his/her current episode; denoted at MDS item A1600, Entry date and A1700 = 2 (Reentry).
Resident	A person being cared for in a Nursing Facility.
Resident ID	A unique internal resident ID created for each individual nursing facility resident upon the submission of their first assessment/tracking form to the QIES ASAP System. The Resident ID (Res_Int_ID) is based on resident identifying information that includes resident name, social security number, gender, date of birth. All subsequent records for that resident are identified with the same unique Resident ID.
Resident Assessment	A standardized evaluation of each resident's physical, mental, psychosocial and functional status conducted within 14 days of admission to a nursing facility, promptly after a significant change in a resident's status, quarterly and on an annual basis.
Resident Assessment Instrument (RAI)	The designation for the complete resident assessment process mandated by the CMS, including the MDS, Care Areas Assessments (CAAs) and care planning decisions.

Term/Abbreviation	Definition
Resource Utilization Group Version IV (RUG-IV)	A category-based resident classification system used to classify nursing facility residents into groups based on their characteristics and clinical needs.
Roster Quarter	Quarter 1 = 01/01/Current Year to 03/31/Current Year Quarter 2 = 04/01/Current Year to 06/30/Current Year Quarter 3 = 07/01/Current Year to 09/30/Current Year Quarter 4 = 10/01/Current Year to 12/31/Current Year
RUG Element	Those items on the MDS that are used in the RUG-IV grouper classification system.
Stay	A set of contiguous days in the facility.
Target Date	Assessment Reference Date (A2300) or Discharge Date (A2000) or Entry/Reentry Date (A1600)