Office of Medicaid Policy and Planning

TIME-WEIGHTED CMI RESIDENT ROSTER USER GUIDE 48-GROUPER

Myers and Stauffer LC
October 2017

Contents

1 REGULATORY REQUIREMENTS

INTRODUCTION

The Office of Policy and Planning (OMPP) contracted with Myers and Stauffer LC to develop a case mix reimbursement system for Indiana's Medicaid nursing facilities. The case mix system was implemented beginning with rates effective October 1, 1998. Regulations at 405 IAC 1-14.6 set forth the detailed rate calculation. A portion of the rate is adjusted based on the case mix of the residents in each facility, meaning the measure of the intensity of care and services used by similar residents.

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.

SCHEDULE OF CASE MIX ADJUSTMENTS

The case mix reimbursement rates are adjusted quarterly based on the change in case mix of each facility according to the following schedule.

Completed, transmitted and accepted MDS assessments applicable to the Rate Period:	Rate Periods:
January 1 – March 31	July 1 – September 30
April 1 – June 30	October 1 – December 31
July 1 – September 30	January 1 – March 31
October 1 – December 31	April 1 – June 30

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 records transmitted to the QIES ASAP System and accepted by that system. Each MDS assessment and tracking record active during the quarter is assigned a case mix index for the period of the quarter the assessment and tracking record apply. From this information, a day weighted case mix index is calculated for All residents 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 OMPP 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 inactive (expired) assessments or tracking forms are categorized as BC1.

Index maximization (the process by which each assessment is assigned the RUG-IV classification with the highest numeric CMI for which the assessment qualifies) is used to assign each resident to the final RUG-IV classification.

RUG-IV Classification		CMI-48
Extensive Service		
ES3	Extensive Service	3.00
ES2	Extensive Service	2.23
ES1	Extensive Service	2.22
Rehabilitation		
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
Special Care High		
HE2	Special Care-High + Depressive Mood Symptoms	1.88
HE1	Special Care-High	1.47
HD2	Special Care-High + Depressive Mood Symptoms	1.69
HD1	Special Care-High	1.33
HC2	Special Care-High + Depressive Mood Symptoms	1.57
HC1	Special Care-High	1.23
HB2	Special Care-High + Depressive Mood Symptoms	1.55
HB1	Special Care-High	1.22
Special Care Low		
LE2	Special Care-Low + Depressive Mood Symptoms	1.61
LE1	Special Care-Low	1.26
LD2	Special Care-Low + Depressive Mood Symptoms	1.54
LD1	Special Care-Low	1.21
LC2	Special Care-Low + Depressive Mood Symptoms	1.30
LC1	Special Care-Low	1.02
LB2	Special Care-Low + Depressive Mood Symptoms	1.21
LB1	Special Care-Low	0.95
Clinically Complex		
CE2	Clinically Complex + Depressive Mood Symptoms	1.39
CE1	Clinically Complex	1.25
CD2	Clinically Complex + Depressive Mood Symptoms	1.29
CD1	Clinically Complex	1.15
CC2	Clinically Complex + Depressive Mood Symptoms	1.08
CC1	Clinically Complex	0.96
CB2	Clinically Complex + Depressive Mood Symptoms	0.95
CB1	Clinically Complex	0.85
CA2	Clinically Complex + Depressive Mood Symptoms	0.73
CA1	Clinically Complex	0.65

RUG-IV Classification		CMI-48
Behavioral Symptoms & Cognitive Performance		
BB2	Behavioral Symptoms & Cognitive Performance + 2 or more RN Programs	0.81
BB1	Behavioral Symptoms & Cognitive Performance	0.75
BA2	Behavioral Symptoms & Cognitive Performance + 2 or more RN Programs	0.58
BA1	Behavioral Symptoms & Cognitive Performance	0.53
Reduced Physical Function		
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	0.43

CMI-48 Low Needs	CMI-48-BC1 Low Needs
0.29	0.28
0.28	0.27
0.21	0.20
0.19	0.18

IDENTIFICATION OF MDS ASSESSMENTS/RECORDS

The identification of the MDS assessments on the Resident Roster depends on the assessment coding at A0310A, B, C, and F 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 (A0310C)	MDS 3.0 (A0310F)
Admission assessment	NC	01	99	0	99
Quarterly assessment	NQ	02	99	0	99
Annual assessment	NC	03	99	0	99
Significant change in status assessment	NC	04	99	0	99
Significant correction of prior full assessment	NC	05	99	0	99
Significant correction of prior quarterly assessment	NQ	06	99	0	99

PPS (Medicare) Scheduled Assessments (A0310B)	MDS 3.0 Item Set Code (ISC)	MDS 3.0 (A0310A)	MDS 3.0 (A0310B)	MDS 3.0 (A0310C)	MDS 3.0 (A0310F)
5-day assessment	NP	99	01	0	99
14-day assessment	NP	99	02	0	99
30-day assessment	NP	99	03	0	99
60-day assessment	NP	99	04	0	99
90-day assessment	NP	99	05	0	99

PPS (Medicare) Unscheduled Assessments (A0310C)	MDS 3.0 Item Set Code (ISC)	MDS 3.0 (A0310A)	MDS 3.0 (A0310B)	MDS 3.0 (A0310C)	MDS 3.0 (A0310F)
Start of Therapy assessment	NS	99	07	1	99
End of Therapy assessment	NO	99	07	2	99
Both Start and End of Therapy assessment	NO	99	07	3	99
Change of Therapy assessment	NO	99	07	4	99

Discharge Assessments (A0310F)	MDS 3.0 Item Set Code (ISC)	MDS 3.0 (A0310A)	MDS 3.0 (A0310B)	MDS 3.0 (A0310C)	MDS 3.0 (A0310F)
Discharge – return not anticipated assessment	ND	99	99	0	10
Discharge – return anticipated assessment	ND	99	99	0	11

MDS Tracking Forms (A0310F)	MDS 3.0 Item Set Code (ISC)	MDS 3.0 (A0310A)	MDS 3.0 (A0310B)	MDS 3.0 (A0310C)	MDS 3.0 (A0310F)
Entry/Re-entry tracking	NT	99	99	0	01
Discharge – death in facility tracking	NT	99	99	0	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, A0310C and A0310F.

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

The record type NC/01/01/0/99 indicates a combined OBRA Admission with a 5-day PPS assessment.

A complete list of the Item Set Codes can be found in the RAI Manual in Chapter 2.

3 TIME-WEIGHTED CMI RESIDENT ROSTER DETAILS

DISTRIBUTION SCHEDULE

The Indiana 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 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	**01/25**	**04/25**	**07/25**	**10/25**
Final Report Cutoff Date	02/15	05/15	08/15	11/15
Final Report Posting Date	**03/07**	**06/07**	**09/07**	**12/07**

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 listed.

For each resident listed, assessment and tracking records are displayed in sequential date order. These assessment/records include the latest assessment or tracking record completed, transmitted, and accepted by the QIES ASAP System on or prior to the beginning date of the quarter. Additionally, all active assessments or tracking records completed during the quarter are displayed. The same information is listed for residents admitted during the quarter.

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 first name and last name, Social Security Number, gender, date of birth 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 records are listed on the Resident Roster with the following information:

Record Information	Description
Resident Name	Legal name of resident as submitted on the MDS assessment.
Record Type	Determined from MDS values at A0310 A, B, C, 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 date 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 date.
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 48 RUG-IV classifications.
Payment Source	Determination of Payment Source; Medicare, Medicaid, or Other.

Resident Roster Summary Page

The last page of the Resident Roster includes a summary of the total number of days for each of the 48 RUG-IV classifications, the calculated number of CMI points for Medicaid and All Residents and the day weighted CMI average for Medicare and Other 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 if transmitted as of the cutoff date of the Resident Roster.

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

C. For purposes of the Resident Roster process, the following types of assessment combinations are used only to obtain discharge dates (A2000) and discharge status (A2100).

(ISC)	(A0310A)	(A0310B)	(A0310C)	(A0310F)
ND	99	99	0	10, 11
NT	99	99	0	12

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

E. Days are counted from the entry date, if entered the facility during the quarter, 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. For purposes of Indiana Medicaid reimbursement only, each assessment is considered active for a maximum of 113 days, measured from the target date. An assessment that is not followed by any other assessment or Discharge assessment or Death in Facility tracking form within 113 days of the preceding record's assessment reference date will have inactive days counted for that assessment after day 113. The assessment is then considered an inactive assessment (or expired). During the inactive period following an expired assessment (beginning on day 114) 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) 10/14/2015

The subsequent Quarterly assessment was transmitted with the following:

- Assessment reference date (A2300) 03/15/2016

Record Type	Target Date	RUG Class	Start Date	Start Date Field	End Date	Days	Case Mix Index	Payment Source
NQ/02/99/0/99	10/14/15	CB1	01/01/16		02/03/16	34	0.85	Medicaid
NQ/02/99/0/99	10/14/15	BC1	02/04/16		03/14/16	40	0.43	Medicaid
NQ/02/99/0/99	03/15/16	CB1	03/15/16	A2300	03/31/16	17	0.85	Medicaid
					Total Days	91		

Counting 113 days from the A2300 date (10/14/2015) of the first Quarterly assessment results in 02/03/2016, meaning the active days covered by the first Quarterly assessment end on this date. From the 114th day (02/04/2016) until the day prior to the A2300 date of the next Quarterly assessment (03/15/2016), the days are counted at the inactive RUG-IV classification BC1. The days from the second Quarterly assessment count from the ARD (03/15/2016) 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 Indiana 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 record was transmitted with the following:

- Entry date (A1600) 04/12/2015 with the A1700 = 1

The Admission assessment was transmitted with the following:

- Assessment reference date (A2300) 01/24/2016
- Entry date (A1600) on Admission assessment 04/12/2015

A Discharge assessment was transmitted with the following:

- Discharge date (A2000) 03/02/2016

Record Type	Target Date	RUG Class	Start Date	Start Date Field	End Date	Days	Case Mix Index	Payment Source
NT/99/99/0/01	04/12/15	BC1	01/01/16		01/23/16	23	0.43	Medicaid
NC/01/99/0/99	01/24/16	CC2	01/24/16	A2300	03/01/16	38	1.08	Medicaid
ND/99/99/0/11	03/02/16		03/02/16	A2000	03/02/16			
					Total days	61		

Inactive days begin on the start of the quarter (01/01/2016) because the entry date of 04/12/2015 is greater than 14 days prior to the assessment reference date of 01/24/2016 of the Admission assessment. Days begin counting on the assessment reference date of 01/24/2016 of the Admission assessment through the day prior to the discharge date of 03/02/2016.

Entry Tracking Record

I. If an Entry Tracking record indicates a new admission and is followed by a Discharge assessment or Death in Facility Tracking record within 14 days, 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 an acute care setting (A2100 = 03, 05, 08, or 09).
- **RAB** – when discharge status was other than death or discharged to an acute care setting (A2100 = 01, 02, 04, 06, 07, or 99).

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

- Entry date (A1600) 12/25/2015 with A1700 = 1, Admission

The Discharge assessment was transmitted with the following:

- Discharge date (A2000) 01/07/2016
- 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/99/99/0/01	12/25/15	LC2	01/01/16		01/06/16	6	1.30	Medicaid
NT/99/99/0/12	01/07/16		01/07/16	A2000	01/07/16			
					Total Days	6		

When an Entry Tracking record is the first and only record for a new admission 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 example, the discharge status is deceased (08); resulting in a RUG classification of LC2. The Entry Tracking record must be coded A1700 = 1, Admission.

J. Entry Tracking records 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 record 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 record was submitted followed by an Admission/5-day PPS assessment with the following:

Quarterly assessment:

- Assessment Reference Date (A2300) 11/15/2015

Discharge assessment:

- Discharge date (A2000) 01/06/2016

Entry Tracking record:

- Entry Date (A1600) 03/01/2016 with A1700 = 1, Admission

Admission/5-day PPS assessment:

- Assessment Reference Date (A2300) 03/13/2016 and the entry date (A1600) 03/01/2016

Record Type	Target Date	RUG Class	Start Date	Start Date Field	End Date	Days	Case Mix Index	Payment Source
NQ/02/03/0/99	11/15/15	ES2	01/01/16		01/05/16	5	2.23	Medicare
ND/99/99/0/11	01/06/16		01/06/16	A2000	01/06/16			
NT/99/99/0/01	03/01/16		03/01/16	A1600	03/01/16			
NC/01/01/0/99	03/13/16	ES3	03/01/16	A1600	03/31/16	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) 01/06/2016. The Entry Tracking record is transmitted followed by an Admission/5-day assessment which begins counting at the entry date, (A1600) 03/01/2016, through the end of the quarter. The Entry Tracking record must be coded A1700 = 1, Admission. Note that no days are assigned to the Entry Tracking record but instead the entry date A1600 (03/01/2016) is assigned to the days counted for the Admission/5-day assessment as noted in the "Start Date Field" column.

K. If the Entry Tracking record (denoted as a reentry) is <u>not</u> followed by an assessment, but is preceded by an assessment that is not inactive, 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 record was submitted but was not followed by an assessment. Assessments/tracking records were transmitted with the following:

Quarterly assessment:

- Assessment Reference Date (A2300) 12/30/2015

Discharge assessment:

- Discharge date (A2000) 01/06/2016

Entry Tracking record:

- Entry Date (A1600) 01/15/2016 with A1700 = 2, Reentry

Record Type	Target Date	RUG Class	Start Date	State Date Field	End Date	Days	Case Mix Index	Payment Source
NQ/02/07/3/99	12/30/15	RAC	01/01/16		01/05/16	5	1.36	Medicare
ND/99/99/0/11	01/06/16		01/06/16	A2000	01/06/16			
NT/99/99/0/01	01/15/16	RAC	01/15/16	A1600	03/31/16	77	1.36	Medicare
					Total Days	82		

The Entry Tracking record is transmitted but is not followed by an assessment. Since there is no new assessment within 14 days from the reentry date A1600 (01/15/2016), the RUG-IV classification is taken from the preceding active assessment and applied to the Entry Tracking record period. The Entry Tracking record must be coded A1700 = 2, Reentry.

Missing or Out of Order Assessments

L. 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) 12/15/2015

Admission/5-day Medicare assessment:

- Assessment Reference Date (A2300) 02/21/2016 including an entry date (A1600) 02/10/2016

Record Type	Target Date	RUG Class	Start Date	Start Date Field	End Date	Days	Case Mix Index	Payment Source
NQ/02/99/0/99	12/15/15	LD1	01/01/16		02/20/16	51	1.21	Medicaid
NC/01/01/0/99	02/21/16	ES1	02/21/16	A2300	03/31/16	40	2.22	Medicare
					Total Days	91		

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

Records with Therapy

M. ***Effective January 1, 2018 (405 IAC 1-14.6)***
When a resident is assigned a RUG-IV classification category of “Rehabilitation”, the Time-Weighted CMI Resident Roster Report shall examine the therapy start and therapy end dates for each episode of therapy (as provided on both the MDS and Web Portal transmissions).

Each episode of therapy (physical therapy, occupational therapy, and speech-language pathology and audiology services (i.e. speech therapy)) will then be compared to the day count assigned to the resident on theTime-Weighted CMI Resident Roster Report.

If a difference is noted between the therapy episode and the day count assigned on the Time-Weighted CMI Resident Roster Report, the record will be split to reflect a classification category of “Rehabilitation” when a therapy episode occurred and reclassified to exclude therapy services from the record for the remaining day count of the Time-Weighted CMI Resident Roster Report.

If no end date for a therapy episode is found, an end date will be assigned using the regimen start date + 1 day.

In this example, the resident began the quarter with the following:

Medicare 30-day assessment:

- Assessment Reference Date (A2300) 12/05/2016

Medicare 60-day assessment:

- Assessment Reference Date (A2300) 01/02/2017

Speech-Language Pathology and Audiology Services

- Regimen Start Date 12/03/2016
- Regimen End Date 02/01/2017

Occupational Therapy

- Regimen Start Date 12/03/2016
- Regimen End Date – Not Provided

Physical Therapy:

- Regimen Start Date 12/04/2016
- Regimen End Date – Not Provided

Record Type	Target Date	RUG Class	Start Date	Start Date Field	End Date	Days	Case Mix Index	Payment Source
NP/99/03/99	12/05/16	RMB	01/01/17		01/01/17	1	1.65	Medicare
NP/99/04/99	01/02/17	RHC	01/02/17	A2300	02/03/17	31	1.58	Medicare
NP/99/04/99	01/02/17	PD1	02/04/17		03/31/17	58	1.06	Medicare
					Total Days	90		

In this example, no end dates are found for the occupational or physical therapy regimens; however, an end date of 02/01/2017 was transmitted Speech-Language Pathology and Audiology Services.

As the therapy episode end date is prior to the end date of the active Medicare 60 day assessment, the record is split after the episode end date of 02/01/2017.

The record is then split and reclassified on 02/02/2017 to exclude therapy services from the record for the remaining day count of the Time-Weighted CMI Resident Roster Report.

Low Needs CMI Application

N. ***Effective January 1, 2010 (405 IAC 1-14.6)***
For purposes of Indiana Medicaid reimbursement **only**, Medicaid residents that meet all the following conditions are considered “low needs” and will be assigned alternate CMIs.

(1) The Medicaid resident classifies into one (1) of the following Reduced Physical Function RUG groups: PB2, PB1, PA2, and PA1.

(2) The resident has a cognitive status indicated by a brief interview of mental status score (BIMS) greater than or equal to ten (10) or, if there is not a BIMS score, a cognitive performance score (CPS) of 0, 1 or 2.

(3) The resident is not experiencing occasional, frequent, or complete bowel incontinence control.

(4) The resident has not been admitted to any Medicaid-certified nursing facility before January 1, 2010.

(5) Any qualifying low needs assessments that are subsequently determined to be inactive shall be assigned ninety-six percent (96%) of the CMI associated with the low needs RUG classification.

In this example, the Quarterly assessment meeting low needs criteria was transmitted with the following:

- Assessment reference date (A2300) 12/10/2015

The subsequent Discharge was transmitted with the following:

- Discharge date (A2000) 01/15/2016

Record Type	Target Date	RUG Class	Start Date	Start Date Field	End Date	Days	Case Mix Index	Payment Source
NQ/02/99/0/99	12/10/15	PB1-LN	01/01/16		01/14/16	14	0.28	Medicaid
ND/99/99/0/11	01/15/16		01/15/16	A2000	01/15/16			
					Total Days	14		

Since the Quarterly assessment met the low needs criteria, the low needs RUG classification is reflected (PB1-LN) and associated CMI (0.28).

Note:
The low needs CMI is not applied to the All residents CMI utilized in the Normalization process.

SPECIAL ASSESSMENT CONDITIONS

The following assessment combinations shall be displayed on the Time-Weighted Resident Roster with days and indices as follows:

- When the assessment type equals a standalone OMRA unscheduled start of therapy (99/07/1/99) apply the following order:
  - When classifies into Rehabilitation display Rehabilitation RUG, days and CMI
  - When classifies into Extensive Services display Extensive Services RUG, days and CMI
  - When classifies into neither Rehabilitation or Extensive Services then no RUG, days or CMI shall be displayed
- When the assessment type equals a combined OMRA unscheduled start of therapy (XX/07/1/XX) apply the following order:
  - When classifies into Rehabilitation display Rehabilitation RUG, days and CMI
  - When not Rehabilitation display the non-Rehabilitation RUG*, days and CMI
- When the assessment type equals a standalone OMRA unscheduled both start and end of therapy (99/07/3/99) apply the following order:
  - When classifies into Rehabilitation display Rehabilitation RUG, days and CMI
  - When not Rehabilitation display the non-Rehabilitation RUG*, days and CMI
- When the assessment type equals a combined OMRA unscheduled both start and end of therapy (XX/07/3/XX) apply the following order:
  - When classifies into Rehabilitation display Rehabilitation RUG, days and CMI
  - When not Rehabilitation display the non-Rehabilitation RUG*, days and CMI

*A non-Rehabilitation RUG is any RUG classification within Extensive Services, Special Care High, Special Care Low, Clinically Complex, Behavioral Symptoms and Cognitive Performance or Reduced Physical Function which the assessment meets the classification criteria.

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 (01-07) 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 Medicaid recipient number is a twelve (12) digit number, beginning with a ten (10) and ending with a ninety-nine (99).

- 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 (01-07); 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 PRELIMENARY 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 records 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:

- Review any BC1 RUG classifications and, if appropriate, submit any completed missing assessments or tracking records or complete any modifications of previously transmitted records, when applicable, to correct the reason causing the BC1 RUG classification assignment.
- Keep in mind that assessments transmitted after the cut-off date of the Preliminary Resident Roster displayed as BC1 will automatically be listed on the Final Resident Roster including the associated RUG and CMI.
- 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.
- Determine if all residents in the facility at any time during the quarter are listed on the Resident Roster.
- Review the listed assessments and tracking records for each listed resident to determine if each assessment/tracking record is accounted for on the Resident Roster.
- Review the start date and end date for accuracy.
- Determine if each Medicaid resident is correctly identified as Medicaid for any non-PPS assessment days by reviewing MDS item A0700 Medicaid Number.
- Review the RUG-IV classification attributed to Entry Tracking records 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 records (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.

The Final CMI Resident Roster report averages are used in the determination of the facility's quarterly case mix rate adjustment.

4 GENERAL CASE MIX REIMBURSEMENT METHODLOGY

The Indiana Medicaid reimbursement system is based on recognition of the provider's allowable costs for the administrative, capital, direct care, indirect and therapy components, plus potential add-on payments. The following is not an attempt to be all inclusive regarding the rate calculation; rather it is to provide a summary of the various rate components.

BASIC ELEMENTS

- ✓ Annual rate period from July 1 through June 30
- ✓ Administrative component
- ✓ Capital component
- ✓ Direct care component
- ✓ Indirect care component
- ✓ Therapy component
- ✓ Potential add-on component
- ✓ Quarterly rate adjustments for changes in Medicaid acuity
- ✓ Quarterly rates effective July 1, October 1, January 1, April 1

ADMINISTRATIVE COMPONENT

The portion of the Medicaid rate that shall reimburse providers for allowable administrative services and supplies, including prorated employee benefits based on salaries and wages. Administrative services and supplies include the following:

(1) Administrator and co-administrators, owners' compensation (including director's fees) for patient-related services.
(2) Services and supplies of a home office that are:
    (A) Allowable and patient-related; and
    (B) Appropriately allocated to the nursing facility.
(3) Office and clerical staff.
(4) Legal and accounting fees.
(5) Advertising.
(6) All staff travel and mileage.
(7) Telephone and Internet.
(8) License dues and subscriptions.
(9) All office supplies used for any purpose, including repairs and maintenance charges and service agreements for copiers and other office equipment.
(10) Working capital interest.
(11) State gross receipts taxes.
(12) Utilization review costs.

(13) Liability insurance.
(14) Management and other consultant fees.
(15) Qualified intellectual disability professional.
(16) Educational seminars for administrative staff.
(17) Support and trouble-shooting, maintenance, and license fees for all general and administrative computer software and hardware such as accounting or other data processing activities.
(18) Court appointed guardian, financial institution, or third party trust costs not covered by resident personal funds.
(19) Pre-employment related costs such as background checks, drug testing, and employment contingent physicals.
(20) Nursing consulting services, whether provided by internal facility personnel, central office personnel, or contracted, that are not directly related to the provision of hands-on resident care. Such nursing consulting services include, but are not limited to: health survey, quality assurance processes, and MDS consultation (excluding data input and coding).

CAPITAL COMPONENT

The portion of the Medicaid rate that shall reimburse for the use of allowable capital-related items. Capital-related items include:

(1) Fair rental value allowance.
(2) Property taxes.
(3) Property insurance.
(4) Non-capitalized costs associated with minor equipment purchases that are not directly attributed to a specific department.

DIRECT CARE COMPONENT

The portion of the Medicaid rate that shall reimburse for allowable direct patient care services and supplies, including prorated employee benefits based on salaries and wages. Direct care services and supplies include:

(1) Nursing and nursing aide services.
(2) Nurse consulting services directly related to the provision of hands-on resident care.
(3) Pharmacy consultants.
(4) Medical director services.
(5) Nurse aide training.
(6) Medical supplies.
(7) Oxygen.
(8) Medical records costs.
(9) Rental costs for low air loss mattresses, pressure support surfaces, and oxygen concentrators. Rental cost for these items are limited to $1.50 per resident day.
(10) Support and license fees for software utilized exclusively in hands-on resident care support, such as MDS assessment software and medical records software.
(11) Replacement dentures for Medicaid residents provided by the facility that exceed state Medicaid plan limitations for dentures.
(12) Legend and nonlegend sterile water products used for irrigation or humidification.
(13) Educational seminars for direct care staff.
(14) Skin protectants, sealants, moisturizers, and ointments that are applied on an as needed basis by the member, nursing facility care staff, or by prescriber's order as a part of routine care.
(15) Parenteral and enteral nutrition costs other than meals, nutritional supplements, sterile water, and legend and non-legend drugs.
(16) Costs for the coding and input of MDS data.

INDIRECT CARE COMPONENT

The portion of the Medicaid rate that shall reimburse for allowable indirect patient care services and supplies, including prorated employee benefits based on salaries and wages. Indirect care services and supplies include:

(1) Dietary services and supplies.
(2) Raw food.
(3) Patient laundry services and supplies.
(4) Patient housekeeping services and supplies.

(5) Plant operations services and supplies.
(6) Utilities.
(7) Social services.
(8) Activities supplies and services.
(9) Recreational supplies and services.
(10) Repairs and maintenance.
(11) Cable or satellite television throughout the nursing facility, including residents' rooms.
(12) Pets, pet supplies and maintenance, and veterinary expenses.
(13) Educational seminars for indirect care staff.
(14) Non-ambulance transportation costs related to activities and other non-covered services.
(15) Admissions.
(16) Behavioral and Psychological consulting services.

THERAPY COMPONENT

The portion of the direct costs for therapy services, including prorated employee benefits based on total salaries and wages, rendered to Medicaid residents that are not reimbursed by other payers.

POTENTIAL ADD-ON COMPONENT

- Ventilator add-on
    - Must provide inpatient services to more than eight (8) ventilator-dependent residents
- Special Care Unit (SCU) for Alzheimer's disease or dementia add-on
    - Determined based on specific criteria
- Quality Score add-on
    - Determined based on specific criteria

TIME-WEIGHTED NORMALIZATION PROCESS

The normalized allowable per patient day cost for the direct care component; and allowable per patient day costs for the therapy, indirect, administrative, and capital components are established once per year for each provider based on the annual financial report.

The rate effective date of the annual rate review is July 1 of each year.

Subsequent to the annual rate review, the direct care component of the Medicaid rate will be adjusted quarterly to reflect changes in the provider's case mix index for Medicaid residents. This adjustment is used to adjust the direct care component that becomes effective on the second calendar quarter following the updated case mix index for Medicaid residents.

Complete details regarding the Medicaid rate calculation can be found at 405 IAC 1-14.6

GENERAL CORRECTIVE REMEDY AND APPEAL COMPONENTS

MDS Case Mix Review

Periodic MDS case mix reviews are conducted in the field on site based on risk determined by the facilities previous MDS review results. MDS case mix reviews performed on an expanded sample of assessments resulting in greater than twenty percent (20%) unsupported will receive the following corrective remedy:

- The administrative component of the Medicaid rate effective for the calendar quarter following completion of the MDS case mix review shall be reduced as follows:
    - First MDS review 15% reduction
    - Second consecutive MDS review 20% reduction
    - Third consecutive MDS review 30% reduction
    - Fourth consecutive MDS review 50% reduction
    - All remaining consecutive MDS reviews 50% reduction
- Reimbursement lost as a result of any corrective remedies shall not be recoverable.

Complete details regarding the MDS review can be found at 405 IAC 1-14.6-4

Administrative Reconsideration; Appeal

Reconsideration requests regarding the Medicaid rate shall be in writing and include the following:

- Specifics as to issue(s) and rationale to be considered
- Received no later than 45 days after release of the rate
- Following review of the reconsideration request details any of the following may occur:
    - Medicaid rate may be amended
    - Challenged procedure may be amended
    - Affirm the original Medicaid rate
    - Provider shall be notified of final decision within 45 days of receipt of request
- After completion of the reconsideration procedure the provider may initiate an Appeal.

Complete details regarding the Administrative reconsideration process can be found at 405 IAC1-14.6-22

Complete details regarding the Appeal process can be found at IC 4-21.5-3

Note:
Indiana Administrative Code (IAC) and Indiana Code (IC) are subject to change. Please check the most current version of the statute and rule.

5 RESOURCES

The Indiana 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

- **www.cms.gov/NursingHomeQualityInits/** - This site is maintained by the CMS and provides extensive information about the MDS, data submission, Medicare PPS RUG-IV 66-Group classification, etc.
- **www.qtso.com** - 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.
- **www.mslc.com/indiana -** This site is maintained by Myers and Stauffer LC and is the location in which the Supportive Documentation Guidelines is posted, as well as other materials applicable to the Indiana Case Mix Reimbursement/Review system.

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/MDS30RAIManual.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.
- **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 Office of Medicaid Policy and Planning and provide the Roster Reports as well as technical assistance. The phone number of the Myers and Stauffer Help Desk is 1-317-816-4122 and is also provided on the Time-Weighted Resident Roster CMI 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://www.gtso.com/download/guides/MDS/mds_30/Prvdr_Users_Sec2.pdf**
    - .

6 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.

Term/Abbreviation	Definition
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 Indiana Medicaid purposes only, the period following an expired assessment beginning with Day 114 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
Item Set Code (ISC)	A code based upon combinations of reasons for assessment (A0310 items A, B, C, 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 = 01-05 or 07 and A0310C = 1-4).
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).

Term/Abbreviation	Definition
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.
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)