Mississippi Division of Medicaid

CASE MIX MASTER ROSTER REPORT USER GUIDE

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The Case Mix Master Roster Report is a list of residents for each Medicaid certified nursing facility, displaying every resident who resided in the nursing facility during the roster quarter based on MDS assessments and tracking forms transmitted to and accepted by the QIES ASAP System. A case mix index is assigned to each MDS assessment and tracking form (under certain circumstances). From this information, a facility average day weighted case mix index is calculated.

RUG-IV 48-GROUP CLASSIFICATION MODEL, VERSION 1.03

Beginning July 1, 2014 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). This grouper uses certain MDS data elements to place assessments into one of the RUG groups based on similar resource needs.

CASE MIX INDEX

The Case Mix Index (CMI) set is the standard nursing-only CMI set published by CMS for RUG-IV, 48-Group, identified as F01. The days attributable to expired (inactive) or delinquent assessments or tracking forms are categorized as BC1.

Index maximization is used to assign each resident to the final RUG-IV classification. Below is a table of the 48-Groups and associated CMI.

RUG-IV Classification		CMI
ES3	**Extensive Service**	3.000
ES2		2.230
ES1		2.220
RAE	**Rehabilitation**	1.650
RAD		1.580
RAC		1.360
RAB		1.100
RAA		0.820

RUG-IV Classification		CMI	Alzh. CMI
HE2	Special Care-High	1.880	
HE1		1.470	
HD2		1.690	
HD1		1.330	
HC2		1.570	
HC1		1.230	
HB2		1.550	
HB1		1.220	
LE2	Special Care-Low	1.610	
LE1		1.260	
LD2		1.540	
LD1		1.210	
LC2		1.300	
LC1		1.020	
LB2		1.210	
LB1		0.950	
CE2	Clinically Complex	1.390	1.779
CE1		1.250	1.600
CD2		1.290	1.651
CD1		1.150	1.472
CC2		1.080	1.382
CC1		0.960	1.229
CB2		0.950	1.216
CB1		0.850	1.088
CA2		0.730	0.934
CA1		0.650	0.832
BB2	Behavioral Symptoms & Cognitive Performance	0.810	1.393
BB1		0.750	1.290
BA2		0.580	0.998
BA1		0.530	0.912
PE2	Reduced Physical Function	1.250	1.600
PE1		1.170	1.498
PD2		1.150	1.472
PD1		1.060	1.357
PC2		0.910	1.165
PC1		0.850	1.088
PB2		0.700	0.896
PB1		0.650	0.832
PA2		0.490	0.627
PA1		0.450	0.576
BC1	Inactive/Expired	0.450	0.450

IDENTIFICATION OF MDS RECORDS

The identification of the MDS assessments and item set code on the Roster Report 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	NC	01	99	99
Quarterly	NQ	02	99	99
Annual	NC	03	99	99
Significant change in status	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	ND	99	99	10
Discharge – return anticipated	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	NT	99	99	01
Discharge – death in facility	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, Federal OBRA Reason for Assessment
- A0310B, PPS Assessment
- A0310F, Entry/discharge reporting

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/99/99/01 indicates the Entry Tracking Form and NQ/02/99/99 indicates an OBRA Quarterly not combined with a PPS or Discharge assessment or tracking records.

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

2 CASE MIX MASTER ROSTER REPORT DETAILS

DISTRIBUTION SCHEDULE

The Mississippi Web Portal is utilized to distribute Interim and Quarter Final Roster Reports for each quarter to each Medicaid nursing facility. The Quarter Final Rosters are copied to the portal by the third Monday of the second month following the quarter end date. The following schedule is utilized (unless otherwise notified).

Roster Report Schedule	Quarter Close Date	03/31 Report	Quarter Close Date	06/30 Report	Quarter Close Date	09/30 Report	Quarter Close Date	12/31 Report
1st Interim	03/13	03/20	06/13	06/20	09/13	09/20	12/13	12/20
2nd Interim	03/31	04/07	06/30	07/07	09/30	10/07	12/31	01/07
3rd Interim	04/21	04/28	07/21	07/28	10/21	10/28	01/21	01/28
Quarter Final Roster	05/05*	**Third Monday of second month.**	08/05*	**Third Monday of second month.**	11/05*	**Third Monday of second month.**	02/05*	**Third Monday of second month.**

The facility can submit MDS data applicable to the Quarter Final Roster until 5:00 pm on the fifth (5th) day of the second month following the quarter end date.

If the quarter close date is on a weekend or state and/or federal holiday, the MDS data must be submitted on or before the first business day following such weekend/holiday to be included on the Quarter Final Roster

***Please note that no additional bed holds can be entered after this cut-off date.**

SELECTION OF RESIDENTS AND RECORDS

Residents that have been discharged prior to or on the first day of the quarter will not be listed on the Roster Report. 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 Roster Report. All residents admitted during the quarter will be listed.

For each resident listed, assessments (including discharges) and tracking forms are displayed in sequential date order. This includes the latest assessments and/or tracking forms that are active during the quarter and completed, transmitted, and accepted by the QIES ASAP System on or prior to the quarter close date. The same information is listed for residents admitted during the quarter.

Bed hold periods will also be displayed in sequential date order if applicable during the quarter.

ROSTER REPORT 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
Based on above; CMS assigns a unique Resident ID	Resident ID

Roster Report Elements

Assessments and tracking forms are identified on the Roster Report and include the information described in the following table:

Record Data	Description
Processing Code (Proc. Code)	Identifies the following conditions: ▪ A=Alzheimer's CMI ▪ B=No current assessment to date (following Entry record) ▪ C=Past due days ▪ D=Bed hold with a begin date prior to the quarter begin date ▪ E=Bed hold with an end date after the quarter end date ▪ R=Nurse review (record reviewed - No RUG change) ▪ S=Nurse review (record reviewed - RUG change) ▪ V=Ventilator dependent care
Resident Name	Legal name transmitted on the MDS (A0500).
Resident ID	Unique resident identifier number assigned by CMS.
Medicaid Number	Unique resident Medicaid number transmitted on the MDS (A0700).
Room Number	Resident room number transmitted on the MDS (A1300).
Admission Date	Admission entry date transmitted on the MDS (A1600).
Record Type	Item Set Code plus submitted values from A0310 A, B, F.
Target Date	Assessment Reference Date (A2300) or Discharge Date (A2000) or Entry/Reentry Date (A1600).
RUG-IV Classification	A record assigned one of the RUG-IV 48-Groups.
Begin Date	Calculated from: ▪ start of the quarter, or ▪ a date within the record, or ▪ a date within the preceding record, or ▪ bed hold begin date reported by provider
Begin Date Field	The MDS item (field) date location where the Begin Date was obtained (Assessment Reference Date [A2300] or Discharge Date [A2000] or Entry/Reentry Date [A1600]).
End Date	Calculated from: ▪ the end of the quarter, or ▪ a date within the record, or ▪ a date within the following record, or ▪ bed hold end date reported by provider, or ▪ the last date the record is active
Final Discharge Date	Identifies a final discharge date for a resident in a bed hold period or a discharge-return not anticipated (D/10) or death discharge (D/12), OR a final discharge date for a discharge-return anticipated (D/11) when there is a gap between the bed hold period and the next assessment.
Code	Identifies the discharge status transmitted in A2100 on the Discharge assessment by the provider.
Days	Calculated as the number of days between the Begin Date and End Date of an assessment or bed hold period.
Case Mix Index	A numerical score assigned to each of the RUG-IV 48-Groups.
CMI Points	Total CMI points by multiplying the number of days by the CMI value assigned to the assessment.

Roster Report Summary Page

The last page of the Roster Report includes a summary of the total number of days at each RUG-IV classification: the calculated number of CMI points for Regular days and Regular Bed Hold days; Alzheimer days and Alzheimer's Bed Hold days and Total days. In addition, the summary reports total beds listed, total days in period, total bed days available, facility average CMI and occupancy rate.

CALCULATION OF DAYS

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

General Rules (Rules A-D)

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

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

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

D. Days are counted from the first day of the quarter or admission date if admitted after the beginning of the quarter, until either the assessment reference date (A2300) of the next assessment, the beginning of a bed hold period, the end of the quarter or until a discharge, whichever comes first, unless the maximum number of days for the assessment has been reached.

Expired Assessment (Rule E)

E. DOM allows no more than 92 days between assessments. For purposes of Mississippi Medicaid reimbursement only, 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 an assessment or Discharge assessment or Death in Facility tracking form within 92 days of the preceding record's assessment reference date (target date) does not have additional days counted for that record after day 92. The record is then considered an expired (or inactive) assessment. During the inactive period following an expired assessment (starting on day 93) until the start of the next assessment (A2300) or the end of the quarter, days are counted at the inactive/expired RUG-IV classification BC1.

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

- Assessment reference date (A2300) 12/272018

No subsequent assessment was transmitted before the quarter close date.

Record Type	Target Date	RUG Class	Begin Date	Begin Date Field	End Date	Final Discharge Date	Code	Days	Case Mix Index	CMI Points
NQ/02/99/99	12/27/18	RAA	01/01/19		03/28/19			87	0.820	71.340
NQ/02/99/99	12/27/18	BC1	03/29/19		03/31/19			3	0.450	1.350
					Total			90		72.690

Adding 92 days to the A2300 date of the first Quarterly assessment results in 03/28/2019, meaning the active days covered by the Quarterly assessment end on this date. From the 93rd day (03/29/2019) until the end of the quarter the days are counted at the inactive/expired RUG-IV classification BC1.

Late Admission Assessment (Rule F)

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

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

- Entry date (A1600) 04/12/2018
- Entry reason (A1700) = 1 (admission)

The Admission assessment was transmitted with the following dates:

- Assessment reference date (A2300) 01/24/2019
- Entry date (A1600) on Admission assessment 04/12/2018

A Discharge assessment was transmitted with the following date:

- Discharge date (A2000) 03/02/2019

Record Type	Target Date	RUG Class	Begin Date	Begin Date Field	End Date	Final Discharge Date	Code	Days	Case Mix Index	CMI Points
NT/99/99/01	04/12/18	BC1	01/01/19		01/23/19			23	0.450	10.350
NC/01/99/99	01/24/19	CC2	01/24/19	A2300	03/01/19			37	1.080	39.960
ND/99/99/10	03/02/19		03/02/19	A2000	03/02/19	03/02/19	02			
					Total			60		50.310

Inactive/expired days begin on the start of the quarter because the entry date of 04/12/2018 is greater than 14 days prior to the assessment reference date 01/24/2019 of the Admission assessment. Days begin counting on the assessment reference date of 01/24/2019 of the Admission assessment through the day prior to the discharge date of 03/02/2019.

There were no bed hold days reported following the discharge.

Discharge Assessments (Rule G)

G. When a sequence of Discharge assessments is submitted with no assessment or bed hold days between the discharge assessments, 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) 12/10/2018

First Discharge assessment:

- Discharge date (A2000) 01/15/2019

Second Discharge assessment:

- Discharge date (A2000) 02/01/2019

Record Type	Target Date	RUG Class	Begin Date	Begin Date Field	End Date	Final Discharge Date	Code	Days	Case Mix Index	CMI Points
NQ/02/99/99	12/10/18	PB1	01/01/19		01/14/19			14	0.650	9.100
ND/99/99/11	01/15/19		01/15/19	A2000	01/15/19		03			
Bed Hold-H		PB1	01/15/19		01/29/19	01/30/19		15	0.650	9.750
ND/99/99/10	02/01/19		02/01/19	A2000	02/01/19	02/01/19	01			
					Total			29		18.850

The first discharge (D/11) date of 01/15/2019 stops the count of days for the Quarterly assessment on the day before the discharge date. Bed hold days begin and end on the 15th bed hold day (01/15/2019 through 01/29/2019). ***The Discharge 10-return not anticipated is not required.***

Entry Tracking Form (Rules H-J)

H. 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) 11/15/2018

Discharge assessment:

- Discharge date (A2000) 01/06/2019

Entry Tracking Form:

- Entry Date (A1600) 03/01/2019
- Entry reason (A1700) = 1 (admission)

Admission/5-day PPS assessment:

- Assessment Reference Date (A2300) 03/13/2019
- Entry date (A1600) 03/01/2019

Record Type	Target Date	RUG Class	Begin Date	Begin Date Field	End Date	Final Discharge Date	Code	Days	Case Mix Index	CMI Points
NQ/02/99/99	11/15/18	ES2	01/01/19		01/05/19			5	2.230	11.150
ND/99/99/11	01/06/19		01/06/19	A2000	01/06/19		03			
Bed Hold-H		ES2	01/06/19		01/20/19	01/21/19		15	1.000	15.000
NT/99/99/01	03/01/19		03/01/19	A1600	03/01/19					
NC/01/01/99	03/13/19	ES3	03/01/19	A1600	03/31/19			31	3.000	93.000
					Total			51		119.150

Days begin counting for the Quarterly assessment on the first day of the quarter through the day prior to the discharge date (A2000) 01/06/2019. Bed hold days begin counting on the discharge date up to the 15th day (01/06/2019 through 01/20/2019). The Entry Tracking Form is transmitted followed by an Admission/5-day assessment and begins counting at the entry date, 03/01/2019, through the end of the quarter. The Entry Tracking Form reason must be coded A1700 = 1 (admission).

I. If an Entry Tracking Form (admission) is not followed by an 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 be assigned a BC1 for the days starting from the entry date (A1600) to the day prior to the discharge date (A2000).

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

- Entry date (A1600) 12/25/2018
- Entry reason (A1700) = 1 (admission)

The Death in Facility Tracking From was transmitted with the following information:

- Discharge date (A2000) 01/07/2019
- Discharge status was deceased (A2100 = 08)

Record Type	Target Date	RUG Class	Begin Date	Begin Date Field	End Date	Final Discharge Date	Code	Days	Case Mix Index	CMI Points
NT/99/99/01	12/25/18	BC1	01/01/19		01/06/19			6	0.450	2.700
NT/99/99/12	01/07/19		01/07/19	A2000	01/07/19	01/07/19	08			
					Total			6		2.700

When an Entry Tracking Form is the first record for a new admission and is followed by a Discharge assessment or Death in Facility Tracking Form within 14 days with no assessment between, the RUG-IV classification and associated CMI are classified as a BC1.

J. If the Entry Tracking Form (reentry) is not followed by an assessment, but is preceded by an active assessment, 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 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. Records were transmitted with the following:

Quarterly assessment:

- Assessment Reference Date (A2300) 12/30/2018

Discharge assessment:

- Discharge date (A2000) 01/06/2019

Entry Tracking Form:

- Entry Date (A1600) 01/15/2019
- Entry reason (A1700) = 2 (reentry)

Record Type	Target Date	RUG Class	Begin Date	Begin Date Field	End Date	Final Discharge Date	Code	Days	Case Mix Index	CMI Points
NQ/02/99/99	12/30/18	ES2	01/01/19		01/05/19			5	2.230	11.150
ND/99/99/11	01/06/19		01/06/19	A2000	01/06/19		03			
Bed Hold-H		ES2	01/06/19		01/14/19			9	1.000	9.000
NT/99/99/01	01/15/19	ES2	01/15/19	A1600	03/29/19			74	2.230	165.020
NT/99/99/01	01/15/19	BC1	03/30/19		03/31/19			2	0.450	0.900
					Total			90		186.070

The Entry Tracking Form is transmitted but is not followed by an assessment. Since there is no assessment within 14 days from the reentry date (A1600), the RUG-IV classification is taken from the preceding active assessment. The Entry Tracking Form must be coded (A1700) = 2 (reentry). The Quarterly assessment became inactive/expired on 03/30/2019; inactive/expired days begin 03/30/2019 through 03/31/2019.

Missing or Out of Order Assessments (Rule K)

K. When an Admission assessment is out of order and 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) 12/15/2018

Admission/5-day Medicare assessment:

- Assessment Reference Date (A2300) 02/21/2019
- Entry date (A1600) 02/10/2019

Record Type	Target Date	RUG Class	Begin Date	Begin Date Field	End Date	Final Discharge Date	Code	Days	Case Mix Index	CMI Points
NQ/02/99/99	12/15/18	LD1	01/01/19		02/20/19			51	1.210	61.710
NC/01/01/99	02/21/19	ES1	02/21/19	A2300	03/31/19			39	2.220	86.580
					Total			90		148.290

An Admission assessment should only be completed on an admission. This is considered “Out of Sequence”. Since this Admission assessment is out of sequence, days begin counting from the assessment reference date (A2300) 02/21/2019.

Bed Hold Criteria (Rule L)

L. Bed hold begin and end dates shall be submitted through the Mississippi Web Portal no later than the close date of the Quarter Final Roster Report. The dates submitted in the portal must reflect the actual bed hold period.

Days reimbursed (bed hold) by home/therapeutic leave including hospital observational stays (where the hospital does not admit the resident) are counted for a maximum of 15 consecutive days per absence since CMS does not require a discharge form to be completed.

- Home/therapeutic leave (**Bed Hold-T**)
  a. Bed hold begin date is required when resident begins the home/therapeutic leave (first day on leave and not in facility).
  b. Bed hold end date is required when resident ends the home/therapeutic leave (last day on leave and not in facility).
  c. Bed hold end date must be equal to the lesser of:
     - The 15th continuous leave day.
     - Day prior to the target date of the subsequent assessment.
     - Last day resident is out of facility.
     - Day prior to return date (return date into the facility is not a leave day).
     - End of quarter date.
  d. Both begin and end dates are submitted through the Web Portal only when both dates are confirmed.
  e. Bed hold end date shall not exceed 15 continuous days per absence.
  f. If the resident has utilized the 15 consecutive day maximum, the resident must return to the facility for 24 hours before the nursing facility can be reimbursed for a new temporary leave period.
  g. Total annual therapeutic bed hold days shall not exceed 42 regular days and 6 holiday days:
     - Holiday days include the day before, day of and day after Thanksgiving and Christmas, for a grand total annual of 48 days.

In this **therapeutic** bed hold example, the resident entered with the following:

Admission assessment:
- Assessment Reference Date (A2300) 11/05/2018

Quarterly assessment:
- Assessment Reference Date (A2300) 02/06/2019

Therapeutic Bed Hold Example:

Record Type	Target Date	RUG Class	Begin Date	Begin Date Field	End Date	Final Discharge Date	Code	Days	Case Mix Index	CMI Points
NC/01/99/99	11/05/18	RAD	01/01/19		02/05/19			36	1.580	56.880
NQ/02/99/99	02/06/19	RAC	02/06/19	A2300	03/13/19			36	1.360	48.960
Bed Hold-T		RAD	03/14/19		03/19/19			6	1.000	6.000
NQ/02/99/99	02/06/19	RAC	03/20/19		03/31/19			12	1.360	16.320
					Total			90		128.160

The therapeutic bed hold begin and end dates are reported in the Mississippi Web Portal. In this example, the resident is on therapeutic leave for six (6) days then returns to the facility. When the resident returns, with no change in condition and or no assessment completed, days resume from the previous active assessment on 03/20/2019.

- Hospital leave **(Bed Hold-H)**
  a. Hospital leave must be preceded by a Discharge-return anticipated (D/11).
  b. Bed hold begin date is required when the resident is admitted and begins the hospital leave:
     - Hospital bed hold begin date is equal to the date the resident was admitted as a hospital in-patient.
  c. Bed hold end date is required when resident ends the hospital leave (last day in hospital and not in facility).
  d. Both begin and end dates are submitted through the Web Portal only when both dates are confirmed.
  e. Bed hold end date shall not exceed 15 continuous days per absence.
  f. Bed hold end date must be equal to the lesser of:
     - The 15th continuous leave day.
     - Day prior to the target date of subsequent entry or assessment.
     - Last day resident is out of facility and is a hospital in-patient.
     - End of quarter date.
  g. If the resident has utilized the 15 consecutive day maximum, the resident must return to the facility for 24 hours before the nursing facility can be reimbursed for a new temporary leave period.
  h. There is no annual hospital bed hold days limitation.

In this **hospital** bed hold example (in facility 24 hours), the resident entered with the following:
- Entry date (A1600) 02/10/2019

The subsequent combined Discharge/PPS assessment was transmitted with the following:
- Discharge date (A2000) 02/14/2019
- Bed hold begin and end dates are as follows: 02/14/2019 through 02/28/2019

The subsequent Entry record and Discharge assessment was transmitted with the following:
- Entry date (A1600) 03/01/2019
- Discharge date (A2000) 03/02/2019
- Bed hold begin and end dates are as follows: 03/02/2019 through 03/07/2019

The subsequent Entry record and Admission assessment was transmitted with the following:

- Entry date (A1600) 03/08/2019
- Admission assessment ARD (A2300) 03/10/2019

Hospital Bed Hold Example:

Record Type	Target Date	RUG Class	Begin Date	Begin Date Field	End Date	Final Discharge Date	Code	Days	Case Mix Index	CMI Points
NT/99/99/01	02/10/19		02/10/19	A1600	02/10/19					
NP/99/01/11	02/14/19	RAE	02/10/19	A1600	02/13/19		03	4	1.650	6.600
Bed hold-H		RAE	02/14/19		02/28/19			15	1.000	15.000
NT/99/99/01	03/01/19		03/01/19	A1600	03/02/19					
ND/99/99/11	03/02/19		03/02/19	A2000	03/02/19		03			
Bed hold-H		RAE	03/02/19		03/07/19			6	1.000	6.000
NT/99/99/01	03/08/19		03/08/19	A1600	03/08/19					
NC/01/99/99	03/10/19	HD2	03/08/19	A1600	03/31/19			24	1.690	38.400
					Total			49		66.000

Bed hold period begin on the discharge date (02/14/2019) and continue for a maximum of 15 consecutive days. In this example, the resident returned to the facility for 24 hours then discharged. The second bed hold period begins on the day of discharge (03/02/2019) until the day prior to the entry date (03/08/2019). The resident must be in the facility for 24 hours before the nursing facility can be reimbursed for a new temporary leave period.

- Hospital leave – 24 Hour Rule (Bed Hold-H)
- Requires a two-step bed hold reporting process

Step #1

a. Hospital leave must be preceded by a Discharge-return anticipated (D/11).
b. Bed hold begin date is required when the resident is admitted and begins the hospital leave:
    - Hospital bed hold begin day is equal to the date the resident was admitted as a hospital in-patient.
    - Bed hold end date is required when resident ends the hospital leave (last day in hospital and not in facility).
    - Bed hold end date is equal to the day prior to the return date.
    - Both begin and end dates are submitted through the Web Portal only when both dates are confirmed.

Step #2

a. When resident returns to facility and returns back to the hospital in less than 24 hours:
    - Second bed hold begin date is equal to the day of return and discharge (but didn't stay 24 hours).
    - Bed hold end date is required when resident ends the hospital leave (last day in hospital and not in facility).
    - Bed hold end date is equal to the day prior to the return date.
    - Both begin and end dates are submitted through the Web Portal only when both dates are confirmed.

In this **hospital 24-hour** bed hold example (less than 24 hours), the resident entered with the following:

- Entry date (A1600) 02/10/2019

The subsequent combined Discharge/PPS assessment was transmitted with the following:

- Discharge date (A2000) 02/14/2019
- Bed hold begin and end dates are as follows: 02/14/2019 through 02/18/2019

The subsequent Entry record and Discharge assessment was transmitted with the following:

- Entry date (A1600) 02/19/2019
- Discharge date (A2000) 02/19/2019
- Bed hold begin and end dates are as follows: 02/19/2019 through 02/23/2019

The subsequent Entry record and Admission assessment was transmitted with the following:

- Entry date (A1600) 02/24/2019
- Admission assessment ARD (A2300) 03/02/2019

Hospital 24-Hour Bed Hold Example:

Record Type	Target Date	RUG Class	Begin Date	Begin Date Field	End Date	Final Discharge Date	Code	Days	Case Mix Index	CMI Points
NT/99/99/01	02/10/19		02/10/19	A1600	02/10/19					
NP/99/01/11	02/14/19	RAE	02/10/19	A1600	02/13/19		03	4	1.650	6.600
Bed hold-H		RAE	02/14/19		02/18/19			5	1.000	5.000
NT/99/99/01	02/19/19		02/19/19	A1600	02/19/19					
ND/99/99/11	02/19/19		02/19/19	A2000	02/19/19		03			
Bed hold-H		RAE	02/19/19		02/23/19			5	1.000	5.000
NT/99/99/01	02/24/19		02/24/19	A1600	02/24/19					
NC/01/99/99	03/02/19	HD2	02/24/19	A1600	03/31/19			36	1.690	60.840
					Total			50		77.440

The first bed hold period begins on the discharge date (02/14/2019) and continues until the day prior to the “same day” entry and discharge that was less than 24 hours in the facility (02/18/2019). The second bed hold period begins on the day of discharge (02/19/2019) until the day prior to the entry date (02/23/2019).

Note:

It is important to note that when a resident returns and discharges the same day and is in the facility less than 24 hours, that the bed hold periods must be entered twice in the Web Portal; first reflecting the beginning and end of the bed hold period prior to the second discharge and the second reflecting the bed hold period reflecting the same day entry and discharge and ending on the day prior to the return date.

Home/Therapeutic Temporary Leave Clarification Effective November 1, 2019

Effective November 1, 2019, the Administrative Code Title 23: Medicaid Part 207: Institutional Long Term Care, Chapter 2: Nursing Facility, Rule 2.5: Reimbursement and Rule 2.8: Temporary Leave Payment, revised and clarified the definition of home/therapeutic temporary leave days.

Home/therapeutic temporary leave days are defined as:

(1) Eight (8) consecutive hours or more during the day excluding dialysis, chemotherapy, physical therapy, speech therapy, occupational therapy, or medical treatments that occur two or more days per week or

(2) An absence at twelve midnight (12 a.m.) or

(3) A hospital observation stay of eight (8) or more consecutive hours

Bed hold period CMIs are equal to the preceding assessment CMI if equal to 1.00 or less, or is equal to 1.00 if the preceding assessment CMI is great than 1.00.

REVIEW OF INTERIM ROSTER REPORT

The Interim Roster Report is provided as a tool for use by the facility in determining whether any missing or incorrect assessment/records or bed holds are noted and allows the facility a review period to evaluate assessments/records displayed on the roster. All assessment corrections 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 quarter close date; no manual alterations of the Roster Report are considered. Additionally, all edits to the bed hold days must be made by the quarter close date.

In reviewing the Interim Roster Report, the following steps are suggested, but not limited to:

- Review any BC1 RUG classification(s) 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.
- Keep in mind that assessments transmitted after the close date of the Interim Roster Report may display a false BC1 RUG classification and the (non-displayed) assessment will automatically be listed on the next Interim or Quarter Final Roster Report.
- Verify the accuracy of bed hold days.
- Verify accuracy of Room # and Admission date.
- Determine if all residents in the facility at any time during the quarter are listed on the Roster Report.
- Determine if each resident is identified only once. If the same resident appears as if they were two separate residents, contact the RAI Coordinator for the proper correction process.
- Review the listed assessments and tracking forms for each resident to determine if all assessments/records are accounted for on the Roster Report.
- Review the bed hold begin date and end date for accuracy.
- Missing or corrected (if applicable) assessments that have been transmitted and accepted after the close date(s) will not be reflected on the Roster Report.
- 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.
- Review the type of Entry tracking record (A1700=1 [admission] or A1700=2 [reentry]) to ensure that the reason fits the sequence of records displayed.
- Review “code” column for accuracy of discharge status (A2100).

Any corrections including transmissions must be completed by the predetermined quarter close date.

ROSTER REPORT CMI CALCULATION

The day weighted calculations from the detail pages of the Roster Report for all 48 RUG classifications are displayed on the last two pages of the Roster Report. CMI points are calculated for each RUG classification for 1) regular days, 2) regular bed hold days, 3) Alzheimer’s days, 4) Alzheimer’s bed hold days, and 5) total days.

For each RUG-IV classification, the assigned CMI is multiplied by the total number of days from each RUG classification to arrive at total RUG CMI points. The sum of all of the CMI points divided by the sum of all days represents the facility average CMI.

The Quarter Final Roster Report CMI average is used in the determination of the facility’s case mix rate adjustment.

3 RESOURCES

The Mississippi Medicaid facility's Case Mix Master Roster Report 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 ensure 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, 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/Mississippi/Resources.aspx - This site is maintained by Myers and Stauffer LC and is the location in which the Supportive Documentation Requirements is posted, as well as other materials applicable to the Mississippi Case Mix 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/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 Division of Medicaid and provide the Roster Reports as well as technical assistance. The phone number of the Myers and Stauffer Help Desk is 1- 800-773-8609 and is also provided on the Case Mix Master 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.

4 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 (ASAP) System	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.
Bed Hold	A date-defined time frame (with a beginning and end date) that identifies a period of time that a resident was not present for care in a Nursing Facility.
Bed Hold Period	Identifies the days associated with Hospital and/or Therapeutic bed hold days.
Begin Date	The first day the resident is on Hospital and/or Therapeutic leave and not in the facility.
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.
CMS MDS Welcome Page	The portal accessed by the facility using the MDCN connection process that allows the facility to submit MDS 3.0 data.
CMSNet	The communication system used to electronically submit data to the QIES ASAP System. Each person at the NF who is submitting data must have an individual password.

Term/Abbreviation	Definition
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.
End Date	The last day the resident is on Hospital and/or Therapeutic leave and not in the facility.
Final Validation Report (FVR)	A report generated by the QIES ASAP System after a file containing MDS assessments/tracking forms is completely processed, detailing the records processed and any errors that were identified.
Hospital Leave	Holding a bed for a resident when they have been discharged and admitted to a hospital.
Inactive/expired period	For Mississippi 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 Roster Report quarter. This is sometimes referred to as a delinquent assessment.
Index Maximization	The term used to define the process by which “Each assessment shall be included in the RUG-IV category with the highest numeric CMI for which the assessment qualifies.”
Initial Feedback Report (IFR)	This report is generated by the QIES ASAP System when a file of MDS data is first electronically submitted and indicates whether the file is accepted or rejected.
Internal Resident ID	See Resident Internal ID.
Item Set Code (ISC)	A code based upon combinations of reasons for assessment (A0310 items) 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 record is in the QIES ASAP System database but the information in the record 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 process and 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.
Patient Driven Payment Model (PDPM)	A Medicare payment model that improves payment accuracy and appropriateness by focusing on the patient/resident, rather than the volume of services provided. Effective 10/1/2019.
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 be 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 A0310B = 08).

Term/Abbreviation	Definition
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 stay; denoted at MDS item A1600, Entry date and A1700 = 2 (Reentry).
Resident	A person being cared for in a Nursing Facility.
Resident Internal ID	An internal resident ID created for each individual nursing facility resident upon the submission of their first record to the QIES ASAP System. The Resident ID (Res_Int_ID) is based on resident identifying information such as name, social security number, gender etc. All subsequent records for the resident are tagged with the same 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.
Target Date	Assessment Reference Date (A2300) or Discharge Date (A2000) or Entry/Reentry Date (A1600).
Therapeutic Leave	Holding a bed for a resident when they are on therapeutic leave.