Core of Nursing Knowledge: MDS, Reimbursement and Quality Programs

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Agenda

- MDS Management
  - MDS Accuracy, using MDS Reports
- Medicare Initiatives
  - PDPM Overview
    - Rate Components
    - MDS and ICD10 Coding and PDPM
    - PDPM Assessment Schedule
  - IMPACT Act/SNF QRP
    - SNF QRP Measures
    - Annual Payment Update (APU) Calculation
    - Threshold reports; Review and Correct Reports; Preview Reports
  - Value Based Purchasing
- Quality Measures
  - Short Stay vs. Long Stay
  - QM Risk Adjustments
  - QM Calculations
  - CASPER reports
  - Using QMs to improve quality
- Medicaid Quality Incentive Programs
- Recent updates to the 5 Star rating program
  - Survey Domain
  - Staffing Domain
  - QM Domain

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MDS Management

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Uses of the MDS

- Resident Assessment and Care Planning
- Reimbursement
  - Medicaid
  - Medicare
- Quality Measures
  - Impacts survey
  - 5 star rating/nursing home compare web site

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MDS Accuracy

MDS Accuracy is critical to:

- Proper care planning
- Proper payment
- Accurate Quality Indicators and related survey implications

Nurse executives and facility administration play a critical role in monitoring MDS accuracy, timeliness, and implementation of strong RAI process systems

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What is an Accurate Assessment?

The RAI process has multiple regulatory requirements.

Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that

- **(1) the assessment accurately reflects the resident's status**
- (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals
- **(3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.**

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What is an Accurate Assessment?

In addition, an accurate assessment **requires collecting information from multiple sources**

Those sources must include the **resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable.**

It is important to note here **that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy** (what the resident's actual status was during that observation period) by the IDT completing the assessment.

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Assessment Accuracy

MDS accuracy: assessment must match the resident's status as of the assessment reference date

Assessment reference date is the common date from which each participant in the assessment will count back the designated number of days for their section to establish the observation period

MDS is a snapshot based on the ARD

MDS manual contains definitions, instructions, clarifications and examples critical to accurate completion of the MDS

MDS is a functional assessment

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Steps for Assessment

Talk to the resident
Talk to the family/significant others
Talk to the staff
Review the record
Observe yourself

Pay attention to the specific look back period and item specific coding instructions

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MDS Accuracy

Updated MDS Manual

- Most recent update: September, 201 9 (was your manual up to date prior to that?)
- http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

Errata Document: ?

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MDS Accuracy

RAI Manual Contents:

- Chapter 1: RAI Process Overview
- Chapter 2: Assessment Timing and Scheduling
- Chapter 3: Item by Item Coding Instructions
- Chapter 4: Care Area Assessments and Care Planning
- Chapter 5: Corrections Process
- Chapter 6: Medicare Reimbursement and Billing
- Appendices

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MDS Management

Key Reports

- Validation Report
- CASPER (QM), preview reports, review and correct reports, PBJ Reports, SNF QRP reports
- "State" Reports (In MITS)
  - MDS Weekly Reports (Previously "Successfully Grouped Report")
  - Preliminary Quarterly Report
  - MDS Final Quarterly Report
  - MDS Final Semi-annual Report

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Patient Driven Payment Model (PDPM)

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PDPM Overview

- Patient characteristics (diagnoses, conditions) reported on MDS drive payment
- Therapy minutes no longer drive payment
- Group and concurrent therapy capped at 25% of total therapy delivered
- Rate is the total of six components
  - Five case mix components each use a different "grouper" methodology
  - One "flat-rate" non-case-mix component
- Utilizes tapering over the course of a stay

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Accuracy with Diagnosis and Conditions Coding on Initial Assessment is Critical

For most Part A stays, reimbursement for the entire stay is based on the Initial Assessment (previously known as the 5-day)

Success under PDPM requires a more thorough, complete and accurate assessment earlier in the stay

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Variable Per Diem Adjustment

NTA Component

- Days 1-3: 300%
- Days 4-100: 100%

PT and OT Components

Days 1-20 are paid at 100%

Every seven days thereafter, the rate would decrease by 2%

Days 21-27: 98%	Days 84-90: 80%
Days 28-34: 96%	Days 91-97: 78%
Days 35-41: 94%	Days 98-100: 76%

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Example Resident – PDPM (Day 1-3)

Component	Base Fed Rate		Case-Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	$59.33	x	1.55	x		x	1.00	=	$91.96
OT	$55.23	x	1.55	x		x	1.00	=	$85.61
SLP	$22.15	x	2.85	x		x		=	$63.13
NTA	$78.05	x	1.85	x		x	3.00	=	$433.18
Nursing	$103.46	x	1.43	x	1.00	x		=	$148.10
Non-Case-Mix Component	$92.63	x		x		x		=	$92.63
							Total	**=**	**$914.60**

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Example Resident – PDPM (Day 4-20)

Component	Base Fed Rate		Case-Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	$59.33	x	1.55	x		x	1.00	=	$91.96
OT	$55.23	x	1.55	x		x	1.00	=	$85.61
SLP	$22.15	x	2.85	x		x		=	$63.13
NTA	$78.05	x	1.85	x		x	1.00	=	$144.39
Nursing	$103.46	x	1.43	x	1.00	x		=	$148.10
Non-Case-Mix Component	$92.63	x		x		x		=	$92.63
							Total	**=**	**$625.81**

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Example Resident – PDPM (Day 21-27)

Component	Base Fed Rate		Case-Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	$59.33	x	1.55	x	[redacted]	x	0.98	=	$90.12
OT	$55.23	x	1.55	x	[redacted]	x	0.98	=	$83.89
SLP	$22.15	x	2.85	x	[redacted]	x	[redacted]	=	$63.13
NTA	$78.05	x	1.85	x	[redacted]	x	1.00	=	$144.39
Nursing	$103.46	x	1.43	x	1.00	x	[redacted]	=	$148.10
Non-Case-Mix Component	$92.63	x	[redacted]	x	[redacted]	x	[redacted]	=	$92.63
							Total	**=**	**$622.26**

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Example Resident – PDPM (Day 28-30)

Component	Base Fed Rate		Case-Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	$59.33	x	1.55	x	[redacted]	x	0.96	=	$88.28
OT	$55.23	x	1.55	x	[redacted]	x	0.96	=	$82.18
SLP	$22.15	x	2.85	x	[redacted]	x	[redacted]	=	$63.13
NTA	$78.05	x	1.85	x	[redacted]	x	1.00	=	$144.39
Nursing	$103.46	x	1.43	x	1.00	x	[redacted]	=	$148.10
Non-Case-Mix Component	$92.63	x	[redacted]	x	[redacted]	x	[redacted]	=	$92.63
							Total	**=**	**$618.71**

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Example Resident – PDPM 30 Days

Day 1-3	=>	3 days @ $914.60	=	$2,743.80
Day 4-20	=>	17 days @ $625.81	=	$10,638.77
Day 21-27	=>	7 days @ $622.26	=	$4,355.82
Day 28-30	=>	3 days @ $618.71	=	$1,856.13
			Total =	$19,594.52

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PDPM Components and Drivers

PT – Primary Reason for SNF Stay, Recent Surgery, Function Score

OT – Primary Reason for SNF Stay, Recent Surgery, Function Score

SLP – Acute Neuro, SLP Comorbidities, Cognition, Swallowing Symptoms, Mechanically Altered Diet

Nursing – RUG IV Clinical Qualifiers, PHQ-9, Function Score, Restorative Nursing

Non-therapy Ancillaries (NTAs) – Diagnoses and Conditions

Non-case-mix component

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PT and OT Components – 16 Payment Groups

- 1st Tier Assignment
  - Primary Reason for the SNF Stay
  - Recent Surgery Requiring Active SNF Care
- 2nd Tier Assignment
  - Function Score from Section GG

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PT/OT Classification Groups & Case-Mix Weights

Clinical category	Section GG function score	PT OT case-mix group	PT case-mix index	OT case-mix index
Major Joint Replacement or Spinal Surgery	0–5	TA	1.53	1.49
Major Joint Replacement or Spinal Surgery	6–9	TB	1.89	1.83
Major Joint Replacement or Spinal Surgery	10–23	TC	1.88	1.88
Major Joint Replacement or Spinal Surgery	24	TD	1.92	1.53
Other Orthopedic	0–5	TE	1.42	1.41
Other Orthopedic	6–9	TF	1.81	1.59
Other Orthopedic	10–23	TG	1.67	1.64
Other Orthopedic	24	TH	1.16	1.15
Medical Management	0–5	TI	1.13	1.17
Medical Management	6–9	TJ	1.42	1.44
Medical Management	10–23	TK	1.52	1.54
Medical Management	24	TL	1.09	1.11
Non-Orthopedic Surgery and Acute Neurologic	0–5	TM	1.27	1.30
Non-Orthopedic Surgery and Acute Neurologic	6–9	TN	1.48	1.49
Non-Orthopedic Surgery and Acute Neurologic	10–23	TO	1.55	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08	1.09

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SLP Component – 12 Payment Groups

1st Tier: Presence of neurologic condition, SLP-related comorbidity or cognitive impairment:

- None (lowest rate)
- Any one
- Any two
- All three (highest rate)

SLP-related comorbidity: CVA, TIA or stroke: Hemiplegia or hemiparesis; TBI; Trach; Vent; Laryngeal cancer; Apraxia, dysphagia, ALS, oral cancers, speech and language deficits

Cognitive impairment: based on BIMS or CPS

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SLP Component

2nd Tier: Presence of swallowing disorder or mechanically altered diet

- Neither (lowest rate)
- Either
- Both (highest rate)

NOTE: Functional Score from GG does not impact this component

NOTE: MDS coding of these two items is often not accurate in my experience

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SLP Classification Groups & Case-Mix Weights

[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
Any one	Neither	SD	1.46
Any one	Either	SE	2.33
Any one	Both	SF	2.97
Any two	Neither	SG	2.04
Any two	Either	SH	2.85
Any two	Both	SI	3.51
All three	Neither	SJ	2.98
All three	Either	SK	3.69
All three	Both	SL	4.19

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Nursing Component – 25 Payment Groups

1st Tier:

- Extensive services
- Special care high
- Special care low
- Clinically complex
- Behavior symptoms/cognition
- Reduced physical function
- See Nursing Qualifiers Handout

2nd Tier:

- Function Score (GG)
- PHQ9 Score (Mood)
- Restorative Nursing

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Nursing Classification Groups & Case-Mix Weights

RUG–IV nursing RUG	Extensive services	Clinical conditions	Depression	Number of restorative nursing services	ADL-based function score	PDPM nursing case-mix group	Nursing case-mix index
ES3	Tracheostomy & Ventilator				0–14	ES3	4.04
ES2	Tracheostomy or Ventilator				0–14	ES2	3.06
ES1	Infection				0–14	ES1	2.91
HE2/HD2		Serious medical conditions e.g. comatose, septicemia, respiratory therapy.	Yes		0–5	HDE2	2.39
HE1/HD1		Serious medical conditions e.g. comatose, septicemia, respiratory therapy.	No		0–5	HDE1	1.99
HC2/HB2		Serious medical conditions e.g. comatose, septicemia, respiratory therapy.	Yes		6–14	HBC2	2.23
HC1/HB1		Serious medical conditions e.g. comatose, septicemia, respiratory therapy.	No		6–14	HBC1	1.85
LE2/LD2		Serious medical conditions e.g. radiation therapy or dialysis.	Yes		0–5	LDE2	2.07
LE1/LD1		Serious medical conditions e.g. radiation therapy or dialysis.	No		0–5	LDE1	1.72
LC2/LB2		Serious medical conditions e.g. radiation therapy or dialysis.	Yes		6–14	LBC2	1.71
LC1/LB1		Serious medical conditions e.g. radiation therapy or dialysis.	No		6–14	LBC1	1.43

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Nursing Classification Groups & Case-Mix Weights

CE2/CD2		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns.	Yes		0–5	CDE2	1.86
CE1/CD1		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns.	No		0–5	CDE1	1.62
CC2/CB2		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns.	Yes		6–14	CBC2	1.54
CA2		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns.	Yes		15–16	CA2	1.08
CC1/CB1		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns.	No		6–14	CBC1	1.34
CA1		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns.	No		15–16	CA1	0.94
BB2/BA2		Behavioral or cognitive symptoms		2 or more	11–16	BAB2	1.04
BB1/BA1		Behavioral or cognitive symptoms		0–1	11–16	BAB1	0.99
PE2/PD2		Assistance with daily living and general supervision		2 or more	0–5	PDE2	1.57
PE1/PD1		Assistance with daily living and general supervision		0–1	0–5	PDE1	1.47
PC2/PB2		Assistance with daily living and general supervision		2 or more	6–14	PBC2	1.21
PA2		Assistance with daily living and general supervision		2 or more	15–16	PA2	0.70
PC1/PB1		Assistance with daily living and general supervision		0–1	6–14	PBC1	1.13
PA1		Assistance with daily living and general supervision		0–1	15–16	PA1	0.66

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Non-therapy Ancillary (NTA) Component

50 conditions and services qualify for point values of 1, 2, 3, 4, 5, 7 or 8 points (most are 1 point)

12 +	NA	3.25
9-11	NB	2.53
6-8	NC	1.85
3-5	ND	1.34
1-2	NE	0.96
0	NF	0.72

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NTA Component Issues

- Importance of Capturing on the 5-day
- What makes a diagnosis active
  - Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death **during the 7-day look-back period**
  - Planning for Care - This section identifies active diseases and infections that **drive the current plan of care.**
  - Remember when looking at the last seven days you can include days prior to admission to this SNF, depending on your ARD
- Using I8000 effectively

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Other Important Issues

Improving preadmission and admission process

Improving interview techniques

Evaluate role and skills of MDS Coordinator

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Admission Process Considerations

Having a more thorough, complete and accurate assessment of the resident's overall clinical condition much earlier in the stay will lead to success under PDPM

Evaluate your preadmission and admission process to ensure your team is conducting a through clinical assessment

Consider a preadmission (or early after admission) visit with the resident to begin gathering a more comprehensive clinical history (see Healthy History Questionnaire handout)

Utilize critical thinking skills to not only gather documented diagnoses, but to look for diagnoses that may be missing

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Conducting the Resident Interview

- Appendix D for overview
- BIMS – Section C – Impacts Cognition Category and QMs
- PHQ9 – Section D – Impacts reimbursement (Depression = score 10+), QMs
- Preferences – Section F
- Pain – Section J

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Conducting the Resident Interview

- Introduce yourself to the resident
- Be sure the resident can hear you
  - Don't mumble or rush
  - Ask if they own a hearing aid, other device
  - Help get the device in place before the interview
  - May need to offer headphones/hearing amplifier
- Ask if the resident would like an interpreter
- Find a quiet, private area where you are not likely to be interrupted or overheard
  - Background noise, distractions should be avoided
  - Privacy of personal information being asked

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Conducting the Resident Interview

- Sit where the resident can see you clearly and you can see his or her expression
  - Have you face well lighted
  - Minimize glare
  - Ask the resident where you should sit so they can see you best
- Establish rapport and respect
  - Can engage in general conversation to help
  - If the resident asks a question or makes a request, try to address the question or request before moving on to next question

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Conducting the Resident Interview

- Explain the purpose of the questions
  - Introduce the topic and explain you are going to ask a series of questions
  - Explain that the questions are asked of every one to make sure that nothing is missed
  - Highlight what you will ask
  - End by explaining that their answers will help develop an appropriate care plan
  - Each interview item contains suggested explanations and introductions – see the MDS manual instructions in Chapter 3

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Conducting the Resident Interview

- Say ***and show*** the item responses
  - Prepare cue cards in large, clear print and show the resident while you verbally review the response options
  - Residents can respond verbally, by pointing to the response on the cue card, or by writing it down
- Ask the questions exactly as the appear in the questionnaire
  - Use non-judgmental approach
  - Don't be afraid of the answers – you are there to hear it
  - Actively listen –greater insight beyond direct answer

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Conducting the Resident Interview

- Break the question apart if necessary (not to be used for the memory test)
  - Unfolding – ask a general question about the symptom followed by a sequence of more detailed questions if they report the symptom as present
  - Disentangling – separating item with several parts into smaller pieces and allowing the resident to respond to each piece
  - See examples that follow

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Conducting the Resident Interview

- Unfolding example:
  - Read the item to the resident and ask if they have it at all. I they say yes, then ask "Do you have it every day?" If no, then "Did you have it at least half the days in the last two weeks?"
- Disentangling example:
  - An item asks about poor appetite and overeating – ask "poor appetite?" and pause for response, then ask "overeating?" and wait for response. If either are rated positively, code for yes. Code for highest frequency of the two.

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Conducting the Resident Interview

- Clarify using echoing
  - Echoing = repeating part of the resident's response
  - Can be very helpful in the clinical items
  - Resident gives a related response, but doesn't respond directly or use the response scale provided
  - Echoing can help you try to clarify the response by allowing another opportunity to provide the appropriate responses
- Repeat the response options as needed
- Move on to another question if the resident is unable to answer

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Chapter 3: Coding Instructions Related to PHQ-9©

If the resident uses his or her own words to describe a symptom, this should be briefly explored. If you determine that the resident is reporting the intended symptom but using his or her own words, ask him to tell you how often he or she was bothered by that symptom.

If the resident has difficulty selecting between two frequency responses, code for the higher frequency.

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Chapter 3: Coding Instructions Related to PHQ-9©

Noncommittal responses such as "not really" should be explored.

Residents may be reluctant to report symptoms and should be gently encouraged to tell you if the symptom bothered him or her, even if it was only some of the time.

This is known as probing.

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Chapter 3: Coding Instructions Related to PHQ-9©

Probe by asking neutral or nondirective questions such as:

- "What do you mean?"
- "Tell me what you have in mind."
- "Tell me more about that."
- "Please be more specific."
- "Give me an example.

Additional coding tips, examples and clarifications can be found in Chapter 3

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Additional Interview Tips

Put the resident at ease

Use cue cards

Allow the resident enough time to process questions and answer options

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Interviewing Video

Youtube.com

Search "CMS Interviewing Vulnerable Elders"

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Additional PDPM Topics

Interrupted Stay Policy

Interim Payment Assessments

CMS website has a page dedicated to PDPM exclusively

- Topic specific fact sheets
- Frequently Askes Questions
- ICD-10 crosswalk tools

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IMPACT Act and SNF QRP

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IMPACT Act

The IMPACT Act (2014) required CMS to specify standard assessment tools across PAC providers (HH, SNF, IRF, LTCH) along with cross-setting QMs in four domains:

- Functional status
- Cognitive function and changes in cognition
- Skin integrity and changes in skin integrity
- Incidence of major falls

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SNF Quality Reporting Program (QRP)

- 2% penalty for failure to report required data
  - Dashes in IMPACT Act items
    - 5 day PPS assessment
    - End of the Medicare Stay assessment
    - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QRP-Table-for-Reporting-Assessment-Based-Measures-for-the-FY-2023-SNF-QRP-APU.pdf
  - Failure to complete End of the Medicare Stay Assessment

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SNF QRP Measures

- Changes in Skin Integrity Post Acute Care: Pressure Ulcer/Injury
- Falls with Major Injury
- Functional Assessment/Care Plan
- Discharge Self-Care Score
- Discharge Mobility Score
- Change in Self-Care Score
- Change in Mobility Score
- Drug Regimen Review
- * Potentially Preventable 30-day Post-Discharge Readmission
- * Discharge to Community
- * Medicare Spend Per Beneficiary

* indicates resident level data not provided, only facility level

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Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

Measures the percentage of Part A residents whose discharge assessment indicates one or more new or worsened Stage 2-4 pressure ulcers, or **unstageable pressure ulcers due to slough/eschar, non-removable dressing/device, or deep tissue injury,** compared to the 5-day assessment.

Risk adjusted using a number of clinical covariates

National Average = 2.9%

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Falls With Major Injury

This quality measure reports the percentage of Medicare Part A SNF Stays where one or more falls with major injury were reported during the SNF stay

Major injury defined as:

- bone fractures,
- joint dislocations,
- closed head injuries with altered consciousness, or
- subdural hematoma

National Average = 1.0%

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Discharge Scores: Self Care, Mobility

These two measures calculate an actual score at the time of discharge for self care items and mobility items and also calculate an "expected score"

The measure calculate what percentage of your part A stays met or exceeded their "expected" score

"Expected" score is not the same thing as the discharge goal – see next slide

National Average % exceeding Self-Care score = 46.7%

National Average % exceeding Mobility score = 39.6%

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Discharge Scores Self Care, Mobility

"Expected" discharge score is calculated based on:

- Primary Medical Condition Category (I0020)
- Admission Self-Care and Mobility Scores (GG0130, GG0170)
- Prior Surgery (J2000)
- Prior Functioning: Everyday Activities (GG0100A-D)
- Prior Device Use (GG0110 A-E)
- Presence of Stage 2-4 Pressure Ulcer (M0300)
- Cognitive Status (BIMS or CPS)
- Urinary and Bowel Incontinence Status (H0300, H0400)
- History of Falls (J1700)
- Presence of Parenteral/IV or Tube Feeding on Admission (K0510)
- Clinical Comorbidities: Infections (crosswalk provided)

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Calculating the Self-Care Score

The Self-Care assessment items used for Self-Care score calculations are:

a. GG0130A3. Eating
b. GG0130B3. Oral hygiene
c. GG0130C3. Toileting hygiene
d. GG0130E3. Shower/bathe self
e. GG0130F3. Upper body dressing
f. GG0130G3. Lower body dressing
g. GG0130H3. Putting on/taking off footwear

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Calculating the Self-Care Score

Valid codes and code definitions for the coding of the Self-Care items are:

06 – Independent
05 – Setup or clean-up assistance
04 – Supervision or touching assistance
03 – Partial/moderate assistance
02 – Substantial/maximal assistance
01 – Dependent
07 – Resident refused
09 – Not applicable
10 – Not attempted due to environmental limitations
88 – Not attempted due to medical condition or safety concerns

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Calculating the Self-Care Score

To obtain the self-care score, use the following procedure:

- If code is between 01 and 06, then use code as the score.
- If code is 07, 09, 10, or 88, then recode to 01 and use this code as the score.
- If the self-care item is skipped (^), dashed (-) or missing, recode to 01 and use this code as the score..

Sum the scores of the self-care items to create a self-care score for each Medicare Part A SNF stay record.

Scores can range from 7 to 42, with a higher score indicating greater independence.

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Calculating the Mobility Score

The Mobility assessment items used for discharge Mobility score calculations are:

- GG0170A3. Roll left and right
- GG0170B3. Sit to lying
- GG0170C3. Lying to sitting on side of bed
- GG0170D3. Sit to stand
- GG0170E3. Chair/bed-to-chair transfer
- GG0170F3. Toilet transfer
- GG0170G3. Car transfer
- GG0170I3. Walk 10 feet
- GG0170J3. Walk 50 feet with two turns
- GG0170K3. Walk 150 feet
- GG0170L3. Walking 10 feet on uneven surfaces
- GG0170M3. 1 step (curb)
- GG0170N3. 4 steps
- GG0170O3. 12 steps
- GG0170P3. Picking up object

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Calculating the Mobility Score

To obtain the mobility score, use the following procedure

- If code is between 01 and 06, then use code as the score.
- If code is 07, 09, 10, or 88, then recode to 01 and use this code as the score.
- If the mobility item is skipped (^), dashed (-), or missing, recode to 01 and use this code as the score.

Sum the scores of the mobility items to create a mobility score for each Medicare Part A SNF stay.

Scores can range from 15 – 90, with a higher score indicating greater independence.

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Drug Regimen Review Conducted with Follow-Up for Identified Issues

Calculated using the following MDS items for PPS assessments:

- Drug Regimen Review (N2001)
- Medication Follow-up (N2003)
- Medication Intervention (N2005)

This is a process measure, the optimal score is 100%

National Average = 90.8%

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Change in Self-Care and Mobility Scores

Self Care and Mobility Scores are calculated for the 5 day and the PPS Discharge as described in the previous slides

These measures compare the discharge self-care and mobility scores to those scores on admission to calculate a change in score

A positive change represents an improvement and a negative change represents a decline

National Average Change in Self-Care Score: 7.1

National Average Change in Mobility Score: 16.2

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SNF QRP – Claims Based Measures

Potentially Preventable Readmissions (PPR)

- Monitors first 30 days post SNF DC to community, uses unplanned and potentially preventable hospital readmissions
- Potentially Preventable:
  - Respiratory: COPD, asthma, aspiration PNA, bacterial PNA, flu
  - Cardiac: CHF, hypo/hypertension, some arrhythmias
  - Some diabetic complications
  - Skin/subcutaneous: pressure ulcers, infections
  - Septicemia
  - GI/GU: UTI, dehydration, gastroenteritis, acute kidney failure, electrolyte imbalance, intestinal impaction

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SNF QRP – Claims Based Measures

Discharge to Community (DTC)

- 31 days post DC
- No unplanned rehospitalizations or death in 31 days post discharge
- (Different timeframe than 5 Star measure)

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SNF QRP – Claims Based Measures

Medicare Spend Per Beneficiary (MSPB)

National Median $26,465

This measure looks at average amount billed to Medicare during Part A stays and an "associated period"

This measure is risk adjusted

If your risk adjusted spend is less than the national average, your score is <1.00

If your risk adjusted spend is greater than the national average, your score is >1.00

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SNF QRP Monitoring

Review and Correct Report
Provider Threshold Report
Resident Level Quality Measure Report
Facility Level Quality Measure Report

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SNF QRP Monitoring: Review Sample Resident-Level QM Report

Resident B
- Did not trigger the following undesirable outcomes:
  - QM1: Pressure ulcer/injury
  - QM2: Falls (with major injury)
- Did trigger the following desirable outcomes:
  - QM3: Functional assessment/care plan
  - QM5: Discharge mobility score
  - QM6: Drug regimen review
- Did not trigger the following desirable outcomes:
  - QM4: Discharge self-care score
- Change in function: self-care = 2
- Change in function: mobility = 25

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SNF QRP Monitoring: Review Sample Resident-Level QM Report

Resident E

- Did not trigger the following undesirable outcomes:
  - QM1: Pressure ulcer/injury
  - QM2: Falls (with major injury)
- Did trigger the following desirable outcomes:
  - QM3: Functional assessment/care plan
  - QM6: Drug regimen review
- Was excluded from the following measures:
  - QM4: Discharge self-care score
  - QM5: Discharge mobility score
  - QM 7: Change in function: self-care
  - QM8: Change in function: mobility

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SNF QRP Monitoring: Review Sample Facility-Level QM Report

Source: Minimum Data Set3.0

- Pressure ulcer/injury: facility 4%, national avg 2.9%
- Falls (with major injury): facility 0%, national avg 1%
- Functional assessment/care plan: facility 100%, national avg 98.8%
- Discharge self-care score: facility 31.8%, national avg 46.7%
- Discharge mobility score: facility 45.5%, national avg 39.6%
- Drug regimen review: facility 92.6%, national avg 90.8%
- Change in self-care: facility 6.8, national avg 7.1
- Change in mobility: facility 16.5, national avg 16.2

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SNF QRP Monitoring: Review Sample Facility-Level QM Report

Source: Medicare Fee-For-Service Claims

- PPR: facility 7.17%, national avg 7.67%
- DTC: facility 46.21%, national avg 52.88%
  - Note that for both of these measures, the facility falls within the 95% confidence interval, is considered to be performing "not different" from the national rate
- MSPB: facility $23,267, national avg $26,465, facility score = 0.88

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SNF QRP Monitoring

What is your process/frequency for reviewing SNF QRP reports?

- Review SNF QRP Review and Correct Report

How does your facility manage outcomes during a Part A stay?

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Value Based Purchasing (VBP)

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Value Based Purchasing

- FY 2021 (October 1, 2020 rates)
  - Skilled Nursing Facility 30 Day All-Cause Readmission Measure (SNFRM-NQF2510)
  - Fiscal year 2019 (10/1/201 8– 9/30/2019)
  - Improvement FY 2019 over FY 2017
- What happens in FY 2022 (October 1, 2021 rates)?
  - CMS has signaled their intent to not use hospitalization rates for periods effected by the pandemic in the VBP program

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Value Based Purchasing: Update

CARES Act allows CMS to add additional measures

The "without" is still limited to 2%

2022 Technical Expert Panels

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SNFRM Risk Adjustment

Covariates used in the measure:

- Age, gender
- Proximal hospitalization LOS
- Time in ICU?
- ESRD
- # Acute care hospitalizations in 365 days before proximal hospitalization
- Principal diagnosis

System-specific surgical indicators

- Kidney, cardiac, vascular patients with surgical indicators are higher risk
- Ortho with surgical indicator are lower risk

Individual comorbidities

- ESRD, diabetes, heart failure, pressure ulcers

Multiple comorbidities

- Charlson Comorbidity Index is calculated using both the number and seriousness of comorbidities

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What is the Rehospitalization Score?

Rehospitalization Score used to calculate payment rate can range from 0 to 100 points

Higher of the facility "Achievement" score or "Improvement" score

Facilities are ranked based on Rehospitalization Score to determine payment adjustment

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More About the Rehospitalization Score

Achievement Score of 0 to 100 is awarded based on ranking of the rehospitalization rate in the performance period

- SNFs in lowest 25% receive 0 points
- SNFs in top 5% receive 100 points
- Formula proposed for allocating points to remaining SNFs

Achievement threshold:

- FY 2019: .79590
- FY2020: .80218
- FY 2021: .79476

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More About the Rehospitalization Score

Improvement Score of 0 to 90 points awarded based on improvement over a two-year period

A unique improvement range is established for each SNF that defines the difference between their baseline period score and the national benchmark established

Benchmark

- FY 2019: .83601
- FY 2020: .83721
- FY 2021: .83212

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More About the Rehospitalization Score

Improvement Score, Continued

- If performance period score is equal to or lower than improvement threshold, 0 points awarded
- If performance period score is equal to or higher than the benchmark, 90 points awarded
- If period score is greater than improvement score, but less than the benchmark, between 0 and 90 points will be awarded using a proposed formula

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More About the Rehospitalization Score

- SNF Part A payment adjustment will be based on rehospitalization score ranking
- Facilities will be told the payment adjustment at least 60 days prior to rate effective date
- Notified via CASPER – SEE HANDOUT

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Quality Measures

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Quality Measures for Public Reporting

- Part of Nursing Home Quality Initiative, CMS' effort to improve quality of care in nursing homes
- Recalculated and reposted quarterly
  - Facilities receive preview in "Folder" in MDS system
  - Nursing Home Compare website

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Quality Measures for Survey Process and Quality Assurance

- Indicators of possible problems, used in off-site preparation
  - Must be validated onsite via record review, interviews, direct observation
- Includes
  - Clinical QMs used for public reporting
  - 4 additional clinical QMs in CASPER
  - No vaccination QMs

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Use of Assessments to Generate QMs

- Assessments are used in several different ways to calculate the QMs
  - Most QMs looks for specific information on the target assessment (for example, Restraints)
  - Antipsychotic present, not on initial assessment (S) compares the "initial" assessment to all subsequent assessments
  - ADL Decline (L) and Ability to Move Independently Worsened (L) compare the target assessment with the "prior" assessment
  - The other method is to look at all assessments in the entire episode – this is called the look-back scan
    - New or Worse Pressure Ulcer (S), Falls With Major Injury (L), Falls (L)

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Use of Claims to Generate QMS

- Short stay measures that use claims data combined with MDS data to calculate the measures
  - Successful discharge to community
  - Outpatient ED visits
  - Rehospitalization
- Measures use Medicare claims, although MDS data is used to build stays and for some risk adjustment variables
- Measures only include Medicare fee-for-service beneficiaries
- Only include those who were admitted to the nursing home following an inpatient hospitalization
- Measures are rolling 12 months; updated every six months

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Glossary Terms

- Stay
  - Consecutive days in the facility
  - Starts with any type of entry and stops with any type of discharge
- Episode
  - Include one or more stays
  - Begins with an "Admission" and ends with death or discharge return not anticipated, or if discharged return anticipated but does not return within 30 days
- Cumulative Days in Facility
  - Number of days in each stay in this episode
  - Determines if the resident is short stay or long stay

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Short Stay vs Long Stay

All residents whose latest episode either ends during the target period or is ongoing at the end of the target period are selected for computing the QMs

- **Short Stay:** CDIF is less than or equal to 100 days as of the end of the target period
- **Long Stay:** CDIF is greater than or equal to 101 days at the end of the target period

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Example #1

Resident Admits January 7

Discharged Returned anticipated March 27

Returns to facility April 3

As of September 30, this resident has had one episode which included two stays:

- January 7 – March 27 (80 days)
- April 3 – September 30 (180 days)

When QMs are calculated for March 31, this resident will trigger short stay measures (CDIF=80)

When QMs are calculated for April 30, this resident will trigger long stay measures (CDIF=107)

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Example #2

Resident Admits January 7

Discharged Home returned not anticipated March 27

Falls at home sent to ER and returns to facility April 3

As of September 30, this resident has had two episodes

- January 7 – March 27 (80 days)
- April 3 – September 30 (180 days)

When QMs are calculated for March 31, this resident will trigger short stay measures (CDIF=80)

When QMs are calculated for April 30, this resident will trigger short stay measures (CDIF=27)

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QM Record Definitions
Short Stay

Initial Assessment. First assessment after admission entry record at beginning of selected episode

Must be:

- Admission assessment (A0310A = 01) *OR*
- 5-day or Readmission/Return (A0310B = 01, 06) *OR*
- Discharge assessment (A0310F = 10 or 11)

Target date must be no more than 130 days prior to target date of target record

Same record cannot qualify as both initial and target

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QM Record Definitions
Short Stay

Look-Back Scan. A scan of all assessments within the episode to see if certain QM events or conditions occurred

Includes target assessment and earlier assessment that are:

- OBRA scheduled assessment (A0310A = 01-06) *OR*
- PPS scheduled assessment (A0310B = 01-06) *OR*
- Discharge assessment (A0310F= 10 or 11)

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QM Record Definitions
Long Stay

Prior Assessment. Latest assessment within the episode that is 46 to 165 days prior to the target assessment

Must be

- OBRA scheduled assessment (A0310A = 01-06) *OR*
- PPS scheduled assessment (A0310B = 01-06) *OR*
- Discharge assessment (A0310F= 10 or 11)

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QM Record Definitions
Long Stay

Look-Back Scan. Evaluates all assessments in current episode with target dates no more than 275 days prior to the target assessment

Must be

- OBRA scheduled assessment (A0310A = 01-06) *OR*
- PPS scheduled assessment (A0310B = 01-06) *OR*
- Discharge assessment (A0310F= 10 or 11)

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Basic Calculation

Each QM is calculated based on specific MDS items

- When resident's MDS responses indicate resident has the QM condition, that assessment increases the facility score
- Higher scores indicate possible problems, except scores related to vaccinations
- Lower scores indicate less occurrence of the QM condition, considered to reflect better care (except vaccination QMs)
- For vaccination QMs, higher scores reflect better care, because they indicate that a higher proportion of residents received the vaccine

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Basic Calculation

Basic calculation is a simple ratio expressed as a percentage that results in an indication of a facility's performance for each measure at a given point in time

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Basic Calculation

Numerator: The top number of the fraction; the actual number of residents who had the QM condition

Divided by

Denominator: Bottom number of the fraction; the number of eligible residents with assessments

X 100

Equals percentage of residents with the QM condition

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Risk Adjustments
Exclusions

Residents who are not included in the numerator or denominator due to a certain diagnosis or condition.

Example: Antipsychotic measures exclude residents with Schizophrenia, Tourette's and Huntington's

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Risk Adjustments
Stratification

Divides residents into high-risk and low-risk

- High-risk who get a pressure ulcer (L)
- Low-risk who lose control of their bowel/bladder (L)

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Risk Adjustments
Covariates

Adjust for individual resident characteristics or health conditions that are essentially out of the facility's control that may contribute to worse outcomes for a particular QM

- The residents with those conditions are not excluded, levels the playing field when a facility has more residents with the covariate conditions that other facilities have

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Risk Adjustments
Covariates

- Four QMs utilize a Covariate
  - New or Worse Pressure Ulcer (S)
    - On initial assessment: impaired bed mobility, occasional bowel incontinence, diabetes, PVD, low BMI
  - Indwelling Catheter (L)
    - On prior assessment: frequent bowel incontinence or stage 2,3 or 4 PU
  - Improvement in Function (S)
    - Looks at a variety of clinical indicators on the initial assessment
  - Residents whose Ability to Move Independently Worsened (L)
    - Late loss ADL, severe cognitive impairment, linear age, gender, vision, oxygen use

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Risk Adjustment - Regression

- Used in Claims-based Measures
- Statistical process for estimating the relationships among variables
- May include demographic and clinical information from claims and/or the MDS
- Similar in concept to Covariate

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CASPER QM Reports
Facility Quality Measure Report

Review CASPER QM report in handouts

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Improving Your Quality Measures

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MDS Accuracy

Inaccurate coding definitions be problematic

- QM scores are derived from MDS data
- Inaccurate coding can result in misleading Quality Measure scores and 5 Star ratings
- Inaccurate MDS coding can result in inappropriate resident care
- Inaccurate MDS coding can impact reimbursement

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Quality Improvement

Quality Improvement Activities

- Continuous monitoring of key aspects of key systems
- Individual accountability for key systems – put someone in charge of the system
- Don't look at QMs in silos - review related QM scores when doing root cause analysis
- Identify and correct problems before they become trends

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Quality Improvement

Use available data for quality improvement

- QMs, 5 Star rating
- Internal tracking reports
  (skin, weight, falls, infections, behavior, etc.)
- Survey history
- Resident, family, staff satisfaction surveys
- Resident, family, staff, physician complaints

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Medicaid Quality Incentive Programs

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Medicaid Quality Incentive Payments

Quality incentive Program (RC5165.26)

- FY 2022 rate is $1.32 per point, maximum 22.5 points available
- The lowest 25% of facilities do not qualify for any payment (FY '22 = 9.5 points)
- Average payment is $19.17
- 705 SNFs earned a quality incentive payment
- FY2023 state budget adds additional $$ to the program

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Quality Incentive Program

Uses four CMS long stay quality measures:

- Pressure ulcers (0 to 5 points)
- UTIs (0 to 5 points)
- Catheter (0 to 5 points)
- Ability to move independently (0 to 7.5 points)

Points are assigned based on the CMS cut points used in the 5 star rating program using the prior calendar year's 4 quarter average scores (see next slides)

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Percent of residents who have/had a catheter inserted and left in their bladder

0% to 0.5%	5 points
0.51% to 1.26%	4 points
1.27% to 2.17%	3 points
2.18% to 3.56%	2 points
3.57% or higher	0 points

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Percent of residents with a urinary tract infection

0% to 0.7%	5 points
0.71% to 1.6%	4 points
1.61% to 2.72%	3 points
2.73% to 4.52%	2 points
4.53% or higher	0 points

Note coding instructions for UTI

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Percent of residents whose ability to move independently worsened

0% to 8.21%	7.5points
8.22% to 11.21%	6.75 points
11.22% to 13.5%	6 points
13.51% to 15.68%	5.25 points
15.69% to 17.6	4.5 points
17.61% to 19.55%	3.75 points
19.565 to 21.53%	3 points
21.54% to 23.94%	2.25 points
23.95% to 17.47%	1.5 points
27.48% or higher	0 points

Coding is based on locomotion on unit: how resident moves between locations in their room and adjacent corridor on same floor (G0110 E)

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Percent of high risk residents with pressure ulcers

0% to 3.77%	5 points
3.78% to 5.84%	4 points
5.85% to 7.83%	3 points
7.84% to 10.57%	2 points
10.58% or higher	0 points

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Managing Medicaid Quality Programs

Do you monitor the quality measures that are included?

How often?

Note that the Percent of residents whose ability to move independently worsened is worth the most points in the "new" program, so if you aren't earning all the available points, that might be a good measure to focus on

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5 Star Rating Program Update

Changes Since 2019

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Overview

Stars calculation are based on:

State Health Inspections

- This is the foundation for your final rating
- Facility must have had at least 2 standard surveys or they will have no rating

Staffing

- Level of staffing can pull basic score in one direction or the other

Quality Measures

- QM score can pull star rating in one direction or the other

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Overview

Facility receives four different star ratings

One for each domain

Overall, cumulative rating

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Overall Rating

1. Start with your star rating for survey
2. Look at staffing star rating:
   A. If 4 or 5 stars AND higher than you started with for survey => add 1 star
   B. If 1 star => subtract 1 star
3. Look at QM overall star rating:
   A. If 5 stars => add 1 star
   B. If 1 star => subtract 1 star

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Overall Rating

Health Inspection rating counts more than the other two

If Health Inspection is one star, the Overall rating cannot be upgraded by more than one star based on Staffing and QM

For a Special Focus Facility that has not graduated, a yellow "caution" sign will be posted instead of a star rating

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State Health Inspections

- Points are assigned to deficiencies found during the three most recent surveys
  - Each deficiency weighted by scope and severity (see chart)
  - More recent annual surveys weighted more heavily than earlier surveys
    - Most recent = ½ of overall score
    - 1st Prior = 1/3 of overall score
    - 2nd prior = 1/6 of overall score
- Substantiated complaints for the previous 36 months also count and are weighted the same as the standard surveys

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Table 1
Health Inspection Score: Weights for Different Types of Deficiencies

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J 50 points* (75 points)	K 100 points* (125 points)	L 150 points* (175 points)
Actual harm that is not immediate jeopardy	G 20 points	H 35 points (40 points)	I 45 points (50 points)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D 4 points	E 8 points	F 16 points (20 points)
No actual harm with potential for minimal harm	A 0 point	B 0 points	C 0 points

Note: Figures in parentheses indicate points for deficiencies that are for substandard quality of care.
Shaded cells denote deficiency scope/severity levels that constitute substandard quality of care if the requirement which is not met is one that falls under the following federal regulations: 42 CFR 483.13 resident behavior and nursing home practices; 42 CFR 483.15 quality of life; 42 CFR 483.25 quality of care.
* If the status of the deficiency is "past non-compliance" and the severity is Immediate Jeopardy, then points associated with a "G-level" deficiency (i.e. 20 points) are assigned.
Source: Centers for Medicare & Medicaid Services

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State Health Inspections

Penalizes for *revisits* after the first one

Weights for Repeat Visits	
Revisit Number	**Noncompliance Points**
First	0
Second	50% health inspection score
Third	70% health inspection score
Fourth	85% health inspection score

Points from complaint deficiencies are added to health inspection score before calculating revisit points

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State Health Inspections

Star rating

- Based on relative performance within the state
- The 10% with lowest deficiency scores = 5 stars
- Middle 70% = 2, 3, or 4 stars, with equal number (~23.22%) in each category
- The 20% with highest deficiency scores = 1 star
- A facility's rating does not change because of new surveys in other facilities that affect the statewide distribution

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Updates to Survey Scoring

A red hand "stop" sign was added on NHC to facilities with:

1) ***Harm-level*** *abuse citation in the most recent survey cycle: Facilities cited for abuse where residents were found to be harmed (Scope/Severity of G or higher) on the most recent standard survey or on a complaint survey within the past 12 months*
2) ***Repeat*** *abuse citations: Facilities cited for abuse where residents were found to be potentially harmed (Scope/Severity of D or higher) on the most recent standard survey or on a complaint survey within the past 12 months* ***and*** *on the previous (i.e., second most recent) standard survey or on a complaint survey in the prior 12 months (i.e., from 12 to 24 months ago)*

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Updates to Survey Scoring

Facilities with the abuse icon have their health inspection rating capped at a maximum of 2 stars.

Due to the methodology used to calculate the overall rating, the best overall quality rating a facility that has received the abuse icon can have is 4 stars

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Updates to Survey Scoring



Included tags :

F600 = protection from all types of abuse, such as physical, mental, sexual abuse, physical punishment, and neglect by anybody

F602 = protection from wrongful use of resident's belongings or money – misappropriation

F603 = protection from separation from others – involuntary seclusion

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Staffing

- RN hours per patient day
  - RNs
  - RN director of nursing
  - RNs with administrative duties
- Total staffing hours per patient day includes
  - RN (as described above)
  - LPN/LVN
  - Nurse aide hours
    - Certified nurse aides
    - Aides in training
    - Medication aides/technicians

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Staffing

Ratings based on "expected" staffing (now called case-mix staffing) levels calculated based on resident acuity using RUGs

Staffing is **case-mix adjusted**

- RUG-IV groups calculated on last business day of each quarter for each resident there; uses quarter in which the staffing data was collected
- Uses most recent info - can be composite from most recent comprehensive, full, quarterly, & PPS assessments for a particular resident

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Staffing

$$\text{Hours}_{\text{adjusted}} = (\text{Hours}_{\text{reported}}/\text{Hours}_{\text{expected}}) * \text{Hours}_{\text{national average}}$$

Reported: Hours reported during annual survey

Case-Mix: Reported hours based on RUG-IV

National average: Mean across all facilities

Total Nursing Staffing Example
3 reported ÷ 6 expected = ½ x national average 4.214 = 2.107 adjusted hours

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Staffing

Examples:

Reported	Expected	National Average	Adjusted
4.0	4.0	4.214	4.2140
4.0	4.2	4.214	4.0133
4.0	4.3	4.214	3.9200
4.0	4.5	4.214	3.7457

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Staffing

Table 4
Staffing and Rating (updated April 2019)

RN rating and hours		Total nurse staffing rating and hours (RN, LPN and nurse aide)				
		1	2	3	4	5
		< 3.108	3.108 – 3.579	3.580 - 4.037	4.038 – 4.407	≥4.408
1	< 0.317	★	★	★★	★★	★★★
2	0.317 - 0.507	★★	★★	★★	★★★	★★★
3	0.508 – 0.730	★★	★★★	★★★	★★★	★★★★
4	0.731 – 1.048	★★★	★★★	★★★★	★★★★	★★★★
5	≥1.049	★★★	★★★★	★★★★	★★★★★	★★★★★

Note: Adjusted staffing values are rounded to three decimal places before the cut points are applied.

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Staffing – Additional Notes

Reduce the number of days without an RN for a one-star staffing assignment: Beginning in April 2019, the threshold for the number of days without an RN onsite that triggers an automatic downgrade to one-star will be reduced from seven days to four days.

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January 2022: Additional Staffing Information

- Weekend Staffing
  - Total Nurse hours
  - RN hours
- Staffing Turnover
  - Nursing staff turnover
  - RN turnover
  - Administrator turnover
- This data is currently being publicly reported, but doesn't effect the 5 Star rating; CMS plans to incorporate into the 5 Star rating in July refresh

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Quality Measures - April 2019 Changes

Short-stay and long-stay ratings: two separate QM ratings will be calculated and displayed:

- Short stay rating
- Long stay rating

These two ratings will be averaged, using **equal weighting**, to determine an overall QM rating to include in the overall facility rating

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Quality Measures - April 2019 Changes

QM weightings and scoring: Some QMs will now count more than others, based on clinical significance and room for improvement:

- "High" importance QMs will contribute 150 points per measure to the score; points increase with each decile
- "Medium" importance QMS will contribute 100 points each to the score; points increase with each quintile

Implement a process for continual improvement of QM thresholds: "Cut points" will automatically adjust every six months to incorporate 50% of the improvement that has been shown in the preceding six months. (In other words, your QM rating will become a moving target the same way the survey domain is a moving target.)

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Quality Measures Used in the 5 Star – 9 Long Stay Measures

MDS Long Stay Measures
- Falls with major injury
- High-risk with pressure ulcers
- UTI
- Catheter
- Need for help with ADL increased *
- Antipsychotic meds *
- Ability to move independently worsened *

Claims-based Long Stay Measures
- Hospitalizations per 1,000 resident days *
- ED visits per 1,000 resident days *

* denotes measures assigned 150 points

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Quality Measures Used in the 5 Star – 6 Short Stay Measures

MDS Short Stay Measures
- Improvement in function
- New antipsychotic meds
- New or worsening pressure ulcers *

Claims-based Short Stay Measures
- Successful return from home and community from a SNF *
- Rehospitalization after a nursing home admission *
- ED visit *

* denotes measures assigned 150 points

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Changes to QM Calculation in Five Star

Table 6
Point Ranges for the QM Ratings (as of October 2019)

QM Rating	Long-Stay QM Rating Thresholds	Short-Stay QM Rating Thresholds	Overall QM Rating Thresholds
★	155–469	144-473	299–943
★★	470–564	474–567	944–1,132
★★★	565–644	568–653	1,133–1,298
★★★★	645–734	654–739	1,299–1,474
★★★★★	735–1,150	740 – 1,150	1,475–2,300

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