Managing Reimbursement and Quality Metrics

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Agenda – Session 1

- Medicaid Reimbursement Issues
  - Quality Incentive Program
  - Case Mix and Direst Care Rates
- Overview of Quality Measures
- Detailed Quality Measure Review
- Improving Quality Measures
- 5 Star Rating Methodology

Medicaid Reimbursement Issues

Ohio Medicaid Quality Incentive Program

July 1, 2025 Rate (Effective for 6 months)

- MDS Based QM's – Four calendar quarters of 2024:
  - LS Pressure Ulcers: 0-5 points
  - LS Catheters: 0-5 points
  - LS UTI's: 0-5 points
  - LS Ability to Move Independently Worsened: 0 – 7.5 points
  - LS Increased ADL Help: 0 – 7.5 points
  - LS Falls w/major injury: 0-5 points
  - LS Antipsychotics: 0-7.5 points
- Total Nursing Staff Hours: 0-5 points
- (Revised): Occupancy > 75% in CY 2024: 3 points (<75%: 0 points)

More About the July 1, 2025 QIP Calculation

- "Threshold" to Keep QM points = 32
- $ Amount per point = $1.14
- 677 facilities were at or above the required threshold
- 234 facilities were below the threshold
  - 153 facilities earned 3 points for occupancy
  - 81 facilities received no quality incentive payment at all

January 1, 2026 Rate (Effective for 6 months)

- MDS Based QM's – Q3 2024, Q4 2024, Q1 2025 and Q2 2025):
  - LS Pressure Ulcers: 0-5 points
  - LS Catheters: 0-5 points
  - LS UTI's: 0-5 points
  - LS Ability to Move Independently Worsened: 0 – 7.5 points
  - LS Increased ADL Help: 0 – 7.5 points
  - LS Falls w/major injury: 0-5 points
  - LS Antipsychotics: 0-7.5 points
- Total Nursing Staff Hours: 0-5 points
- (Revised): Occupancy > 75% in CY 2024: 3 points (<75%: 0 points)
- Threshold and $ per point do not recalculate for January rate settings

How Does ODM Calculate My QIP Points?

MDS Long-Stay Measures	2024Q1	2024Q2	2024Q3	2024Q4	4Q avg	Rating Points
Lower percentages are better						
Percentage of residents experiencing one or more falls with major injury	5.3%	2.7%	1.3%	5.1%	3.6%	40
Percentage of residents with pressure ulcers	4.4%	6.9%	2.9%	3.6%	4.4%	80
Percentage of residents with a urinary tract infection	0.0%	2.7%	0.0%	1.3%	1.0%	80
Percentage of residents with a catheter inserted and left in their bladder	0.0%	0.0%	0.0%	0.0%	0.0%	100
Percentage of residents whose need for help with daily activities has increased	10.9%	7.9%	6.5%	9.2%	8.7%	135
Percentage of residents who received an antipsychotic medication	13.7%	19.2%	17.8%	16.9%	16.9%	80
Percentage of residents whose ability to walk independently worsened	15.4%	18.9%	14.1%	12.3%	15.2%	120

- Ohio uses the points assigned by CMS based on the 4-quarter average and divides by 20, unless you are in the lowest quintile/decile, then you get 0 points
  - 20 points in a QM worth 100 points
  - 15 points in a QM worth 150 points

CMS Cut Points

Percentage of residents experiencing one or more falls with major injury (long-stay)	100	0.0000	0.0134
	80	0.0135	0.0246
	60	0.0247	0.0356
	40	0.0357	0.0514
	20	0.0515	1.0000

- Table A3 from the 5-Star technical User's Guide (see additional handouts)
- Move the decimal point over two spaces to the right to create percentages
- 100 (5) points = 0% - 1.34%
- 80 (4) points = 1.35% - 2.46%
- 60 (3) points = 2.47% - 3.56%
- 40 (2) points = 3.57% - 5.14%
- 20 (0) points = 5.15% - 100%

Case Mix Adjusted Total Nurse Staffing

	Reported Hours per Resident per Day (HRD)	Reported HRD (Decimal)	National Average: Reported HRD (Decimal)	Case-Mix HRD	National Average: Case-Mix HRD	Case-Mix Adjusted HRD
All days						
Total nurse (RN, LPN, LVN, and Nurse Aide) hours	4 hours and 17 minutes	4.278	3.966	4.031	3.842	**4.077**
RN hours	33 minutes	0.549	0.671	0.699	0.857	**0.523**
LPN/LVN hours	1 hour and 7 minutes	1.125	0.670	0.907	0.865	**1.078**
Nurse aide hours	2 hours and 36 minutes	2.606	2.334	2.424	2.010	**2.484**
Physical therapist hours	2 minutes					
Weekend (Saturday and Sunday)						
Total nurse (RN, LPN, LVN, and Nurse Aide) hours	3 hours and 44 minutes	3.730	3.422	3.569	3.402	**3.555**
RN hours	12 minutes	0.196				

- The Five Star only reports on quarter at a time, ODM averages four quarters together to get a 4-quarter average using the same four quarters that are used in the Quality Measures

How Does ODM Calculate My Staffing points?

Adjusted Total Nurse Staffing (Hours per Resident per Day)	100	5.070	Or higher
	90	4.499	5.069
	80	4.151	4.498
	70	3.910	4.150
	60	3.692	3.909
	50	3.493	3.691
	40	3.293	3.492
	30	3.051	3.292
	20	2.722	3.050
	10	0.000	2.721

- 90 or 100 points = 5 (4.49 or higher)
- 70 or 80 points = 4 (3.91 – 4.498)
- 50 or 60 points = 3 (3.493 – 3.909)
- 30 or 40 points = 2 (3.051 – 3.492)
- 10 or 20 points = 0 (3.050 or lower)

Strategies for Improving Medicaid Quality Incentive Program Points

Improving Quality Measures

- Improving quality measures is not an MDS function, it requires improving clinical practices
  - Root cause analysis – 5 Why's
  - Focused implementation of improvement strategies
- You need to understand the details of how each quality measure is calculated
  - QM Technical Users Guide

Strategy for Measures that were Frozen

- The July 1, 2025 rate is the first to use the new measures that replaced the three measures that were frozen as of September 30, 2023 due to changes to the MDS item set
  - LS High Risk Pressure Ulcers
  - LS ADL Decline
  - LS Ability to Move Independently Worsened
- Make sure your IDT understands the details as to how these new measures are calculated (see next slides)

Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (LS) (NEW)

- This measure reports the percent of long-stay residents whose need for help with late-loss Activities of Daily Living (ADLs) has increased when compared to the prior assessment.
- Numerator: Long-stay residents with selected target and prior assessments that indicate the need for help with late-loss Activities of Daily Living (ADLs) has increased when the selected assessments are compared.
- The four late-loss ADL items are:
  - Sit to Lying (GG0170B),
  - Sit to Stand (GG0170D),
  - Eating (GG0130A), and
  - Toilet Transfer (GG0170F).
- An increase in need for help is defined as a decrease in two or more coding points in one late-loss ADL item or one point decrease in coding points in two or more late-loss ADL items. Note that for each of these four ADL items, if the value is equal to [07, 09, 10, 88] on either the target or prior assessment, then recode the item to equal [01] to allow appropriate comparison.

Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (LS) (NEW)

- Denominator: All long-stay residents with a selected target and prior assessment, except those with exclusions.
- Exclusions:
  - 1. All four of the late-loss ADL items indicate dependence or activity was not attempted on the prior assessment
  - 2. Three of the late-loss ADLs indicate dependence (value [01]) or activity was not attempted (values [07, 09, 10, 88]) on the prior assessment, as in exclusion 1 AND the fourth late-loss ADL indicates substantial/maximal assistance (value [02]) on the prior assessment.
  - 3. Comatose or missing data on comatose (B0100 = [1, -]) on the target assessment.
  - 4. Prognosis of life expectancy is less than 6 months (J1400 = [1, -]) on the target assessment.
  - 5. Hospice care (O0110K1b = [1, -]) on the target assessment.
  - 6. The resident is not in the numerator and 6.1. Sit to Lying (GG0170B) = [-]) on the prior or target assessment, or 6.2. Sit to Stand (GG0170D = [-]) on the prior or target assessment, or 6.3. Eating (GG0130A) = [-]) on the prior or target assessment, or 6.4. Toilet Transfer (GG0170F) = [-]) on the prior or target assessment.17
  - 7. No prior assessment is available to assess prior function.
  - 8. Prior or target assessment date before 10/01/2023

Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (LS) (NEW)

- Clinical Discussion:
  - How are we assessing
    - Sit to Lying (GG0170B),
    - Sit to Stand (GG0170D),
    - Eating (GG0130A), and
    - Toilet Transfer (GG0170F).
  - How do we monitor changes in performance between assessments?
  - What clinical processes could affect this measure?
- MDS Discussion:
  - If resident improves enough to return to their baseline, schedule anther MDS within the quarter to capture the improvement and negate the decline
  - If the resident does not return to baseline, schedule another assessment 46 days later

Percent of Residents Whose Ability to **Walk** Independently Worsened (LS)

- This measure reports the percent of long-stay residents who experienced a decline in independence of locomotion during the target period.
- Numerator: Long-stay residents with a selected target assessment and at least one qualifying prior assessment who have a decline in locomotion when comparing their target assessment with the prior assessment.
- Decline identified by:
  - 1. Recoding all values (GG0170I = [07, 09, 10, 88]) to (GG0170I = [01]).
  - 2. A decrease of one or more points on the **"Walk 10 feet"** item between the target assessment and prior assessment (GG0170I on target assessment – GG0170I on prior assessment ≤ -1).22

Percent of Residents Whose Ability to **Walk** Independently Worsened (LS)

- Denominator: Long-stay residents who have a qualifying target assessment and at least one qualifying prior assessment, except those with exclusions.
- Exclusions - Residents satisfying any of the following conditions:
  - 1. Comatose or missing data on comatose (B0100 = [1, -]) at the prior assessment.
  - 2. Prognosis of less than 6 months at the prior assessment as indicated by:
    - 2.1. Prognosis of less than six months of life (J1400 = [1]), or
    - 2.2. Hospice use (O0110K1b = [1]), or
    - 2.3. Neither indicator for being end-of-life at the prior assessment (J1400 ≠ [1] and O0110K1b ≠ [1]) and a missing value on either indicator (J1400 = [-] or O0110K1b = [-]).
  - 3. Resident dependent or activity was not attempted during locomotion on prior assessment (GG0170I = [01, 07, 09, 10, 88]).
  - 4. Missing data on locomotion on target or prior assessment (GG0170I = [-]).

Percent of Residents Whose Ability to Walk Independently Worsened (LS) (NEW)

- Clinical Discussion:
  - How are we assessing resident's usual performance walking 10 feet?
  - How do we monitor changes in performance between assessments?
  - What clinical systems could affect this measure?
- MDS Discussion:
  - If resident improves enough to return to their baseline, schedule anther MDS within the quarter to capture the improvement and negate the decline
  - If the resident does not return to baseline, schedule another assessment 46 days later

More about Scheduling for QMs that Compare an Assessment to a Prior Assessment

- These quality measures identify the most recent assessment ("target assessment") during the reporting period and compare it to an assessment that is at least 46 days prior to the target assessment.
- If a person experiences a "temporary" decline that is captured on an MDS and subsequently returns fully to their baseline status, you can do another assessment as soon as the baseline performance becomes the resident's usual performance over a three-day period again (see Example 1)
- If a person experiences a decline and does not fully return to their baseline performance, you want to schedule a new MDS 46 days after the assessment that first captured the decline (see Example 2)

Example 1

- Resident had a quarterly with an ARD of March 17, and was able to walk 10 feet independently
- The next quarterly is due no later than June 17.
- On June 11 the resident is feeling poorly and tests positive for Covid. During this illness, she stays in bed most of the time and does not walk 10 feet. The quarterly with an ARD of June 15 captures that walking 10 feet was not attempted due to medical condition, and this triggers Ability to walk independently worsened.
- On June 21, the resident is fully recovered and begins to walk 10 feet independently again.

Example 1, Continued

- The resident walks 10 feet independently on June 21, 22 and 23.
- Another quarterly should be completed with an ARD of June 23. This will capture that they have returned to their baseline from the March 17 assessment and will cause them to stop triggering for the decline
- Report period: April 1 – June 30
- Target Assessment = June 23 (most recent assessment as of June 30) and captures independent status
- Prior assessment = March 17, which also captured independent status
  - Once the June 23 assessment is completed, the June 17 assessment will be ignored, as it is not at least 46 days prior to the target assessment
- This only works when the resident makes a full recovery to their baseline

Example 2

- Resident had a quarterly with an ARD of March 17, and was able to walk 10 feet independently
- The next quarterly is due no later than June 17.
- On June 11 the resident has a stroke and is sent to the hospital. Upon return from the hospital, a significant change in status assessment is completed on June 27 and captures that walking 10 feet was not attempted due to medical condition, triggering Ability to walk independently worsened.
- On July 5, the resident begins to walk 10 feet, but requires the assistance of two staff, which is considered to be dependent.

Example 2, continued

- The resident continues to make slow progress and by July 25, they are walking with substantial or maximal assistance.
- August 11 is 46 days after June 27, which was the last MDS completed. By August 11, the resident continues to need partial or moderate staff assistance to walk 10 feet.
- An MDS should be completed with an ARD of August 11, because that is the first day that the new assessment would not still trigger a decline
- Target assessment = August 11 (partial/moderate assistance)
- Prior assessment = June 27 (not attempted due to medical condition)
  - If you do not wait until August 11, the prior assessment would continue to be March 17 (independent)

Percent of Residents With Pressure Ulcers (LS) (NEW)

- This measure captures the percentage of long-stay residents with Stage II-IV or unstageable pressure ulcers.
- Numerator - All long-stay residents with a selected target assessment that meet the following condition:
  - 1. Stage II-IV or unstageable pressure ulcers are present
- Denominator - All long-stay residents with a selected target assessment except those with exclusions.
- Exclusions
  - 1. Target assessment is an ORBA Admission assessment (A0310A = [01]) or a PPS 5-Day assessment (A0310B = [01]).
  - 2. If the resident is not included in the numerator and any of the following conditions are true: (any pressure ulcer staging item is dashed)

Percent of Residents With Pressure Ulcers (LS) (NEW) - Covariates

Covariates used to risk-adjust this measure include:

1. Impaired Functional Mobility: Lying to Sitting on Side of Bed on target assessment.[27]
   - 1.1 Covariate = [1] if GG0170C = [01, 02, 07, 09, 10, 88].
   - 1.2 Covariate = [0] if GG0170C = [03, 04, 05, 06, -].
2. Bowel Incontinence on target assessment.
   - 2.1 Covariate = [1] if H0400 = [1, 2, 3].
   - 2.2 Covariate = [0] if H0400 = [0, 9, -].
3. Peripheral Vascular Disease or Peripheral Arterial Disease, or Diabetes Mellitus on target assessment.
   - 3.1 Covariate = [1] if I0900 = [1] or I2900 = [1], else covariate = [0].
4. Indicator of low body mass index based on height (K0200A) and weight (K0200B) on target assessment.
   - 4.1 Covariate = [1] if BMI ≥ [12.0] ***and*** BMI ≤ [19.0].
   - 4.2 Covariate = [0] if BMI > [19.0].
   - 4.3 If Covariate has not been set to [1] or [0] based on logic in 4.1 and 4.2, then Covariate = [0].
5. Malnutrition or at risk of malnutrition on target assessment.
   - 5.1 Covariate = [1] if I5600 = [1], else covariate = [0].
6. Dehydrated on target assessment.
   - 6.1 Covariate = [1] if J1550C= [1], else covariate = [0].
7. Infections: Multidrug-Resistant Organism (MDRO), Pneumonia, Septicemia, or Urinary Tract Infection on target assessment.
   - 7.1 Covariate = [1] if I1700 = [1] ***or*** I2000 = [1] ***or*** I2100 = [1] ***or*** I2300 = [1], else covariate = [0].
8. Moisture Associated Skin Damage on target assessment.
   - 8.1 Covariate = [1] if M1040H = [1], else covariate = [0].
9. Hospice Care on target assessment.
   - 9.1 Covariate = [1] if O0110K1b = [1], else covariate = [0].

Percent of Residents With Pressure Ulcers (LS) (NEW)

- Clinical Discussion:
  - How do we assess wounds?
  - How do we monitor wounds between assessments?
  - What clinical processes could help reduce pressure ulcers?
- MDS Discussion:
  - Once a previously captured pressure ulcer heals, schedule a new assessment within the same calendar quarter is possible
  - Are we properly assessing all of the covariate conditions

Percent of Residents with a Urinary Tract Infection (LS)

- The measure reports the percentage of long stay residents who have a urinary tract infection.
- Numerator: Long-stay residents with a selected target assessment that indicates urinary tract infection within the last 30 days (I2300 = [1]).
- Denominator All long-stay residents with a selected target assessment, except those with exclusions
- Exclusions: Target assessment is an admission assessment (A0310A = [01]) or a PPS 5-Day assessment (A0310B = [01]

Percent of Residents with a Urinary Tract Infection (LS)

- Clinical Discussion:
  - What clinical processes could affect this measure?
  - What usually leads to a diagnosis of a UTI?
- MDS Discussion:
  - Pay attention to coding instructions for a UTI: code only if both physician diagnosis and infection surveillance tool indicating UTI were present within the past 30 days
    - it is not relevant if resident was still receiving antibiotic in the lookback period
  - If you have already captured a UTI, look for an opportunity to do a new MDS within the same quarter on day 31 after the physician diagnosis/completion of the tool
  - If you are suspect a resident may have a UTI and their MDS is due within the next 30 days, open and complete an assessment today before you have an actual diagnosis

Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (LS)

- This measure reports the percentage of residents who have had an indwelling catheter in the last 7 days.
- Numerator: Long-stay residents with a selected target assessment that indicates the use of indwelling catheters (H0100A = [1]).
- Denominator: All long-stay residents with a selected target assessment, except those with exclusions.

Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (LS)

- Exclusions
  - Target assessment is an admission assessment (A0310A = [01]) or a PPS 5-Day assessment (A0310B = [01]).
  - Target assessment indicates neurogenic bladder (I1550 = [1])
  - Target assessment indicates obstructive uropathy (I1650 = [1])
- Covariates
  - Frequent bowel incontinence on prior assessment (H0400 = [2, 3]).
  - Pressure ulcers at stages II, III, or IV on prior assessment

Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (LS)

- Clinical Discussion:
  - How often do we admit people with a catheter? What is process for removing?
  - How often do we initiate catheter use in a current resident? What are the common causes?
  - What clinical systems could affect this measure?
- MDS Discussion:
  - If a catheter has been captured on an MDS and then is removed, schedule a new MDS before the end of the quarter
  - Capture diagnosis of neurogenic bladder or obstructive uropathy when appropriate, query the physician if necessary

Percent of Residents Who Received an Antipsychotic Medication (LS)

- This measure reports the percentage of long-stay residents who are receiving antipsychotic drugs in the target period.
- Numerator: Long-stay residents with a selected target assessment where the following condition is true: antipsychotic medications received. This condition is defined as follows: (N0410A = [1, 2, 3, 4, 5, 6, 7]).
- Denominator: Long-stay nursing home residents with a selected target assessment except those with exclusions.

Percent of Residents Who Received an Antipsychotic Medication (LS)

- Exclusions:
  - Any of the following related conditions are present on the target assessment (unless otherwise indicated):
    - Schizophrenia (I6000 = [1]).
    - Tourette's syndrome (I5350 = [1]).
    - Tourette's syndrome (I5350 = [1]) on the prior assessment if this item is not active on the target assessment and if a prior assessment is available.
    - Huntington's disease (I5250 = [1]).

Percent of Residents Who Received an Antipsychotic Medication (LS)

- Clinical Discussion:
  - What interventions can we try before implementing a new antipsychotic?
  - What is the process for attempting gradual dose reductions?
  - What additional clinical systems could affect this measure?
- MDS Discussion:
  - If an antipsychotic has been captured and is subsequently discontinued, schedule a new MDS before the end of the calendar quarter
  - Be sure to capture diagnoses of Schizophrenia, Tourette's syndrome or Huntington's disease if appropriate

Upcoming Change to Antipsychotic Measure

- Beginning with the October 2025 refresh, CMS will incorporate Medicare Part D prescription drug data, state-level Medicaid claims data and Medicare Advantage encounter data along with MDS data to calculate this measure.
- CMS projects that the average reported rate of LS residents receiving an antipsychotic will increase from 14.64% to 16.98%
- This will trigger a recalibration of the scoring for this measure and the existing “cut points” will be recalibrated

Upcoming Change to Antipsychotic Measure

- Medicare Part D Prescription Drug Event (PDE) Data, Medicaid Claims Data (T-MSIS and Medicare Advantage (Part C) Encounter Data will all capture each time a prescription is dispensed
- Medicare Part A/B Claims data will be used to validate presence of excluding diagnoses reported on the MDS

Percent of Residents Experiencing One or More Falls With Major Injury

- This measure reflects the percent of long-stay residents who have experienced one or more falls with a major injury reported in the target period or the look back period.
- Numerator: Long-stay residents with one or more look back scan assessments that indicate one or more falls that resulted in major injury
- Denominator: All long-stay nursing home residents with one or more lo0k-back scan assessments, unless J1900 is dashed on all look back scan assessments

How the Look-Back Scan Works

- When you run you QM report for the reporting period, the target assessment is the most recent assessment that was completed.
- The look-back scan starts with the ARD of the target assessment, and looks backwards for an additional 275 days and evaluates whether the target assessment or any other assessment in the look-back scan period is coded for a fall with a major injury
- Example: If the reporting period is April 1 – June 30, 2025 and the last MDS done during that quarter had an ARD of June 19, the look-back scan would scan from June 19 back to September 17, 2024. If ANY assessment with an ARD between those two dates has a fall with a major injury, the resident will trigger

Strategy for Falls With Major Injury

- Clinical Discussion:
  - What is our process for assessing risk for falls?
  - What is our process for implementing interventions once someone has had a fall?
  - What clinical systems could affect this measure?
- MDS Discussion:
  - Fall with a major injury is defined as a bone fracture, joint dislocation, closed head injury with altered consciousness, subdural hematoma; do not code other "bad" falls
  - Once you have reported a fall with major injury, schedule another assessment 276 days after the ARD of the assessment that reported the fall with major injury

Changes to Falls – October 1, 2025 RAI Manual Update

- FALL: Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat) *or the result of an overwhelming external force (e.g., a resident pushes another resident).*
- An intercepted fall occurs when the resident would have fallen if they had not caught themself or had not been intercepted by another person – this is still considered a fall.
- CMS understands that challenging a resident's balance and training them to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls. *However, if there is a loss of balance during supervised therapeutic interventions and the resident comes to rest on the ground, floor or next lower surface despite the clinician's effort to intercept the loss of balance, it is considered a fall.*

Changes to Falls – October 1, 2025 RAI Manual Update

- New Example *6. The therapist had Resident S, who has Parkinson's disease, stand on one foot during their therapy session to intentionally challenge the resident's balance. Despite providing contact guard assistance and use of safety mats, Resident S fell and landed on their left side. An X ray was ordered due to pain and swelling of the left wrist which confirmed a distal radius fracture of the left wrist.*
  - *Coding: J1800 would be coded 1, yes and J1900C would be coded 1, one.*
  - *Rationale: Despite safety precautions in place, Resident S sustained a radius fracture as a result of a fall during a therapeutic intervention with physical therapy. This is a fall, as the clinician's interventions did not intercept the loss of balance, and the resident landed on the floor and sustained a fracture, which is a major injury.*

Changes to Falls With Major Injury – October 1, 2025 RAI Manual Update

- MAJOR INJURY Includes, *but is not limited to, traumatic* bone fractures, joint dislocations/subluxations, internal organ injuries, amputations, spinal cord injuries, head injuries, *and crush injuries*.
- New coding tip: Fractures confirmed to be pathologic (vs. traumatic) are not considered a major injury resulting from a fall.

Changes to Falls With Major Injury – October 1, 2025 RAI Manual Update

Differentiating from Traumatic vs. Pathological Fractures

- *7. Resident A, who has osteoporosis, falls, resulting in a right hip fracture. The Emergency Department physician confirms that the fracture is a result of the resident's bone disease and not a result of the fall.*
  - *Coding: J1800 would be coded 1, yes and J1900C would be coded 0, none.*
  - *Rationale: The physician determined that the fracture was a pathological fracture due to osteoporosis. Because the fracture was determined to be pathological, it is not coded as a fall with major injury.*
- *8. Resident L, who has osteoporosis, falls, resulting in a right hip fracture. The physician in the acute care hospital confirms that the fracture is a result of the resident's fall and not the resident's history of osteoporosis.*
  - *Coding: J1800 would be coded 1, yes and J1900C would be coded 1, one.*
  - *Rationale: Because the physician determined that the fracture was a result of the fall, it is a traumatic fracture and, therefore, is a fall with major injury.*

Future Changes to Falls With Major Injury QM

- CMS is considering changing this measure to incorporate additional data sources similar to the changes being made to the antipsychotic measure
- The timing of such a change has not yet been announced

Action Plan

- Strengthen your team's root cause analysis skills, the best-case scenario is that QM events are avoided altogether, or caught early enough that they can be resolved before having to capture on an MDS
- As the case mix score freeze comes to an end and facilities start to once again focus on case mix maximization, be sure to be aware of the QM ramifications of completing "extra" or "early" assessments to capture changes in acuity
- When each MDS is completed, the team should be aware of which QMs where triggered form the assessment and develop a "mitigation" plan (See QM Reporting tool in the additional handouts)

Transitioning to PDPM for Medicaid Case Mix

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PDPM Transition Schedule

- January 1, 2026 rate
  - 1/3 PDPM, 2/3 RUGs
    - PDPM uses Q2 and Q3 2025 scores
    - RUGs uses score from January 1, 2025 rate (Q2 and Q3 2024)
- July 1, 2026 rate
  - 2/3 PDPM, 1/3 RUGs
    - PDPM uses Q4 2025 and Q1 2026 scores
    - RUGs uses score from January 1, 2025

PDPM Transition Schedule

- January 1, 2027 rate
  - 2/3 PDPM, 1/3 RUGs
    - PDPM uses Q2 and Q3 2026 scores
    - RUGs uses score from January 1, 2025 rate
  - *There are conflicting opinions regarding this rate period, ODM has told some providers that this rate period will be 100% PDPM using Q2 and Q3 2026, we are awaiting clarification*
- July 1, 2027 rate
  - 100% PDPM
    - Uses Q4 2026 and Q1 2027

PDPM Conversion Factor

ORC 5165.19: (4) The department shall multiply each cost per case-mix unit determined under division (C) (1) of this section by the peer group average case-mix score in effect on December 31, 2025, divided by the peer group average case-mix score determined under section 5165.192 of the Revised Code for the semiannual period beginning January 1, 2026.

The product determined under this division for each nursing facility's peer group shall be the cost per case-mix unit used to determine the nursing facility's per Medicaid day payment rate for direct care costs under division (A)(1) of this section for the period beginning January 1, 2026, and ending on the day before the department's next rebasing conducted after that date takes effect.

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PDPM Nursing Component Details

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Nursing Component – Function Score

- Section GG based function score
  - Eating
  - Toileting Hygiene
  - "Bed Mobility" - Average of:
    - Sit to lying
    - Lying to sitting on side of the bed
  - "Transfer"- Average of:
    - Sit to stand
    - Chair/bed-to-chair transfer
    - Toilet transfer
- Scoring Assignment
  - 4: set up or independent
  - 3: supervision or touching assist
  - 2: partial/moderate assist
  - 1: substantial/maximal assist
  - 0: dependent, refused, n/a
- Functional Categories
  - 0-5 (highest CMI)
  - 6-14
  - 15-16 (lowest CMI)

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Section GG Coding Hints

- Capture resident's "Usual Performance" over the three-day assessment period
- Coding is based on a clinical assessment and should reflect a collaboration between therapy and nursing if the individual is on therapy caseload
- If the resident requires the assistance of two helpers, code "dependent"
- Partial/moderate assistance vs. substantial/maximal assistance
- Coding should be based on an actual assessment, not what you think the resident is capable of

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Nursing Component – 25 Payment Groups

- 1st Tier ("Major Category"):
  - Extensive services
  - Special care high
  - Special care low
  - Clinically complex
  - Behavior symptoms/cognition
  - Reduced physical function
- 2nd Tier ("End Splits"):
  - Function Score
  - PHQ9 Score
  - Restorative Nursing

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Extensive Services

- Residents satisfying the following two conditions:
  - Having a function score of 14 or lower.
  - While a resident, receiving:,
    - ventilator/respirator, and/or
    - tracheostomy care, or
    - infection isolation.
  - P O-6: examples of when the isolation criteria would NOT apply include UTIs, encapsulated pneumonia and wound infections
    - See next slide for coding criteria

• Trach AND Vent	ES3 A	3.84
• Trach OR Vent	ES2 B	2.90
• Isolation	ES1 C	2.77

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O0110M1, Isolation or Quarantine for Active Infectious Disease

- Code for "single room isolation" only when all of the following conditions are met:
  - 1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
  - 2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
  - 3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
  - 4. The resident must remain in their room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

Special Care High

- Residents satisfying the following two conditions:
  - Having a function score of 14 or lower.
  - Receiving any of the following:
    - comatose,
    - septicemia,
    - diabetes with daily insulin injections and insulin order changes on at least 2 days,
    - quadriplegia with function score of 11 or lower
    - Asthma, COPD or other chronic lung disease, with shortness of breath when lying flat
    - fever with pneumonia, vomiting, weight loss, or tube feeding*
    - parenteral/IV feeding, or
    - respiratory therapy 7 out of the last 7 days.

Special Care High Opportunities

- Septicemia or IV fluids during hospitalization
- Monitor people with DMII and daily insulin injections for insulin order changes
- Fever: baseline temp plus 2.4 degrees
- Asthma, COPD or lung disease with SOB when lying flat
  - What do you code as other lung disease?
  - How do you assess shortness of breath?

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J1100: Shortness of Breath

- Steps for Assessment: Interview the resident about shortness of breath. Many residents, including those with mild to moderate dementia, may be able to provide feedback about their own symptoms.
  - 1. If the resident is not experiencing shortness of breath or trouble breathing during the interview, **ask the resident** if shortness of breath occurs when he or she engages in certain activities.
  - 2. **Review the medical record** for staff documentation of the presence of shortness of breath or trouble breathing. **Interview staff** on all shifts, **and family/significant other** regarding resident history of shortness of breath, allergies or other environmental triggers of shortness of breath.
  - 3. **Observe the resident** for shortness of breath or trouble breathing. Signs of shortness of breath include: increased respiratory rate, pursed lip breathing, a prolonged expiratory phase, audible respirations and gasping for air at rest, interrupted speech pattern (only able to say a few words before taking a breath) and use of shoulder and other accessory muscles to breathe.
  - 4. If shortness of breath or trouble breathing is observed, note whether it occurs with certain positions or activities.

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J1100: Shortness of Breath

- Coding Instructions:
  - Check J1100C: if shortness of breath or trouble breathing is present when the resident attempts to lie flat. **Also code this as present if the resident avoids lying flat because of shortness of breath.**

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Special Care High Opportunities, Continued

- Respiratory Therapy 15 minutes per day 7 out of the last 7 days
  - Count only time clinician spent with the resident
  - Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function.
  - Respiratory therapy services include coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse.
  - A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws

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Special Care High

HDE2	D 2.27
HDE1	E 1.88
HBC2	F 2.12
HBC1	G 1.76

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	HDE2
0-5	No	HDE1
6-14	Yes	HBC2
6-14	No	HBC1

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Special Care Low

- Residents satisfying the following two conditions:
  - Having a function score of 14 or lower
  - Receiving any of the following:
    - cerebral palsy with function score of 11 or lower,
    - multiple sclerosis with function score of 11 or lower,
    - Parkinson's disease with function score of 11 or lower,
    - respiratory failure and oxygen therapy while a resident,
    - tube feeding,*
    - ulcer treatment with two or more ulcers including venous ulcers, arterial ulcers or pressure ulcers at stage II or higher,
    - ulcer treatment with any stage III or IV pressure ulcer,
    - foot infections or wounds with application of dressing,
    - radiation therapy while a resident, or
    - dialysis while a resident.

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Special Care Low Opportunities

- Section O – In the last 14 days while a resident
  - If a resident has not met the definition of "discharge", they are still a resident
  - Can capture services and treatments provided as an outpatient
  - Can capture services and treatments provided in the ER if never admitted to the hospital and returns within 24 hours
- Respiratory failure with oxygen
  - Do all of your orders for oxygen include a diagnosis?

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Special Care Low

LDE2	H 1.97
LDE1	I 1.64
LBC2	J 1.63
LBC1	K 1.35

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	LDE2
0-5	No	LDE1
6-14	Yes	LBC2
6-14	No	LBC1

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Clinically Complex

- Residents receiving any of the following:
  - Clinical qualifiers for Extensive, Special Care High or Special Care Low without required function score
  - pneumonia,
  - hemiplegia with function score of 11 or lower,
  - surgical wounds or open lesions with treatment,
  - burns,
  - chemotherapy while a resident,
  - oxygen therapy while a resident,
  - IV medications while a resident, or
  - transfusions while a resident.

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Clinically Complex

CDE2	L	1.77
CDE1	M	1.53
CBC2	N	1.47
CBC1	O	1.03
CA2	P	1.27
CA1	Q	0.89

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	CDE2
0-5	No	CDE1
6-14	Yes	CBC2
6-14	No	CBC1
15-16	Yes	CA2
15-16	No	CA1

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Behavioral Symptoms and Cognitive Performance

- Residents satisfying the following two conditions:
  - Having a function score of 11 or higher.
  - Having behavioral or cognitive performance symptoms, involving any of the following:
    - difficulty in repeating words, temporal orientation, or recall (score on the Brief Interview for Mental Status <=9),
    - difficulty in making self understood, short-term memory, or decision making (score on the Cognitive Performance Scale >=3),
    - hallucinations,
    - delusions,
    - physical behavioral symptoms toward others,
    - verbal behavioral symptoms toward others,
    - other behavioral symptoms,
    - rejection of care, or
    - wandering.

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Behavior Symptoms and Cognitive Performance

BAB2 R 0.98

BAB1 S 0.94

Nursing Function Score	Restorative Nursing	PDPM Nursing Classification
11-16	2 or more	BAB2
11-16	0 or 1	BAB1

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Reduced Physical Function

- Residents whose needs are primarily for support with activities of daily living and general supervision.
- (Residents who didn't group anywhere else)

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Reduced Physical Function

PDE2	T	1.48
PDE1	U	1.39
PBC2	V	1.15
PBC1	X	1.07
PA2	W	0.67
PA1	Y	0.62

Nursing Function Score	Restorative Nursing	PDPM Nursing Classification
0-5	2 or more	PDE2
0-5	0 or 1	PDE1
6-14	2 or more	PBC2
6-14	0 or 1	PBC1
15-16	2 or more	PA2
15-16	0 or 1	PA1

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Case Mix Index Recap

Nursing CMG	Nursing CMI
ES3	3.84
ES2	2.90
ES1	2.77
HDE2	2.27
HDE1	1.88
HBC2	2.12
HBC1	1.76
LDE2	1.97
LDE1	1.64
LBC2	1.63
LBC1	1.35
CDE2	1.77
CDE1	1.53
CBC2	1.47
CA2	1.03
CBC1	1.27
CA1	0.89
BAB2	0.98
BAB1	0.94
PDE2	1.48
PDE1	1.39
PBC2	1.19
PA2	0.67
PBC1	1.07
PA1	0.62

- See Additional Handouts for
  - PDPM Nursing Component 1st Tier Qualifiers
  - PDPM Nursing Component Case Mix Indexes

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IDT Collaboration and Documentation

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Medicaid Case Mix Meeting

- During scheduled assessments
  - Collaboratively assess the resident's usual performance for self-care and mobility tasks
  - Ensure scheduled respiratory therapy treatments or restorative nursing programs occur and are documented
  - Assess shortness of breath

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Medicaid Case Mix Meeting

- Between scheduled assessments
  - Review upon return from hospital stay
    - Using an early ARD could capture diagnoses treated during the hospital stay
    - Using an early ARD could capture IV fluids administered for nutrition or hydration during the hospital stay
  - Monitor for changes in condition
    - New diagnoses that will increase case mix
    - New treatments that will change case mix
  - Monitor for "missing" reimbursement criteria
    - Diagnosis of Asthma, COPD or other lung disease: monitor for shortness of breath while lying flat
    - DM diagnosis with daily insulin injections: monitor for 2 days with insulin order changes in a 7-day period

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Communication and Documentation

- Improving documentation should not be solely the responsibility of the MDS Coordinator, the facility administrator and all nursing leadership need to be involved
- Documentation needs to be monitored in real time and ongoing feedback provided
- Look for ways to streamline documentation
- MDS staff need to be part of the clinical team so that they are always aware of changes in residents that might affect case mix and/or quality measures

"Medicaid Only" Case Mix Scores

Who is “Medicaid”?

- Case mix reports start with every resident who was in the facility on the last day of the calendar quarter and any residents who were discharged return anticipated and pulls their last assessment as of the end of the quarter
- If that last assessment is a Medicare 5-day assessment, they are “MCARE” for that quarter, even if Medicaid is their secondary

Who is “Medicaid”?

- If the most recent assessment is NOT a Medicare 5-day, then they look at the resident’s social security number and compare it to the state’s database of people who have been approved for Medicaid. If the social security number does not match the state’s database of eligible recipients, they are “NSSN”
- If the social security number does match, then they look at the ARD of that assessment to see if it is on or after the effective date of Medicaid eligibility. If the ARD is before that date, they are “NELIG” for that quarter

Who is "Medicaid"?

- If the last MDS in the quarter is NOT a Medicare 5-day assessment, the social security number matches the state's database of eligible recipients, and the ARD is on or after the effective date of Medicaid eligibility, they are "MCAID" for case mix
- Review the "Weekly Report" after each MDS transmission to review "MCAID" status

Manage "Medicaid Only" Case Mix Scores

- If a resident is Medicaid pending at the end of the quarter and would generate a high case mix score, you may want to schedule a quarterly at the end of the quarter
  - If the resident is subsequently approved retroactive back into the quarter they will count in the score if approved prior to the rate setting run date
- Timing of assessments for a Medicaid resident in a skilled stay
- Timing of assessments for a Medicaid resident following a hospital stay

Quality Measure Overview

Quality Measure Programs/Locations

- CASPER
  - Facility QAPI activities
  - Surveyor use
- Care Compare (Previously Nursing Home Compare)
- 5 Star
  - Ohio Medicaid Quality Incentive Program
- IMPACT Act/SNF QRP
  - Part A only measures
- Value Based Purchasing
  - 30 day All-Cause Rehospitalization Score, used to adjust Medicare rates

Use of Assessments to Generate QMs

- Software uses assessments in several different ways to calculate the QMs
  - 1. For most QMs, looks for specific information on the target assessment (most recent assessment in the quality reporting period)
    - See next slide for the list on QMs calculated this way
    - For these quality measures, as soon as you submit a new MDS that doesn't trigger the QM, the resident will drop off

Quality Measures Based Only on the Most Recent Assessment

- Pressure Ulcer (L) (5*)
- Physical Restraints (L)
- Antipsychotic Meds (L) (5*)
- Antianxiety/Hypnotic (L)
- Behavior Symptoms affecting Others (L)
- Depression Symptoms (L)
- UTI (L) (5*)
- Catheter Inserted/Left in Bladder (L) (5*)
- Lo-Risk Loss of Bowel/Bladder Control (L)
- Excess Weight Loss (L)

Use of Assessments to Generate QMs

- Software uses assessments in several different ways to calculate the QMs
  - 2. One short stay measure compares initial and a subsequent assessment
    - Antipsychotic present, not on initial assessment (S) (5*)
  - 3. Two long stay measures compare the target assessment with a prior assessment
    - ADL Decline (L) (5*)
    - Ability to Walk Worsened (L) (5*)

Use of Assessments to Generate QMs

- Software uses assessments in several different ways to calculate the QMs
  - 4. Two measures look at a number of assessments in the episode – that is, utilize the "look-back scan"
    - Falls With Major Injury (L) (5*)
    - Falls (L)
  - 5. One measure looks at the PPS Discharge Assessment
    - Pressure Ulcer/Injury (S) (5*)

Use of Assessments to Generate QMs

- Software uses assessments in several different ways to calculate the QMs
  - 6. One measure compares the PPS Discharge Assessment to the PPS 5-day assessment
    - Improvement in Function (S) (5*)

Claims Based Measures

- Measures use Medicare claims, although the MDS is still used to build stays and for some risk adjustment variables
- Short stay claims-based measures only include Medicare fee-for-service beneficiaries
- Measures are risk adjusted, using items from claims, the enrollment database and the MDS
- Measures are rolling 12 months; updated every six months

Glossary Terms Critical to QM Calculations

- 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

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
  - **Target Period:** The span of time that defines the QM reporting period (e.g., a calendar quarter).

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 any short stay measures (CDIF=80)
- When QMs are calculated for April 30, this resident will trigger any long stay measures, short stay will drop off (CDIF=107)

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 different 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)

Quality Measures Only Reflect Current Episode

- If a resident has had multiple **episodes**, quality measure calculations only use data related to the current episode
- Remember, the only way for a resident who has been in your facility to start a new episode is:
  - 1. Discharged return not anticipated and subsequently return to the facility, or
  - 2. Discharged return anticipated but returns to the facility more than 30 days later

Example #1

- Resident Admits January 7
- Significant change in status in February captures a new antipsychotic med and a fall with major injury
- 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 antipsychotic measure (CDIF=80)
- When QMs are calculated for April 30, this resident will trigger long stay Fall with Major Injury measure, but short stay antipsychotic will drop off (CDIF=107) – unless another assessment was completed after the SCSA in February where there is no antipsychotic, the resident will trigger long stay antipsychotic

Example #2

- Resident Admits January 7
- Significant change in status in February captures a new antipsychotic med and a fall with major injury
- 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 Antipsychotic measure (CDIF=80)
- When QMs are calculated for April 30, this resident will trigger short stay measures FROM THE CURRENT EPISODE (CDIF=27)
  - The events reported on the February significant Chane will not be captured as this is outside the current episode

Additional QM Record Definitions Related to **Short Stay** Quality Measures

- **Initial Assessment.** First assessment after admission entry record at beginning of selected episode
- Apples to the Short Stay Antipsychotic Measure, which compares subsequent assessments during the first 100 days to the 'initial" assessment to see if the short stay resident started a "new" antipsychotic

Additional QM Record Definitions Related to Long Stay Quality Measures

- **Prior Assessment.** Latest assessment within the episode that is 46 to 165 days prior to the target assessment
- Applies to Long Stay ADL Decline and Ability to Move Independently Worsens, which compare the most recent assessment in the reporting period to the "prior" assessment
- Example:
  - Admission assessment 1/17: Late loss ADL's require supervision
  - Significant Change 3/20: Late loss ADL's require extensive assistance
  - Quarterly assessment 4/6: Late loss ADL's require extensive assistance
  - March 31 Quality Measures will capture ADL decline by comparing 3/20 assessment to 1/17 assessment
  - If no additional assessments are completed, the June 30 Quality Measures will also capture ADL decline by comparing 4/6 assessment to 1/17 assessment. It will not compare 4/6 assessment to 3/20 assessment because it is not at least 46 days prior

Additional QM Record Definitions Related to Long Stay Quality Measures

- **Prior Assessment.** Latest assessment within the episode that is 46 to 165 days prior to the target assessment
- Applies to Long Stay ADL Decline and Ability to Move Independently Worsens, which compare the most recent assessment in the reporting period to the "prior" assessment
- Strategy:
  - If the resident returns to their baseline status after a decline has been captured on an MDS, schedule a new MDS immediately
  - If the resident does not return to their baseline, schedule a new MDS 46 days after the ARD of the assessment that captured the decline

Additional QM Record Definitions Related to Long Stay Quality Measures

- **Look-Back Scan.** Evaluates all assessments in current episode with target dates no more than 275 days prior to the target assessment
- Applies to Long Stay Falls, Fall with a Major Injury
- Example:
  - Most recent assessment ("target assessment") ARD is 3/27/24
  - 275 days prior to 3/27/24 is 6/25/2023
  - March 31 Quality Measures would include a fall or fall with a major injury reported on **any** assessment with an ARD between 6/25/23 through 3/27/24, assuming this entire period is within the current episode

Record Selection Period

- Short Stay quality measure record selection period is the most recent **SIX** months
- Long Stay quality measure record selection period is the most recent **THREE** months
- Discharged residents will count in quality measures when their discharge assessment falls within the record selection period

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 and improvement in function
  - Basic calculation is a simple ratio expressed as a percentage that results in an indication of a facility's performance relative to each indicator at a given point in time

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 facility residents with assessments who could have had the QM condition

X 100

Equals percentage of residents with the QM condition

Risk Adjustments - Exclusions

- Residents who are not included in the numerator or denominator due to a certain diagnosis or condition.
- Example: Antipsychotic measures exclude people with Schizophrenia, Tourette's, Huntington's

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

Risk Adjustments - Covariates

- Five QMs use a Covariate
  - Indwelling Catheter (L)
    - On prior assessment: frequent bowel incontinence or stage 2,3 or 4 PU
  - Residents whose Ability to Walk Independently Worsened (L)
    - Late loss ADL, severe cognitive impairment, linear age, gender, vision, oxygen use
  - Percent of Residents With New/Worsened Bowel or Bladder Incontinence (L)
    - Severe cognitive impairment on target assessment, Sit to Lying on prior assessment, Sit to Stand on prior assessment, Walk 10 Feet or Wheel 50 Feet with Two Turns on prior assessment, depending on the resident's wheelchair use

Risk Adjustments - Covariates

- Five QMs use a Covariate
  - Percent of Residents With Pressure Ulcers (L)
    - Impaired Functional Mobility: Lying to Sitting on Side of Bed on target assessment, Bowel Incontinence on target assessment, Diabetes Mellitus, Peripheral Vascular Disease or Peripheral Arterial Disease on target assessment, Indicator of low body mass index based on height (K0200A) and weight (K0200B) on target assessment, Malnutrition or at risk of malnutrition on target assessment, Dehydrated on target assessment, Infections: Septicemia, Pneumonia, Urinary Tract Infection or Multidrug-Resistant Organism on target assessment, Moisture Associated Skin Damage on target assessment, Hospice Care on target assessment.
  - Discharge Function Score (S)
    - 1. Age group 2. Admission function – continuous form65 3. Admission function – squared form66 4. Primary medical condition category 5. Interaction between admission function and primary medical condition category 6. Prior surgery 7. Prior functioning: self-care 8. Prior functioning: indoor mobility (ambulation) 9. Prior functioning: stairs 10. Prior functioning: functional cognition 11. Prior mobility device use 12. Stage 2 pressure ulcer/injury 13. Stage 3, 4, or unstageable pressure ulcer/injury 14. Cognitive abilities 15. Communication impairment 16. Urinary Continence 17. Bowel Continence 18. History of falls 19. Nutritional approaches 20. High BMI 21. Low BMI 22. Comorbidities 23. No physical or occupational therapy at the time of admission

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, but more complex

Risk Adjustments - Stratification

- Divides residents into high-risk and low-risk
  - High risk pressure ulcer
  - Low risk loss of bowel and bladder control
- With the changes to QMs as a result of the October 1 2023 MDS changes, CMS will not longer use stratification as a risk adjustment and these two measures will include all long stay residents instead of only “high risk” or “low risk” residents

Facility Level Quality Measure Report

iQIES Report

MDS 3.0 Facility-Level Quality Measure (QM) Report

Report Period:	03/01/2025 - 08/31/2025	**Report Run Date:**	09/04/2025
Comparison Group:	01/01/2025 - 06/30/2025	**Data Calculation Date:**	09/01/2025
		Report Version Number:	3.05

Legend

Note: Dashes represent a value that could not be computed
Note: S = short stay, L = long stay
Note: C = complete; data available for all days selected, I = incomplete; data not available for all days selected
Note: * is an indicator used to identify that the measure is flagged

Generating Facility-Level Quality Measure Report

- For Medicaid Quality Incentive monitoring, you need to run calendar quarters
- For survey preparation, you want to run the six months ending with the most recently ended month

Facility Level Quality Measure Report

Measure Description	CMS ID	Data	Num	Denom	Facility Observed Percent	Facility Adjusted Percent	Comparison Group State Average	Comparison Group National Average	Comparison Group National Percentile
Pressure Ulcers (L)	N045.02	C	6	83	7.2%	7.4%	4.6%	6.3%	66
Phys restraints (L)	N027.02	C	0	83	0.0%	0.0%	0.1%	0.1%	0
Falls (L)	N032.02	C	42	83	50.6%	50.6%	45.3%	44.5%	65
Falls w/Maj Injury (L)	N013.02	C	1	83	1.2%	1.2%	3.5%	3.4%	23
Antipsych Med (S)	N011.03	C	0	29	0.0%	0.0%	1.1%	1.8%	0
Antipsych Med (L)	N031.04	C	9	81	11.1%	11.1%	7.6%	14.4%	44
Antianxiety/Hypnotic Prev (L)	N033.03	C	0	32	0.0%	0.0%	8.2%	7.3%	0
Antianxiety/Hypnotic % (L)	N036.03	C	8	74	10.8%	10.8%	25.5%	19.6%	20
Behav Sx affect Others (L)	N034.02	C	32	81	39.5%	39.5%	25.0%	18.3%	90*

Detailed Selected Quality Measure Review

Percent of Residents With New or Worsened Bowel or Bladder Incontinence (LS)

- This measure reports the percent of long-stay residents with new or worsened bowel or bladder incontinence between the prior assessment and target assessment.
- Numerator: Long-stay residents with selected target and prior assessments that indicate a new or worsened case of bowel (H0400) or bladder (H0300) incontinence has occurred when the selected assessments are compared. Residents meet the definition of new or worsened bowel or bladder incontinence if any of the following conditions are true:
- CONDITION A: A new case of bowel incontinence is defined as an increase in one or more coding points on the bowel continence item (H0400) from always continent to either occasionally, frequently, or always incontinent. Residents meet the definition of a new case of bowel incontinence if the following is true:
  - Level at prior assessment (H0400 = [0]); Level at target assessment (H0400 = [1, 2, 3]).

Percent of Residents With New or Worsened Bowel or Bladder Incontinence (LS)

- Numerator, continued:
- CONDITION B: A worsened case of bowel incontinence is defined as an increase in one or two coding points on the bowel continence item (H0400) from occasionally incontinent to frequently or always incontinent or from frequently incontinent to always incontinent. Residents meet the definition of a worsened case of bowel incontinence if any of the following are true:
  - Level at prior assessment (H0400 = [1]); Level at target assessment (H0400 = [2, 3]) or
  - Level at prior assessment (H0400 = [2]); Level at target assessment (H0400 = [3]).
- C: A new case of bladder incontinence is defined as an increase in one or more coding points on the bladder continence item (H0300) from always continent or occasionally incontinent to frequently or always incontinent. Residents meet the definition of a new case of bladder incontinence if the following is true:
  - Level at prior assessment (H0300 = [0, 1]); Level at target assessment (H0300 = [2, 3]).

Percent of Residents With New or Worsened Bowel or Bladder Incontinence (LS)

- Numerator, continued:
- CONDITION D: A worsened case of bladder incontinence is defined as an increase in one coding point on the bladder continence item (H0300) from frequently incontinent to always incontinent. Residents meet the definition of a worsened case of bladder incontinence if the following is true:
  - Level at prior assessment (H0300 = [2]); Level at target assessment (H0300 = [3]).

Percent of Residents With New or Worsened Bowel or Bladder Incontinence (LS)

- Denominator: All long-stay residents with a selected target and prior assessment, except those with exclusions.
- Exclusions:
  - 1. Target assessment is an admission assessment (A0310A = [01]) or a PPS 5-Day assessment (A0310B = [01]).
  - 2. Resident is not in numerator and H0300 = [-] or H0400 = [-] on the prior assessment or on the target assessment.
  - 3. Resident is comatose (B0100 = [1]) or comatose status is missing (B0100 = [-]) on the prior assessment, or on the target assessment.
  - 4. Resident has an indwelling catheter (H0100A = [1]) or indwelling catheter status is missing (H0100A = [-]) on the prior assessment, or on the target assessment.
  - 5. Resident has an ostomy (H0100C = [1]) or ostomy status is missing (H0100C = [-]) on the prior assessment, or on the target assessment.
  - 6. No prior assessment is available to assess prior function.
  - 7. Prior or target assessments with dates before 10/01/2023. Co

Percent of Residents With New or Worsened Bowel or Bladder Incontinence (LS)

- Covariates used to risk-adjust this measure include:
- 1. Severe cognitive impairment on target assessment.
- 2. Sit to Lying function on prior assessment.
- 3. Sit to Stand function on prior assessment.
- 4. Walk 10 Feet or Wheel 50 Feet with Two Turns function on prior assessment, depending on the resident's wheelchair use.
- 5. Covariates in 2-4 are missing if no prior assessment is available.

Percent of Residents Who Were Physically Restrained (LS)

- This measure reports the percent of long-stay nursing facility residents who are physically restrained on a daily basis.
- Numerator: Long-stay residents with a selected target assessment that indicates daily physical restraints, where:
  - 1. Trunk restraint used in bed (P0100B = [2]), or
  - 2. Limb restraint used in bed (P0100C = [2]), or
  - 3. Trunk restraint used in chair or out of bed (P0100E = [2]), or
  - 4. Limb restraint used in chair or out of bed (P0100F = [2]), or
  - 5. Chair prevents rising used in chair or out of bed (P0100G) = [2])

Percent of Residents Who Were Physically Restrained (LS)

- Denominator All long-stay residents with a target assessment, except those with exclusions
- Review definitions for proper coding of restraints

Discharge Function Score

- This measure is a SNF QRP measure that is replacing the Improvement in Function (S) measure.
- The Discharge Function Score measure estimates the percentage of Medicare Part A SNF stays that meet or exceed an expected discharge function score.
- This is a QM where triggering is a positive occurrence. You want as many residents as possible to trigger because it indicates an expected improvement from admission to discharge (i.e., the observed discharge function score met or exceeded the expected discharge function score).

Functional Items Used in the Calculation

GG0130A3 (Eating Self-Care Discharge Performance)

GG0130B3 (Oral Hygiene Self-Care Discharge Performance)

GG0130C3 (Toileting Hygiene Self-Care Discharge Performance)

GG0170A3 (Roll Left and Right Mobility Discharge Performance)

GG0170C3 (Lying to Sitting on Side of Bed Mobility Discharge Performance)

GG0170D3 (Sit to Stand Mobility Discharge Performance)

GG0170E3 (Chair/Bed-to-Chair Transfer Mobility Discharge Performance)

GG0170F3 (Toilet Transfer Mobility Discharge Performance)

GG0170I3 (Walk 10 Feet Mobility Discharge Performance)*

GG0170J3 (Walk 50 Feet With 2 Turns Mobility Discharge Performance)*

GG0170R3 (Wheel 50 Feet With 2 Turns Mobility Discharge Performance)*

*see next slide

Functional Items Used in the Calculation

*Count Wheel 50 feet with 2 turns (GG0170R) value twice to calculate the total observed discharge function score for stays where (i) Walk 10 feet (GG0170I) has an activity not attempted (ANA) code at both admission and discharge and (ii) either Wheel 50 feet with 2 turns (GG0170R) or Wheel 150 feet (GG0170S) has a code between 01 and 06 either at admission or at discharge.

*The remaining stays use Walk 10 feet (GG0170I) + Walk 50 feet with 2 turns (GG0170J) to calculate the total observed discharge function score.

In either case, 10 items are used to calculate a resident's total observed discharge score and scores range from 10 – 60.

Functional Items Used in the Calculation

- GG: Functional Abilities – Discharge
  - Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason
  - The end of the stay is the last three days of the stay; ending with the last covered day
  - The "score" is the code that was used on the MDS, unless you use an activity did not occur code, which converts to 01
  - Is the team discussing usual performance at the end of the stay like you do for other assessments? Is both therapy and nursing involved in the determination?

Covariates Used to Calculate "Expected" Discharge Function Score

1. Age group
2. Admission function – continuous form
3. Admission function – squared form

   Admission function uses the same self care and mobility items as are used in the discharge score, the more dependent on admission, the less improvement will be expected

4. Primary medical condition category

   When you choose between the 13 categories in I0020

5. Interaction between admission function and primary medical condition category

Covariates Used to Calculate "Expected" Discharge Function Score

6. Prior surgery
   J2000: did the resident have major surgery during the 100 days prior to admission
7. Prior functioning: self-care - GG0100A
8. Prior functioning: indoor mobility (ambulation) – GG 0100B
9. Prior functioning: stairs – GG0100C
10. Prior functioning: functional cognition – GG0100D
    Prior functioning: Indicate the resident's usual ability with everyday activities prior to the current illness, exacerbation or injury
11. Prior mobility device use
    Indicate devices and aids used by the resident prior to the current illness, exacerbation or injury

Covariates Used to Calculate "Expected" Discharge Function Score

12. Stage 2 pressure ulcer/injury
13. Stage 3, 4, or unstageable pressure ulcer/injury

14. Cognitive abilities
15. Communication impairment

16. Urinary continence
17. Bowel continence
18. History of falls

Covariates Used to Calculate "Expected" Discharge Function Score

19. Nutritional approaches – Tube feeding, TPN
20. High body mass index (BMI)
21. Low BMI

22. Comorbidities

    Septicemia, Isolation, Cancer, Dementia, Schizophrenia, Depression, Bipolar, Psychotic-other than schizophrenia, Paraplegia, Quadriplegia, Multiple Sclerosis, Coronary Artery Disease, Hemiplegia or Hemiparesis, Cerebrovascular Accident, TIA, or Stroke, Aphasia, Pneumonia, impaired vision, ESRD, Dialysis, Hip fracture, Limb prosthesis, or Training and skill practice in Amputation care

23. No physical or occupational therapy at the time of admission

Improving Quality Measures

Quality Improvement

- Review MDS 3.0 Facility-Level Quality Measure Report regularly and monitor QM events in real-time
- Root cause analysis: 5 Why's
- Sustainable QM improvement comes from improving clinical systems
- QMs that compare current assessment to the prior assessment are susceptible to documentation inconsistency
- MDS scheduling strategies

5 Star Rating Methodology

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

Overview

- Facility receives four different star ratings
  - One for each domain
  - Overall, cumulative rating

Overall Rating

- 1. Start with your star rating for survey
- 2. Look at staffing star rating:
  - A. If 5 stars => 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

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, no rating is displayed – a yellow caution sign show up

State Health Inspections

- Points are assigned to deficiencies found during the two most recent surveys
  - Each deficiency weighted by scope and severity (see chart)
  - More recent annual surveys weighted more heavily than earlier surveys
    - Most recent = 3/4 of overall score
    - 1st Prior = 1/4 of overall score
    - 2nd Prior is still displayed, but doesn't affect the survey rating
- Substantiated complaints for the previous 36 months also count and are weighted the same as the standard surveys
  - Complaint surveys within the past 12 months are in cycle 1 (3/4)
  - Complaint surveys between 13 and 36 months are in cycle 2 (1/4)

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

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

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

Staffing

- The overall staffing rating is based on six separate staffing measures; points are assigned based on the facility's performance in each of the six measures.
- The points are then summed and the total number of points is used to determine the overall staffing star rating

Six Staffing Measures, Effective July 2022

- Case-mix adjusted total nurse staffing (100 points)
- Case-mix adjusted RN staffing (100 points)
- Case-mix adjusted total nurse staffing on the weekend (50 points)
- Total nurse turnover (50 points)
- Registered Nurse turnover (50 points)
- Administrator turnover (30 points)

Staffing – Case Mix Adjusted Hours PPD

- 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

Staffing

- CMS adjusts the reported staffing ratios for case-mix, using the nursing Case-mix Groups (CMGs) and corresponding nursing Case-mix Indexes (CMIs) from the Patient-Driven Payment Model (PDPM)2 .
- There are 25 nursing CMGs under the PDPM. The nursing CMIs3 are shown in Table A1.
- CMS calculates “case-mix hours” based on the distribution of nursing CMGs within each facility, PDPM nursing CMIs, and the reported national average staffing level.

Staffing Case Mix Adjusted HRD

	Reported Hours per Resident per Day (HRD)	Reported HRD (Decimal)	National Average: Reported HRD (Decimal)	Case-Mix HRD	National Average: Case-Mix HRD	Case-Mix Adjusted HRD
All days						
Total nurse (RN, LPN, LVN, and Nurse Aide) hours	3 hours and 53 minutes	3.880	3.849	4.061	3.828	**3.857**
RN hours	33 minutes	0.545	0.678	0.719	0.674	**0.513**
LPN/LVN hours	1 hour	1.008	0.888	0.916	0.883	**0.958**
Nurse aide hours	2 hours and 26 minutes	2.326	2.303	2.430	2.290	**2.194**
Physical therapist hours	3 minutes					
Weekend (Saturday and Sunday)						
Total nurse (RN, LPN, LVN, and Nurse Aide) hours	3 hours and 59 minutes	3.985	3.404	3.562	3.386	**3.115**
RN hours	13 minutes	0.221				

The average number of residents for your facility (based on MDS census) for January 1 - March 31, 2025 is 86.6.

The Nursing CMI ratio for your facility is 1.055. This is calculated as your facility's weighted average nursing case-mix index 1.458 divided by the national average nursing case-mix index 1.381.

The Case-Mix HRD values are calculated as: Nursing CMI Ratio * the national average of reported HRD.

The Case-Mix Adjusted HRD values are calculated as: (Reported HRD/Case-Mix HRD) * the national average of case-mix HRD.

Case-Mix Adjusted RN Staffing Hours PPD
Revised July 2024

- 000 – 0.274 10 points
- 0.275 – 0.367 20 points
- 0.368 – 0.439 30 points
- 0.440 – 0.512 40 points
- 0.513 – 0.590 50 points
- 0.591 – 0.677 60 points
- 0.678 – 0.785 70 points
- 0.786 - 0.933 80 points
- 0.934 – 1.201 90 points
- 1.202 or higher 100 points

Case-Mix Adjusted Total Nurse Staffing Hours PPD Revised July 2024

- 000 – 2.721 10 points
- 2.722 – 3.050 20 points
- 3.051 – 3.292 30 points
- 3.293 – 3.492 40 points
- 3.493 – 3.691 50 points
- 3.692 – 3.909 60 points
- 3.910 – 4.150 70 points
- 4.151 – 4.498 80 points
- 4.499 – 5.069 90 points
- 5.070 or higher 100 points

Case-Mix Adjusted Total Nurse Staffing on Weekend Hours PPD Revised July 2024

- 000 – 2.353 5 points
- 2.354 – 2.636 10 points
- 2.637 – 2.861 15 points
- 2.862 – 3.043 20 points
- 3.044 – 3.232 25 points
- 3.233 – 3.428 30 points
- 3.429 – 3.667 35 points
- 3.668 – 3.957 40 points
- 3.958 – 4.463 45 points
- 4.464 or higher 50 points

RN Turnover % Revised July 2024

• 80.001 - 100	5 points	• 41.668 – 44.444	30 points
• 66.668 – 80.000	10 points	• 35.715 – 41.667	35 points
• 60.001– 66.667	15 points	• 28.572 – 35.714	40 points
• 52.942 – 60.000	20 points	• 20.001` – 28.571	45 points
• 44.445 – 52.941	25 points	• 0.000 – 20.000	50 points

Total Nurse Turnover % Revised July 2024

• 69.793 - 100	5 points	• 45.680 – 49.254	30 points
• 62.792 – 69.792	10 points	• 41.740 – 45.679	35 points
• 57.693 – 62.791	15 points	• 37.501 – 41.739	40 points
• 53.426 – 57.692	20 points	• 31.127 – 37.500	45 points
• 49.255 – 53.425	25 points	• 0.000 – 31.126	50 points

Number of Administrator Departures

- 0 30 points
- 1 25 points
- 2 + 10 points

Point Ranges for the Staffing Rating July 2022

- < 155 points *
- 155 – 204 points **
- 205 – 254 points ***
- 255 – 319 points ****
- 320 – 380 points *****

- (REMEMBER – effective July 2022, you must have 5 Stars for staffing to add a star to your overall rating)

Staffing – Additional Notes

- Providers with 4 or more days in a calendar quarter without RN (job codes 5, 6 or 7) hours will receive a one-star staffing rating for the quarter
- Providers that fail to submit staffing data by the required deadline will receive a one-star rating for the quarter
- Facilities who fail to respond to a PBJ audit, or for whom the audit identifies significant discrepancies between reported hours and verified hours will receive a one-star staffing rating for the quarter

Quality Measures - April 2019 Changes

- **Short-stay and long-stay ratings:** two separate QM ratings calculated and displayed:
  - Short stay rating
  - Long stay rating
- These two ratings are averaged, using **equal weighting**, to determine an overall QM rating to include in the overall facility rating

Quality Measures - April 2019 Changes

- **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.)
- **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

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

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

QM Rating Cut Points Effective January 2025

Table 5
Point Ranges for the QM Ratings (as of *January 2025*)

QM Rating	Long-Stay QM Rating Thresholds	Short-Stay QM Rating Thresholds	Overall QM Rating Thresholds
★	155–*465*	144–*438*	299–*904*
★★	*466–565*	*439–525*	*905–1,091*
★★★	*566–640*	*526–625*	*1,092–1,266*
★★★★	*641–735*	*626–719*	*1,267–1,455*
★★★★★	*736*–1,150	*720*–1,150	*1,456*–2,300

Note: the short-stay QM rating thresholds are based on the adjusted scores (after applying the factor of 1,150/800 to the unadjusted scores)

Q and A

Agenda – Session 2

- Fundamentals of Accurate Assessments
- Patient Driven Payment Model
  - Components and Drivers
  - Rate Calculations
  - Interrupted Stay Policy
  - Assessment Timing and Scheduling
- SNF Quality Reporting Program
  - Review Current and Future SNF QRP Measures
  - Calculating the Annual Payment Update
- SNF Value Based Purchasing Program Changes

Fundamentals of Accurate Assessments

Uses of the MDS

- Resident Assessment and Care Planning
- Reimbursement
  - Medicaid
  - Medicare
- Quality Indicators/Quality Measures
  - Impacts survey
  - 5 star rating/nursing home compare web site
  - SNF QRP – CMS monitoring outcomes as we transition to new payment system

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.**

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.

What is an Accurate Assessment?

- Nursing homes are left to determine
  - (1) who should participate in the assessment process
  - (2) how the assessment process is completed
  - (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual.

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

MDS Accuracy

- Updated MDS Manual
  - Most recent update: August 2025, Effective October 1
  - (was your manual up to date prior to that?)
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html
- Errata Document

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

Impact – Return Anticipated vs. Not Anticipated

- Return Anticipated
  - Completed when the resident is expected to return within 30 days
    - Hospital stay
    - Frequent respite stays
  - Resident remain is case mix score
  - Resident remains in current episode for QMs
  - Only reentry tracking and possibly significant change assessment on reentry
- Return Not Anticipated
  - Completed when the resident is not expected to return within 30 days
    - Discharge home or lower level of care
    - Discharge to another nursing home
  - Resident excluded from case mix, ends current episode for QMs
  - Treated as new admission upon return

Discharge vs. LOA

- Discharge:
  - Permanent discharge home
  - Resident is admitted to the hospital
  - Resident is in a hospital observation stay > 24 hours
  - Discharge assessment is required
- Leave of Absence
  - Temporary home visit or therapeutic leave
  - Hospital observation stay < 24 hours, resident not admitted to the hospital
  - No discharge assessment or re-entry tracking completed

Death in Facility Record

- Completed when resident dies in the facility or while on a leave of absence from the facility
- Tracking record only
- Must be completed within 7 days of the death
- Must be transmitted within 14 days of the death
- Discharge date is always the day of death, even if person was on an LOA at time of death

Patient Driven Payment Method (PDPM) Overview

The Most Important Takeaway

- Accuracy with Diagnosis and Conditions Coding on Initial Medicare Assessment (5-day) 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 thorough, complete and accurate assessment early in the stay***

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 – flat amount that is the same for each resident

PDPM Components and Drivers – Understand Information Sources

- PT – I0020B, J2100 – J5000, GG0130 – GG0170
- OT – I0020B, J2100 – J5000, GG0130 – GG0170
- SLP – I0020B, MDS check box items and I8000, BIMS, K01000, K01510C
- Nursing – MDS check box items, GG0130 – GG0170, PHQ-9©,
- Non-therapy Ancillaries (NTAs) – MDS check box items, I8000
- Different components under PDPM look at different MDS items, you may need to code the same diagnosis or condition in more than one place to get credit in each component

PDPM Components and Drivers - Example

- For an admission with Acute Respiratory Failure with Hypoxia
  - I0020B = J96.01 to get the correct PT and OT score
    - J96.01 maps to Medical Management
  - I6300 = checked to get the correct Nursing score
    - Respiratory Failure with oxygen while a resident = Special Care Low
  - I8000 = J96.01 to get the correct NTA score
    - Cardio-respiratory failure/shock = 1 NTA point

Self Care and Mobility: Section GG and the Function Score

PT and OT Components – Function Score

- 2nd Tier: Functional score based on certain GG items
  - Eating
  - Oral hygiene
  - Toileting hygiene
  - "Bed Mobility" - Average of:
    - Sit to lying
    - Lying to sitting on side of bed
  - "Transfer" – Average of:
    - Sit to stand
    - Chair/bed-to-chair transfer
    - Toilet transfer
  - "Walking" - Average of:
    - Walk 50 feet w/2 turns
    - Walk 150 feet
- Scoring Assignment
  - 4: set up or independent
  - 3: supervision or touching assist
  - 2: partial/moderate assist
  - 1: substantial/maximal assist
  - 0: dependent, refused, n/a
- Functional Categories
  - 0-5
  - 6-9
  - 10-23
  - 24
  - Which pays the most varies by clinical category

Nursing Component – Function Score

- 2nd Tier: GG based function score
  - Eating
  - Toileting Hygiene
  - "Bed Mobility" – Average of:
    - Sit to lying
    - Lying to sitting on side of the bed
  - "Transfer" - Average of:
    - Sit to stand
    - Chair/bed-to-chair transfer
    - Toilet transfer
- Scoring Assignment
  - 4: set up or independent
  - 3: supervision or touching assist
  - 2: partial/moderate assist
  - 1: substantial/maximal assist
  - 0: dependent, refused, n/a
- Functional Categories
  - 0-5 (highest rate)
  - 6-14
  - 15-16 (lowest rate)

Function Scores Issues

- There are two separate function scores under PDPM
- What is the "best" score is different for PT/OT and Nursing
- Function Scores are the opposite of what we're used to with RUGs
  - The most independent people have the highest function scores
  - The most dependent people* have the lowest scores

Section GG Coding Hints

- Capture resident's "Usual Performance" over the observation period
  - On the initial assessment, the observation period is the first three days of the SNF stay or until initiating therapeutic interventions
  - On the PPS Part A discharge Assessment, the observation period is the last three days of the part A stay
  - On the IPA, the observation period is the ARD plus two days prior
- Coding should reflect a collaboration between therapy and nursing
- If the resident requires the assistance of two helpers, code "dependent"
- Partial/moderate assistance vs. substantial/maximal assistance
- Coding should be based on an actual assessment, not what you think the resident is capable of

PT and OT Component Issues

PT and OT Components – 16 Payment Groups

- 1st Tier: Diagnosis that represents the primary reason for the SNF stay
  - Major Joint Replacement or Spinal Surgery
  - Other Orthopedic
    - Non-surgical orthopedic/musculoskeletal
    - Ortho surgery except major joint or spinal surgery
  - Medical Management
    - Medical Management
    - Acute infection
    - Cancer
    - Pulmonary
    - Cardiovascular and coagulations
  - Non-Orthopedic Surgery and Acute Neurologic
    - Non-orthopedic surgery
    - Acute Neurologic

PT/OT Classification Groups & Case-Mix Weights

Clinical Category	GG Function Score	PT & OT Case-Mix Group	PT CMI	OT CMI
Major Joint Replacement or Spinal Surgery	0-5	TA	1.45	1.41
	6-9	TB	1.61	1.54
	10-23	TC	1.78	1.60
	24	TD	1.81	1.45
Other Orthopedic	0-5	TE	1.34	1.33
	6-9	TF	1.52	1.51
	10-23	TG	1.58	1.55
	24	TH	1.10	1.09
Medical Management	0-5	TI	1.07	1.12
	6-9	TJ	1.34	1.37
	10-23	TK	1.44	1.46
	24	TL	1.03	1.05
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.20	1.23
	6-9	TN	1.40	1.42
	10-23	TO	1.47	1.47
	24	TP	1.02	1.03

I0020: Indicate the resident's primary medical condition category

- Steps for Assessment
- 1. Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.
- Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay; then proceed to I0020B and enter the International Classification of Diseases (ICD) code for that condition, including the decimal.

J2100: Recent Surgery Requiring Active SNF Care

- Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?
- Note: the surgery question only effects the category assignment for certain ICD-10 codes; it isn't always relevant for reimbursement

J2100: Recent Surgery Requiring Active SNF Care

- Coding Tips
- Generally, major surgery for item J2100 refers to a procedure that meets the following criteria:
  - 1. the resident was an inpatient in an acute care hospital for at least one day in the 30 days prior to admission to the skilled nursing facility (SNF), and
  - 2. the surgery carried some degree of risk to the resident's life or the potential for severe disability.

J2300 – J5000: Recent Surgeries Requiring Active SNF Care – Steps for Assessment

- 1. Identify recent surgeries: The surgeries in this section must have been documented by a physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days and must have occurred during the inpatient stay that immediately preceded the resident's Part A admission.
  - Medical record sources for recent surgeries include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available.
  - Although open communication regarding resident information between the physician and other members of the interdisciplinary team is important, it is also essential that resident information communicated verbally be documented in the medical record by the physician to ensure follow-up.
  - Surgery information, including past history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity and follow-up.

J2300 – J5000: Recent Surgeries Requiring Active SNF Care – Steps for Assessment

- 2. Determine whether the surgeries require active care during the SNF stay: Once a recent surgery is identified, it must be determined if the surgery requires active care during the SNF stay. Surgeries requiring active care during the SNF stay are surgeries that have a direct relationship to the resident's primary SNF diagnosis, as coded in I0020B.
  - Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered surgeries that do not require active care during the SNF stay.
  - Check the following information sources in the medical record for the last 30 days to identify "active" surgeries: transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and official diagnostic reports, and other sources as available.

J2300 – J5000: Recent Surgeries Requiring Active SNF Care

- Coding Instructions
- Code surgeries that are documented to have occurred in the last 30 days, and during the inpatient stay that immediately preceded the resident's Part A admission, that have a direct relationship to the resident's primary SNF diagnosis, as coded in I0020B.

J2300 – J5000: Recent Surgeries Requiring Active SNF Care – Coding Tips

- In the rare circumstance of the absence of specific documentation that a surgery requires active SNF care, the following indicators may be used to confirm that the surgery requires active SNF care:
  - The inherent complexity of the services prescribed for a resident is such that they can be performed safely and/or effectively only by or under the general supervision of skilled nursing. For example:
    - The management of a surgical wound that requires skilled care (e.g., managing potential infection or drainage).
    - Daily skilled therapy to restore functional loss after surgical procedures.
    - Administration of medication and monitoring that requires skilled nursing.

SLP Component Issues

SLP Component – 12 Payment Groups

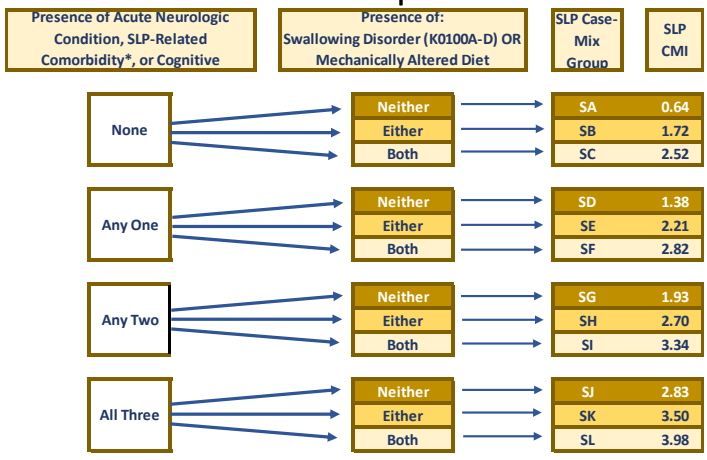
- 1st Tier: Presence of neurologic condition, SLP-related comorbidity or cognitive impairment:
  - None (lowest rate)
  - Any one
  - Any two
  - All three (highest rate)
- SLP-related comorbidity: CVA, TIA or stroke; Hemiplegia or hemiparesis; TBI; Trach; Vent; *Laryngeal cancer; Apraxia, dysphagia, ALS, oral cancers, speech and language deficits (italicized = I8000)*
- Cognitive impairment: based on BIMS or CPS

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

SLP Classification Groups & Case-Mix Weights



*SLP- Related Comorbidities:
Aphasia (I4300); CBA, TIA, or Stroke (I4500); Hemiparesis (I4900); TBI (I5500); Tracheostomy (O0100E2); Ventilator (O0100F2); Laryngeal Cancer, Apraxia, Dysphagia, ALS, Oral Cancers, Speech and Language Deficits (I8000)

** Cognitive Impairment:
This PDPM Cognitive level is based on the Brief Interview for Mental Status (BIMS) or the PDPM staff assessment for mental status. See the CMS PDPM Calculation worksheet in chapter 6 of the RAI User's Manual.

SLP Component Considerations

- 1st tier assignment: Acute Neurologic, SLP comorbidities, cognitive impairment
  - Acute Neurologic primary reason for SNF stay pays lower PT and OT components, but increases SLP component
  - SLP Comorbidities
    - some are "check box" items, others need specific ICD10 codes entered into I8000
    - CMS PDPM website ICD10 file has the specific ICD10 codes that qualify (example – dysphagia only r/t cerebrovascular events)
  - See discussion of the BIMS score in the interview section later

SLP Component Considerations

- 2nd tier assignment:
  - Signs and symptoms of a **potential** swallowing disorder (see next slides)
  - Mechanically altered diet – CMS is monitoring increased use of mechanically altered diets, be sure the need is well documented

SLP Discussion: K0100 – Swallowing Symptoms

- Steps for Assessment
- 1. Ask the resident if he or she has had any difficulty swallowing during the 7-day look-back period. Ask about each of the symptoms in K0100A through K0100D. Observe the resident during meals or at other times when he or she is eating, drinking, or swallowing to determine whether any of the listed symptoms of possible swallowing disorder are exhibited.
- 2. Interview staff members on all shifts who work with the resident and ask if any of the four listed symptoms were evident during the 7-day look-back period.

SLP Discussion: K0100 – Swallowing Symptoms

- Steps for Assessment, continued
- 3. Review the medical record, including nursing, physician, dietician, and speech language pathologist notes, and any available information on dental history or problems. Dental problems may include poor fitting dentures, dental caries, edentulous, mouth sores, tumors and/or pain with food consumption.

SLP Discussion: K0100 – Swallowing Symptoms

- **K0100A, loss of liquids/solids from mouth when eating or drinking**. When the resident has food or liquid in his or her mouth, the food or liquid dribbles down chin or falls out of the mouth.
- **K0100B, holding food in mouth/cheeks or residual food in mouth after meals.** Holding food in mouth or cheeks for prolonged periods of time (sometimes labeled pocketing) or food left in mouth because resident failed to empty mouth completely.
- **K0100C, coughing or choking during meals or when swallowing medications.** The resident may cough or gag, turn red, have more labored breathing, or have difficulty speaking when eating, drinking, or taking medications. The resident may frequently complain of food or medications "going down the wrong way."
- **K0100D, complaints of difficulty or pain with swallowing.** Resident may refuse food because it is painful or difficult to swallow.
- **K0100Z, none of the above**: if none of the K0100A through K0100D signs or symptoms were present during the look-back

NTA Component Issues

Non-therapy Ancillary (NTA) Component – 6 Payment Groups

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

• NA: 12 or higher	3.06
• NB: 9-11	2.39
• NC: 6-8	1.74
• ND: 3-5	1.26
• NE: 1-2	0.91
• NF: 0	0.68

NTA Component Considerations

- Review NTA Diagnoses and Conditions Checklist
- Note the source of each item – where on the MDS is it pulled from?
- Review item specific coding instructions

NTA Component Sources

Section H: Bladder and Bowel

- Intermittent Catheterization
  - H0100D
  - Assigned 1 point
- Ostomy
  - H0100C
  - Assigned 1 point

Section K: Nutritional Status

- Feeding Tube
  - K0510B2 (while a resident)
  - Assigned 1 point
- Parenteral IV Feeding
  - K0510A2
  - Assigned 7 or 3 points

Section M: Skin Conditions

- Diabetic Foot Ulcer
  - M1040B
  - Assigned 1 point
- Stage 4 Pressure Ulcer
  - M0300D1
  - Assigned 1 point
- Foot Infection **or** Other open lesion on the foot
  - M1040A or M1040C
  - Assigned 1 point

NTA Component Sources

Section O: Special Treatments, Procedures, and Programs

- IV Medication
  - O0100H2 (while a resident)
  - Assigned 5 points
- Ventilator or Respirator
  - O0100F2 (while a resident)
  - Assigned 4 points
- Transfusion
  - O0100I2 (while a resident)
  - Assigned 2 points
- Radiation
  - O0100B2 (while a resident)
  - Assigned 1 point
- Suctioning
  - O0100D2 (while a resident)
  - Assigned 1 point
- Tracheostomy Care
  - O0100E2 (while a resident)
  - Assigned 1 point
- Isolation
  - O0100M2 (while a resident)
  - Assigned 1 point

NTA Component Sources

Section I: Active Diagnoses (I0100-I7900)

- Wound Infection
  - I2500
  - Assigned 2 points
- Diabetes Mellitus
  - I2900
  - Assigned 2 points
- Multiple Sclerosis
  - I5200
  - Assigned 2 points
- Asthma, COPD, Chronic Lung Disease
  - I6200
  - Assigned 2 points
- Inflammatory Bowel Disease
  - I1300
  - Assigned 1 point
- Multi-Drug Resistant Organism (MDRO)
  - I1700
  - Assigned 1 point
- Malnutrition
  - I5600
  - Assigned 1 point

NTA Component Sources

Section I: Additional Active Diagnoses (I8000)

- Lung Transplant Status
  - Assigned 3 points
- Major Organ Transplant Status, Except Lung
  - Assigned 2 points
- Opportunistic Infections
  - Assigned 2 points
- Bone/Joint/Muscle Infections/Necrosis – except Aseptic Necrosis of Bone
  - Assigned 2 points
- Chronic Myeloid Leukemia
  - Assigned 2 points
- Endocarditis
  - Assigned 1 point
- Immune Disorders
  - Assigned 1 point
- End-Stage Liver Disease
  - Assigned 1 point
- Narcolepsy and Cataplexy
  - Assigned 1 point
- Cystic Fibrosis
  - Assigned 1 point
- Specified Hereditary Metabolic/Immune Disorders
  - Assigned 1 point

NTA Component Sources

Section I: Additional Active Diagnoses (I8000) (each 1 point)

- Morbid Obesity
- Psoriatic Arthropathy and Systemic Sclerosis
- Chronic Pancreatitis
- Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
- Complications of Specified Implanted Device or Graft
- Aseptic Necrosis of Bone
- Cardio-Respiratory Failure and Shock
- Myelodysplastic Syndromes and Myelofibrosis
- Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies
- Diabetic Retinopathy (Except Proliferative)
- Severe Skin Burn or Condition
- Intractable Epilepsy
- Disorders of Immunity – Except Immune Disorders
- Cirrhosis of Liver
- Respiratory Arrest
- Pulmonary Fibrosis and Other Chronic Lung Disorders

Recap: NTA Component Items >1 Point

High Point Items

- HIV/AIDS (claim) 8
- Parenteral/IV – High 7
- IV Meds 5
- Vent/respirator 4
- Parenteral/IV – Low 3
- Lung transplant (I8000) 3

2 Point items

- transfusion
- organ transplant, except lung (I8000)
- MS
- opportunistic infections (I8000)
- asthma - COPD - lung disease
- necrosis, except aseptic necrosis of bone (I8000)
- chronic myeloid leukemia (I8000)
- wound infection
- diabetes mellitus

NTA Component Considerations – Section I

- 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
- One of my most common findings have been diagnoses that weren't coded as being active that I think could have been
- Prioritizing I8000

NTA Component – Nutrition Related Items

- Ulcerative Colitis, Crohn's Disease or Inflammatory Bowel Disease I1300 = Checked (1 point)
- Diabetes Mellitus I2900 = Checked (2 points)
- Malnutrition I5600 = Checked (1 point)
- Feeding Tube K0510B2 = Checked (1 point)
- Parenteral/IV Feeding (Level High) K0510A2 = Checked AND K0710A2=3 (7 points)
- Parenteral/IV Feeding (Level Low) K0510A2 = Checked AND K0710A2 = 2 AND K0710B2 = 2 (3 points)
- Morbid Obesity I8000 A-J= appropriate ICD (1 point)

Morbid Obesity

- Morbid Obesity Diagnoses that are considered "Morbid Obesity" for the NTA Component
  - E6601 Morbid (severe) obesity due to excess calories
    - BMI 35-40 AND experiencing obesity related health conditions such as high blood pressure or diabetes
  - E6602 Morbid (severe) obesity with alveolar hypoventilation
  - Z6841 Body mass index (BMI) 40.0-44.9, adult
  - Z6842 Body mass index (BMI) 45.0-49.9, adult
  - Z6843 Body mass index (BMI) 50-59.9 , adult
  - Z6844 Body mass index (BMI) 60.0-69.9, adult
  - Z6845 Body mass index (BMI) 70 or greater, adult

Malnutrition

- Facilities should have a policy for assessing malnutrition or *at risk for malnutrition* on admission
  - Example, from ASPEN: BMI < 18.5, chronic disease, increased metabolic requirements, altered diets or diet schedules, inadequate nutrition intake, weight loss 5% in 30 days, 10% or 10 pounds in 6 months
- Requires a physician diagnosis, which could be prompted by the nutrition professional's assessment and recommendation
- Nutrition review should happen early in the stay to capture Dr agreement/diagnosis for malnutrition, risk for malnutrition, morbid obesity or other nutrition services related diagnoses by ARD

IV Fluids: NTA vs. Nursing Component

- For the NTA component, the parenteral or IV must be delivered while the person was a resident of the facility in order to receive credit
- **For the nursing component, you receive credit for parenteral or IV's administered in the last seven days, regardless of if they were administered while the person was a resident or not**

Nursing Component Issues

Nursing Component – 25 Payment Groups

- 1st Tier:
  - Extensive services
  - Special care high
  - Special care low
  - Clinically complex
  - Behavior symptoms/cognition
  - Reduced physical function
- 2nd Tier:
  - Function Score
  - PHQ9 Score
  - Restorative Nursing

Extensive Services

- Residents satisfying the following two conditions:
  - Having a function score of 14 or lower.
  - While a resident, receiving:
    - tracheostomy care,
    - ventilator/respirator, and/or
    - infection isolation.
      - P O-6: examples of when the isolation criteria would NOT apply include UTIs, encapsulated pneumonia and wound infections
      - See next slide for coding criteria

- Trach AND Vent ES3 A 3.84
- Trach OR Vent ES2 B 2.90
- Isolation ES1 C 2.77

Isolation Requirements and MDS Coding

- RAI User's Manual, page O-5 states: Code for "single room isolation" only when **all of the following conditions** are met:
  - 1. The resident **has active infection** with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission
  - 2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect
  - 3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in a room alone **and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation**
  - 4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g., rehabilitation, activities, dining, etc.)

Special Care High

- Residents satisfying the following two conditions:
  - Having a function score of 14 or lower.
  - Receiving any of the following:
    - comatose,
    - septicemia,
    - diabetes with daily insulin injections and insulin order changes on at least 2 days,
    - quadriplegia with function score of 11 or lower
    - Asthma, COPD or other chronic lung disease, with shortness of breath when lying flat
    - fever with pneumonia, vomiting, weight loss, or tube feeding*
    - parenteral/IV feeding, or
    - respiratory therapy 7 out of the last 7 days.

Special Care High

HDE2 D 2.27
HDE1 E 1.88
HBC2 F 2.12
HBC1 G 1.76

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	HDE2
0-5	No	HDE1
6-14	Yes	HBC2
6-14	No	HBC1

Special Care Low

- Residents satisfying the following two conditions:
  - Having a function score of 14 or lower
  - Receiving any of the following:
    - cerebral palsy with function score of 11 or lower,
    - multiple sclerosis with function score of 11 or lower,
    - Parkinson's disease with function score of 11 or lower,
    - respiratory failure and oxygen therapy while a resident,
    - tube feeding,*
    - ulcer treatment with two or more ulcers including venous ulcers, arterial ulcers or stage II or higher pressure ulcers,
    - ulcer treatment with any stage III or IV pressure ulcer,
    - foot infections or wounds with application of dressing,
    - radiation therapy while a resident, or
    - dialysis while a resident.

Special Care Low

LDE2	H 1.97
LDE1	I 1.64
LBC2	J 1.63
LBC1	K 1.35

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	LDE2
0-5	No	LDE1
6-14	Yes	LBC2
6-14	No	LBC1

Clinically Complex

- Residents receiving any of the following:
  - Clinical qualifiers for Extensive, Special Care High or Special Care Low without required function score
  - pneumonia,
  - hemiplegia with function score of 11 or lower,
  - surgical wounds or open lesions with treatment,
  - burns,
  - chemotherapy while a resident,
  - oxygen therapy while a resident,
  - IV medications while a resident, or
  - transfusions while a resident.

Clinically Complex

CDE2	L 1.77
CDE1	M 1.53
CBC2	N 1.47
CBC1	O 1.03
CA2	P 1.27
CA1	Q 0.89

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	CDE2
0-5	No	CDE1
6-14	Yes	CBC2
6-14	No	CBC1
15-16	Yes	CA2
15-16	No	CA1

Behavioral Symptoms and Cognitive Performance

- Residents satisfying the following two conditions:
  - Having a function score of 11 or higher.
  - Having behavioral or cognitive performance symptoms, involving any of the following:
    - difficulty in repeating words, temporal orientation, or recall (score on the Brief Interview for Mental Status <=9),
    - difficulty in making self understood, short term memory, or decision making (score on the Cognitive Performance Scale >=3),
    - hallucinations,
    - delusions,
    - physical behavioral symptoms toward others,
    - verbal behavioral symptoms toward others,
    - other behavioral symptoms,
    - rejection of care, or
    - wandering.

Behavior Symptoms and Cognitive Performance

BAB2 R 0.98

BAB1 S 0.94

Nursing Function Score	Restorative Nursing	PDPM Nursing Classification
11-16	2 or more	BAB2
11-16	0 or 1	BAB1

Reduced Physical Function

- Residents whose needs are primarily for support with activities of daily living and general supervision.
- (Residents who didn't group anywhere else)

Reduced Physical Function

PDE2	T 1.48
PDE1	U 1.39
PBC2	V 1.15
PBC1	X 1.07
PA2	W 0.67
PA1	Y 0.62

Nursing Function Score	Restorative Nursing	PDPM Nursing Classification
0-5	2 or more	PDE2
0-5	0 or 1	PDE1
6-14	2 or more	PBC2
6-14	0 or 1	PBC1
15-16	2 or more	PA2
15-16	0 or 1	PA1

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 28-34: 96%
  - Days 35-41: 94%

  - Days 84-90: 80%
  - Days 91-97: 78%
  - Days 98-100: 76%

PDPM Interrupted Stay Policy

Interrupted Stay

- An "interrupted" SNF stay is defined as one in which a resident is discharged from SNF care and subsequently readmitted to the same SNF (not a different SNF) within 3 days or less after the discharge (the "interruption window").
  - The interruption window is a 3-day period, starting with the calendar day of Part A discharge and including the 2 immediately following calendar days, ending at midnight. In other words, the resident must return to the same SNF by 11:59 p.m. at the end of the third calendar day.
  - The interruption window begins on the first non-covered day following a Part A-covered stay and ends at 11:59 p.m. on the third consecutive non-covered day following a Part A-covered stay.

Interrupted Stay

- If both conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A stay for the purposes of both the variable per diem schedule and the assessment schedule.
- The variable per diem schedule continues from the day of the previous discharge.
  - For example, if the resident was discharged on Day 7, payment rates resume at Day 7 upon readmission.
  - The assessment schedule also continues from the day of the previous discharge. Thus, no new 5-Day assessment is required upon the subsequent readmission, although the optional IPA may be completed at clinician's discretion.

Interrupted Stay

- If a resident is readmitted to the same SNF more than 3 consecutive calendar days after discharge, OR in any instance when the resident is admitted to a different SNF (regardless of the length of time between stays), then the Interrupted Stay Policy does not apply, and the subsequent stay is considered a new stay.
- In such cases, the variable per diem schedule resets to Day 1 payment rates, and the assessment schedule also resets to Day 1, necessitating the completion of a new 5-Day assessment.

PDPM Interrupted Stay Policy

- If the resident discharges from the SNF and returns to the same SNF within 3 midnights
  - Original stay resumes, only reentry tracking is required
  - Remains in the same payment categories (unless an IPA completed)
  - Variable rate adjustment ***does not*** reset back to day 1
- If the resident returns to the SNF after midnight of the third day
  - Treated like a new stay
  - New 5-day assessment for case mix group assignment
  - Variable rate adjustment ***does reset*** to day 1

Interrupted Stay

- Example 1: Mrs. A is admitted to the SNF on 11/07/19. She is admitted to a hospital on 11/20/19. She returns to the same SNF on 11/25/19.
- Because Mrs. A is readmitted to the same SNF more than three calendar days after discharge, this would be considered a new stay.
- The assessment schedule would be reset to Day 1, beginning with a new 5-Day assessment, and the variable per diem schedule would begin from Day 1.
- 11/20/19 DRA: Interrupted stay = No, PPS Discharge = yes, A2400c = 11/20
- New 5-day (ARD between 11/25 – 12/2): A2400b = 11/25

Interrupted Stay

- Example 2: Mr. B is admitted to the SNF on 11/07/19. He is admitted to the hospital on 11/20/19. He is admitted to *a different SNF* on 11/22/19.
- Because Mr. B is admitted to a different SNF, this would be considered a new stay.
- The assessment schedule would be reset, beginning with a new 5-Day assessment, and the variable per diem schedule would begin from Day 1. A2400b = 11/22

Interrupted Stay

- Example 3: Mrs. C is admitted to the SNF on 11/07/19. She is admitted to a hospital on 11/20/19. She returns to the same SNF on 11/22/19.
- Because Mrs. C is admitted to the same SNF within three days from the point of discharge, this would be considered a continuation of the previous stay.
- No 5-Day assessment would be required upon readmission, though the IPA would be an option. The variable per diem would continue from Day 14 (Day of Discharge).
- 11/20 DRA: Interrupted stay = yes, PPD discharge = no, a2400c = --

Interrupted Stay Policy

- OBRA Discharge definitions remain unchanged
- When a Part A resident meets the definition of an OBRA discharge, you will code it also as either an interrupted stay (A0310G1) or a Part A PPS discharge assessment (A0310H)
- FAQ 13.20: **How should providers complete item A0310G1 , "Is this SNF Part A interrupted stay"?**
  - In order to complete this item, providers should wait to observe if the patient returns on an interrupted stay before coding the ND.

Interrupted Stay Policy - FAQs

13.16: Would the issuance of a denial notice, such as a NOMNC or SNFABN, prior to the patient's departure have any effect on the Interrupted Stay Policy?

- No, the policy would be the same in this situation. The basic purpose of the interrupted stay policy is to ensure that when two segments of a patient's stay in the facility are separated by only a brief absence, the variable per diem payment adjustment is not inappropriately reset to Day 1 upon the patient's return. The issuance of a denial notice such as a NOMNC or SNFABN prior to the patient's departure would not, in itself, have any effect on the nature of the care needed by the patient upon subsequent resumption of SNF care, the costs of readmission, or the way in which providers would be paid under the PDPM.

Interrupted Stay Policy - FAQs

13.17: Would the issuance of an OBRA Discharge Return Not Anticipated assessment have any effect on the Interrupted Stay Policy?

- No, the policy would be the same in this situation. While the provider may have prepared a discharge plan for this patient based on the notion that the patient would not return, the patient's return to the SNF within that 3-day window would suggest that either the patient was not adequately prepared for discharge or may have been discharged too early from the facility. Further, providers should consider the possibility that a patient may return before finalizing the precise discharge type coded on the MDS. Finally, we believe that exempting such discharges from the interrupted stay policy could incentivize providers to merely code discharges in this manner only for this purpose and without sufficient basis.

Interrupted Stay Policy - FAQs

13.18 How will the Interrupted Stay Policy interact with the SNF Quality Reporting Program (QRP), specifically with regard to matching stays?

- We are aware that admissions and discharges are currently coded for purposes of the SNF QRP in a way that might conflict with how stays will be captured under the new PDPM. CMS is revising the codes so that a hospital admission and return to the SNF does not trigger a new Medicare stay for purposes of the SNF QRP. We are revising the codes so that a Medicare stay is captured the same way for purposes of the SNF QRP and the PDPM.

Interrupted Stay Policy - FAQs

- 13.22: **How does the interrupted stay policy affect Medicare physician certification?**

- The existing requirements governing level of care certification and recertification timeframes are tied to a beneficiary's SNF admission. If a beneficiary is discharged from the SNF (or from the covered Part A stay) and then resumes covered SNF care within the interruption window, the subsequent resumption would not be considered a new admission and, thus, would not trigger a new certification/recertification schedule

PDPM Assessment Scheduling Issues

PDPM Assessment Schedule

- Required PDPM Assessments:
  - 5-day Scheduled Assessment
    - ARD between day 1-8, completed within 14 days of the ARD (unless combined with the admission assessment which must be completed by day 14)
    - Establishes the "base" rate for the entire stay unless an optional IPA is completed
    - Used in SNF QRP calculations
  - SNF Part A Discharge Assessment
    - Requires reporting of therapy days, minutes for surveillance activities
    - Used in SNF QRP
- Optional Interim Payment Assessment (IPA)
  - Each facility determines when completion is appropriate

5-Day Assessment Issues

- ARD selection
  - To capture diagnoses, you need an actual physician diagnosis on or before the ARD
  - If you use an early enough ARD, you could capture a diagnosis that was active during the hospital stay, but not during the SNF stay
  - If you use an early enough ARD, you can capture IV fluids administered during the hospital stay
- ARD must be set on the MDS or in the facility software during the ARD window or default or provider liability is incurred

Interim Payment Assessment Considerations

- IPA changes the rate on the ARD
- IPA cannot be combined with any other type of assessment
- OBRA Significant Change in Status still required for a Part A resident if criteria are met
  - Resident is experiencing a “major” decline or improvement that affects two or more areas of care
  - Resident is not expected to return to their baseline within 14 days
  - Specific requirements related to hospice
- Things to consider related to IPA
  - Has there been a change in condition?
  - Has there been an interrupted stay?
  - Is there a new diagnosis or treatment that effects PDPM rates?
  - We will discuss several scenarios after reviewing the rate calculations

PDPM Rate Calculations

Sample Resident

- PT/ OT CMG = TO (Acute Neurologic, 10-23) CMI = 1.47/1.47
  - Primary reason for the SNF stay = Exacerbation of Parkinson's disease
  - Function Score = 14
- SLP CMG = SH (any two, either) CMI = 2.70
  - Acute neuro due to Parkinson's as primary reason for SF stay
  - Cognitive Impairment (BIMS = 11)
  - Coughing while taking meds
- NTA CMG = NC (6-8) CMI = 1.74
  - COPD (2), DM (2), Acute respiratory failure w/hypoxia (1), risk for malnutrition (1)
- Nursing CMG = LBC1 CMI = 1.35
  - Parkinson's disease
  - Function Score = 11
  - PHQ9© = 4

Example Resident – PDPM (Day 1-3)

Component	Base Fed Rate		Case-Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	70.26	x	1.47	x		x	1.00	=	$103.28
OT	$65.41	x	1.47	x		x	1.00	=	$96.15
SLP	$26.23	x	2.70	x		x		=	$70.82
NTA	$92.41	x	1.74	x		x	3.00	=	$482.38
Nursing	$122.48	x	1.35	x	1.00	x		=	$165.35
Non-Case-Mix Component	$109.68	x		x		x		=	$109.68
							Total	=	**$1027.66**

Example Resident – PDPM (Day 4-20)

Component	Base Fed Rate		Case-Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	70.26	x	1.47	x		x	1.00	=	$103.28
OT	$65.41	x	1.47	x		x	1.00	=	$96.15
SLP	$26.23	x	2.70	x		x		=	$70.82
NTA	$92.41	x	1.74	x		x	1.00	=	160.79
Nursing	$122.48	x	1.35	x	1.00	x		=	$165.35
Non-Case-Mix Component	$109.68	x		x		x		=	$109.68
							Total	=	**$706.07**

Example Resident – PDPM (Day 21-27)

Component	Base Fed Rate		Case-Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	70.26	x	1.47	x		x	0.98	=	$101.22
OT	$65.41	x	1.47	x		x	0.98	=	$94.23
SLP	$26.23	x	2.70	x		x		=	$70.82
NTA	$92.41	x	1.74	x		x	1.00	=	160.79
Nursing	$122.48	x	1.35	x	1.00	x		=	$165.35
Non-Case-Mix Component	$109.68	x		x		x		=	$109.68
							Total	=	**$702.09**

Example Resident – PDPM (Day 21-27)

Component	Base Fed Rate		Case-Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	70.26	x	1.47	x		x	0.96	=	$99.15
OT	$65.41	x	1.47	x		x	0.96	=	$92.31
SLP	$26.23	x	2.70	x		x		=	$70.82
NTA	$92.41	x	1.74	x		x	1.00	=	160.79
Nursing	$122.48	x	1.35	x	1.00	x		=	$165.35
Non-Case-Mix Component	$109.68	x		x		x		=	$109.68
							Total	=	**$698.10**

Example Resident – PDPM 30 Days

Day 1-3	=>	3 days	@	$1,027.66
Day 4-20	=>	17 days	@	$ 706.07
Day 21-27	=>	7 days	@	$ 702.09
Day 28-30	=>	3 days	@	$ 698.10

Interim Payment Assessment (IPA) Scenario 1

- Resident's primary reason for the SNF stay is a hip replacement, she also has COPD and diabetes, but during the observation period of the 5 day no SOB is noted and there is only 1 day with insulin order changes although she gets daily insulin injections, so the nursing case mix group is PBC1. There are no speech related comorbidities, no symptoms of a swallowing disorder and she has a regular diet.
- Throughout the stay, you would want to pay particular attention to SOB or insulin order changes…

Interim Payment Assessment (IPA) Scenario 2

- The 5 day assessment captured the following case mix groups:
  - PT/OT: TK
  - SLP: SE
  - Nursing: PBC1
  - NTA: ND
- After a two day interrupted stay, the following would be captured if an assessment were completed:
  - PT/OT: TK (no change)
  - SLP: SD
  - Nursing: HDE1
  - NTA: NC
- Would you complete an IPA?
- Would you complete a Significant Change in Status?

Interim Payment Assessment (IPA) Scenario 3

- On the 5 day assessment, the following case mix groups were captured:
  - PT/OT: TK SLP: SH NSG: LBC1 NTA: NB (9 – 11)
- Three weeks later, the resident is experiencing an overall decline in condition. She has had another TIA (one was captured during the 5 day observation period), has a significant weight loss, a new stage 2 pressure ulcer and a UTI. She needs significantly more assistance with dressing and personal hygiene. The team doesn't expect her to return to her baseline within the next two weeks. She has completed the IV meds that were captured on the 5 day assessment.
- Would you complete an IPA?
- Would you complete a significant change?

Medicare Huddle: PDPM from Start to Finish

- Pre-admission assessment
  - Primary reason for the SNF Stay
  - Surgery?
  - Start NTA capture
- First 24 hours
  - Thorough admission assessments by discipline
  - Start evaluating diagnoses
    - Missing diagnoses? (e.g., morbid obesity)
    - Need more detail? (“unspecified”)
  - Preliminary rate estimate
- Within 72 hours
  - Finalize ARD decision
  - Finalize primary reason for the SNF stay
  - Collaboratively code GG
  - Continue to finalize diagnoses
  - Schedule interviews
  - Preliminary rate estimate
- ARD Review
- Ongoing stay
  - Monitor need for IPA
  - Monitor outcomes progress

PDPM Tools

- See Additional Handouts
  - PDPM Nursing 1st Tier Category Qualifiers Overview
    - additional handouts, page 32
  - “Audit” tool
    - Additional handouts, page 33

SNF Value Based Purchasing (VBP) Program Overview

SNF VBP Program Overview

- The Centers for Medicare & Medicaid Services (CMS) awards incentive payments to skilled nursing facilities (SNFs) through the SNF VBP Program to encourage SNFs to improve the quality of care they provide to patients.
- Currently performance in the SNF VBP Program is based on a single measure of **all-cause hospital readmissions**.

SNF VBP Program Overview

- As a result of Protecting Access to Medicare Act od 2014 (PAMA), CMS began applying incentive payments for SNFs on October 1, 2018.
- PAMA specifies that under the SNF VBP Program, SNFs:
  - Are evaluated by their performance on a hospital readmission measure;
  - Are assessed on both improvement and achievement, and scored on the higher of the two;
  - Receive quarterly confidential feedback reports containing information about their performance; and
  - Earn incentive payments based on their performance.

SNF VBP Program Overview

- In 2021, Congress amended Section 1888(h) of the Social Security Act to allow the HHS Secretary to apply up to **nine additional measures** to the SNF VBP Program.
- CMS adopted additional measures in the FY 2023 SNF PPS final rule (pages 47564–47580) and the FY 2024 SNF PPS final rule (pages 53276-53304).
- For more information about the SNF VBP Program's measures, see the SNF VBP Program Measures webpage.

SNF VBP Program Funding

- As required by statute, CMS withholds 2% of SNFs' Medicare fee-for-service (FFS) Part A payments to fund the SNF VBP Program. This 2% is referred to as the "withhold".
- CMS is then required to redistribute between 50% and 70% of this withhold to SNFs as incentive payments.

SNF VBP Program Funding

- CMS redistributes 60% of the withhold to SNFs as incentive payments, and the remaining 40% of the withhold is retained in the Medicare Trust Fund, as finalized in the FY 2018 SNF PPS final rule (pages 36619–36621).
- CMS applies incentive payments prospectively to all Medicare fee-for-service (FFS) Part A claims paid under the SNF PPS for the applicable Program year (beginning October 1).

SNF VBP Program Expansion

FY 2025 Medicare Rates: One Measure

- SNF 30-Day All-Cause Readmission Measure (SNFRM)

FY 2026 Medicare Rates: Four Measures

- SNFRM
- **Nursing Staff Turnover (5 Star)**
- **Total Nurse Staffing (5 Star)**
- **SNF Healthcare-Associated Infections Requiring Hospitalization (SNF HAI)**

FY 2026 Medicare Rates – Data Collection Periods

- First Performance Period
  - FY 2024
  - October 1, 2023 – September 30, 2024
- First Baseline Period
  - FY 2022
  - October 1, 2021 – September 30, 2022

FY 2027 Medicare Rates: Eight Measures

- SNFRM
- Nursing Staff Turnover
- Total Nurse Staffing
- SNF HAI
- **Falls With Major Injury LS**
- **Discharge Function Score**
- **Long-Stay Hospitalization (5 Star)**
- **Discharge to Community PAC SNF (SNF QRP)**

FY 2027 Medicare Rates – Data Collection Periods

- First Performance Period
  - FY 2025
  - October 1, 2024 – September 30, 2025
- First Baseline Period
  - FY 2023
  - October 1, 2022 – September 30, 2023

FY 2028 Medicare Rates: Eight Measures

- SNFRM
- Nursing Staff Turnover
- Total Nurse Staffing
- SNF HAI
- Falls With Major Injury
- Discharge Function Score
- Long-Stay Hospitalization
- DTC PAC SNF
- **SNF Within-Stay Potentially Preventable Readmission (SNF WS PPR)**

FY 2028 Medicare Rates – Data Collection Periods

- SNF WS PPR First Performance Period
  - FY 2025 and FY 2026
  - October 1, 2024 – September 30, 2026
- SNF WS PPR First Baseline Period
  - FY 2022 and FY 2023
  - October 1, 2021 – September 30, 2023

SNF QRP and VBP Validation Program

- The SNF Validation Program is an audit-driven initiative aimed at evaluating the accuracy of quality measure data elements derived from the Minimum Data Set (MDS), which are used in the Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) and Quality Reporting Programs (QRP) for assessing quality of care and measuring quality of care improvement.
- The primary purpose of the validation program is to ensure that the data used to calculate SNF VBP and QRP measures are accurate for quality measurement purposes.
- https://www.cms.gov/files/document/data-validation-process-frequently-asked-questions.pdf

SNF QRP and VBP Validation Program

- 1500 facilities will be chosen each year for validations, each facility will be asked to submit 10 records
- SNFs are notified of selection through their Internet Quality Improvement and Evaluation System (iQIES) MDS 3.0 Provider Preview Reports folder. The selection notification will contain instructions for documentation submission, the list of sample residents for which medical records are being requested and contact information for the data validation contractor.
- SNFs have 45 days to provide the information in PDF format; no other formats are accepted, and social security numbers must be redacted

SNF Quality Reporting Program (QRP)

SNF QRP Measures

- Discharge to Community
- Potentially Preventable 30-day Post-Discharge Readmission
- Medicare Spend Per Beneficiary
- Falls with Major Injury
- Changes in Skin Integrity
- Drug Regimen Review
- Discharge Function Score

SNF Quality Reporting Program Annual Payment Update

- 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/files/document/snf-qrp-table-reporting-assessment-based-measures-and-spades-fy-2025-snf-qrp-apupdf.pdf
    - See additional handouts
  - Failure to complete End of the Medicare Stay Assessment
- Providers have to report 100% of the required items on at least 90% of Medicare 5-day and Part A PPS discharge assessments each calendar year to avoid the 2% penalty

SNF QRP Monitoring

- There is a FAQ document for SNF QRP
- Provider Threshold Report
- Review and Correct Report
- Facility Level Quality Measure Report
- Resident Level Quality Measure Report

- How are you managing your outcomes during the Part A stay?

SNF QRP Changes

- SNF QRP Measure #9: Transfer of Health Information to the Provider-Post-Acute Care
  - This measure was finalized in the FY 2020 SNF PPS Final Rule which was published in the Federal Register on August 7, 2019 (84 FR 38755 through 38761). Data collection for this measure will begin on October 1, 2023.
- SNF QRP Measure #10: Transfer of Health Information to the Patient-Post-Acute Care
  - This measure was finalized in the FY 2020 SNF PPS Final Rule which was published in the Federal Register on August 7, 2019 (84 FR 38761 through 38764). Data collection for this measure will begin on October 1, 2023.
- SNF QRP Measure #16: SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization
  - This measure was finalized in the FY2022 SNF PPS Final Rule, which was published in the Federal Register on August 4, 2021 (86 FR.42473 through 42480). Public reporting began 4/29/2022.

SNF QRP Changes - CDC NHSN Measures

- Data for these measures are submitted via the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN):
- **SNF QRP Measure #11: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (CBE #3636)**
  - This measure was finalized in the FY 2022 SNF PPS Final Rule, which was published in the Federal Register on August 4, 2021 (86 FR 42480 through 42489). Data submission for this measure began October 1, 2021.
- **SNF QRP Measure #12: Influenza Vaccination Coverage among Healthcare Personnel (HCP) (CBE #0431)**
  - This measure was finalized in the FY 2023 SNF PPS Final Rule, which was published in the Federal Register on August 3, 2022 (87 FR 47537 through 47544). Data submission for this measure began October 1, 2022.
- Information related to the procedures using the CDC NHSN for data submission for the Influenza Vaccination Coverage among HCP measure can be found on the NHSN website.
- For NHSN questions: NHSN@cdc.gov.

Q and A Day 2