All Thing MDS Related For the Nurse Manager

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Agenda

- Fundamentals of Accurate Assessing
- Medicaid Reimbursement Issues
  - Medicaid Quality Incentive Program
  - Medicaid Case Mix
- CMS 5 Star Rating Program
- Quality Measure Calculations
- Patient Driven Payment Model

Fundamentals of Accurate Assessments

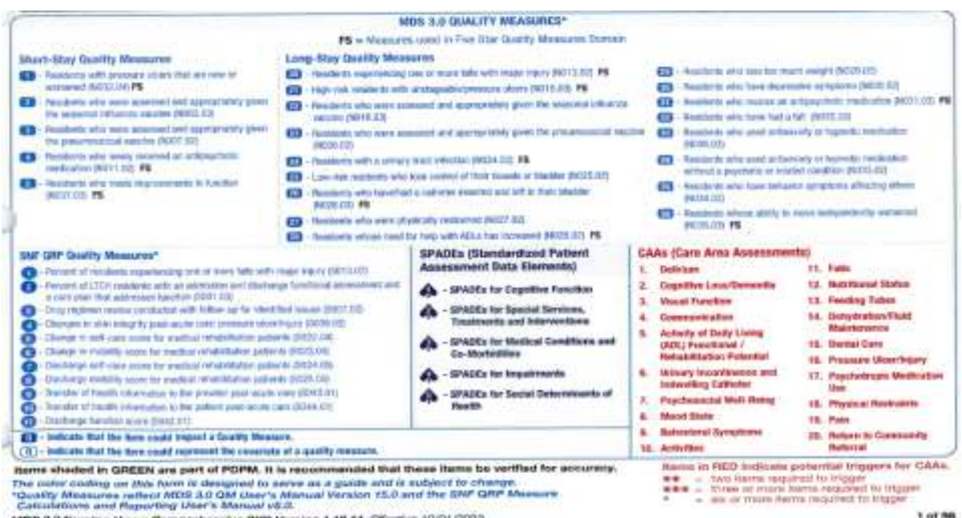
OBRA '87

- The Minimum Data Set (MDS) is part of the Resident Assessment Instrument (RAI) mandated by the Omnibus Reconciliation Act of 1987 (OBRA '87)
- Dramatically changed nursing facility regulatory environment and the survey process to improve quality of care
- Requires a periodic standardized assessment of each resident in order to develop an individualized, person-centered plan of care and monitor each resident's progress toward their goals, mandating that we help each person attain or maintain their highest practicable level of functioning

Uses of the MDS

- Resident Assessment and Care Planning
  - Survey implications
- 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
- Review Color Coded MDS (see next slide)

Color Coding Key



MDS 3.0 QUALITY MEASURES*

Short-Stay Quality Measures

Long-Stay Quality Measures

SNF QRP Quality Measures*

SPADEs (Standardized Patient Assessment Data Elements)

- SPADEs for Cognitive Function
- SPADEs for Special Services, Treatments and Interventions
- SPADEs for Medical Conditions and Co-Morbidities
- SPADEs for Impairments
- SPADEs for Social Determinants of Health

CAAs (Care Area Assessments)

1. Delirium
2. Cognitive Loss/Dementia
3. Visual Function
4. Communication
5. Activity of Daily Living (ADL) Functional / Rehabilitation Potential
6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Well-Being
8. Mood State
9. Behavioral Symptoms
10. Activities
11. Falls
12. Nutritional Status
13. Feeding Tubes
14. Dehydration/Fluid Maintenance
15. Dental Care
16. Pressure Ulcer/Injury
17. Psychotropic Medication Use
18. Physical Restraints
19. Pain
20. Return to Community Referral

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: October 1, 2024
  - (was your manual up to date prior to that?)
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html
- Errata Document(s)

RAI Manual Contents

- Chapter 1: The RAI Process (overview)
- Chapter 2: Assessments for the RAI (assessment timing and scheduling requirements)
- Chapter 3: Item-by-Item Guide to the MDS 3.0 (coding instructions, examples, clarifications)
- Chapter 4: Care Area Assessment (CAA) Process and Care Planning
- Chapter 5: Submission and Correction of the MDS Process
- Chapter 6: Medicare SNF Prospective Payment System

RAI Manual Contents

- Appendices
  - Appendix A: Glossary and Common Acronyms
  - Appendix B: State Agency and CMS Locations RAI/MDS Contacts
  - Appendix C Care Area Assessment (CAA) Resources
  - Appendix D: Interviewing to Increase Resident Voice in MDS Assessments
  - Appendix E: Patient Health Questionnaire (PHQ) Scoring Rules and Instruction for BIMS (When Administered In Writing)
  - Appendix F: MDS Item Matrix
  - Appendix G: References
  - Appendix H: MDS 3.0 Forms

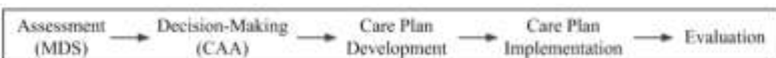
More About Assessment Accuracy

- MDS accuracy: assessment must match the resident's status as of the assessment reference date
- Assessment reference date is the common date from which each participant in the assessment will count back the designated number of days for their section to establish the observation period
- MDS is a snapshot based on the ARD
- MDS manual contains definitions, instructions, clarifications and examples critical to accurate completion of the MDS
- MDS is a functional assessment

Steps for Assessment

- Chapter 3 provides "Steps for Assessment" for each MDS item or section, which describes how to assess each item
- These steps for assessment include:
  - Talk to the resident
  - Talk to family, significant others
  - Talk to staff
  - Review the medical record
  - Observe yourself

The RAI Process



MDS Sections

- A: Identification Information
- B: Hearing, Speech and Vision
- C: Cognitive Patterns
- D: Mood
- E: Behavior
- F: Preferences for Customary Routine and Activities
- GG: Functional Abilities and Goals
- H: Bladder and Bowel
- I: Active Diagnoses
- J: Health Conditions
- K: Swallowing/Nutritional Status
- L: Oral Status
- M: Skin Conditions
- N: Medications
- O: Special Treatments, Procedures and Programs
- P: Restraints and Alarms
- Q: Participation in Assessment and Goal Setting
- V: Care Area Assessment (CAA) Summary
- X: Correction request
- Z: Assessment Administration

OBRA Required Assessments

- Entry tracking, death tracking
- Admission (comprehensive)
- Quarterly
- Significant Change in Status (comprehensive)
- Annual (comprehensive)
- Discharge (return anticipated or return not anticipated)
- Facilities can be cited for late or missed assessments, inaccurate assessments, late submission
- When we discuss the Medicare reimbursement, we will review PPS required assessments

Care Area Assessments

Table 1. Care Area Assessments in the Resident Assessment Instrument, Version 3.0

1. Delirium	2. Cognitive Loss/Dementia
3. Visual Function	4. Communication
5. Activity of Daily Living (ADL) Functional / Rehabilitation Potential	6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Well-Being	8. Mood State
9. Behavioral Symptoms	10. Activities
11. Falls	12. Nutritional Status
13. Feeding Tubes	14. Dehydration/Fluid Maintenance
15. Dental Care	16. Pressure Ulcer/Injury
17. Psychotropic Medication Use	18. Physical Restraints
19. Pain	20. Return to Community Referral

Care Area Assessments

- The CAA process provides a framework for guiding the review of triggered areas, and clarification of a resident’s functional status and related causes of impairments.
- It also provides a basis for additional assessment of potential issues, including related risk factors.
- The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care.

Care Area Assessments

- When implemented properly, the CAA process should help staff:
  - Consider each resident as a whole, with unique characteristics and strengths that affect their capacity to function;
  - Identify areas of concern that may warrant interventions;
  - Develop, to the extent possible, interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well-being, in the context of the resident’s condition, choices, and preferences for interventions; and
  - Address the need and desire for other important considerations, such as advanced care planning and palliative care; e.g., symptom relief and pain management.

Care Planning

- As required at 42 CFR 483.21(b), the comprehensive care plan is an interdisciplinary communication tool.
  - It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being.
  - The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident’s written plan of care
- Baseline care plans are also required and must be developed with 48 hours of admission

Medicaid Reimbursement Issues

Summary of Per Diem Rates

Line	Category	Schedule	Line	Allowable Rate Per Diem
1	Ancillary and Support Price	2.0	4	$ 67.01
2	Capital Price	2.0	5	$ 10.79
3	Direct Care Rate	3.0	3	$ 144.83
4	Tax Rate	4.0	8	$ 2.78
5	Critical Access Nursing Home Rate Add-On *			$ 0.00
6	Sub-Total (Line 1 - Line 5)			$ 225.41
7	Add-On per ORC 5165.15(B)			$ 16.44
8	Quality Payment Rate per ORC 5165.26 **	6.0	8	$ 41.10
9	Subtotal			$ 282.95
10	Deduction for Occupancy <65% (5%) ***			$ 0.00
11	Total Rate			$ 282.95

* In accordance with Ohio Revised Code Section 5165.23(B),a five percent increase will be added to Critical Access Nursing Facilities

**In accordance with ORC 5165.26(C), if total points are below the 25th percentile, points are reduced to zero. In accordance with ORC 5165.26(D), if a nursing facility is included on list A of the Special Focus Facilities list, no quality add-on is permitted.

***In accordance with ORC 5165.23 C, if occupancy is less than 65%, deduct 5% from the total rate.

- Note the occupancy penalty deduction of 5% on line 10 if occupancy <65%
- Would have been a $14.15 reduction

Ohio Medicaid Case Mix

Direct Care Rate Calculation

- 1. Direct Care Price (Peer Group Two) $48.41
- 2. Semi-Annual Case Mix Score 2.9007
- Direct Care Rate (Line 1 x Line2) $140.42

- Direct care prices: PG One - $49.94; PG Three - $44.39
- Semi-annual case mix score used for July 1 rates are the average of the December 31 and March 31 quarters
- Rates recalculate for January 1 using the average of June 30 and September 30 case mix scores

HB 33 and Ohio Medicaid Case Mix

- The state budget enacted July 1, 2023 calculated each facility's direct care rate as described on the previous slide.
- Ohio's case mix methodology is currently based on RUG IV and changes to the MDS effective October 1, 2023 removed and changed certain MDS items needed to calculate RUG IV scores, which would require facilities to complete an Optional State Assessment (OSA) with each OBRA required assessment for Medicaid residents in order to continue to calculate case mix scores.
- The budget bill gave each facility the choice of completing OSA's and having their direct care rate update every six months or to freeze their direct care rate starting January 1, 2024 based on the March 31 2023 case mix score

July 1, 2025 Rate Proposals

- CMS only allow states to use the OSA process through September 30, 2025 and then they must transition to some other case mix methodology
- How Ohio will transition case mix methodology will be decided through the state budget process, which is currently in progress

Overview of State Budget Process

Ohio Budget Process

- Ohio's Medicaid reimbursement methodology is outlined in statute (state law), and is usually subject to change with every biennial budget
- Our next budget begins July 1, 2025
- The Governor released his version of the budget in February
- The budget then went to the House of Representatives, who debated and passed their own version of the budget
- It was then sent to the Senate, who are deliberating and will pass their version of the budget

Ohio Budget Process, Continued

- A conference committee is then appointed to reconcile the items that are different between the three versions of the budget
- The negotiated budget compromise then goes to the Governor to sign and takes effect on July 1, 2025
- We often don't know the final details about how we will be paid until the Governor signs the budget on June 30
- Regardless of the details of the budget, assessments with ARDs on or after April 1, 2025 are likely to affect reimbursement starting in January 2026

Ohio Medicaid Case Mix Methodology

- The Governor's budget proposed the following related to case mix and direct care rates
  - 1. Continuing the case mix freeze for rates July 1, 2025 – December 31, 2025
  - 2. Transitioning to PDPM for rates starting January 1, 2026
    - A. The Governor's proposal would use the nursing component of PDPM to calculate case mix scores
    - B. January 1, 2026 rates would average together case mix scores for Medicaid residents for the quarters ending June 30, 2025 and September 30, 2025
    - C. The January 1 rate would be based 1/3 on the PDPM rate calculated above and 2/3 the frozen rate you currently have
    - D. For July 1, 2026 rates it would be 2/3 PDPM (sing the quarters ended December 31 , 2025 and March 31, 2026 and 1/3 the frozen rate
    - E. For January 1, 2027 it would be 100% based on PDPM

Ohio Medicaid Quality Incentive Program

January 1, 2025 Rate (Effective for 6 months)

- MDS Based QM's; average for most recent available 4 quarters, probably Q3 2023, Q42023, Q1 2024, Q2 2024 (unless otherwise noted)
  - LS Pressure Ulcers: 0-5 points (will use four quarters ending 9/30/23)
  - LS Catheters: 0-5 points
  - LS UTI's: 0-5 points
  - LS Ability to Move Independently Worsened: 0 – 7.5 points (4 quarters ending 9/30/23)
  - (NEW) LS Increased ADL Help: 0 – 7.5 points (4 quarters ending 9/30/23)
  - (NEW) LS Falls w/major injury: 0-5 points
  - (NEW) LS Antipsychotics: 0-7.5 points
- (NEW) Total Nursing Staff Hours: 0-5 points (from 5 Star/PBJ)
- (Revised): Occupancy > 75% in CY 2023: 3 points (<75%: 0 points)
- 50.5 points maximum, threshold and $ per point will not recalculate

Assigning Points

Quality Measure	For QM values ...		Number of QM points is...
	Between...	And...	OH Poi[illegible]
Percentage of residents who have/had a catheter inserted and left in their bladder (long-stay)	0.0000	0.0050	100 5
	0.0051	0.0126	80 4
	0.0127	0.0217	60 3
	0.0218	0.0356	40 2
	0.0357	1.0000	20 0

Assigning Points

- https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf
- Table A-3

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
  - OHCA offers "Managing Reimbursement and Quality Measures" quarterly

Strategy for Recently Unfrozen Measures

Three measures have been frozen due to MDS changes October 1, 2023 and were unfrozen in January 2025 to include four quarters under the new calculations

ADL Decline
Ability to Walk Independently Worsened
Pressure Ulcers

Your team needs to understand how the replacement measures are calculated and the new “cut points” (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 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 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)

Strategy for Measures Using the Most Recent Assessment

- MQIP Measures that only look at the most recent assessment
  - LS Catheter
  - LS UTIs
  - LS Antipsychotics
- If a person has triggered any of these QMs during a calendar quarter, watch for opportunity to complete another assessment before the end of the quarter if the triggering condition resolves
- Pay attention to coding instructions for a UTI: code only if both physician diagnosis and infection surveillance tool indicating UTI were both within the past 30 days, not relevant if resident was still receiving antibiotic in the lookback period

Strategy for Measures Comparing Two Assessments

- Consistent documentation and assessment are critical for measures that compare two assessments to each other
  - ADL Decline
  - Ability to Walk Worsened
- MDS scheduling strategy for a person who has already triggered a decline measure during a quarter
  - 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

Strategy for Falls With Major Injury

- Fall with a major injury: bone fracture, joint dislocation, closed head injury with altered consciousness, subdural hematoma
- 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

CMS 5 Star Rating System

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

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

- Effective with the July 2022 refresh, CMS revised the methodology for calculating the Staffing star rating.
- The new 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

Staffing

- Effective with the July 2024 refresh, CMS revised the case mix adjusted staffing measures to use PDPM case mix indexes instead of RUG IV
  - Adjusted RN Staffing (Hours per Resident Day)
  - Adjusted Total Nurse Staffing (hours per Resident Day)
  - Adjusted Total Nurse Staffing on Weekends (Hours per Resident Day)
- The July refresh uses PBJ data for January 1 through March 31 2024

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

Case-Mix Adjusted RN Staffing Hours PPD

- 000 – 0.260 10 points
- 0.261 – 0.351 20 points
- 0.352 – 0.425 30 points
- 0.426 – 0.504 40 points
- 0.505 – 0.590 50 points
- 0.591 – 0.691 60 points
- 0.692 – 0.818 70 points
- 0.819 - 0.991 80 points
- 0.992 – 1.297 90 points
- 1.298 or higher 100 points

Case-Mix Adjusted Total Nurse Staffing Hours PPD

- 000 – 2.746 10 points
- 2.747 – 3.029 20 points
- 3.030 – 3.247 30 points
- 3.248 – 3.444 40 points
- 3.445 – 3.652 50 points
- 3.653 – 3.868 60 points
- 3.869 – 4.104 70 points
- 4.105 – 4.428 80 points
- 4.429 – 4.953 90 points
- 4.954 or higher 100 points

Case-Mix Adjusted Total Nurse Staffing on Weekend Hours PPD

- 000 – 2.349 5 points
- 2.350 – 2.612 10 points
- 2.613 – 2.809 15 points
- 2.810 – 2.984 20 points
- 2.985 – 3.173 25 points
- 3.174 – 3.381 30 points
- 3.382 – 3.622 35 points
- 3.623 – 3.895 40 points
- 3.896 – 4.327 45 points
- 4.328 or higher 50 points

RN Turnover %

- 81.082 - 100 5 points
- 71.054 – 81.081 10 points
- 62.964 – 71.053 15 points
- 56.978 – 62.963 20 points
- 49.124 – 56.977 25 points
- 45.162 – 49.123 30 points
- 39.624 – 45.161 35 points
- 33.109 – 39.623 40 points
- 24.529 – 33.108 45 points
- 0.000 – 24.528 50 points

Total Nurse Turnover %

Range	Points	Range	Points
72.679 - 100	5 points	48.697 – 52.353	30 points
65.742 – 72.678	10 points	44.849 – 48.696	35 points
60.700 – 65.471	15 points	40.595 – 44.848	40 points
56.392 – 60.699	20 points	34.417 – 40.594	45 points
52.354 – 56.391	25 points	0.000 – 34.416	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)

Improving Your Five Star Rating

- Ensure accurate MDS coding
  - Capture risk adjustment items
  - Evaluate ADL documentation systems and MDS coding accuracy
  - Understand ARD options
- Evaluate clinical systems
- Perform root cause analysis
- Don’t try to work on too many things at once
- Try to resolve clinical issues before they are captured on an MDS

Quality Measures Calculation Overview

Quality Measure Programs/Locations

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

Quality Improvement

- Quality improvement is not an MDS function
- MDS timing can help improve quality measures, but consistent quality measure improvement is the result of improving clinical systems
- Quality improvement starts with a root cause analysis
  - The 5 "Why's"
  - Use data to validate theories
- Be strategic with plan implementation

Use of Assessments to Generate QMs

- Calculations use assessments in several different ways to generate 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

- Hi-risk/Unstageable 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 Move Independently 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)

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

- **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 3/27/22
  - 275 days prior to 3/27/22 is 6/25/2021
  - March 31 Quality Measures would include a fall or fall with a major injury reported on **any** assessment with an ARD between 6/25/21 through 3/27/22, 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, short stay 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**

- Three QMs use a Covariate
  - Residents who Made Improvements in Function (S)
    - Age, gender, severe cognitive impairment, long form ADL, heart failure, CVA, TIA or stroke, hip fracture or other fracture
  - Indwelling Catheter (L)
    - On prior assessment: frequent bowel incontinence or stage 2,3 or 4 PU
  - Residents whose Ability to Move Independently Worsened (L)
    - Late loss ADL, severe cognitive impairment, linear age, gender, vision, oxygen use

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 ulcers (through September 30, 2023)
  - Low risk loss of bowel and bladder control

QM CASPER Reports

iQIES Report

CMS

MDS 3.0 Facility-Level Quality Measure (QM) Report

Report Period: 04/01/2023 - 06/30/2023
Comparison Group: 11/01/2022 - 04/30/2023
Report Run Date: 07/20/2023
Data Calculation Date: 07/20/2023
Report Version Number: 3.03

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
Note: For the Improvement in Function (S) Measure, a single * indicates a Percentile of 25 or less (higher Percentile values are better)

Facility ID: Facility Name: CCN: City/State:

QM CASPER Reports

MDS Measures

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
Hi-risk/Unstageable Pres Ulcer (L)	N015.03	C	3	59	5.1%	5.1%	8.3%	9.1%	27
Phys restraints (L)	N027.02	C	0	81	0.0%	0.0%	0.1%	0.1%	0
Falls (L)	N032.02	C	49	81	60.5%	60.5%	45.1%	43.6%	89*
Falls w/Maj injury (L)	N013.02	C	3	81	3.7%	3.7%	3.7%	3.5%	60
Antipsych Med (S)	N011.02	C	0	14	0.0%	0.0%	1.9%	1.9%	0
Antipsych Med (L)	N031.03	C	15	76	19.7%	19.7%	13.3%	14.8%	75*
Antianxiety/Hypnotic Prev (L)	N033.02	C	0	30	0.0%	0.0%	7.3%	6.7%	0
Antianxiety/Hypnotic % (L)	N036.02	C	11	69	15.9%	15.9%	22.9%	19.4%	40
Behav Sx affect Others (L)	N034.02	C	12	78	15.4%	15.4%	24.0%	18.8%	51
Depress Sx (L)	N030.02	C	6	73	8.2%	8.2%	24.7%	9.1%	72
UTI (L)	N024.02	C	1	81	1.2%	1.2%	1.4%	2.5%	47

QM CASPER Reports

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
Cath Insert/Left Bladder (L)	N026.03	C	0	73	0.0%	0.0%	0.9%	1.7%	0
Lo-Risk Lose B/B Con (L)	N025.02	C	13	30	43.3%	43.3%	45.0%	48.5%	40
Excess Wt Loss (L)	N029.02	C	1	69	1.4%	1.4%	7.5%	6.6%	16
Incr ADL Help (L)	N028.02	C	8	66	12.1%	12.1%	13.8%	15.2%	41
Move Indep Worsens (L)	N035.03	C	7	45	15.6%	14.7%	15.0%	18.9%	40
Improvement in Function (S)	N037.03	C	5	6	83.3%	87.0%	75.8%	74.6%	74

SNF Measures

Measure Description	CMS ID	Numerator	Denominator	Facility Observed Percent	Facility Adjusted Percent	National Average
Pressure Ulcer/Injury[1]	S038.02	1	31	3.2%	3.5%	2.7%

[1] The Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (S038.02) measure is calculated using the SNF QRP measure specifications and is based on 12 months of data (07/01/2022 - 06/30/2023).

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Patient Driven Payment Method (PDPM) Overview

PDPM Overview

- Patient characteristics (diagnoses, conditions) reported on MDS drive payment for Medicare Part A
- Rate is the total of six components
  - Five case mix components each use a different “grouper” methodology
  - One “flat-rate” non-case-mix component
- Variable Per Diem Rate adjustment is used to adjust rates over the course of the stay

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%

Example Resident – PDPM (Day 1-3)

Component	Base Fed Rate		Case-Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	66.06	x	1.55	x		x	1.00	=	$102.39
OT	$61.49	x	1.55	x		x	1.00	=	$95.31
SLP	$24.66	x	2.85	x		x		=	$70.29
NTA	$86.88	x	1.85	x		x	3.00	=	$482.19
Nursing	$114.15	x	1.43	x	1.00	x		=	$163.23
Non-Case-Mix Component	$103.12	x		x		x		=	$103.12
							Total	**=**	**$1016.53**

Example Resident – PDPM (Day 4-20)

Component	Base Fed Rate		Case-Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	66.06	x	1.55	x		x	1.00	=	$102.39
OT	$61.49	x	1.55	x		x	1.00	=	$95.31
SLP	$24.66	x	2.85	x		x		=	$70.29
NTA	$86.88	x	1.85	x		x	1.00	=	170.73
Nursing	$114.15	x	1.43	x	1.00	x		=	$163.23
Non-Case-Mix Component	$103.12	x		x		x		=	$103.12
							Total	=	**$695.07**

Example Resident – PDPM (Day 21 -27)

Component	Base Fed Rate		Case-Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	66.06	x	1.55	x		x	0.98	=	$100.34
OT	$61.49	x	1.55	x		x	0.98	=	$93.39
SLP	$24.66	x	2.85	x		x		=	$70.29
NTA	$86.88	x	1.85	x		x	1.00	=	$160.73
Nursing	$114.15	x	1.43	x	1.00	x		=	$163.23
Non-Case-Mix Component	$103.12	x		x		x		=	$103.12
							Total	=	**$691.10**

Example Resident – PDPM (Day 28 - 30)

Component	Base Fed Rate		Case-Mix Index		Special Adjustors		Variable per diem		Payment (per diem)
PT	66.06	x	1.55	x		x	0.96	=	$98.29
OT	$61.49	x	1.55	x		x	0.96	=	$91.49
SLP	$24.66	x	2.85	x		x		=	$70.29
NTA	$86.88	x	1.85	x		x	1.00	=	160.73
Nursing	$114.15	x	1.43	x	1.00	x		=	$163.23
Non-Case-Mix Component	$103.12	x		x		x		=	$103.12
							Total	**=**	**$687.25**

Example Resident – PDPM 30 Days

Day 1-3 => 3 days @ $1,016.53
Day 4-20 => 17 days @ $695.07
Day 21-27 => 7 days @ $691.10
Day 28-30 => 3 days @ $687.25

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

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***

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
  - Average of:
    - Sit to lying
    - Lying to sitting on side of bed
  - Average of:
    - Sit to stand
    - Chair/bed-to-chair transfer
    - Toilet transfer
  - 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
  - Average of:
    - Sit to lying
    - Lying to sitting on side of the bed
  - 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)

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

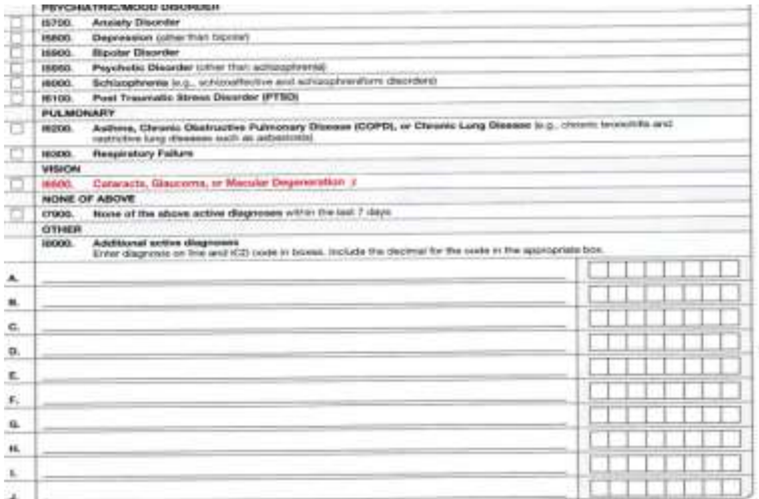
Clinical Category	GG Function Score	PT & OT Case-Mix Group	PT CMI	OT CMI
Major Joint Replacement or Spinal Surgery	0-5	TA	1.45	1.41
	6-9	TB	1.61	1.54
	10-23	TC	1.78	1.60
	24	TD	1.81	1.45
Other Orthopedic	0-5	TE	1.34	1.33
	6-9	TF	1.52	1.51
	10-23	TG	1.58	1.55
	24	TH	1.10	1.09
Medical Management	0-5	TI	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

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

Section I: Active Diagnoses



PSYCHIATRIC/MOOD DISORDER

- ☐ I5700. **Anxiety Disorder**
- ☐ I5800. **Depression** (other than bipolar)
- ☐ I5900. **Bipolar Disorder**
- ☐ I5950. **Psychotic Disorder** (other than schizophrenia)
- ☐ I6000. **Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- ☐ I6100. **Post Traumatic Stress Disorder (PTSD)**

PULMONARY

- ☐ I6200. **Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
- ☐ I6300. **Respiratory Failure**

VISION

- ☐ I6500. Cataracts, Glaucoma, or Macular Degeneration

NONE OF ABOVE

- ☐ I7900. **None of the above active diagnoses** within the last 7 days

OTHER

I8000. **Additional active diagnoses**
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

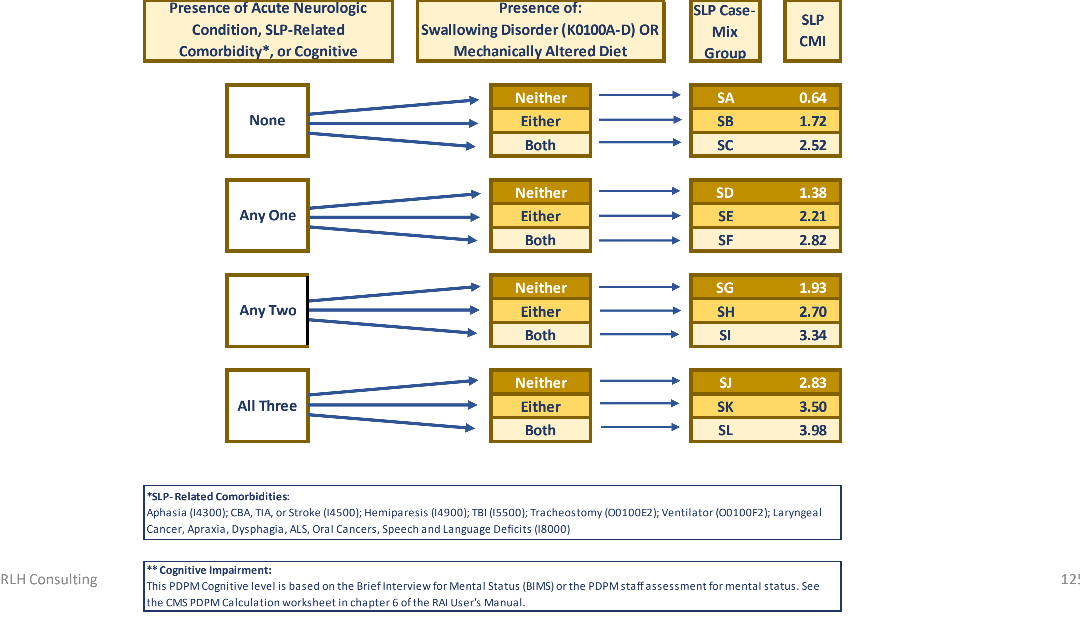
A.
B.
C.
D.
E.
F.
G.
H.
I.
J.

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



Presence of Acute Neurologic Condition, SLP-Related Comorbidity*, or Cognitive	Presence of: Swallowing Disorder (K0100A-D) OR Mechanically Altered Diet	SLP Case-Mix Group	SLP CMI
None	Neither	SA	0.64
	Either	SB	1.72
	Both	SC	2.52
Any One	Neither	SD	1.38
	Either	SE	2.21
	Both	SF	2.82
Any Two	Neither	SG	1.93
	Either	SH	2.70
	Both	SI	3.34
All Three	Neither	SJ	2.83
	Either	SK	3.50
	Both	SL	3.98

***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.

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

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 3.15
- NB: 9-11 2.46
- NC: 6-8 1.79
- ND: 3-5 1.29
- NE: 1-2 0.93
- NF: 0 0.70

NTA Component Considerations

- Review NTA Diagnoses and Conditions Checklist:

https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/downloads/pdpm_fact_sheet_ntacomorbidityscoring_v2_508.pdf

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

Recap: NTA Component Items >1 Point

High Point Items

Item	Points
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

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

Other Important Issues

- Improving preadmission and admission process
- Improving interview techniques
- Evaluate role and skills of MDS Coordinator

Admission Process Considerations

- Having a more thorough, complete and accurate assessment of the resident's overall clinical condition much earlier in the stay will lead to success under PDPM
- Evaluate your preadmission and admission process to ensure your team is conducting a through clinical assessment
- Consider a preadmission (or early after admission) visit with the resident to begin gathering a more comprehensive clinical history (see Healthy History Questionnaire handout)
- Utilize critical thinking skills to not only gather documented diagnoses, but to look for diagnoses that may be missing

Conducting the Resident Interview

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

Additional Interview Tips

- Put the resident at ease
- Use cue cards
- Allow the resident enough time to process questions and answer options
- CMS Interview Training Video:
  - Youtube.com
  - Search “CMS Interviewing Vulnerable Elders”

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
    - 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

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

Additional PDPM Topics

- Interrupted Stay Policy
- Interim Payment Assessments
- CMS website has a page dedicated to PDPM exclusively
  - Topic specific fact sheets
  - Frequently Askes Questions
  - ICD-10 crosswalk tools

Triple Check

- All aspects of Medicare claims should be reviewed for accuracy prior to billing Medicare, including (but not limited to):
  - Accuracy of MDS coding and supporting documentation
  - Beneficiary information
  - Presence of required certification/recertification