LeadingAge® Indiana

COURAGE IGNITED

Managing Medicaid Quality Scores

Quality Program Calculations

July 23- June 24

Quality Score Criteria Prior June 23- July 24

- The calculated TQS for each provider is converted to a Quality Rate Add-on payment for the Medicaid reimbursement rate based on the scale and calculation noted in the table below. The Quality Rate Add-on has a maximum value of $18.45 and a minimum value of $0.00.

Nursing Facility TQS	Nursing Facility Quality Rate Add-On
23 and below	$0
24 – 79	Proportional Quality Rate Add-on determined as follows: $18.45 – [(80 – Facility TQS) × 0.323684]
80 – 100	$18.45

CMS Long Stay Quality Measures

- Each facility's TQS utilized will be determined for the annual period of July 1, 2023 – June 30, 2024 based on the sum of the points from the three quality domains below (Up to 60 Points):
    1. Percentage of long-stay residents whose need for help with daily activities has increased. (Measure code – 401)
    2. Percentage of long-stay residents who self report moderate to severe pain. (Measure code– 402)
    3. Percentage of high risk long-stay residents with pressure ulcers. (Measure code – 453)
    4. Percentage of long-stay residents with a catheter inserted and left in their bladder. (Measure code – 406)
    5. Percentage of long-stay residents with a urinary tract infection. (Measure code – 407)
    6. Percentage of long-stay residents who were physically restrained. (Measure code – 409)
    7. Percentage of long-stay residents experiencing one or more falls with major injury. (Measure code – 410)
    8. Percentage of long-stay residents who received an antipsychotic medication. (Measure code – 419)
    9. Percentage of long-stay residents whose ability to move independently worsened. (Measure code – 419)

- For each quality measure, the nursing facility has CMS points assigned based on the nursing facility's individual measure performance as compared to measure cut point ranges published January 2017 by CMS in the Technical Users Guide for the Design for the Nursing Home Compare Five-Star Quality Rating System. CMS measure scores are individually determined in 20 point increments (20 – 100). TQS points for this domain will be awarded based on the nursing facility's aggregated long-stay quality CMS measure scores as determined in the table below:

MDS Based Long-Stay Quality Scores	TQS Points Awarded
540 and below	0
541 – 699	Proportional quality points awarded as follows: 60 - [(700 - facility long-stay quality score) × 0.375]
700 and above	60

Nursing Home Health Survey Domain

- Each nursing facility will be awarded up to twenty-five (25) quality points based on its nursing home health survey score. Each nursing facility's quality points under this domain shall be determined as follows:

Nursing Home Health Survey Scores	Quality Points Awarded
21 and below	25
22 – 77	Proportional quality points awarded as follows: 25 – [(Nursing Home Health Survey Score – 21) × 0.4385965]
78 and above	0

Nursing Facility Staffing Ration Measure

- Each nursing facility will be awarded up to fifteen (15) quality points based on its staffing ratio score. The staffing ratio is calculated as the Total Reported Nurse Staffing Hours per Resident Day (includes RN/LPN/CNA hours) divided by the Case Mix (Expected) Total Nurse Staffing Hours per Resident Day. For staffing ratio calculation purposes, the numerator of the staffing ratio score will also include the addition of respiratory therapy hours, payroll based journal job code 24 (Respiratory Therapist) and job code 25 (Respiratory Therapy Technician), published by CMS in the payroll based journal employee detail files for the same reporting quarter. Each nursing facility's quality points under this domain shall be determined as follows:

Nursing Facility Staffing Ratio	Quality Points Awarded
Less than or equal to 25th percentile of Indiana Facilities	0
Greater than 25th percentile and less than 75th percentile of Indiana Facilities	Proportional Quality Points Awarded as Follows: (25th Percentile Value – Facility Staffing Ratio) / (25th Percentile Value – 75th Percentile Value) * 15 Total Points
Equal to or greater than 75th percentile of Indiana Facilities	15

Quality Program Calculations

July 24- June 27

Quality Program Calculation- Effective 07/01/24- 06/30/27

- For the Legacy System base rates effective July 1, 2024 through June 30, 2027 as described in 405 IAC 1-14.7, the Office establishes a TQS (TQS) that is utilized in the calculation of the Quality Rate Add-on for each nursing facility's Medicaid base reimbursement rate. The TQS and associated Quality Rate Add-on are calculated each July 1 and January 1 and remain in effect for the succeeding six month rate period. For rate periods July 1, 2027 and after, there will not be a Quality Rate Add-on component in the base Medicaid reimbursement rate, as TQSs will be utilized solely for supplemental payment purposes. The TQS is nursing facility specific and comprised of calculated quality points from the following quality domains:
    1. CMS published Minimum Data Set (MDS) Based Long-Stay Quality Measures
    2. CMS published Claims Based Long-Stay Quality Measures
    3. CMS published Staffing Data from Payroll Based Journal Records

Source of Selected Quality Measure Data

1. The MDS Based Quality Measures Data Table published by CMS
    a. File Location: https://data.cms.gov/provider-data/
        i. Select Nursing home including rehab services link
        ii. Select MDS Quality Measures
        iii. Archived data: https://data.cms.gov/provider-data/archived- data/nursinghomes
    b. Quality Domain Supported: CMS Published MDS Based Long-Stay
        Quality Measures
2. The Medicare Claims Based Quality Measures published by CMS.
    a. File Location: https://data.cms.gov/provider-data/
        i. Select Nursing home including rehab services link
        ii. Select Medicare Claims Quality Measures
        iii. Archived data: https://data.cms.gov/provider-data/archived- data/nursinghomes
    b. Quality Domain Supported: CMS Published Medicare Claims Based
        Long-Stay Quality Measures

3. The Provider Information file published by CMS.
    a. File location: https://data.cms.gov/provider-data/
        i. Select Nursing home including rehab services link
        ii. Select Provider Information
        iii. Archived data:
        https://data.cms.gov/provider-data/archived-data/nursinghomes
    b. Quality Domains Supported:
        i. Staffing Ratio (without RT hours)
        1. Total Reported Nurse Staffing Hours per Resident Day
        2. Case Mix (Expected) Nurse Staffing Hours per Resident Day
        ii. Health Survey Score
4. The Payroll Based Journal Daily Nurse Staffing published by CMS
    a. File Location
    https://data.cms.gov/quality-of-care/payroll-based-journal-daily-nurse-staffing
    b. Quality Domain Supported: Staffing Ratio (utilized for Respiratory Therapy hours)

Source Quality Measure Data Time Period

- The quality measures utilized in the calculation of the TQS and the associated Quality Rate Add- on component will utilize the information from the sources noted above published by CMS. The TQS and associated Quality Rate Add-on are calculated each July 1 and January 1 and remain in effect for the succeeding six month rate period. The July TQS will be based on CMS published files as of the preceding January, and January TQS values will be based on CMS published files as of the preceding July.

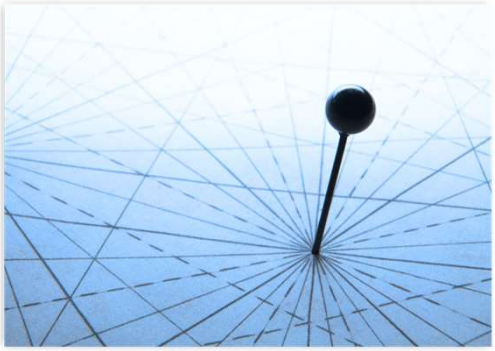
Quality Add-on Calculation

- The calculated TQS for each nursing facility is converted to a Quality Rate Add-on payment for the Medicaid reimbursement rate. There will be no maximum or minimum thresholds to receive a Quality Rate Add-on payment. The Quality Rate Add-on will be based on a calculated value per quality point. The calculated value per quality point is established at a value to achieve a targeted system expenditure equivalent to the SFY 2024 Quality Rate Add-on. The Quality Rate Add-on will be calculated as follows:

Quality Rate Add-on Calculation		
A.	Facility TQS	
B.	Facility Medicaid Day Projection for SFY	
C.	Total Quality Weight	Sum of the products of A * B for each nursing facility
D.	SFY 2024 Quality Rate Add-On Statewide Expenditures	
E.	Calculated Value Per Quality Point	D / C
F.	Total Quality Rate Add-on	A * E

Quality Measures

- Each facility's TQS is determined for each July 1 and January 1 based on the sum of the quality points from each individual measure:
- The quality measures, percentile universe, maximum and minimum performance percentiles (measure cut points), and total points available are denoted in the table below:



Quality Measures	Domain	Percentile Universe	Minimum Performance Percentile	Maximum Performance Percentile	Total Available Points
Percentage of long-stay residents experiencing one or more falls with major injury (Measure Code 410)	MDS Based Measure	National	0.40	0.90	100.0
Percentage of high risk long-stay residents with pressure ulcers (Measure Code 453)	MDS Based Measure	National	0.40	0.90	100.0
Number of hospitalizations per 1000 long-stay resident days (Measure Code 551)	Claims Based Measure	National	0.40	0.90	150.0
Number of outpatient emergency department visits per 1000 long-stay resident days (Measure Code 552)	Claims Based Measure	National	0.40	0.90	150.0
Total nurse staffing ratio	Staffing	Indiana	0.40	0.90	125.0

Performance and Scoring

- Nursing Facilities will receive quality points for each individual measure. The measure quality scores are determined as follows:

Quality Measure Score	Quality Point Awarded
Below Minimum Performance Percentile	0
Between Minimum Performance Percentile and Maximum Performance Percentile	(Minimum Performance Percentile Value – Facility Value) / (Minimum Performance Percentile Value – Maximum Performance Percentile Value) * Total Available Points
Above Maximum Performance Percentile	Total Available Points

- The TQS for each nursing facility is based on the sum of the quality points for each individual quality measure in the table above.

CMS Published MDS Based Long-Stay Quality Measures Domain and CMS Published Claims Based Long-Stay Quality Measures Domain

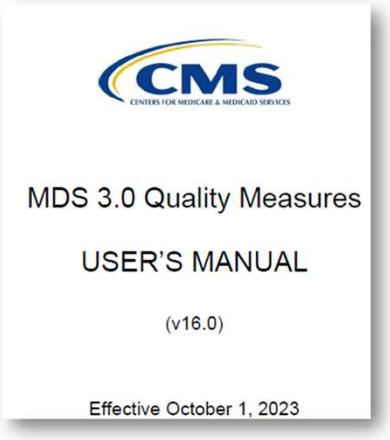
- The TQS points for each measure of these domains are determined using the four quarter average percentage for each long-stay quality measures.

Nursing Facility Staffing Ratio Measure

- The staffing ratio is calculated as the Total Reported Nurse Staffing Hours per Resident Day (includes RN/LPN/CNA hours) divided by the Case Mix (Expected) Total Nurse Staffing Hours per Resident Day. For staffing ratio calculation purposes the numerator of the staffing ratio score will also include the addition of respiratory therapy hours, payroll based journal job code 24 (Respiratory Therapist) and job code 25 (Respiratory Therapy Technician) hours, published by CMS in the payroll based journal employee detail files for the same reporting quarter.

Missing Quality Measures

- Long-Stay Measures (both MDS and Claims Based)
- Nursing facilities missing a raw value for a long-stay quality measure will be assigned qualitynpoints based on the statewide average points for each individual measure.



LeadingAge Indiana

INALA Indiana Assisted Living Association

Missing Quality Measures

- ***Staffing Measure***
- Nursing facilities with missing staffing information for the base quality period will utilize information from prior quarter CMS published staffing values with the following adjustments:
  - CMS Data available from one (1) calendar quarter previous will have the calculated nursing facility staffing quality points multiplied by 0.80.
  - CMS Data available from two (2) calendar quarters previous will have the calculated nursing facility staffing quality points multiplied by 0.60.
  - CMS Data available from three (3) calendar quarters previous will have the calculated nursing facility staffing quality points multiplied by 0.40.
  - CMS Data available from four (4) calendar quarters previous will have the calculated nursing facility staffing quality points multiplied by 0.20.
  - If no information is available for any of the four (4) previous CMS calendar quarters, the facility will receive a zero (0) for the measure.

Profit Add- On

- For facilities that have allowable rate component costs lower than the direct care, indirect care, or capital rate ceiling, a profit add-on is determined for the Medicaid base rate in accordance with 405 IAC 1-14.7. The profit add-on will be reduced depending on the facility's TQS percentage. The calculation of the TQS percentage is as follows:

TQS	Percentage for Profit Add-on Calculation
275 – 625	100%
61 - 274	Proportional percentage calculated as follows: 100% + ((Facility TQS – 275) / 215))
60 and below	0%

Managing the Quality

MDS Long Stay Quality Measures

Falls with Major Injury

Currently coded for falls with Major injury in Section J

Exclusions

- Resident is excluded if the following is true for ***all*** look-back scan assessments:

1. The number of falls with major injury was not coded (J1900C = [-]).

Clinical Systems:

Falls review with root cause analysis
Falls prevention upon admission
Change of condition and therapy referrals
Medication review

Percent of Residents with Pressure Ulcers

Coded for stage 2-4 or unstageable pressure ulcers

Exclusions: Admission or 5 day assessment only or dashed information for wounds.

Covariates: Impaired functional mobility (Lying to sitting, sitting to lying), Bowel Incontinence, DM, PVD, PAD, Low BMI, Malnutrition (risk for), Dehydration, Infection (Pneumonia, UTI, Sepsis, MDRO), MASD, Hospice

Clinical Systems:

- Daily review of new skin areas
- ADL accuracy
- Turning/repositions programs

Antipsychotics

Received an Antipsychotic
– For assessments with target dates on or after 10/01/2023: (N0415A1 = [1]).
Exclusions:
1. The following is true for all assessments in the look-back scan (excluding the initial assessment):
1.1. For assessments with target dates on or after 10/01/2023: (N0415A1 = [-]).10
2. Any of the following related conditions are present on any assessment in a look-back scan:
2.1. Schizophrenia (I6000 = [1]).
2.2.Tourette's syndrome (I5350 = [1]).
2.3.Huntington's disease (I5250 = [1]).

Clinical System:
Review orders for new antipsychotics in morning clinical review
GDR Meeting
Behavior Management and Activity Programs

Percent of Residents Whose Ability to Walk Independently Worsened

- 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 he "Walk 10 feet" item between the target assessment and prior assessment (GG0170I on target assessment – GG0170I on prior assessment ≤ -1)

Exclusions: Comatose (or dashed), 6<mo to live or hospice, dependent or not attempted or dashed answer to GG0170I

Covariates: Eating, Toilet transfers, Sit to stand, Walk 10 ft coding from prior assessments. Severe Cognitive Impairment from prior assessment. Age, Gender, O2 use, Vision impairment.

Clinical Systems: GG Assessment accuracy, Restorative, Therapy partners

Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased

- 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 Siting 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] either the target or prior assessment, then recode the item to equal [01] to allow appropriate comparison.

Exclusions: All four of the late-loss ADL items indicate dependence or activity was not attempted on the prior assessment, Three of the late-loss ADLs indicate dependence (value [01]) or activity was not attempted AND the fourth late-loss ADL indicates substantial/maximal assistance, Comatose, 6<mo to live or hospice, dashed GG items.

Covariates: None

Clinical Systems: GG Assessment accuracy, Restorative, Therapy partners

Urinary Tract Infection

Coded for UTI last 30 days in section I

Exclusions

- Target assessment is an admission assessment (A0310A = [01]) ***or*** a PPS 5-Day assessment (A0310B = [01]).
- Target assessment indicates that indwelling catheter status is missing (H0100A = [-]).

Clinical Systems

McGeers review

Coded on admission if from hospital stay

Infection control and perineal care

Catheter

Coded as having an indwelling catheter in section H

Exclusions: Admission assessment, dashed answer Neurogenic Bladder, Obstructive Uropathy (I)

Covariates: frequently incontinent bowel, Stage 2-4 pressure ulcer

Clinical systems:

New admission review, Urology referrals, MDS Coding

Physical Restraints

Coded as having a restraint in section P

No exclusions or covariate (unless dashed)

Clinical systems:

- Therapy review for least restrictive device
- Device/Restraint assessment
- Proper consents and periodic removal

Claims Based Quality Measures

Long Stay

Hospitalizations Per 1,000 Long Stay Resident Days

The numerator for the measure is the number of admissions to an acute care or critical access hospital, for an inpatient stay or outpatient observation stay, occurring while the individual is a long-term nursing home resident.

Exclusions: not a Medicare beneficiary or the resident was enrolled in Medicare managed care during any portion of the stay, i.e. between admission and discharge or the end of the target period (whichever is earlier); No quarterly or comprehensive MDS assessment within 120 days prior to the day the resident became a long-stay resident; OR data were missing for any of the claims or MDS items used to construct the numerator or denominator, or for risk-adjustment.

- the resident was enrolled in hospice care; the resident was not in the nursing home for any reason during the episode, including days admitted to an inpatient facility or other institution, or days temporarily residing in the community.

Covariates: Age, Gender, Race/Ethnicity, #acute care days in prior year, outcome specific comorbid index

Clinical systems to manage:

Advanced Care Planning	InterACT Program
Rounds on acute patients	Hospice/Palliative Care

Number of Outpatient Emergency Department Visits per 1,000 Long Stay Residents

The numerator for the measure is the number of visits to an emergency department that did not result in an inpatient hospital stay or outpatient observation stay, occurring while the individual is a long-term nursing home resident. Outpatient ED visits are included in the measure regardless of diagnosis.

Exclusions: not a Medicare beneficiary or the resident was enrolled in Medicare managed care during any portion of the stay, i.e. between admission and discharge or the end of the target period (whichever is earlier); No quarterly or comprehensive MDS assessment within 120 days prior to the day the resident became a long-stay resident; OR data were missing for any of the claims or MDS items used to construct the numerator or denominator, or for risk-adjustment.

- the resident was enrolled in hospice care; the resident was not in the nursing home for any reason during the episode, including days admitted to an inpatient facility or other institution, or days temporarily residing in the community.

Covariates: Age, Gender, Race/Ethnicity, #acute care days in prior year, outcome specific comorbid index

Clinical systems to manage:

Advanced Care Planning	Rounds on acute patients
InterACT Program	Hospice/Palliative Care

References

- Myers and Stauffer's QM Manual
- Quality Measures Manuals