



**MLN Connects®**

**National Provider Call Transcript**



**Centers for Medicare & Medicaid Services  
SNF Quality Reporting Program Call  
MLN Connects National Provider Call  
Moderator: Leah Nguyen  
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This transcript was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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**Operator:** At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Leah Nguyen. Thank you. You may begin.

## Announcements and Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I'd like to welcome you to this MLN Connects National Provider Call on the Skilled Nursing Facility, or SNF, Quality Reporting Program. [MLN Connects Calls](#) are part of the [Medicare Learning Network®](#).

During this call, you will learn about the reporting requirements for the new SNF Quality Reporting Program, effective October 1<sup>st</sup>, 2016. The Improving Medicare Post-Acute Care Transformation Act of 2014, or IMPACT Act, established the program and requires the submission of standardized data.

Before we get started, I have a couple of announcements. You should have received a link to the presentation for today's call in previous registration emails. If you have not already done so, you may view or download the presentation from the following URL—[go.cms.gov/npc](http://go.cms.gov/npc). Again, that URL is [go.cms.gov/npc](http://go.cms.gov/npc). At the left side of the webpage, select National Provider Calls and Events, then select the July 12<sup>th</sup> call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the [MLN Connects Call](#) website. Registrants will receive an email when these materials are available.

Lastly, registrants were given the opportunity to submit questions. We will address some of these questions before the question-and-answer session.

At this time, I would like to turn the call over to our first presenter, Sharon Lash from the Division of Chronic and Post-Acute Care of the Center for Clinical Standards and Quality.

## Presentation

Sharon Lash: Thank you, Leah. Good afternoon everyone, and welcome to the National Provider Call. My name is Sharon Lash. I'm an RN consultant, and my current role with the DCPAC—I'm going to abbreviate that from now on—is the SNF QRP coordinator. Today, my RTI colleague, Research Triangle Institute colleague Dr. Laura Smith and I will present a high-level overview of the Skilled Nursing Facility Quality Reporting Program. And as Leah mentioned, it will be followed up by a question-and-answer segment.

So, if you please follow along with the slides, I will try to remember to identify the slide numbers as we move along. Today's agenda—we'll provide an overview of the IMPACT Act, the background legislation for the Post-Acute Care Quality Reporting Program, the SNF QRP policy overview, the quality measures, and resources that you may access to find more information.

### **Overview of IMPACT Act of 2014 and SNF QRP**

Sharon Lash: The background – the legislative background of the Post-Acute Care Quality Reporting Program is found in the Improving Medicare Post-Acute Care Transformation, or IMPACT, Act. And herein, I— hereinafter, I will refer to it as the IMPACT Act. And that was passed in 2014, on October 6<sup>th</sup> enacted into law. What it does is require standardized patient assessment data across post-acute care settings that is intended to improve quality care and outcomes. It is to enable data element uniformity across the post-acute care providers, allow for a comparison of quality and data across PAC settings. It should improve person-centered, goal-driven discharge planning, should enhance exchangeability of data, and help with a coordinated care across the post-acute care spectrum. For more information, the link below is to the [act](#).

On slide number 5, the driving forces of the IMPACT Act include purposes such as improvement of Medicare beneficiary outcomes foremost. But also, it is to provide – help providers access longitudinal information to facilitate coordinated care across the spectrum of post-acute care to enable comparable data and quality across PAC settings, improve hospital discharge planning, and research to enable payment models based on patient characteristics.

So why is there more and more attention being paid to post-acute care, and why are we implementing, you know, the Quality Reporting Program? Why is Congress passing legislation? Well, there are escalating costs associated with post-acute care. For example, the Medicare Payment Advisory Commission published a report in 2015 that indicated that Medicare's payments to the more than 29,000 PAC providers totaled \$59 billion in 2013. And that's more than doubling since 2001. So there is an escalating cost. So, there is also a lack of data standards and lack of interoperability across PAC settings. And there is a goal of establishing payment rates according to the individual characteristics of the patient and not so much the care setting.

On slide 6, these are the current PAC settings that the quality reporting programs have been developed for since, well, IRFs and – Inpatient Rehab Facilities and Long-Term Care Hospitals have been in effect for a few years now. But, with the IMPACT Act, it added Home Health Agencies and Nursing Homes. And you'll see the quality measures that all four of these settings are developing and are implementing. So, when you see our new functional measures, it's in – not in just SNFs, but it's across these four PAC providers.

So the requirements for reporting assessment data, you know, will be the MDS. They must submit standardized assessment data through PAC assessment instruments under

applicable reporting provisions. So, of course, the SNF world uses the MDS and Home Health, IRF, and LTCH all have their discrete assessment instruments. So, you can see that the public reporting and, you know, final implementation dates are listed in these bubble boxes here. The data must be submitted now with respect to admission and discharge for each resident, or more frequently, as required. I might note that one of the major differences between IRF and LTCH and the SNF settings is that, right now, the SNF settings do not use CDC NHSN data, so – whereas the IRF and LTCH do. But the other assessment-based items are shared across these four settings. And Home Health Agencies will be the last to come online with the Quality Reporting Program next year in – on January 1<sup>st</sup>.

So the data categories in these – in the IMPACT Act include functional status; cognitive function and mental status; special services, treatments, and interventions; medical conditions and comorbidities; impairments; other – and other categories, as required by the Secretary.

On to page number – slide number 8. The IMPACT Act specifies five quality measure domains. And these include functional status, cognitive function, and changes in function and cognitive function as one domain. Another is skin integrity and changes in skin integrity. A third is medication reconciliation. The fourth is incidence of major falls. And the fifth is communicating the existence of and providing for the transfer of health information and care preferences.

The IMPACT Act also calls for resource use and other measures. So, resource use and other measures will be specified for reporting, which may include standardized assessment data in addition to claims data. So, resource use and other measure domains could be total estimated Medicare Spending per Beneficiary, discharge to community, and measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates. And these are all claims-based measures. So, when these are claims-based measures, there is nothing additional the provider must do to – because we, CMS, will go directly to the claims and get the data from there.

So in response to the reporting requirements under the act, CMS established the Skilled Nursing Facility Quality Reporting Program and its quality reporting requirements in the fiscal year 2016 SNF Prospective Payment System final rule. The Quality Reporting Program requirements is – are found in a rider with the SNF PPS rule. So, per the statute, SNFs that do not submit the required quality measures data may receive a 2-percentage-point reduction to their annual payment update for the applicable payment year. So, the program is effective October 1<sup>st</sup>, 2016. And for more information regarding the [SNF QRP](#), please visit our page that is kind of under construction. We are adding to it daily. We're reorganizing it. If you've ever visited the – or IRF or LTCH websites, the quality reporting websites, we're going to try to align as closely as we can with our information dissemination because of the alignment of the rule, you know, across the PAC settings.

### **SNF QRP Policy Overview**

Sharon Lash: So then next, I'm going to present the SNF QRP policy overview. I have just completed the IMPACT Act overview.

So, in the final rule, I will present the – these six major policies were finalized in August of last year in the SNF PPS fiscal year 2016 final rule. The six policies that I'm going to cover today are – is:

- Number one is participation and timing for new Skilled Nursing Facilities who have new survey – who have new CMS certification numbers.
- The second is data collection timelines and requirements for the fiscal year 2018 payment determination and subsequent years.
- The third is data completion threshold.
- The fourth is exception and extension requirements.
- The fifth is Reconsideration and Appeals Procedures.
- And the sixth is public display of quality data.

### **Participation/Timing for New SNFs**

Sharon Lash: So, the participation and timing for new SNFs, on slide number 13 – now, I'm going to read the first bullet, and it's very – it's derived – it's taken directly from the rule, so it's very, very technical. But there's a simple interpretation, or translation, right after that. So, the first bullet is: "A new Skilled Nursing Facility would be required to begin reporting data on any quality measures finalized for that program year by no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number notification letter."

So, more simply stated, for example, if a facility receives its CCN number on October – on August 28<sup>th</sup>, 2016, 30 days are added to that. So, August 28<sup>th</sup>, plus 30 days is September 27<sup>th</sup>. And so, the next quarter – calendar year quarter following that is October 1. And that is when the facility would be required to begin reporting. I hope that clarifies that kind of rather technical description.

### **Reporting Requirements for FY 2018 Payment Determination**

Sharon Lash: So, the data collection timelines and requirements for the fiscal year 2018 payment determination is based on one quarter of data from 2016, which is from October 1<sup>st</sup> through December 31<sup>st</sup> of 2016. So this means that fiscal year 2018 compliance determination will be based on data submitted for admissions to this facility

on and after October 1<sup>st</sup>, 2016, and discharged from the Skilled Nursing Facility up to and including December 31<sup>st</sup>. I want to point out to you that providers will have until May 15<sup>th</sup>, 2017, to correct and/or submit their quality data from the fiscal year 2018 reporting year. So the APU determination for fiscal year 2018 will be based on one quarter of data submitted on the fourth quarter of this year.

On – excuse me. So on slide number – sorry. Bear with me. There we go. So, the data collection timelines – and we’re on – we’re still on slide 15. The data collection timelines and requirements for the fiscal year 2018 payment determination is currently for assessment items. So right now, SNFs currently submit MDS 3.0 data to CMS through the Quality Improvement and Evaluation System, well – otherwise known as QIES, Assessment Submission and Processing system – so ASAP – so the QIES ASAP system. And the three measures that will be introduced by Laura Smith later are all MDS-derived. So, the October 1<sup>st</sup>, 2016, implementation of the SNF QRP will not change your process of the MDS 3.0 data submission through QIES. It will all happen through that mechanism.

On slide number 16, the data collection timelines and requirements for the fiscal year 2018 payment determination will include some changes to the MDS 3.0. And these changes are the Part A PPS Discharge Assessment and the assess – and the addition of Section GG. Now, I want to remind you that all four of the PAC providers that I mentioned before will be completing Section GG. And that is in, you know, compliance with the requirements of the standardized assessment items. So that is why Section GG has been introduced. You know, we don’t want it to be a redundancy, but it is a new way of measuring functions that can be applied to all PAC provider settings.

So, as far as the Part A PPS Discharge Assessment, it was developed to inform current and future SNF QRP measures and the calculation of these measures. It consists of demographic, administrative, and clinical items. The Part A PPS Discharge Assessment is completed when a resident’s Medicare Part A stay ends, but the resident remains in the facility, for example, and is not physically discharged from that facility. Also, if the Medicare Part A stay ends on the day of or 1 day before the date of physical discharge, the OBRA discharge assessment and PPS Part A discharge assessment are both required and may be combined.

### **Data Completion Threshold**

Sharon Lash: On slide number 18, the data threshold – the data completion threshold. Beginning with fiscal year 2018 payment determination, SNFs must report all of the data necessary to calculate the quality measures on at least 80 percent of the MDS assessments that they submit.

An SNF is considered to be compliant with the Quality Reporting Program if all of the data necessary to calculate the measures have been submitted to fully calculate the quality measures. So, stated another way, 100 percent of the items used to calculate the

SNF QRP measures must be completed on at least 80 percent of the MDS records submitted by a provider.

So, you know, this directly relates to dash use. So, a measure cannot be calculated, for example, when the use of a dash indicates that the facility was unable to perform, for example, a pressure ulcer assessment. But I want to point out, though, that we have done some background research and want to assure you that on the two measures that are included in the QRP, the pressure ulcers and fall measures, providers far exceed that threshold right now on the existing measures. So, I just want to reassure you that, you know, you're already, you know, all – halfway there, and what you need to do is just pay particular attention to Section GG functional assessment data and Part A discharge assessment to main – monitor your compliance with the Quality Reporting Program requirements.

### **Reconsideration and Exception/Extension Procedures**

Sharon Lash: So, our experience has shown, with other quality reporting programs—and this is, by no means, a new concept at CMS—we have had quality reporting programs for a number of years now—that there are times when providers are unable to submit quality data due to extraordinary circumstances beyond their control, for example, natural or manmade disasters. And, therefore, we have adopted exception and extension requirements. So, a provider may provide – request an exception or extension for the Quality Reporting Program within 90 days of the date that the extraordinary circumstances occurred.

The SNF may [request an exception or extension](#) by submitting a written request to CMS via email to the [SNF Reconsideration mailbox](#). And you can find that on our webpage, and the link is noted here on this slide – on slide 20.

On slide 21, there are reconsideration and appeals procedures for requirements – I mean, you know, for facilities – sorry – who are found to be noncompliant. And they can – and you can request reconsideration of this decision if you feel that it has been derived in error. So you may file for reconsideration if you believe that the finding of noncompliance is in error.

The procedure for [requesting reconsideration](#) is by email to the CMS [SNF Reconsideration mailbox](#). And the link is noted there.

### **Public Display of Quality Data**

Sharon Lash: Now, public display of quality data, this – there is a requirement in the IMPACT Act for this data to be publicly reported, and it is scheduled to begin in fall of 2018. So, the public reporting will include a period for review, correction of quality data prior to the public display of the SNF performance data. So, we have not yet determined the location and manner in which the Quality Reporting Program data measures are

publicly displayed. And we will be developing those requirements in the next fiscal year SNF PPS rule. So that will be coming out in the SNF PPS fiscal year 2018 as a rider. So, please do watch for that. And we're also interested in your feedback about where the best place for that quality reporting would be. So, we do look forward to your feedback on that.

So that concludes my presentation today on the policy aspects of the Quality Reporting Program, and I will take – turn it over back to Leah. Thank you very much for your attention.

## **Keypad Polling**

Leah Nguyen: Thank you, Sharon. At this time, we will pause for a few moments to complete keypad polling. Ronni, we're ready to start polling.

**Operator:** CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you're the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Please continue to hold while we complete the polling.

Please continue to hold while we complete the polling.

Thank you for your participation. I'd now like to turn the call back over to Leah Nguyen.

## **Presentation Continued**

Leah Nguyen: Thank you, Ronni. I'd like to introduce our second presenter, Laura Smith, Senior Health Services Researcher from RTI International.

Dr. Laura Smith: Thank you, Leah. My name is Laura Smith. And in addition to providing support to CMS as part of the RTI team for the development of measures for the SNF QRP, I have been the RTI lead for development and testing of the MDS-based measures for nursing home – the Nursing Home Quality Initiative since 2011.

## **SNF QRP Quality Measures**

Dr. Laura Smith: I'm on slide 25. In this part of the presentation, I'm going to go into a bit more detail about the three quality measures affecting the fiscal year 2018 payment determination that were finalized for adoption into the SNF QRP in the FY 2016 SNF PPS



final rule. As Sharon mentioned, all three of these quality measures use assessment data from the MDS.

The following slides will present basic information about the specifications for these quality measures. Information about item coding is not included in this presentation. However, I have included a brief high-level overview of the new Section GG items in my discussion of the new function goals of care measure at the end.

Slide 26. More information about the calculation of these quality measure and MDS items included in the calculations of the QMs can be found in the document titled "[SNF QRP—Specifications for the Quality Measures Adopted through the FY 2016 Final Rule](#)," which can be found by clicking through the link shown on slide 26. Additionally, slides from the recent [SNF QRP training](#) that were held on June 20<sup>th</sup> can be found on the SNF – the CMS SNF QRP webpage, and these include more details regarding all the concepts Sharon and I are discussing with you today.

### **Application of Percent of Residents Experiencing One or More Falls with Major Injury**

Dr. Laura Smith: Starting with slide 27, the first measure I am going to talk about today is the Application of Percent of Residents Experiencing One or More Falls with Major Injury. But before I get into the details of the measure specification, I want to pause for a moment and talk a little about the title of this SNF QRP measure, specifically, what we mean by those first two words in the title, which are "Application of."

Many of you may be familiar with the Long Stay measure, which is currently reported on Nursing Home Compare, that applies to nursing home residents who stayed in the nursing home for 101 or more days. The Long Stay measure, which captures the percent of long stay residents experiencing one or more falls with major injury during their episode of nursing home care, has been endorsed by the National Quality Forum. This SNF QRP measure is a modification of that Long Stay measure where the specifications have been modified to apply to the SNF Medicare Part A population. Therefore, we're calling the SNF QRP measure an Application of Percent of Residents Experiencing One or More Falls with Major Injury. In the subsequent slides, I will talk some more about the nitty-gritty of the measure, including the measure's purpose and how we define a Medicare Part A stay, as well as the population for the SNF QRP measure.

Moving on to slide 28, this QM is intended for use as a cross-setting measure to meet the requirements of the IMPACT Act of 2014 addressing the domain of major falls. This QM reports the percentage of resident Medicare Part A stays where one or more falls with major injury occurred during the SNF stay. Major injury is defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma.

So, as I promised, with this next slide, which is number 29, I'm going to talk about the definition of the Medicare Part A stay. Medicare Part A stay is defined as the period of

time between the start of a resident's Medicare Part A covered stay and the corresponding end date for that stay.

The start date and end date for the Medicare Part A stay are identified by a 5-day PPS assessment and an associated discharge, which, as Sharon explained previously, may be a standalone PPS – excuse me – Part A PPS Discharge or a Part A PPS Discharge combined with an OBRA discharge. The start date for the Medicare Part A stay is derived from item A2400B, which is labeled as the start date of the most recent Medicare stay. As for the end date, for a resident who is not discharged from the nursing home at the end of their Medicare-covered service, they will have a standalone Part A PPS Discharge. And at the – and the end date of their Medicare Part A stay will be derived from the item A2400C. For residents who are physically discharged on the same day or the day after their – the end of their Medicare-covered services, the end of their Medicare Part A stay will be the same as the discharge date obtained from their OBRA discharge, which is item A2000.

Note that there is an important difference from the nursing home episodes that are used as the unit of analysis for the Nursing Home Quality Initiative measures reported on nurse – currently reported on Nursing Home Compare. For the measures currently reported on Nursing Home Compare, if a resident's initial PPS stay ends with a discharge with return anticipated to the nursing home, that resident's episode will continue if the resident reenters the same facility within 30 days. So, for example, in the case of a resident who was discharged with return anticipated who reenters the facility and is still eligible for their SNF benefit upon reentry, they would still – that incident would still be considered a single episode. But it would be counted as two separate Medicare Part A stays because that initial discharge with return anticipated would mark the end of the first Part – Medicare Part A stay, and that 5-day PPS completed at reentry would mark the beginning of a new Medicare Part A stay.

Slide number 30 gives an overview of the construction of the SNF QRP falls measure, which takes the form of a proportion with a numerator and a denominator. I'm going to read through the equation, and then I'll walk back through to explain more thoroughly what it means.

The numerator is defined as the number of resident Medicare Part A stays with one or more look-back scan assessments that indicate one or more falls that – excuse me, resulted in major injury. The denominator is defined as the number of resident Medicare Part A stays with one or more assessments that are eligible for a look-back scan, except those with exclusions. So, stated more simply, the numerator of the measure is the number of Medicare Part A stays where a resident experienced at least one fall that resulted in major injury. I'm going to talk a little bit more about what I mean by a look-back scan and why it's important in just a minute. But the more simple summary of the denominator, in the meantime, is that the denominator is the number

of completed Medicare Part A stays with end dates occurring during the time – same time period as the numerator, except those with exclusions.

Note that the unit of analysis for this measure is the resident Medicare Part A stay rather than just the resident. So, this means that a resident will be counted more than once in the measure if they have more than one completed Medicare Part A stay ending during the 12-month measure time period. This also means that a resident could be counted more than once in a numerator. So, for example, if a resident had two completed Medicare Part A stays and had an injurious fall happen in each of those stays—so, I’m talking about two separate injurious falls, one occurring in each stay—that resident would be counted twice in the numerator, once for each stay that had an injurious fall occur during it.

And so, returning to that term that I mentioned earlier, the look-back scan, what we mean by that is that all assessments completed during the resident’s Medicare Part A stay will get reviewed for information about whether or not there was an injurious fall. A look-back scan of all assessments completed for the resident’s Medicare Part A stay is necessary to get a full picture of whether a fall with major injury occurred during the resident’s stay because, if a resident has an interim assessment between their 5-day PPS and the end of their Medicare Part A stay, the item on the discharge will only look back to that interim assessment. The look-back scan allows the interim assessment to be examined for report of any injurious falls occurring between admission and that interim assessment. Slide 31, we show the list of assessments that are eligible for inclusion in that look-back scan.

Moving on to slide 32. If you recall, the simplified definition of the denominator for the falls measure is the number of completed Medicare Part A stays with end dates occurring during the measure time period, except those with exclusions. So on this slide, I’m going to briefly review what the measure denominator exclusions are.

A resident Medicare Part A stay is excluded if none of the assessments that are included in the look-back scan has a usable response for the item indicating the presence of a fall with major injury during the selected time window. In other words, the stay is excluded if information on falls with major injury is missing on item J1900C. Pardon me, let – I’m going to say that again, which is, the stay will be excluded if information on falls with major injury is missing on all assessments in the look-back scan in that resident’s stay. And I’ll say it one more way—and this is probably the simplest way, and maybe I should have led with it—which is, to be included in the measure, a resident must have at least one assessment in their Part A stay with a valid response to the item reporting information on falls with major injury. And note that this measure is not risk-adjusted.

### **Percent of Patients or Residents with Pressure Ulcers That Are New or Worsened**

Dr. Laura Smith: Moving on to the second measure we'll be discussing today, Percent – and this is slide 33 – Percent of Patients or Residents with Pressure Ulcers That Are New or Worsened. I will give you a similar review and the measure purpose and calculation.

Slide 34. This QM is adopted as a cross-setting measure to meet the requirements of the IMPACT Act of 2014 addressing the domain of skin integrity and changes in skin integrity. This measure is intended to encourage PAC providers to prevent pressure ulcer development or worsening and to closely monitor and appropriately treat existing ulcers.

Slide 35 gives an overview of the construction of the SNF QRP pressure ulcer measure, which also takes the form of a proportion with a numerator and a denominator. The numerator is the number of residents with an MDS 3.0 assessment indicating one or more Stage 2, 3, or 4 pressure ulcers that are new or worsened since admission to the facility. The denominator for this measure is the number of residents with one or more MDS 3.0 assessments that are eligible for a look-back scan, except for those with exclusions.

Slide 36. We determine whether there is a new or worsened pressure ulcer based on an examination of all assessments in a resident's episode for reports of Stage 2, 3, or 4 pressure ulcers that were not present or were at a lesser stage on admission.

The cases that are excluded are excluded for the following reasons shown on slide 37. Cases are excluded if data is missing on items to calculate the measure and if there is no initial assessment available to derive data for risk adjustment. I'll talk in more detail about risk adjustment over the next few slides.

Risk adjustment is used to account for variation from facility to facility and the medical and functional complexity of SNFs' resident populations. This is in recognition that some residents may be at higher risk than others for poor outcomes due to their clinical status independent from the quality of care provided by the facility. Risk adjustment is based on resident characteristics. These resident characteristics, which we call covariates when they are used in risk adjustment, were selected because they are known to put residents at increased risk for skin breakdown or to impact the ability to heal.

There are four resident characteristics, or covariates, for this measure, which we have listed here on slide 39. They are the following: limited or more assistance in bed mobility self-performance as indicated on the initial assessment; bowel incontinence, at least occasionally, as indicated on the initial assessment; the initial assessment indicates that the resident has diabetes or peripheral vascular disease or low BMI as indicated on the initial assessment.

## **Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function**

Dr. Laura Smith: The last measure I'm going to talk about today, starting with slide 40, is the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function. This is an NQF-endorsed Long-Term Care Hospital measure that has been modified for application to the SNF's Medicare Part A stay population. Therefore, you are again seeing that phrase "Application of" in the title of an SNF QRP measure.

Slide 41. CMS has adopted this measure to satisfy the IMPACT Act requirements for CMS to specify QMs and PAC providers to report standardized data regarding functional status, cognitive function, and changes in function and cognitive function. This QM reports the percent of residents with an admission and a discharge functional assessment and at least one goal that addresses function.

Slide 42. Similar to our discussion of the first two measures in this presentation, this slide gives an overview of the construction of the measure, which also takes the form of a proportion with a numerator and a denominator. The numerator for this measure is the number of Medicare Part A covered resident stays with a – with functional assessment data for each self-care and mobility activity and at least one self-care or mobility goal. The denominator of the measure is the number of Medicare Part A stays ending during the same time period as the numerator.

Slide 43. For this measure, the design recognizes that when a resident has what we're calling an incomplete stay, collection of discharge functional status data might not be feasible. And I'll go into more detail about what we mean by incomplete stay on the next slide. But in the meantime, for residents with incomplete stays, admission functional status data and at least one treatment goal is required, but discharge functional status data would not be required to be reported.

On slide 44, specifically, we define residents who have incomplete stays as those residents with incomplete stays due to a medical emergency, residents who leave the SNF against medical advice, or residents who die while in the SNF. Otherwise, all residents' Medicare Part A stays ending during the measure period not meeting the criteria for incomplete stays will be considered complete stays.

This measure is not risk-adjusted.

In the next series of slides, starting with slide 46, I'm going to walk through a high-level discussion of the new Section GG items. Please note that there are multiple useful resources available for folks to get additional detail regarding coding, as well as regarding the construction of this measure. Please refer to the [draft RAI Manual Version 1.14](#), which is in the Related Links section of the CMS [MDS 3.0 RAI Manual](#) webpage where – and then, there are also more detailed slides, which I mentioned

earlier in my presentation, which are from the SNF QRP training, that are posted on the CMS [SNF QRP](#) webpage.

The IMPACT Act requires that CMS implement cross-setting quality measures, and the Section GG items, which are used to calculate this measure, were developed and tested for use in post-acute care settings, specifically, Skilled Nursing Facilities, Inpatient Rehab Facilities, Long-Term Care Hospitals, and Home Health Agencies. These items assess the need for assistance with self-care and mobility items, and they focus on a resident's self-care and mobility. They capture resident admission performance, resident discharge goal, and resident's performance at discharge.

Slide 47 displays the brief rationale for the – of self-care mobility items included in Section GG. During a Medicare Part A stay, residents may have self-care or mobility limitations on admission that are important to capture. In addition, residents may be at risk of further functional decline during their stay in the SNF. And the GG items allow us to capture that information.

On slides 48 and 49, we have included screenshots of the self-care admission and discharge Section GG items. Slide 48 shows the items found on the 5-day PPS assessment for self-care, which includes three activities—eating, oral hygiene, and toileting hygiene. Briefly, eating is defined as the ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table or tray. Oral hygiene is defined as the ability to use suitable items to clean teeth. Toilet hygiene is the ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. And, as I mentioned earlier, there – you can find more detail about these items in the [RAI Version 1.14 Manual](#).

Clinicians are requested to complete codes for the resident's usual performance at admission for these three activities using a 6-point scale, as well as a goal for these three activities at discharge using the same 6-point scale. I will give an overview of the 6-point scale used for these items in a few slides.

The discharge self-care items are shown on slide 49, where you see that only the resident's usual performance at the end of the PPS stay is requested, whereas on admission, both the admission performance and the goals were requested.

Slide 50 shows the 6-point scale that should be used for completing the GG0130 self-care items. As mentioned previously, clinicians are requested to code the resident's usual performance. GG items use a 6-point scale along with three additional codes for when an activity was not attempted. Note that the GG items use a lower score to indicate more dependence. You can see here that code 1 equals dependent. And then, logically, higher scores indicate more independence. So, 6, which is the highest code possible, indicates the resident is independent for the activity. The – other coding levels are as follows:

This document has been edited for spelling and punctuation errors.

- Five indicates setup or cleanup assistance, which is that the helper sets up or cleans up and the resident completes the activity. In other words, the helper assists only prior to or following the activity.
- Code 4 indicates supervision or touching assistance was needed, where the helper provides verbal cues or touching or steadying assistance as the resident completes the activity.
- Code 3 indicates partial or moderate assistance is provided, which indicates that the helper does less than half of the effort.
- Code 2 indicates substantial or maximal assistance, meaning the helper does more than half of the effort.
- And, lastly, as mentioned earlier, 1 indicates that the resident was dependent for the activity. In other words, the helper does all of the effort or the assistance of two or more helpers is required for the resident to complete the activity.

If an activity was not attempted, there are three additional codes to indicate the reason that it wasn't. These are:

- 7, which indicates the resident refused;
- 9, which indicates that the activity was not applicable; and
- 88, which indicates that the activity was not attempted due to a medical condition or safety concern.

Regarding coding for the discharge goal, which is requested on the 5-day assessment, we have included some coding tips on slide 51:

- Clinicians should use the 6-point scale to code the resident's discharge goals. So, please do not use codes 7, 9, or 88, which, you'll recall from the last slide, are the reasons why an activity was not attempted.
- Licensed clinicians can establish a resident's discharge goals at the time of admission based on discussions with the resident and family, professional judgment, and the professional's standard of practice. Goals should be established as part of the resident's care plan.
- Clinicians may goal – clinicians may code one goal for each self-care and mobility item included in Section GG at the time of the 5-day PPS assessment.

- A minimum of one self-care or mobility goal must be coded per resident stay on the 5-day PPS assessment to meet the requirements as a measure numerator.

Slides 52 and 53 show the admission and discharge mobility items. Similar to the self-care items, on the 5-day PPS assessment, there are items for scoring a resident's admission activity performance and a resident's discharge goals for those activities. Mobility items include performance on:

- B—the ability to move from sitting on the side of the bed to lying flat on the bed,
- C—the ability to safely move from lying on the back to sitting on the side of the bed,
- D—the ability to safely come to a standing position from sitting in a chair or side of the bed,
- E—the ability to safely transfer to and from a bed to a chair or a wheelchair, and
- F—toilet transfer.

There are additional items regarding residents' ability and goals with regard to walking or wheeling. Which items are completed are dependent on the response to item H1, which asks clinicians to report whether a resident walks. If a resident does not walk at admission and a walking goal is not clinically indicated, clinicians are asked to complete item Q1, which asks whether a resident uses a wheelchair or scooter. If a resident does use a wheelchair or scooter, the clinician is asked to complete items R and S, which request information on resident performance, wheeling activities, and what type of wheelchair or scooter is used for that activity. If the resident does not walk at admission and a walking goal is clinically indicated, clinicians are asked to complete the discharge goals for items J and K, which are walking activities. And then, they should proceed to item Q1 and, subsequently, respond to the wheeling activity items if the resident does use a wheelchair or scooter at admission. If a resident does walk at admission, then the clinician is requested to complete the walking items J and K and the additional wheeling items, if applicable.

Slide 53 shows the discharge mobility items. These will only be completed at the end of a resident's Medicare Part A stay if a standalone Part A PPS Discharge is completed or in the case where a Part A PPS Discharge is combined with an OBRA discharge and that discharge from this facility is planned, as indicated by item A0310G equaling 1. Note that no goals are requested at discharge and, therefore, the screening item regarding whether a resident walks, which is H3 on this slide, only has two responses—yes or no.



On slide 54, we show again the 6-point scale used for the Section GG item responses. Note that the scale ranges from the highest value, indicating the most independent, to the lowest, including – indicating the most dependent.

### **SNF QRP Resources**

Dr. Laura Smith: Lastly, on page 55, we are sharing some additional information for SNF QRP resources. Information about SNF QRP measures and requirements, as well as updates, announcements, training materials, fact sheets, and other resources, are available on the link to the [SNF QRP](#) webpage. Please also make note of the address for the SNF QRP Help Desk, which is available for general questions about the SNF QRP reporting requirements, deadlines, and SNF QRP QMs. And I'll read out that address in case you don't have the slides in front of you. The address is SNFQualityQuestions—that's all one word, no spaces—at cms.hhs.gov. I will say that one more time, which is [snfqualityquestions@cms.hhs.gov](mailto:snfqualityquestions@cms.hhs.gov).

This concludes the segment of the presentation on the SNF QRP QMs. Thank you so much for your attention, and I'll hand the floor back over to Sharon Lash.

### **Question-and-Answer Session**

Sharon Lash: Hi. Thank you, Laura. That was very interesting and very helpful. I just wanted to reinforce the SNF quality question help desk – we are – it is being responded to now, and we encourage you to use that for any additional questions.

I'm going to just talk about a little bit of the upcoming activities. We do anticipate more training opportunities in September with another National Provider Call that will be in a webcast format, so you will be able to follow along with the – with the slide presentation. And that will be sometime in mid-September. I don't have a firm date yet. But Leah will keep everybody apprised of the dates with her email blasts and other LISTSERV® activities.

Now I'm going to go and address some of the most commonly asked questions that we received prior to this training. And, you know, one of the most common questions we're getting—and this is including in the help desk—is that – are swing beds subject to the SNF quality reporting requirements?

And I just want to say for the record that, according to the fiscal year 2016 SNF PPS final rule, Critical Access Hospitals with swing beds are not required to submit quality data under the SNF QRP. However, non-Critical Access Hospital swing beds are subject to SNF QRP requirements. And for more information about the requirements for swing bed providers, please visit the website under the [Medicare fee-for-service payment SNF PPS swing bed](#). And we can – I will be – we will be publishing a fact sheet on the SNF QRP in the next few days. And that link is included on this – on that fact sheet. So having said that, that's one of the most common questions that we received.

Will the payment system be affected in any way for Skilled Nursing Facilities? Is there any effect on consolidated billing and/or the 100-day stay?

And all I want to say is that we are not attaching any, you know, additional requirements other than the 2-percent annual payment update determination based on the quality reporting. So, if you are compliant with the quality reporting of the measures that we are collecting, you will receive your 2-percent annual payment update, and none of the other 100-day stay consolidated billing issues are affected.

One writer asked, “Who should most likely be responsible for reporting the quality measures, for example, nursing, billing, or accounting?”

And we would just respond that whoever is normally collecting your MDS data would just continue to do so. We don’t proscribe who should complete your MDS item sets for the quality reporting programs. So, I would, you know, just urge you to follow your facility’s policies and transmission requirements for the MDS.

And I think that’s – that pretty much covers the most commonly asked questions. I hope that we have helped you understand the requirements of the SNF QRP. And like Laura said, I want to reinforce, if you go to the SNF QRP webpage, under the Nursing Home Quality Initiative, please look for the provider training slides that were presented in the June onsite provider training in Atlanta. There is more information there, and we urge you to access that at your convenience.

OK, Leah. That’s all I have. Over to you.

Leah Nguyen: Thank you, Sharon. Our experts will now take your questions. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your question to just one. If you would like to ask a followup question or have more than one question, you may press star 1 to get back into the queue, and we’ll address additional questions as time permits.

All right, Ronni. Ready to take our first question.

**Operator:** To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to ensure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Melody Malone.

Melody Malone: This is Melody Malone with TMF Health Quality Institute. I know that the final RAI Manual is due out September of 2016. Will there be video training, and will it be posted on the MDS 3.0 training site for the new Section GG and the other new pieces to the MDS?

Sharon Lash: Laura, I – may I pass that to you?

Dr. Laura Smith: Sure. I know that we have developed a video training. We have Anne Deutsch on the line, who may be able to at least speak generally about that. I'm not sure what the plans are in terms of when that would be posted. Anne, can I impose on you?

Dr. Anne Deutsch: Sure. So, yes, indeed, there is a video. And I'm not sure the timeframe for when that'll be posted or location. But certainly, it would be announced on the [SNF QRP](#) website.

Leah Nguyen: Thank you.

Melody Malone: Thank you.

**Operator:** Your next question comes from the line of Diana Chavis.

Diana Chavis: Hi. This is Diana Chavis with Palmetto Health Baptist Subacute Rehab Unit. And I had a question about short stay residents and where you combine the admission and discharge assessments for those that stay from, you know, 5 or 7 days and in regards to the functional assessments and how that's going to be measured on those patients?

Sharon Lash: This is Sharon, and I would like our – my colleagues from Research Triangle Institute to address that, please.

Dr. Anne Deutsch: So, this is Anne. So, I'm happy to address that. So, for this quality measure, as Laura mentioned, it is really just documenting that a functional assessment was conducted at the time of admission and discharge and that there is at least one goal documented at the time of admission. The timeframe for the admission assessment is 3 calendar days, and the timeframe for the discharge assessment is also 3 calendar days. So even though I know the assessment is actually called a 5-day, the assessment timeframe is only 3 days. So, if a patient – resident is admitted, you know, on, let's say, a Monday, the assessment would need to be conducted for admission between the Monday, Tuesday, Wednesday. And if they were – that individual was discharged the next Monday, the discharge assessment would be Saturday, Sunday, or Monday for the timeframe.

Diana Chavis: So there will be no more combining admission and discharge for short stay residents?

Dr. Anne Deutsch: Can you clarify what you mean by that?

Dr. Laura Smith: I – Anne, I think I can actually...

Dr. Anne Deutsch: OK, great.

Dr. Laura Smith: ...answer that.

Dr. Laura Smith: So, it's not that there will be no combining; it's that there would be the expectation that GG170 and GG130 for the discharge – so, the discharge versions of the GG items would be completed as long as there's been a gap in time, between the start of the Part A stay and the end of the Part A stay, that is, more than 2 days. So you wouldn't – it's just that you – so we will have some instances where a combined – when we will be looking for discharge responses for a combined assessment. But, there may be some cases, when the stay is very short and the skip pattern is set up for the discharge items, where you would not complete the discharge items that they're – if you pick the difference between A2400C and A2400B and that difference is 2 or less, you would not complete the discharge items.

Leah Nguyen: Thank you.

Dr. Laura Smith: You're welcome.

Diana Chavis: OK. Thank you. That answers my question.

**Operator:** Your next question comes from the line of Nancy Fredrich.

Nancy Fredrich: This is Nancy Fredrich, and I'm with Cooper County Memorial Hospital in Boonville, Missouri. And we have – we're IPPS, and we have a swing bed. And my question is just clarification. As I'm listening to this, there will not be any extra work needed to gather data for these quality measures, because they will all be required measures on the MDS of each of the patients. Am I hearing that correctly?

Sharon Lash: The Quality Reporting Program assessment items that are included in this program are all on the MDS. There are additional items now being added in the form of the discharge – Part A discharge assessment and Section GG. So that is the additional work that may be encountered – that you will encounter on the MDS. But in addition to that, you know, I might add that you may want to check the status of your quality reporting via the measures. So you will – there will be review reports and correct reports, and they will be available next year because you do have a 4½-months review

and correct period. So you would be accessing CASPER, you know, the QIES-based app system, to look at your reports. But those – that is the extent of the additional work that you would – you know, that is entailed in your – in monitoring your compliance and being compliant with the Quality Reporting Program.

Leah Nguyen: Thank you.

**Operator:** Your next question comes from the line of Dane Meyer.

Dane Meyer: Good afternoon. Thank you for the presentation. My name's Dane Meyer, and I am a research nurse with the Optimistic Project, which is a pilot project out of Indianapolis. My question was on the risk adjustment covariates. You mentioned an important item regarding classification on decubitus ulcers. And the reason I am inquiring about this is there are those occasions where we find that the Skilled Nursing Facility estimation and the numeration of decubitus ulcers varies from the hospital. Will the reporting information be taken solely off the MDS at the nursing facility, or will they also include that hospital notation?

Sharon Lash: My colleagues at RTI will field that question.

Dr. Laura Smith: Sure. So, this measure is based solely on the MDS. So we would – the IPPS would not be factored in. But we appreciate your insight into that, though.

Dane Meyer: All right. Thank you.

Leah Nguyen: Thank you.

**Operator:** Your next question comes from the line of Kelly Brown.

Kelly Brown: Hi. I am calling from Beaumont Health in Michigan. From slide 8 for the quality domain communicating the existence and providing for the transfer of health information and care preferences, I'm just curious to know, how do the – how should the SNFs prepare for this measure – or for this domain, and how will the data for this measure be collected?

Sharon Lash: At this time, we are investigating that ourselves. We are not, you know, planning any requirements on the part of the provider to – you know, beyond the MDS information, realizing that the Skilled Nursing Facility provider community is very diverse in terms of the technologies that are – that they use. So – but that is – you know, in the ideal state, is that we would like interoperability of data across the PAC care providers. But, really, what – you know, we have to start at our – you know, from our end is standardizing our data first. So, that's where we're going to start. But I – you know, right now, I couldn't really say that I could recommend how you can start to plan for that, except to say that, you know, we are – we know that the shift to electronic records is

happening across all provider settings and, you know, for any provider, it's something to bear in mind. That's all I have to say. Thank you.

Leah Nguyen: Thank you.

**Operator:** Your next question comes from the line of Appalena Udell.

Appalena Udell: Hi, good afternoon. My name is Appalena Udell. I'm a health lawyer in physician representation in California, Colorado, and Washington. First, I just want to say thank you so much. This call has been exceptionally helpful. And I'm wondering if you know when the notice of fiscal year 2018 compliance will be issued and, specifically, whether or not that will be before or after the FY '16/'17 deadline?

Sharon Lash: Yes. It should be – as proposed, we – it's 30 days prior to the fiscal year – so, beginning fiscal year. So it would be giving us enough time to calculate all of the data, do our reconsiderations, you know – I mean, you know, corrections. And then the APU determination is done, I believe – and, RTI, you can correct me – but it is 30 days prior to that fiscal year beginning. Is that right?

Dr. Laura Smith: Anne, do you know the answer to that? I'm afraid that...

Dr. Anne Deutsch: No. Sorry.

Sharon Lash: Hi. Thank you for that question. Please send that to our help desk box, and we can compile a formal response for you. That is the...

Dr. Laura Smith: It's on slide 55.

Sharon Lash: Slide 55. Thank you.

Leah Nguyen: Thank you.

**Operator:** Your next question comes from the line of Marilyn Washington.

Marilyn Washington: Hi. This is Marilyn from Bio-Pacific Therapy. I am just calling to find out regarding GG and the training for it. We're kind of discussing it with our MDS as to who might be responsible. A lot of it is very specific, of course, going in the wheelchair and/or ambulating and turning. And for patients who are not on therapy, therapy will not have any idea of that. So, is there a plan or a recommendation as to who should be responsible for that, therapy or the nursing with the TNAs?

Sharon Lash: This is Sharon. Thank you for that question. I would like my colleagues from Research Triangle Institute to provide an answer for you there.

Dr. Anne Deutsch: Sure. So, this is Anne. So, certainly, physical therapists, occupational therapists, speech language pathologists, and nurses are the typical staff involved in the assessment of self-care and mobility items. If the patient – resident is not seen by a therapist, certainly, nurses can do the assessment. I do want to mention that you need to follow the Federal – well, the facility as well as Federal/State policies in terms of which staff members can actually perform an assessment because this is an assessment. And, so, it needs to be in compliance with facility, Federal, and State requirements.

Marilyn Washington: OK. Thank you.

**Operator:** Your next question comes from the line of Joe Seal.

Joe Seal: Hi. Thank you. Could you please tell me if the status of a patient as being hospice, either upon admission or during their stay, would change any of the reporting requirements?

Sharon Lash: This is Sharon from CMS. And I believe, no – the answer is no. It – as long as a resident is on a PPS Part A Skilled Nursing Facility stay, those quality measures would be collected as – you know, as you do with the MDS items.

Joe Seal: Thank you.

Leah Nguyen: Thank you.

**Operator:** Your next question comes from the line of Dona Hewitt.

Dona Hewitt: Hi, there. Thanks for taking my question. I'm calling from Telemedicine Solutions in Illinois. This is kind of a followup to the question just asked. We run section – we work on sections and reports for our IRF, LTCH, and SNF clients. And I have noticed that, with the most recent releases for the IRF and the LTCH, they no longer have to report as pressure ulcers or Kennedy ulcers. They have a definition in the manual, and they say they don't have to be coded on the quality report. And I'm wondering if you foresee that coming down the pike for SNF. And as a followup, do you see any of the NPUAP changes coming in October or not?

Sharon Lash: Thank you for that question. I'd like to direct that over to RTI for their response. Thank you.

Dr. Laura Smith: So, I'm only going to be able to give you sort of a partial answer. So, I would recommend, if you don't mind, going ahead and sending in your question to the [helpdesk email](#), which was referenced earlier on page 55. I'm not aware of what's in the works related to the Kennedy ulcers. I can – related to the NPUAP changes, I can just assure you that we are aware of those. But again, that's something, I think, that we

would need to sort of take a little bit of time on giving you a more complete response on that.

Dona Hewitt: OK. Thank you.

**Operator:** Your next question comes from the line of Melody Malone.

Melody Malone: Yes. On page 30, the measure specification for falls with a major injury—can you please help me understand again why that’s called long stay since all the other long stay quality measures deal with someone who’s had days in facility—101 days or more—which is not really the definition of Part A?

Sharon Lash: Hi. Thank you for that question. And I – this is Sharon from CMS. And I had trouble to comprehend that myself when I first came to DCPAC. So I’m going to address this back to Laura, who was describing what an application of a measure really implies, and help kind of demystify that for you. Over to you, Laura.

Dr. Laura Smith: Sure. Happy to do it. Yes, it’s an understandable question. So, basically, the reason why this is called an Application of Percent of Residents, etc., Long Stay is because of the existence of that NQF-endorsed Long Stay measure. What is being collected and reported on for the SNF QRP is basically a modification of that Long Stay measure to apply to the Medicare Part A stay. And so, we are still using – we still reference that NQF-endorsed measure title, which is the Long Stay measure. But then, we’re referring to it for the SNF QRP as an application of that specification because, basically, we’ve taken the long stay specification and respecified it to apply to the Medicare Part A stay population. So, it is a little – I agree it is a little bit awkward to have the long stay in there, but that’s why it’s included; it’s because we’re explicitly referencing that NQF-endorsed measure and saying that we have – are applying that specification to the Medicare Part A stay population for the SNF QRP. Does that help?

Melody Malone: It does. I work with quality measures all the time. I think that’s going to be a very difficult thing for everyone to get and understand. And let me do a followup question because my followup question has to do, on slide 35, with pressure ulcers. Can you explain what selected time window means in the numerator vs. the use of look-back scan?

Dr. Laura Smith: Sure. And so, that actually ends up – oh, and, Sharon, I assume you want me to keep going. This, basically, is referring to – there’re two different things being referred to here. So, that selected time window actually has to do with kind of the time period for which we’re looking for cases where there was a new or worsened pressure ulcer. So, over the past 12 months, what’s the count of cases that had a new or worsened ulcer? So that has more to do with at the population level – that 12-month window. The look-back scan is at the individual level. And so, basically, the look-back



scan is looking over the resident assessments for the – whether or not there was a new or worsened ulcer.

Leah Nguyen: Thank you.

**Operator:** Your next question comes from the line of Marilyn Washington.

Marilyn, your line is open.

Marilyn Washington: Hello. Yes. My conference – I – you had answered – I had answered and you had answered my question.

Leah Nguyen: Thank you.

Marilyn Washington: Hello. Thank you.

**Operator:** If you would like to ask a question, press star 1 on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

Your next question comes from the line of Kimberly Gimmarro.

Kimberly Gimmarro: Hi. Thank you for the call today. It's been very informative. And I have used the email on a number of these payment reform sites, and the team is very helpful. My question is for slide 29. There were a couple of alternate descriptions of the difference between the Long Stay and Short Stay measure for falls with major injury, and I wonder if those could be repeated. Slide 29.

Sharon Lash: Thank you for that question. I'll direct this over to Laura.

Dr. Laura Smith: Sure. Let's see. So, slide 29, more specifically, is talking about the unit of analysis that the measure is based on. I'll start there and, then, if that doesn't – if you want to ask me to explain further, well, I could speak more. But, starting just with the Medicare Part A stay, what I was talking about is how the units that – the unit of analysis that this measure is based on – so, what we're counting is fundamentally different than the unit of analysis or what is counted for the Long and Short Stay measures that we are currently reporting on Nursing Home Compare. And so, for the SNF QRP, we're using the Medicare Part A stay. For the Nursing Home Compare reporting—the NHQI measures—we use resident episode. And so, what I was talking about was where you – there will be situations where – there're multiple situations where that episode that's used – the thing that we count for the Nursing Home Compare is quite different – going to be quite different than the Medicare Part A stay.

So, the example I gave was if you had somebody who was admitted into the nursing home, they have a 5-day assessment completed, they get discharged with return anticipated, and then they reenter the nursing home within 30 days and have a new 5-day PPS. For the Nursing Home Compare measures, that would just be one thing to count. That would be one episode because, as people may or may not be familiar that, for the episode definitions for the NHQI measures, you can have an episode that has multiple stays in it as long as there is a return anticipated when the person is discharged. And so, a person would have gone – so, they get admitted, they get discharged with return anticipated, they come back to the same facility, and they, say, they end up getting discharged, return not anticipated. So in the Nursing Home Compare measures, that's – you're going to only count that once. With the Medicare Part A stay, if you look at that same person, they're going to have two Medicare Part A stays because at the point – so, if you look at that beginning, there's a 5-day at discharge with return anticipated. That discharge with return anticipated – if you look at the coding instructions for A2400C, basically, that is the end of the Medicare Part A stay. And so when the person reenters the facility and has a new 5-day assessment, that's the start of a new Medicare Part A stay. Did that...

Kimberly Gimmarro: That's perfect.

Leah Nguyen: Thank you.

Kimberly Gimmarro: That's exactly what I needed to hear again.

Dr. Laura Smith: Excellent.

Leah Nguyen: Ronni, we have time for one final question.

Dr. Laura Smith: Sure.

**Operator:** Your next question comes from the line of Rich McCune.

Rich McCune: Yes. I just wanted to clarify on the percent of patients or residents with pressure ulcers that are new or worsened, that seems essentially the same as the current quality measure for short stay residents. Would the only difference be that, now once the discharge assessment changes in October, you could potentially capture a short stay resident that might have something develop at the end of their stay? Thank you.

Sharon Lash: Laura?

Dr. Laura Smith: So...

Sharon Lash: I'm going to punt this to you.

Dr. Laura Smith: Yes. And so, that is correct. That was the – what the measure was finalized for the FY 2016 rule. And that is correct, that we will basically have that additional data point for – coming from the Part A discharge. I will say that we know that that’s not necessarily aligned with the IRF and LTCH admission and discharge assessments. So that – but that is what – how it was finalized for the rule. Yes. So, that’s pretty much the same as the Short Stay measure.

Rich McCune: And just as a quick followup, the – unlike the other two measures, even in your printed slides, it doesn’t specifically say Medicare Part A residents only. So, it would capture all short stay residents. Is that correct?

Dr. Laura Smith: I – if you don’t mind, if you could send this query to the help desk, we will get you a more complete answer.

## Additional Information

Leah Nguyen: Thank you. Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can [email](#) it to the address listed on slide 55 of the presentation.

An audio recording and written transcript of today’s call will be posted to the [MLN Connects Call](#) website. We will release an announcement in the [MLN Connects Provider eNews](#) when these are available.

On slide 58 of the presentation, you will find information and a URL to evaluate your experience with today’s call. Evaluations are anonymous, confidential, and voluntary.

Again, my name is Leah Nguyen. I would like to thank our presenters and also thank you for participating in today’s MLN Connects Call on the SNF Quality Reporting Program. Have a great day, everyone.

**Operator:** This concludes today’s call. Presenters, please hold.

-END-

