

Centers for Medicare & Medicaid Services
Questions and Answers
Open Door Forum: SNF/LTC Open Door Forum
Tuesday, August 6, 2024

1. Question and comment: My suggestion to CMS is to consider finding a way, perhaps, to include additional information related to the discharge function score in relationship to the expected Discharge Function Score. I've had many questions from facilities that have been frustrated to look at their iQIES reports and other reports that really only indicates residents that trigger for that quality measure, but there is no indication for those residents that don't trigger. Why? Certainly not knowing the expected Discharge Function Score in comparison to the reported Discharge Function Score and then, the list of co-variants is extensive. It would be helpful in terms of being able to use that information as actionable data for quality improvement and facilities to have more information about that particular quality measure. And there are others as well that have an expected score I think that would be helpful to have more insight into what the reports are showing and how we can improve. So just a suggestion there for future reporting capacity from CMS.

Then I had a question related to Value-Based Purchasing and the policy that has been finalized now in relationship to the corrections to baseline year data if the technical specifications have been updated in a future performance year. In the final rule, CMS indicated, "We don't believe that it is fair or appropriate to calculate performance period measures resulting using the updated measure specifications and then compare those results to the performance standards and baseline period measure results that were calculated using the previous measure specifications to generate the achievement and improvement score." So, the "apples to apples" comparison is a good thing.

My question is, for the Total Staff Per Resident Per Day quality measure coming up for FY2026, as we know we have a performance year that is 2024 and the staffing numbers with a five-star rating and everything currently, with those updates are acuity adjusted with the PDPM Nursing CMI (Case Mix Index) in the baseline year 2022 for that quality measure they were acuity adjusted with RUG (Resource Utilization Groups) scores and STRIVE (Staff Time and Resource Intensity Verification) data. My question is, will CMS apply this policy to this particular quality measure as it applies to the upcoming 2026 implementation into Value-Based Purchasing?

- A. Answer: I believe I can say keep an eye on your inboxes. We are anticipating having further news on this measure and approach very soon.
2. Question: We wanted to receive some clarification regarding IV antibiotics that are given after a dialysis session when its indication is completely unrelated to End-Stage Renal Diagnosis (ESRD), and if the administration should be coded under 0110-H1 (IV Medications While a Resident). It's my understanding that the reason why it is administered after the dialysis has to do with not having additional lines, and according to

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the ESRD PPS (End-Stage Renal Disease Prospective Payment System) consolidated billing, you know, the SNF is responsible for the cost of these medications, and I wanted to confirm if it could be coded as “IV administered while a resident.”

- a. Answer: The response we provided is if you have IV medications that are furnished outside of the ESRD treatment and it is something that is not being covered under the ESRD payment, and it is something that is meeting the various criteria that we outline on Page 0-6 of the MDS manual, then that is something that can be captured in the 0110-H1B, I think it is.
3. Question: My question is in regard to the quality measures that will unfreeze come January, and the January report should include Quarter 4 data for the calculation of the four-quarter average. However, the quality measure when we run the reports for Quarter 4 right now just to see the percentages and the patients that are flagging. Because it took two assessments for comparison, many patients didn't have a second assessment until Quarter 1. So, the denominators are very low and potentially nonexistent. I've got facilities that are showing no data or facilities that had one patient in the denominator, and that patient did have a decline, so they are at 100% for decline in ADLs (Activities of Daily Living) or Locomotion. My question is because of the Quarter 4 data not being, in my opinion, usable because of the caveats to those calculations of those ADL quality measures, do you know if you plan to use only a three-quarter average and throw out Quarter 4? Will there be adjustments made for those Quarter 4 data, since the fluctuation of that percentage could be extremely high, low, or no available data because of the way it calculates? Can you give any insight into what we can expect about when those unfreeze in January based on the Quarter 4 data?
 - a. Answer: It is anticipated that the data for 2023 Q4 will be used with the new ADL measure (and locomotion measure) when they are calculated in January 2025. The four-quarter average for each measure is calculated as a weighted average using the following formula:

$$QM_{4Quarter} = [(QM_{Q1} * D_{Q1}) + (QM_{Q2} * D_{Q2}) + (QM_{Q3} * D_{Q3}) + (QM_{Q4} * D_{Q4})] / (D_{Q1} + D_{Q2} + D_{Q3} + D_{Q4})$$

Where QM_{Q1} , QM_{Q2} , QM_{Q3} , and QM_{Q4} correspond to the adjusted QM values for the four most recent quarters and D_{Q1} , D_{Q2} , D_{Q3} and D_{Q4} are the denominators (number of eligible residents for the particular QM) for the same four quarters.

Having a small denominator for 2023 Q4 with the new ADL or locomotion measures will not be unique to an individual facility, and since the four-quarter calculation is weighted by the denominator in each quarter, having a small denominator in Q4 (with high or low performance) will not have a significant impact on the facility's full measure. CMS will continue to evaluate the data prior to the January 2025 refresh.

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4. Question: In chapter 6 of the Medicare Processing Manual, it discusses rules related to the VA (Veteran Affairs) Community Nursing Home Fee Schedule as it relates to PDPM billing. We've reached out to all of the resources available on their website for clarifications on some billing questions and have yet to get clarification. Is there someone at your office that we could contact to help us get those answers?
 - a. Answer: You would need to be contacting someone at the VA. We are not able to speak to policies that lie outside of Medicare.
5. Question: My question pertains to the quality measures unfreezing, and will we be able to find out ahead of time what the new cut points will be for the new quality measures? Or will we have to wait until you have made the reports public?
 - a. Answer: An updated Nursing Home Care Compare Technical Users' Guide with the new cut points will be released ahead of time. We don't have a specific date yet, but it will be before the new measures are posted.
6. Question: I have a question about some of the exclusions for the Discharge Function Score Measure, and the discharge, mobility, and self-care. I did submit this to the QRP helpdesk, but I have a follow-up question to it. So, one of the exclusions is "resident discharge to hospice or received hospice services while resident," and obviously the way to indicate discharge to hospice is a 2105 discharge status. Unfortunately, a 2105 is not on the NP discharge assessments. So, when I submitted this to the QRP helpdesk, they said that the only way that hospice would be an exclusion is if the patient is physically discharged to the facility from hospice, but 99% of the time when a resident is transferred from Medicare A to hospice, they do remain in the facility. So, my question is, on the NPE (National Provider Enrollment), are we allowed to code 001100K1B, which is "hospice while a resident," on the NPE if the patient is being discharged to hospice the next day, because that would be the only way to capture the exclusion.
 - a. Answer: If no hospice services were provided during the time 001100K1B is not coded on the NPE. I do have your question, and I will be responding to you in writing on the other ones as well.
7. Question: I just was wondering if there's been any consideration for the QRP data elements when we have an unplanned discharge, PPS discharge. The elements are needed when Part A PPS Discharge A0310H equals 1. However, it doesn't reference anything about that being unplanned, and I know that a lot of our facilities have had issue gathering that data when someone goes out, say in the middle of the night or you know, just unexpectedly during the day if they are acutely needing to be transferred to the hospital. So, is there going to be any consideration of maybe taking those data elements away when there is an unplanned discharge? Or is that going to continue to count against us in the 90% threshold?
 - a. Answer: CMS has considered which items are required on a stand-alone unplanned discharge. The items required to be completed for a specific assessment depends on the type of assessment being completed, specifically A0310, which determines the ISC. The impact on QRP requirements depends on the assessment type, specifically A0310B, A0310F, A0310G and A0310H.

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When a discharge assessment is a stand-alone and is unplanned (A0310B=99, A0310F=10 or 11, A0310G=2, A0310H=1), then certain items are skipped, such as the interview items. However, when a discharge assessment is combined with another assessment, some items will not be skipped and are expected to be coded due to the requirements related to the other assessment type. For example, when a discharge assessment is combined with the 5-day PPS assessment (A0310B=01, A0301F=10 or 11, A0310G=2, A0310H=1), interview items are required as part of the PPS 5-day assessment.

Should you have further questions related to the SNF QRP, please contact SNFQualityQuestions@cms.hhs.gov

8. Question: I just want to make sure I understand the response that was given related to the IV medication question that came up earlier. Maybe I misunderstood the question, but the instructions on page 0-6 indicate do not include IV admissions that were administered during dialysis. Maybe I misunderstood the question.
 - a. Answer: Right. So, this is not in reference to IV medications provided during dialysis. They are provided after dialysis.
9. Question: I need a clarification. We have one of our facilities that low stars related to the schizophrenia audit. I asked multiple questions to the email that CMS provided me. It's been more than a year. We immediately, at the time last year, corrected everything that came up on the report. So, it's now been a full year, and our star report is still showing our QMs (quality measures) that were degraded to a one. I need to get in touch with someone who can look at this. We were told it would be for a year. It's now over a year, our QMs are still a one. I reached out to all of the mailboxes and emails sent to me. I get the same answers. We have to look at it, revise it, and review it, and see if you actually made corrections. This was done already last year. So, who is responsible to look at this and give us back our—we were a five-star facility in QMs, and we now became a one, so we lost two stars.
 - a. Answer: We still do monitor facilities' data after audits, and we will at times do a reaudit to ensure that the facility has corrected what was identified during the audit. I'm not sure the status of your particular facility, but it is not automatically reversed based on a time frame. We monitor the data to make sure that we see the changes that we expect based on the findings from the original audit.
10. Question: I have a question in regards to the staffing star. If we have a facility that we believe the census is in error that calculated our staffing star, how do we go about appealing that? We had a situation where some discharges were completed on the 15th of May—all submitted, all accepted, but the staffing star was calculated with a census that's like 20 more than what was actually there, and 10 more than that, the facility would actually even hold, that has the capacity for.

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- a. Answer: I'll mention that we calculate your census based on the MDS assessments that are submitted, and what we basically do is look for admission assessments and count up everyone that has an admission assessment who does not have a discharge assessment, and we do that for every day, and that then is your daily census. So, the census that we calculate is exclusively based off of adherence to the MDS timelines. If there is something specific or different that happened in your situation, we would be happy to take a look at it. Email NHStaffing@cms.hhs.gov and you can mention that you brought this up on the SNF ODF.
- 11. Question: My question is related to the five-star measures. I want to know if the calculation of overall five stars is a linear or an overall calculation. So, for example, a facility is one star for health inspection and one star for staffing and five star for quality measures. Will that one star for staffing negate the five star for quality measures, or will it make the facility go up to five stars? The same question would be if they are a one-star for health inspection, five-star for staffing, and one-star for quality measures, will it go the other way?
 - a. Answer: I'm going to post a link to the Five-Star Technical Users' Guide which describes the exact methodology used to calculate your star ratings. I going to post the web page, and it is in the download section of this web page. It goes in order of steps. Starts with the inspection rating, then goes to staffing rating and then goes to quality measure rating.
- 12. Question: With concerning the census and when that calculation is done. Is it done by all MDSes as far as discharge MDSes, etc. by the end of the last day of the quarter? Or is it based on the same time frame as when the staffing data is submitted? Since obviously residents could be discharged within the last couple of days of the quarter but the MDSes would not be submitted until completed which could be up to 14 days after the actual discharge date.
 - a. Answer: We do use a lag to allow for enough time for the MDS data to be submitted, and it is more than enough time. I believe it is either 120 or 150 days we may use. But the specifications for this are in that same Five-Star Technical Users' Guide. That's the link that's downloadable on the page.
- 13. Question: Regarding penalties and CMS' changes to the, you know, enforcements. I know it was mentioned about the previously cited deficiencies. I am just trying to clarify or expand on previously cited—would that be at harm levels? Is that for any previously cited deficiencies? What would that encompass?
 - a. Answer: It is for deficiencies that still meet the enforcement policies for...that are in Chapter 7 of the State Operations Manual. So, these are situations where a deficiency met our enforcement policies but due to the timing of surveys and timings of different surveys, enforcement was not imposed but normally would have been. So, it's the same types of deficiencies that would normally get enforcement but in this case, didn't.
- 14. Question: I heard all of these things about the schizophrenia audits, and it raised a question that might have come across on that topic. So, the result of the schizophrenia

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audit if the provider doesn't pass or admits that they were in error is that there is a suppression for a period of time of their quality measure for anti-psychotics, and that was mentioned earlier in terms of when that gets lifted, but my question is different. What I have seen in the CMS data tables, the QM one that is published quarterly, is that once that suppression happens, it goes backward before the audit was conducted for several quarters. I have not figured out exactly how many on average it goes back, but it goes back, and while that may not affect star ratings going forward, we in Ohio—I'm from Ohio—we use the anti-psychotic measure as one of our, one of our quality measures for Medicaid purposes for reimbursement, and that sort of retroactive suppression of data can be, can be very harmful in that context. So, I was just curious why that, why that happens and why the suppression isn't prospective from the time of the audit.

- a. Answer: I don't think we have the capacity to apply a retrospective suppression. When the data comes in, we calculate ratings, we post those ratings, calculate measures, post those measures, calculate the ratings. And then it is at a later—usually at a later point in time when we conduct an audit. The findings of those audits are collected and then the following month that the findings from an audit, from failure or attestation, are applied. So, I would love to see some examples of that and would be happy to take a look at it.

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