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Presenter:

- Theresa Lang, RN, BSN, WCC
  - Vice President Clinical Consulting
  - SMS for 21 years
  - Over 40 years LTC experience
  - Areas of Expertise
    - AHIMA Approved ICD-10 Trainer
    - Clinical Operations and Training
    - Medicare
    - MDS
    - Wound Care

theresa.lang@specializedmed.com
One thing in common? What is it?

Quality
- Quality Reporting
  - Medicare Part A FFS
- QM used for 5 Star
  - All residents
    - MDS 4 quarters 4th-2015 and 1/2/3 of 2016
    - Claims based data for 3 measures
      - 1/1/15- 12/31/15
- QM used for Survey: CASPER
  - All residents
- QM used for Value Based Purchasing
  - Only Medicare FFS residents

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NNHQCC Quality Composite Measure Score
- The NNHQCC Quality Composite Measure Score is calculated by dividing the sum of the numerators and the sum of the denominators for all 13 long-stay quality measures and multiplying by 100.
  - For influenza and pneumococcal vaccinations, the measures are reversed so that the numerators for all measures represent missed opportunities for vaccination.
  - A lower Composite Score is better and the NNHQCC goal is to achieve a composite at or below 6.00.

NNHQCC Quality Composite Measure Score
- It is important to pay attention to high percentages, as these are the measures that will be driving your Composite Score higher (not desirable), while measures with low percentages will be the ones that are driving your Composite Score lower (desirable).
- Source: CMS 11SOW Nursing Home Collaborative Composite Data
- 1NQF: National Quality Forum

Quality Confusion
- The steps in calculating the measures are different
  - Included assessments
  - Excluded assessment
  - Time frames
- This is why reports can not always be compared to each other
- The following reports all ran on 4/17/17
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SNF Quality Reporting Program (QRP)

- The IMPACT Act of 2014 mandated the establishment of the SNF QRP.
- As finalized in the FY 2016 SNF PPS final rule, beginning with FY 2018 and each subsequent FY, the Secretary shall reduce the market basket update (also known as the Annual Payment Update, or APU) by 2 percentage points for any SNF that does not comply with the quality data submission requirements with respect to that FY.
Quality Measures Crosswalk

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>New Quality Measures*</th>
<th>Casper Reports</th>
<th>Nursing Home Compare</th>
<th>Five-Star QM Rating</th>
<th>Composite Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Frame</td>
<td></td>
<td>6 month national comparison Facility can control dates</td>
<td></td>
<td>Scores are calculated monthly by the QIN-QIO, with each reporting month representing a rolling six-month time period.</td>
<td></td>
</tr>
</tbody>
</table>

### Short Stay Quality Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Quality Measure Crosswalk</th>
<th>Casper Reports</th>
<th>Nursing Home Compare</th>
<th>Five-Star QM Rating</th>
<th>Composite Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Report Moderate to Severe Pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New or Worsened Pressure Ulcers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessed and Appropriately Given the Seasonal Influenza Vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessed and Appropriately Given the Pneumococcal Vaccine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newly Received Antipsychotic Medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residents Who Made Improvements in Function</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residents Who Were Re-Hospitalized After a Nursing Home Admission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Claims Based</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residents Who Were Successfully Discharged to the Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Claims Based</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Copyright 2017 Specialized Medical Services, Inc.
<table>
<thead>
<tr>
<th>Long Stay Quality Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents Who Have Had An Outpatient Emergency Department Visit <em>(Claims Based)</em></td>
</tr>
<tr>
<td>One or More Falls with Major Injury</td>
</tr>
<tr>
<td>Self-Report Moderate to Severe Pain</td>
</tr>
<tr>
<td>High-Risk Residents with Pressure Ulcers</td>
</tr>
<tr>
<td>Assessed and Appropriately Given the Seasonal Influenza Vaccine</td>
</tr>
<tr>
<td>Assessed and Appropriately Given the Pneumococcal Vaccine</td>
</tr>
<tr>
<td>Urinary Tract Infection</td>
</tr>
<tr>
<td>Low-Risk Residents who Lose Control of Bowel or Bladder</td>
</tr>
<tr>
<td>Catheter Inserted and Left in Bladder</td>
</tr>
<tr>
<td>Residents Who Were Physically Restrained</td>
</tr>
<tr>
<td>Residents Whose Need for Help with Activities of Daily Living Increased</td>
</tr>
<tr>
<td>residents Whose Ability To Move Independently Worsened</td>
</tr>
<tr>
<td>Residents Who Lose Too Much Weight</td>
</tr>
<tr>
<td>Residents Who Have Depressive Symptoms</td>
</tr>
<tr>
<td>Residents Who Have Received An Antipsychotic Medication</td>
</tr>
<tr>
<td>Residents Who Received an Antianxiety or Hypnotic Medication +</td>
</tr>
<tr>
<td>Prevalence Quality Measures (Long Stay) SURVEYOR</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Prevalence of Falls</td>
</tr>
<tr>
<td>Prevalence of Behavior Symptoms Directed Towards Others</td>
</tr>
<tr>
<td>Prevalence of Antianxiety/Hypnotic Use</td>
</tr>
<tr>
<td>Number of Quality Measures Affecting System</td>
</tr>
</tbody>
</table>

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IMPACT Act:
Quality Measure Domains and Timelines

1. Functional status, cognitive function, and changes in function and cognitive function
   - SNF: October 1, 2016
   - IRF: October 1, 2016
   - LTCH: October 1, 2016
   - HHA: January 1, 2019

2. Skin integrity and changes in skin integrity
   - SNF: October 1, 2016
   - IRF: October 1, 2016
   - LTCH: October 1, 2016
   - HHA: January 1, 2017

3. Medication Reconciliation
   - HHA: January 1, 2017
   - SNF: October 1, 2016
   - IRF: October 1, 2016
   - LTCH: October 1, 2016

---

2018 QRP Reporting Requirements

- The FY 2018 reporting year is based on one quarter of data from 10/1/16 – 12/31/16.
  - This means that FY 2018 compliance determination will be based on data submitted for admissions to the SNF on and after October 1, 2016, and discharged from the SNF up to and including December 31, 2016.
  - Providers have until May 15, 2017 to correct and/or submit their quality data from the FY 2018 reporting year.
2018 QRP Reporting Requirements

- The FY 2018 reporting year is based on one quarter of data from 10/1/16 – 12/31/16.
  - Providers must submit all data necessary to calculate SNF QRP measures on at least 80% of the MDS assessments submitted to be in compliance with FY 2018 SNF QRP requirements.
  - Use of dashes will impact the calculation of the 20%.

2018 QRP Reporting Requirements

- No changes to the MDS submission process
- NEW:
  - New quality measures to be used for payment purposes
  - Addition of the PPS Discharge Assessment
    - Will be used for current as well as future QRP measures and their calculation

<table>
<thead>
<tr>
<th>Name of Measure</th>
<th>Data Collection Source</th>
<th>Data Collection Period</th>
<th>Data Submission Deadline for FY 2018 Payment Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF# 0678: percent of Patients or Residents with Pressure Ulcers that are New or Worsened</td>
<td>MDS</td>
<td>10/01/16-12/31/16</td>
<td>May 15, 2017</td>
</tr>
<tr>
<td>NQF# 0674: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)</td>
<td>MDS</td>
<td>10/01/16-12/31/16</td>
<td>May 15, 2017</td>
</tr>
<tr>
<td>NQF#2631: Application of Percent of Long-Term Care Hospital Patients with and Admission and Discharge Functional Assessment and a Care Plan that Addresses Function</td>
<td>MDS</td>
<td>10/01/16-12/31/16</td>
<td>May 15, 2017</td>
</tr>
</tbody>
</table>
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QRP Measure Types

- Process Measure
  - Indicates what a provider does to maintain or improve health
    - Admission/Discharge Functional Assessment

- Outcome Measure
  - Reflects the impact of the health care service or intervention on the health status of patients
    - Pressure Ulcers
    - Falls with major injury

QRP Definitions

- Risk Adjustments
- Only Pressure Ulcers are Risk Adjusted
  - Exclusions: outcomes not under SNF control or where outcome may be unavoidable
  - Stratification: low/high risk based on characteristics
  - Covariates: resident characteristics that may affect risk of a certain outcome

QRP Measures affecting FY2018 payment

- The fall and pressure ulcer QM calculations are unchanged from the current process
  - Only using Medicare Part A FFS patients

- Fall and pressure ulcers have been added to the NEW discharge assessment 10/1/2016
- Admission and discharge functional assessment and care plan- NEW
PU QRP

- Reports the percent of patients/residents with Stage 2-4 pressure ulcers that are new or worsened since admission.
- For residents in a SNF, the measure is calculated by examining all assessments during a resident’s Medicare Part A stay for reports of Stage 2-4 pressure ulcers that were not present or were at a lesser stage since admission.
- For SNF residents, this measure is restricted to Medicare Part A residents.

Keys to the PU QM

- MDS coding of covariates
  - Section M
    - Present on admission
    - Staging
    - Worsening
  - Diagnosis
  - Bed Mobility
    - Rule of 3
  - Bowel Incontinence

Fall QM Calculation

- Definitions
  - Injury Related to Fall: Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after, the fall and attributed to the fall.
  - Injury (Except Major): Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain.
  - Major Injury: Defined as a bone fracture, joint dislocation, closed-head injury with altered consciousness, or subdural hematoma.
Fall QM Calculation

- **SNF:**
  - For SNFs, the item (J1900C) is collected on the MDS 3.0 assessments, which may be OBRA discharge, PPS 5-, 14-, 30-, 60-, 90-day, SNF PPS Part A Discharge Assessment, or OBRA admission, quarterly, annual or significant change assessments, included in a SNF resident’s stay.
  - Because the SNF measure includes assessments occurring between admission to the facility and discharge, the MDS 3.0 items ask providers to identify falls since admission/entry or reentry or prior assessment, whichever is more recent.

---

Key Resources

- SNF QRP Training materials
- Fact Sheets
- Help Desk Quarterly Q & A documents

---

SNF Quality Reporting Program- Specifications for the Quality Measure adopted through the Fiscal Year 2016 Final Rule (August 2015)

- MUST HAVE- READ and UNDERSTAND
- Pressure Ulcer Section updated August 2016
- Available at in Download Section
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QRP Additional Resources

- CMS Post-Acute Care Quality Initiative website

- IMPACT Act of 2014 can be found at:
  - [http://www.gpo.gov/fdsys/pkg/BILLS-113hr4994enr/pdf/BILLS-113hr4994enr.pdf](http://www.gpo.gov/fdsys/pkg/BILLS-113hr4994enr/pdf/BILLS-113hr4994enr.pdf)
  - [https://www.govtrack.us/congress/bills/113/hr4994](https://www.govtrack.us/congress/bills/113/hr4994)

Summary

* The IMPACT Act requires that:
  - PAC providers report to CMS (by certain dates) standardized assessment data elements in certain quality measure domains and assessment categories; and
  - CMS make assessment data elements interoperable.

* CMS will:
  - Standardize (aka align/harmonize) data elements;
  - Make data elements interoperable by linking to health IT standards, and
  - Make available to the public reports mapping assessment data elements to health IT standards (more on this to follow).

* Use of standardized and interoperable PAC assessment data elements are key enablers to achieving service delivery and payment reform envisioned in the CMS Quality Strategy.

Value Based Purchasing

- Affordable Care Act (2010) requires the Secretary of Health and Human Services to develop a plan to implement a VBP program for Medicare payments under Title XVIII of the Social Security Act

- Has been in the SNF PPS payment rules beginning in FY 2015
  - 10/1/2014

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Value Based Payments Replaces Fee For Service

- Value Based Payments (VBP) pays for outcomes and not for the volume of services
- Total cost of care for a population
- Must focus on the most complex individuals who:
  - Drive most of the costs; and
  - Get care in multiple sites from multiple providers

CMS GOAL
30% by 2016
50% by 2018

Value Based Payments (VBP) replaces fee for service. Total cost of care for a population must focus on the most complex individuals who drive most of the costs and get care in multiple sites from multiple providers. CMS goal is 30% by 2016 and 50% by 2018.

VBP Roadmap
- Continuous Quality Improvement Framework
  - Revised regulations Fall 2016
- Defining the SNFVBP Population
  - Quality for all residents including Dual Eligibles, Private Pay, Medicare

VBP Roadmap
- Enhanced Data Infrastructure and Validation Process – performance incentives not simply report data
- Performance Scoring and Evaluation Model
  - Performance scoring process based on attainment of a specific target, overall improvement or a combination of the two
VBP Roadmap

- Funding Source/Performance Incentive Funds
  - A funding source for linking payment to quality. Potential options include payment withholds that could be earned back based on quality performance or by tying payment updates to overall quality performance.

- Transparency and Public Reporting
  - Making VBP program data publicly available will enable beneficiaries and their families to make informed decisions about their care.

VBP Roadmap

- Coordination across Medicare Payment System
  - Coordinates and aligns with existing VBP, pay-for-reporting, and quality monitoring systems.

Payment Impact 10/1/2017

- Reductions:
  - 2.2% Sequestration
  - ALL PROVIDERS WILL SEE 2.2% decrease

- Additional deductions
  - 2% failure to set discharge goals, admission/discharge status
  - 2% failure to submit MDS
  - 2% excess use of dashes

- POTENTIAL 8.2% decrease
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Payment Impact 10/1/2018
- Reductions:
  - 2.2% Sequestration
  - 2% for readmission penalty
    - Only 50-70% will be repaid to the providers via the claims process (SE1621)
- ALL PROVIDERS WILL SEE 4.2% decrease
- Additional deductions
  - 2% failure to set discharge goals, admission/discharge status
  - 2% failure to submit MDS
  - 2% excess use of dashes
- POTENTIAL 10.2% decrease

VBP Methods
- Quality Performance Funded by Payment Withholds:
  - The base payments to all SNFs will be reduced (or withheld) by a certain percentage
  - High performing SNFs would receive back their base payments (and potentially receive an additional amount for exceeding quality standards).
  - Low-performing SNFs that did not meet the quality metrics would not receive any performance payments.

VBP Methods
- Quality Performance Incentives with Penalties for Low Performance:
  - Payment incentives to high performers
  - Assess penalties to the lowest performers
  - Hold harmless a middle group

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Value Based Purchasing

- [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF-VBP-RTC.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF-VBP-RTC.pdf)
- 2012

What is next

- CJR
  - Joint Replacement Bundles
    - Hospital stays down from 3.58 days to 2.96 days
    - SNF stays down 1.3 days
    - Readmission rates down also at 30-60-90 day 0
- Next Bundles
  - Sepsis
  - CHF
- Bundles only allow discharge to a 3 star or higher facility
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---

**Design for Nursing Home Compare**

Five-Star Quality Rating System:

Technical Users’ Guide

January 2017

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**Key to 5 Star Rating** is knowing your placement in the cut-tables

---

**5 Star Reference**

- Includes the cut point tables
- Survey weighted values
- CMI Staffing adjustment
QM, 5 Star, VBP: Taking the Confusion Out of All the Reports and the Impact of QMs on Reimbursement

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5 Star System

- Health Inspections –
  - last 3 years of onsite inspections, including both standard surveys and any complaint surveys
  - The most recent survey findings are weighted more than the prior two years.

Table 1
Health Inspection Score: Weights for Different Types of Deficiencies

<table>
<thead>
<tr>
<th>Severity</th>
<th>Isolated</th>
<th>Pattern</th>
<th>Widespread</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate jeopardy to resident health or safety</td>
<td>J</td>
<td>K</td>
<td>L</td>
</tr>
<tr>
<td>Actual harm that is not immediate jeopardy</td>
<td>G</td>
<td>H</td>
<td>I</td>
</tr>
<tr>
<td>No actual harm with potential for more than minimal harm that is not immediate jeopardy</td>
<td>D</td>
<td>E</td>
<td>F</td>
</tr>
<tr>
<td>No actual harm with potential for minimal harm</td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
</tbody>
</table>

Note: Figures in parentheses indicate points for deficiencies that are for substandard quality of care. Shaded cells denote deficiency severity levels that contribute substandard quality of care if the requirement the facility is not meeting is related to the following federal regulations: 42 CFR 482.13 resident behavior and nursing home practices, 42 CFR 483.15 quality of life, 42 CFR 483.20 quality of care.

Table 2
Weights for Repeat Revisits

<table>
<thead>
<tr>
<th>Revisit Number</th>
<th>50 percent of health inspection score</th>
<th>60 percent of health inspection score</th>
<th>70 percent of health inspection score</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>0</td>
<td>50 points</td>
<td>60 points</td>
</tr>
<tr>
<td>Second</td>
<td>50 percent of health inspection score</td>
<td>70 percent of health inspection score</td>
<td></td>
</tr>
<tr>
<td>Third</td>
<td>60 percent of health inspection score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fourth</td>
<td>70 percent of health inspection score</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The health inspection score includes points from deficiencies cited on the standard health inspection and complaint inspections during a given survey cycle.

- The top 10 percent (with the lowest health inspection weighted scores) in each state receive a health inspection rating of five stars.
- The middle 70 percent of facilities receive a rating of two, three, or four stars, with an equal number (approximately 25.33 percent) in each rating category.
- The bottom 20 percent receive a one-star rating.
Events that change your Inspection 5 Star rating

- New survey
- Complaint survey
- 2nd, 3rd, 4th revisit
- IDR resolutions
- "aging" of surveys

5 Star System

- Staffing
  - number of hours of care provided on average to each resident each day by nursing staff.
    - Total Nursing Hours
    - Total RN hours
      - Includes DON and nurses with administrative duties
  - NOW: updated quarterly rather than annually
    - 7/1/2016
    - PBJ reports
  - Case Mix adjusted

5 Star System

- Staffing
  - HRR = total hours for each nursing discipline/resident census/14 days
  - Hours are adjusted by Case Mix (RUGs) ALL RESIDENTS

<table>
<thead>
<tr>
<th>Type of staff</th>
<th>National average hours per resident per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total nursing staff (Ktda + LPN + RDA)</td>
<td>4.0000</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>6.7472</td>
</tr>
</tbody>
</table>
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5 Star System

- Quality Measures (QMs) –
  - Had 16 different physical and clinical measures.
  - Long Term- LOS greater than 100 days
    - 9 measures
  - Short Stay- LOS less than 100 days
    - 4 measures
  - Claims based
    - 3 measures

Overview of Claims-Based Measures

- Measures use Medicare fee-for-service claims data only
  - Medicare Advantage data is excluded because CMS does not have access to data at this time (31% of Medicare population nationally)
- MDS is used in building stays and for some risk-adjustment variables
- Claims-based measures include only those residents who were admitted to the nursing home following an inpatient hospitalization and are short-stay
- Measures are risk-adjusted, using items from claims, the enrollment database and the MDS

Table 4
National Star Cut Points for Staffing Measures, Based on Case-Mix Adjusted Hours per Resident Day (updated April 2012)

<table>
<thead>
<tr>
<th>Staff type</th>
<th>1 star lower</th>
<th>1 star upper</th>
<th>2 stars lower</th>
<th>2 stars upper</th>
<th>3 stars lower</th>
<th>3 stars upper</th>
<th>4 stars lower</th>
<th>4 stars upper</th>
<th>5 stars lower</th>
<th>5 stars upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>1.280</td>
<td>0.779</td>
<td>1.059</td>
<td>0.979</td>
<td>1.059</td>
<td>0.779</td>
<td>1.059</td>
<td>0.779</td>
<td>1.059</td>
<td>0.779</td>
</tr>
<tr>
<td>Total</td>
<td>1.280</td>
<td>0.779</td>
<td>1.059</td>
<td>0.979</td>
<td>1.059</td>
<td>0.779</td>
<td>1.059</td>
<td>0.779</td>
<td>1.059</td>
<td>0.779</td>
</tr>
</tbody>
</table>

Note: Adjusted staffing values are rounded to three decimal places before the cut points are applied.
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Claims based Measures

- Percentage of short-stay residents who were successfully discharged to the community (Claims-based)
- Percentage of short-stay residents who have had an outpatient emergency department visit (Claims-based)
- Percentage of short-stay residents who were re-hospitalized after a nursing home admission (Claims-based)

QM Rating

Facilities that receive a QM rating are in one of the following categories:

- They have points for all of the QMs.
- They have points for only the nine long-stay QMs (long-stay facilities).
- They have points for the nine long-stay QMs and the 4 MDS-based short-stay QMs.
- They have points for only the seven short-stay QMs (short-stay facilities).
- They have points for only the four MDS-based short-stay QMs.

No values are reported for nursing homes with data on fewer than five long-stay QMs and fewer than four short-stay QMs. No QM rating is generated for these nursing homes.

Rescaling occurs for long stay and short stay facilities.

QM Cut Point

<table>
<thead>
<tr>
<th>QM Rating</th>
<th>Point Range July 2016</th>
<th>Point Range January 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>★</td>
<td>275 – 600</td>
<td>325 – 709</td>
</tr>
<tr>
<td>★★</td>
<td>670 – 750</td>
<td>700 – 889</td>
</tr>
<tr>
<td>★★★</td>
<td>760 – 820</td>
<td>850 – 969</td>
</tr>
<tr>
<td>★★★★</td>
<td>830 – 904</td>
<td>970 – 1054</td>
</tr>
<tr>
<td>★★★★★</td>
<td>905 – 1150</td>
<td>1055 – 1000</td>
</tr>
</tbody>
</table>
How to Calculate the 5-Star Rating

Step 1: Start with health inspection five-star rating.

Step 2: Add one star to the Step 1 result if staffing rating is four or five stars and greater than the health inspection rating; subtract one star if staffing is one star. The overall rating cannot be greater than five or less than one star.

Step 3: Add one star to the Step 2 result if the quality measure rating is five stars; subtract one star if the quality measure rating is one star.

Step 4: If the health inspection rating is one star, then the overall quality rating cannot be upgraded by more than one star based on the staffing and quality measure ratings.

Step 5: If the nursing home is a Special Focus Facility that has not graduated, the maximum overall quality rating is three stars.

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