Lisa Thomson
Vice President
www.pathwayhealth.com
Objectives

• Identify the purpose of the PEPPER and CASPER (OSCAR) report
• Identify the purpose of the Quality Measures and Five Star reports, incorporating the new public reporting requirements.
• Interpret the individual reports and identify the outlier data that places a facility at greater risk
• Discuss implementations strategies incorporating this data
The Journey Begins...
Preparation for Change

Innovation
Technology
Strategy
Leadership
New Era of Healthcare – Quality and Efficiency

The goal is to move providers into quadrant 4 – high quality and efficiency


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VBP is Around the Corner
Stake Holders in Performance Measurement

- US Department of HHS
  - CMS (also CMS 5 Star reporting and SNF VBP)
  - AHRQ
- MedPAC
- GAO
- OIG
- State Medicaid programs
- NQF - NQS initiatives
- Affordable Care Act – driving quality outcomes, increasing performance
• Government Accountability Office
  – Medicare Program is at high risk for fraud, waste, and abuse

• Office of Inspector General
  – In 2012, 25% of SNF claims were billed in error
  – Monitor COT, Add to FPS, CMS to instruct MAC, RAC to closely monitor SNFs

• Centers for Medicare and Medicaid Services
  – In 2013, SNFs were required to have a compliance program
Compliance Program

• A SNF should conduct regular audits to ensure services provided are necessary and that charges for Medicare services are correctly documented and billed.

• PEPPER
  – Program for
  – Evaluating
  – Payment
  – Patterns
  – Electronic
  – Report

• First available to SNFs in 2013
  – SNF PEPPER Version Q4FY12

• Latest report available May 2014
  – SNF PEPPER Version Q4FY13

• August – HX Data
• Compares SNF to SNF nationally, regionally, and individually

• 2013 (1st PEPPER) received USPS around 8/30/13

• Envelope with red print on the outside “Your facility specific PEPPER”

• Many perceived as junk mail
• **PEPPER does not identify the presence of improper payments, but it can be used as a guide for auditing and monitoring efforts.**

• **A SNF can use PEPPER to compare its claims data over time to identify areas of potential concern and to identify changes in billing practices.**
• PEPPERs are not available for public release
  – They are released only to CEO, President, or Administrator

• TMF Health Quality Institute, a CMS contractor, produced the report

• SNFs received them by USPS in 2013 but will receive them on-line in 2014

• TMF provides an Access database to MACs, FIs, and Recovery Auditors (RACs)
  – FATHOM or First-look Analysis Tool for Hospital Outlier Monitoring (secured access point)
How To Obtain the PEPPER Report

• SNF Swing-Bed Units
  – Via QualityNet

• Other SNFs
  – Visit PEPPERresources.org
  – Hover over “PEPPER”
  – Select “Secure PEPPER Access”
  – Review Instructions and access portal

• Join the listserv to receive notification when PEPPER reports are available
Based on OIG report

- CMS and OIG indicate high Medicare expenses could be suggestive of over coding
- CMS indicates that 20% highest expenses are questionable
- CMS identifies expenses above the 80% percentile as potential outliers
- CMS identifies that the bottom 20% of outliers are potential under coding
- The bottom 20th percentile as outlier may be perceived as evidences of poor Quality of Care
Important Alert:
PEPPERs will no longer be mailed to providers who previously received their PEPPERs by mail. They will now be able to access them through a secure portal from this website beginning in April 2014. Those providers who have been receiving their PEPPERs through QualityNet will continue to do so.

For details and more information click here. Sign up to receive an email notification when PEPPERs are available.

“We use PEPPER to monitor high-risk areas and potential physician education needs related to documentation or admission practices.”

Welcome to PEPPER Resources

PEPPERresources.org is the official site for information, training and support related to the Program for Evaluating Payment Patterns Electronic Report (PEPPER).

PEPPER provides provider-specific Medicare data statistics for discharges/services vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments as well as potential underpayment.
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This website is developed and maintained by TMF Health Quality Institute, under contract with the Centers for Medicare & Medicaid Services to provide comparative data reports to providers and to Medicare Administrative Contractors in support of efforts to reduce Medicare fee-for-service improper payments. PEPPER was previously distributed to hospitals by their state Medicare Quality Improvement Organization (QIO) in support of the Hospital Payment Monitoring Program. QIOs are no longer involved in providing these reports.
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Training and Resources for Skilled Nursing Facilities

PEPPER Resources

Training to help Skilled Nursing Facilities (SNF) use and understand PEPPER are under development. TMF will develop a recorded web-based training session in August, which will be made available on this website. In addition, a listing of target areas will be added.

Right click on the file names below and select “Save Target As…” to save to your computer. To receive updates on training and other resources, please join our small list.

Current PEPPER User’s Guide


Jurisdictions:

- View a list of the 12 MAC jurisdictions and the number of providers in each jurisdiction in total and by state for PEPPER Q4FY13 (56 KB XLS).
- View a list of the 14 MAC/FI jurisdictions and the number of SNFs in each jurisdiction in total and by state for Q4FY12 (58 KB XLS).

PEPPER Training Update (May 2014):

- Skilled Nursing Facility (SNF) PEPPER Update – This session reviews what has changed and what is the same in the new Q4FY13 SNF PEPPER Release. It includes a demonstration of how SNFs can access their PEPPER via the Secure PEPPER Access Portal. (Duration: 56:55, requires Flash 10.0 or later)
- Access alternate file format and a transcript of this training
- Download the PowerPoint slides (466KB, PDF) for the SNF PEPPER update training session.

PEPPER Training (August, 2013):

- Skilled Nursing Facility (SNF) PEPPER Training: Session 1 – This session reviews the new PEPPER for SNFs. It includes the history and background of PEPPER and a description of the areas at risk for improper Medicare payments. It also discusses percentiles and percentiles and the comparison groups. (Duration: 37:23, requires Flash 10.0 or later)
- Skilled Nursing Facility PEPPER Training: Session 2 – This session is a demonstration of a SNF PEPPER to review the reports included, and a discussion about how the PEPPER can be used. (Duration: 36:30, requires Flash 10.0 or later)
- Skilled Nursing Facility PEPPER Training Session 3 – This session is about how to obtain and use the SNF PEPPER, plus it offers other helpful resources. (Duration: 12:59, requires Flash 10.0 or later)
- Access alternate file formats and a transcript of these training.
- Download the PowerPoint slides (934KB, PDF) for the SNF PEPPER training session.
Training and Resources

PEPPER Training (August, 2013):

- Skilled Nursing Facility (SNF) PEPPER Training: Session 1 – This session reviews the new PEPPER for SNFs. It includes the history and background of PEPPER and a description of the areas at risk for improper Medicare payments. It also discusses percents and percentiles and the comparison groups. (Duration: 37:23, requires Flash 10.0 or later)

- Skilled Nursing Facility PEPPER Training: Session 2 – This session is a demonstration of a SNF PEPPER to review the reports included, and a discussion about how the PEPPER can be used. (Duration: 30:30, requires Flash 10.0 or later)

- Skilled Nursing Facility PEPPER Training Session 3 – This session is about how to obtain and use the SNF PEPPER; plus it offers other helpful resources. (Duration: 12:59, requires Flash 10.0 or later)

- Access alternate file formats and a transcript of these training.

- Download the PowerPoint slides (934KB, PDF) for the SNF PEPPER training session.

Demonstration PEPPER:

- Demonstration PEPPER version Q4FY13 (672 KB XLS, updated 3/19/2014)

What is PEPPER?
The SNF PEPPER is a report that summarizes a SNF’s Medicare claims data in areas that may be at risk for abuse or improper payment. PEPPER compares a SNF’s claims data statistics with aggregate statistics for other SNFs in the state, MAC/IF jurisdiction and the nation. SNFs with high billing patterns (at or above the national 90th percentile) are identified as “outliers” and are encouraged to ensure that they are complying with Medicare payment policy; that services provided to beneficiaries are medically necessary and that medical record documentation supports the services that are billed.

PEPPER cannot identify the presence of improper payments; only a review of the medical record can determine whether services are medically necessary and appropriately billed.

Distribution
View the distribution schedule.

Other Resources:

- View a list of the Skilled Nursing Facility target areas (PDF).

- View this slide presentation (PPT file, updated 7-11-2013) on percents and percentiles to help understand the differences between “percent” and “percentile” and how they are used in PEPPER.

- Contact TMF through the Help/Contact Us page to request examples of Triple Check tools from Skilled Healthcare.
Welcome to PEPPER Resources

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## PEPPER Distribution

IMF will distribute PEPPER according to the schedule and methods below.

### 2014 Distribution Schedule

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Distribution Date</th>
<th>Distribution Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-term acute care hospitals</td>
<td>Quarterly, on or about March 6, June 3 and August 31, 2014</td>
<td>QualityNet secure file exchange</td>
</tr>
<tr>
<td>Long-term acute care hospitals</td>
<td>Annually, in early April 2014</td>
<td>Available electronically to the hospital CEO, president or administrator via secure portal on PEPPERresources.org</td>
</tr>
<tr>
<td>Critical access hospitals</td>
<td>Annually, on or about April 18, 2014</td>
<td>QualityNet secure file exchange</td>
</tr>
<tr>
<td>Inpatient psychiatric facilities</td>
<td>Annually, between April 18 and May 9, 2014</td>
<td>Free-standing IPFs and IPF Distinct Part Units of short-term acute care hospitals: Electronically via QualityNet secure file exchange</td>
</tr>
<tr>
<td>Inpatient rehabilitation facilities</td>
<td>Annually, on or about April 18, 2014</td>
<td>Free-standing IRFs: Available electronically to the IRF’s CEO, president or administrator via secure portal on PEPPERresources.org IRF Distinct Part Units of short-term acute care hospitals: Electronically via QualityNet secure file exchange</td>
</tr>
<tr>
<td>Hospices</td>
<td>Annually, on or about April 25, 2014</td>
<td>Available electronically to the hospice’s CEO, president or administrator via secure portal on PEPPERresources.org</td>
</tr>
<tr>
<td>Partial Hospitalization Programs</td>
<td>Annually, on or about April 18, 2014</td>
<td>PHPs administered through Community Mental Health Centers, IRFs, long-term acute care hospitals and children’s hospitals: Available electronically to the PHP’s CEO, president or administrator via secure portal on PEPPERresources.org PHPs administered through short-term acute care hospitals and IPFs via QualityNet secure file exchange</td>
</tr>
<tr>
<td>Skilled nursing facilities</td>
<td>Annually, on or about May 5 through May 12, 2014</td>
<td>SNFs/swingbeds that are part of a short-term acute care hospital (3rd digit in the PTAN/CMS certification number/provider number = &quot;U&quot;): Electronically via QualityNet secure file exchange SNFs that are part of another type of hospital (3rd digit in the PTAN/CMS certification number/provider number = 5 or 6): Available electronically to the SNF’s CEO, president or administrator via secure portal on PEPPERresources.org Note: SNFs that are part of a critical access hospital will not receive PEPPER.</td>
</tr>
</tbody>
</table>

For those providers receiving their PEPPERs through a secure file exchange with QualityNet: View important information about QualityNet accounts, including how to register.
Please complete the following fields to access your PEPPER. A provider's PEPPER is only available to that individual provider's Chief Executive Officer, President or Administrator. Corporate Office and/or facility management companies seeking access to PEPPERS for all member organizations will need to coordinate with each individual provider to obtain their PEPPER.

TMF Health Quality Institute is committed to ensuring and maintaining the confidentiality of each provider's PEPPER. Likewise, all recipients of PEPPER are expected to maintain and safeguard the confidentiality of privileged data or information.

I certify that I am the ☐ CEO ☐ President ☐ Administrator

of this health care provider and further certify that I have the actual authority to receive PEPPER and all other confidential information concerning this health care provider. If a provider does not have a management position with any of these titles, the person who has the authority to make decisions on behalf of the organization should check the box for the title that best describes their position.

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Provider Name</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Email</th>
<th>Confirm Email</th>
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<table>
<thead>
<tr>
<th>Provider City</th>
<th>Provider State / Territory</th>
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<thead>
<tr>
<th>Provider Type</th>
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</table>

CMS certification number  (also referred to as Provider Number or PTAN)

<table>
<thead>
<tr>
<th>Validation code  (Patient Control Number or Medical Record Number)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
• 6-digit CMS Certification Number
  – Also referred to as the provider number or PTAN
    • Provider Transaction Access Number
    • Issued when the Medicare contractor approves facility enrollment
  – Not the same as the tax id or NPI number
  – Will have 3rd digit of “5” or “6”
    • Hospital-based swing bed unit PEPPERs, with 3rd digit of “U” are not available on the portal; they are distributed via QualityNet
• Patient Control Number (form locator 03a) or Medical Record Number (form locator 03b) from the UB-04 claim of a traditional fee-for-service Medicare beneficiary receiving services during September 2013 ("from" or "through" date between September 1 – 30, 2013)
Interpret the Individual Reports
• Episodes of care ending between October 1, 2010, through September 30, 2013
  – Remember:
    • 10/1/10 (FY 2011) RUGS III (53) to RUGS IV (66)
    • 10/1/11 (FY 2012) Change of Therapy (COT) Assessments

• An episode of care is created from the UB04 claims submitted by a SNF for each beneficiary
  – A beneficiary could have multiple episodes within this time frame
Six PEPPER Target Areas

- Identified by CMS as being potentially at risk for improper Medicare payments.

### Therapy RUGs with High ADLs
- **Numerator:** Days billed of RUGs RUX, RVX, RHX, RMX, RUC, RVC, RHC, RMC, RLB
- **Denominator:** Days billed for all Therapy RUGS
- **ADLs:** 11 - 16

### Non-Therapy RUGs with High ADLs
- **Numerator:** Days billed SSC, CC2, CC1, BB2, BB1, PE2, PE1, IB2, IB1 in RUGs III; HE2, HE1, LE2, LE1, CE2, CE1, BB2, BB1, PE2, PE1 in RUGs IV
- **Denominator:** Days billed for all non-therapy RUGS
- **ADLs:** 16-18 in RUGs III; 11 – 16 in RUGs IV

### COT Assessment
- **Numerator:** Count of assessments with AI second digit “D”
- **Denominator:** Count of all assessments
- **Change of Therapy** Assessments started 10/1/11 (FY 2012)

### Ultrahigh Therapy RUGs
- **Numerator:** Days billed with RUGs RUX, RUL, RUC, RUB, RUA
- **Denominator:** Days billed for all therapy RUGs
- **Ultra High Criteria:** 720 minutes or more per week, at least 2 therapies, one of them at least 5 days & the second at least 3 days

### Therapy RUGs
- **Numerator:** Days billed for all therapy RUGS
- **Denominator:** Days billed for all therapy and non-therapy RUGS

### 90+ Day Episodes of Care
- **Numerator:** Episodes of care at the SNF with LOS 90+ days
- **Denominator:** All episodes of care at the SNF
- **Maximum:** 100 days per benefit period
PEPPER Data Restrictions

- Statistics will not display when the numerator or denominator count is less than 11 for a target area in any time period.
  - Some SNFs may not see any data for some target areas or time periods
  - A few SNFs will not have a PEPPER available
• Payment rates for therapy RUGs are typically higher than those for non-therapy RUGs

• Medicare typically pays more for higher levels of therapy, and generally pays the most for ultrahigh therapy

• SNFs should ensure that the amount of therapy beneficiaries receive is:
  – Appropriate,
  – Necessary, and
  – Documentation supports the level of care and services provided

  • Medicare Benefit Policy Manual, Chapter 8, Section 30.2.2.1
Take Note (2)

• Medicare reimburses up to 100 days of skilled care per beneficiary spell of illness

• SNFs should ensure that beneficiaries are receiving services that are necessary

• SNFs should also ensure that beneficiaries receive skilled care the entire duration of their SNF stay
3 Types of Reports

- SNF Compare Report for Q4 FY 2013 (1)
- SNF Target Area Reports for FY 2011, 2012, & 2013 (6)
- Top RUG Reports for FY 2013 (4)
  - SNF
    - All Episodes
    - 90+ Days Episodes
  - Jurisdiction
    - All Episodes
    - 90+ Days Episodes
**SNF Compare Targets Report**

**Skilled Nursing Facility PEPPER**

**Compare Targets Report, Four Quarters Ending Q4 FY 2013**

- **Target Count** is most recent fiscal year
  - FY13
  - 10/1/12 – 9/30/13

- **3 Comparison Groups**
  - National
  - MAC Jurisdiction
  - State

---

<table>
<thead>
<tr>
<th>Target</th>
<th>Description</th>
<th>Target Count</th>
<th>Percent</th>
<th>SNF National %ile</th>
<th>SNF Jurisdic. %ile</th>
<th>SNF State %ile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy High ADL</td>
<td>Proportion of days billed within episodes of care ending in the report period with RUG equal to RUL, RHY, FHYX, FIMX, RUC, RVC, RHC, RMC, RLB, to days billed within episodes of care ending in the report period for all therapy RUGs</td>
<td>3,833</td>
<td>78.4%</td>
<td>17.3</td>
<td>12.0</td>
<td>13.6</td>
</tr>
<tr>
<td>Nontherapy High ADL</td>
<td>Proportion of days billed within episodes of care ending in the report period with RUG equal to S3C, C3C, C1, BB2, BB1, PE2, PE1, BB2, BB1 in RUG IV, to days billed within episodes of care ending in the report period for all</td>
<td>119</td>
<td>18.2%</td>
<td>38.6</td>
<td>32.5</td>
<td>40.2</td>
</tr>
<tr>
<td>Change of Therapy Assessment</td>
<td>Proportion of assessments with AI second digit equal to D within episodes of care ending in the report period</td>
<td>167</td>
<td>6.7%</td>
<td>15.0</td>
<td>19.0</td>
<td>10.8</td>
</tr>
<tr>
<td>Ultrahigh Therapy RUGs</td>
<td>Proportion of days billed within episodes of care ending in the report period with RUG equal to RUL, RUC, RUB, RUA, to days billed within episodes of care ending in the report period for all therapy RUGs</td>
<td>7,466</td>
<td>35.8%</td>
<td>27.6</td>
<td>31.9</td>
<td>31.8</td>
</tr>
<tr>
<td>Therapy RUGs</td>
<td>Proportion of days billed within episodes of care ending in the report period for therapy RUGs, to days billed within episodes of care ending in the report period for all therapy and nontherapy RUGs</td>
<td>20,847</td>
<td>97.0%</td>
<td>77.6</td>
<td>88.2</td>
<td>92.1</td>
</tr>
<tr>
<td>90+ Day Episodes of Care</td>
<td>Proportion of episodes of care ending in the report period at the SNF with a length of stay of 90+ days, to all episodes of care ending in the report period at the SNF</td>
<td>27</td>
<td>3.2%</td>
<td>2.4</td>
<td>3.4</td>
<td>1.4</td>
</tr>
</tbody>
</table>
• Target Area Percents are calculated by dividing the numerator by the denominator (See Slide 15), then multiplying by 100.

• Example:
  – Numerator count = 20, and
  – Denominator count = 100
  – \( \frac{20}{100} \times 100 = 20\% \)

• Target Area Percent is 20% 
• This lets the SNF know its billing patterns
Based on OIG report

- CMS and OIG indicate high Medicare expenses could be suggestive of over coding
- CMS indicates that 20% highest expenses are questionable
- CMS identifies expenses above the 80% percentile as potential outliers
- CMS identifies that the bottom 20% of outliers are potential under coding
- The bottom 20th percentile as outlier may be perceived as evidences of poor Quality of Care
Calculating Percentiles

• The Percentiles give context by helping a provider understand how it compares to other providers.

• Definition of a Percentile:
  – The percentage of providers with a lower target area percent

• To calculate Percentiles for all providers in a comparison group (nation, jurisdiction, or state) the target area percents are sorted from largest to smallest for each time period.

• Example:
  – If 40% of the providers’ target area percents were lower than provider A, then provider A would be at the 40th percentile.
The top two providers’ percents are at or above the 80th percentile.

The bottom two providers’ percents are at or below the 20th percentile.
Risk for Improper Medicare Payments

- Target area percents for all SNFs with reportable data are ordered from highest to lowest.

- The target area percent below which 80% of all SNFs’ target area percents fall, is the 80th percentile.

- SNFs whose target percents are at or above the 80th percentile (that is, the top 20%) are considered at risk for improper Medicare payments.
• Percentile values at or above the 80th percentile
  – **National**
  – Jurisdiction
  – State

• “Target Count”
  – If more than one area is at or above the 80th percentile, the one with the higher/est target count should be given a higher priority than the other(s)
Detail of One Target Area PEPPER Report

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing or decreasing Target Percent over time resulting in outlier status
- Your Target Percent (first row in the table below) is above the national 80th percentile
- Your Target Percent is below the national 20th percentile

Therapy RUGs With High ADL

<table>
<thead>
<tr>
<th>YOUR SNF</th>
<th>10/1/10 - 9/30/11</th>
<th>10/1/11 - 9/30/12</th>
<th>10/1/12 - 9/30/13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Area Percent</strong></td>
<td>21.8%</td>
<td>17.6%</td>
<td>18.4%</td>
</tr>
<tr>
<td><strong>Target Count</strong></td>
<td>4,611</td>
<td>3,888</td>
<td>3,833</td>
</tr>
<tr>
<td><strong>Denominator Count</strong></td>
<td>21,133</td>
<td>20,963</td>
<td>20,847</td>
</tr>
<tr>
<td><strong>Target (Numerator) Average Length of Stay</strong></td>
<td>20.0</td>
<td>20.0</td>
<td>19.2</td>
</tr>
<tr>
<td><strong>Denominator Average Length of Stay</strong></td>
<td>17.2</td>
<td>16.6</td>
<td>16.1</td>
</tr>
</tbody>
</table>

COMPARATIVE DATA

- National 80th Percentile: 46.3%, 47.7%, 48.0%
- Jurisdiction 80th Percentile: 47.0%, 47.5%, 48.2%
- State 80th Percentile: 49.0%, 48.6%, 49.3%
- National 20th Percentile: 18.3%, 19.3%, 19.7%
- Jurisdiction 20th Percentile: 21.4%, 21.9%, 22.8%
- State 20th Percentile: 19.4%, 20.6%, 21.5%

SUGGESTED INTERVENTIONS FOR HIGH OUTLIERS:
This could indicate a risk of potential overcoding of beneficiaries' activities of daily living (ADL) status. The SNF should determine whether the amount of assistance beneficiaries need with ADL as reported on the MDS is supported and consistent with medical record documentation.

SUGGESTED INTERVENTIONS FOR LOW OUTLIERS:
This could indicate a risk of potential undercoding of beneficiaries' ADL status. The SNF should determine whether the amount of assistance beneficiaries need with ADL as reported on the MDS is supported and consistent with medical record documentation.

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Components of Each Report

- Graph
- SNF Data Table
- Comparative Data Table
- Interpretive Guidance & Suggested Interventions
### Six PEPPER Target Areas

- **Identified by CMS as being potentially at risk for improper Medicare payments.**

<table>
<thead>
<tr>
<th>Target Area</th>
<th>Numerator</th>
<th>Denominator</th>
<th>ADLs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Therapy RUGs with High ADLs</strong></td>
<td>Days billed of RUGs RUX, RVX, RHX, RMX, RUC, RVC, RHC, RMC, RLB</td>
<td>Days billed for all Therapy RUGS</td>
<td>11 - 16</td>
</tr>
<tr>
<td><strong>Non-Therapy RUGs with High ADLs</strong></td>
<td>Days billed SSC, CC2, CC1, BB2, BB1, PE2, PE1, IB2, IB1 in RUGs III; HE2, HE1, LE2, LE1, CE2, CE1, BB2, BB1, PE2, PE1 in RUGs IV</td>
<td>Days billed for all non-therapy RUGS</td>
<td>16-18 in RUGs III; 11 – 16 in RUGs IV</td>
</tr>
<tr>
<td><strong>COT Assessment</strong></td>
<td>Count of assessments with AI second digit “D”</td>
<td>Count of all assessments</td>
<td></td>
</tr>
<tr>
<td><strong>Ultrahigh Therapy RUGs</strong></td>
<td>Days billed with RUGs RUX, RUL, RUC, RUB, RUA</td>
<td>Days billed for all therapy RUGs</td>
<td></td>
</tr>
<tr>
<td><strong>Therapy RUGs</strong></td>
<td>Days billed for all therapy RUGs</td>
<td>Days billed for all therapy and non-therapy RUGs</td>
<td></td>
</tr>
<tr>
<td><strong>90+ Day Episodes of Care</strong></td>
<td>Episodes of care at the SNF with LOS 90+ days</td>
<td>All episodes of care at the SNF</td>
<td>Maximum 100 days per benefit period</td>
</tr>
</tbody>
</table>
## Therapy RUGs with High ADLs

<table>
<thead>
<tr>
<th>Suggested Interventions If At/Above 80&lt;sup&gt;th&lt;/sup&gt; Percentile</th>
<th>Suggested Interventions If At/Below 20&lt;sup&gt;th&lt;/sup&gt; Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of potential over-coding of ADL status</td>
<td>Risk of potential under-coding of ADL status</td>
</tr>
<tr>
<td>Education – orientation, at least quarterly</td>
<td>Education – orientation, at least quarterly</td>
</tr>
<tr>
<td>Concurrent audits</td>
<td>Concurrent audits</td>
</tr>
</tbody>
</table>

©Pathway Health 2013
## Non-therapy RUGs with High ADLs

<table>
<thead>
<tr>
<th>Suggested Interventions If At/Above 80(^{th}) Percentile</th>
<th>Suggested Interventions If At/Below 20(^{th}) Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of potential over-coding of ADL status</td>
<td>Risk of potential under-coding of ADL status</td>
</tr>
<tr>
<td>Education – orientation, at least quarterly</td>
<td>Education – orientation, at least quarterly</td>
</tr>
<tr>
<td>Concurrent audits</td>
<td>Concurrent audits</td>
</tr>
</tbody>
</table>

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## Change of Therapy Assessment

### Suggested Interventions If At/Above 80<sup>th</sup> Percentile

This could indicate the SNF is experiencing challenges with delivering services as anticipated

Look at therapy availability, scheduling
Can care planning be improved?

### Suggested Interventions If At/Below 20<sup>th</sup> Percentile

N/A

Note: SNFs using the COT infrequently or not at all may be targeted by MACs or RACs for review to establish whether therapy assessments are being completed as required
<table>
<thead>
<tr>
<th>Suggested Interventions If At/Above 80th Percentile</th>
<th>Suggested Interventions If At/Below 20th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>This could indicate the SNF is improperly billing for therapy services</td>
<td>N/A</td>
</tr>
<tr>
<td>Is the therapy provided reasonable and medically necessary?</td>
<td></td>
</tr>
<tr>
<td>Is the amount of therapy reported on the MDS supported by documentation in the medical record?</td>
<td></td>
</tr>
</tbody>
</table>
## Therapy RUGs

### Suggested Interventions If At/Above 80th Percentile

This could indicate the SNF is improperly billing for therapy services

Is the therapy provided reasonable and medically necessary?

Is the amount of therapy reported on the MDS supported by documentation in the medical record?

### Suggested Interventions If At/Below 20th Percentile

N/A
### Suggested Interventions If At/Above 80th Percentile

This could indicate the SNF is continuing treatment beyond the point where those services are necessary.

Review all documentation to ensure that beneficiaries’ continued care is appropriate and they received a skilled level of care.

Review plans of care for appropriateness.

Assess appropriateness of discharge plans.

### Suggested Interventions If At/Below 20th Percentile

N/A
SNF Top RUGs Report Example

- FY 2013
  - 10/1/12 through 9/30/13

Total of 2 SNF Reports

- Top RUGS for the SNF (To the left)
- Top RUGs for the SNF for episodes of care with 90+ days

Each Report
- Up to 20 RUG Codes
- Must have at least 11 days billed to the respective RUG to appear

<table>
<thead>
<tr>
<th>RUG Code</th>
<th>Description</th>
<th>Number of RUG Days Dilled</th>
<th>% of RUG Days to Total Days</th>
<th>% of RUG billed to RUG Length</th>
<th>EOC with the RUG Dilled to Total RUG Length</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAV</td>
<td>Rehabilitation Very High with ADL 6 - 10</td>
<td>15,522</td>
<td>18.5%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>PVA</td>
<td>Rehabilitation Very High with ADL 6 - 10</td>
<td>3,851</td>
<td>4.6%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RUA</td>
<td>Rehabilitation Ultra High with ADL 6 - 10</td>
<td>2,733</td>
<td>3.3%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RVA</td>
<td>Rehabilitation Very High with ADL 6 - 10</td>
<td>2,454</td>
<td>2.9%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>PVA</td>
<td>Rehabilitation Very High with ADL 6 - 10</td>
<td>1,870</td>
<td>2.2%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RUA</td>
<td>Rehabilitation Ultra High with ADL 6 - 10</td>
<td>1,556</td>
<td>1.8%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RUA</td>
<td>Rehabilitation Ultra High with ADL 6 - 10</td>
<td>945</td>
<td>1.1%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RUA</td>
<td>Rehabilitation Ultra High with ADL 6 - 10</td>
<td>762</td>
<td>0.9%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RUA</td>
<td>Rehabilitation Ultra High with ADL 6 - 10</td>
<td>63</td>
<td>0.1%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RUA</td>
<td>Rehabilitation Ultra High with ADL 6 - 10</td>
<td>106</td>
<td>0.1%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RUA</td>
<td>Rehabilitation Ultra High with ADL 6 - 10</td>
<td>116</td>
<td>0.1%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RUA</td>
<td>Rehabilitation Ultra High with ADL 6 - 10</td>
<td>120</td>
<td>0.1%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RUA</td>
<td>Rehabilitation Ultra High with ADL 6 - 10</td>
<td>116</td>
<td>0.1%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RUA</td>
<td>Rehabilitation Ultra High with ADL 6 - 10</td>
<td>86</td>
<td>0.1%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RUA</td>
<td>Rehabilitation Ultra High with ADL 6 - 10</td>
<td>74</td>
<td>0.1%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RUA</td>
<td>Rehabilitation Ultra High with ADL 6 - 10</td>
<td>69</td>
<td>0.1%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RUA</td>
<td>Rehabilitation Ultra High with ADL 6 - 10</td>
<td>60</td>
<td>0.1%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RUA</td>
<td>Rehabilitation Ultra High with ADL 6 - 10</td>
<td>50</td>
<td>0.1%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RUA</td>
<td>Rehabilitation Ultra High with ADL 6 - 10</td>
<td>30</td>
<td>0.1%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
<tr>
<td>RUA</td>
<td>Rehabilitation Ultra High with ADL 6 - 10</td>
<td>23</td>
<td>0.1%</td>
<td>27.0%</td>
<td>17.6</td>
</tr>
</tbody>
</table>

* An episode of care (EOC) is defined as a series of claims from a SNF for a beneficiary where the difference between the “Through Date” of one claim and the “From Date” of the subsequent claim is less than or equal to 30 days. The “From” and “Through” dates in form locate the timeframe covered period on the claims identify the span of service dates included in a particular bill. The “From” date is the earliest date of service on the claim.

Note: RUGs will display for which there are a total of at least 11 days billed to the respective RUG during the most recent fiscal year.
# Jurisdiction-Wide Top RUGs Report

**Jurisdiction Top RUGs for All Episodes of Care** (EOC), Most Recent 4 Qtrs.

In Descending Order by Number of RUG Days Billed

**Total of 2 Reports**

- Top RUGS for the Jurisdiction (To the left)
- Top RUGs for the Jurisdiction for episodes of care with 90+days

### Each Report

- **“Top 20” RUG Codes**
- Must have at least 11 days billed to the respective RUG to appear

## FY 2013

- 10/1/12 through 9/30/13

### Report Details

<table>
<thead>
<tr>
<th>RUG Code</th>
<th>Description</th>
<th>Number of Days Billed</th>
<th>% of Days of EOC</th>
<th>% of Days of EOC Billed by RUG</th>
<th>Average Length of Stay</th>
<th>Top Jurisdiction-Wide</th>
<th>Top RUGs Jurisdiction-wide</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUG</td>
<td>Rehabilitation Ultralow with ADL 6+10</td>
<td>1872,668</td>
<td>24.5%</td>
<td>24.2%</td>
<td>23.2%</td>
<td>312,203</td>
<td>312,203</td>
</tr>
<tr>
<td>RUG</td>
<td>Rehabilitation Ultralow with ADL 7+10</td>
<td>1006,029</td>
<td>13.9%</td>
<td>18.9%</td>
<td>25.9%</td>
<td>195,203</td>
<td>195,203</td>
</tr>
<tr>
<td>RUG</td>
<td>Rehabilitation Very High with ADL 8+10</td>
<td>531,704</td>
<td>7.3%</td>
<td>7.8%</td>
<td>16.8%</td>
<td>88,000</td>
<td>88,000</td>
</tr>
<tr>
<td>RUG</td>
<td>Rehabilitation Ultralow with ADL 8+5</td>
<td>531,704</td>
<td>7.3%</td>
<td>7.8%</td>
<td>16.8%</td>
<td>88,000</td>
<td>88,000</td>
</tr>
<tr>
<td>RUG</td>
<td>Rehabilitation Very High with ADL 9+11</td>
<td>519,947</td>
<td>7.1%</td>
<td>7.6%</td>
<td>19.1%</td>
<td>86,509</td>
<td>86,509</td>
</tr>
<tr>
<td>RUG</td>
<td>Rehabilitation Very High with ADL 9+5</td>
<td>318,583</td>
<td>4.5%</td>
<td>5.1%</td>
<td>14.5%</td>
<td>53,500</td>
<td>53,500</td>
</tr>
<tr>
<td>RUG</td>
<td>Rehabilitation High with ADL 10+11</td>
<td>288,362</td>
<td>4.0%</td>
<td>4.8%</td>
<td>18.2%</td>
<td>49,200</td>
<td>49,200</td>
</tr>
<tr>
<td>RUG</td>
<td>Rehabilitation High with ADL 9+10</td>
<td>243,316</td>
<td>3.3%</td>
<td>3.6%</td>
<td>15.4%</td>
<td>41,000</td>
<td>41,000</td>
</tr>
<tr>
<td>RUG</td>
<td>Rehabilitation Medium with ADL 6+10</td>
<td>189,118</td>
<td>2.6%</td>
<td>2.9%</td>
<td>12.5%</td>
<td>32,500</td>
<td>32,500</td>
</tr>
<tr>
<td>RUG</td>
<td>Rehabilitation High with ADL 8+6</td>
<td>130,892</td>
<td>1.8%</td>
<td>2.0%</td>
<td>12.8%</td>
<td>21,000</td>
<td>21,000</td>
</tr>
<tr>
<td>RUG</td>
<td>Rehabilitation Medium with ADL 9+5</td>
<td>95,018</td>
<td>1.3%</td>
<td>1.3%</td>
<td>12.3%</td>
<td>16,000</td>
<td>16,000</td>
</tr>
<tr>
<td>RUG</td>
<td>Social Care, Low Needs and ADL 6+14</td>
<td>64,295</td>
<td>0.9%</td>
<td>0.9%</td>
<td>29.0%</td>
<td>10,000</td>
<td>10,000</td>
</tr>
<tr>
<td>RUG</td>
<td>Social Care, Low Needs and ADL 7+14</td>
<td>45,277</td>
<td>0.6%</td>
<td>0.6%</td>
<td>17.2%</td>
<td>7,600</td>
<td>7,600</td>
</tr>
<tr>
<td>RUG</td>
<td>Executive Services, Geriatric and ADL 1+12</td>
<td>67,220</td>
<td>0.9%</td>
<td>0.9%</td>
<td>40.0%</td>
<td>10,000</td>
<td>10,000</td>
</tr>
<tr>
<td>RUG</td>
<td>Social Care, High Needs and ADL 15+16</td>
<td>40,946</td>
<td>0.6%</td>
<td>0.6%</td>
<td>16.6%</td>
<td>7,000</td>
<td>7,000</td>
</tr>
<tr>
<td>RUG</td>
<td>Social Care, High Needs and ADL 14+10</td>
<td>36,259</td>
<td>0.5%</td>
<td>0.5%</td>
<td>15.8%</td>
<td>6,000</td>
<td>6,000</td>
</tr>
<tr>
<td>RUG</td>
<td>Social Care, High Needs and ADL 12+2</td>
<td>35,717</td>
<td>0.5%</td>
<td>0.5%</td>
<td>13.1%</td>
<td>5,600</td>
<td>5,600</td>
</tr>
<tr>
<td>RUG</td>
<td>Social Care, High Needs and ADL 9+1</td>
<td>34,141</td>
<td>0.5%</td>
<td>0.5%</td>
<td>12.3%</td>
<td>5,000</td>
<td>5,000</td>
</tr>
<tr>
<td>RUG</td>
<td>Social Care, High Needs and ADL 11+14</td>
<td>33,153</td>
<td>0.5%</td>
<td>0.5%</td>
<td>11.9%</td>
<td>4,800</td>
<td>4,800</td>
</tr>
<tr>
<td>RUG</td>
<td>Social Care, High Needs and ADL 11+14</td>
<td>5,969,493</td>
<td>100.0%</td>
<td>100.0%</td>
<td>18.2%</td>
<td>992,463</td>
<td>992,463</td>
</tr>
</tbody>
</table>

*An episode of care (EOC) is defined as a series of claims from a SNF for a beneficary where the difference between the “Through Date” of one claim and the “From Date” of the subsequent claim is less than or equal to thirty days. The “From” and “Through” dates in form locator 8 statement covers period on the claim identify the span of service dates included in a particular bill, the “From” date is the earliest date of service on the claim.*

>Note: RUGs will display for which there are a total of at least 11 days billed to the respective RUG during the most recent fiscal year.
### Jurisdictions

<table>
<thead>
<tr>
<th>MAC</th>
<th>Process Medicare Part A &amp; B Claims for These States</th>
<th>MAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands</td>
<td>Noridian Healthcare Solutions, LLC</td>
</tr>
<tr>
<td>5</td>
<td>Iowa, Kansas, Missouri, Nebraska Indiana, Michigan</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
</tr>
<tr>
<td>6</td>
<td>Arkansas, Colorado, New Mexico, Oklahoma, Texas, Louisiana, Mississippi Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania (Part B for Arlington &amp; Fairfax counties &amp; city of Alexandria in Virginia)</td>
<td>Novitas Solutions, Inc.</td>
</tr>
<tr>
<td></td>
<td>Florida, Puerto Rico, U.S. Virgin Islands</td>
<td>First Coast Service Option, Inc.</td>
</tr>
<tr>
<td>10</td>
<td>Alabama, Georgia, Tennessee</td>
<td>Cahaba Government Benefit Administrators, LLC</td>
</tr>
<tr>
<td>11</td>
<td>North Carolina, South Carolina, Virginia, West Virginia (See Part B Virginia exclusions for “L” above)</td>
<td>Palmetto GBA, LLC</td>
</tr>
<tr>
<td>15</td>
<td>Kentucky, Ohio</td>
<td>GCS Administrators, LLC</td>
</tr>
</tbody>
</table>
Internal Audits -- QAPI

- Pre-Billing Audits
- Medicare Meeting
Pre-Billing Audit

• “Clean Claim”
  – A claim that can be processed without obtaining additional information from the provider or a third party

• A focused “Medicare Meeting”
  – Draft UB-04
  – Information confirmed by someone not directly responsible for data
    • Examples: Administrator verifies therapy log for minutes & days
      DON verifies Validation Report
      Billing Office verifies Physician Certifications
What to Check at Pre-Billing Audit

- Name, HICN, DOB, sex match CWF
- Admission dates & qualifying hospital stay dates
- Copy of Medicare card
- MD orders
- Therapy minutes match Section O of MDS
- MDS submitted & accepted
- RUG & modifiers match
- Correct number of days billed for each MDS
  - Default days
  - Provider liability days
- Physician certifications
- Therapy certifications
- Diagnoses sequenced
- Ancillary charges
- Medicare as Secondary Payer
- **Nursing & therapy documentation**
  - Admission note
  - Weekly note
  - Discharge note/summary
  - Re-instatement note
• Chapter 8
  – Coverage of Extended Care (SNF) Services
    – New Section 30.2.2.1
      • Documentation to support skilled care determinations

• Chapter 15
  – Covered Medical and Other Health Services (Part B Therapy)
Other Data Sources
Internal Sources for Trend Analysis

• CASPER (QEIS)
  – Reason for Assessment Report (RFA)

• MDS 3.0 Software
  – RUG Reports
  – ADL Reports

• Financial Software
  – Length of Stay
External Sources: The First PEPPER

• First PEPPER
  - Q4FY12
  - Statistics for FY10, FY11, FY12
  - State comparison group included SNFs in the same state within the same MAC jurisdiction
  - First page was a letter
  - Majority were mailed in hard-copy format 8/13

• This PEPPER
  - Q4FY13
  - Statistics for FY11, FY12, FY13
  - State comparison group includes all SNFs in the same state, regardless of whether they are in the same jurisdiction
  - First page is “Purpose”
  - Electronic distribution as Microsoft Excel workbook via Secure PEPPER Portal or QualityNet
OSCAR to CASPER!
OSCAR 3 and 4

- **Online Survey Certification and Reporting**
- Prior to 10/1/10
- Provided by surveyors at the time of annual survey entrance conference
- OSCAR 3
  - All facility deficiencies from the last 4 years
- OSCAR 4
  - Most recent survey deficiencies and comparisons to state, CMS region, and nation
  - “672” information
- “A roadmap to previous survey issues”
Common Acronyms

• CASPER
  – Certification and Survey Provider Enhance Reporting system

• QIES
  – Quality Improvement and Evaluation System
  – ASAP
    • Assessment Submission and Processing System

• ASPEN
  – Automated Survey Processing Environment

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Implementation of the MDS 3.0 on October 2010,
- Appendix P of the State Operations Manual was revised.
- CMS officially changed the terminology of Online Survey Certification and Reporting (OSCAR) to Certification and Survey Provider Enhanced Reporting (CASPER) per S&C letter 10-27.
- CASPER/QEIS are part of a large relational database operating within CMS’s Automated Survey Processing Environment (ASPEN)
• During the annual survey
  – Facility is required to submit reports to the State Agencies, these reports are the 802, 671 and 672.

• It is important that these reports are submitted accurately to the State

• CMS analyzes the data
  – The administrative purpose of survey data is to support the survey and certification function.
  – Every "institutional" health care provider in the United States that is certified to provide services under either Medicare or Medicaid (or both) is listed in survey data.
Access your CASPER Reports

• MDS 3.0 Quality Measure Report Manual
  – Instructions on how to access reports
  – How to interpret your data
  – Survey preparation
  – Surveyors preparation based on your data
  – Quality Improvement activities

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CASPER Reports

- Password protected and encrypted
- MDS 3.0 reports are automatically purged after 60 days
• National Associations and their state affiliates provide resources and support
  – AHCA and Leading Age
• Updated on a quarterly basis
CASPER Survey Reports

- Survey History
- Complaint Trends
- Life Safety
- F Tags Cited
  - Scope and Severity
- Why is this important?
Identifying Risk

• Compare your data against state, CMS region, and national data to help assess risk of survey deficiencies
  – Facility’s own trends
  – State, regional, and national “hot topics”

• Remember:
  – Repeat F Tag citations can lead to stronger penalties!
  – Resident condition data (672) “outliers” may be indicative of your unique population, but does facility documentation and policies and procedures support this assumption
### Resident Census and Conditions of Residents

<table>
<thead>
<tr>
<th>ADL</th>
<th>Independent</th>
<th>Assist of One or Two Staff</th>
<th>Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>F79</td>
<td>F80</td>
<td>F81</td>
</tr>
<tr>
<td>Dressing</td>
<td>F82</td>
<td>F83</td>
<td>F84</td>
</tr>
<tr>
<td>Transferring</td>
<td>F85</td>
<td>F86</td>
<td>F87</td>
</tr>
<tr>
<td>Toilet Use</td>
<td>F88</td>
<td>F89</td>
<td>F90</td>
</tr>
<tr>
<td>Eating</td>
<td>F91</td>
<td>F92</td>
<td>F93</td>
</tr>
</tbody>
</table>

#### A. Bowel/Bladder Status

- **F94** With indwelling or external catheter
  - **F95** Of the total number of residents with catheters, how many were present on admission? __________
- **F96** Occasionally or frequently incontinent of bladder
- **F97** Occasionally or frequently incontinent of bowel
- **F98** On urinary toileting program
- **F99** On bowel toileting program

#### B. Mobility

- **F100** Bedfast all or most of time
- **F101** In a chair all or most of time
- **F102** Independently ambulatory
- **F103** Ambulation with assistance or assistive device
- **F104** Physically restrained
  - **F105** Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints? __________
- **F106** With contractures
- **F107** Of the total number of residents with contractures, how many had a contracture(s) on admission? __________
• Track your F Tags as well as the severity and scope from year to year
  – Annual surveys and Complaint surveys
  – What does your latest Quality Assurance monitoring show? Are you still in compliance?

• Keep your 672 and 802 forms up to date
  – MDS software
  – Manual updates with admissions & discharges
  – Increase the frequency of updates within survey window
CASPER MDS Specific Data
• **Certification and Survey Provider Enhanced Reports**

• Accessed through the MDS 3.0 submission portal

• 13 reports are available and the provider can specify the date range for each report

• qtso.com for Chapter 6 of the QTSO Technical Support Manual
GENERAL INFORMATION

MDS 3.0 Nursing Home (NH) Provider reports are requested on the CASPER Reports page (Figure 6-1).

Figure 6-1. CASPER Reports Page – MDS 3.0 NH Provider Reports Category
Figure 11-1. CASPER Reports Page – MDS 3.0 QM Reports Category
# MDS 3.0 User Guides & Training Information

## Manuals and Guides

**MDS 3.6 Provider User’s Guide - (Updated 09/2013)**

Choose the Section

**CASPER Reporting User’s Guide For MDS Providers - (Updated 09/2013)**

Choose the Section

Note: This version of the CASPER User’s Guide is specifically for MDS Providers.

Choose the Section

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cover</td>
<td>(updated 10/2012)</td>
</tr>
<tr>
<td>1</td>
<td>Introduction (updated 03/2012)</td>
</tr>
<tr>
<td>2</td>
<td>Functionality (updated 09/2012)</td>
</tr>
<tr>
<td>3</td>
<td>Utility Reports (updated 11/2012)</td>
</tr>
<tr>
<td>4</td>
<td>MDS 3.0 Nursing Home Provider Reports (updated 03/2012)</td>
</tr>
<tr>
<td>5</td>
<td>MDS 3.0 Swing Bed Provider Reports (updated 02/2012)</td>
</tr>
<tr>
<td>6</td>
<td>MDS 3.0 Swing Bed Final Validation Report (updated 09/2013)</td>
</tr>
<tr>
<td>7</td>
<td>MDS 3.0 Quality Measure (QM) Reports (posted 03/2013)</td>
</tr>
<tr>
<td>Appendix A</td>
<td>Quick Reference</td>
</tr>
</tbody>
</table>
13 Reports

- MDS 3.0 Activity
- MDS 3.0 Admission/Re-Entry
- MDS 3.0 Assessments with Error Number XXXX
- Discharges
- MDS 3.0 Error Detail by Facility
- MDS 3.0 Error Number Summary by Facility by Vendor
- MDS 3.0 Errors by Field by Facility
- MDS 3.0 Missing Assessments
- MDS 3.0 NH Assessment Print
- MDS 3.0 Reason for Assessment Statistics
- MDS 3.0 Roster
- MDS 3.0 Submission Statistics by Facility
- MDS 3.0 Vendor List
MDS 3.0 Activity Report

• Lists the accepted assessments, tracking records, and inactivation requests that were submitted by or on behalf of a facility during a specified timeframe.
  – Use to determine workload.
  – Use to determine if record was submitted.
  – Run monthly or more frequently.
MDS 3.0 Assessments with Error Number XXXX

• Lists the assessments submitted with a specified error for a facility during a specified timeframe.
  – Use to identify assessments with certain fatal errors that were submitted that need to be corrected and resubmitted.
  – Use to determine which assessments were not completed under CMS timing rules (i.e., OBRA quarterly and yearly rules).
  – Use to identify a pattern with coding or an area in need of training.
  – Use to identify software-related errors.
MDS 3.0 Discharges

• Lists the residents discharged (A0310F = 10, 11, or 12) from a facility during a specified timeframe.
  – When a discharged resident appears on the MDS 3.0 Roster report, use this report to determine if discharge was accepted in the ASAP database.
  – Use to derive a list of all residents discharged since the last survey or other time period.
  – Run monthly or more frequently.

• Section 5 contains the error and warning messages.
MDS 3.0 Missing OBRA

• Lists the residents in select facilities for whom the target date of the most recent OBRA assessment (other than a discharge or death record) is more than 138 days prior to the report run date.

• The report also includes residents for whom no OBRA record was submitted for a current episode that began more than 60 days prior to the report run date.

• Use as a QA tool to ensure all assessment have been successfully submitted.
MDS 3.0 RFA Statistics

• Summarizes for a facility the reasons for assessment for accepted assessments submitted during a specified timeframe.
  – Use to monitor /evaluate workload during an identified timeframe.
  – Great tool for leaders to use!!!
MDS 3.0 Roster

• Lists residents of a facility for whom the latest accepted, federally required assessment is not a Discharge assessment. (A0310F = 10, 11, or 12)
  – Use to determine a list of all current residents at time of survey.
  – Use as a QA tool to ensure all current residents have an entry record and all discharge residents have a discharge record in the ASAP database. **CMS FOCUS!!!**

• Section 6 contains MDS 3.0 NH provider reports (section 8 is swing bed provider reports).

• Section 7 contains the MDS 3.0 NH final validation report (section 9 is swing bed final validation report).

• Section 10 contains MDS 3.0 submitter validation report.
Quality Measures
Purpose of QMs

Provide the public, information about:

– quality of care at nursing homes
  • assist in choosing a nursing home
– care at a nursing home where they or family members already live
– to facilitate discussions with nursing home staff regarding the quality of care

Provide data to the nursing home to help them in their quality improvement efforts
All Quality Measures

Visit: National Guideline Clearinghouse | Health Care Innovations Exchange | AHRQ Home

NQMC is a public resource for evidence-based quality measures and measure sets. NQMC also hosts the HHS Measure Inventory.

Search the site:

Search Tips Advanced Search About Search

Show Advanced Search filters

The HHS Measure Inventory, a repository of measures separate from the NQMC, captures measures currently being used by the agencies of the U.S. Department of Health and Human Services for quality measurement, improvement, and reporting. Only some of the measures in the HHS Measure Inventory meet criteria for inclusion in the NQMC.

Visit the HHS Measure Inventory

©Pathway Health 2013
Measure Inventory for QMs

The HHS Measure Inventory is a separate repository of measures currently being used by the agencies of the U.S. Department of Health and Human Services for quality measurement, improvement, and reporting.

Search the HHS Inventory:

- Measure Inventory: Use this faceted browse to filter the Measure Inventory by specific categories of interest.
- Measure Matrix: Create a table by selecting two fields to filter Measure Inventory content.
- Glossary: View clarifying definitions for fields and values in HHS measures.
Summary of QMs

• 18 MDS 3.0-based
  – 5 short-stay
  – 13 long-stay

• 4 surveyor-only long-stay measures

• National and state benchmarks used for comparison purposes
  – National benchmarks used for ranking purposes (percentiles)
  – Surveyors are directed to focus on any QM at the 75th percentile or greater
MDS 3.0-Based Short Stay QMs

1. Self-report moderate to severe pain
2. Have pressure ulcers that are new or worsened*
3. Newly received an anti psychotic medication
4. Were assessed and appropriately given the seasonal influenza vaccine
5. Were assessed and appropriately given the pneumococcal vaccine
MDS 3.0-Based Long Stay QMs (1 of 3)

1. Experienced one or more falls with major injury

2. Self-report moderate or severe pain*

3. Are high risk residents with pressure ulcers

4. Were assessed and appropriately given the seasonal influenza vaccine

5. Were assessed and appropriately given the pneumococcal vaccine
<table>
<thead>
<tr>
<th></th>
<th>MDS 3.0-Based Long Stay QMs (2 of 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>• Have a urinary tract infection</td>
</tr>
<tr>
<td>7</td>
<td>• Are low risk residents and lose control of bowel or bladder</td>
</tr>
<tr>
<td>8</td>
<td>• Have/Had a catheter inserted and left in the bladder*</td>
</tr>
<tr>
<td>9</td>
<td>• Were physically restrained</td>
</tr>
<tr>
<td>10</td>
<td>• Have an increased need for help with daily activities</td>
</tr>
</tbody>
</table>
MDS 3.0-Based Long Stay QMs (3 of 3)

11. Lose too much weight

12. Have depressive symptoms

13. Received an antipsychotic medication
MDS 3.0-Based Survey Only QMs

1. Prevalence of falls

2. Prevalence of psychoactive medication use, in the absence of psychotic or related conditions

3. Prevalence of antianxiety/hypnotic Use

4. Prevalence of behavior symptoms affecting others
Quality Measure Definitions


©Pathway Health 2013
Admission & Re-Entry

Admission

• Has never been admitted before OR
• Has been in this facility previously and is returning after a discharge return not anticipated OR
• Has been in this facility previously and was discharged return anticipated and is returning more than 30 days after discharge

Re-Entry

• Discharged return anticipated AND
• Returned to the facility within 30 days of discharge
Stay

The period of time between a resident’s entry into a facility and either a discharge or the end of the target period, whichever comes first

• A set of contiguous days in a facility
• Start of stay = either an admission or re-entry
• End of stay = discharge, death in facility record or the end of the target period
A period of time spanning one or more stays

- Begins with an Admission Entry
- Ends with
  - Discharge return not anticipated OR
  - Discharge return anticipated but did not return within 30 days of discharge OR
  - A death in facility tracking record OR
  - The end of the target period
Total number of days within an episode during which the resident was in the facility

- May contain one or more stays
- Only days in the facility count
- Outside days (home, hospital, etc.) do not count
- Entry day is counted, but discharge day is not unless it is the same day as entry
- Counting stops with the last record in the target period if that record is a discharge assessment or a death in facility record OR if the end of the period is reached, whichever is earlier

CDIF: Cumulative Days in Facility
Short Stay

• An episode with CDIF less than or equal to 100 days as of the end of the target period

Long Stay

• An episode with CDIF greater than or equal to 101 days as of the end of the target period
Risk Adjustment
What Is Risk Adjustment?

- Risk adjustment refines quality measure rates to better reflect the prevalence of problems that facilities should be able to address
  - Why?
    - To ensure comparisons across facilities are “fair” and not skewed by the presence of special populations

- **Example:** If a facility has more short-stay residents with diabetes, their expected rate for pressure ulcers is higher than the average facility. Therefore, “to level the playing field,” their rate will be adjusted downward.
Three Types of Risk Adjustments

- Exclusions
- Risk Groups
- Covariates
Exclusions

- Residents removed from calculations if their outcomes are not under the facility’s control
- Residents whose outcome may be unavoidable
- Residents removed if certain MDS items are missing
- All QMs except the vaccination QMs have some exclusions
QMs divided into high or low risk groups according to the diseases/conditions the residents have that make them likely to have the condition.

Two QMs
- High risk pressure ulcers
- Low risk residents who lose control of their bladder or bowel
Covariates

Resident level risk factors used to risk adjust facility QM rates higher or lower based on proportion of residents with the defined characteristics

Three QMs

- Residents with pressure ulcers that are new or worsened (short term)
- Residents who self-report moderate to severe pain (long term)
- Residents who have/had a catheter inserted and left in their bladder (long term)
**Covariate Effect on Pain QM**

- **Expect** lower rate if there are fewer cognitively intact residents reporting (or staff not identifying) pain.
- **Expect** higher rate if there are more cognitively intact residents reporting more pain.

©Pathway Health 2013
Quality Measures Reports
• Made possible by the national analytic reporting system, the Certification and Survey Provider Enhanced Reporting (CASPER) system

• Access via CMS Welcome screen – same screen through which assessments are transmitted to QIES ASAP national database
  – Click MDS link, then
  – Click CASPER Reporting Online Reports link
Figure 11-1. CASPER Reports Page – MDS 3.0 QM Reports Category
QM Report Access

Report: MDS 3.0 Facility Quality Measure Report

Begin Date (mm/dd/yyyy): 04/01/2011
End Date (mm/dd/yyyy): 09/30/2011
Comparison Group: 04/01/2011-09/30/2011
Data was calculated on: 10/28/2011
• Three reports
  – Facility Quality Measure Report
  – Resident Level Quality Measure Report
  – Monthly Comparison Report

• Reports default to a 6-month reporting period ending with the most recently ended month
  – Users may change the dates of the reporting period manually
• Displays
  – Each QM
  – Numerator and denominator used for the calculation for each QM
  – Facility percentage
  – Comparison of facility score with all facilities in state and nation
• Assists to identify possible areas for further emphasis in facility quality improvement activities or investigation during the survey process
**Sample QM Report**

**Figure 11.3. CASPER Reports Submit Page - MDS 3.0 Facility Quality Measure Report**

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Num</th>
<th>Denom</th>
<th>Facility Observed Percent</th>
<th>Facility Adjusted Percent</th>
<th>Comparison Group State Average</th>
<th>Comparison Group National Average</th>
<th>Comparison Group National Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>0676</td>
<td>0</td>
<td>4,453</td>
<td>0.0%</td>
<td>23.7%</td>
<td>23.1%</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>0677</td>
<td>0</td>
<td>1,036</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
<td>19.7%</td>
<td>16.6%</td>
</tr>
<tr>
<td>0679</td>
<td>378</td>
<td>591</td>
<td>64.0%</td>
<td>64.0%</td>
<td>16.4%</td>
<td>10.2%</td>
<td>99%</td>
</tr>
<tr>
<td>0678</td>
<td>557</td>
<td>2,516</td>
<td>22.1%</td>
<td>0.0%</td>
<td></td>
<td>2.1%</td>
<td>2.7%</td>
</tr>
<tr>
<td>0667</td>
<td>0</td>
<td>1,567</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>0674</td>
<td>0</td>
<td>1,567</td>
<td>0.0%</td>
<td>2.3%</td>
<td>2.5%</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>0684</td>
<td>0</td>
<td>1,568</td>
<td>99.9%</td>
<td>99.9%</td>
<td>11.2%</td>
<td>8.2%</td>
<td>99%</td>
</tr>
<tr>
<td>0685</td>
<td>0</td>
<td>1,539</td>
<td>0.0%</td>
<td>0.0%</td>
<td>12.7%</td>
<td>10.7%</td>
<td>0</td>
</tr>
<tr>
<td>0686</td>
<td>0</td>
<td>1,539</td>
<td>0.0%</td>
<td>0.0%</td>
<td>12.2%</td>
<td>7.9%</td>
<td>0</td>
</tr>
<tr>
<td>0688</td>
<td>0</td>
<td>9</td>
<td>0.0%</td>
<td>22.0%</td>
<td>19.8%</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

This report may contain privacy protected data and should not be released to the public.

* Fictitious, sample data is depicted.
Facility QM Report

• Upper Left
  – Facility ID information
  – Date data was calculated
    • Data is calculated weekly

• Upper Right
  – Report Period – Period of time covered by the report
  – Comparison Group – Data calculated monthly with two-month delay
  – Run Date – Date the report was accessed by the facility
First two left-most columns QMs listed by name and ID numbers

Remaining columns include facility data and comparison group information

**Num**
- Numerator; top number of the fraction
- The number of residents with the QM condition in the reporting period

**Denom**
- Denominator; number of residents with assessments evaluated for the QM condition
- Based on time frame of the reporting period and, for some QMs, focus on a specific subgroup of that number
**Observed Percent**

- Numerator $\div$ denominator \times 100
- For QMs not risk adjusted, this is the final score – the percentage of residents with the QM condition

**Adjusted Percent**

- Results after a covariate is applied to the observed percent as risk adjustment
- Pertains to three QMs; for them, this is the final QM score
Comparison Group State Average

- Statewide percentage; the average of the QM percentages for all facilities in the state
- Should be used for comparison to the facility-specific score

Comparison Group National Average

- National percentage; the average of the QM percentages for all facilities in the nation
- Should be compared to the facility-specific score
State and national percentages are not benchmarks

Percentile $< 75^{\text{th}}$ or score $\geq$ the state or national average is not necessarily indicative of satisfactory performance

- If the state and/or nation are not doing particularly well on a certain QM issue, then those levels should not be viewed as the goal to achieve
Resident Level QM Report

• Identifies all residents, active and discharged, included in the QM calculations
  – They are the residents in the numerator of the calculations

• Also indicates which QMs triggered for each resident

• Important tool that facilitates detailed record reviews of residents in the numerator of a QM for use in QA/QI activities and survey process
**Figure 11-5. MDS 3.0 Resident Level Quality Measure Report**

*Fictitious, sample data is depicted.*
Monthly Comparison Report

- Summarizes comparison of facility’s performance to state and national averages
- Made available to the public on NHC
- Not included
  - Long-stay QMs with denominator ≤ 30
  - Short-stay QMs with denominator ≤ 20
  - High-triggered percentages
## CASPER Report

### MDS 3.0 Quality Measure Monthly Comparison Report

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure Description</th>
<th>Facility Percent</th>
<th>State Percent</th>
<th>National Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0676</td>
<td>Self-Reported (SR) Moderate/Severe Pain (S)</td>
<td>0.0%</td>
<td>23.7%</td>
<td>23.1%</td>
</tr>
<tr>
<td>0677</td>
<td>Self-Reported (SR) Moderate/Severe Pain (L)</td>
<td>6.5%</td>
<td>19.7%</td>
<td>16.6%</td>
</tr>
<tr>
<td>0679</td>
<td>High-Risk Residents with Pressure Ulcers (L)</td>
<td>71.8%</td>
<td>16.4%</td>
<td>10.2%</td>
</tr>
<tr>
<td>0678</td>
<td>New/Worsened Pressure Ulcers (S)</td>
<td>0.0%</td>
<td>2.1%</td>
<td>2.7%</td>
</tr>
<tr>
<td>0687</td>
<td>Physical Restraint (L)</td>
<td>0.0%</td>
<td>0.6%</td>
<td>2.1%</td>
</tr>
<tr>
<td>0674</td>
<td>Falls (L)</td>
<td>3.0%</td>
<td>28.3%</td>
<td>35.1%</td>
</tr>
<tr>
<td>0674</td>
<td>Falls with Major Injury (L)</td>
<td>0.1%</td>
<td>2.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>0674</td>
<td>Psychoactive Medication Use in Absence of Psychotic or Related Condition (L)</td>
<td>0.0%</td>
<td>1.1%</td>
<td>1.6%</td>
</tr>
<tr>
<td>0674</td>
<td>Anxiety/Hypnotic Medication Use (L)</td>
<td>0.0%</td>
<td>2.0%</td>
<td>1.7%</td>
</tr>
<tr>
<td>0674</td>
<td>Behavior Symptoms Affecting Others (L)</td>
<td>2.4%</td>
<td>15.0%</td>
<td>22.0%</td>
</tr>
<tr>
<td>0690</td>
<td>Depressive Symptoms (L)</td>
<td>&gt;=90%</td>
<td>11.2%</td>
<td>8.2%</td>
</tr>
<tr>
<td>0684</td>
<td>Urinary Tract Infection (L)</td>
<td>0.2%</td>
<td>12.7%</td>
<td>10.7%</td>
</tr>
<tr>
<td>0686</td>
<td>Catheter Inserted and Left in Bladder (L)</td>
<td>12.7%</td>
<td>12.3%</td>
<td>7.9%</td>
</tr>
<tr>
<td>0685</td>
<td>Low-Risk Residents Who Lose Bowel/Bladder Control (L)</td>
<td>0.5%</td>
<td>41.4%</td>
<td>36.6%</td>
</tr>
<tr>
<td>0689</td>
<td>Excessive Weight Loss (L)</td>
<td>&gt;=90%</td>
<td>17.5%</td>
<td>10.0%</td>
</tr>
<tr>
<td>0688</td>
<td>Need for Help with ADLs Has Increased (L)</td>
<td>6.4%</td>
<td>22.0%</td>
<td>19.6%</td>
</tr>
</tbody>
</table>
How To Use the CASPER Reports

• State and National comparison group data are calculated monthly on the first day of the month.
  – Data calculation is delayed by 2 months in order to allow for submission of late and corrected assessments.

• Your QM data is calculated weekly for the assessments submitted since the previous week’s data calculation.
How To Use The Data

• Strong programs of Performance Improvement (QAPI)
  – Continuous monitoring of key aspects of key systems
  – Correlate related QM scores with each other for clues to causative factors
  – Identify and correct problems before they become trends
  – Individual accountability for key systems – put someone in charge of the system

• Quality Management is Key
• Misunderstandings about coding definitions can be disastrous
  – QM scores are derived from MDS data
  – Inaccurate coding can result in misleading Quality Measure scores
  – Inaccurate MDS coding can result in inappropriate resident care
• ADLs (Section G)
  – Rule of 3, ADL algorithm
• Pressure Ulcers (Section M)
  – No back-staging, definition of worsening pressure ulcer
• Influenza Vaccine (Section O)
  – Capturing vaccine from season just ended when new season hasn’t started yet
• Restraints (Section P)
  – Code only if the device meets the definition of daily restraint
• Urinary Tract Infection (Section I)
  – Definition is very specific; code only if definition is met
Resources

- www.cms.gov/NursingHomeQualityInits
  - MDS 3.0 Quality Measures User’s Manual
  - RAI User’s Manual
  - CMS MDS 3.0 Training Materials
- www.qualityforum.org
- www.oig.hss.gov
The Five Star Rating System
## Five Star Ratings

### Medicare.gov Results

The screen shows the Medicare.gov Nursing Home Results page, which displays a list of nursing homes available within 10 miles from the center of ZIP Code 22031. The user has selected three nursing homes to compare:

1. **The Virginian**
   - Distance: 0.5 miles
   - Overall Rating: Much Above Average
   - Health Inspections: Above Average
   - Staffing: Much Above Average
   - Quality Ratings: Above Average

2. **B. ILIFF Nursing Home and Rehab**
   - Distance: 3.4 miles
   - Overall Rating: Average
   - Health Inspections: Above Average
   - Staffing: Above Average
   - Quality Ratings: Above Average

3. **C. Fairfax Nursing Center Inc**
   - Distance: 4.2 miles
   - Overall Rating: Above Average
   - Health Inspections: Average
   - Staffing: Much Above Average
   - Quality Ratings: Average
Nursing Home Compare Website

- [http://www.medicare.gov/NHCompare](http://www.medicare.gov/NHCompare)
- Each nursing home participating in Medicare and/or Medicare is assigned an overall rating between one and five stars

  - 5 Stars = Much above average*
  - 1 Star = Much below average*

* Compared to other nursing homes in the state
Three Categories

• 1 – 5 stars assigned to each category

Health Inspections

Staffing

Quality Measures
Health Inspections

Last 3 Years

Most Recent Survey Findings Are Weighted More Than the Prior 2 Years

Standard Surveys and Complaint Surveys

Most Recent Year = 50%
2 Years Ago = 1/3
3 years Ago = 1/6
<table>
<thead>
<tr>
<th>Severity/Scope</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 50 points</td>
<td>K 100 points</td>
<td>L 150 points</td>
</tr>
<tr>
<td></td>
<td>(75 points if SQC)</td>
<td>(125 points if SQC)</td>
<td>(175 points if SQC)</td>
</tr>
<tr>
<td>Actual harm that is not immediate jeopardy</td>
<td>G 20 points</td>
<td>H 35 points</td>
<td>I 45 points</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(40 points if SQC)</td>
<td>(50 points if SQC)</td>
</tr>
<tr>
<td>No actual harm with potential for more than minimal harm that is</td>
<td>D 4 points</td>
<td>E 8 points</td>
<td>F 16 points</td>
</tr>
<tr>
<td>not immediate jeopardy</td>
<td></td>
<td></td>
<td>(20 points if SQC)</td>
</tr>
<tr>
<td>No actual harm with potential for minimal harm</td>
<td>A 0 points</td>
<td>B 0 points</td>
<td>C 0 points</td>
</tr>
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</table>
### Staffing

<table>
<thead>
<tr>
<th>RN Hours/Resident/Day</th>
<th>Total Staffing (RNs, LPNs, CNAs) /Resident/Day</th>
</tr>
</thead>
</table>

- **Staffing Data Submitted by the Facility at Time of Standard Survey**
- **Adjusted Based Upon Resident Acuity (RUG-IV CMIs)**
Quality Measures

- 5 Short Stay QMs
- 13 Long Stay QMs
- 9 of the 18 QMs Are Used to Calculate the Star Rating

Charts

Graphs

©Pathway Health 2013
**Five Star QMs**

- **Short Stay (2)**
  - Pain
  - Pressure Ulcers

- **Long Stay (7)**
  - Falls with Major Injury
  - Pain
  - Pressure Ulcers
  - UTIs
  - Catheters
  - Physical Restraints
  - ADL Assistance
• **Scoring**
  
  – All 9 QMs are given equal weight
  
  – 1 to 100 points are assigned to each QM based on facility performance
  
  – Percentiles based on national distribution for all the QMs except for the ADL measure, which is state-specific
    
    • More affected by case-mix variation
    
    • Influenced by differences in State Medicaid policies
  
  – Cut points for the QMs were set based on the QM distributions averaged across Q2, Q3, & Q4 of 2011 and will remain in effect until at least July 2014
<table>
<thead>
<tr>
<th>Step</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Start with the Health Inspections Rating</td>
</tr>
</tbody>
</table>
| 2    | Add 1 star if the Staffing Rating is 4 or 5 stars and greater than the Health Inspections Rating  
      Subtract 1 star if the Staffing Rating is 1 star |
| 3    | Add 1 star if the Quality Measures Rating is 5 stars  
      Subtract 1 star if the Quality Measures Rating is 1 star |
| 4    | If the Health Inspections Rating is 1 star, then the Overall Rating cannot be upgraded by more than 1 star based on the Staffing and Quality Measure Ratings |
| 5    | If a nursing home is a Special Focus Facility, the maximum Overall Rating is 3 stars |
CMS’ Five-Star quality ratings for the health inspection domain are based on the relative performance of facilities within a State. This approach helps to control for variation between States. Facility ratings are determined using these criteria:

- The top 10 percent (lowest 10 percent in terms of health inspection deficiency score) in each State receive a five-star rating.
- The middle 70 percent of facilities receive a rating of two, three, or four stars, with an equal number (approximately 23.33 percent) in each rating category.
- The bottom 20 percent receive a one-star rating.

## Cut Point Table 1

**Star Cut Points for Health Inspection Scores - by State - (08-01-2014)**

<table>
<thead>
<tr>
<th>State</th>
<th>Number of Facilities</th>
<th>1 star</th>
<th>2 stars</th>
<th>3 stars</th>
<th>4 stars</th>
<th>5 stars</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Upper</td>
<td>Lower</td>
<td>Upper</td>
<td>Lower</td>
<td>Upper</td>
</tr>
<tr>
<td>Alabama</td>
<td>226</td>
<td>&gt;39.333</td>
<td>≤39.333</td>
<td>&gt;28.667</td>
<td>≤18.000</td>
<td>≤8.000</td>
</tr>
<tr>
<td>Alaska</td>
<td>17</td>
<td>&gt;204.333</td>
<td>≤204.333</td>
<td>&gt;106.667</td>
<td>≤60.000</td>
<td>≤12.667</td>
</tr>
<tr>
<td>Arizona</td>
<td>145</td>
<td>&gt;62.000</td>
<td>≤62.000</td>
<td>&gt;39.333</td>
<td>≤29.333</td>
<td>≤13.333</td>
</tr>
<tr>
<td>Arkansas</td>
<td>227</td>
<td>&gt;126.000</td>
<td>≤126.000</td>
<td>&gt;71.333</td>
<td>≤48.667</td>
<td>≤25.333</td>
</tr>
<tr>
<td>California</td>
<td>1,214</td>
<td>&gt;86.000</td>
<td>≤86.000</td>
<td>&gt;57.333</td>
<td>≤41.333</td>
<td>≤20.667</td>
</tr>
<tr>
<td>Colorado</td>
<td>209</td>
<td>&gt;101.333</td>
<td>≤101.333</td>
<td>&gt;60.667</td>
<td>≤42.000</td>
<td>≤18.000</td>
</tr>
<tr>
<td>Connecticut</td>
<td>229</td>
<td>&gt;74.000</td>
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<td>&gt;52.667</td>
<td>≤34.667</td>
<td>≤18.000</td>
</tr>
<tr>
<td>D. C.</td>
<td>19</td>
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<td>≤219.000</td>
<td>&gt;76.000</td>
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<td>≤32.000</td>
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<td>&gt;90.000</td>
<td>≤64.000</td>
<td>≤36.000</td>
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<tr>
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<td>≤4.667</td>
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<td>≤76.667</td>
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<td>≤25.333</td>
<td>≤10.000</td>
</tr>
<tr>
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<td>≤12.000</td>
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<td>≤8.667</td>
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<tr>
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<td>≤116.667</td>
<td>&gt;72.000</td>
<td>≤46.000</td>
<td>≤22.667</td>
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<tr>
<td>Kentucky</td>
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<td>≤95.833</td>
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<td>≤25.333</td>
<td>≤10.667</td>
</tr>
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<td>Louisiana</td>
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<td>≤89.750</td>
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<td>≤11.667</td>
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<tr>
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<td>≤6.667</td>
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<td>&gt;78.667</td>
<td>≤78.667</td>
<td>&gt;53.333</td>
<td>≤35.333</td>
<td>≤14.667</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>417</td>
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<td>≤40.667</td>
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<td>≤12.000</td>
<td>≤3.333</td>
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<tr>
<td>Michigan</td>
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<td>≤108.833</td>
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<tr>
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<td>≤56.000</td>
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<td>≤12.000</td>
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<tr>
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<td>≤78.667</td>
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<td>≤29.333</td>
<td>≤12.000</td>
</tr>
</tbody>
</table>
Description of Staffing Data File

The accompanying, comma delimited data file can be read by a number of computer programs, including standard spreadsheet programs. It contains one record for every nursing home currently shown on Nursing Home Compare. Each of these records contains the CMS Certification Number (CCN) for the provider, the name of the provider, the city and state in which the provider is located, and 15 staffing values, calculated as hours per resident per day. The 15 staffing variables are divided into 3 groups of 5 values each. The first group of values include values derived from those reported by the nursing home on the CMS 671 and 672 reporting forms. The second group of values represents CMS’s calculation of expected staffing time based on the RUGS 53 staff time values for residents in the nursing home at the time of the survey. The third group of values represents the adjusted time, which is calculated by this formula:

\[ \text{Hours Adjusted} = \left( \frac{\text{Hours Reported}}{\text{Hours Expected}} \right) \times \text{Hours National Average} \]

For a much more extensive discussion on the calculation of staffing values and ratings, please see the Five Star Nursing Home Quality Rating System Technical Users Guide found at:


CMS will update this spreadsheet on a monthly basis, coinciding with website updates.
<table>
<thead>
<tr>
<th>Provider Name</th>
<th>CITY</th>
<th>STATE</th>
<th>Total</th>
<th>Length</th>
<th>Expected Hours Per Resident Per Day</th>
<th>Expected Hours Per Resident Per Day</th>
<th>Adjusted Hours Per Resident Per Day</th>
<th>Adjusted Hours Per Resident Per Day</th>
</tr>
</thead>
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<td>BUTTERFLY HOSPICE HOME INC</td>
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<td>BIRMINGHAM</td>
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<td>AL</td>
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<td>3.9265</td>
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</tbody>
</table>
Nursing Home Compare
Five-Star Quality Rating System:
Year Five Report
[Public Version]

Final Report

June 16, 2014

Prepared for
Centers for Medicare & Medicaid Services (CMS)
AGAResearch Contracts & Grants Division
C2-21-15 Central Building
7500 Security Boulevard
Baltimore, MD 21244-1800

Prepared by
Abt Associates Inc.

Overall Ratings Nationally - 5 Years

Figure 3.7 Distribution of Overall Quality Ratings, 2009 - 2013

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Health Inspection Ratings

Figure 3.8  Distribution of Health Inspection Ratings, 2009 - 2013
QM Ratings

Figure 3.9 Distribution of Quality Measure Ratings, 2009 - 2013*

*Note that the QM rating was held constant for all nursing homes between March 2011 and July 2012. In July 2012, with the new rating design, the rating of individual nursing homes could change, but the overall distribution was maintained at December 2011 levels. For October 2012 (and going forward), both the ratings of individual nursing homes and the overall distribution can change.
Figure 3.11 Distribution of RN Staffing Ratings, 2009 - 2013
Data Updates affecting 5 Star Rating
Use the QM Preview Reports

• Available in the facility’s shared folders on CMS’ QIES website
  – (Same way you got to CASPER)

• Allow provider to see quality measure percent values prior to being posted on NHC

• QM values for the most recent quarter

• Corresponds with the NHC reporting cycle
Resources

- www.cms.gov
- 5 Star Quality Rating System Technical User’s Guide
Leadership Thoughts
• Determine Quality Profile: Assess Organization Data
• Review Internal Processes: Optimize Data
• Establish an Information Agenda for Planning
• Plan to handle “bad” or “inaccurate” data
  – “GIGO”
• Leadership today – Data Driven Decisions!

Your data is key to positive outcomes

©Pathway Health 2013
Data Management – Leader’s Role

• Important Role in health care today and beyond

• Improving clinical and operational performance
  – Collecting
  – Analyzing
  – Interpreting
  – Acting
  – Improvement
Data and Quality Strategy

Continuous Monitoring
Data Assessment

Match & Consolidate

Match

Enhance

Correct

Standardize

Parse

Analyze

Measure

Continuous Monitoring

YOUR DATA

Data Cleansing

Enhance
Preparation
Operational Readiness Assessment
Services
Internal Systems
Team composition
Increase clinical competencies
Validation and benchmark data
Excellent outcomes – quality and financial

Evaluate, reposition, partner and implement