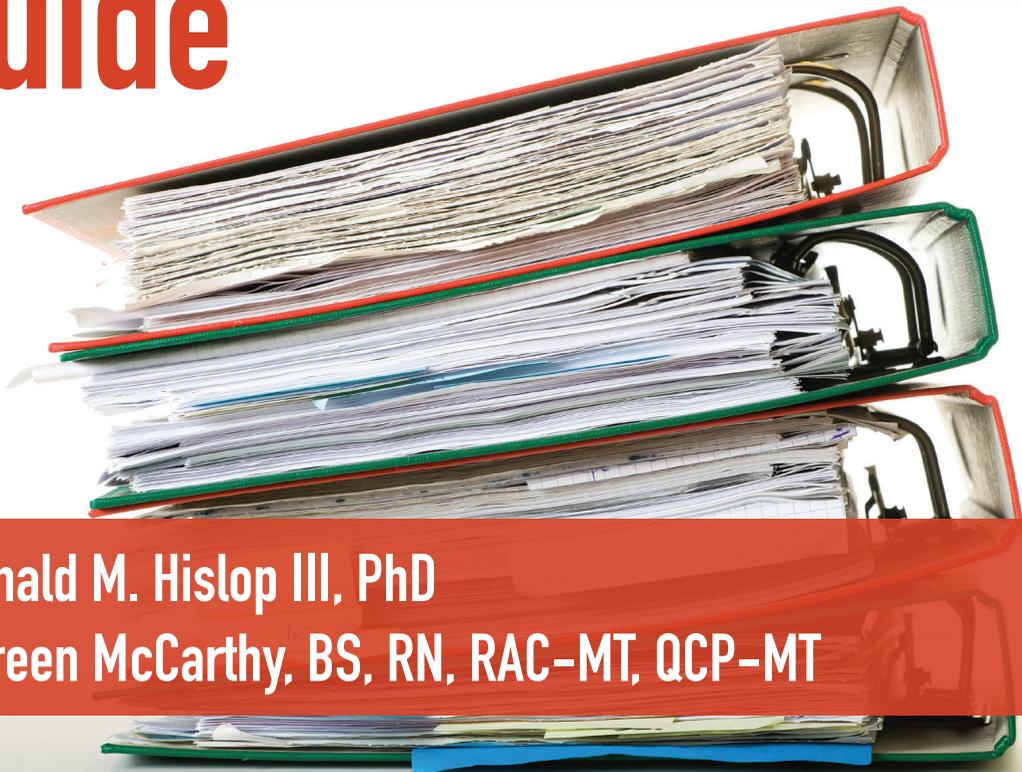




# Five-Star Quality Rating System Technical Users' Guide



Reginald M. Hislop III, PhD

Maureen McCarthy, BS, RN, RAC-MT, QCP-MT

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# Contents

<b><i>About the Authors</i></b> .....	<b>V</b>
<b><i>Chapter 1: Using the Technical Users' Guide for Five-Star Reporting</i></b> .....	<b>1</b>
Introduction to the Manual .....	1
Health Inspection .....	4
Quality Measures .....	5
<b><i>Chapter 2: How to Employ Strategic Opportunities for Marketplace Differentiation</i></b> .....	<b>11</b>
Value-Based Purchasing .....	12
What Should SNFs Do? .....	12
<b><i>Chapter 3: Five-Star Technical Users' Guide and Cutpoints Table</i></b> .....	<b>21</b>
Introduction .....	22
Methodology for Constructing the Ratings .....	26
Staffing Domain .....	32
Quality Measure Domain .....	37
Overall Nursing Home Rating (Composite Measure) .....	49
Change in Nursing Home Rating .....	50
Appendix .....	53
Introduction .....	60
<b><i>Chapter 4: How to Improve Quality</i></b> .....	<b>65</b>
Ensuring Ongoing Quality .....	68
How to Determine Overall Facility Five-Star Rating .....	69
Continued Focus on Efforts to Improve Care .....	71





# About the Authors

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Hislop's practice focus is strategy, health and economic policy, and business and corporate development. Hislop has over 30 years of experience as an executive and consultant in the development, operations, and financing of all aspects of healthcare with particular experience in postacute care. He is the author of over 250 published articles and research reports, as well as a frequent speaker on the national level and a consultant and advisor to numerous trade, investment, and professional organizations. His internationally read website on health policy is [www.rhislop3.com](http://www.rhislop3.com).

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## About the Authors

McCarthy has been a registered nurse for 30 years with experience as an MDS coordinator, director of nursing, rehab director, and Medicare specialist. She is a recognized leader and expert in clinical reimbursement in the SNF environment. Currently, she is the president for the Association of Long Term Care Financial Managers; the Medicare and MDS 3.0 advisor for the Connecticut Association of Health Care Facilities; and an advisor to the J13 Medicare contractor National Government Services Provider Advisory Group. McCarthy is an advisor to the New York State Health Facilities Association on the Nursing Leadership Committee, as well as the Payment for Services Group. She is also an editorial advisor for HCPro.

McCarthy is certified in the resident assessment process and Quality Assurance and Performance Improvement by nationally recognized organizations and holds Master Teacher status with AANAC. She holds a degree in business management as well as a nursing degree. She released her first co-authored publication, *The Long-Term Care Compliance Toolkit*, in September 2011; in June 2015, she followed it with *ICD-10 Compliance: Process Improvement and Maintenance for Long Term Care*. In October 2016, she published *Medicare Audits: A Survival Guide for Skilled Nursing Facilities*.



## Chapter 1

# Using the Technical Users' Guide for Five-Star Reporting

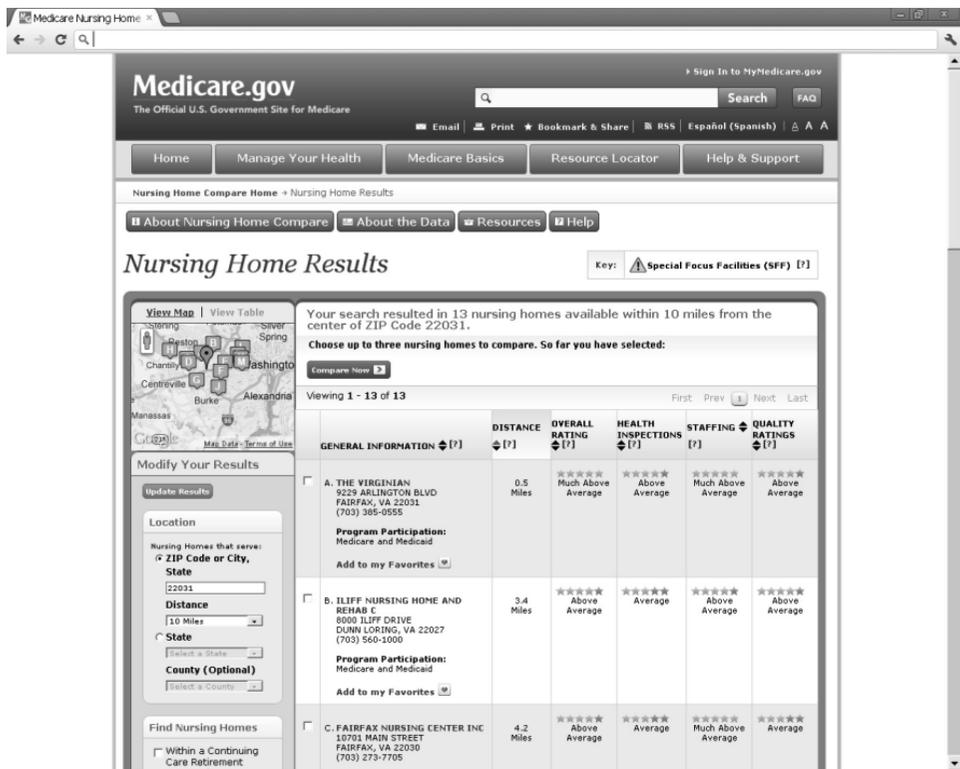
## **Introduction to the Manual**

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As quality and value take a front row seat in the reimbursement world, more emphasis will need to be placed on monitoring and improving your long-term care (LTC) facility's standings. The best way to achieve this is by monitoring for trends and changes to the five-star report ratings. This book will help show the many ways to improve quality and value through regular report monitoring.

In the five-star rating system, skilled nursing facilities (SNF) receive a report on their standings from the Centers for Medicare & Medicaid Services (CMS). The reports are accessed through the Quality Improvement and Evaluation System (QIES) portal, where the MDS assessments are submitted. Each provider has a unique username and password to access the system and retrieve the reports. The MDS quality data reported is nine months old, and a new quarter's worth of data is updated each quarter. The reports are also updated monthly for any survey changes not captured during the quarterly updates—usually this happens after an informal dispute resolution of an appealed survey citation received during the inspection. Staffing data is collected through the CMS 671 form completed during the annual health inspection survey.

The resulting reports are used as a “report card” to grade nursing homes on their care and outcomes. Insurers, healthcare systems, and accountable care organizations (ACO) use these ratings to determine which providers to work with. This creates a preferred provider network for the area, where providers attempt to improve care and reduce spending, and all partners share the financial risk. Consumers also use the five-star rating system to compare and choose a nursing home for themselves or loved ones, using the Nursing Home Compare website to compare facilities (*www.nursinghomecompare.com*). The number of stars a facility has earned in each domain are reported, and users can dive deeper into the value scores that make up each domain by clicking on the links in each section.



Formal and informal healthcare networks are growing in prominence thanks to healthcare reform. Providers are identifying higher-performing organizations within their communities to partner with. Outcomes reported through quality measures, along with reduced spending, are key areas of focus when it comes to selecting high performers.

## ***Tracking costs***

Organizations will now need to watch how much they are spending on each resident admitted to their facility during a Medicare Part A stay. CMS is also watching how much is being spent and will begin to compare SNFs to other providers in the next few years. A measure called Medicare Spending per Beneficiary is due to be added (in FY 2018) to the SNF Quality Reporting Program. This measure will monitor how many Medicare dollars are being spent per beneficiary for postacute care received within the postacute hospital index.

Tracking costs by a new concept called “episodes of care” will have most post-acute providers learning a new skill in the coming years. Providers will need to adeptly switch from a resource-reimbursed system to a system that incentivizes cost reduction. Similar to bundled payments, payments for an episode of care are tied to an event and the services received to treat a condition. This can include hospital services, inpatient rehab facility stays, long-term acute care stays, SNF stays, and home health or outpatient services. The episode will be initiated with the hospital admission and include all services received until 30, 60, or 90 days after admission.

## ***Monitoring quality metrics***

In addition to monitoring expenditures and tracking spending per episode of care, regular monitoring of quality metrics is another area of focus that providers can use to improve standings with a potential healthcare partner. Providers should be using the facility five-star reports at least quarterly to determine whether changes are necessary to maintain or increase their rating.

Changes identified in the five-star reports should be examined for improvement or decline. For some measures, such as vaccinations, an increasing score is a positive trend (i.e., more residents are being vaccinated). For others, such as percentage of residents who developed pressure injuries, an increasing score is a negative trend (i.e., more residents are getting these injuries, formerly known as pressure ulcers). Negative trends should be identified and addressed as soon as possible to mitigate their impact.

## **Health Inspection**

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The annual health inspection survey sets the basis of the star system. This book explains the health inspection domain and the scoring system that determines the domain's star rating (see page 26). The last page of the five-star report lists the surveys used in the star rating for this domain. As explained in the manual, surveys for the past three years are included, as well as re-surveys and substantiated complaint surveys within the past 36 months. Because this domain sets the basis for the star calculation, it is important to continually strive to improve survey results.

### ***Improving survey results***

The number one way to improve survey results is to stay “survey ready” every day. Understanding the expectations of surveyors, and making sure that staff follow the rules every day, will help ingrain proper procedure. Then, when being monitored during a survey, appropriate performance will be second nature to your staff.

Accessing the OSCAR reports on the CASPER reporting section of the QIES MDS submission portal can also aid in improving survey results. These reports show the survey history of your facility over the past three years. Knowing what deficiencies have plagued the facility in the past can help guide improvements. For instance, if your investigation shows that pressure injuries are not being identified in a timely manner, the skin program needs to be evaluated. Then, body audit processes would need to be tested for weaknesses in system, process, or outcomes.

### ***Staffing***

The CMS 671 form is used in the staffing domain for the star rating. It reports the staffing in the two weeks prior to survey and is requested by the survey team. As quarterly payroll-based journal (PBJ) data is collected and refined, staffing hours will likely be updated quarterly. This domain is the second calculation in the five-star rating system (see page 32). It looks at the reported staffing from the CMS

671 and compares it to the expected staffing, which is based on RUG acuity levels reported for all residents from the most recent quarter. Therefore, if your survey was November 1, the most recent quarter would be through September 30. The calculation compares the acuity levels of the facility residents to the staffing hours. After that, there is a final national comparison used to get the adjusted staffing figures. Both staffing calculations—the total staffing and the RN staffing—hold the same weight. CMS has not indicated whether LPNs with administrative duties will correlate to RN hours under the PBJ reporting, as they do currently.

## Quality Measures

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SNF providers often use the five-star reports to monitor their improvement efforts. The Quality Measure (QM) portion of the reports currently holds four quarters' worth of data, and providers can view their trends as new quarters of data are released (see page 37). Declining ratings are analyzed for changes in resident population or clinical programs during that quarter. Although providers are required to have a QAA committee, they will also need to have a Quality Assurance and Performance Improvement (QAPI) plan as of November 28, 2017. Efforts to improve quality ratings should be captured in the facility QAPI plans (Figure 1.1). QAPI plans will need to be developed and given to state surveyors at the start of annual health inspection surveys in FY 2018, so initiation of a QAPI plan while investigating quality reporting isn't a bad idea. After implementing their QAPI plan, facilities can then assess their root cause analysis via their Performance Improvement Project (PIP) assignment tool (Figure 1.2).

**Figure 1.1**

Facility QAPI plan

Sub-committee: \_\_\_\_\_  
 Area requiring improvement: \_\_\_\_\_  
 Current level of performance: \_\_\_\_\_  
 Baseline (acceptable level of performance): \_\_\_\_\_

Plan	Data	Analysis	Action	Follow-up/ Deadline

**Figure 1.2**

PIP assignment tool

QAPI committee meeting date: \_\_\_\_\_

Area requiring improvement: Based on data reported to the QAPI committee the deficient practice that needs improvement is:

Falls     Wounds     Elopement     Infection control     Weight loss

Medication errors

Other: \_\_\_\_\_

---

Data analysis: The data reported to the QAPI committee indicates the acceptable level of performance has not been met as determined by:

BASELINE (acceptable level of performance):	RESULT OF ROOT CAUSE ANALYSIS:
---	--------------------------------

Persons responsible for implementing plan:

Process to be implemented to reach acceptable level of performance:

Individual resident intervention needed     Facilitywide program change needed

Start date: \_\_\_\_\_ Evaluation date: \_\_\_\_\_ Deadline: \_\_\_\_\_

Impact of change:

Successful implementation of process changes noted above. Baseline attained on (date) \_\_\_\_\_.

New policy, or policy update required.

Implemented process change did not reach baseline.

Continue change for 30 more days to allow additional time for staff to comply with new system.

New changes will be implemented and tested for 30 days to bring measured activity to baseline (new plan).

Check only 1:

Committee will report to quality improvement committee only when performance falls below baseline.

Committee will report to quality improvement committee next quarter regarding movement toward baseline.

Many of the quality measure areas are linked based on the functions they assess. For instance, activities of daily living, improvement in function, and decline in locomotion are all related to each other because they report on functional areas and the assistance required by the resident. Therefore, when a facility is looking to improve one of these areas, all three will be affected because they all relate to assessing and improving functional performance. A restorative nursing program may address all three measures and improve them based on the additional restorative services received by the residents.

Improvement in quality measures should strengthen both documentation and clinical programming. Facilities should never try to skew the QM values to give the illusion of improvement. When the clinical programming improves and is documented correctly, the QMs will also improve. Fortunately, this process typically also improves revenue because the clinical programs are functioning appropriately and documentation supports the MDS coding. Quality clinical care and correct documentation lead to accurate and increased reimbursement, with less non-payment claims occurring for each facility.

### ***Addressing declines in quality***

The QMs are mainly pulled from MDS assessments. There are three claims-based measures as well, which have a different measurement window. The MDS-based measures are collected on most assessments sent to the federal repository through the QIES portal. Each time an MDS is completed and submitted, the data is calculated and compared. The five-star reports are generally updated each quarter; therefore, the best time to address any declining quality scores is as soon as the reports are released.

Once a decline is discovered, the related QM should be investigated to determine why the decline is happening.

Sometimes the reason is related to the population being admitted to the facility. If more residents with unstable pressure injuries are being admitted, for example, this could explain a greater incidence of residents triggering for such injuries. At

that point, pressure injury care and treatment should be reviewed to determine whether changes need to be made.

Other areas of investigation may involve supportive documentation. At times, documentation can fall short even when the proper processes are being followed. Documentation that doesn't support the medical record can result in inaccurate MDS coding and false reporting of quality scores.

Finally, auditing MDS assessments for coding accuracy is an important step in avoiding inaccurate quality scores. Inaccurate coding is often related to misunderstanding coding requirements or concepts as set forth in the *Resident Assessment Instrument Manual*. Continued focus on education and accurate coding can help ensure quality scores accurately reflect resident care.

### ***Checking accuracy***

The process of reviewing the results of the QM domain include verifying that the MDS coding is correct. The RN assessment coordinator may have misunderstood the question, the coding, or the intent of a specific MDS section. Education and training in the MDS process can reduce these types of errors. MDS assessments with errors may be corrected to reflect the accurate coding, if done within the allotted time frame (currently, this window is within three years of the assessment reference date).

Once this process has been accomplished and the coding has been verified, the next step is to assess the supportive documentation. Documentation assessment is more than just reviewing the nursing notes—it involves analyzing the whole medical record and the assessments and progress notes of the interdisciplinary team. Any discrepancies in documentation should be addressed with their authors in real time as issues are discovered. Continued focus on the improvement process from month to month will have the most long-lasting effect.



# Five-Star Quality Rating System Technical Users' Guide

Stay compliant with the most up-to-date Five-Star Quality Rating System. ***The Five-Star Quality Rating System Technical Users' Guide*** includes CMS' technical guide to the Five-Star Rating System, as well as expert analysis and insight into how providers can use the guide, how ratings are affected, and what providers can do to improve their rating. Industry experts **Reginald M. Hislop III, PhD**, and **Maureen McCarthy, RN, BS, RAC-MT, CQP**, provide analysis and insight to assist facilities in determining their overall facility five-star rating, employing strategic opportunities for marketplace differentiation, and driving performance with quality care that can translate to maximum star ratings.

This valuable resource provides word-for-word CMS regulatory guidance covering virtually every aspect of a nursing home's quality rating system, including:

- Health inspections
- Staffing
- Quality Measures

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