CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Michelle Baass | Director

SNF WQIP PL 24-002

DATE: August 19, 2024

TO: ALL SNF WQIP PARTICIPANTS

SUBJECT: MDS Data Completeness Updated 150-Day Exclusion Methodology and Technical Clarification

PURPOSE:

This Policy Letter (PL) outlines updated MDS Data Completeness methodology and technical clarification for the Skilled Nursing Facility (SNF) Workforce & Quality Incentive Program (WQIP). DHCS updated the Minimum Data Set (MDS) Data Completeness Metric methodology using 150-day exclusion approach. This change is effective retroactively for Program Year (PY) 1 (2023) of SNF WQIP. The Technical Program Guide for PY 2 will include similar methodology.

BACKGROUND:

The Program Year (PY) 1 WQIP Technical Guide previously included the methodology for the calculation of the MDS Data Completeness metric for long-stay residents based on the stay definitions provided by the Centers for Medicare & Medicaid Services (CMS). However, residents who stopped receiving assessments and did not have a discharge assessment would continue to be included in the denominator for subsequent quarters as their stay would be considered to still be ongoing based on CMS' stay logic. In response to concerns expressed by SNF stakeholders and to align with CMS metric definitions, DHCS revising the logic for the MDS Data Completeness Metric regarding methodology for determining the end of a stay.

The MDS Data Completeness metric impacts the scoring of other MDS metrics. If a facility has an MDS data completeness rate of less than 90 percent then the final MDS score is set to zero, if the MDS data completeness rate is 90-95 percent then the final score is reduced by 50 percent, and if the MDS data completeness rate is at or above 95 percent, then their MDS final score remains the same.

For more details on the previous MDS Data Completeness methodology, please refer to page 24 of the PY 1 WQIP Technical Program Guide .

POLICY

Effective for PY 1, DHCS will count a person as a resident of the facility for all quarters which fall between their latest assessment and the 150 days after (i.e., if the 150-day period overlaps between two quarters, they will be included in both quarters as DHCS will assume that they are

still in the facility up to the 150-day date). DHCS would then consider them no longer to be in the facility on the 150th day. However, if the facility begins to submit assessments for the resident at a later date that are not the start of a new episode (i.e., the new assessment is not a new entry assessment which indicates the start of a new stay/episode as defined by CMS' stay logic) then DHCS will consider the resident to still be in the facility.

Updated MDS Data Completeness Methodology

To ensure facilities submit the appropriate MDS assessments, DHCS will require facilities to meet a 90 percent MDS data completeness threshold to receive points for the MDS clinical metrics. The data completeness methodology is designed to reflect the percentage of residents who had an assessment with a qualifying reason for assessment (RFA) submitted for each quarter they resided in a facility. Based on the MDS guidelines for assessment submissions (i.e., frequency and timing), facilities should submit at least one assessment with a qualifying RFA that can be used as a target assessment in each quarter the resident is in the facility. The MDS data completeness will be defined as the percentage of patients who have an assessment submitted for each quarter they resided in a facility. For this metric, Health Services Advisory Group (HSAG) will only use MDS assessments that had a submission date within 60 days of the target date and will be limited to long-stay residents to reflect the population of the MDS Clinical Metrics Measurement Area. The data completeness rate will be calculated for each quarter and aggregated into an annual rate by summing the quarterly numerators and dividing it by the sum of the quarterly denominators. To calculate the MDS data completeness, the following criteria will be used:

- Numerator: The numerator criteria for the data completeness metric includes long-stay residents who had an assessment submitted with a qualifying RFA (A0310A = [01,02,03,04,05,06], or A0310B = [01], or A0310F = [10,11]) during the quarter.
- Denominator: The denominator will include the long-stay residents who are identified for each facility during the quarter. To determine the long-stay residents in each quarter, HSAG will use the stay definitions and instructions for a well-constructed data stream provided by CMS in the MDS 3.0 Quality Measures User's Manual Version 16.0. Based on this, a resident stay is considered ongoing until either a discharge or death assessment (A0310F = [10, 12]) is reported, a discharge assessment with return anticipated (A0310F = [11]) is reported but the resident did not return, or the end of the reporting period (i.e., the end of each quarter). If a resident does not have a reported discharge assessment, the stay logic considers the stay ongoing, and the resident will be included in the denominator if their cumulative days in the facility are greater than or equal to 101 days as of the end of the quarter. To account for residents who did not have a discharge assessment and residents who were recorded as deceased, HSAG will incorporate the following exclusion criteria:
    - For any resident who does not have a discharge assessment and stopped receiving assessments, HSAG will consider them to be in the facility for 150 days after their latest assessment. Once 150 days or more with no assessments have

passed, HSAG will consider them to no longer be in the facility starting on the 150th day after their latest assessment and they will not be included in the denominator population for the following quarters. Please note, a resident will be included in the denominator of the facility for all quarters that fall between their latest assessment and the 150th day after (e.g., if a resident's latest assessment is in quarter 1 and the 150-day period ends in quarter 3, they will be included in the denominator for quarters 1-3). However, if the facility submits a non-admission assessment for the resident at a later date that is not the start of a new episode (i.e., the new assessment is not an admission assessment that indicates the beginning of a new episode (A0310F = [01] and A1700 = [1]) as defined by CMS' stay logic), then the resident will be considered to still be in the facility and will included in the denominator for all prior quarters. For example, if a resident's latest assessment was in quarter 1 and received no assessments for the following 150 days, but then receives an assessment in quarter 4 that does not indicate the start of a new episode (i.e., it is not a new admission assessment), then this resident will be included in the denominator for all four quarters.

- Additionally, the following optional exclusion will be applied if the resident is not eligible for the numerator: The resident had a death in a facility assessment (A0310F = [12]) during the selection period. This optional exclusion is applied to not penalize facilities for residents who were deceased during the selection period before an assessment with a qualifying RFA can be performed.

HSAG will use assessments with a target date up to one year prior to the start of the PY 1 measurement period for the purposes of determining resident stays and calculating the MDS data completeness rate (i.e., for PY 1, this will include assessments with a target date on or after July 1, 2021). These calculations will include assessments submitted up until two months after the end of the measurement period (i.e., for PY 1, HSAG will use assessments submitted by the end of August 2023 for the purposes of the measure calculations). Additionally, HSAG will include one additional look forward quarter of data (i.e., Q3 2023 for PY 1) to determine if residents have any additional assessments after the 150-day exclusion period. For PY 1, this look forward period will include assessments with a target date on or before September 30, 2023 that were submitted by the end of November 2023. This additional look forward quarter will be used for the purposes of evaluating the 150-day exclusion criteria and will not be included in the MDS data completeness rate.

A copy of this Policy Letter is posted on the SNF WQIP website at https://www.dhcs.ca.gov/services/Pages/SNF-WQIP.aspx. The updated MDS Data Completeness metric methodology outlined above will be incorporated into the WQIP Technical Program Guide for PY2 (2024). If you have any questions regarding this policy letter, please contact SNFWQIP@DHCS.ca.gov.

ORIGINAL SIGNED BY JEFFREY NORRIS, MD

Value-Based Payment Branch Chief
Quality and Population Health Management (QPHM)
Department of Healthcare Services