The Ohio Department of Medicaid's MyCare MDS Quality Measures Methods

Provider Agreement Effective July 1, 2019 to June 30, 2020

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OVERVIEW

These methods include six minimum data set (MDS) nursing facility quality measures which are based on CMS MDS 3.0 Quality Measures User's Manual (v13.0).

Separate rates will be calculated for the opt-in and opt-out populations for each measure. The opt-in population includes members who are enrolled in a MyCare Ohio Plan (MCOP) and are part of the Integrated Care Delivery System (ICDS) demonstration. The opt-out population includes members that are enrolled in an MCOP but are not included in the ICDS demonstration.

In order to determine MCOP enrollment on a quarterly basis, Ohio Department of Medicaid (ODM) will generate an MCOP- specific *MyCare Ohio Plan Quarterly Enrollment File* to be used by the MCOP to validate enrollment for the calculation of quality and data quality metrics. The MCOP must submit a file to ODM specifying any enrollment span deletions and/or additions pertaining to the enrollment information in the *MyCare Ohio Plan Quarterly Enrollment File,* or confirm that the MCOP does not have any changes to ODM's enrollment information. This file should also contain an identifier for the members' opt status. If the MCOP submits addition and/or deletion information, the MCOP must certify that the information is accurate and complete and may be audited by ODM and/or on behalf of ODM. Discrepancies between ODM's and the MCOP's data files will be sent to the Bureau of Managed Care for resolution, including potential system corrections to member enrollment. ODM will use the most current final quarterly enrollment file, including additions and deletions submitted by the MCOP, to calculate the MyCare measures described in this methodology.

Measurement Period

Measurement Eligible Population

To be included in the measurement period, members must meet the following criteria:

- Age 18 and older at the time of enrollment.
- Eligible for full Medicare Parts A, B, and D and full Medicaid.
- Reside in an ICDS Demonstration county.[1]

The following populations will be excluded from enrollment during the measurement period:

- Individuals under the age of 18.
- Individuals who died at any time during the measurement period.
- Individuals who used hospice services. Members who used hospice services will be identified using the Hospice Value Set. Please refer to Appendix B for a complete list of values.
- Individuals who are Medicare and Medicaid eligible and are on a delayed Medicaid spend down.
- Individuals enrolled in both Medicare and Medicaid who have other third party creditable health care coverage.
- Individuals with ID and other DD who are otherwise served through an IDD 1915(c) HCBS waiver or an ICF-IDD.
- Individuals enrolled in PACE.
- Individuals participating in the CMS IAH demonstration.

Measurement Data Sources

The sources of the data for calculating the measures are as follows:

(1) MDS Data
(2) MCOP Quarterly Enrollment File
(3) MITS Demographic Information (for determining deceased members)
(4) MCOP Submitted Encounter Data (for determining hospice members)

The measurement results will be presented by MCOP and opt-status for each measure.

[1] There are a total of 29 demonstration counties: Butler, Clark, Clermont, Clinton, Columbiana, Cuyahoga, Delaware, Franklin, Fulton, Geauga, Greene, Hamilton, Lake, Lorain, Lucas, Madison, Mahoning, Medina, Montgomery, Ottawa, Pickaway, Portage, Stark, Summit, Trumbull, Union, Warren, Wayne, and Wood.

Definitions

Demonstration (Opt-in Population)–contains dual-eligible consumers who elected the full integrated service package (i.e., enrolled in MyCare Ohio). Members who do not have an opt-out flag in the MyCare Ohio Plan Quarterly Enrollment File will be considered opt-in for that month.

Medicaid-Only (Opt-out Population)–contains Medicaid-only consumers that are enrolled in an MCOP. The opt-out flag included in the MCOP Quarterly Enrollment File will be used to determine this status.

Episode and Stay Determination Logic

Prior to calculating the quality measures using MDS data, Long Stay determinations are assigned to each resident. Long Stay logic depends on the target period, the type of stay, and the construction of episodes in calculating the total number of days a resident has been at a particular facility.

The target period is the span of time that defines the quality measure reporting period. Long Stay measures evaluate the calendar year.

A stay is the period of time between a resident's entry into a facility and either a discharge, death, or the end of the target period. The start of the stay is either an admission entry (A0310F = [01] and A1700 = [1]) or a re-entry (A0310F = [1] and A1700 = [2]). An admission entry occurs when: 1) the resident has never been admitted to the facility before, 2) has been at the facility before and was discharged without an anticipated return (A0310F = [10]), or 3) was discharged with an anticipated return (A0310F = [11]) but did not return within 30 days of discharge. A re-entry occurs when the resident was discharged with an anticipated return (A0310F = [11]) and returned within 30 days of discharge. The end of the stay is the earliest of the following: 1) a discharge assessment (A0310F = [10, 11]), 2) death in a facility (A0310F = [12]), or 3) the end of the target period.

An episode consists of one or more stays and is defined as a contiguous set of days in a facility. An episode begins with an admission and ends with either: 1) a discharge assessment where a return is not anticipated (A0310F = [10]), 2) a discharge assessment with return anticipated (A0310F = [11]) but the resident did not return within 30 days, 3) death (A0310F = [12]), or the end of the target period. In constructing an episode, two or more stays can be rolled into one episode. If a record is defined as a re-entry, then that stay and the previous stay are counted in the same episode. A resident can have multiple re-entries that can be combined into one episode, if the re-entries occur in sequence without any gaps of 30 days or greater.

Once an episode has been constructed, the number of cumulative days in a facility (CDIF) is calculated. Days outside of the facility are not counted toward the CDIF. If the most recent episode in the target period has a CDIF that is greater than or equal to 101 days, the episode is considered a Long Stay.

Target Assessment

The target assessment criteria are used to identifythe assessment that will be used to calculate the following measures:

- Percent of Residents Experiencing One or More Falls with Major Injury
- Percent of High-Risk Residents with Pressure Ulcers
- Percent of Residents with a Urinary Tract Infection
- Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder
- Percent of Residents Who Were Physically Restrained
- Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased

The target assessment includes a selection period of the most recent 12 months. A target assessment is the most recent assessment within the episode that has a qualifying reason for assessment (RFA) (A0310A = [01,02,03,04,05,06], or A0310B = [01], or A0310F = [10,11]) and has a target date that is no more than 120 days before the end of the episode.

Look-Back Scan

The look-back scan is used in assessing the Percent of Residents Experiencing One or More Falls with Major Injury measure. The selection period includes all assessments within the current episode, with a qualifying RFA (see description above), and includes a target date no more than 275 days prior to the target assessment (including the target assessment).

Prior Assessment

The prior assessment is used in assessing the Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased measure. The selection period includes the latest assessment that is 46 to 165 days before the target assessment, has a qualifying RFA (see description above), and is contained within the resident's episode. If no qualifying assessment exists, the prior assessment is considered missing.

Nursing Facility MDS Quality Measures

Please refer to Appendix A of this methodology for the attribution of members to an MCOP and opt status for the MDS Quality measures.

Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

The percentage of long-stay residents who have experienced one or more falls with major injury reported in the measurement period or look-back period.

Numerator: Total number of long-stay residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury (J1900C = [1,2]).

Denominator (Demonstration [Opt-in]): Total number of opt-in long-stay nursing home residents with one or more look-back scan assessments, except those with exclusions.

Denominator (Medicaid-only [Opt-out]): Total number of opt-out long-stay nursing home residents with one or more look-back scan assessments, except those with exclusions.

Exclusions: Resident is excluded from the denominator if one of the following is true for ***all*** of the look-back scan assessments:

1. The number of falls with major injury was not coded (J1900C = [-]).

Data Sources: MDS data
MCOP Quarterly Enrollment File

Report Period:
Measurement period: January – December 2019
Look-back period: January – December 2018

Measure Steward: CMS (v13.0)

Percent of High-Risk Residents with Pressure Ulcers (Long Stay)

The percentage of long-stay, high-risk residents with Stage II through IV or unstageable pressure ulcers.

Numerator: Total number of long-stay residents with a selected target assessment that meets the following condition:

1. Stage II-IV or unstageable pressure ulcers are present, as indicated by ***any*** of the following six conditions:
    a. M0300B1 = [1, 2, 3, 4, 5, 6, 7, 8, or 9], or
    b. M0300C1 = [1, 2, 3, 4, 5, 6, 7, 8, or 9], or
    c. M0300D1 = [1, 2, 3, 4, 5, 6, 7, 8, or 9] or
    d. M0300E1 = [1, 2, 3, 4, 5, 6, 7, 8, or 9] or
    e. M0300F1 = [1, 2, 3, 4, 5, 6, 7, 8, or 9] or
    f. M0300G1 = [1, 2, 3, 4, 5, 6, 7, 8, or 9].

Denominator (Demonstration [Opt-in]): Total number of opt-in long-stay residents with a selected target assessment who meet the definition of high-risk (see criteria below), except those with exclusions.

Denominator (Medicaid-only [Opt-out]): Total number of opt-out long-stay residents with a selected target assessment who meet the definition of high-risk (see criteria below), except those with exclusions.

Residents are defined as high-risk if they meet ***one or more*** of the following three criteria on the target assessment:

1. Impaired bed mobility or transfer indicated, by ***either or both*** of the following:
    a. Bed mobility, self-performance (G0110A1) = [3, 4, 7, 8]
    b. Transfer, self-performance (G0110B1) = [3, 4, 7, 8]
2. Comatose (B0100 = [1])
3. Malnutrition or at risk of malnutrition (I5600 = [1]) (checked)

Exclusions: The following exclusions apply when determining the denominator:

1. Target assessment is an OBRA admission assessment (A0310A = [01]), or a Prospective Payment System (PPS) 5-day assessment (A0310B = [01]).
2. If the resident is not included in the numerator (i.e., the resident did not meet the pressure ulcer conditions for the numerator) and ***any*** of the following conditions are true:
    a. M0300B1 = [-]
    b. M0300C1 = [-]
    c. M0300D1 = [-]
    d. M0300E1 = [-]
    e. M0300F1 = [-]
    f. M0300G1 = [-].

Data Sources: MDS data
MCOP Quarterly Enrollment File

Report Period:
Measurement period: January – December 2019

Measure Steward: CMS (v13.0)

Percent of Residents with a Urinary Tract Infection (Long Stay)

The percentage of long-stay residents who have a urinary tract infection.

Numerator: Total number of long-stay residents with a selected target assessment that indicates urinary tract infection within the last 30 days (I2300 = [1]).

Denominator (Demonstration [Opt-in]): Total number of opt-in long-stay residents with a selected target assessment, except those with exclusions.

Denominator (Medicaid-only [Opt-out]): Total number of opt-out long-stay residents with a selected target assessment, except those with exclusions.

Exclusions: The following exclusions apply when determining the denominator:

1. Target assessment is an admission assessment (A0310A = [01]), or a PPS 5-day assessment (A0310B = [01]).
2. Urinary tract infection value is missing (I2300 = [-]).

Data Sources: MDS data
MCOP Quarterly Enrollment File

Report Period:
Measurement period: January – December 2019

Measure Steward: CMS (v13.0)

Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long Stay)

The percentage of long-stay residents who have/had an indwelling catheter in the last 7 days.

Numerator: Total number of long-stay residents with a selected target assessment that indicates the use of indwelling catheters (H0100A = [1]).

Denominator (Demonstration [Opt-in]): Total number of opt-in long-stay residents with a selected target assessment, except those with exclusions.

Denominator (Medicaid-only [Opt-out]): Total number of opt-out long-stay residents with a selected target assessment, except those with exclusions.

Exclusions: The following exclusions apply when determining the denominator:

1. Target assessment is an admission assessment (A0310A = [01]), or a PPS 5-day assessment (A0310B = [01]).
2. Target assessment indicates that indwelling catheter status is missing (H0100A = [-]).
3. Target assessment indicates neurogenic bladder (I1550 = [1]) or neurogenic bladderstatus is missing (I1550 = [-]).
4. Target assessment indicates obstructive uropathy (I1650 = [1]) or obstructive uropathy status is missing (I1650 = [-]).

Data Sources: MDS data
MCOP Quarterly Enrollment File

Report Period:
Measurement period: January – December 2019

Measure Steward: CMS (v13.0)

Percent of Residents Who Were Physically Restrained (Long Stay)

The percentage of long-stay nursing facility residents who are physically restrained on a daily basis.

Numerator: Total number of long-stay residents with a selected target assessment that indicates daily physical restraints, where:

- Trunk restraint used in bed (P0100B = [2]), or
- Limb restraint used in bed (P0100C = [2]), or
- Trunk restraint used in chair or out of bed (P0100E = [2]), or
- Limb restraint used in chair or out of bed (P0100F = [2]), or
- Chair prevents rising used in chair or out of bed (P0100G= [2]).

Denominator (Demonstration [Opt-in]): Total number of opt-in long-stay residents with a selected target assessment, except those with exclusions.

Denominator (Medicaid-only [Opt-out]): Total number of opt-out long-stay residents with a selected target assessment, except those with exclusions.

Exclusions: Resident is not in the numerator and any of the following is true:

- P0100B = [-], or
- P0100C = [-], or
- P0100E = [-], or
- P0100F = [-], or
- P0100G = [-].

Data Sources: MDS data
MCOP Quarterly Enrollment File

Report Period:
Measurement period: January – December 2019

Measure Steward: CMS (v13.0)

Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long Stay)

The percentage of long-stay residents whose need for help with late-loss Activities of Daily Living (ADLs) has increased when compared to the prior assessment.

Numerator: Total number of long-stay residents with a selected target and prior assessments that indicate the need for help with late-loss ADLs has increased when the selected assessments are compared (see criteria below). The four late-loss ADL items are self-performance bed mobility (G0110A1), self-performance transfer (G0110B1), self-performance eating (G0110H1), and self-performance toileting (G0110I1).

An increase is defined as an increase in two or more coding points in one late-loss ADL item or one-point increase in coding points in two or more late-loss ADL items. Note, for each of the four ADL items, if the value is equal to [7, 8] on either the target or prior assessment, then recode the item to equal [4] to allow appropriate comparison.

Residents meet the definition of increased need of help with late-loss ADLs if ***either*** of the following is true:

1. ***At least two*** of the following are true (note that in the notation below, [t] refers to the target assessment, and [t-1] refers to the prior assessment):
    a. Bed mobility: ([Level at target assessment (G0110A1[t])] - [Level at prior assessment (G0110A1[t-1])]) > [0], ***or***
    b. Transfer: ([Level at target assessment (G0110B1[t])] - [Level at prior assessment (G0110B1[t-1])]) > [0], ***or***
    c. Eating: ([Level at target assessment (G0110H1[t])] - [Level at prior assessment (G0110H1[t-1])]) > [0], ***or***
    d. Toileting: ([Level at target assessment (G0110I1[t])] - [Level at prior assessment (G0110I1[t-1])]) > [0].
2. ***At least one*** of the following is true:
    a. Bed mobility: ([Level at target assessment (G0110A1[t])] - [Level at prior assessment (G0110A1[t-1])]) > [1], ***or***
    b. Transfer: ([Level at target assessment (G0110B1[t])] - [Level at prior assessment (G0110B1[t-1])]) > [1], ***or***
    c. Eating: ([Level at target assessment (G0110H1[t])] - [Level at prior assessment (G0110H1[t-1])]) > [1], ***or***
    d. Toileting: ([Level at target assessment (G0110I1[t])] - [Level at prior assessment (G0110I1[t-1])]) > [1].

Denominator (Demonstration [Opt-in]): Total number of opt-in long-stay residents with a selected target and prior assessment, except those with exclusions. Members must not have an opt-out flag in the MCOP Quarterly Enrollment file during each month of the measurement period.

Denominator (Medicaid-only [Opt-out]): Total number of opt-out long-stay residents with a selected target and prior assessment, except those with exclusions.

Exclusions: The following exclusions apply when determining the denominator:

1. All four of the late-loss ADL items indicate total dependence on the prior assessment, as indicated by:
    a. Bed mobility (G0110A1) = [4, 7, 8] and
    b. Transferring (G0110B1) = [4, 7, 8] and
    c. Eating (G0110H1) = [4, 7, 8] and
    d. Toileting (G0110I1) = [4, 7, 8].
2. Three of the late-loss ADLs indicate total dependence on the prior assessment, as in #1 AND the fourth late-loss ADL indicates extensive assistance (value 3) on the prior assessment.
3. If the resident is comatose (B0100 = [1, -]) on the target assessment.
4. Prognosis of life expectancy is less than 6 months (J1400 = [1, -]) on the target assessment.
5. Hospice care (O0100K2 = [1, -]) on the target assessment.
6. The resident is not in the numerator and
    a. Bed mobility (G0110A1) = [-] on the prior or target assessment, or
    b. Transferring (G0110B1) = [-] on the prior or target assessment, or
    c. Eating (G0110H1) = [-] on the prior or target assessment, or
    d. Toileting (G0110I1) = [-] on the prior or target assessment.

Data Sources: MDS data
MCOP Quarterly Enrollment File

Report Period:
Measurement period: January – December 2019
Look-back period: January – December 2018[2]

Measure Steward: CMS (v13.0)

[2] The look-back period will not use an entire calendar year's data for the prior assessment. Prior assessments only look back 46 to 165 days before the target assessment.

Appendix A

IPRO will use the attribution logic described in the table below for the six MDS Quality Measures.

<table>
<tr><th>Measure</th><th>Denominator</th><th>Numerator</th></tr>
<tr><td>Percent of High-Risk Residents with Pressure Ulcers</td><td rowspan="5">Most recent episode during the measurement period, as identified using MDS data, that is greater than 100 days with a target assessment that is within 120 days of the end of the stay. Each episode will be attributed to a plan and opt-status based on enrollment around the target assessment.

- Member must be enrolled from the target assessment to the end of their episode.
- Member must be enrolled either for the 3 months prior to their target assessment OR from the beginning of their episode (whichever time period is the shortest will count).</td><td rowspan="5">When determining numerator compliance, numerator events will be attributed to the same MCOP as the denominator and only assessments that occurred while the member was enrolled will be considered.</td></tr>
<tr><td>Percent of Residents with a Urinary Tract Infection</td></tr>
<tr><td>Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder</td></tr>
<tr><td>Percent of Residents Who Were Physically Restrained</td></tr>
<tr><td>Percent of Residents Experiencing One or More Falls with Major Injury</td></tr>
<tr><td>Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased</td><td>Members must meet all the criteria described above and members must have a prior assessment that is 46 to 165 days before their target assessment.</td><td>Members must meet all the criteria described above, with the exception that members do not need to be enrolled with the same plan on the date of their prior assessment.</td></tr>
</table>

Appendix B

IPRO will use the Hospice Value Set to exclude members who received hospice services during the measurement periods.

Code System	Code
CPT	99377, 99378
HCPCS	G0182, G9473, G9474, G9475, G9476, G9477, G9478, G9479, Q5003, Q5004, Q5005, Q5006, Q5007, Q5008, Q5010, S9126, T2042, T2043, T2044, T2045, T2046
UBREV	0115, 0125, 0135, 0145, 0155, 0235, 0650, 0651, 0652, 0655, 0656, 0657, 0658, 0659