Net Health

HEALTH CARE AUTHORITY

New Mexico Nursing Facility HCQS VBP Program Overview

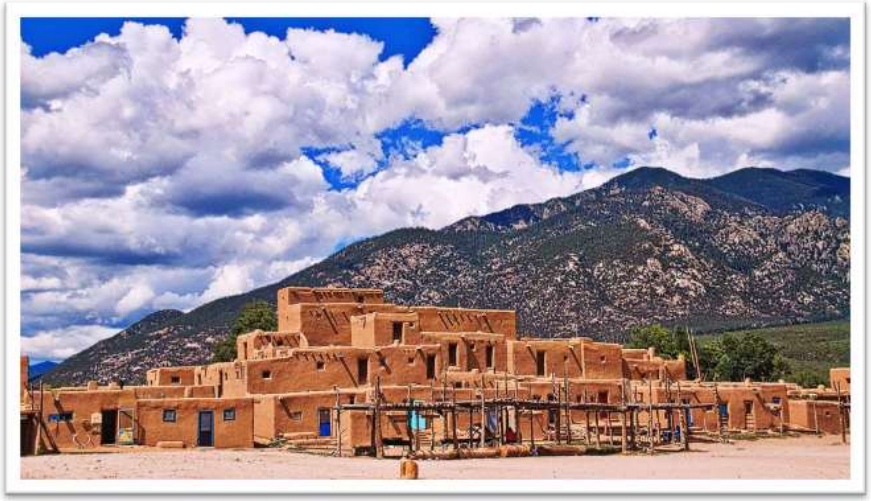
August 20, 2025

BEFORE WE START…

On behalf of all colleagues at the Health Care Authority, we humbly acknowledge we are on the ancestral lands of the original peoples of the Pueblo, Apache, and Diné past, present, and future.

With gratitude we pay our respects to the land, the people and the communities that contribute to what today is known as the **Great State of New Mexico**.

Learn more: About Taos Pueblo at Taospueblo.com



A cloudy morning looking over Taos Pueblo
Photo provided by elpueblolodge.com

Objectives

1. Identify the core elements of the quality-incentive portion of the redesigned HCQS VBP program.
2. Explain the structural measure requirements and the role they play within the HCQS VBP program.
3. Evaluate your current quality measure and survey results to estimate your performance tier.

Agenda

1. Introduction
2. Regulatory Landscape
3. HCQS VBP Program Overview
4. Structural Measure Requirements
5. Current QM performance in Net Health application
6. Performance Tier Estimation
7. Q&A

Introduction

EXECUTIVE SUMMARY

The **Health Care Quality Surcharge (HCQS)** was created by Senate Bill 246 (SB246) in the 2019 Regular Legislative Session. The program imposes a daily surcharge on certain types of Facilities, including Nursing Facilities (NF) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), for non-Medicare bed days. The purpose of the surcharge is to increase each Facility's Medicaid reimbursement rates by at least the rate of nursing home inflation and to provide bonus payments to Medicaid Certified Facilities (NFs only) based on performance data.

Per SB246, the purpose of the Health Care Quality Surcharge Act is to enhance federal financial participation in Medicaid to increase Medicaid provider reimbursement rates and support facility quality improvement efforts in skilled nursing facilities, intermediate care facilities, and intermediate care facilities for individuals with intellectual disabilities.

HCQS PAYMENT MECHANICS

Surcharge Add-On: Paid on a per diem basis to Facilities (NF and ICD/IID). The Surcharge Add-On is calculated by HCA and provided to the MCOs and Nursing Facilities. This amount will change each July 1st in accordance with the statute.

MBI Increase: Added to the rate paid on a per diem basis to Facilities (NF only). HCA will increase the current rate by stated MBI Increase percentage on July 1st in accordance with the statute.

Quality Payment: Quarterly supplemental incentive payment that is only applicable to Nursing Facilities.

GOALS OF HCQS QUALITY PAYMENT

- Incentivize Nursing Facility providers to improve or maintain high quality outcomes for Medicaid beneficiaries.
- Increase access to services for Medicaid beneficiaries.
- Better value for Medicaid funds spent on care.

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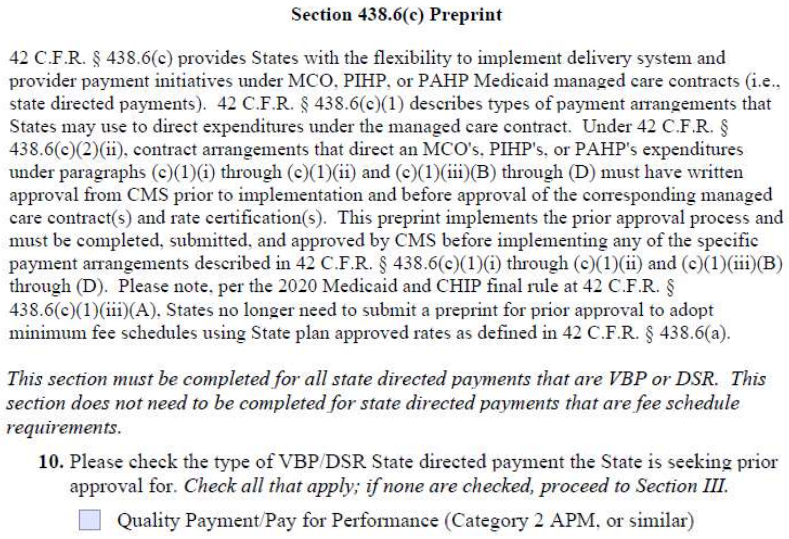
Regulatory Landscape

CMS Expectations

- On 5/10/24, CMS published the Medicaid Program; Medicaid and CHIP Managed Care Access, Finance, and Quality final rule to advance CMS's efforts to improve access to care, quality and health outcomes, and better address health equity issues for Medicaid and CHIP managed care enrollees.

- One key section of this final rule focuses on **State Directed Payments** (SDPs). Payment to providers under the SDP:
  - Cannot be conditioned upon administrative activities, such as the reporting of data nor upon the participation in learning collaboratives or similar administrative activities
  - Must use a common set of performance measures across all payers and providers
  - Must use measurable performance targets which demonstrate maintenance or improvement over baseline data on all metrics that will be used to measure the performance that is the basis for payment to the provider from the MCO

CMS Preprint



Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)

Quality = 22
Performance = 24
Outcomes = 5
Target = 10

- Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services.
- Identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement.
- Please describe the methodology used to set the performance targets for each measure.
- Discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?
- For state-developed measures, please briefly describe how the measure was developed.
- To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. Describe how this payment arrangement is expected to advance the goal(s) and objective(s).
- Evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy.
- Performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives.

OIG 2024 Work Plan

In July, the OIG added the following item to its 2024 Work Plan:

State Directed Payments in Medicaid Managed Care

"For selected State directed payments in Medicaid managed care, our objective is to determine whether the State:

1) Obtained CMS approval for the directed payment proposal
2) Complied with CMS-approved requirements and outcomes in the approved proposal
3) Ensured that directed payments were made according to the approved proposal"

QIO 13th Scope of Work (2024-2029)
CMS Quality Improvement Program

- Key areas of focus:
  - ✓ OUTCOMES (Improve quality and health outcomes across the care journey)
  - ✓ ALIGNMENT (Align and coordinate across programs and care settings)
  - ✓ SCIENTIFIC ADVANCEMENT (Transform health care using science, analytics, and technology)

- A summed severity score methodology is used to evaluate nursing facility quality performance
  - ✓ Health inspection, staffing, clinical, utilization, cybersecurity, emergency preparedness
  - ✓ 21 outcome measures (including Falls with Major Injury)
  - ✓ 10 process measures

CMS 2023 Quality Conference deck

HCQS VBP Program Overview

Guiding Principles

- Align with state quality strategy, goals and objectives.
- Minimize administrative burden on healthcare providers.
- Leverage and build on existing processes and tools.
- Develop a program that will be transparent and simple to understand to influence behavior and outcomes.
- Provide actionable insights to help drive performance outcomes with no surprises.
- Account for variation across healthcare providers.
- Distribute payments based on performance relative to targets.
- Implement regular program reviews to evaluate effectiveness and make any changes needed.

Minimum Requirements for Provider Participation

- Medicaid Certified Nursing Facility
- Required contracts/agreements executed with the Data Intermediary and MCOs
- Must submit required data to Data Intermediary and meet data completeness standards*
- Must have Medicaid utilization during the measurement quarter to receive payment

*Net Health will develop data completeness standards for MDS data submission based on historical volumes of Facility data submissions. Failure to meet the minimum data completeness standards will result in suspension of payment calculations pending results of a Facility audit. If the Facility can provide appropriate documentation to support the decrease in MDS volume, payment calculations will resume. Specific audit requirements and timelines will be developed.

Components of the Program

- Funding mechanism
- Quality measurement
- Assessing performance
- Linking performance to payment
- Ongoing evaluation & changes

Quality Payment Components

Tiered Percentage Quality Payment

- Performance is based on quality measures
- Total funds available each quarter is determined by HCA/actuarial vendor
- Facility maximum payment = per diem rate * Facility bed days
- Facility maximum payment is adjusted by a tiered percentage based on quality performance
- Unearned funds go to the high-acuity pool

High-Acuity Add-On

- Additional per-diem payment based on Facility's High-Acuity Medicaid Bed Days (residents with certain behavioral and complex neurological diagnoses)
- Total funds available is determined by the residual funds from tiered percentage quality payments

Disqualification Events

To ensure fair and equitable performance across Facilities, certain events will result in no payment for the performance quarter.

- **No MDS submission for the quarter**
- **MDS submission below data completeness standard**
- **No Medicaid utilization (bed days) for the quarter**

HCQS VBP
Quality Measures

	Name	Identifier	Data Source
1	**LS prevalence of PU**	CMS N045.01	Calculated from MDS data
2	**LS falls with major injury**	CMS N013.02	Calculated from MDS data
3	**LS weight loss**	CMS N029.02	Calculated from MDS data
4	**LS worsened ADL**	CMS N028.03	Calculated from MDS data
5	**LS Hospitalization**	Net Health NQF #2827	Calculated from MDS data
6	**Infection Control Program** ***Structural Measure***	State-Derived	Facility attestation
7	**Patient Experience** ***Structural Measure***	State-Derived	Facility attestation
8	**Behavioral Health Care Coordination** ***Structural Measure***	State-Derived	Facility attestation
9	**CMS Health Inspection Score**	CMS	Reported by CMS

Structural Measures

For structural measures, Facilities will attest each quarter to whether specific, auditable performance requirements have been met or not met.

Specific requirements for each quarter will be determined with input from the stakeholder workgroup.

Infection Control Program Structural Measure

- Facility has an effective infection control program that includes pursuing improved outcomes in resident and employee vaccination rates, prevention of healthcare-acquired infections, and antibiotic stewardship.

Patient Experience Structural Measure

- Facility completes the operational readiness, training, implementation, and operationalization activities necessary to measure patient experience, which is directly related to the quality and safety of healthcare services delivered and impacts health outcomes.

Behavioral Health Care Coordination Structural Measure

- Facility completes the operational readiness, training, implementation, and operationalization activities necessary to effectively coordinate care for residents with behavioral health needs.

Monitored Only Measures

Monitored only measures are quality metrics that are tracked and reported but not directly tied to financial incentives or penalties. Changing QMs to “monitored only” after performance targets have been achieved helps ensure that performance does not decline on these measures when providers shift focus and resource allocation to new measures in the program.

- **Long Stay Antipsychotic (CMS N031.04)**
- **Long Stay Influenza Vaccine (CMS N016.03)**
- **Long Stay Pneumococcal Vaccine (CMS N020.02)**
- **Long Stay Depression (CMS N030.03)**

Assessing Performance & Linking Performance to Payment

Each Quality Measure (QM) is worth a certain number of points.

Compare each facility's QM values to established cut points.

Assign points for each QM based on cut point range, then sum the points.

Total number of points determines the Facility's performance tier.

Performance tier determines percentage of maximum facility-specific

Residual funds are distributed to the High-Acuity Add-On pool.

High-Acuity Add-On

Additional per-diem payment based on Facility's High-Acuity Medicaid Bed Days (residents with certain behavioral and complex neurological diagnoses)

Total funds available is determined by the residual funds from tiered percentage quality payment

Scoring (Calculation of Points)

NAME	IDENTIFIER	DATA SOURCE	BASELINE TIMEFRAME	POINTS				
				20	40	60	80	100
Long Stay Prevalence of Pressure Ulcers	CMS N045.01	Calculated from MDS data	CY 2024	≥16.28%	11.11-16.27%	7.63-11.10%	4.28-7.62%	< 4.28%
Long Stay Falls with Major Injury	CMS N013.02	Calculated from MDS data	CY 2024	≥7.48%	4.97-7.47%	3.20-4.96%	1.67-3.19%	< 1.67%
Long Stay Weight Loss	CMS N029.02	Calculated from MDS data	CY 2024	≥12.13%	8.66-12.12%	5.84-8.65%	2.97-5.83%	< 2.97%
Long Stay Worsened ADL	CMS N028.03	Calculated from MDS data	CY 2024	≥29.30%	21.51-29.29%	15.64-21.50%	10.39 - 15.63%	< 10.39%
Long Stay Hospitalization	Net Health NQF #2827	Calculated from MDS data	CY 2024	≥19.45%	13.80-19.44%	9.03-13.79%	4.30-9.02%	< 4.30%

NAME	IDENTIFIER	DATA SOURCE	BASELINE TIMEFRAME	POINTS	
				0	100
Infection Control Program Structural Measure	State-Derived	Facility attestation	CY 2025	Requirements not met	Requirements met
Patient Experience Structural Measure	State-Derived	Facility attestation	CY 2025	Requirements not met	Requirements met
Behavioral Health Care Coordination Structural Measure	State-Derived	Facility attestation	CY 2025	Requirements not met	Requirements met

NAME	IDENTIFIER	DATA SOURCE	BASELINE TIMEFRAME	POINTS				
				0	50	100	150	200
CMS Health Inspection Score	CMS	Reported by CMS	CY 2024	TBD*	TBD*	TBD*	TBD*	TBD*

*Health Inspection Score cut points TBD secondary to CMS changes effective 7/30/25.

Determination of Performance Tier

The total number of points determines the Facility's performance tier. The performance tier determines the percentage of maximum Facility-specific payment the Facility receives.

TIER	POINTS REQUIRED
Tier 1	820-1000
Tier 2	640-810
Tier 3	460-630
Tier 4	290-450
Tier 5	100-280

The applicable tier percentage is applied to the per diem rate, and the resulting rate is multiplied by the number of Medicaid Bed Days attributable to the Facility to determine the Tiered Percentage Quality Payment for that Facility.

Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
100%	75%	50%	25%	0%

Quality Payment Components

Tiered Percentage Quality Payment

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Structural Measure Requirements

About Structural Measures in VBP Programs

Focus on whether the **right systems, capabilities, or infrastructure** are in place to support high-quality care, rather than directly measuring patient outcomes or processes of care

- Useful when:
  - There's no standardized process or outcome measure available for a domain
  - Need foundational readiness before expecting outcome improvements
- Assess the capacity of a provider or organization to deliver care that meets quality standards
- Typically involve verifying the presence of:
  - Policies, procedures, and protocols
  - Workforce competencies
  - Health IT systems
  - Reporting capabilities
  - Participation in registries or quality improvement initiatives
- Advantages:
  - Low data collection burden (e.g. attestation or documentation review)
  - Can drive standardization of best practices
  - Provide a foundation for future quality improvements
- Involve activities that are completely within participating providers' control
- Must lead to meaningful implementation of objective measurement to be effective

Structural Measure Process for Participating Providers

1	LISTEN & LEARN
2	SHARE INFORMATION & FEEDBACK
3	FOCUS ON CURRENT STATE, DESIRED STATE, & GAPS
4	PLAN FOR THE DESIRED STATE
5	OPERATIONALIZE THE DESIRED STATE
6	TRANSTION TO OUTCOMES MEASUREMENT

Proposed Structural Measure Requirements

Infection Control Program

Quarter	Attestation Requirements	Data Submission	Attest & Submit By
Q3 2025 July-September	**Active participation in at least one meeting with other Nursing Facilities by one or more of the following from the Facility: DON/DNS, Nursing Quality Specialist, ICP*** Focus on Education & Information: regulatory requirements, Nursing Facility best practices, current state of Infection Control Program/ICP compliance in NM Nursing Facilities	N/A	10/xx/2025
Q4 2025 October - December	**Active participation in one meeting with other Nursing Facilities by one or more of the following from the Facility: DON/DNS, Nursing Quality Specialist, ICP*** Focus on Current State Infection Control Programs in NM Nursing Facilities: sharing of best practices, challenges, and outcomes	Answer 5-10 questions about your current Infection Control Program and Infection Preventionist	1/xx/2026
Q1 2026 January - March	*TBD: Identification of gaps between current and desired state; planning resourcing, competencies, SOPs, training, data collection and evaluation*	Answer 5-10 questions about quarter's activities	4/xx/2026
Q2 2026 April - June	*TBD: Implementation/operationalization of desired state; attest to effective Infection control program and Infection Preventionist in place*	Answer 5-10 questions about quarter's activities	7/xx/2026

*Other individuals and facility team members are welcome to attend, but there must be at least one active participant with one of the stated roles in the facility.

Proposed Structural Measure Requirements

Patient Experience

Quarter	Attestation Requirements	Data Submission	Attest & Submit By
Q3 2025 July-September	**Active participation in at least one meeting with other Nursing Facilities by one or more of the following from the Facility: DON/DNS, Quality Specialist, QAPI Coordinator, Administrator/ED, Director of Social Services*** Focus on Education & Information: the importance of patient experience of care, current state in long-term and post-acute care, and Nursing Facility best practices	N/A	10/xx/2025
Q4 2025 October - December	**Active participation in one meeting with other Nursing Facilities by one or more of the following from the Facility: DON/DNS, Quality Specialist, QAPI Coordinator, Administrator/ED, Director of Social Services*** Focus on Current State of Patient Experience in NM Nursing Facilities: sharing of best practices, challenges, and outcomes	Answer 5-10 questions about your current Patient Experience of Care processes	1/xx/2026
Q1 2026 January - March	*TBD*	TBD	4/xx/2026
Q2 2026 April - June	*TBD*	TBD	7/xx/2026

*Other individuals and facility team members are welcome to attend, but there must be at least one active participant with one of the stated roles in the facility.

Proposed Structural Measure Requirements

Behavioral Health Care Coordination

Quarter	Attestation Requirements	Data Submission	Attest & Submit By
Q3 2025 July-September	**Active participation in at least one meeting with other Nursing Facilities by one or more of the following from the Facility: DON/DNS, Quality Specialist, QAPI Coordinator, Administrator/ED, Director of Social Services*** Focus on Education & Information: the importance of care coordination for individuals with behavioral health needs, NM Quality Strategy priority, learnings from other care settings	N/A	10/xx/2025
Q4 2025 October - December	**Active participation in one meeting with other Nursing Facilities by one or more of the following from the Facility: DON/DNS, Quality Specialist, QAPI Coordinator, Administrator/ED, Director of Social Services*** Focus on Current State of Care Coordination in NM Nursing Facilities: sharing of best practices, challenges, and outcomes	Answer 5-10 questions about your current Care Coordination processes	1/xx/2026
Q1 2026 January - March	**Active participation in one meeting with other Nursing Facilities by one or more of the following from the Facility: DON/DNS, Quality Specialist, QAPI Coordinator, Administrator/ED, Director of Social Services*** Focus on Current State of Behavioral Health Care Coordination in NM Nursing Facilities: dialogue with MCOs	TBD	4/xx/2026
Q2 2026 April - June	*TBD*	TBD	7/xx/2026

*Other individuals and facility team members are welcome to attend, but there must be at least one active participant with one of the stated roles in the facility.

Proposed First Meeting (Q3 2025)

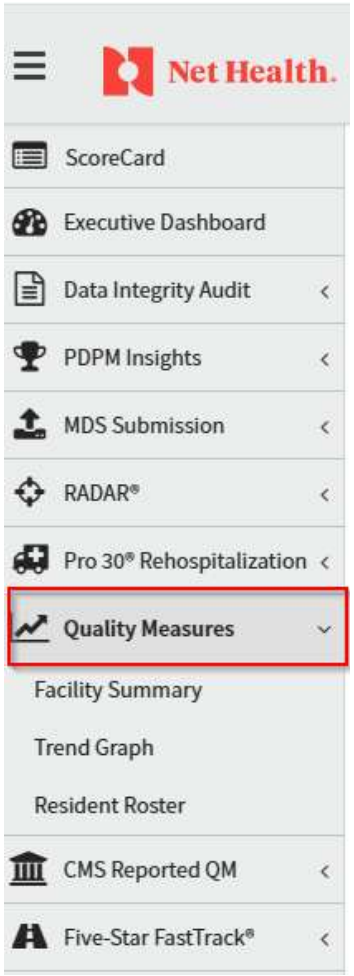
- Combined meeting for all 3 structural measures
- 1 ½ hours total (30 minutes for each structural measure)
- 3 options with dates in September
- Required participants (roles based on each structural measure) must attend entire meeting
- Active participation – engaged, camera on, must answer each poll question, use of chat, speaking not required (but encouraged!)

Subsequent meetings will likely be separate for each measure

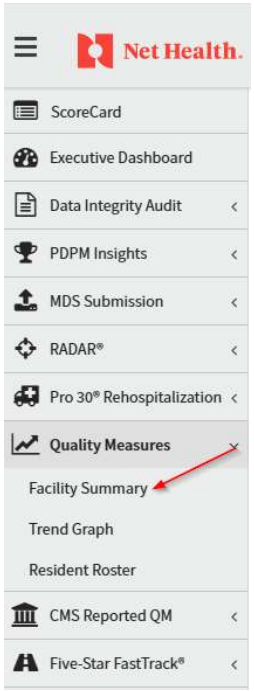
Net Health Value-Based Care Solutions

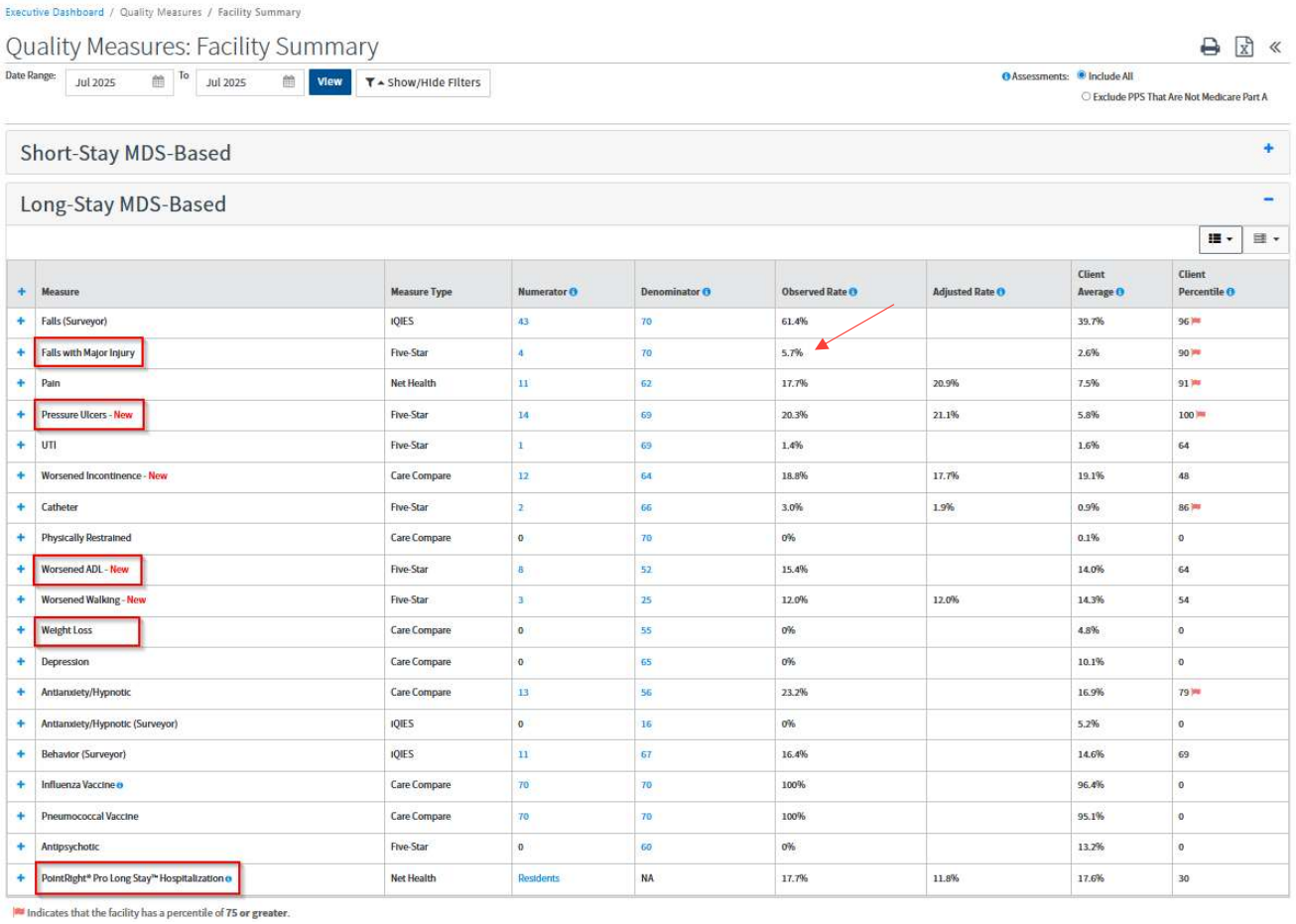
Evaluate Current Performance - QMs

Check current performance on the MDS-based quality measures in the HCQS VBP program in the **Quality Measures** solution in the Net Health Value-Based Care Solutions application.



Quality Measures: Facility Summary





Executive Dashboard / Quality Measures / Facility Summary

Quality Measures: Facility Summary

Date Range: Jul 2025 To Jul 2025 View Show/Hide Filters

Assessments: Include All / Exclude PPS That Are Not Medicare Part A

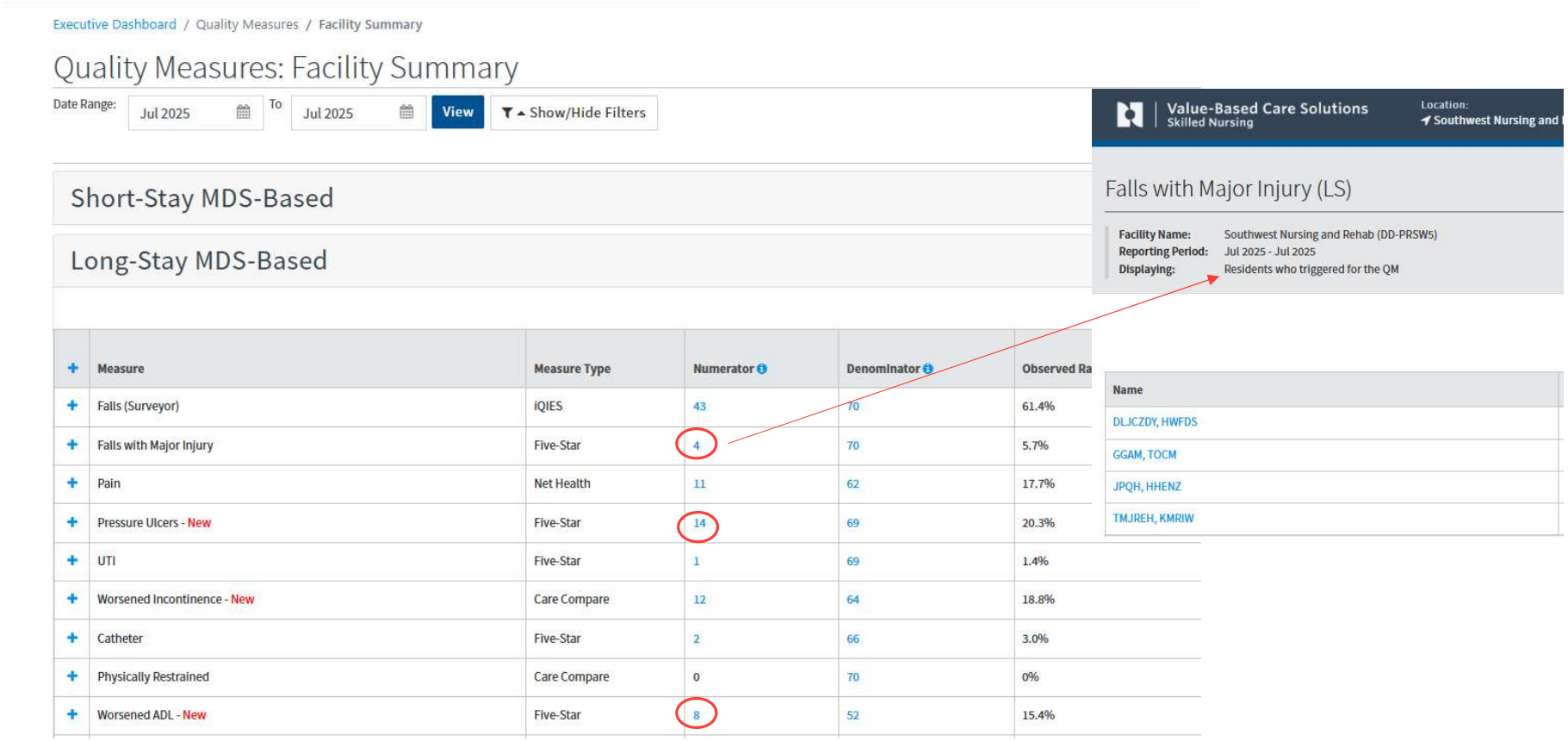
Short-Stay MDS-Based

Long-Stay MDS-Based

Measure	Measure Type	Numerator	Denominator	Observed Rate	Adjusted Rate	Client Average	Client Percentile
Falls (Surveyor)	IQIES	43	70	61.4%		39.7%	96
Falls with Major Injury	Five-Star	4	70	5.7%		2.6%	90
Pain	Net Health	11	62	17.7%	20.9%	7.5%	91
Pressure Ulcers - New	Five-Star	14	69	20.3%	21.1%	5.8%	100
UTI	Five-Star	1	69	1.4%		1.6%	64
Worsened Incontinence - New	Care Compare	12	64	18.8%	17.7%	19.1%	48
Catheter	Five-Star	2	66	3.0%	1.9%	0.9%	86
Physically Restrained	Care Compare	0	70	0%		0.1%	0
Worsened ADL - New	Five-Star	8	52	15.4%		14.0%	64
Worsened Walking - New	Five-Star	3	25	12.0%	12.0%	14.3%	54
Weight Loss	Care Compare	0	55	0%		4.8%	0
Depression	Care Compare	0	65	0%		10.1%	0
Antianxiety/Hypnotic	Care Compare	13	56	23.2%		16.9%	79
Antianxiety/Hypnotic (Surveyor)	IQIES	0	16	0%		5.2%	0
Behavior (Surveyor)	IQIES	11	67	16.4%		14.6%	69
Influenza Vaccine	Care Compare	70	70	100%		96.4%	0
Pneumococcal Vaccine	Care Compare	70	70	100%		95.1%	0
Antipsychotic	Five-Star	0	60	0%		13.2%	0
PointRight® Pro Long Stay™ Hospitalization	Net Health	Residents	NA	17.7%	11.8%	17.6%	30

Indicates that the facility has a percentile of 75 or greater.

Quality Measures: Facility Summary



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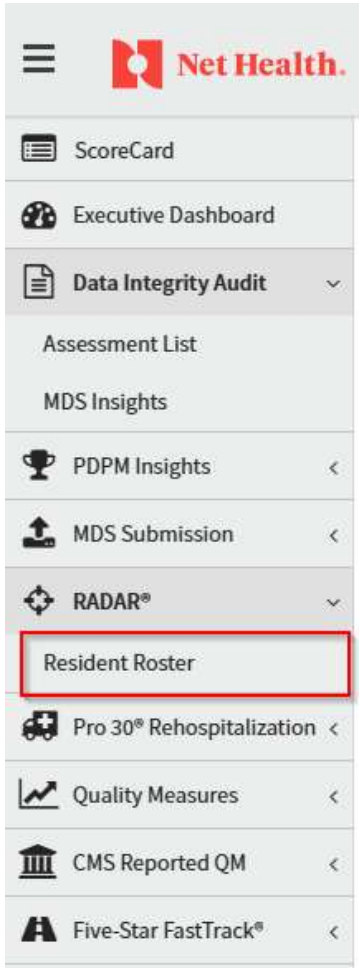
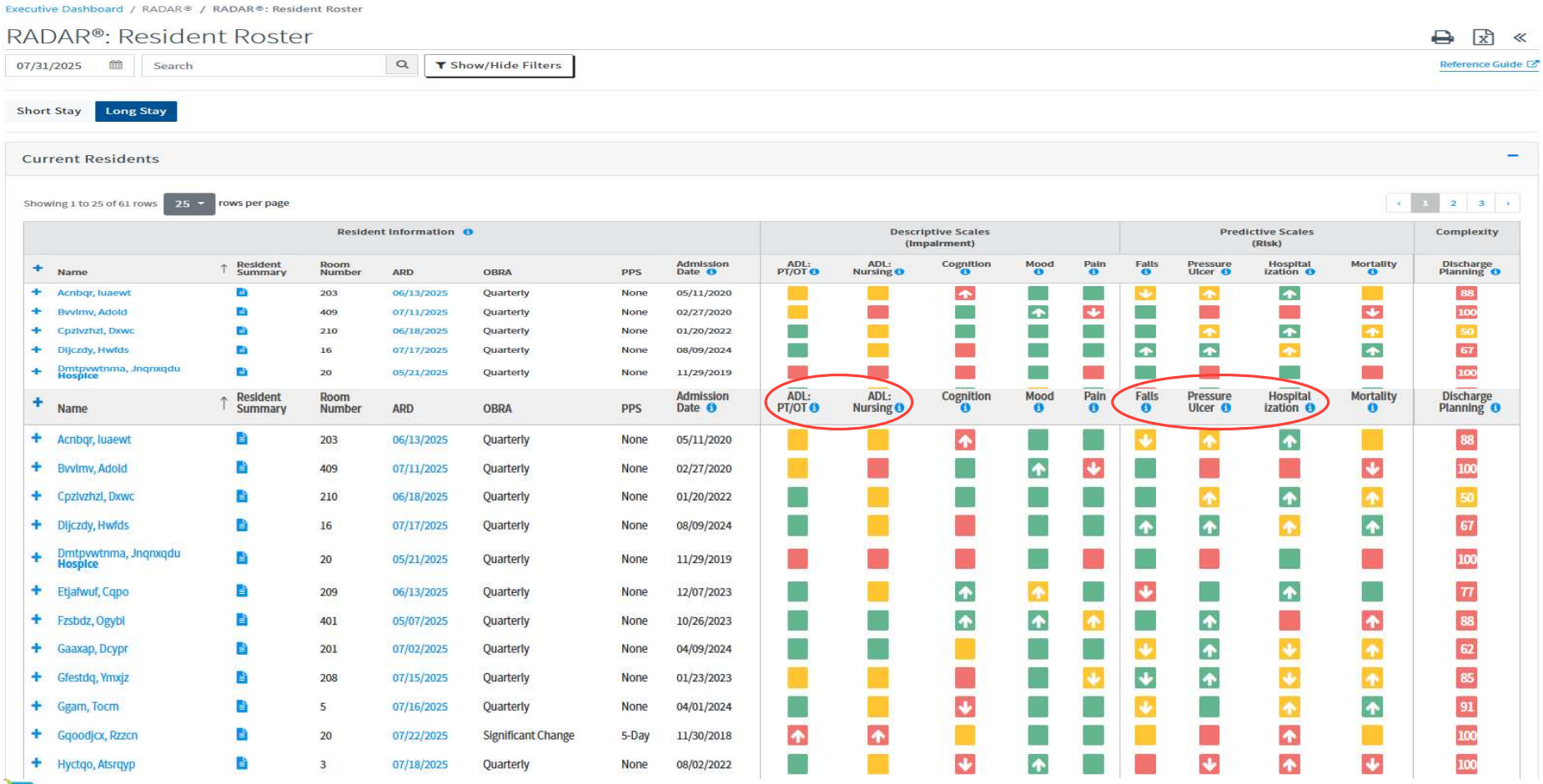
UTI	Five-Star	1	69	1.4%
Worsened Incontinence - New	Care Compare	12	64	18.8%
Catheter	Five-Star	2	66	3.0%
Physically Restrained	Care Compare	0	70	0%
Worsened ADL - New	Five-Star	8	52	15.4%

Identify Residents at Risk

Use the **RADAR®** Resident Roster to identify which residents are at risk for triggering the target QMs.

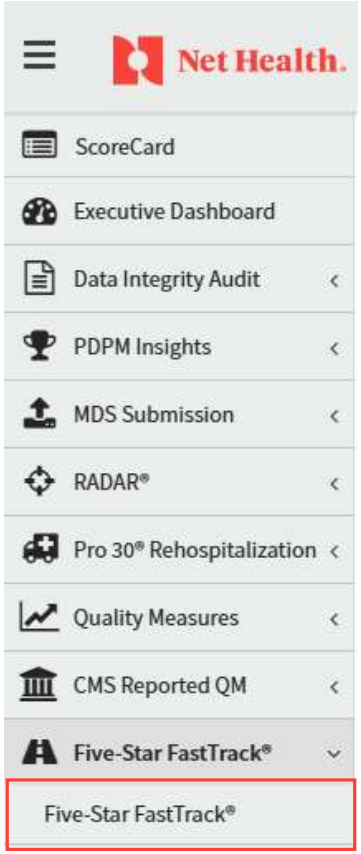


RADAR® Resident Roster

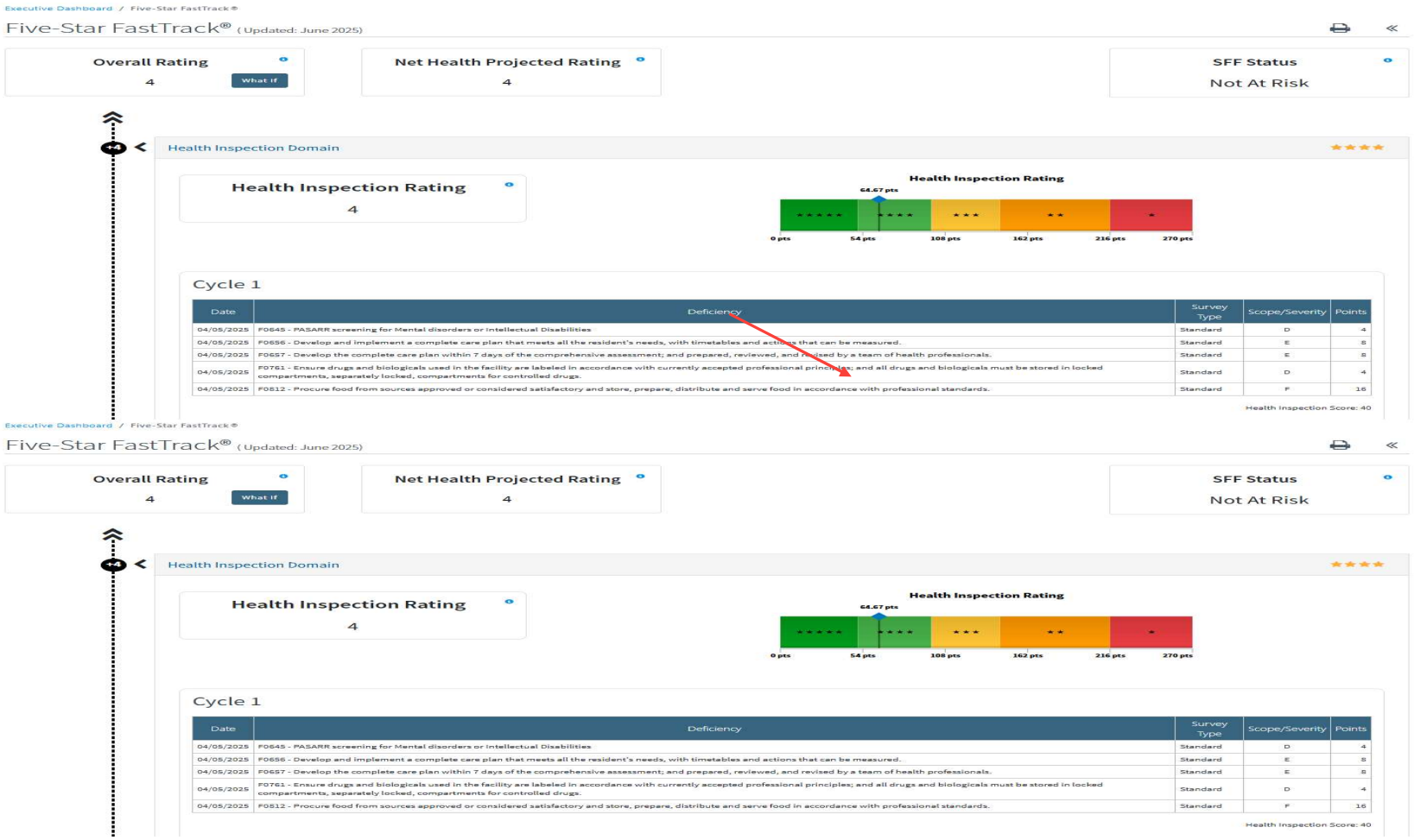


Evaluate Current Performance – Health Inspection Score

Review current CMS Health Inspection Score and survey results in **Five-Star FastTrack®**.



Five-Star FastTrack®: Health Inspection Score



Executive Dashboard / Five-Star FastTrack®
Five-Star FastTrack® (Updated: June 2025)
Overall Rating
4
What If
Net Health Projected Rating
4
SFF Status
Not At Risk
Health Inspection Domain
Health Inspection Rating
4
Health Inspection Rating
64.67 pts
0 pts
54 pts
108 pts
162 pts
216 pts
270 pts
Cycle 1
Date
Deficiency
Survey Type
Scope/Severity
Points
04/05/2025 F0645 - PASARR screening for Mental disorders or Intellectual Disabilities Standard D 4
04/05/2025 F0656 - Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Standard E 8
04/05/2025 F0657 - Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Standard E 8
04/05/2025 F0761 - Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Standard D 4
04/05/2025 F0812 - Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Standard F 16
Health Inspection Score: 40

Performance Tier Estimation

Estimating Your Q1 Performance Tier

- Use your current QM rates to determine the points earned per measure based on the information in the Scoring (Calculation of Points) table.

NAME	IDENTIFIER	DATA SOURCE	BASELINE TIMEFRAME	POINTS				
				20	40	60	80	100
Long Stay Prevalence of Pressure Ulcers	CMS N045.01	Calculated from MDS data	CY 2024	≥16.28%	11.11-16.27%	7.63-11.10%	4.28-7.62%	< 4.28%
Long Stay Falls with Major Injury	CMS N013.02	Calculated from MDS data	CY 2024	≥7.48%	4.97-7.47%	3.20-4.96%	1.67-3.19%	< 1.67%
Long Stay Weight Loss	CMS N029.02	Calculated from MDS data	CY 2024	≥12.13%	8.66-12.12%	5.84-8.65%	2.97-5.83%	< 2.97%
Long Stay Worsened ADL	CMS N028.03	Calculated from MDS data	CY 2024	≥29.30%	21.51-29.29%	15.64-21.50%	10.39 - 15.63%	< 10.39%
Long Stay Hospitalization	Net Health NQF #2827	Calculated from MDS data	CY 2024	≥19.45%	13.80-19.44%	9.03-13.79%	4.30-9.02%	< 4.30%

- Sum the total number of points for the 5 MDS-calculated measures.

Estimating Your Q1 Performance Tier

- Add the number of points you expect to earn for each structural measure.

NAME	IDENTIFIER	DATA SOURCE	BASELINE TIMEFRAME	POINTS	
				0	100
Infection Control Program Structural Measure	State-Derived	Facility attestation	CY 2025	Requirements not met	Requirements met
Patient Experience Structural Measure	State-Derived	Facility attestation	CY 2025	Requirements not met	Requirements met
Behavioral Health Care Coordination Structural Measure	State-Derived	Facility attestation	CY 2025	Requirements not met	Requirements met

- Meeting the requirements for each structural measure in a quarter earns 300 points.

Estimating Your Q1 Performance Tier

- Cut points for the CMS Health Inspection Score are being recalculated secondary to CMS changes to the Health Inspection Score effective 7/30/25.

- The CMS public star rating can be used as a general proxy for cut point ranges.

NAME	IDENTIFIER	DATA SOURCE	BASELINE TIMEFRAME	POINTS				
				0	50	100	150	200
CMS Health Inspection Score	CMS	Reported by CMS	CY 2024	TBD*	TBD*	TBD*	TBD*	TBD*

1★ 2★ 3★ 4★ 5★

- Add the estimated number of points for the CMS Health Inspection Score.

Estimating Your Q1 Performance Tier

- The total number of points for all 9 measures determines the Facility's Performance Tier.

TIER	POINTS REQUIRED
Tier 1	820-1000
Tier 2	640-810
Tier 3	460-630
Tier 4	290-450
Tier 5	100-280

- The Performance Tier determines the maximum Facility-specific payment the Facility receives.

Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
100%	75%	50%	25%	0%

Considerations – Historical Tier Distribution

Tier	% of Facilities*	What it means
Tier 1	12%	Exceptional performance – top group in the state; small, highly competitive group
Tier 2	33%	Strong performance – often very close to Tier 1 thresholds
Tier 3	19.50%	Mid-range performance – typically strong in some measures with opportunities in others
Tier 4	19.50%	Below average – usually driven by a few measures; targeted action can improve standing
Tier 5	16%	Multiple improvement opportunities; historically, facilities in this tier moved up with focused efforts

*Estimates based on historical data used to set the cut points. The actual current distribution could differ depending on actual performance.

- Upward movement is achievable. Even one or two improved measures can change tier placement.
- Completing the required actions for the structural measures earns 300 points (Tier 4).
- Continue tracking performance against the cut points using the Net Health Quality Measures, Five-Star FastTrack® and RADAR® solutions until the new HCQS VBP Dashboard is released.

Questions?