



New Mexico Nursing Facility HCQS VBP Program Overview

August 20, 2025



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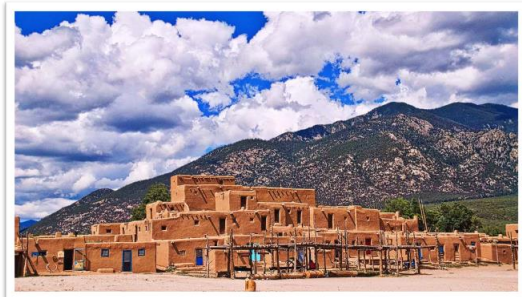
BEFORE WE START...

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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



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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.



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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



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Introduction



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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.



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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.



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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



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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



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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



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- 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.

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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"


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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


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HCQS VBP Program Overview



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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.



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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.

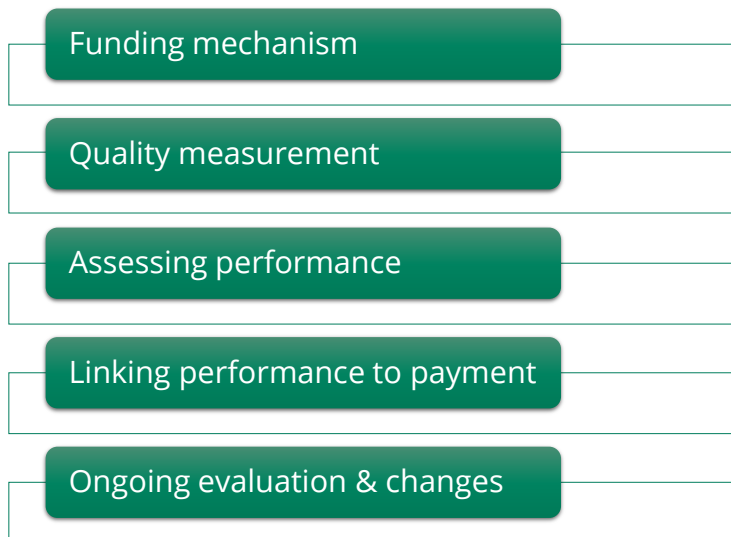


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Components of the Program



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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



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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**



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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 <i>Structural Measure</i>	State-Derived	Facility attestation
7	Patient Experience <i>Structural Measure</i>	State-Derived	Facility attestation
8	Behavioral Health Care Coordination <i>Structural Measure</i>	State-Derived	Facility attestation
9	CMS Health Inspection Score	CMS	Reported by CMS



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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.



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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)**



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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.



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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



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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.



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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%



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Structural Measure Requirements



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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
- 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
- Participation in registries or quality improvement initiatives



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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	TRANSITION TO OUTCOMES MEASUREMENT



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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	<i>TBD: Identification of gaps between current and desired state; planning resourcing, competencies, SOPs, training, data collection and evaluation</i>	Answer 5-10 questions about quarter's activities	4/xx/2026
Q2 2026 April - June	<i>TBD: Implementation/operationalization of desired state; attest to effective Infection control program and Infection Preventionist in place</i>	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.

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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



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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



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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



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Net Health Value-Based Care Solutions



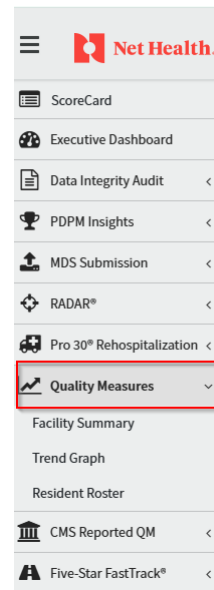
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Evaluate Current Performance - QMs

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.

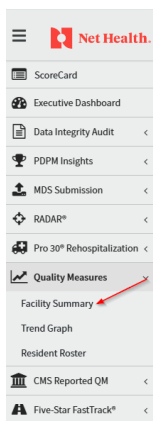


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Quality Measures: Facility Summary



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)	QIES	43	70	61.4%		39.7%	96 th
Falls with Major Injury	Free Star	4	10	5.1%		3.0%	99 th
Pain	Net Health	11	63	17.3%	20.3%	7.3%	93 th
Pressure Ulcers - New	Free Star	14	69	20.3%	21.3%	5.0%	100 th
UTI	Free Star	1	69	1.4%		1.6%	64
Wound Incidence - New	Care Compare	12	64	18.8%	17.3%	19.1%	48
Catheter	Free Star	2	66	3.0%	1.9%	0.9%	96 th
Physically Restrainted	Care Compare	0	70	0%		0.3%	0
Wound ADE - New	Free Star	8	52	15.4%		14.0%	64
Wound Healing - New	Free Star	3	25	12.0%	12.0%	14.3%	54
Weight Loss	Care Compare	0	55	0%		4.4%	0
Depression	Care Compare	0	65	0%		10.1%	0
Anticoagulant/Agonist	Care Compare	13	56	23.2%		16.9%	79 th
Anticoagulant/Agonist (Surveyor)	QIES	0	35	0%		0.3%	0
Behavior (Surveyor)	QIES	11	47	23.4%		14.0%	69
Influenza Vaccine	Care Compare	70	70	100%		96.4%	0
Pneumococcal Vaccine	Care Compare	70	70	100%		95.1%	0
Antipsychotic	Free Star	0	69	0%		13.2%	0
Prevalence of Long Stay Hospitalizations	Net Health	Residents	NA	17.3%	13.4%	17.6%	20

NA indicates that the facility has a percentile of 98 or greater.



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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

Short-Stay MDS-Based

Long-Stay MDS-Based

Measure	Measure Type	Numerator	Denominator	Observed Ratio
Falls (Surveyor)	IQIES	43	70	61.4%
Falls with Major Injury	Five-Star	4	70	5.7%
Pain	Net Health	11	62	17.7%
Pressure Ulcers - New	Five-Star	14	69	20.3%
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%

Value-Based Care Solutions Skilled Nursing		Location Southwest Nursing and Rehab
Falls with Major Injury (LS)		
Facility Name:	Southwest Nursing and Rehab (DD-PSIRS)	
Reporting Period:	Jul 2025 - Jul 2025	
Displaying:	Residents who triggered for the QM	
Name		
DILCZK, HWFDS		
GGAM, TDCM		
JRQH, HHENZ		
TMUREH, KMDW		



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Identify Residents at Risk

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

Net Health.	
ScoreCard	
Executive Dashboard	
Data Integrity Audit	▼
Assessment List	
MDS Insights	
PDPM Insights	<
MDS Submission	<
RADAR®	▼
Resident Roster	
Pro 30® Rehospitalization	<
Quality Measures	<
CMS Reported QM	<
Five-Star FastTrack®	<



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RADAR® Resident Roster

Executive Dashboard / RADAR® / RADAR®: Resident Roster

RADAR®: Resident Roster

07/31/2025

Search

Q

Show/Hide Filters

[Reference Guide](#)

Short Stay

Long Stay

Current Residents

Showing 1 to 25 of 61 rows

25 rows per page

Resident Information							Descriptive Scales (Impairment)					Predictive Scales (Risk)				Complexity
Name	Resident Summary	Room Number	ARD	OBRA	PPS	Admission Date	ADL-PTOT	ADL-Nursing	Cognition	Mood	Pain	Falls	Pressure Ulcer	Hospitalization	Mortality	Discharge Planning
Acrbqr, Iaaewf		203	06/13/2025	Quarterly	None	05/11/2020										88
Bvltmv, Adold		409	07/11/2025	Quarterly	None	02/27/2020										100
Cpzhvhd, Dnawc		210	06/18/2025	Quarterly	None	01/20/2022										50
Dljczdy, Hwefds		16	07/17/2025	Quarterly	None	08/09/2024										67
Dntgwwmima, Inqnaqdu Hoagdu		20	05/21/2025	Quarterly	None	11/29/2019										100
Eljafwof, Cqgo		209	06/13/2025	Quarterly	None	12/07/2023										77
Fzbdz, Cqygd		401	05/07/2025	Quarterly	None	10/26/2023										88
Gaaxap, Dcypr		201	07/02/2025	Quarterly	None	04/09/2024										62
Glesddq, Ymajz		208	07/15/2025	Quarterly	None	01/23/2023										85
Ggam, Tocm		5	07/16/2025	Quarterly	None	04/01/2024										91
Gqoodjca, Rzczn		20	07/22/2025	Significant Change	5-Day	11/30/2018										100
Hycqqa, Abnrgpp		3	07/18/2025	Quarterly	None	08/02/2022										100

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Evaluate Current Performance – Health Inspection Score

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

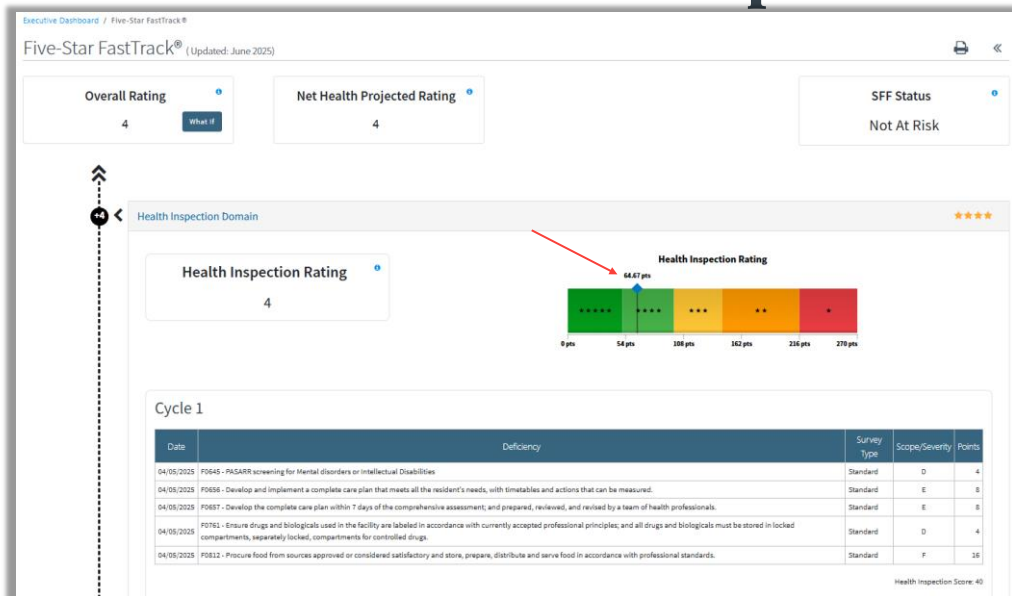
	ScoreCard
	Executive Dashboard
	Data Integrity Audit <
	PDPM Insights <
	MDS Submission <
	RADAR® <
	Pro 30® Rehospitalization <
	Quality Measures <
	CMS Reported QM <
	Five-Star FastTrack® >
	Five-Star FastTrack®

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Five-Star FastTrack®: Health Inspection Score



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Performance Tier Estimation

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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.



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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.



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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.



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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%



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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.



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Questions?



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