Core Measure 9.3: Frequently Asked Questions (FAQs)

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The following FAQs provide additional clarification for reporting Core Measure 9.3: *Minimizing Facility Length of Stay*. The detailed specifications for this measure can be found in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements. The Reporting Requirements document and corresponding Value Sets Workbook are available on the following website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html.

Core Measure 9.3 General Information

1. **What is the intent of Core Measure 9.3?**

   The intent of the measure is to assess the proportion of admissions to a facility that result in a successful discharge to a community residence within 100 days or less of the facility admission. An observed performance rate, an expected performance rate, and the ratio of observed to expected rates are reported.

2. **Please define "Calendar Year, beginning CY2," which is listed as the Reporting Period.**

   CY2 refers to the MMP's second calendar year in the demonstration, which varies across MMPs. MMPs should report Core Measure 9.3 starting with their second year of operation. For example, if a new MMP began participation in its respective demonstration on 1/1/2022, it should start reporting Core Measure 9.3 for CY 2023. Please refer to the General Guidance within the Notes section of the Core Measure 9.3 Reporting Requirements for information on when an MMP should begin reporting this measure.

Identifying Data Elements A and B

3. **Should facility stays include skilled nursing level of care, rehabilitation facilities, and custodial level of care?**

   Yes, facility stays include skilled nursing, rehabilitation, and custodial level of care.

4. **Should long-term care hospitals be included as a facility?**

   No, long-term care hospitals should not be considered a facility. Please refer to the Core Measure 9.3 Reporting Requirements for the full definition of a facility and value sets workbook for the codes to use to identify a facility admission.

5. **Are psychiatric admissions without medical counted as a facility stay?**

   No, psychiatric admissions without medical are not counted as a facility stay. A facility includes a Medicaid- or Medicare-certified nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

6. **For data element A, are partially paid claims included where at least one service line of a claim is not paid?**

   Yes, partially paid claims should be included in data element A only.

7. **Is a hospital admission required for data element A?**

   No, a hospital admission is not required for data element A.

8. **Step 3 of data element A discusses the removal of admissions when both a facility and a hospital are involved and it is unclear how to calculate length of stay (LOS) when members transition from different settings. Please clarify the definition of facility admission and calculation of LOS for this step.**

   The "from the community" requirement for data element A is explained in Step 2: "Remove facility admissions that are direct transfers from another facility." Step 3 follows similar logic, which can be interpreted as "count a facility admission if the member is transferred to a facility from a hospital only if the member entered the hospital from the community (i.e., they were not admitted to the hospital from a facility)." The logic for Step 3 is very similar to that of Step 2 (i.e., look at the admission date for the hospital stay and see if they had a facility stay that ended on the admission date or the day before).

9. **If the member goes into a custodial care setting from the Skilled Nursing Facility (SNF), is that counted as a discharge to the community since that is where the member will reside?**

   No, a member who is discharged from a SNF to a custodial care setting is not counted as a discharge to the community, as custodial care is considered a facility stay.

10. **If a member is transferred directly from a hospital to a facility, is this considered a direct transfer without a gap greater than one day?**

    Yes, the assumption is that the transition from hospital to a facility is a direct transfer with no gap greater than one day. For example, a member presents at the emergency department (ED) at a Critical Access Hospital (CAH) on 7/1/2022. The member is admitted to the CAH on 7/1/2022 for one day. On 7/2/2022, the member is transferred directly from the CAH to a larger regional hospital for inpatient services because the regional hospital was better equipped to care for the member. The member is discharged from the regional hospital to a SNF on 7/15/2022. In this scenario, the MMP should consider the transfer from the regional hospital to the SNF as a direct transfer. Nothing in the scenario indicates the member did not live in the community prior to the initial hospital admission or that the member had any prior facility claims. Therefore, this admission can be included as a facility admission for data element A.

11. **How is a discharge to the community defined? Are there data value sets that will be provided?**

    The definition of a discharge to the community is provided in the Notes section of the Core Measure 9.3 Reporting Requirements. There is no value set to capture discharges to the community.

12. The Core Measure 9.3 Reporting Requirements indicate that reporting should be based on paid claims. Should a member be considered discharged to the community if claims are denied during their facility stay?

No. While the absence of paid claims can be a potential indicator that the member was discharged to the community, it should not be assumed that since a claim was denied that the member was discharged to the community. For example, if a facility bills incorrectly resulting in a denied facility claim, it cannot be assumed that the member was discharged to the community. Further, identification of a discharge to the community for data element B entails evaluating a variety of claims to confirm the member's discharge status, including the absence of any continued facility claims subsequent to the data element A facility admission.

13. If a member is admitted to a facility after June 30 of the current reporting period but is discharged before October 31 of reporting period, should the admission AND discharge be captured in the current reporting period?

No, the admission and discharge should both be included in the following year's reporting. The admission (data element A) should fall between July 1 of the prior reporting period and June 30 of the current reporting period. The discharge (data element B) should fall between July 1 of the prior reporting period and October 31 of the current reporting period. Please also note that data element B is a subset of data element A.

In this scenario, the member is admitted after the time period specified above, so the admission should not be reported during the current reporting period. Because the admission (data element A) is not reported during the current reporting period, the discharge also should not be identified for potential data element B inclusion during the current reporting period (even if the date falls within the allowable time period), since data element B is a subset of data element A.

For example, if a member is admitted to a SNF from the community on 7/15/2022 and is discharged back to the community on 9/30/2022, this admission and discharge should be included in CY 2023 reporting.

14. If a member is admitted to a facility between July 1 of the year prior to the reporting period and June 30 of the current reporting year but is discharged after October 30, should the admission AND discharge be captured in the current reporting period?

The admission should be captured in the current reporting period's reporting since it occurs within the time period specified. The discharge should not be reported in data element B because it did not occur within 100 days or less of the admission.

For example, if a member is admitted to a custodial care setting from the community on 7/15/2022 and is discharged back to the community on 11/6/2022, the admission is included in CY 2023 reporting (data element A), but the discharge is numerator negative and does not qualify for inclusion in data element B. Please note that data element C should still be calculated in this scenario, as data element C should be reported for each facility admission reported in data element A.

15. **For the exclusions noted in data element A Step 2, should all admissions from one facility to another facility be considered a direct transfer if the discharge date from the first facility precedes the admission date to the second facility by one calendar day or less, or only those where the original admission date was prior to the reporting period?**

    Per data element A Step 2, first identify and remove transfers for which the original admission date to the facility is prior to July 1 of the year prior to the reporting period. For these transfers, both the original admission and the transfer admission should be excluded from the measure. Otherwise, keep the original admission date as the date of the new facility admission. Then, identify and remove all admissions that are direct transfers. All admissions from one facility to another facility would be considered a direct transfer if the discharge date from the first facility precedes the admission date to the second facility by one calendar day or less.

16. **If a 24-hour hospital observation period spans into a new day (i.e., 3/4/2022 to 3/5/2022), and the outpatient claim looks like it has a "length of stay" similar to an acute inpatient claim, should the outpatient stay that encompasses two days in the 24-hour observation period be treated as an episode connecting event similarly to acute inpatient admit/discharges?**

    No. Observation stays, regardless of duration, are not inpatient hospital admissions (or discharges); therefore, they should not be counted as hospital admissions even if they exceed 24 hours.

Risk Adjustment Weighting

17. **For the diagnosis, should MMPs use all chronic conditions? Is the diagnosis just the primary/admit diagnosis?**

    When determining the Diagnosis risk adjustment category, assign all applicable Chronic Conditions Data Warehouse (CCW) code(s) to the facility admission based on the facility admission's diagnoses using the CCW Categories value set. For direct transfers, use all diagnoses that occurred during the episode (i.e., original admission diagnoses and direct transfer's diagnoses). Exclude diagnoses that cannot be mapped to the Risk Adjustment Weights value set. Only CCW categories with a weight will be included in the risk adjustment. If a weight in not included on the 'Weights' tab, then it is not associated with higher or lower rates for discharge to community.

18. **Are there only five diagnosis risk weights? Will updates for diagnoses and weights be updated for new diagnoses?**

    Please refer to the Core Measure 9.3 Reporting Requirements for instructions on assigning a CCW code to the facility admission based on its diagnoses. Weights are only applied to the following diagnoses: Asthma, Intellectual disabilities, Mental health conditions, Stroke, Alzheimer's disease and related disorders.

19. **How far back should MMPs look for hospitalizations prior to the facility admission for the weight?**

    MMPs should determine if the member had any acute hospitalizations in the six months prior to the reporting period.

20. The weight for acute hospitalization as 1 is provided as a positive number, which is contrary to the negative sign for the 2+ hospitalization. Should the weight be negative for 1 hospitalization?

No. The positive weight for this category is accurate.

21. If there is no risk adjustment weight assigned to a risk adjustment category, should the weight be assigned "0"?

No, a weight of zero is not assumed. If the risk adjustment determination results in no weight being assigned (e.g., Male 18-44 category for age/gender) this means the category is the reference category and does not have a weight assigned.

22. For days of enrollment, the weight for less than 180 days of enrollment category is not provided on the 'Weights' tab in the Value Sets Workbook. Is a weight of zero assumed?

This is the reference group, similar to the Male 18-44 group identified in FAQ #21 above, and therefore does not have a weight. A weight of zero is not assumed; they just do not get a 1 for the 180+ days of enrollment covariate.

23. What is the definition of expected discharge?

The expected discharge is based on risk adjustment calculations defined in the Core Measure 9.3 Reporting Requirements, instead of an actual observed discharge. For the definition of expected discharge, please refer to the Core Measure 9.3 Reporting Requirements.

Claims Data and Value Sets

24. Should paid claims be used to identify all data elements?

Reporting using paid claims is only applicable to the identification of data element A. Please refer to the CY 2023 Core Measure 9.3 Reporting Requirements for guidance on using paid claims to report data element A.

25. Are the type of bill codes provided in the Identifying Facility value set within the Core Value Sets Workbook to be used with an "AND" or "OR" condition with the 18 revenue codes in the same value set?

The type of bills in the Identifying Facility value set within the Core Value Sets Workbook should be used with an "OR" condition with the 18 revenue codes. All MMPs should align with the current Identifying Facility value set within the Core Value Sets without modifications, and include these claims as facility claims based on the measure specifications. By not deviating from the most current applicable Core Value Sets, Core Measure 9.3 rates will be comparable across MMPs (i.e., all MMPs are consistently reporting in the same manner and utilizing the same value set).

26. Should identification of custodial care be based on claims data or a combination of claims data and capitation codes (IC50)?

Identification of custodial care should be based on claims data.

27. How are custodial care claims versus SNF claims identified?

MMPs should rely on the Identifying Facility value set that is available within the Core Value Sets Workbook for reporting. MMPs should also refer to the definition of facility in the Core Measure 9.3 Reporting Requirements.

28. Are all data elements identified by claims data only?

Yes, all data elements are identified using claims data.

29. For newly enrolled members, from a claims perspective, their facility admission may appear new as the member is new with the MMP; however, the members may in fact have been in a facility for some time before. Should these members be reported by the new MMP?

For newly enrolled members, MMPs will need to use the data available to report.

30. When calculating this measure, should members who opted out of the MMP within 160 days of the facility admission and subsequently enrolled into the MMP at a later date, be included?

No. As noted in the definition for data element A, the MMPs should only include members who were "continuously enrolled from the date of the facility admission through 160 days following the facility admission date, with no gaps in enrollment." The MMPs should include all facility admissions for members who meet this definition, regardless of whether they are disenrolled as of the end of the reporting period (i.e., at the end of the year). Medicaid-only members should not be included.

31. If an MMP is excluding admissions primarily based on their inpatient admission code, should facility admissions with an inpatient admission code of 9 (indicating 'information not available') be excluded from data element A?

Please refer to the Core Measure 9.3 Reporting Requirements to identify exclusion criteria and confirm exclusions for data element A. If an MMP uses admission codes as a method by which to identify exclusions, and a value of "9" arises, the MMP may review other available data to identify if these exclusions are met. The exclusions must be clearly met in order to exclude an admission from data element A.

32. Can discharge codes be used to identify transfers to the community?

MMPs should not rely upon discharge codes to identify discharges to the community. MMPs should look for discharges that were not followed by a subsequent facility admission within 60 days of the discharge to the community.

33. To identify hospital claims that are not facility admissions, is it feasible for MMPs to use the remaining inpatient facility codes from the Core Value Sets Workbook?

MMPs should refer to their organization's method for identifying hospital claims.

34. UBREV codes 0550, 0551, 0552, 0559 bring in Home Health claims. Are these codes acceptable for MMPs to report?

The value sets were determined by the measure steward, Mathematica. At this time, Mathematica has not provided guidance on excluding these codes from the Identifying Facility value set. Therefore, MMPs should include these codes when reporting this measure. By adhering to the most current applicable Core Value Sets, Core Measure 9.3 rates will be comparable across MMPs (i.e., all MMPs are consistently reporting in the same manner and utilizing the same value set).

35. Why are code descriptions missing for some of the code types in the Core Value Sets Workbook?

The UB code descriptions are not included in the values sets by the measure steward. NCQA includes the UB codes with the permission of the American Hospital Association (AHA). The UB codes, including revenue code and type of bill, do not include descriptions. MMPs may contact AHA directly to obtain descriptions for the UB codes.

36. The value sets provided do not contain all nursing facility revenue codes. Should MMPs supplement with any additional codes?

The MMPs should follow the value sets provided in the Core Value Sets Workbook. This will allow for comparable results across MMPs. By adhering to the most current applicable Core Value Sets, Core Measure 9.3 rates will be comparable across MMPs (i.e., all MMPs are consistently reporting in the same manner and utilizing the same value set).

Additional Information—Scenario Examples

37. A member is admitted to a nursing facility on 1/1/2022 and the MMP pays a nursing facility claim for dates of service 1/1/2022 – 1/14/2022. Subsequently, the MMP pays a second nursing facility claim for the same member with dates of service from 1/15/2022 – 1/28/2022. The MMP denies a third nursing facility claim for this member with dates of service from 1/29/2022 – 2/14/2022. If the MMP receives and pays a subsequent nursing facility claim with dates of service from 2/15/2022 – 2/28/2022, how should the MMP identify these admissions for reporting in data element A?

In this scenario, the first two paid claims with dates of service spanning 1/1/2022 – 1/28/2022 would be considered one continuous stay and counted in data element A. Since this stay did not result in a successful discharge to the community it would not be counted in data element B. Additionally, the paid claim with a date of service beginning on 2/15/2022 is considered a separate facility admission and would be counted in data element A.

38. If a member is admitted/transferred to a SNF, remains in the SNF for 160 days and then discharges to home for 50 days, then is admitted back to the SNF for another 160 days, would that count as two admissions to the facility for data element A?

Yes, this would count as two admissions to the facility for data element A. However, the discharges would not count in data element B for the following reasons: 1) since the discharge was more than 100 days after admission and 2) because there was a readmission to the facility within 60 days of discharge to home. Please note, this is assuming both admissions happen during the intake period.

39. A member is admitted to the hospital on 9/1/2022. The member is discharged to a SNF on 9/10/2022. Upon recovery, the member is discharged to home on 11/18/2022. In this scenario, language such as "discharged from… and then admitted to…" is used, however, the claims data show these movements between the hospital to the SNF as transfers, with specified transfer codes. Can MMPs use the specific transfers that translate to the scenario provided?

Yes, transitions between the hospital and SNF settings can be treated as transfers.

40. If a member is discharged from the hospital and admitted to a SNF on 6/10/2022 and remains in the SNF as of 10/31/2022 without a discharge to the community, can this scenario be reported in data element B?

As indicated in the Core Measure 9.3 Reporting Requirements, discharges from a facility to the community during the reporting period are defined as those between July 1 of the year prior to the reporting period through October 31 of the current reporting period. In this scenario, no discharge to the community occurred and the member's length of stay in the SNF is 143 days (i.e., date of the last day of the current reporting period [10/31/2022] minus the facility admission date [6/10/2022]). Therefore, this scenario cannot be counted in data element B.

41. A member is admitted to the hospital from the community on 6/1/2022. The member is discharged from the hospital and admitted to an ICF/IID on 6/15/2022. Upon recovery, the member is discharged to home on 9/30/2022. On 10/14/2022, the member is readmitted to the hospital. Is the discharge to home counted in data element B?

No, the MMP should not count the discharge to community in data element B because a readmission to the hospital occurred within 60 days of the discharge back to the community. However, the admission to the ICF/IID does count as a facility admission and should be reported in data element A.

42. A member is admitted to a SNF on 4/15/2022 and transitions from the SNF to the hospital on 5/1/2022. The member is discharged from the hospital and returns to the SNF on 5/15/2022. Which days should be counted as a facility admission for CY 2023?

In this scenario, both SNF stays and the hospital stay should be combined as a single facility admission for data element A, beginning with the initial SNF admission on 4/15/2022.

43. A member is admitted to the hospital on 2/1/2022. The member is discharged from the hospital and admitted to a SNF on 3/15/2022. The member experiences a significant decline in health and is re-admitted to the hospital where the member expires on 3/20/2022. Should this scenario be reported in data elements A and B?

The MMP should count the admission to the SNF as a facility admission in data element A. However, since the member died within 60 days of the readmission, the member should not be counted as discharged to the community in data element B.

44. If a member is admitted to a SNF directly from a custodial care setting, should this member be excluded from data element A?

In this scenario, the SNF admission is a direct transfer; therefore, the SNF admission would not count as a new facility admission in data element A. The initial custodial admission, however, should be evaluated for inclusion in data element A, based on the timing of the admission. For identification of how to identify direct transfers, refer to data element A, Step 2 in the Core Measure 9.3 Reporting Requirements.

45. A member is admitted to a custodial care setting on 3/15/2022 and did not discharge to the community (i.e., a community residence) during the reporting period. Should the member's admission to custodial care be included in data element A?

Yes, the member's admission to the custodial care setting on 3/15/2022 should be counted as a facility admission in data element A. As the member has not discharged to a community residence, this member would not meet criteria for data element B.