DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-23-01-NH
EXPIRED EFFECTIVE: October 4, 2024

DATE:	June 6, 2025
ORIGINAL POSTING DATE:	September 20, 2023
TO:	State Survey Agency Directors
FROM:	Director, Quality, Safety & Oversight Group (QSOG)
SUBJECT:	***EXPIRED:*** Updates to Nursing Home Care Compare Staffing and Quality Measures

Memo Expiration Information:

Expiration Date	***October 4, 2024***
Expiration Information	***Revised the timeline for adjusting the quality measures so that all affected quality measures are updated at the same time. See QSO-25-01-NH***

Memorandum Summary

- **Adjustment to Staffing and Quality Measures:** CMS will update the staffing level case-mix adjustment methodology and replace some of the Quality Measures (QMs) used on Nursing Home Care Compare, in order to accommodate changes to the Minimum Data Set (MDS). Additionally, CMS will discontinue the CMS-672 form since the section G MDS data, used to populate this form, is being eliminated.
- **Penalty for Providers that Fail to Submit Staffing Data:** To incentivize providers to submit accurate staffing data, CMS will revise the staffing rating methodology so providers that fail to submit staffing data or submit erroneous data receive the lowest score possible for corresponding staffing turnover measures.

Background:

In 2008, CMS added the Five Star Rating System to the Medicare.gov website Nursing Home Compare (now known as Care Compare). The rating system comprises three rating domains: Health inspections, Staffing, and Quality Measures. CMS has periodically made improvements to the website and rating system. A set of staffing measures were developed from Payroll-Based Journal (PBJ) data to describe the staffing provided in nursing homes, and a set of quality measures was developed from Minimum Data Set (MDS) and Medicare claims data to describe the quality of care provided in nursing homes. Staffing and quality measures are adjusted for the needs of the nursing home residents using the MDS. To accommodate changes to the MDS, CMS will be updating the staffing level case-mix adjustment methodology and replacing some of the Quality Measures (QMs) used on Nursing Home Care Compare. We note that CMS has recently issued a proposed rule to establish new minimum staffing requirements. The actions described in this memorandum are separate from the proposed rule. CMS will review and address any comments related to the proposed rule through the rulemaking process. To review and submit comments to the proposed rule, please visit the Federal Register.
CMS will also be removing the CMS-672 form (Resident Census and Conditions of Residents) since the Section G MDS data used to populate this form is being discontinued.

Furthermore, to help incentivize providers to submit accurate staffing data, CMS will revise the staffing rating methodology so providers that fail to submit staffing data or submit erroneous data will receive the lowest score possible for corresponding staffing turnover measures.

Discussion:

Adjusting Staffing and Quality Measures

Currently, CMS adjusts the nurse staffing measures using a case-mix methodology that is based on MDS items from the previous Medicare Prospective Payment System (SNF PPS), RUG-IV. CMS also uses some of these MDS items to risk-adjust some of the QMs. However, in October 2023, items in the MDS (Section G) will be eliminated and replaced by new (Section GG) items. This necessitates changes to the staffing case-mix adjustment method and some of the QMs on Nursing Home Care Compare that currently use Section G items.

Therefore, CMS will be changing the staffing case-mix adjustment methodology to a model based on the SNF payment Patient-Driven Payment Model (PDPM), which was implemented in 2019. PDPM replaced RUG-IV for the SNF PPS in October 2019 and uses a similar classification structure as RUG-IV. Beginning in April 2024, CMS will freeze (i.e., hold constant) the staffing measures for three months while we make this transition. In July 2024, CMS will post nursing home staffing measures based on the new PDPM methodology. To minimize the potential disruption associated with the implementation of the new case-mix adjustment methodology, CMS will revise the staffing rating thresholds to maintain the same overall distribution of points for affected staffing measures.

The MDS changes also have implications for 4 of 15 QMs used in the Nursing Home Five Star Rating System. QMs impacted by the MDS G-GG transition:

- Percentage of Residents Who Made Improvements in Function (short stay)
- Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (long-stay)
- Percent of Residents Whose Ability to Move Independently Worsened (long stay)

- Percent of High-Risk Residents with Pressure Ulcers (long stay)

Starting in April 2024, CMS will freeze (hold constant) these four measures on Nursing Home Care Compare. In October 2024, CMS will replace the short-stay functionality QM with the new cross-setting functionality QM, which is used in the SNF Quality Reporting Program (QRP). The remaining three measures will continue to be frozen until January 2025 while the data for the equivalent measures are collected.

Updating the CMS forms 671 and 672

The changes to the MDS also necessitate changes to forms that are completed on surveys. Specifically, fields on the CMS-672 form can no longer be completed due to the removal of Section G from the MDS. Also, CMS and surveyors no longer use these MDS-based fields on the CMS-672 form as part of the survey process. Therefore, effective September 29, 2023, facilities are no longer required to complete these fields (F79 – F145) and surveyors are no longer be required to enter this information (fields F79 – 93) in the survey system. The census information (fields F75-F78), the ombudsman information (fields F146 and F147), and the medication error rate (field F148) should still be completed. On October 22, the census, medication error rate, and ombudsman information fields will be relocated to the form CMS-671, and the CMS-672 form will be removed. This change will help streamline the survey process for surveyors and facilities. We are aware that researchers and other stakeholders may use CMS-672 data, so we will be exploring other ways to make MDS-based data publicly available to all stakeholders through a separate mechanism.

Assigning Lowest Turnover Score Possible to Providers that Fail to Submit Staffing Data

Staffing in nursing homes has a substantial impact on the quality of care and outcomes residents experience. Nursing homes receive points based on how they perform on each staffing measure; these points are used to assign star ratings. Currently, nursing homes that fail to submit staffing data or submit erroneous data for staffing levels (hours per resident per day) receive a one-star staffing rating for the quarter in which the data are reported. However, nursing homes that fail to submit data in order to calculate staff turnover, have their staff turnover measures excluded from the staffing rating calculation. Thus, there is no impact to their score. Posting accurate and complete staffing data is important to CMS's commitment to transparency. Therefore, to further incentivize facilities to submit accurate staffing data, beginning in April 2024, CMS will revise the staffing rating methodology so providers that fail to submit staffing data or submit erroneous data receive the lowest score possible for corresponding staff turnover measures.

More information about the changes described in this memorandum is provided in the Nursing Home Care Compare Five Star Technical Users' Guide.

Contact:
For questions or concerns relating to this memorandum, please contact BetterCare@cms.hhs.gov

Effective Date:
Immediately. Please communicate to all appropriate staff within 30 days.

/s/
David R. Wright

Resources to Improve Quality of Care:

Check out CMS's new Quality in Focus interactive video series. The series of 10–15 minute videos are tailored to provider types and aim to reduce the deficiencies most commonly cited during the CMS survey process, like infection control and accident prevention. Reducing these common deficiencies increases the quality of care for people with Medicare and Medicaid. Learn to:

- *Understand surveyor evaluation criteria*
- *Recognize deficiencies*
- *Incorporate solutions into your facility's standards of care*

See the Quality, Safety, & Education Portal Training Catalog, and select Quality in Focus

Get guidance memos issued by the Quality, Safety and Oversight Group by going to CMS.gov page and entering your email to sign up. Check the box next to "CCSQ Policy, Administrative, and Safety Special Alert Memorandums" to be notified when we release a memo.