



Nursing Home Compare Claims- Based Quality Measure Technical Specifications

Final

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This revision describes the how the changes to the MDS made in October 2023 affected the data elements used to calculate the risk adjustment models for the claims-based measures. Version 1.18.11 of the MDS 3.0 replaces Section G with Section GG to characterize the functional status of both short- and long-term stay nursing home residents. Additionally, several other minor changes to the MDS necessitated adding, renaming, or dropping certain data elements from the risk-adjustment models for the claims-based measures.

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PERCENTAGE OF SHORT-STAY RESIDENTS WHO WERE RE-HOSPITALIZED AFTER A NURSING HOME ADMISSION

Measure Name

The measure name is Percentage of Short-Stay Residents Who Were Re-Hospitalized after a Nursing Home Admission.

Purpose of Measure

If a nursing home sends many residents back to the hospital, it may indicate that the nursing home is not properly assessing or taking care of its residents who are admitted to the nursing home from a hospital.

This claims-based quality measure was first reported by CMS in April 2016 and integrated into the Five-Star Quality Rating System in July 2016. It reports the percentage of short-stay residents who were re-hospitalized after a nursing home admission. The next sections describe the specifications and risk-adjustment methodology for this measure.

Measure Description and Specifications

The short-stay re-hospitalization measure determines the percentage of all nursing home residents who entered or reentered a nursing home, from a hospital, who were re-admitted to a hospital for an unplanned inpatient stay or outpatient observation stay within 30 days of entry/reentry. Higher values of the short-stay re-hospitalization measure indicate worse performance on the measure.

See Table 1 for detailed specifications for the measure.

Numerator: The numerator for the measure is the number of nursing home stays¹ where the resident had one or more unplanned inpatient admissions or one or more outpatient claims for an observation stay within 30 days of entry/reentry. This includes inpatient or observation stays occurring after discharge from the nursing home but within the 30-day timeframe.

Planned inpatient readmissions are not counted in the numerator since they are not a signal of quality of care. CMS's Planned Readmissions Algorithm (Version 4.0 2021) is used to classify hospitalizations as planned or unplanned.² Planned readmissions algorithm uses the principal discharge diagnosis category and all procedure codes on the inpatient discharge claim for the readmission, coded using the AHRQ Clinical Classification System (CCS) software. The planned readmissions algorithm is based on two principles:

1. Hospital readmissions are always planned if procedures related to bone marrow, kidney, or other organ transplantation took place or the principal discharge diagnosis for the readmissions were

¹ Note that a stay is defined as a set of contiguous days in a facility. A stay begins when a resident enters a nursing facility (based on the entry/reentry date from the MDS) and ends when the person leaves the nursing home (based on discharge date from the MDS, regardless of whether the discharge was planned, or the resident was anticipated to return to the facility).

² The CMS Planned Readmissions Algorithm (Version 4.0 2021) is used to construct CMS's 2021 Hospital-Wide Readmission Measure, described in the April 2021 Hospital-Wide Readmission measure Updates and Specifications Report – Version 10.0. Accessed on *QualityNet* at: <https://qualitynet.cms.gov/inpatient/measures/readmission/resources#tab3>

related to maintenance chemotherapy/radiotherapy, rehabilitation care, fitting of prostheses, or adjustment of devices.

2. Planned hospital readmissions include those in which one of a pre-specified list of potential procedures took place, but readmissions for acute illness or for complications of care are never classified as “planned.”

Unless the hospital readmission met the algorithm definition of planned, it is considered unplanned and counted as a hospital readmission in the measure. Observation stays are included in the measure regardless of their diagnosis.

Denominator: The measure includes Medicare beneficiaries enrolled in both Parts A and B³ who entered or reentered the nursing home from a hospital, were not enrolled in hospice during their nursing home stay, and who were not identified as comatose based on the MDS admission assessment. The denominator for the measure is the number of eligible nursing home stays meeting the following criteria:

- Nursing home stays that were preceded by an inpatient hospitalization are identified using stay dates linked to Medicare Part A claims. If the hospital discharge date is within one day of the stay start date (i.e., entry/reentry date), then the stay is defined as having been preceded by an inpatient hospitalization and is eligible to be included in the measure.
- Medicare beneficiaries are identified using the CMS Enrollment Database. Nursing home stays are excluded if the resident was enrolled in a Medicare Advantage plan for any part of the stay or was not enrolled in both Medicare Parts A and B for any part of the stay.
- A nursing home stay is excluded if the ‘from’ and ‘thru’ dates on any hospice claim overlap the nursing home stay.
- A nursing home stay is excluded if the resident was indicated to be comatose (B0100 = [01]) or if B0100 was missing on the first Minimum Data Set 3.0 (MDS) assessment after the start of the nursing home stay.
- A nursing home stay is excluded if it cannot be linked to at least one MDS assessment with a target date within 14 days of the start of the stay, or if data were missing for any of the claims or MDS items used for the numerator, denominator, or risk-adjustment.

³ Because the measure uses Medicare claims data, it can only be calculated for Medicare fee-for-service beneficiaries. Enrollment in Part A is required to identify inpatient admissions. Enrollment in Part B is required to identify outpatient observation stays.

Table 1. Percentage of Short-Stay Residents who were Re-hospitalized after a Nursing Home Admission

Measure Description	The percent of short-stay residents who entered or reentered the nursing home from a hospital and were re-admitted to a hospital for an unplanned inpatient stay or observation stay within 30 days of the start of the nursing home stay.
Numerator and Denominator Window	The numerator and denominator include stays that started over a 12-month period. The data are updated every quarter (in January, April, July, and October of each year), with a lag time of six months (i.e., stays that started 6-18 months ago).
Numerator	The numerator includes nursing home stays for beneficiaries who: <ul style="list-style-type: none"> a) met the inclusion criteria for the denominator; AND b) were admitted to a hospital for an inpatient stay or outpatient observation stay (revenue codes 0760, 0762) within 30 days of entry/reentry to the nursing home, regardless of whether they were discharged from the nursing home prior to the hospital readmission. Inpatient hospitalizations and observation stays are identified using Medicare claims; AND c) the hospital readmission did not meet the definition of a planned hospital readmission (identified using principal discharge diagnosis and procedure codes on Medicare claims for the inpatient stay)
Denominator	Included in the measure are stays for residents who: <ul style="list-style-type: none"> a) entered or reentered the nursing home within one day of discharge from an inpatient hospitalization (note that inpatient rehabilitation facility and long-term care hospitalizations are not included). These hospitalizations are identified using Medicare Part A claims; AND b) entered or reentered the nursing home within the 12-month target period
Denominator Exclusions	Short-stay residents are excluded if: <ul style="list-style-type: none"> a) the resident did not have fee-for-service parts A and B Medicare enrollment for the entire risk period (defined as the calendar month of the index hospitalization through the calendar month that follows the month during which the resident was discharged from the nursing home); OR b) the resident was ever enrolled in hospice care during their nursing home stay; OR c) the resident did not have an initial MDS assessment (within 14 days of entry/reentry) to use in constructing covariates for risk-adjustment; OR d) the resident was comatose (B0100 = [01]) or missing data on comatose on the first MDS assessment after the start of the stay; OR e) data were missing for any of the claims or MDS items used to construct the numerator or denominator, or for risk-adjustment.
Covariates	See Tables 2 and 3 for the list of claims-based and MDS-based covariates included in the logistic regression for calculating the facilities' expected rates, and the Appendix tables for the risk-adjustment model coefficients.

Risk Adjustment

The goal of risk adjustment is to account for differences across nursing homes in patient demographic and clinical characteristics that might be related to the outcome but not to the quality of care provided by the nursing home. Covariates include both items from claims that preceded the start of the stay and information from the first MDS assessment with a target date within 14 days of the beginning of the stay.

Claims-based covariates: Table 2 details the rationale for each of the covariates constructed using Medicare claims and enrollment data and used in the risk-adjustment model of the short-stay re-hospitalization measure.

Table 2. Covariates Constructed from Claims and Used in the Risk-Adjustment Model for Short-Stay Residents who were Re-hospitalized after a Nursing Home Admission

Variable	Rationale
Age	Demographic characteristic that is often important for outcomes of nursing home residents and associated with higher frailty and increasing number of comorbidities.
Sex	Demographic characteristic that is important for predicting hospital readmission for the nursing home population.
Length of stay during the hospitalization preceding the nursing home stay	Patients who are hospitalized for longer periods of time may require more complex care because they are often sicker. In addition, bed rest from prolonged hospitalizations often leads to deconditioning and functional impairment.
Any time spent in the intensive care unit (ICU) during the hospitalization preceding the nursing stay	ICU stays are an important indicator of medical severity and a predictor of post-acute care resource use.
Ever enrolled in Medicare under disability coverage	This is an indicator of overall patient complexity, as qualification for Medicare because disability requires the presence of serious chronic medical conditions that limit the ability to work.
End-Stage Renal Disease (ESRD)	This factor has been identified as a risk factor in prior studies of outcomes among nursing home residents.
Number of acute care hospitalizations in the 365 days before the beginning of the nursing stay	More hospitalizations in the previous year may be associated with declining health and increased complexity of care.
Principal diagnosis as categorized using AHRQ's single-level Clinical Classification System (CCS)	First diagnosis from the Medicare claim corresponding to the prior hospitalization as coded by AHRQ's CCS
Outcome-Specific Comorbidity Index	Patients with multiple or more severe comorbidities will tend to be frailer, putting them at increased risk for being readmitted to a hospital. This index is based on the clinical conditions included in the Charlson Comorbidity Index and captures the complexity beyond the linear additivity of the individual comorbidities. See the sub-section below for more details.

MDS-based covariates: For each measure, a clinical and MDS expert identified a list of MDS items most likely to increase or decrease the likelihood of the outcome. These items span multiple domains: functional status, clinical conditions, clinical treatments, and clinical diagnoses. Some of the “risk factors” were dropped from the list because they were closely related to existing quality metrics used in the Five-Star Quality Rating, and the outcome is only adjusted for risk factors that are unrelated to the quality of care at the facilities. Likewise, we also excluded factors related to conditions that increase the risk for readmission to the hospital by short-stay nursing home residents only when proper care and management are not provided by the facility. These exclusions were based on the set of conditions considered to be potentially preventable for the Potentially Preventable 30-Day Post-Discharge Readmission Measure for the Skilled Nursing Facility Quality Reporting Program (QRP).⁴

The remaining set of MDS-based risk factors were included in the final model if they were statistically significant predictors of the outcome after adjusting for the claims-based variables, regardless of whether

⁴ RTI International. Measure Specifications for Measures Adopted in the FY 2017 SNF QRP Final Rule. July 2016. Accessed at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Measure-Specifications-for-FY17-SNF-QRP-Final-Rule.pdf>

they were positively or negatively associated with the outcome. In general, our approach involved the following steps using national data:

- (1) divide the MDS-based covariates into groups with similar content focus;
- (2) run separate logistic regressions of the outcome on the claims-based covariates and these groups of MDS-based covariates, and retain the MDS-based covariates statistically significant at the $p < 0.20$ level;
- (3) regroup the retained MDS-based covariates into fewer groups but with similar content focus;
- (4) run separate logistic regressions of the outcome on the claims-based covariates and these fewer groups of MDS-based covariates and retain the MDS-based covariates with statistical significance at the $p < 0.10$ level;
- (5) combine all MDS-based covariates into one model with the claims-based covariates, run a logistic regression and retain the MDS-based covariates statistically significant at the $p < 0.05$ level;
- (6) calculate goodness of fit statistics to assess how well predicted values generated by the model were related to actual outcomes;
- (7) apply the final model to two smaller, randomly selected validation samples from the same data and retain the model if the goodness of fit is similar to the goodness of fit when applied to the national data set (else, reconsider the initial set of MDS-based covariates that were tested).

The set of items included in the risk adjustment model is listed in Table 3. Note that in Version 1.18.11 of MDS 3.0 (effective October 1, 2023), Section G, which includes functional status items, was replaced by Section GG. The risk adjustment models will not include Section G items starting in July, 2024 and will be replaced with Section GG items in July 2025, when all states will have implemented Section GG.

Comorbidity index: The risk-adjustment model includes an outcome-specific comorbidity index to partially adjust facility-level rates for the case-mix of residents at the facility, with respect to comorbidity status at the start of residents' stays. The comorbidity index is based on the 17 disease condition categories initially developed by Charlson/Deyo.⁵ Using the ICD-10-CM coding algorithm developed by Quan et al. (2005), we identified the Charlson comorbidities in any of the 21 diagnosis coding fields on all inpatient hospital claims in the 365 days preceding the patient's nursing home stay. Weights were calculated for each diagnosis indicator through logistic regression of the short-stay re-hospitalization measure, using all nursing home stays included in the measure in the 12-month target period. The comorbidity index includes only the subset of the 17 ICD-10-CM based disease conditions for which the logistic regression coefficient was significant at a probability level of 0.05 or better. The coefficients are used to create a comorbidity index value for each nursing home stay, and these index values are used in the logistic regression risk-adjustment model.

⁵ Quan H, Sundararajan V, Halfon P, et al. Coding algorithms for defining comorbidities in ICD-9-CM and ICD-10 administrative data. *Medical Care* 2005;43(11):1130-1139. The 17 conditions categories include: Myocardial infarction, chronic heart failure, peripheral vascular disease, cerebrovascular disease, dementia, chronic obstructive pulmonary disease, rheumatoid arthritis, ulcers, mild liver disease, diabetes mellitus, diabetes with sequelae, paralysis, chronic renal disease, cancer, moderate to severe liver disease, metastatic cancer, and HIV/AIDS.

Table 3. Covariates Constructed from MDS Items and Used in the Final Risk-Adjustment Model for Short-Stay Residents who were Re-hospitalized after a Nursing Home Admission

Category	MDS Item
Functional status	<p>Rarely/never makes self-understood by others (B0700)</p> <p>Cognitive status not completely intact (C0100 – C1000)</p> <p>Cognitive assessment missing (C0100 and C0600)</p> <p>Acute change in mental status (C1310A)</p> <p>Rejected care for past four to seven days (E0800)</p> <p>Wandering once or more in the past week (E0900)</p> <p>Coughing or choking during meals or when swallowing medications (K0100C)</p>
Section G items (removed in July 2024) → Section GG (to be added in July 2025)	<p>Walks in room independently or with supervision or limited assistance (G0110C1 → GG0170I1)</p> <p>Walks in corridor independently or with supervision or limited assistance (G011D1 → GG0170J1)</p> <p>Wanders <i>and</i> walks in room or corridor independently or with supervision or limited assistance (G0110C1 and G0110D1 → GG0170I1 and GG0170J1)</p> <p>Two-person support needed with one or more ADLs (G0110A2 – G0110J2 → GG0130A – GG0130I and GG0170A – GG0170S)</p> <p>Extensive assistance/dependence in eating (G0110H1 → GG0130A)</p>
Clinical conditions	<p>Shortness of breath or trouble breathing with exertion (J1100A)</p> <p>Shortness of breath or trouble breathing when sitting at rest (J1100B)</p> <p>End-stage prognosis (J1400)</p> <p>Internal bleeding (J1550D)</p> <p>Venous/Arterial ulcer present (M1030)</p> <p>Surgical wound (M1040E)</p>
Clinical treatments	<p>Ostomy care (H0100C)</p> <p>Parenteral/IV feeding (K0520A)</p> <p>Feeding tube (K0520B)</p> <p>Antibiotic received (N0415F)</p> <p>Chemotherapy for cancer (O01101A)</p> <p>Radiation for cancer (O0110B1)</p> <p>Oxygen therapy (O0110C1)</p> <p>Ventilator or respirator (O0100F1)</p> <p>IV medications (O0110H1)</p> <p>Transfusion (O0110I1)</p> <p>Respiratory therapy (O0400D2)</p>
Clinical diagnoses	<p>Cancer (I0100)</p> <p>Anemia (I0200)</p> <p>Ulcerative Colitis/Crohn's disease/inflammatory bowel disease (I1300)</p> <p>Viral hepatitis (I2400)</p> <p>Alzheimer's disease (I4200)</p> <p>Non-Alzheimer's dementia (I4800)</p> <p>Seizure disorder or epilepsy (I5400)</p>
Other	<p>Returned to the nursing home following hospitalization (A1700-2 and A1805)</p> <p>First assessment after reentry was for significant change in status (A0310A-04)</p>

Measure Calculations

Observed rate: The actual (observed) rate for a nursing home is calculated as the number of stays where the resident met the numerator criteria divided by the total number of stays that met the denominator criteria in the target period.

Expected rate: The risk adjustment model is estimated using logistic regression. The results from the logistic regression are used to calculate the probability of the outcome for each nursing home stay. This probability can be interpreted as the patient's risk of that outcome given their clinical and demographic profile. The expected rate for each nursing home is the average probability across all nursing home stays at the nursing home that are included in the measure in the target period. The logistic regression coefficients used to calculate the probability, including the weights used to calculate the outcome-specific comorbidity index, are reported in Appendix Table A.

Risk-standardized rate: To obtain the risk-standardized rate for any nursing home, the observed rate is divided by the expected rate which is then multiplied by the nationally observed rate—i.e., the sum of all nursing home stays where the resident met the numerator criteria divided by the sum of all nursing home stays that met the denominator criteria in the target period.

$$\frac{\text{Observed Rate}}{\text{Expected Rate}} \times \text{National Rate} = \text{Risk Standardized Rate}$$

NUMBER OF HOSPITALIZATIONS PER 1,000 LONG-STAY RESIDENT DAYS

Measure Name

The measure name is Number of Hospitalizations per 1,000 Long-Stay Resident Days.

Purpose of Measure

If a nursing home transfers long-term residents to the hospital more often than expected then it may indicate that the nursing home is not properly assessing or taking care of its residents.

This claims-based quality measure was first reported on Nursing Home Compare in October 2018 and was integrated into the Five-Star Quality Rating System in April 2019. It reports the ratio of unplanned hospitalizations per 1,000 long-stay resident days. The next sections describe the specifications and risk-adjustment methodology for this measure.

Measure Description and Specifications

The long-stay hospitalizations measure determines the number of unplanned inpatient admissions or outpatient observation stays that occurred among permanent (i.e., long-stay) residents of a nursing home during a one-year period, expressed as the number of unplanned hospitalizations for every 1,000 days that the long-stay residents were admitted to the facility (i.e., “long-stay resident days”). Higher values of the long-stay hospitalizations measure indicate worse performance on the measure. See Table 4 for detailed specifications for the measure.

Numerator: The numerator for the measure is the number of admissions to an acute care or critical access hospital, for an inpatient stay or outpatient observation stay, occurring while the individual is a long-term nursing home resident.

Planned inpatient admissions are not counted in the numerator since they are unrelated to the quality of care at the nursing home. Hospitalizations are classified as planned or unplanned using the same version of CMS’s Planned Readmissions Algorithm that is used to calculate the short-stay re-hospitalizations measure in the Nursing Home Compare Five-Star Rating system.⁶ The algorithm identifies planned admission using the principal discharge diagnosis category and all procedure codes listed on the inpatient discharge claim, coded using the AHRQ Clinical Classification System (CCS) software. Unless the hospital readmission met the algorithm definition of planned, it is considered unplanned and counted as a hospital readmission in the measure. Observation stays are included in the measure regardless of diagnosis. The numerator also excludes unplanned inpatient admissions and observation stays that occur while a resident is enrolled in hospice.⁷

⁶ The CMS Planned Readmissions Algorithm (Version 4.0 2021), which is also to construct CMS’s 2021 Hospital-Wide Readmission Measure, described in the April 2021 Hospital-Wide Readmission measure Updates and Specifications Report – Version 10.0. Accessed on *QualityNet* at: <https://qualitynet.cms.gov/inpatient/measures/readmission/resources#tab3>

⁷ Hospice days are identified by Medicare FFS Hospice claims.

Table 4: Number of Hospitalizations per 1,000 Long-Stay Resident Days

Measure Description	Number of unplanned inpatient admissions or all-cause outpatient observation stays at an acute care or critical access hospital occurring in the target period and while the individual is a long-term nursing home resident.
Numerator and Denominator Window	All days after the resident's one-hundredth cumulative day in the nursing home or the beginning of the 12-month target period (whichever is later) and until the day of discharge, the day of death, or end of the 12-month target period (whichever is earlier).
Numerator	The numerator includes all inpatient hospital admissions or outpatient observation stays for Medicare beneficiaries who: <ul style="list-style-type: none">a) met the inclusion criteria for the denominator; ANDb) were admitted to an acute care or critical access hospital for an inpatient stay or outpatient observation stay (revenue codes 0760, 0762) while they were residing in the nursing home and not enrolled in hospice; ANDc) were not admitted for a planned hospital inpatient admission (identified using principal discharge diagnosis and procedure codes on the inpatient discharge claims for the hospitalization).
Denominator	The sum of all long-stay days in the target period, divided by 1,000. A long-stay day is any day after a resident's one-hundredth cumulative day in the nursing home or the beginning of the 12-month target period (whichever is later) and until the day of discharge, the day of death, or the end of the 12-month target period (whichever is earlier).
Denominator Exclusions	Long-stay residents meeting any of the following criteria are excluded: <ul style="list-style-type: none">a) the resident was not a Medicare beneficiary or the resident was enrolled in Medicare managed care during any portion of the stay, i.e., between admission and discharge or the end of the target period (whichever is earlier); ORb) the resident did not have a quarterly or comprehensive MDS assessment within 120 days prior to the day the resident became a long-stay resident; ORc) data were missing for any of the claims or MDS items used to construct the numerator or denominator, or for risk-adjustment. Long-stay days meeting any of the following criteria are excluded: <ul style="list-style-type: none">a) the resident was enrolled in hospice care;b) the resident was not in the nursing home for any reason during the episode, including days admitted to an inpatient facility or other institution, or days temporarily residing in the community.
Covariates	See Tables 5 and 6 for the list of claims-based and MDS-based covariates included in the negative binomial regression for calculating facilities' expected rates, and the Appendix tables for the regression coefficients.

Denominator: The measure includes Medicare FFS beneficiaries enrolled in both Parts A and B⁸ with a single stay or sequence of stays⁹ during which the individual resides in the nursing home for a total of 101 days or more without a gap of 30 contiguous days living in the community or other institution. The denominator is the total number of days (in thousands) during the target period that all long-stay residents were in the nursing home facility after they obtained long-term resident status (i.e., after 100 cumulative days at the facility).¹⁰ The denominator does not include the days between nursing home stays, including days that a resident is admitted to an inpatient facility or other institution, or days the resident was enrolled in hospice.

Example of Measure Calculation

For an example of how the measure is calculated, consider the following scenario. Nursing Home Z had a total of 75 long-stay residents, who had a total of 27,375 eligible days as long-stay residents during the target period. There was a total of 28 unplanned hospitalizations and 7 observation stays among these residents during the period. The denominator is equal to 27,375 long-stay resident days divided by 1000, or 27.375. The numerator is equal to 35 (28 unplanned hospitalizations and 7 observation stays). Nursing Home Z's long-stay hospitalizations rate for 2018 is 1.28 hospitalizations per 1,000 long-stay resident days ($= 35 / 27.375$). For a facility with an average daily census of 75 long-stay residents, this equates to approximately 3 residents being sent to the hospital in each month ($= 75 \text{ residents} * 1.28 \text{ hospitalizations} * 30 \text{ days} / 1000 \text{ days}$).

Risk Adjustment

The goal of risk adjustment is to account for differences across nursing homes in medical acuity, functional impairment, and frailty of the long-stay residents but not factors related to the quality of care provided by the nursing home. The data for the risk adjustment model is derived from Medicare inpatient claims data prior to the day the resident became a long-stay resident (i.e., after 100 cumulative days in the facility) and from the most recent quarterly or comprehensive MDS assessment within 120 days prior to the day the resident became a long-stay resident. Variables for the risk-adjustment model were identified based primarily on clinical relevance, but also on the criteria of statistical significance and contribution to the explanatory power of the model.

Claims-based covariates: Table 5 details the rationale for each of the covariates constructed using Medicare claims and enrollment data and used in the risk-adjustment model of the long-stay hospitalizations measure.

⁸ Because the measure uses Medicare claims data, it can only be calculated for Medicare fee-for-service beneficiaries. Enrollment in Part B is required to identify all potential outpatient observation stays and outpatient emergency department visits.

⁹ A stay is defined as a set of contiguous days in a facility. A stay begins when a resident enters a nursing facility (based on the entry/reentry date from the MDS) and ends when the person leaves the nursing home (based on discharge date from the MDS, regardless of whether the discharge was planned, or the resident was anticipated to return to the facility).

¹⁰ In other words, for each resident, the total number of long-stay days is the cumulative days residing in the facility, beginning with the time the resident became a long-stay resident (or the start of the observation period if long-stay status was already obtained) and ending with either a discharge or the end of the reporting period (whichever comes first). The denominator is the sum of all long-stay days in the target period, divided by 1,000.

Table 5. Covariates Constructed from Claims and Used in the Risk-Adjustment Model for the Number of Hospitalizations per 1,000 Long-Stay Resident Days

Variable	Rationale
Age	Demographic characteristic that is often important for outcomes of nursing home residents and associated with higher frailty and greater comorbidity
Sex	Demographic characteristic that is important for predicting hospitalization for the nursing home population
Race/Ethnicity	Socio-demographic characteristic that is potentially associated with certain comorbidities and medical history
Number of acute care hospitalizations in the 365 days before the day the resident became a long-stay resident or the beginning of the 12-month target period (whichever is later)	More hospitalizations in the previous year may be associated with declining health and increased complexity of care.
Outcome-Specific Comorbidity Index	Patients with multiple or more severe comorbidities will tend to be frailer, putting them at increased risk for being admitted to a hospital. This index is based on 17 clinical conditions included in the Charlson Comorbidity Index and captures the complexity beyond the linear additivity of the individual comorbidities. Diagnoses are identified using inpatient claims in the 365 days before the day the resident became a long-stay resident or the beginning of the 12-month target period (whichever is later).

MDS-based covariates: For each measure, a clinical and MDS expert identified a list of MDS items most likely to increase or decrease the likelihood of the outcome. These items span multiple domains: functional status, clinical conditions, clinical treatments, and clinical diagnoses. Some of the “risk factors” were dropped from the list because they were closely related to existing quality metrics used in the Five-Star Quality Rating, and the outcome is only adjusted for risk factors that are unrelated to the quality of care at the facilities. Likewise, we also excluded factors related to conditions that increase the risk for hospitalization only when proper care and management are not provided by the facility. These exclusions were based on the set of conditions selected by CMS and RTI International as potentially avoidable hospitalizations among dually eligible beneficiaries in a nursing home setting.¹¹

The remaining set of MDS-based risk factors were included in the final model if they were statistically significant predictors of the outcome after adjusting for the claims-based variables, regardless of whether they were positively or negatively associated with the outcome. In general, our approach involved the following steps using national data from 2016:

- (1) divide the MDS-based covariates into groups with similar content focus;
- (2) run separate negative binomial regressions of the outcome on the claims-based covariates, the number of long-stay days the resident was in the facility, the number of long-stay days

¹¹ Walsh EG, Frieman M, Haber S, et al. Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and Community-Based Services Waiver Programs. RTI International: Final Task 2 Report. August 2010. Accessed at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/costdriverstask2.pdf>

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- squared, and these groups of MDS-based covariates, then retain the MDS-based covariates statistically significant at the $p < 0.20$ level;
- (3) regroup the retained MDS-based covariates into fewer groups but with similar content focus;
 - (4) run separate negative binomial regressions of the outcome on the claims-based covariates, long-stay days and days squared, and these fewer groups of MDS-based covariates and retain the MDS-based covariates with statistical significance at the $p < 0.10$ level;
 - (5) combine all MDS-based covariates into one model with the claims-based covariates, long-stay days, and days squared, then run a negative binomial regression and retain the MDS-based covariates statistically significant at the $p < 0.05$ level;
 - (6) calculate goodness of fit statistics to assess how well predicted values generated by the model were related to actual outcomes;
 - (7) apply the final model to two smaller randomly selected validation samples from the same data and retain the model if the goodness of fit is similar to the goodness of fit when applied to the national data set (else, reconsider the initial set of MDS-based covariates that were tested).

The set of items included in the risk adjustment model is listed in Table 6. Note that in Version 1.18.11 of MDS 3.0 (effective October 1, 2023), Section G, which includes functional status items, was replaced by Section GG. The risk adjustment models will not include Section G items starting in July, 2024 and will be replaced with Section GG items in July 2025, when all states will have implemented Section GG.

Comorbidity index: The risk-adjustment model includes an outcome-specific comorbidity index to partially adjust facility-level rates for the case-mix of residents at the facility, with respect to comorbidity status shortly before the day that the residents became long-stay residents. The comorbidity index is based on the 17 disease condition categories initially developed by Charlson/Deyo.¹² Using the ICD-10-CM coding algorithm developed by Quan et al. (2005), we identified the Charlson comorbidities in any of the 21 diagnosis coding fields on all inpatient hospital claims in the 365 days preceding the day the residents became long-stay residents. Weights are calculated for each diagnosis indicator through negative binomial regression of the number of hospitalizations for each long-stay resident included in the measure in the 12-month target period. The regression also controls for the number of long-stay days in the facility and the number of long-stay days squared. The comorbidity index includes the regression intercept coefficient and the coefficients for the subset of the 17 ICD-10-CM based disease conditions for which the regression coefficient was significant at a probability level of 0.05 or better. The coefficients are used to create a comorbidity index value for each nursing home stay, and these index values are used in the negative binomial regression risk-adjustment model for long-stay hospitalizations.

¹² Quan H, Sundararajan V, Halfon P, et al. Coding algorithms for defining comorbidities in ICD-9-CM and ICD-10 administrative data. *Medical Care* 2005;43(11):1130-1139. The 17 conditions categories include: Myocardial infarction, chronic heart failure, peripheral vascular disease, cerebrovascular disease, dementia, chronic obstructive pulmonary disease, rheumatoid arthritis, ulcers, mild liver disease, diabetes mellitus, diabetes with sequelae, paralysis, chronic renal disease, cancer, moderate to severe liver disease, metastatic cancer, and HIV/AIDS.

Table 6. Covariates Constructed from MDS Items and Used in the Final Risk-Adjustment Model for the Number of Hospitalizations per 1,000 Long-Stay Resident Days

Category	MDS Item
Functional status	Rarely/never makes self-understood by others (B0700) Cognitive status moderately impaired, severely impaired, assessed by staff, or assessment is missing (C0100 – C1000) Rejected care for past four to seven days (E0800) Wandering once or more in the past week (E0900)
Section G items (removed in July 2024) → Section GG (to be added in July 2025)	Walks in room independently or with supervision or limited assistance (G0110C1 → GG170I1) Walks in corridor independently or with supervision or limited assistance (G0110D1 → GG170J1) Extensive assistance/dependence in eating (G0110H1 → GG0130A)
Clinical conditions	Shortness of breath or trouble breathing with exertion (J1100A) Shortness of breath or trouble breathing when lying flat (J1100C) End-stage prognosis (J1400) Internal bleeding (J1550D)
Clinical treatments	Anticoagulant received (N0415E) Antibiotic received (N0415F) Diuretic received (N0415G) Chemotherapy for cancer (O0110A1) Radiation for cancer (O0110B1) Oxygen therapy (O0110C1) IV medications (O0110H1) Transfusion (O0110I1) Hospice care after nursing home admission (O0110K1) Isolation or quarantine for active infectious disease (O0110M1) Speech therapy (O0400A4) Respiratory therapy (O0400D2)
Clinical diagnoses	Gastroesophageal reflux disease (GERD) or ulcer (I1200) Ulcerative Colitis/Crohn's disease/inflammatory bowel disease (I1300) Neurogenic bladder (I1550) Multidrug-resistant organism (MDRO) (I1700) Septicemia (I2100) Cerebrovascular accident, transient ischemic attack, or stroke (I4500) Quadriplegia (I5100) Multiple Sclerosis (I5200) Parkinson's disease (I5300) Anxiety disorder (I5700) Respiratory failure (I6300)
Other	Entered nursing home from an inpatient psychiatric (hospital or unit) (A1805)

Measure Calculations

Observed rate: The actual (observed) rate for a nursing home facility is calculated as the total number of inpatient hospital admissions or outpatient observation stays meeting the numerator criteria divided by the total number of all long-stay days that met the denominator criteria (in thousands) in the target period. The measure is reported only for nursing homes that have at least 20 long-stay residents during the target period.

Expected rate: The risk adjustment model is estimated using negative binomial regression of the number of hospitalizations after the resident was a long-stay resident and during the target period. Covariates include the claims-based and MDS-based variables listed in Tables 5 and 6, as well as the number of long-stay days the resident was in the facility and the number of long-stay days squared. The results from the negative binomial regression are used to predict the number of hospitalizations for each long-stay resident given the patient's clinical and demographic profile. The expected rate for each nursing home facility is the sum of the predicted number of hospitalizations for every long-stay resident in the nursing home divided by the total number of all long-stay days at the nursing home that met the denominator criteria in the target period (in thousands). The negative binomial regression coefficients, including the weights used to calculate the outcome-specific comorbidity index are reported in Appendix Table C.

Risk-standardized rate: To obtain the risk-standardized rate for a nursing home facility, the observed rate is divided by the expected rate which is then multiplied by the nationally observed rate. The national rate is calculated as the total number of inpatient hospital admissions or outpatient observation stays meeting the numerator criteria, across all facilities, divided by the total number of all long-stay days that met the denominator criteria (in thousands), across all facilities.

$$\frac{\text{Observed Rate}}{\text{Expected Rate}} \times \text{National Rate} = \text{Risk Standardized Rate}$$

PERCENTAGE OF SHORT-STAY RESIDENTS WHO HAVE HAD AN OUTPATIENT EMERGENCY DEPARTMENT VISIT

Measure Name

The measure name is Percentage of Short-Stay Residents Who Have had an Outpatient Emergency Department Visit.

Purpose of Measure

If a nursing home often sends many of its residents to the emergency department (ED), it may indicate that the nursing home is not properly assessing or taking care of its residents who are admitted to the nursing home from a hospital. Better preventative care and access to physicians and nurse practitioners in an emergency may reduce rates of ED visits.

This claims-based quality measure was first reported by CMS in April 2016 and integrated into the Five-Star Quality Rating System in July 2016. It reports the percentage of short-stay residents who had an outpatient ED visit after a nursing home admission. The next sections describe the specifications and risk-adjustment methodology for this measure.

Measure Description and Specifications

The short-stay outpatient ED visit measure determines the percentage of all nursing home residents who entered or reentered a nursing home, from a hospital, who had an outpatient ED visit (i.e., an ED visit not resulting in an inpatient hospital admission) within 30 days of entry or reentry. Note that higher values of the short-stay outpatient ED visit measure indicate worse performance on the measure.

See Table 7 for detailed specifications for the measure.

Numerator: The numerator for the measure is the number of nursing home stays¹³ where the resident had one or more outpatient claims for an ED visit within 30 days of entry/reentry. This includes outpatient ED visits occurring after discharge from the nursing home but within the 30-day timeframe. Outpatient ED visits are included in the measure regardless of diagnosis.

Outpatient ED visits are not counted in the numerator if the ‘thru’ date on the outpatient claim for the ED visit was equal to the ‘from’ date on an outpatient claim for an observation stay or an inpatient claim for an unplanned hospitalization.¹⁴ In other words, ED visits that were billed as an outpatient event but resulted in admission to a hospital for an observation stay or an unplanned inpatient stay would not be “double-counted” across the short-stay outpatient ED visit measure and the short-stay re-hospitalization measure.

¹³ A stay is defined as a set of contiguous days in a facility. A stay begins when a resident enters a nursing facility (i.e., based on the entry/reentry date from the MDS) and ends when the person leaves the nursing home (based on discharge date from the MDS, regardless of whether the discharge was planned, or the resident was anticipated to return to the facility).

¹⁴ See the specifications for the short-stay measure of residents who were re-hospitalized after a nursing home admission for the description of planned versus unplanned hospital admissions.

Denominator: The measure includes Medicare beneficiaries enrolled in both Parts A and B¹⁵ who entered or reentered the nursing home from a hospital, were not enrolled in hospice during their nursing home stay, and who were not identified as comatose based on the MDS admission assessment. The denominator for the measure is the number of eligible nursing home stays meeting the following criteria:

- Nursing home stays that were preceded by an inpatient hospitalization are identified using stay dates linked to Medicare Part A claims. If the hospital discharge date is within one day of the stay start date (i.e., entry/reentry date), then the stay is defined as having been preceded by an inpatient hospitalization and is eligible to be included in the measure.
- Medicare beneficiaries are identified using the CMS Enrollment Database. Nursing home stays are excluded if the resident was enrolled in a Medicare Advantage plan for any part of the stay or was not enrolled in both Medicare Parts A and B for any part of the stay.
- A nursing home stay is excluded if the ‘from’ and ‘thru’ dates on any hospice claim overlap the nursing home stay.
- A nursing home stay is excluded if the resident was indicated to be comatose (B0100 = [01]) or if B0100 was missing on the first Minimum Data Set 3.0 (MDS) assessment after the start of the nursing home stay.
- A nursing home stay is excluded if it cannot be linked to at least one MDS assessment with a target date within 14 days of the start of the stay, or if data were missing for any of the claims or MDS items used for the numerator, denominator, or risk-adjustment.

¹⁵ Because the measure uses Medicare claims data, it can only be calculated for Medicare fee-for-service beneficiaries. Enrollment in Part A is required to identify inpatient stays that might exclude an outpatient ED visit from the numerator. Enrollment in Part B is required to identify all outpatient emergency department visits and outpatient observation stays that might exclude an outpatient ED visit from the numerator.

Table 7. Percentage of Short-Stay Residents who have had an Outpatient Emergency Department Visit

Measure Description	The percent of short-stay residents who entered or reentered the nursing home from a hospital and visited an emergency department within 30 days of the start of the nursing home stay, and this visit did not result in an inpatient or observation stay.
Numerator and Denominator Window	The numerator and denominator include stays that started over a 12-month period. The data are updated every quarter (in January, April, July, and October of each year), with a lag time of six months (i.e., stays that started 6-18 months ago).
Numerator	The numerator includes nursing home stays for beneficiaries who: <ul style="list-style-type: none"> a) met the inclusion criteria for the denominator; AND b) were admitted to an emergency department (revenue codes 0450, 0451, 0452, 0456, 0459, 0981) within 30 days of entry/reentry to the nursing home, regardless of whether they were discharged from the nursing home prior to the emergency department visit. Outpatient emergency department visits are identified using Medicare Part B claims; AND c) were not admitted to a hospital for an unplanned inpatient stay or observation stay (revenue codes 0760, 0762) immediately after the visit to the emergency department. Inpatient and observation stays are identified using Medicare Parts A and B claims. Planned inpatient stays are identified using principal discharge diagnosis and procedure codes on Medicare claims for the inpatient stay)
Denominator	Included in the measure are stays for residents who: <ul style="list-style-type: none"> a) entered or reentered the nursing home within one day of discharge from an inpatient hospitalization (note that inpatient rehabilitation facility and long-term care hospitalizations are not included). Hospitalizations are identified using Medicare Part A claims; AND b) entered or reentered the nursing home within the 12-month target period
Denominator Exclusions	Short-stay residents are excluded if: <ul style="list-style-type: none"> a) the resident did not have fee-for-service parts A and B Medicare enrollment for the entire risk period (defined as the calendar month of the index hospitalization through the calendar month that follows the month during which the resident was discharged from the nursing home); OR b) the resident was ever enrolled in hospice care during their nursing home stay; OR c) the resident did not have an initial MDS assessment (within 14 days of entry/reentry) to use in constructing covariates for risk-adjustment; OR d) the resident was comatose (B0100 = [01]) or missing data on comatose on the first MDS assessment after the start of the stay; OR e) data were missing for any of the claims or MDS items used to construct the numerator or denominator, or for risk-adjustment.
Covariates	See Tables 8 and 9 for the list of claims-based and MDS-based covariates included in the logistic regression for calculating the facilities' expected rates and the Appendix tables for the risk-adjustment model coefficients.

Risk Adjustment

The goal of risk adjustment is to account for differences across nursing homes in patient demographic and clinical characteristics that might be related to the outcome but not to the quality of care provided by the nursing home. Covariates include both items from claims that preceded the start of the stay and information from the first MDS assessment with a target date within 14 days of the beginning of the stay.

Claims-based covariates: Table 8 details the rationale for each of the covariates constructed using Medicare claims and enrollment data and used in the risk-adjustment model of the short-stay outpatient ED visit measure.

Table 8. Covariates Constructed from Claims and Used in the Risk-Adjustment Model for Short-Stay Residents who have had an Outpatient Emergency Department Visit

Variable	Rationale
Age	Demographic characteristic that is often important for outcomes of nursing home residents and associated with higher frailty and increasing number of comorbidities.
Sex	Demographic characteristic that is important for predicting ED visits for the nursing home population.
Length of stay during the hospitalization preceding the nursing home stay	Patients who are hospitalized for longer periods of time may require more complex care because they are often sicker. In addition, bed rest from prolonged hospitalizations often leads to deconditioning and functional impairment.
Any time spent in the intensive care unit (ICU) during the hospitalization preceding the nursing home stay	ICU stays are an important indicator of medical severity and a predictor of post-acute care resource use.
Ever enrolled in Medicare under disability coverage	This is an indicator of overall patient complexity, as qualification for Medicare because disability requires the presence of serious chronic medical conditions that limit the ability to work.
End-Stage Renal Disease (ESRD)	This factor has been identified as a risk factor in prior studies of outcomes among nursing home residents.
Number of acute care hospitalizations in the 365 days before the beginning of the nursing home stay	More hospitalizations in the previous year may be associated with declining health and increased complexity of care
Principal diagnosis as categorized using AHRQ's single-level Clinical Classification System (CCS)	First diagnosis from the Medicare claim corresponding to the prior hospitalization as coded by AHRQ's CCS
Outcome-Specific Comorbidity Index	Patients with multiple or more severe comorbidities will tend to be frailer, putting them at increased risk for an ED visit. This index is based on the clinical conditions included in the Charlson Comorbidity Index and captures the complexity beyond the linear additivity of the individual comorbidities. See the sub-section below for more details.

MDS-based covariates: For each measure, a clinical and MDS expert identified a list of MDS items most likely to increase or decrease the likelihood of the outcome. These items span multiple domains: functional status, clinical conditions, clinical treatments, and clinical diagnoses. Some of the “risk factors” were dropped from the list because they were closely related to existing quality metrics used in the Five-Star Quality Rating, and the outcome is only adjusted for risk factors that are unrelated to the quality of care at the facilities. Likewise, we also excluded factors related to conditions that increase the risk for ED visits by short-stay nursing home residents only when proper care and management are not provided by the facility. These exclusions were based on the set of conditions considered to be potentially preventable for the Potentially Preventable 30-Day Post-Discharge Readmission Measure for the Skilled Nursing Facility Quality Reporting Program (QRP).¹⁶

The remaining set of MDS-based risk factors were included in the final model if they were statistically significant predictors of the outcome after adjusting for the claims-based variables, regardless of whether

¹⁶ RTI International. Measure Specifications for Measures Adopted in the FY 2017 SNF QRP Final Rule. July 2016. Accessed at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Measure-Specifications-for-FY17-SNF-QRP-Final-Rule.pdf>

they were positively or negatively associated with the outcome. In general, our approach involved the following steps using national data from 2016:

- (1) divide the MDS-based covariates into groups with similar content focus;
- (2) run separate logistic regressions of the outcome on the claims-based covariates and these groups of MDS-based covariates, and retain the MDS-based covariates statistically significant at the $p < 0.20$ level;
- (3) regroup the retained MDS-based covariates into fewer groups but with similar content focus;
- (4) run separate logistic regressions of the outcome on the claims-based covariates and these fewer groups of MDS-based covariates and retain the MDS-based covariates with statistical significance at the $p < 0.10$ level;
- (5) combine all MDS-based covariates into one model with the claims-based covariates, run a logistic regression and retain the MDS-based covariates statistically significant at the $p < 0.05$ level;
- (6) calculate goodness of fit statistics to assess how well predicted values generated by the model were related to actual outcomes;
- (7) apply the final model to two smaller randomly selected validation samples from the same data and retain the model if the goodness of fit is similar to the goodness of fit when applied to the national data set (else, reconsider the initial set of MDS-based covariates that were tested).

The set of items included in the risk adjustment model is listed in Table 9. Note that in Version 1.18.11 of MDS 3.0 (effective October 1, 2023), Section G, which includes functional status items, was replaced by Section GG. The risk adjustment models will not include Section G items starting in July, 2024 and will be replaced with Section GG items in July 2025, when all states will have implemented Section GG.

Comorbidity index: The risk-adjustment model includes an outcome-specific comorbidity index to partially adjust facility-level rates for the case-mix of residents at the facility, with respect to comorbidity status at the start of residents' stays. The comorbidity index is based on the 17 disease condition categories initially developed by Charlson/Deyo.¹⁷ Using the ICD-10-CM coding algorithm developed by Quan et al. (2005), we identified the Charlson comorbidities in any of the 21 diagnosis coding fields on all inpatient hospital claims in the 365 days preceding the patients' nursing home stays. Weights were calculated for each diagnosis indicator through logistic regression of the short-stay outpatient ED visit measure, using all nursing home stays included in the measure in the 12-month target period. The comorbidity index includes only the subset of the 17 ICD-10-CM based disease conditions for which the logistic regression coefficient was significant at a probability level of 0.05 or better. The coefficients are used to create a comorbidity index value for each nursing home stay, and these index values are used in the logistic regression risk-adjustment model.

¹⁷ Quan H, Sundararajan V, Halfon P, et al. Coding algorithms for defining comorbidities in ICD-9-CM and ICD-10 administrative data. *Medical Care* 2005;43(11):1130–1139. The 17 conditions categories include: Myocardial infarction, chronic heart failure, peripheral vascular disease, cerebrovascular disease, dementia, chronic obstructive pulmonary disease, rheumatoid arthritis, ulcers, mild liver disease, diabetes mellitus, diabetes with sequelae, paralysis, chronic renal disease, cancer, moderate to severe liver disease, metastatic cancer, and HIV/AIDS.

Table 9. Covariates Constructed from MDS Items and Used in the Final Risk-Adjustment Model for Short-Stay Residents who have had an Outpatient Emergency Department Visit

Category	MDS Item
Functional status	Rarely/never makes self-understood by others (B0700) Cognitive status not completely intact (C0100 – C1000) Cognitive assessment missing (C0100 and C0600) Acute change in mental status (C1310A) Rejected care for past four to seven days (E0800) Wandering once or more in the past week (E0900) Coughing or choking during meals or when swallowing medications (K0100C)
Section G items (removed in July 2024) → Section GG (to be added in July 2025)	Walks in room independently or with supervision or limited assistance (G0110C1 → GG0170I1) Walks in corridor independently or with supervision or limited assistance (G011D1 → GG0170J1) Wanders and walks in room or corridor independently or with supervision or limited assistance (G0110C1 and G0110D1 → GG0170I1 and GG0170J1) Two-person support needed with one or more ADLs (G0110A2 – G0110J2 → GG0130A – GG0130I and GG0170A – GG0170S) Extensive assistance/dependence in eating (G0110H1 → GG0130A)
Clinical conditions	Shortness of breath or trouble breathing with exertion (J1100A) Shortness of breath or trouble breathing when sitting at rest (J1100B) End-stage prognosis (J1400) Internal bleeding (J1550D) Venous/Arterial ulcer present (M1030) Surgical wound (M1040E) Burn(s) (M1040F)
Clinical treatments	Ostomy care (H0100C) Parenteral/IV feeding (K0520A) Feeding tube (K0520B) Anticoagulant received (N0415E) Antibiotic received (N0415F) Oxygen therapy (O0110C1) Tracheostomy care (O0110E1) Ventilator or respirator (O0110F1) IV medications (O0110H1) Transfusion (O0110I1) Speech therapy (O0400A4) Respiratory therapy (O0400D2)
Clinical diagnoses	Cancer (I0100) Viral hepatitis (I2400) Seizure disorder or epilepsy (I5400) Respiratory failure (I6300)
Other	Returned to the nursing home following hospitalization (A1700-2 and A1805) First assessment after reentry was for significant change in status (A0310A-04)

Measure Calculations

Observed rate: The actual (observed) rate for a nursing home is calculated as the number of stays where the resident met the numerator criteria divided by the total number of stays that met the denominator criteria in the target period.

Expected rate: The risk adjustment model is estimated using logistic regression. The results from the logistic regression are used to calculate the probability of the outcome for each nursing home stay. This probability can be interpreted as the patient's risk of that outcome given their clinical and demographic profile. The expected rate for each nursing home is the average probability across all stays at the nursing home that are included in the measure in the target period. The logistic regression coefficients used to calculate the probability, including the weights used to calculate the outcome-specific comorbidity index, are reported in Appendix Table E.

Risk-standardized rate: To obtain the risk-standardized rate for any nursing home, the observed rate is divided by the expected rate which is then multiplied by the nationally observed rate—i.e., the sum of all nursing home stays where the resident met the numerator criteria divided by the sum of all nursing home stays that met the denominator criteria in the target period.

$$\frac{\text{Observed Rate}}{\text{Expected Rate}} \times \text{National Rate} = \text{Risk Standardized Rate}$$

NUMBER OF OUTPATIENT EMERGENCY DEPARTMENT VISITS PER 1,000 LONG-STAY RESIDENT DAYS

Measure Name

The measure name is Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days.

Purpose of Measure

If a nursing home sends its residents to the emergency department (ED) more often than expected, it may indicate that the nursing home is not properly assessing or taking care of its residents.

This claims-based quality measure was first reported on Nursing Home Compare and incorporated in the Five-Star Quality Rating System in April 2019. It reports the ratio of outpatient ED visits (i.e., ED visits that did not result in an inpatient hospital stay or outpatient observation stay) per 1,000 long-stay resident days. The next sections describe the specifications and risk-adjustment methodology for this measure.

Measure Description and Specifications

The long-stay outpatient ED visits measure determines the number of outpatient ED visits that occurred among permanent (i.e., long-stay) residents of a nursing home during a one-year period, expressed as the number of outpatient ED visits for every 1,000 days that the long-stay residents were admitted to the facility (i.e., “long-stay resident days”). Higher values of the long-stay outpatient ED visits measure indicate worse performance on the measure. See Table 10 for detailed specifications for the measure.

Numerator: The numerator for the measure is the number of visits to an emergency department that did not result in an inpatient hospital stay or outpatient observation stay, occurring while the individual is a long-term nursing home resident. Outpatient ED visits are included in the measure regardless of diagnosis.

Outpatient ED visits are not counted in the numerator if the ‘thru’ date on the outpatient claim for the ED visit is equal to the ‘from’ date on an outpatient claim for an observation stay or an inpatient claim for any hospitalization.¹⁸ In other words, ED visits billed as an outpatient event but that resulted in admission to a hospital for an observation stay or an unplanned inpatient stay would not be “double-counted” by the long-stay outpatient ED visits and hospitalizations measures. The numerator excludes outpatient ED visits that occur while a resident is enrolled in hospice.¹⁹

¹⁸ Note that outpatient ED visits are not counted in the numerator for the long-stay ED measure if they led to either an unplanned or planned hospitalization because the denominator does not include days that a resident was admitted to an inpatient facility or other institution. Therefore, ED visits are excluded from the numerator if they occurred on the same day as an inpatient admission, of any type.

¹⁹ Hospice days are identified by Medicare FFS Hospice claims.

Table 10. Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days

Measure Description	Number of all-cause outpatient emergency department (ED) visits occurring in the target period and while the individual is a long-term nursing home resident. Outpatient ED visits are ED visits that do not result in an outpatient observation stay or inpatient hospital stay.
Numerator and Denominator Window	All days after the resident's one-hundredth cumulative day in the nursing home or the beginning of the 12-month target period (whichever is later) and until the day of discharge, the day of death, or end of the 12-month target period (whichever is earlier).
Numerator	The numerator includes all ED visits for Medicare beneficiaries who: <ul style="list-style-type: none"> a) met the inclusion criteria for the denominator; AND b) had an outpatient (Medicare Part B) claim with revenue codes (0450, 0451, 0452, 0456, 0459, 0981) for an ED visit while they were residing in the nursing home and not enrolled in hospice; AND c) where the 'thru' date on the outpatient claim for the ED visit was not equal to the 'from' date on an outpatient claim for an observation stay (revenue codes 0760, 0762) or an inpatient (Medicare Part A) claim for a hospitalization.
Denominator	The sum of all long-stay days in the target period, divided by 1,000. A long-stay day is any day after a resident's one-hundredth cumulative day in the nursing home or the beginning of the 12-month target period (whichever is later) and until the day of discharge, the day of death, or the end of the 12-month target period (whichever is earlier).
Denominator Exclusions	Long-stay residents meeting any of the following criteria are excluded: <ul style="list-style-type: none"> a) the resident was not a Medicare beneficiary or the resident was enrolled in Medicare managed care during any portion of the stay, i.e., between admission and discharge or the end of the target period (whichever is earlier); b) the resident did not have a quarterly or comprehensive MDS assessment within 120 days prior to the day the resident became a long-stay resident; OR c) data were missing for any of the claims or MDS items used to construct the numerator or denominator, or for risk-adjustment. Long-stay days meeting any of the following criteria are excluded: <ul style="list-style-type: none"> a) the resident was enrolled in hospice care; b) the resident was not in the nursing home for any reason during the episode, including days admitted to an inpatient facility or other institution, or days temporarily residing in the community.
Covariates	See Tables 11 and 12 for the list of claims-based and MDS-based covariates included in the negative binomial regression for calculating facilities' expected rates, and the Appendix tables for the regression coefficients.

Denominator: The measure includes Medicare beneficiaries enrolled in Parts A and B²⁰ with a single stay or sequence of stays²¹ during which the individual resides in the nursing home for a total of 101 days or more without a gap of 30 contiguous days living in the community or other institution. The denominator is the total number of days (in thousands) during the target period that all long-stay residents were in the nursing home facility after they obtained long-term resident status (i.e., after 100 cumulative days at the facility).²² The denominator does not include the days between nursing home stays, days that a resident was admitted to an inpatient facility or other institution, or days the resident was enrolled in hospice.

Example of Measure Calculation

For an example of how the measure is calculated, consider the following scenario. Nursing Home Z had a total of 75 long-stay residents, who had a total of 27,375 eligible days as long-stay residents during the target period. There was a total of 35 outpatient ED visits among these residents during the period. Nursing Home Z's long-stay outpatient ED visits rate for 2018 is 1.28 outpatient ED visits per 1,000 long-stay resident days ($= 35 / 27.375$). For a facility with an average daily census of 75 long-stay residents, this equates to approximately 3 residents with outpatient ED visits in a given month ($= 75 \text{ residents} * 1.28 \text{ visits} * 30 \text{ days} / 1000 \text{ days}$).

Risk Adjustment

The goal of risk adjustment is to account for differences across nursing homes in medical acuity, functional impairment, and frailty of the long-stay residents but not factors related to the quality of care provided by the nursing home. The data for the risk adjustment model is derived from Medicare inpatient claims data prior to the day the resident became a long-stay resident (i.e., after 100 cumulative days in the facility) and from the most recent quarterly or comprehensive MDS assessment within 120 days prior to the day the resident became a long-stay resident. Variables for the risk-adjustment model were identified based primarily on clinical relevance, but also on the criteria of statistical significance and contribution to the explanatory power of the model.

Claims-based covariates: Table 11 details the rationale for each of the covariates constructed using Medicare claims and enrollment data and used in the risk-adjustment model of the long-stay outpatient ED visits measure.

²⁰ Because the measure uses Medicare claims data, it can only be calculated for Medicare fee-for-service beneficiaries. Enrollment in Part A is required to identify inpatient stays that might exclude an outpatient ED visit from the numerator. Enrollment in Part B is required to identify all outpatient emergency department visits and outpatient observation stays that might exclude an outpatient ED visit from the numerator.

²¹ A stay is defined as a set of contiguous days in a facility. A stay begins when a resident enters a nursing facility (based on the entry/reentry date from the MDS) and ends when the person leaves the nursing home (based on discharge date from the MDS, regardless of whether the discharge was planned, or the resident was anticipated to return to the facility).

²² In other words, for each resident, the total number of long-stay days is the cumulative days residing in the facility, beginning with the time the resident became a long-stay resident (or the start of the observation period if long-stay status was already obtained) and ending with either a discharge or the end of the reporting period (whichever comes first). The denominator is the sum of all long-stay days in the target period, divided by 1,000.

Table 11. Covariates Constructed from Claims and Used in the Risk-Adjustment Model for the Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days

Variable	Rationale
Age	Demographic characteristic that is often important for outcomes of nursing home residents and associated with higher frailty and greater comorbidity.
Sex	Demographic characteristic that is important for predicting ED visits for the nursing home population
Race/Ethnicity	Socio-demographic characteristic that is potentially associated with certain comorbidities and medical history
Number of acute care hospitalizations in the 365 days before the day the resident became a long-stay resident or the beginning of the 12-month target period (whichever is later)	More hospitalizations in the previous year may be associated with declining health and increased complexity of care.
Outcome-Specific Comorbidity Index	Patients with multiple or more severe comorbidities will tend to be frailer, putting them at increased risk for being admitted to an ED. This index is based on 17 clinical conditions included in the Charlson Comorbidity Index and captures the complexity beyond the linear additivity of the individual comorbidities. Diagnoses are identified using inpatient claims in the 365 days before the day the resident became a long-stay resident or the beginning of the 12-month target period (whichever is later).

MDS-based covariates: For each measure, a clinical and MDS expert identified a list of MDS items most likely to increase or decrease the likelihood of the outcome. These items span multiple domains: functional status, clinical conditions, clinical treatments, and clinical diagnoses. Some of the “risk factors” were dropped from the list because they were closely related to existing quality metrics used in the Five-Star Quality Rating, and the outcome is only adjusted for risk factors that are unrelated to the quality of care at the facilities. Likewise, we also excluded factors related to conditions that increase the risk for acute care transfers only when proper care and management are not provided by the facility. These exclusions were based on the set of conditions selected by CMS and RTI International as potentially avoidable hospitalizations among dually eligible beneficiaries in a nursing home setting.²³

The remaining set of MDS-based risk factors were included in the final model if they were statistically significant predictors of the outcome after adjusting for the claims-based variables, regardless of whether they were positively or negatively associated with the outcome. In general, our approach involved the following steps using national data from 2016:

- (1) divide the MDS-based covariates into groups with similar content focus;
- (2) run separate negative binomial regressions of the outcome on the claims-based covariates, the number of long-stay days the resident was in the facility, the number of long-stay days

²³ Walsh EG, Frieman M, Haber S, et al. Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and Community-Based Services Waiver Programs. RTI International: Final Task 2 Report. August 2010. Accessed at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/costdriverstask2.pdf>

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- squared, and these groups of MDS-based covariates, then retain the MDS-based covariates statistically significant at the $p < 0.20$ level;
- (3) regroup the retained MDS-based covariates into fewer groups but with similar content focus;
 - (4) run separate negative binomial regressions of the outcome on the claims-based covariates, long-stay days and days squared, and these fewer groups of MDS-based covariates and retain the MDS-based covariates with statistical significance at the $p < 0.10$ level;
 - (5) combine all MDS-based covariates into one model with the claims-based covariates, long-stay days, and days squared, then run a negative binomial regression and retain the MDS-based covariates statistically significant at the $p < 0.05$ level;
 - (6) calculate goodness of fit statistics to assess how well predicted values generated by the model were related to actual outcomes;
 - (7) apply the final model to two smaller randomly selected validation samples from the same data and retain the model if the goodness of fit is similar to the goodness of fit when applied to the national data set (else, reconsider the initial set of MDS-based covariates that were tested).

The set of items included in the risk adjustment model is listed in Table 12. Note that in Version 1.18.11 of MDS 3.0 (effective October 1, 2023), Section G, which includes functional status items, was replaced by Section GG. The risk adjustment models will not include Section G items starting in July, 2024 and will be replaced with Section GG items in July 2025, when all states will have implemented Section GG.

Comorbidity index: The risk-adjustment model includes an outcome-specific comorbidity index to partially adjust facility-level rates for the case-mix of residents at the facility, with respect to comorbidity status shortly before the day that the residents became long-stay residents. The comorbidity index is based on the 17 disease condition categories initially developed by Charlson/Deyo.²⁴ Using the ICD-10-CM coding algorithm developed by Quan et al. (2005), we identified the Charlson comorbidities in any of the 21 diagnosis coding fields on all inpatient hospital claims in the 365 days preceding the day the residents became long-stay residents. Weights are calculated for each diagnosis indicator through negative binomial regression of the number of outpatient ED visits for each long-stay resident included in the measure in the 12-month target period. The regression also controls for the number of long-stay days in the facility and the number of long-stay days squared. The comorbidity index includes the regression intercept coefficient and the coefficients for the subset of the 17 ICD-10-CM based disease conditions for which the regression coefficient was significant at a probability level of 0.05 or better. The coefficients are used to create a comorbidity index value for each nursing home stay, and these index values are used in the negative binomial regression risk-adjustment model for long-stay outpatient ED visits.

²⁴ Quan H, Sundararajan V, Halfon P, et al. Coding algorithms for defining comorbidities in ICD-9-CM and ICD-10 administrative data. *Medical Care* 2005;43(11):1130-1139. The 17 conditions categories include: Myocardial infarction, chronic heart failure, peripheral vascular disease, cerebrovascular disease, dementia, chronic obstructive pulmonary disease, rheumatoid arthritis, ulcers, mild liver disease, diabetes mellitus, diabetes with sequelae, paralysis, chronic renal disease, cancer, moderate to severe liver disease, metastatic cancer, and HIV/AIDS.

Table 12. Covariates Constructed from MDS items and Used in the Final Risk-Adjustment Model for the Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days

Category	MDS Item
Functional status	Rarely/never makes self-understood by others (B0700) Rarely/never able to understand others (B0800) Cognitive status moderately impaired, severely impaired, assessed by staff, or assessment is missing (C0100 – C1000) Rejected care for past four to seven days (E0800) Wandering once or more in the past week (E0900)
Section G items (removed in July 2024) → Section GG (to be added in July 2025)	Walks in room independently or with supervision or limited assistance (G0110C1 → GG170I1)
Clinical conditions	Shortness of breath or trouble breathing with exertion (J1100A) Shortness of breath or trouble breathing when lying flat (J1100C) End-stage prognosis (J1400) Internal bleeding (J1550D) Surgical wound (M1040E)
Clinical treatments	Antibiotic received (N0415F) Diuretic received (N0415G) Chemotherapy for cancer (O0110A1) Radiation for cancer (O0110B1) Oxygen therapy (O0110C1) Tracheostomy care (O0110E1) Ventilator or respirator (O0110F) IV medications (O0110H1) Transfusion (O0110I1) Hospice care after nursing home admission (O0110K1) Speech therapy (O0400A4) Respiratory therapy (O0400D2)
Clinical diagnoses	Cancer (I0100) Gastroesophageal reflux disease (GERD) or ulcer (I1200) Neurogenic bladder (I1550) Septicemia (I2100) Cerebrovascular accident, transient ischemic attack, or stroke (I4500) Quadriplegia (I5100) Multiple Sclerosis (I5200) Parkinson's disease (I5300) Respiratory failure (I6300)
Other	Entered nursing home from an inpatient psychiatric (hospital or unit) (A1805)

Measure Calculations

Observed rate: The actual (observed) rate for a nursing home facility is calculated as the total number of outpatient ED visits meeting the numerator criteria divided by the total number of all long-stay days that met the denominator criteria (in thousands) in the target period. The measure is reported only for nursing homes that have at least 20 long-stay residents during the target period.

Expected rate: The risk adjustment model is estimated using negative binomial regression of the number of outpatient ED visits after the resident was a long-stay resident and during the target period. Covariates include the claims-based and MDS-based variables listed in Tables 11 and 12, as well as the number of long-stay days the resident was in the facility and the number of long-stay days squared. The results from the negative binomial regression are used to predict the number of outpatient ED visits for each long-stay resident given the patient's clinical and demographic profile. The expected rate for each nursing home facility is the sum of the predicted number of outpatient ED visits for every long-stay resident in the nursing home divided by the total number of all long-stay days at the nursing home that met the denominator criteria in the target period (in thousands).

The negative binomial regression coefficients, including the weights used to calculate the outcome-specific comorbidity index are reported in Appendix Table G.

Risk-standardized rate: To obtain the risk-standardized rate for a nursing home facility, the observed rate is divided by the expected rate which is then multiplied by the nationally observed rate. The national rate is calculated as the total number of outpatient ED visits meeting the numerator criteria, across all facilities, divided by the total number of all long-stay days that met the denominator criteria (in thousands), across all facilities.

$$\frac{\text{Observed Rate}}{\text{Expected Rate}} \times \text{National Rate} = \text{Risk Standardized Rate}$$