How the MDS affects Missouri Medicaid Case Mix

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MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES

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Missouri Medicaid Payment Changes

On 6-28-24 the Missouri Department of Social Services (DSS) MO HealthNet Division (MHD) posted a Draft Proposed Amendment to 13 CSR 70-10.020 which outlines the new Medicaid reimbursement methodology for NHs effective for dates of service **beginning July 1, 2024**.

Revisions to the reimbursement plan that I will cover include:

- Changing the resident classification system used to determine the Case Mix Index (CMI) from using Resource Utilization Grouping (RUG) to Patient Driven Payment Model (PDPM);
- Updates to the value based purchasing (VBP) per diem adjustment;
- Clarification on the data used for determining mental illness diagnosis add-on;
- Reviews to be done on MDS submissions and adjustments to the reimbursement rate based on the MDS reviews.

❖ **These reimbursement changes are contingent upon approval by CMS.**

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Case Mix Reimbursement

- Reimbursement levels differ based on the resource needs of the residents as measured by items on the MDS.
- Residents with heavy care needs require more staff resources and payment levels should be higher than for residents with less intensive care needs.
- CMI is a weight or numeric score assigned to a resident classification system grouping that reflects the relative resources predicted to care for a resident.
- The average acuity level of patients in a facility can be determined and expressed by calculating an average of the individual CMI values for each resident.

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Missouri Case Mix Reimbursement

- Over half of the State Medicaid programs use the MDS for their case mix payment systems.
- States have the option of selecting the system that better suits their Medicaid long-term care population.
- Missouri began to use the RUG IV 48 group model classification system on 7-1-22 for CMI.
- Missouri began to use the nursing component of the PDPM group model classification system on 7-1-24 for CMI.
- The CMI goes into the patient care component of a facilities Medicaid rate.

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PDPM Nursing Component

Extensive Services
ES3, ES2, ES1

Special Care High
HDE2, HDE1, HBC2, HBC1

Special Care Low
LDE2, LDE1, LBC2, LBC1

Clinically Complex
CDE2, CDE1, CBC2, CA2, CBC1, CA1

Behavior Symptoms & Cognitive Performance
BAB2, BAB1

Reduced Physical Function
PDE2, PDE1, PBC2, PA2, PBC1, PA1

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Calculation of the Nursing Function Score

- The Nursing Function score is based upon seven ADLs from Section GG: Eating, Toileting Hygiene, Bed Mobility (Sit to Lying, Lying to Sitting on Side of Bed), and Transfer (Sit to Stand, Chair/Bed-to-Chair Transfer, Toilet Transfer). This score indicates the level of functional assistance or support required by the resident.
- The Nursing Function Score ranges from 0 through 16, with 0 being the most dependent and 16 being the most independent.

- For the GG ADLs, if the resident's functional status varies, record the resident's usual ability to perform each activity.
- Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident's medical record.

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Absent GG Documentation

Please note the Missouri Department of Social Services, is aware of potential situations whereby inflated Nursing Function Scores for Section GG of the MDS could occur during the MDS Case-Mix Review process due to absent documentation Considering this unintended result, effective immediately, the Missouri Department of Social Services has directed Myers and Stauffer RN Reviewers to assign a function score of 06 (Independent) for the following Nursing Function Scores when documentation is unavailable to support transmitted values:

- GG0130A – Self-care: Eating
- GG0130C – Self-care: Toileting hygiene
- GG0170B – Mobility: Sit to lying
- GG0170C – Mobility: Lying to sitting on side of bed
- GG0170D – Mobility: Sit to stand
- GG0170E – Mobility: Chair/bed-to-chair transfer
- GG0170F – Mobility: Toilet transfer

The Missouri Department of Social Services will be implementing updates to the Supportive Documentation Requirements (SDRs), reflective of the above information, with the next release date - anticipated to be 10/2024.

(DSS letter to providers dated September 6, 2024)

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Evaluation for Depression

- Signs and symptoms of depression are used as a third-level split for the Special Care High category, Special Care Low category, and Clinically Complex category.
- Residents with signs and symptoms of depression are identified by the Resident Mood Interview (PHQ-2 to 9©) or the Staff Assessment of Resident Mood (PHQ-9-OV©). Instructions for completing the PHQ-2 to 9© are in Chapter 3, Section D. Refer to Appendix E for cases in which the PHQ-2 to 9© or PHQ-9-OV© is complete but all questions are not answered.
- The resident qualifies as depressed for the PDPM nursing component classification in either of the two following cases:
  - The **D0160 Total Severity Score** is greater than or equal to 10 but not 99, **or**
  - The **D0600 Total Severity Score** is greater than or equal to 10.

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Section I – Active Diagnoses

The diagnoses coded in Section I must:

- Have a physician (or physician extender) documented diagnosis in the last 60 days;
- Be active in the last 7-day look-back period. Active diagnoses have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

Check off each active disease. Check all that apply. If a disease or condition is not specifically listed, enter the diagnosis and ICD code in item I8000, Additional active diagnosis.

- Item I2300 UTI, (which does not affect the PDPM Groups but does impact the UTI QM) has specific coding criteria and does not use the active 7-day look-back. Please refer to Page I-12 for specific coding instructions for Item I2300 UTI.

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O0110b: Special Treatments & Procedures

Review medical record to determine whether the resident received or performed any of the treatments, procedures, or programs.

Coding Instructions for Column b. While a Resident: Check all treatments, procedures, and programs that the resident received or performed after admission/entry or reentry to the facility and within the last 14 days.

Coding Tips:

- Facilities may code treatments, programs and procedures the resident performed themselves independently or after set-up by facility staff.
- Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators.

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Restorative Nursing Services

Restorative nursing can affect the Behavior Symptom & Cognitive Performance and Reduced Physical Function groups.

- H0200C Urinary toileting program and/or H0500 Bowel toileting program (count as one service even if both provided)
- O0500A Passive ROM and/or O0500B Active ROM (count as one service even if both provided)
- O0500C Splint or brace assistance
- O0500D Bed mobility and/or O0500F Walking training (count as one service even if both provided)
- O0500E Transfer Training
- O0500G Dressing and/or grooming training
- O0500H Eating and/or swallowing training
- O0500I Amputation/prostheses care
- O0500J Communication training

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Restorative Nursing Services

To code a toileting program or trial on the MDS in items H0200C Urinary toileting program and/or H0500 Bowel toileting program the following documentation must be in the medical record:

- Implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique voiding pattern;
- Evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report; and
- Notations of the resident's response to the toileting program and subsequent evaluations, as needed.

A toileting program does not refer to simply tracking continence status, changing pads or wet garments, or random assistance with toileting or hygiene.

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Restorative Nursing Services

The following criteria for restorative nursing programs must be met in order to code O0500:

- Measurable objective and interventions must be documented in the care plan and in the medical record.
- Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record.
- Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.
- A RN or LPN/LVN must supervise the activities in a restorative nursing program. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.

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Restorative Nursing Services

MO State Regulation: 19 CSR 30-85.042
(23) Facilities shall conduct at least annual in-service education for nursing personnel including training in restorative nursing. This training by a registered nurse or qualified therapist shall include: turning and positioning for the bedridden resident, range of motion (ROM) exercises, ambulation assistance, transfer procedures, bowel and bladder retraining and self-care activities of daily living.

Restorative Nurse Assistant DHSS webpage:
https://health.mo.gov/safety/cnaregistry/rna.php

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Extensive Services			
Services	**Nursing Function Score**	**CMG**	**CMI**
Tracheostomy care while a resident (O0110E1b) **and** Invasive mechanical ventilator while a resident (O0110F1b)	0 – 14	ES3	3.84
Tracheostomy care while a resident (O0110E1b) **or** Invasive mechanical ventilator while a resident (O0110F1b)	0 – 14	ES2	2.90
Isolation or quarantine for active infectious disease while a resident (O0110M1b)	0 – 14	ES1	2.77

If the resident receives a service in this category but their Nursing Function Score is 15 or 16, they classify as Clinically Complex.

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O0110M1b Isolation or quarantine for active infectious disease while a resident

Should only be coded when all of the following conditions are met:

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

- Examples of when the isolation criteria would <u>not</u> apply include urinary tract infections, encapsulated pneumonia, and wound infections.

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Special Care High

Conditions or Services

- Comatose (B0100) **and** completely ADL dependent or ADL did not occur (GG0130A, GG0130C, GG0170B, GG0170C, GG0170D, GG0170E, and GG0170F all equal 01, 09, or 88)
- Septicemia (I2100)
- Diabetes (I2900) **and** insulin injections (N0350A) for all 7 days **and** insulin order changes (N0350B) on 2 or more days
- Quadriplegia (I5100) with Nursing Function Score <=11
- COPD (I6200) **and** SOB when lying flat (J1100C)
- Fever (J1550A) **and** one of the following:
  - Pneumonia (I2000)
  - Vomiting (J1550B)
  - Weight loss (K0300 = 1 or 2)
  - Feeding tube while not or while a resident (K0520B2 or K0520B3) **and**
    - K0710A3 is 51% or more of total calories **or**
    - K0710A3 is 26% to 50% of total calories **and** K0710B3 is 501 cc/day or more
- Parenteral/IV feedings while not or while a resident (K0520A2 or K0520A3)
- Respiratory therapy for all 7 days (O0400D2)

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Special Care High

Nursing Function Score	Depressed	CMG	CMI
0-5	Yes	HDE2	2.27
0-5	No	HDE1	1.88
6-14	Yes	HBC2	2.12
6-14	No	HBC1	1.76

If the resident has a condition or receives a service in this category
but their Nursing Function Score is 15 or 16, they classify as Clinically Complex.

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Respiratory Therapy

O0400D2 Respiratory Therapy Days: Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as treatment for 15 minutes or more in the day.

Respiratory therapy: Only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment. Time that a resident self-administers a nebulizer treatment without supervision of the respiratory therapist or respiratory nurse is not included in the minutes recorded on the MDS. Do not include administration of metered-dose and/or dry powder inhalers in respiratory minutes.

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Respiratory Therapy

For purposes of the MDS, providers should record services for **respiratory therapy** when the following criteria are met:

- The physician orders the therapy;
- The physician's order includes a statement of frequency, duration, and scope of treatment;
- The services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
- The services are required and provided by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
- The services must be reasonable and necessary for treatment of the resident's condition.

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Respiratory Therapy

Appendix A definition of Respiratory therapy: Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.

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Special Care Low

Conditions or Services

- Cerebral palsy (I4400) with Nursing Function Score <=11
- Multiple sclerosis (I5200) with Nursing Function Score <=11
- Parkinson's disease (I5300) with Nursing Function Score <=11
- Respiratory failure (I6300) **and** oxygen therapy while a resident (O0110C1b)
- Feeding tube while not or while a resident (K0520B2 or K0520B3) **and**
  - K0710A3 is 51% or more of total calories **or**
  - K0710A3 is 26% to 50% of total calories **and** K0710B3 is 501 cc/day or more
- 2 or more stage 2 PUs (M0300B1) with 2 or more selected skin treatments*
- Any stage 3 PU (M0300C1), stage 4 PU (M0300D1), or unstageable PU (d/t slough and/or eschar) (M0300F1) with 2 or more selected skin treatments*
- 2 or more venous/arterial ulcers (M1030) with 2 or more selected skin treatments*
- 1 stage 2 PU (M0300B1) and 1 venous/arterial ulcer (M1030) with 2 or more selected skin treatments*
- Foot infection (M1040A), diabetic foot ulcer (M1040B) or other open lesion of foot (M1040C) with application of dressings to feet (M1200I)
- Radiation treatment while a resident (O0110B1b)
- Dialysis treatment while a resident (O0110J1b)

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Special Care Low

*Skin Treatments	Nursing Function Score	Depressed	CMG	CMI
•Pressure relieving chair (M1200A) and/or bed (M1200B) (count as 1 treatment even if both provided) •Turning & repositioning (M1200C) •Nutrition or hydration intervention (M1200D) •PU care (M1200E) •Application of nonsurgical dressings (not to feet) (M1200G) •Application of ointments/medications (not to feet) (M1200H)	0-5	Yes	LDE2	1.97
	0-5	No	LDE1	1.64
	6-14	Yes	LBC2	1.63
	6-14	No	LBC1	1.35

If the resident has a condition or receives a service in this category but their Function Score is 15 or 16, they classify as Clinically Complex.

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Clinically Complex

Conditions or Services	*Skin Treatments
• Pneumonia (I2000) • Hemiplegia/hemiparesis (I4900) with Nursing Function Score <=11 • Open lesions (M1040D) or surgical wounds (M1040E) with any selected skin treatments* • Burns (M1040F) • Chemotherapy while a resident (O0110A1b) • Oxygen therapy while a resident (O0110C1b) • IV medications while a resident (O0110H1b) • Transfusions while a resident (O0110I1b)	• Surgical Wound Care (M1200F) • Application of nonsurgical dressings (other than to feet) (M1200G) • Application of ointments/medications (other than to feet) (M1200H)

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Clinically Complex			
Nursing Function Score	**Depressed**	**CMG**	**CMI**
0-5	Yes	CDE2	1.77
0-5	No	CDE1	1.53
6-14	Yes	CBC2	1.47
15-16	Yes	CA2	1.03
6-14	No	CBC1	1.27
15-16	No	CA1	0.89

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Behavior Symptoms & Cognitive Performance

Cognition and Behaviors

- BIMS score (C0500) <= 9
- Coma (B0100 = 1) **and** completely dependent or activity did not occur (GG0130A, GG0130C, GG0170B, GG0170C, GG0170D, GG0170E, and GG0170F all equal 01, 09 or 88)
- Severely impaired cognitive skills for daily decision making (C1000 = 3)
- 2 or more of the following impairment indicators are present:
  - Problem being understood (B0700 > 0)
  - Short-term memory problem (C0700 = 1)
  - Impaired cognitive skills for daily decision making (C1000 > 0)

  and

  1 or more of the following are present:
  - Sometimes or rarely/never makes self understood (B0700 >= 2)
  - Moderately or severely impaired cognitive skills for daily decision making (C1000 >= 2)
- Hallucinations (E0100A)
- Delusions (E0100B)
- Physical behaviors directed toward others (E0200A = 2 or 3)
- Verbal behavioral symptoms directed toward others (E0200B = 2 or 3)
- Other behavioral symptoms not directed toward others (E0200C = 2 or 3)
- Rejection of care (E0800 = 2 or 3)
- Wandering (E0900 = 2 or 3)

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Behavior Symptoms & Cognitive Performance

Nursing Function Score	Restorative	CMG	CMI
11-16	2 or more services	BAB2	0.98
11-16	0-1 services	BAB1	0.94

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Reduced Physical Function

	Nursing Function Score	Restorative	CMG	CMI
Residents who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the Behavioral Symptoms and Cognitive Performance category but have a Nursing Function Score less than 11 are placed in this category.	0-5	≥ 2 services	PDE2	1.48
	0-5	0-1 services	PDE1	1.39
	6-14	≥ 2 services	PBC2	1.15
	15-16	≥ 2 services	PA2	0.67
	6-14	0-1 services	PBC1	1.07
	15-16	0-1 services	PA1	0.62

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Semi-Annual Case Mix Adjustments

Each facility's patient care per diem rate will be adjusted semi-annually using a current Medicaid CMI. The Medicaid CMI will be updated based on the facility's average Medicaid CMI from the two (2) preceding quarterly calculations. The applicable Medicaid CMI are as follows:

- Effective for dates of service beginning January 1 of each year, each facility's Medicaid CMI will be updated using the average of the preceding July 1 and October 1 quarterly Medicaid CMI calculations.
- Effective for dates of service beginning July 1 of each year, each facility's Medicaid CMI will be updated using the average of the preceding January 1 and April 1 quarterly Medicaid CMI calculations.

(Draft Proposed Amendment to 13 CSR 70-10.020)

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Facility CMI Calculations

- Facility CMI calculations will be based on quarterly point-in-time data snapshots. These snapshot dates are January 1, April 1, July 1, and October 1.
- The midnight census will determine the residents that are included in the facility's CMI.
- The MDS Assessment Reference Date (ARD) will be used to determine the assessments included in each quarterly CMI calculation.
- A look-back period of 180 days will be used to determine the residents include in calculating the facility CMI. The look-back period cutoff date is the day prior to the snapshot (i.e., for the January 1 CMI calculation, the ARD would need to be December 31 or earlier).
- The most current MDS for a resident in the look-back period of 180 days will be used.

(Draft Proposed Amendment to 13 CSR 70-10.020)

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VBP Incentive

The facility shall receive a per diem adjustment for each QM Performance threshold that it meets. The threshold for each QM is based on national cut-points used by CMS in its Five Star Rating System. Each threshold is the maximum QM value a facility can have in order to receive the per diem adjustment. These thresholds are listed in Table A3 of the *Five-Star Quality Rating System*: *Technical Users' Guide* dated January 2017.

SFY 2025 QM Performance Measure Table. Effective for dates of service beginning July 1, 2024, the QM Performance Measure per diem adjustments are as follows:

QM Performance	Threshold	Per Diem Adjustment
Decline in Late-Loss ADLs	< or = 10.0%	$3.04
Decline in Mobility on Unit	< or = 8.0%	$3.04
High-Risk Residents w/ Pressure Ulcers	< or = 2.7%	$3.04
Anti-Psychotic Medications	< or = 6.8%	$3.04
Falls w/ Major Injury	< or = 1.3%	$3.04
In-Dwelling Catheter	< or = 1.1%	$3.04
Urinary Tract Infection	< or = 1.9%	$3.04

(Draft Proposed Amendment to 13 CSR 70-10.020)

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VBP Incentive

A VBP percentage will also be applied to the per diem adjustment for each facility that qualifies for a VBP Incentive. The VBP percentage will be determined by the total QM score calculated from the Five-Star Rating System scores for each of the eight (8) long-stay QMs, as follows: Decline in Late-Loss ADLs, Decline in Mobility on Unit, High-Risk Residents w/ Pressure Ulcers, Anti-Psychotic Medications, Falls w/ Major Injury, In-Dwelling Catheter, Urinary Tract Infection, and Physical Restraints.

The VBP percentage for each scoring range is listed in the following table.

QM Scoring Tier	Minimum Score	VBP Percentage
1	600	100%
2	520	75%
3	440	50%
4	360	25%
5	0	0%

(Draft Proposed Amendment to 13 CSR 70-10.020)

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Semi-Annual Adjustment for VBP Incentive

Each facility's QM Performance data shall be reevaluated semi-annually and the per diem add-on rate shall be adjusted accordingly. The VBP will be recalculated effective for dates of service beginning January 1 and July 1 of each year. The QM Performance data will be updated based on the most current data available as of November 15 for the January 1 rate adjustment and as of May 15 for the July 1 rate adjustment. For facilities that do not have updated data as of the review date, prior period data will be carried forward. This provision will be applied to data frozen by CMS.

(Draft Proposed Amendment to 13 CSR 70-10.020)

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Mental Illness Diagnosis Add-On

If at least forty percent (40%) of a facility's Medicaid participants have the following mental illness diagnosis, the facility shall receive a per diem adjustment of five dollars ($5.00):

(I) Schizophrenia; and

(II) Bi-polar

Semi-Annual Adjustment for Mental Illness Diagnosis Add-On. Each facility's Mental Illness Diagnosis data shall be re-evaluated semi-annually and the per diem add-on rate shall be adjusted accordingly. The Mental Illness Diagnosis will be recalculated effective for dates of service beginning January 1 and July 1 of each year. The Mental Illness Diagnosis data will be updated based on the final resident listing for October for the January 1 rate adjustment and the final resident listing for April for the July 1 rate adjustment.

(Draft Proposed Amendment to 13 CSR 70-10.020)

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Resident Listings

Nursing facilities will be provided a draft resident listing to review for accuracy and will be given a minimum of two weeks to correct resident listings that are not accurate. The draft resident listing will include resident specific information including, but not limited to, the resident's name and identification number, the payment source, the assessment reference date (ARD), the PDPM nursing code and corresponding CMI, and whether the resident has a mental illness diagnosis that qualifies for the mental illness diagnosis add-on which is used to determine the facility's Medicaid CMI and whether the facility qualifies for the Mental Illness Diagnosis Add-On. Nursing facilities will be notified when the draft resident listings are available to review and will include the due date for when all corrections must be done.

(Draft Proposed Amendment to 13 CSR 70-10.020)

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Resident Listings

Facilities may submit corrections to the draft resident listings.

A final resident listing will be prepared based on the draft resident listing plus any corrections submitted by the facility by the due date.

No corrections will be accepted after the due date, unless the division or its authorized contractor has given prior approval.

The final resident listing will be used to determine the CMI and Mental Illness Diagnosis Add-On included in the facility's per diem rate and will be provided when the final per diem rate is determined.

If any of a facility's corrections that were submitted on a timely basis were not captured in the final resident listing, the facility may submit a request to the division or its authorized contractor to review. The request must include documentation supporting their claim.

(Draft Proposed Amendment to 13 CSR 70-10.020)

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MDS Reviews

Beginning July 1, 2024, the division or its authorized contractor shall conduct reviews of a facility's MDS data to verify that residents have been properly classified and that the facility is following CMS procedures and documentation requirements.

- MDS submissions that are not correct will be adjusted and will be used to recalculate the PDPM and associated CMI.
- A facility's per diem rate will be adjusted based on the revisions to the PDPM and associated CMI after the initial training and education period.
  - For reviews completed between July 1, 2024 and December 31, 2025, per diem rates will only be adjusted for increases in the CMI.
  - For reviews completed between January 1, 2026 and December 31, 2026, per diem rates will be adjusted for any changes to the CMI. The per diem rate may be increased or decreased based on the adjusted CMI.
  - For reviews completed after January 1, 2027, per diem rates will only be adjusted for decreases in the CMI.

(Draft Proposed Amendment to 13 CSR 70-10.020)

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Summary

- Documentation in the medical record should support the coding of the MDS.
- The MDS process should be a team effort.
- Education with staff may be needed.
- Follow RAI Manual instructions for item coding and MDS time frames.
- An accurate MDS generates an accurate PDPM Nursing CMG and CMI.

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References

Public Notice of Prospective Reimbursement Plan for Nursing Homes
https://mydss.mo.gov/media/pdf/public-notice-prospective-reimbursement-plan-nursing-facility-and-hiv-nursing-facility

Draft Proposed Amendment of Prospective Reimbursement Plan for Nursing Homes
https://mydss.mo.gov/media/pdf/prospective-reimbursement-plan-nursing-facility-and-hiv-nursing-facility-services

Nursing Home Compare Five-Star Quality Rating System - Technical Users' Guide 2017
https://mydss.mo.gov/media/pdf/nursing-home-compare-five-star-quality-rating-system-technical-users-guide

Myers and Stauffer Missouri webpage
https://myersandstauffer.com/client-portal/missouri/

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References

Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18.11, October 2023
https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual

PDPM nursing component case mix groups (CMG) and case mix index table effective October 1, 2023 as listed in the Final SNF PPS payment rule for FY 2024
https://www.federalregister.gov/documents/2023/08/07/2023-16249/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities#p-155

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