American Hospital Association

Regulatory Advisory

November 15, 2017

HOME HEALTH PPS:
FINAL RULE FOR CY 2018

AT A GLANCE

The Issue:

On Nov. 7, the Centers for Medicare & Medicaid Services (CMS) published its calendar year (CY) 2018 final rule for the home health (HH) prospective payment system (PPS). Under this rule, the agency estimates that HH agencies, including hospital-based agencies, will receive an overall net payment reduction of 0.4 percent (or -$80 million) relative to CY 2017 payments. In addition, the rule did not finalize CMS's proposal to implement a complete redesign of the payment system beginning in CY 2019. For the HH Quality Reporting Program, CMS will remove 235 data elements from 33 OASIS items and add two new measures and one revised measure. As with the other post-acute final rules, CMS has significantly scaled back its proposal to introduce a large number of new standardized patient assessment data elements.

Our Take:

The AHA is very pleased that CMS has tabled its plans to implement an overhaul of the HH PPS in CY 2019. While we supported the overall concept of the proposed redesign, we expressed concern that the implementation and phase-in plans were incomplete and required further development before proceeding. In addition, AHA appreciates that CMS has acknowledged our concerns regarding the expanded patient assessment data reporting requirements and has scaled back its proposal to add several items to the already lengthy OASIS data set. However, we continue to have concerns regarding the two new quality measures and the validity of the data they would report.

What You Can Do:

- ✓ Share this advisory with your senior management team to examine the impact of these changes on your organization for CY 2018.
- ✓ **Participate in the AHA's Nov. 17 members-only call to discuss the rule's major provisions. Click here to register for this 1 p.m. ET call.**

Further Questions:

For questions regarding payment issues, contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org. For questions about the quality provisions, please contact Caitlin Gillooley, associate director of policy, at cgillooley@aha.org.

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OVERVIEW

On Nov. 7, the Centers for Medicare & Medicaid Services (CMS) published its calendar year (CY) 2018 final rule for the home health (HH) prospective payment system (PPS). CMS estimates that under this rule HH agencies will receive a net payment reduction of 0.4 percent, an $80 million decrease, from CY 2017 payment levels. Facility-based HH agencies, such as hospital-based agencies, will be subject to the same impact as the field at large.

In the final rule CMS tables its plans to implement a new payment methodology for CY 2019, called the Home Health Groupings Model (HHGM). That model included a new case-mix methodology that grouped patients into payment categories using primarily clinical characteristics and other patient information, and eliminates therapy service use thresholds that currently are used to case-mix adjust payments. Under this model, as presented in the proposed rule, the current 60-day episode is reduced to a 30-day timeframe.

Further, for the HH Quality Reporting Program, CMS will remove 235 data elements from 33 Outcome and Assessment Information Set (OASIS) items and add two new measures and one revised measure. As with the other post-acute final rules, CMS has significantly scaled back its proposal to introduce a large number of new standardized patient assessment data elements.

FINAL CY 2018 PAYMENT UPDATE

Market-basket Update

Typically, the HH PPS standard rates are updated annually using a HH-specific market basket. However, for CY 2018, a 1.0 percent update was mandated by the Medicare Access and CHIP Reauthorization Act (MACRA).

Final CY 2018 Rates

60-day Episode Rate. For CY 2018, for agencies that submit required quality data, CMS implemented a 60-day episode rate of $3,036.64, an increase from the CY 2017 rate of

$2,989.97. The final CY 2018 rate is calculated by updating the CY 2017 rate with budget neutrality adjustments for wage index and case-mix weights, the statutory 1.0 percent market basket update, and a case-mix cut. The case-mix cut, which is the third of three equal installments, reduces CY 2018 payments for 60-day episodes by a 0.97 percent. CMS implemented this cut to account for the agency's estimated increases in payment between CYs 2012 and 2014 that were not found to correspond to increases in patient acuity.

Low-utilization Payment Adjustment (LUPA) Rates. Episodes with four or fewer visits are subject to a LUPA and are paid on a per-visit basis per type of service. Below are the CY 2017 and CY 2018 per-visit rates used for LUPA episodes.

	CY 2017 Per-visit Rates	CY 2018 Per-visit Rates
HH Aide	$64.23	$64.94
Medical Social Services	$227.36	$229.86
Occupational Therapy	$156.11	$157.83
Physical Therapy	$155.05	$156.76
Skilled Nursing	$141.84	$143.40
Speech-language Pathology	$168.52	$170.38

Non-routine Supplies (NRS) Conversion Factor. NRS include dressings for wounds, syringes, intravenous supplies, catheters and other items. Payment rates for NRS are established by applying a conversion factor to the relative weight assigned to each of the six NRS severity levels. For those agencies submitting quality data, the CY 2018 rates for the six NRS severity levels will be calculated using the NRS conversion factor of $53.03, are listed in Table 11 of the rule and range from $14.31 for the lowest severity level to $558.16 for the highest severity level.

Case-mix Weights

The HH PPS currently uses the home health resource groups (HHRG) along with the patient assessment data collected using the OASIS tool to categorize patients for payment purposes. As of CY 2015, CMS annually recalibrates the HH case-mix weights with more current data to align payments with the most current HH service utilization data. For CY 2018, CMS used CY 2016 claims data to recalibrate the weights for 60-day episode payments, presented in Table 5 of the rule, in a budget-neutral manner.

Area Wage Index

The CY 2018 home health wage index will be updated using FY 2014 hospital cost report data. The pre-floor, pre-classified wage index amounts for CY 2018 are found online. Wage index budget neutrality adjustments are applied to the 60-day episode and national per visit rates used for LUPA cases.

Labor-related Share

The rule maintains a labor-related share of 78.535 percent for the case-mix adjusted 60-day episode rate, as set in the CY 2013 HH PPS final rule.

High-cost Outliers

CMS did not propose any changes to the HH PPS high-cost outlier policy for CY 2018 because its analysis of preliminary CY 2016 claims, in combination with the CY 2018 payment rates, confirmed that, consistent with its estimate in the proposed rule, outlier payments will constitute approximately 2.47 percent of total HH PPS payments in CY 2018. Given the statutory requirement to target up to, but no more than, 2.5 percent of total payments as outlier payments, in CY 2018 CMS maintains the current fixed-dollar-loss ratio of 0.55, which is multiplied by the 60-day episode payment to determine the outlier threshold. The rule also continues the statutorily mandated 10 percent agency-level cap on outlier payments per year.

Rural Add-on

The 3 percent add-on payment for HH services furnished in rural areas, which has been authorized by Congress through several pieces of legislation, is scheduled to expire at the end of CY 2017. Originally established by the Medicare Modernization Act, the add-on was later extended by the Deficit Reduction Act, the Affordable Care Act, and most recently, MACRA.

HOME HEALTH QUALITY REPORTING PROGRAM (QRP)

The Social Security Act required that CMS establish the HH QRP. Starting in CY 2007, HH agencies that fail to meet all HH QRP quality data submission and administrative requirements are subject to a 2.0 percentage point reduction in payments. A detailed summary of the Social Security Act's statutory authority can be found on CMS's HH QRP website.

In this rule, CMS finalizes changes to the measures required in the HH QRP and new requirements for the reporting of certain standardized patient assessment data to meet the mandates of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

New Measures for CY 2020

The HH QRP currently comprises 23 measures. In this final rule, CMS revises one measure, adds two new measures, and removes several data elements from the OASIS. The agency provides a link to the finalized specifications for the quality measures and patient assessment data elements.

Changes in Skin Integrity Post-acute Care: Pressure Ulcer/Injury. CMS will remove the current pressure ulcer measure in the HH QRP, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay), and replace it with a modified version of that measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury. This modified version includes new or worsened unstageable pressure ulcers, including deep tissue injuries (DTIs), in the measure numerator in addition to Stage 2, 3, and 4 pressure ulcers. This modified measure satisfies the requirements of the IMPACT Act domain of skin integrity and changes in skin integrity.

The current measure is calculated using retrospective data elements that assess the number of new or worsened pressure ulcers at each stage, while the new measure is calculated using the number of unhealed pressure ulcers at each stage after subtracting the number that were present upon admission. The data for this measure will be collected using OASIS, which is currently submitted by HH agencies through the QIES ASAP System. In the final rule, CMS notes that they will provide training and guidance prior to implementation to promote consistency in the interpretation of the measure and will update the HH QRP manual with additional examples to further address the coding of unstageable pressure ulcers and those that are "present on admission."

In response to several comments on the CY 2017 HH PPS proposed rule, CMS clarifies that the definitions it uses for pressure ulcers are adapted from the National Pressure Ulcer Advisory Panel.

Application of Percent of Long-term Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function. The IMPACT Act requires CMS to adopt a HH QRP measure that addresses the domain of "Functional status, cognitive function, and changes in function and cognitive function." CMS will implement this measure for the HH QRP beginning with the CY 2020 program year. This process measure calculates the percentage of patients with an admission and discharge functional assessment and treatment goal that addresses function. HH agencies will be required to collect data regarding function activities coded using a six-level rating scale indicating the resident's level of independence.

This measure was originally developed and tested as part of the Post-Acute Care Payment Reform Demonstration (PRD) and was field tested in 12 HH agencies in 2016-2017. The measure requires that at least one activity performance (function) goal is recorded for at least one of the standardized self-care or mobility function items at the start of care. At the time of discharge, goal setting and establishment of a care plan to achieve the goal is reassessed using the same six-level scale. However, if a patient has an unplanned discharge then the discharge functional status data are not required to be reported. CMS will provide initial confidential feedback to HH agencies prior to the public reporting of this measure.

The National Quality Forum (NQF) does not endorse this measure for the HH setting. CMS contends that the current NQF-endorsed HH QRP measures do not meet the specified IMPACT Act domain because they do not include standardized data elements that are included in the other PAC settings' assessment instruments.

Commenters expressed concern that new items associated with this measure will be duplicative of items currently used in OASIS, but CMS contends that these items "measure different assessment scales, coding options for those with medical complexities, and have different definitions for items and activities, and the proposed measure's data elements evaluate usual performance in various manners." CMS does not intend to retire the functional status items currently reported.

Percent of Residents Experiencing One or More Falls with Major Injury. The IMPACT Act also requires CMS to adopt a HH QRP to measure addressing the domain of "incidence of major falls, including falls with major injury." To meet this requirement, CMS will adopt the measure Application of Percent of Residents Experiencing One or

More Falls with Major Injury for which HH agencies would be required to begin submitting data on Jan. 1, 2019. This measure reports the percentage of residents who have experienced falls with major injury during episodes ending in a 3-month period.

This measure was implemented in the skilled nursing facility (SNF) setting in 2011 and uses items that are collected uniformly in each post-acute care (PAC) setting's assessment instrument. However, the measure is not NQF-endorsed for the HH setting (although CMS claims that the agency plans to submit the proposed measure for endorsement "as soon as it is feasible"). In addition, several stakeholders, including the NQF's Measure Application Partnership (MAP), raised concerns about attributing falls to a particular provider as well as data collection regarding falls given that home health clinicians are not present with the patient at all times. The MAP suggested that CMS explore stratification of measure rates by referral origin when publicly reporting data for this measure; while CMS invited feedback on this suggestion in the proposed rule, the agency did not address this stratification methodology in the final rule. In addition, CMS stated that because falls with major injury are considered "never events," the agency does not believe the measure should be risk adjusted.

HHAs are already evaluated on a falls measure, Multifactor Fall Risk Assessment Conducted for All Patients Who Can Ambulate. This is a process-based measure that assesses an HHA's efforts to determine fall risk. CMS purports that this measure is not sufficient because it does not meet the domain of "incidence of falls" (and it is not standardized across PAC settings). Thus, CMS will add two standardized items to the OASIS for collection at end of care, which comprises discharge, death at home, and transfer to an inpatient facility.

In response to comments noting that the HH setting is unique from facility-based care, CMS responded that the agency's analysis of fall risk and prevalence among a cohort of home health patients using 2015 OASIS data showed that "a measure of this type is important for both providers and individuals, to support person centered care to properly assess for the risk of falling accompanied by a major injury to support proper care planning."

Removal of Data Elements from OASIS. CMS will remove 235 data elements from 33 OASIS items collected at various points during the episode of care, including start of care (SOC), resumption of care (ROC), follow-up (FU), transfer, death at home or discharge. CMS notes that these elements are not being used to calculate quality measures, payment, survey outcomes or care planning.

CMS initially proposed to remove 247 data elements from 35 OASIS items. However, some of these items would have been replaced with new or similar data elements as part of CMS's proposal to require HH agencies to collect certain standardized patient assessment data. As this proposal was not fully finalized, as described in the next section of this advisory, CMS will continue to collect all elements from two OASIS items (M1200 and M1730, which will no longer appear on the list of items with elements removed) and three elements for one item (M2030, which will still appear on the list of items with elements removed, as CMS will no longer require the item to be collected upon discharge). These three items are used for payment and the HH QRP, and thus must be retained. See the Appendix for a list of the items that will be removed.

Proposed Standardized Patient Assessment Data Reporting: CY 2019 and CY 2020

In addition to requiring standardization and alignment of quality measures, the IMPACT Act also requires the collection of standardized patient assessment data. The reporting of these data is made a requirement of the PAC quality reporting programs, and as a result, failure to comply with the requirements will result in a payment reduction. Currently, each PAC setting collects different patient assessment data in setting-specific tools. The HH setting collects this data in the OASIS, whereas SNFs, inpatient rehabilitation facilities, and long-term care hospitals collect different data elements in their own tools—the Minimum Data Set (MDS) 3.0, Patient Assessment Instrument (PAI), and Long-term Care Hospital CARE Data Set (LCDS), respectively.

According to the IMPACT Act, the standardized patient assessment data elements must satisfy five domains specified by CMS, which include functional status, cognitive function, special services, medical conditions and comorbidities, and impairments. Some of the items have been tested, either for individual settings or in the PAC Payment Reform Demonstration (PRD) study, and are already implemented in some settings.

CY 2019 Requirements. The IMPACT Act requires HH agencies to report standardized patient assessment data starting with the CY 2019 HH QRP. CMS has determined that the data elements used to calculate the current pressure ulcer measure (Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened, Short Stay) meet the definition of standardized patient assessment data with respect to the "medical conditions and co-morbidities" domain. Thus, successful reporting of that data for admissions and discharges during CY 2018 will satisfy the requirement to report standardized patient assessment data for the CY 2019 HH QRP.

CY 2020 Requirements. In the CY 2018 HH PPS proposed rule, CMS proposed a list of additional data elements that would fulfil the other domains required by the IMPACT Act. The adoption of these data elements would have meant the addition of several new items to the OASIS, and many existing elements would have to be modified or expanded to meet the requirements that the elements be standardized across all PAC settings. AHA and other stakeholders voiced concerns that these changes and additions, required for implementation in a very short time period, would result in enormous burden on post-acute care providers. **In response to these concerns, CMS will not require the implementation of data elements in three of the five categories mandated by the IMPACT Act for CY 2020. These categories are Cognitive Function, Special Services and Treatments, and Impairments.**

CMS finalized its proposal to require HH agencies to report data on two of the three categories for CY 2020: Functional Status and Medical Conditions and Comorbidities. However, CMS states that the data elements already required to calculate existing measures (Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function and the newly finalized Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury) are sufficient to meet the standardized patient assessment data requirements for these two categories. HH agencies will be required to report this data with respect to admissions and discharges that occur between Jan. 1, 2019 and June

30, 2019. Following this initial reporting year, subsequent years for the HH QRP will be based on a full calendar year of data reporting beginning on July 1, 2019. In addition, CMS finalized its proposal to extend the current administrative requirements for quality data to the patient assessment data, which includes:

- Participation
- Exception and Extension
- Reconsiderations
- Data completion thresholds

Table 1 below is the list and our analysis of proposed data elements, including whether they currently exist in the OASIS or other PAC tools, whether they were tested in the PAC PRD, and whether they will be required as part of the reporting of standardized patient assessment data for CY 2020. The data elements that currently exist in the OASIS are still required for reporting by HH agencies, with the exception of those elements removed as finalized in this rule, but will not be tied to the administrative requirements for standardized patient assessment data reporting in CY 2020.

Table 1. AHA Analysis of Finalized Standardized Patient Assessment Data Elements

Domain	Element	Currently in OASIS-C2?	Currently in other PAC tool?	Number of items	Required for CY 2020?
Functional Status	Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	No; Finalized for Adoption in CY 2020 HH QRP	LCDS, MDS 3.0, IRF-PAI	1	Yes
Cognitive Function	Brief Interview for Mental Status (BIMS)	No	MDS 3.0, IRF-PAI	7	No
Cognitive Function	Confusion Assessment Method (CAM)	No	LCDS MDS 3.0	6	No
Cognitive Function	Behavioral Signs and Symptoms	Yes	MDS 3.0,	3	No
Cognitive Function	Patient Health Questionnaire-2	Yes	MDS 3.0,	2	Yes
Special Services	Cancer Treatment: Chemotherapy (IV, Oral, Other)	No	MDS 3.0 (principal)	1-4 (1 principal; 3 sub)	No
Special Services	Cancer Treatment: Radiation	No	MDS 3.0	1	No
Special Services	Respiratory Treatment: Oxygen Therapy (Continuous, Intermittent)	Yes	MDS 3.0,	1-2 (1 principal; 2 sub either/or)	No
Special Services	Respiratory Treatment:	No	MDS 3.0	1-2 (1 principal;	No

	Suctioning (Scheduled, As needed)			2 sub either/or)	
Special Services	Respiratory Treatment: Tracheostomy Care	No	MDS 3.0	1	No
Special Services	Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)	Yes	MDS 3.0,	1-3 (1 principal; 2 sub)	No
Special Services	Respiratory Treatment: Invasive Mechanical Ventilator	Yes	MDS 3.0	1	No
Special Services	Other Treatment: Intravenous (IV) Medications (Antibiotics, Anticoagulation, Other)	Yes	MDS 3.0 (principal)	1-4 (1 principal; 3 sub)	Yes
Special Services	Other Treatment: Transfusions	Yes	MDS 3.0,	1	Yes
Special Services	Other Treatment: Dialysis (Hemodialysis, Peritoneal dialysis)	No	MDS 3.0 LCDS	1-2 (1 principal; 2 sub either/or)	No
Special Services	Other Treatment: Intravenous (IV) Access (Peripheral IV, Midline, Central line, Other)	No	No	1-5 (1 principal; 4 sub)	No
Special Services	Nutritional Approach: Parenteral/IV Feeding	Yes	MDS 3.0, IRF-PAI, LCDS	1	Yes
Special Services	Nutritional Approach: Feeding Tube	Yes	MDS 3.0,	1	Yes
Special Services	Nutritional Approach: Mechanically Altered Diet	Yes	MDS 3.0, IRF-PAI	1	Yes
Special Services	Nutritional Approach: Therapeutic Diet	No	MDS 3.0	1	No
Medical Conditions & Comorbidities	Percent of Resident or Patients with Pressure Ulcers that are New or Worsened	Yes	n/a	1	No, but required for CY 2019
Medical Conditions & Comorbidities	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	No	Revised Measure	1	Yes
Impairments	Hearing	Yes	MDS 3.0,	1	No
Impairments	Vision	Yes	MDS 3.0,	1	Yes

HOME HEALTH VALUE-BASED PURCHASING PROGRAM (VBP)

The home health VBP program was finalized in the CY 2016 HH PPS final rule, which you can read about in detail in our 2015 regulatory advisory. Additional program logistics were finalized in the CY 2017 HH PPS final rule, which you can read about in detail in our 2016 regulatory advisory. All Medicare-certified HH agencies providing services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee and Washington are required to participate in the model.

In this rule, CMS alters the minimum required number of patient surveys for measure calculation and removes one measure from the program.

Minimum Number of Completed Home Health Care Consumer Assessment of Healthcare Providers and System (HHCAHPS) Surveys. As finalized in the CY 2016 HH PPS final rule, HH agencies needed to demonstrate at least 20 episodes of care during a performance year to generate a performance score on HHCAHPS surveys for at least five measures. If a HH agency did not collect at least 20 completed HHCAHPS surveys, the HH agency would not be included in the calculation of performance for all participants and would not have a payment adjustment percentage calculated.

However, CMS believes that increasing the minimum number of surveys from 20 to 40 will better align the HH VBP model with the HHCAHPS policy for the Patient Survey Star Ratings on the *Home Health Compare* website, which uses a minimum of 40 surveys to calculate star ratings. In addition, CMS believes that using more surveys to calculate measures will result in meaningful and less random variations in measure performance by HH agencies.

CMS completed its analysis of the effects on participating HH agencies using the proposed 40 or more completed HHCAHPS surveys as compared to using at least 20 by examining OASIS, claims, and HHCAHPS measures from Jan.1, 2016 through Dec. 31, 2016 (in the proposed rule, CMS had begun this analysis but did not complete it, as the agency did not have the full year's data). The agency found that achievement thresholds did not change by more than ±1.1 percent, while benchmarks could change by as much as -3.1 percent. These differences varied by state, and nearly disappeared for larger-volume HH agencies. In addition, the analysis found that there were no Medicare-certified HH agencies in the pilot states that did not meet the new minimum of 40 surveys for five measures needed to generate a performance score.

After the proposed rule was published, CMS reissued the interim performance reports (IPRs) from October 2016, January 2017 and April 2017, which HH agencies had already received in the months these IPRs were originally issued, showing how scores would change when using the new minimum number of surveys. HH agencies had the opportunity to request recalculations and reconsiderations on the July and August 2017 IPRs, which also showed what scores would be with the new minimum number of surveys; CMS did not receive any recalculation requests.

CMS notes that the agency does not believe that smaller HH agencies will be disadvantaged by the new minimum number of surveys because these agencies are exempt from HHCAHPS reporting requirements.

Removal of Drug Education Measure. CMS will remove one OASIS-based quality measure from the program beginning in performance year 3 (CY 2018), Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care. In its monitoring efforts, CMS has determined that many providers have achieved full performance on this measure. In addition, a technical expert panel expressed concern that this measure does not capture the quality of the education provided by the HHA to the patient or caregiver. **AHA appreciates CMS's removal of this measure from the program.**

NEXT STEPS

The AHA will host a members-only call on Friday, Nov. 17 at 1:00 p.m. ET to discuss the provisions of the final rule. AHA members may register here. Related materials and a recording of this call will be available at www.aha.org/postacute in the HH section.

If you have further questions regarding the final rule's payment provisions, please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org. Questions regarding the quality provisions should be directed to Caitlin Gillooley, associate director, at cgillooley@aha.org.

APPENDIX – Removal of Data Elements from OASIS

Item	Definition	SOC	ROC	FU	Transfer	Death at Home	Discharge
M0903	Date of last (most recent) home visit				1	1	1
M1011	List each inpatient diagnosis and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes)	6	6	6			
M1017	Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes)	6	6				
M1018	Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen. (Mark all that apply.)	6	6				
M1025	Optional Diagnoses (not used for payment)	12	12	12			
M1034	Overall Status	1	1				
M1036	Risk factors	4	4				
M1210	Ability to Hear	1	1				
M1220	Understanding of Verbal Content	1	1				
M1230	Speech and Oral (Verbal) Expression of Language	1	1				1
M1240	Pain Assessment	1	1				
M1300	Pressure Ulcer Assessment: Risk of Developing Pressure Ulcer	1	1				
M1302	Risk of Developing Pressure Ulcers	1	1				
M1320	Status of Most Problematic Pressure Ulcer that is Observable	1	1				1
M1322	Current Number of Stage 1 Pressure Ulcers						1

M1332	Current Number of Stasis Ulcer(s) that are Observable						1
M1350	Skin Lesion or Open Wound	1	1				
M1410	Respiratory Treatments	3	3				
M1501	Symptoms in Heart Failure Patients				1		1
M1511	Heart Failure Follow-up				5		5
M1610	Urinary Incontinence or Urinary Catheter Presence						1
M1615	When does Urinary Incontinence occur	1	1				1
M1750	Psychiatric Nursing Services	1	1				
M1880	Ability to Plan and Prepare Light Meals	1	1				1
M1890	Ability to Use Telephone	1	1				1
M1900	Prior Functioning ADL/IADL	4	4				
M2030	Management of Injectable Medications						1
M2040	Prior Medication Management	2	2				
M2102	Types and Sources of Assistance	6	6				3
M2110	How Often does patient receive ADL/IADL assistance	1	1				
M2250	Plan of Care Synopsis	7	7				
M2310	Reason for Emergent Care				15		15
M2430	Reason for Hospitalization				20		
TOTALS		**70**	**70**	**18**	**42**	**1**	**34**