Let's Get Back to Quality and Data Outcomes

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LeadingAge® Illinois

MOMENTUM

2023 ANNUAL MEETING & EXPO

MARCH 7-8, 2023

Renaissance Schaumburg
Convention Center - Schaumburg, IL
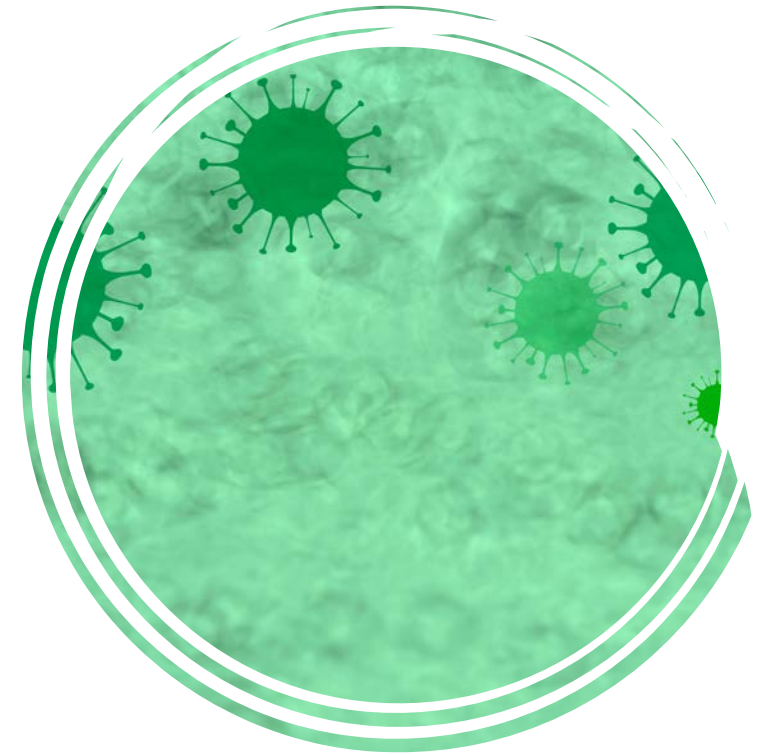
Objectives

1. Identify what quality measure data represents now

2. Describe a process for analyzing data to select the most current information

3. Draft a plan for using quality data for one improvement project
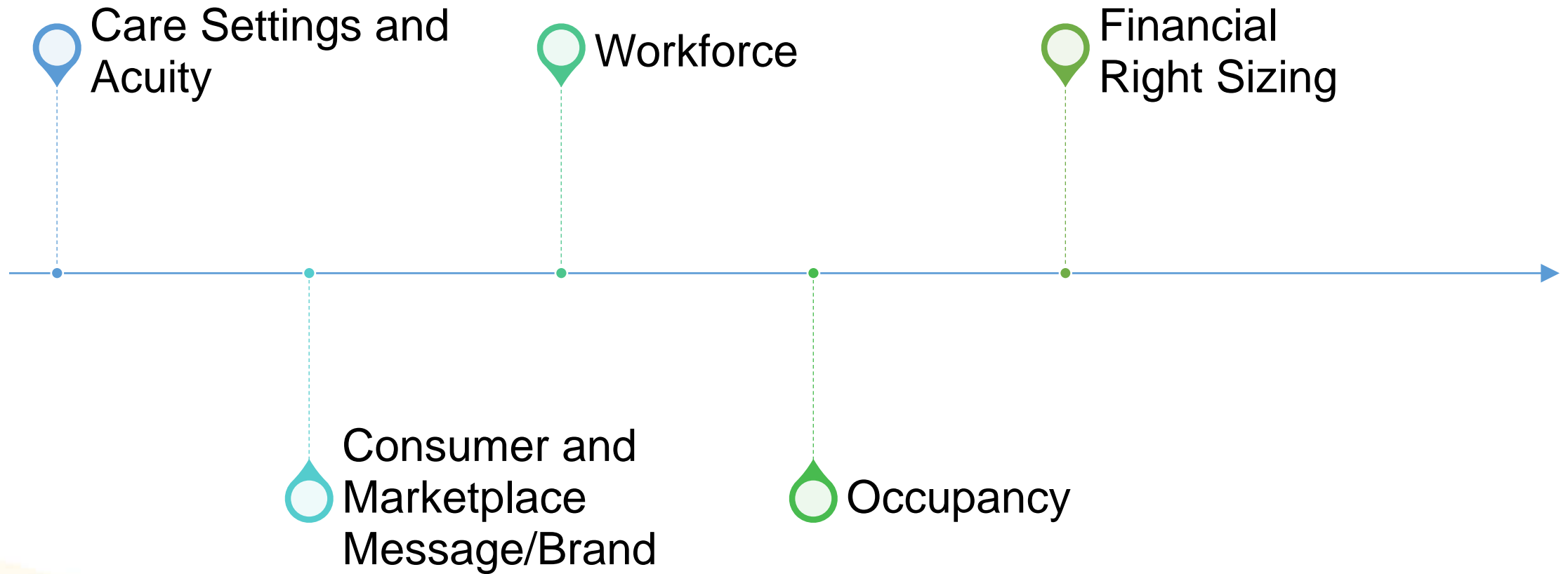
Rapid Pace

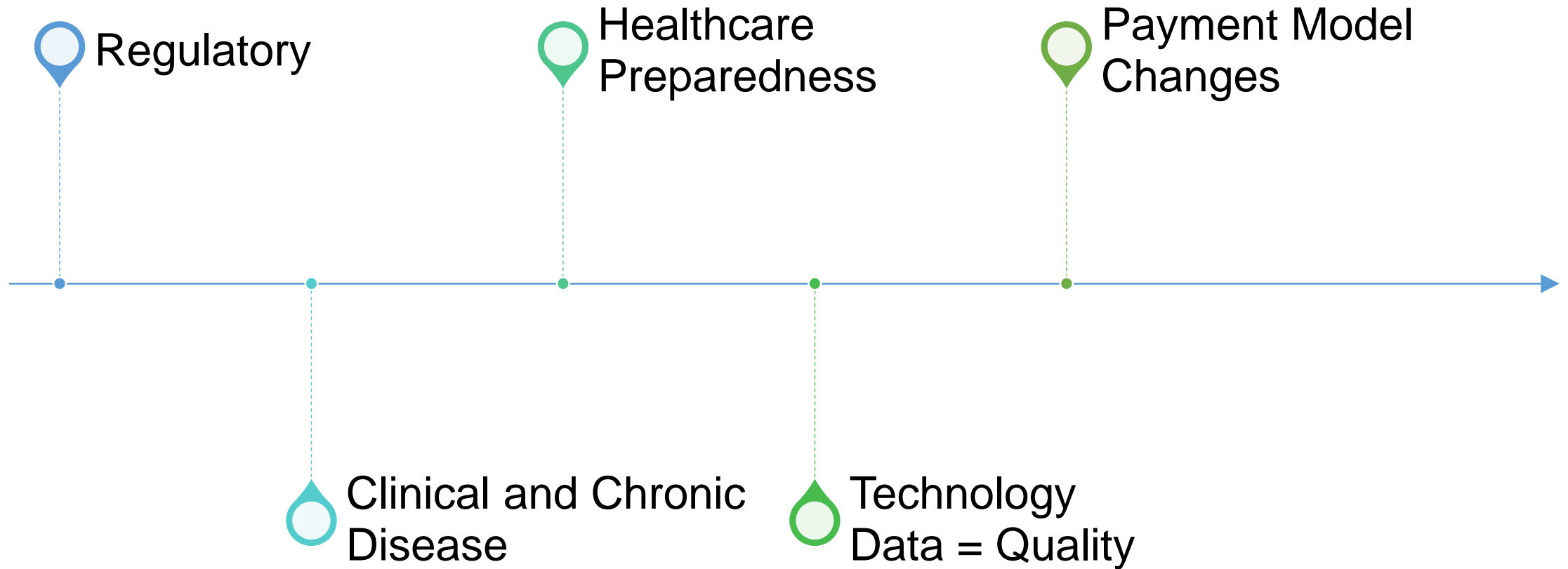*Change*

2022 – Whew!

- New regulations and oversight - RoP Phase 3

- PDPM updates, rates and new MDS Changes 2023

- COVID-19 Continued

- Workforce Shortages

- State of Emergency and Waivers

- New Health Care Platforms

- The new virtual world – way of doing business

- Quality Measurement and Outcomes Changes

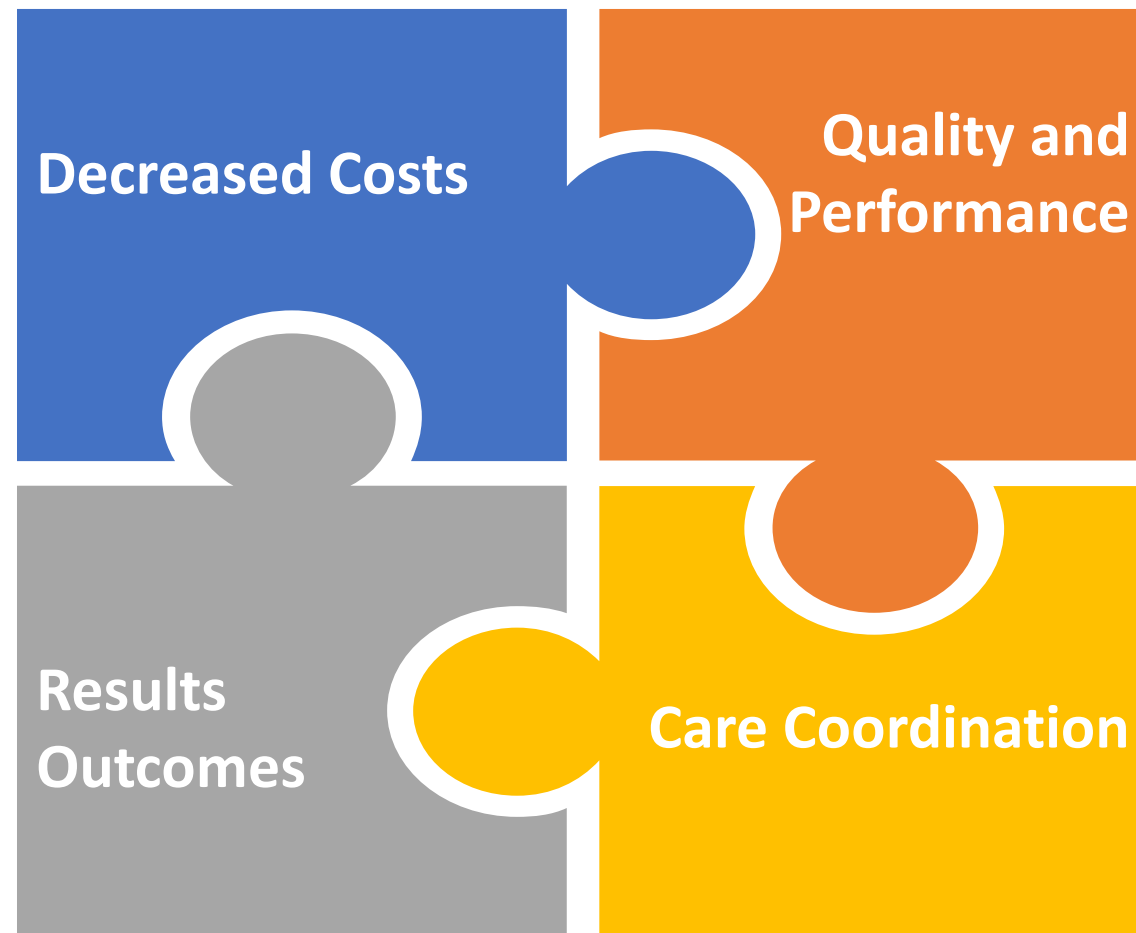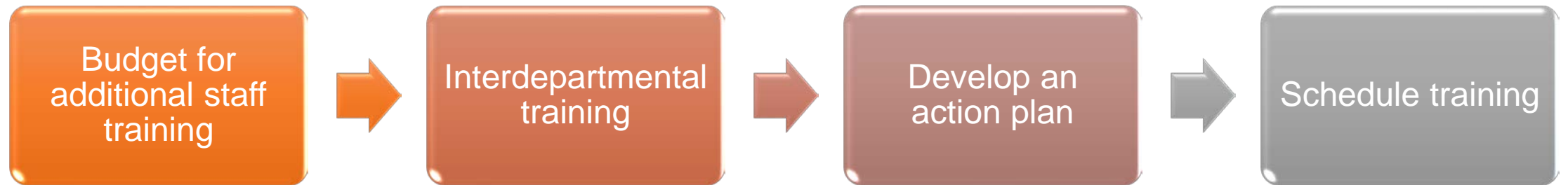- VBP, VBC, APM growing quickly in 2022 and Beyond!

Trends

- Care Settings and Acuity
- Workforce
- Financial Right Sizing
- Consumer and Marketplace Message/Brand
- Occupancy

Trends

Regulatory

Healthcare Preparedness

Payment Model Changes

Clinical and Chronic Disease

Technology Data = Quality

VBP/VBC and Payment Models

- VBP/VBC
- Managed Care
- New Models
- HCBS
- PDPM
- MDS Changes

Decreased Costs

Quality and Performance

Results Outcomes

Care Coordination

MDS Changes - Develop a Transition Plan
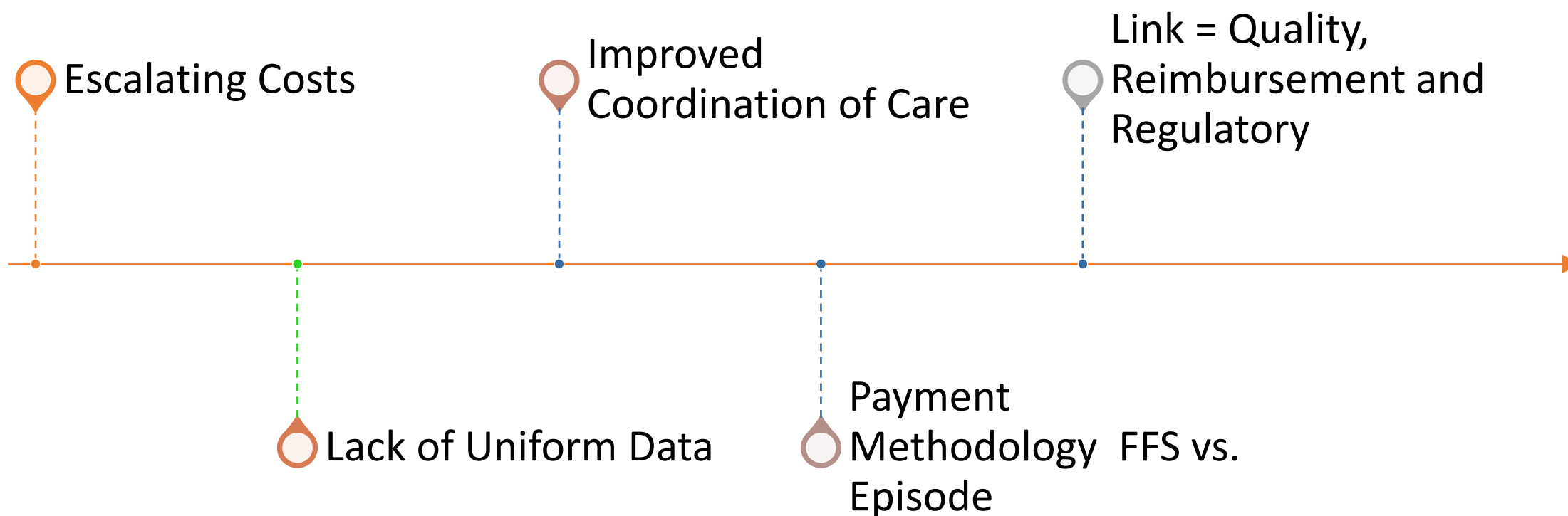
Budget for additional staff training → Interdepartmental training → Develop an action plan → Schedule training
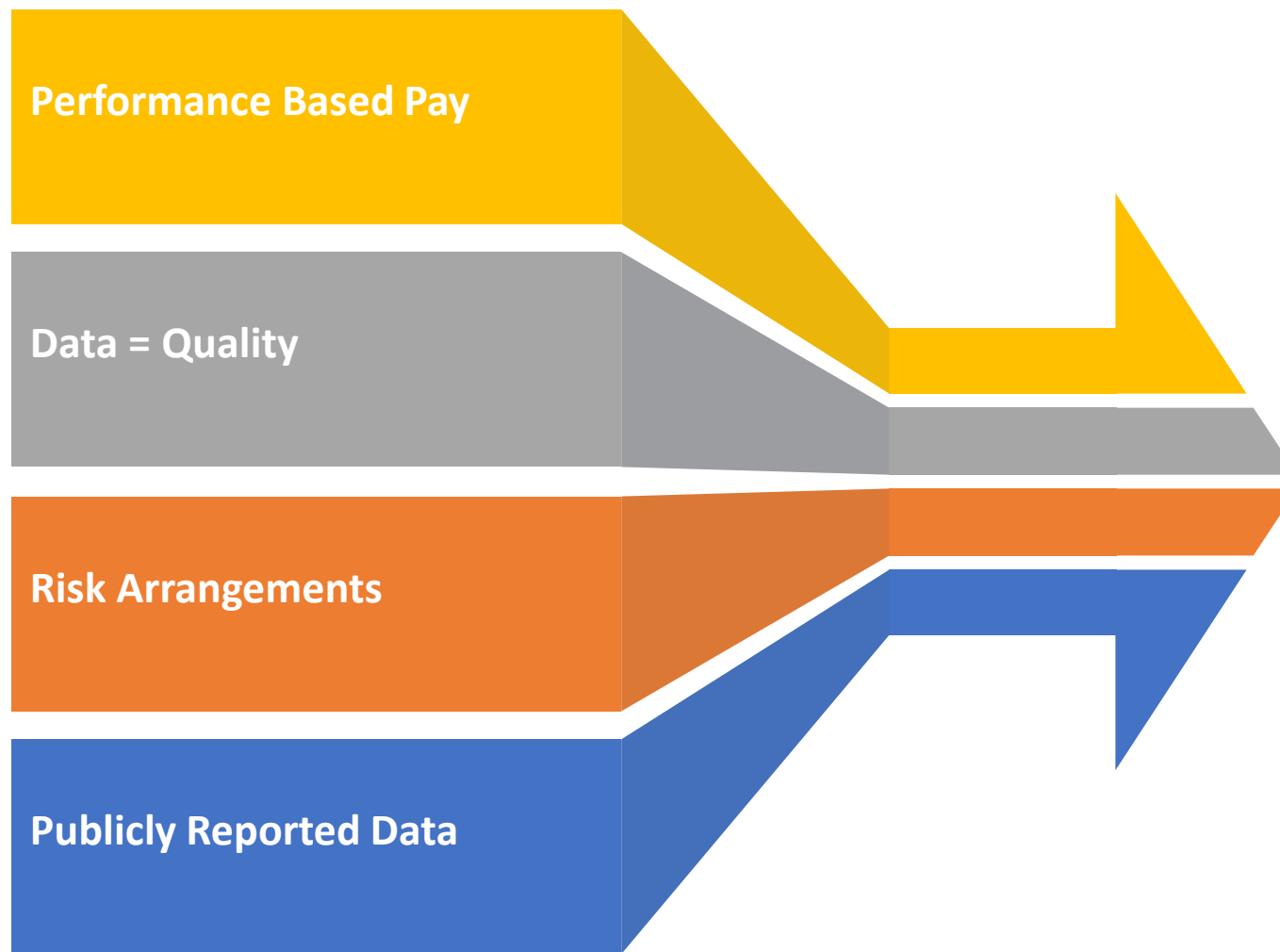
Today and Beyond

NEW! COVID Opportunities

SNF VBP

Medicare Advantage

Bundle Payments

ISNPs

VBID

ACO

Managed Care Organizations

MCOs

New! Advance Regional VBC Model

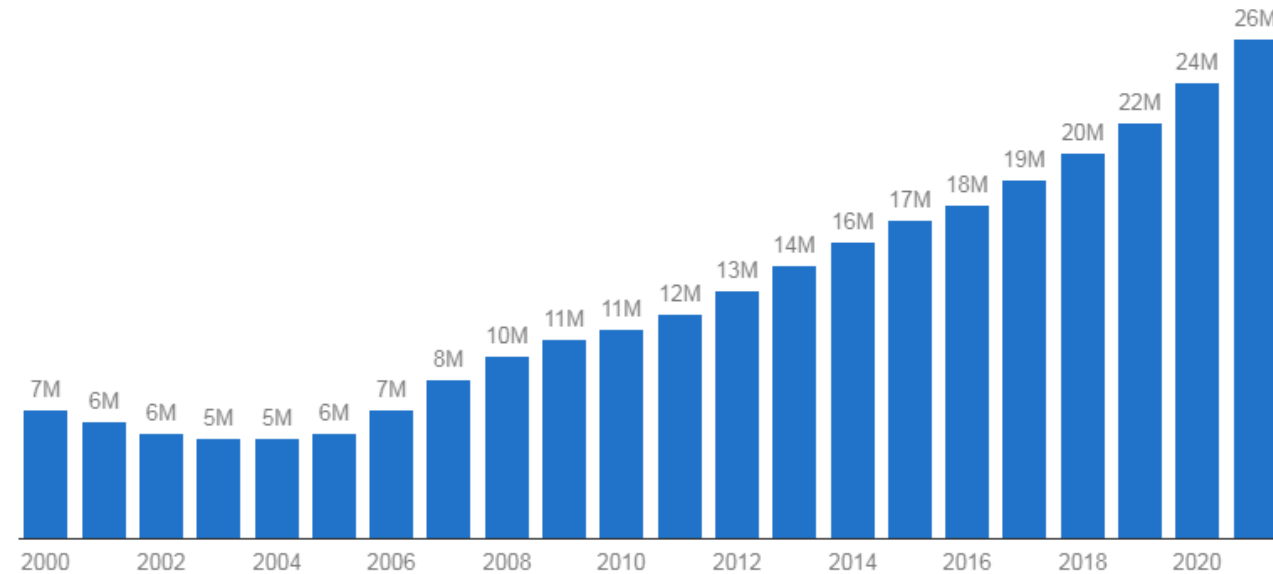**Partners – PPN, PAN, CIN, etc.**

Medicare Advantage

Figure 1

Total Medicare Advantage Enrollment, 2000-2021

Medicare Advantage Enrollment   Medicare Advantage Penetration

NOTE: Includes cost plans as well as Medicare Advantage plans. About 62.7 million people are enrolled in Medicare in 2021
SOURCE: KFF analysis of MPR, "Tracking Medicare Health and Prescription Drug Plans: Monthly Report," 2000-2005; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2006-2017; CCW data from 20 percent of beneficiaries, 2018; and Medicare Enrollment Dashboard 2019-2021. Enrollment numbers from March of the respective year. • PNG

Data Source: *Kaiser Family Foundation (KFF) Medicare Advantage Update*

Medicare Advantage

Figure 5

In 5 percent of counties (accounting for 25% of beneficiaries), beneficiaries can choose among more than 50 Medicare Advantage plans, including 51 counties with more than 60 plans

Medicare Advantage plans in 2022:

- 0 plans (65 counties)
- 1-10 plans (465 counties)
- 11-25 plans (1262 counties)
- 26-50 plans (1280 counties)
- 51-60 plans (100 counties)
- 61 or more plans (51 counties)
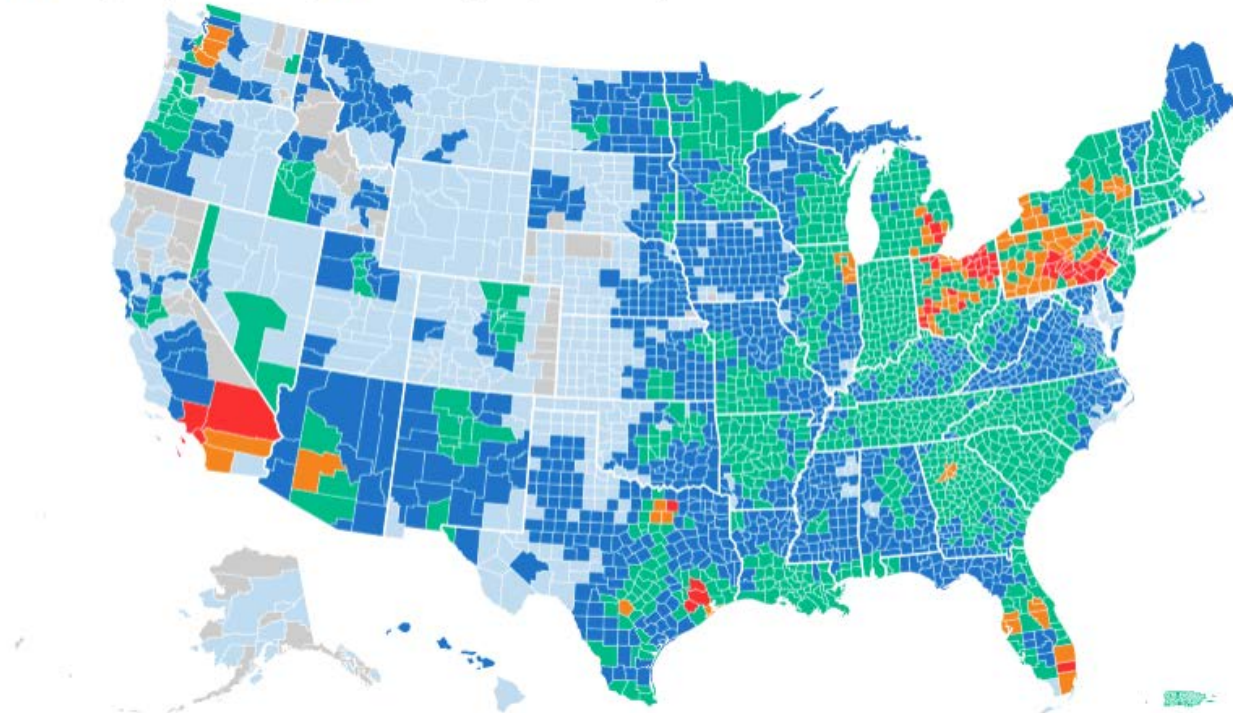
NOTE: Excludes SNPs, EGHPs, HCPPs, PACE, and MMPs.
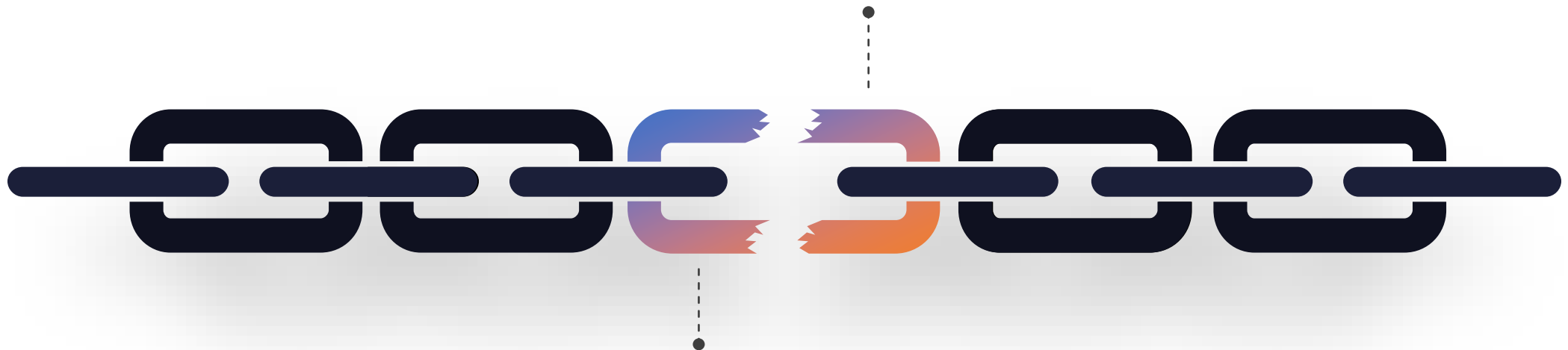SOURCE: KFF analysis of CMS Landscape files for 2022. • PNG

KFF

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Data Source: Kaiser Family Foundation (KFF) Medicare Advantage Update

PATHWAY HEALTH
Insight | Expertise | Knowledge

Information And Expectations

Rapid Pace . Data . Prioritize

Organization Data - The Link

- ALOS – Efficiency and Cost

- Readmission

- Disease State Data (Quality and Outcomes)

- Quality Measures (Overall and Targeted QMs)

- DC to Community

- Alignment with Partners

- Redesign in "New Normal"

- Data = Quality!

Data Driven Decisions

"You can have data without information, but you cannot have information without data."
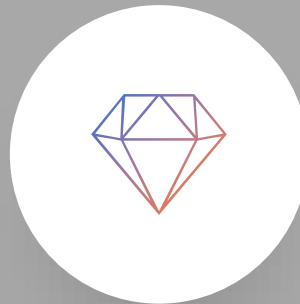
— Daniel Keys Moran

Data �Quality

CMS Expectations

Data Quality
Accuracy
Integrity
Validity

Leadership Data

Internal/Operational/Financial
Quality/Clinical
Public
Compliance
Reimbursement
Strategy/Marketplace

Internal Data

MDS
Claims
NSHN/IC
Survey Outcomes
Quality Measures
SNF QRP/SNF VBP

External Data

Five Star
Compare Website
COVID-19 NH
Transparency
Payers

Key Data Sources

Compare Website

New – Care Compare

All provider types

Updates

COVID-19 Nursing Home Data

NHSN Data

Provider Reported

Benchmarked

Organization Data

Operational

Clinical

Quality Outcomes/Performance

Partnerships

Quality Measures

Five Star

CASPER and Survey

VBP/QRP

New QMs

Public data

Understanding the Impact

Compare Care   Medicare

https://www.medicare.gov/care-compare/

Compare Care   Medicare

https://www.medicare.gov/care-compare/

SFF Status and Ranking

Compare Care   Medicare

Five Star Updates

July 2022 Staffing and Turnover Measures

•Total nurse (RN, licensed practical nurses, and nurse aids) staffing hours per resident per day on weekends.

•Total nurse staff turnover within a given year.

•RN turnover with a given year.

•Number of administrators who have left the nursing home within a given year

NEW – January 2023

• Adjusting QM based on Erroneous Schizophrenia Coding

• Posting Citations Under Dispute
  QSO-23-05-NH

https://www.medicare.gov/care-compare/

Design for *Care Compare*
Nursing Home Five-Star Quality Rating System:

Technical Users' Guide

January 2023

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-23-05-NH

DATE: January 18, 2023

TO: State Survey Agency Directors

FROM: Director, Quality, Safety & Oversight Group (QSOG)

SUBJECT: Updates to the Nursing Home Care Compare Website and Five Star Quality Rating System: Adjusting Quality Measure Ratings Based on Erroneous Schizophrenia Coding, and Posting Citations Under Dispute

Memorandum Summary

• **Adjusting Quality Measure Ratings:** CMS will be conducting audits of schizophrenia coding in the Minimum Data Set data and, based upon the results, adjust the Nursing Home Care Compare quality measure star ratings for facilities whose audits reveal inaccurate coding.

• **Posting Citations Under Dispute:** To be more transparent, CMS will now display citations under informal dispute on the Nursing Home Care Compare website.

Background:
Adjusting Quality Measure Ratings Based on Erroneous Schizophrenia Coding
In 2008, CMS added the Five-Star Quality Rating System to the CMS Nursing Home Compare website. The rating system comprises three rating domains: health inspections, staffing, and quality measures (QMs). One of the QMs reported on Nursing Home Care Compare and included in the star rating calculation is the percentage of long-stay residents who are receiving antipsychotic drugs. This measure excludes residents with diagnoses of schizophrenia, Huntington's disease, or Tourette syndrome. CMS is concerned that some nursing homes have erroneously coded residents as having schizophrenia, which can mask the facilities' true rate of antipsychotic medication use. Therefore, CMS will conduct offsite audits of schizophrenia coding and, based upon the results, adjust the quality measure star ratings for facilities whose audit reveals inaccurate coding.

Posting Citations Under Informal Dispute Resolution and Independent Informal Dispute Resolution (IDR/IIDR)
The Informal Dispute Resolution (IDR) process gives nursing homes an informal opportunity to dispute citations. Additionally, when CMS imposes a civil money penalty, providers have the opportunity to request an Independent IDR (IIDR). Currently, citations under IDR/IIDR are not posted publicly on the Nursing Home Care Compare and the Quality Certification and Oversight Reports (QCOR) website until the dispute is complete. This process usually takes approximately

January 2023 Revisions

Adjusting Quality Measure Ratings Based on Erroneous Schizophrenia Coding

Effective with the January 2023 refresh, CMS will be conducting audits of schizophrenia coding in the Minimum Data Set (MDS) data. Facilities that have coding inaccuracies identified through the schizophrenia MDS audit will have their Quality Measure (QM) ratings adjusted as follows:

• The overall QM and long-stay QM ratings will be downgraded to one star for six months (this drops the facility's overall star rating by one star).
• The short-stay QM rating will be suppressed for six months.
• The long-stay antipsychotic QM will be suppressed for 12 months.

Posting Citations Under Dispute:
To be more transparent, CMS will now display citations under informal dispute on the Nursing Home Care Compare website. While the citations will be publicly displayed, they will not be included in the calculation of a facility's star rating until the dispute is complete (and the survey is considered final).

Changes are identified in red, italicized text.

For more information on these updates see: QSO-23-05-NH

October 2022 Revisions
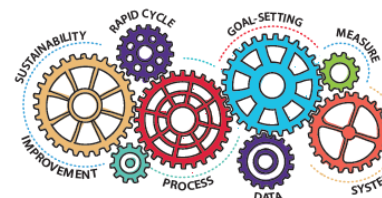
Quality Measure Rating Threshold changes

Effective with the October 2022 refresh, CMS is implementing the planned, regular increases to the Quality Measure (QM) rating thresholds, increasing each rating threshold by one-half of the average improvement in QM scores since the last time the thresholds were set. For the October 2022 refresh, the average improvement was determined from the period of January 2022 – July 2022. The new rating thresholds are shown in Table 5 of this document. Note that the point thresholds for individual QMs did not change. CMS plans to implement these regular increases every six months.

July 2022 Revisions

Changes to the Methodology for the Staffing Rating

Effective with the July 2022 refresh, CMS revised the methodology for calculating the Staffing star rating. The new rating is based on six separate staffing measures. Similar to the Quality Measure (QM) rating, points are assigned based on the performance on each of these six measures. The points are then summed and the total staffing score is compared to staffing rating point thresholds to assign a rating of one to five stars. The six measures are as follows:

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Preview Report

Public Data – Full Access!

https://data.cms.gov/

Public Data - There is More!!!!

https://data.cms.gov/provider-data/archived-data/nursing-homes

Quality Measures: How They Are Developed, Used, & Maintained

Your guide to what goes into building quality measures and what happens after they are built

https://mmshub.cms.gov/sites/default/files/Guide-Quality-Measures-How-They-Are-Developed-Used-Maintained.pdf

Today and Beyond

Quality Data Collection Has Not Stopped
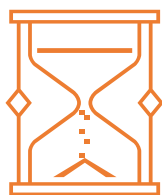
Readmissions

Readmission measure is the first measure for all provider types

COVID and Infections

Data continues - Healthcare Acquired Infections measure is coming soon for all

SNF QRP

The new SNF QRP measures will roll into these "across the board" measures (i.e., falls, Medicare spend per beneficiary), which sets the stage for Value Based Purchasing and Value Based Care.

VBP and VBC

VBP and VBC are moving forward quickly and swiftly!!!

Quality Measures

CASPER, VBP, QRP and more!

UNDERSTAND QUALITY MEASURES

SNF QMs

- **Information**
  - CASPER
  - Nursing Home Compare
  - 5 Star
  - Survey
- **Reimbursement**
  - QRP
  - VBP

Assessment-Based Measures
Minimum Data Set, Version 3.0 (MDS 3.0)

Claims-Based Measures

NEW! CDC - NHSN
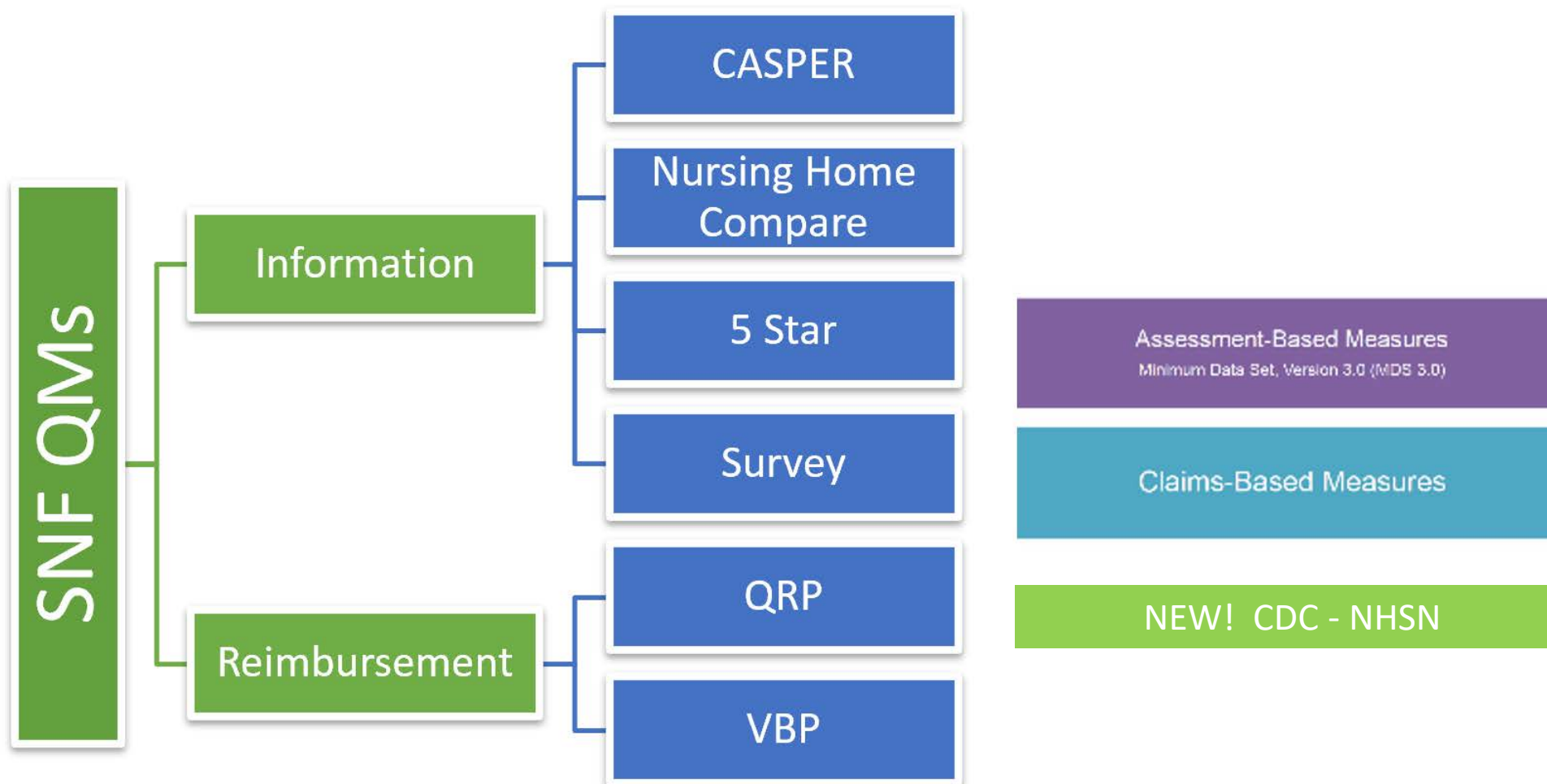
UNDERSTAND QUALITY MEASURES

Quality Measure Group	Payor	Data Source(s)	Residents
CASPER	All	MDS & Claims	All
Nursing Home Compare	All	MDS & Claims	All
5 Star	All	MDS & Claims	All
Survey	All	MDS only	All
Quality Reporting Program (QRP)	Medicare Part A	MDS & Claims	Short Stay Only (< 101 Days)
Value Based Purchasing (VBP)	Medicare Part A	Claims only	Short Stay Only (< 101 Days)

Final Rule 2023

Fiscal Year (FY) 2023 Skilled Nursing Facility Prospective Payment System Final Rule (CMS 1765-F)

- Updates to the Quality Reporting Program (QRP) for 2023 and future years

- Updates to the Value Based Purchasing Program (VBP) for 2023 and future years.

- Recalibration of the Patient Drive Payment Model Parity Adjustment

- Changes to PDPM ICD-10 Code Mapping

- QRP 2024 Influenza vaccines among HCP

- QRP October 1, 2023 include:

  ✓ Transfer of health information measures

  ✓ Standardized elements including race, ethnicity, preferred language, health literacy, social isolation

Goodbye Old Friend

1. **ADL Self-Performance**
   Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times
0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times
7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. **ADL Support Provided**
   Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:
0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. **Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture	☐	☐
B. **Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)	☐	☐
C. **Walk in room** - how resident walks between locations in his/her room	☐	☐
D. **Walk in corridor** - how resident walks in corridor on unit	☐	☐
E. **Locomotion on unit** - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	☐	☐
F. **Locomotion off unit** - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	☐	☐

Resident	Identifier	Date

Section GG | Functional Abilities and Goals - Admission

GG0130. Self-Care (Assessment period is the first 3 days of the stay)

Complete if A0310A = 01 or A0310B = 01. If A0310B = 01, the stay begins on A2400B **and** both columns are required. If A0310B = 99, the stay begins on A1600 **and** only column 1 is required.

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

- 06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

- 07. **Resident refused**
- 09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
- 88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		[Draft MDS3.0 NC Item Set v1.18.11 Oct2023.pdf](#)
☐☐	☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.

Organizational Strategies

- Begin Now
- Review your current process
- Keep abreast of any changes to the EMR.
- Seamless transition from acute care to SNF.

First Step - Quality Measures

Understand . Plan . Implement

Current - Short Stay QUALITY MEASURES

- Percent of Short-Stay Residents Who Were Re-Hospitalized after a Nursing Home Admission
- Percent of Short-Stay Residents Who Have Had an Outpatient Emergency Department Visit
- Percent of Residents Who Newly Received an Antipsychotic Medication
- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
- Percent of Residents Who Made Improvements in Function
- Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine
- Percent of Residents Who Received the Seasonal Influenza Vaccine*
- Percent of Residents Who Were Offered and Declined the Seasonal Influenza Vaccine*
- Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine*
- Percent of Residents Who Were Assessed and Appropriately Given the Pneumococcal Vaccine
- Percent of Residents Who Received the Pneumococcal Vaccine*
- Percent of Residents Who Were Offered and Declined the Pneumococcal Vaccine*
- Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Pneumococcal Vaccine*
- *These measures are not publicly reported but available for provider preview.*

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures
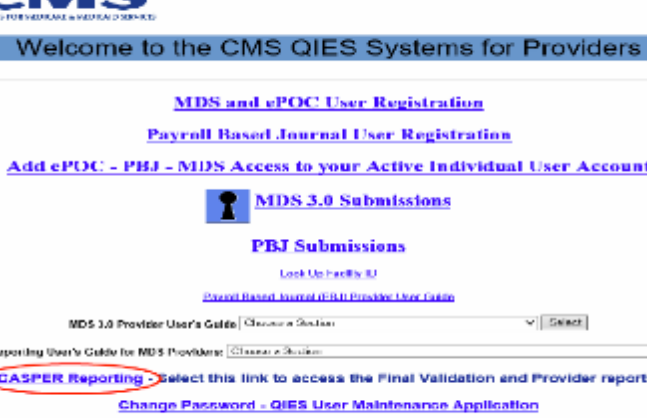
Current - Long Stay QUALITY MEASURES

- Number of Hospitalizations per 1,000 Long-Stay Resident Days
- Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days
- Percent of Residents Who Received an Antipsychotic Medication
- Percent of Residents Experiencing One or More Falls with Major Injury
- Percent of High-Risk Residents with Pressure Ulcers
- Percent of Residents with a Urinary Tract Infection
- Percent of Residents who Have or Had a Catheter Inserted and Left in Their Bladder
- Percent of Residents Whose Ability to Move Independently Worsened
- Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased
- Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine
- Percent of Residents Who Received the Seasonal Influenza Vaccine*
- Percent of Residents Who Were Offered and Declined the Seasonal Influenza Vaccine*
- Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine*
- Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine
- Percent of Residents Who Received the Pneumococcal Vaccine*
- Percent of Residents Who Were Offered and Declined the Pneumococcal Vaccine*
- Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Pneumococcal Vaccine*
- Percent of Residents Who Were Physically Restrained
- Percent of Low-Risk Residents Who Lose Control of Their Bowels or Bladder
- Percent of Residents Who Lose Too Much Weight
- Percent of Residents Who Have Symptoms of Depression
- Percent of Residents Who Used Antianxiety or Hypnotic Medication

These measures are not publicly reported but available for provider preview.

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures

Login

CASPER MDS 3.0 Facility Characteristics Report

- Facility Assessment Annual Update
- Survey Entrance Conference

CASPER MDS 3.0 Facility Level Quality Measure Report

- Review Monthly with Your Team
- QAPI

CASPER Report — Page 1 of 1
MDS 3.0 Facility Level Quality Measure Report

Facility ID: ███████
CCN: ███████
Facility Name: ███████
City/State: ███████

Report Period: 04/01/2021 - 09/30/2021
Comparison Group: 04/01/2021 - 09/30/2021
Report Run Date: 10/01/2021
Data Calculation Date: 10/04/2021
Report Version Number: 3.03

Note: Dashes represent a value that could not be computed
Note: S = short stay, L = long stay
Note: C = complete; data available for all days selected, I = incomplete; data not available for all days selected
Note: ★ is an indicator used to identify that the measure is flagged
Note: For the Improvement in Function (S) Measure, a single * indicates a Percentile of 25 or less (higher Percentile values are better)

Measure Description	CMS ID	Data	Num	Denom	Facility Observed Percent	Facility Adjusted Percent	Comparison Group State Average	Comparison Group National Average	Comparison Group National Percentile
Hi-risk/Unstageable Pres Ulcer (L)	N015.03	C	0	16	0.0%	0.0%	0.0%	0.0%	0
Phys restraints (L)	N027.02	C	0	53	0.0%	0.0%	0.0%	0.0%	0
Falls (L)	N032.02	C	0	53	0.0%	0.0%	0.0%	0.0%	0
Falls w/Maj Injury (L)	N013.02	C	0	53	0.0%	0.0%	0.0%	0.0%	0
Antipsych Med (S)	N011.02	C	0	0	-	-	-	-	-
Antipsych Med (L)	N031.03	C	53	53	100.0%	100.0%	100.0%	100.0%	100 ★
Antianxiety/Hypnotic Prev (L)	N033.02	C	53	53	100.0%	100.0%	100.0%	100.0%	100 ★
Antianxiety/Hypnotic % (L)	N036.02	C	53	53	100.0%	100.0%	100.0%	100.0%	100 ★
Behav Sx affect Others (L)	N034.02	C	0	53	0.0%	0.0%	0.0%	0.0%	0
Depress Sx (L)	N030.02	C	53	53	100.0%	100.0%	100.0%	100.0%	100 ★
UTI (L)	N024.02	C	0	16	0.0%	0.0%	0.0%	0.0%	0
Cath Insert/Left Bladder (L)	N026.03	C	0	16	0.0%	-	-	-	-
Lo-Risk Lose B/B Con (L)	N025.02	C	0	16	0.0%	0.0%	0.0%	0.0%	0
Excess Wt Loss (L)	N029.02	C	16	16	100.0%	100.0%	100.0%	100.0%	100 ★
Incr ADL Help (L)	N028.02	C	0	0	-	-	-	-	-
Move Indep Worsens (L)	N035.03	C	0	0	-	-	-	-	-
Improvement in Function (S)	N037.03	C	0	0	-	-	-	-	-

Measure Description	CMS ID	Numerator	Denominator	Facility Observed Percent	Facility Adjusted Percent	National Average
Pressure Ulcer/Injury[1]	S038.02	94	4,748	2.0%	1.2%	0.2%

[1] The Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (S038.02) measure is calculated using the SNF QRP measure specifications v3.0 addendum and is based on 12 months of data (10/01/2020 - 09/30/2021).

CASPER MDS 3.0 Resident Level Quality Measure Report

- Review at a Minimum Monthly with Your Team
- **Drill down if needed**

Monthly Comparison Report

- Bonus! Can Use to produce bar or line graphs to demonstrate quality progress
- Quarterly Trends

CASPER QM Report Package

CASPER = Certification and Survey Provider Enhanced Reporting

Requested on-demand

Default timeline <u>or</u> Customize the report selection criteria to meet your needs

Quality Measures

Facility Level Quality Measures

Resident Level Listing

Monthly Comparison

Facility Characteristics

MDS 3.0 QM Package Reports

SNF QRP Measures

MDS Based
- Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
- Percent of Long Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function
- Drug Regimen Review Conducted with Follow-Up for Identified Issues—PAC SNF QRP
- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
- Transfer of Health Information to the Provider Post-Acute Care
- Transfer of Health Information to the Patient Post-Acute Care

CDC-NHSN Based
- COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)
- Influenza Vaccination Coverage among Healthcare Personnel (HCP)

Claims Based

- Medicare Spending Per Beneficiary – Post-Acute Care (PAC) SNF QRP

- Discharge to Community - PAC SNF QRP

- Potentially Preventable 30-Day Post-Discharge Readmission Measure – SNF QRP

- SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization

https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/skilled-nursing-facility-quality-reporting-program/snf-quality-reporting-program-measures-and-technical-information

SNF QRP Quick Reference Guides

SNF VBP

- 2014 [Protecting Access to Medicare Act of 2014 (PAMA)](#)
  - PAMA specifies that under the SNF VBP Program, SNFs:
  - Are evaluated by their performance on a hospital readmission measure;
  - Are assessed on both improvement and achievement, and scored on the higher of the two;
  - Receive quarterly confidential feedback reports containing information about their performance; and
  - Earn incentive payments based on their performance.
  - CMS withholds 2% of SNFs' Medicare fee-for-service (FFS) Part A payments to fund the program. This 2% is referred to as the "withhold".

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page

SNF VBP

- Quality Measure
  - SNF Readmission Measure - was on hold, coming back!!!!
  - New Measures Added FY 2023 (Data collection starts – Implement FY 2026)
    - Skilled Nursing Facility Healthcare-Associated Infections (SNF HAI) Requiring Hospitalization measure
    - Total Nurse Staffing Hours per Resident Day (Total Nurse Staffing) (including Registered Nurse [RN], Licensed Practical Nurse [LPN], and Nurse Aide hours) measure.
    - FY 2027 - Discharge to Community (DTC)—Post-Acute Care Measure for SNFs

What is the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program?

The **SNF VBP Program** is a Centers for Medicare & Medicaid Services (CMS) program that awards incentive payments to skilled nursing facilities (SNFs) based on their performance on a measure of all-cause hospital readmissions.

The **SNF VBP Program** encourages SNFs to improve the quality of care they provide to Medicare beneficiaries by reducing unplanned hospital readmissions.

What measure is used?

The **SNF VBP Program** currently uses the **SNF 30-Day All-Cause Readmission Measure (SNFRM; National Quality Forum [NQF] #2510)**, which evaluates the risk-standardized readmission rate (RSRR) of unplanned, all-cause hospital readmissions.

Each SNF receives a SNFRM result for a baseline period and a performance period.

www.cms.gov/files/document/fy-2023-snf-vbp-fact-sheet.pdf

How does the SNF VBP Program affect my SNF's FY 2023 payments?

CMS withholds 2% of SNFs' Medicare FFS Part A payments to fund the Program. CMS redistributes 60% of the withhold to SNFs as incentive payments, and the remaining 40% of the withhold is retained in the Medicare Trust Fund.

Under the measure suppression policy for the FY 2023 Program year, each included SNF receives an incentive payment multiplier equal to 60% of its 2% withhold, resulting in a 1.2% payback percentage for the FY 2023 Program year. SNFs that did not meet the SNFRM's case minimum (25 or more eligible stays) in the performance period (FY 2021) are excluded from the SNF VBP Program for FY 2023; payments to these SNFs in FY 2023 are not affected by the SNF VBP Program and instead these SNFs will receive their full federal per diem rate.

This incentive payment multiplier is applied to your SNF's adjusted federal per diem rate for services provided during the applicable SNF VBP Program year.

How does CMS determine my incentive payment multiplier for the FY 2023 Program year?

Step 1

CMS calculates each SNF's RSRR for both the baseline and performance period.[a]

$$\left(\frac{\text{Predicted \# of readmissions}}{\text{Expected \# of readmissions}} \right) \times \text{National unadjusted readmission rate} = RSRR$$

CMS calculates the achievement threshold[b] and benchmark[c] for the Program year.

The performance standards for the FY 2023 Program year were published in the FY 2021 SNF Prospective Payment System (PPS) final rule (page 47625).

[a] An RSRR is calculated using both the predicted and expected number of readmissions. The predicted number of readmissions is the number of unplanned readmissions predicted based on a SNF's performance, given its unique case mix. The expected number of readmissions is the number of unplanned readmissions that would be expected if the residents at a given SNF were treated at the average SNF.
[b] The achievement threshold for a SNF VBP Program year is the 25th percentile of all SNFs' performance on the SNFRM during the baseline period.
[c] The benchmark for a SNF VBP Program year is the mean of the top decile of all SNFs' performance on the SNFRM during the baseline period.

Step 2

Per the suppression policy finalized in the FY 2023 SNF PPS final rule, CMS assigns each SNF a performance score of zero.[d]

[d] CMS suppressed the use of SNF readmission measure data for purposes of FY 2023 scoring and payment adjustments in the FY 2023 SNF VBP Program year because the continuing effects of the COVID-19 public health emergency on the data used to calculate the SNFRM inhibited CMS's ability to make fair national comparisons of SNFs' performance. Under the suppression policy, CMS calculated an RSRR for both the baseline and performance period and then suppressed the use of SNF readmission measure data for purposes of scoring. CMS instead assigned each SNF a performance score of zero to mitigate the effect that the COVID-19 public health emergency would otherwise have had on SNFs' performance scores and incentive payment multipliers. CMS adopted the suppression policy in the FY 2023 SNF PPS final rule.

Step 3

CMS transforms performance scores for all SNFs using the logistic exchange function.

Logistic Exchange Function

CMS then calculates each SNF's incentive payment adjustment and incentive payment multiplier.

This multiplier is applied to each SNF's adjusted federal per diem rate.

When payments are made for SNF claims, the adjusted federal per diem rate is multiplied by the incentive payment multiplier.

For more information on how performance scores and incentive payment multipliers are determined in a standard Program year, in the absence of a suppression policy, see the SNF VBP Program: FY 2021 Incentive Payment Multiplier Calculation Infographic, the SNF VBP Program Exchange Function Methodology Report, and pages 36616 through 36621 of the FY 2018 SNF PPS final rule.

How can SNFs review their results?

CMS provides confidential feedback reports to SNFs on a quarterly basis through the Quality Improvement and Evaluation System (QIES)/Certification and Survey Provider Enhanced Reports (CASPER) reporting system.

- CMS distributes four quarterly reports each year: an Interim (Partial-Year) Workbook, two Full-Year Workbooks (one each for the baseline period and performance period), and a Performance Score Report.
- SNFs that have problems accessing their reports can email the QIES Technical Support Office Help Desk at iqies@cms.hhs.gov.

The SNF VBP Program's Review and Correction (R&C) process has two phases. Phase 1 and 2 requests are accepted for up to 30 calendar days after dissemination of the applicable report.

- Phase 1: review and submit corrections to readmission measure rates for the baseline and performance periods (applies to Full-Year Workbooks only)
- Phase 2: review and submit corrections to the performance score (applies to Performance Score Reports only)

Where does CMS publicly report SNF VBP Program results?

Provider Data Catalog

CMS publicly reports facility-level and aggregate-level results generally in the fall following distribution of the Performance Score Reports.

Historical SNF VBP Program data are publicly available in the Provider Data Catalog (PDC) archives.

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www.cms.gov/files/document/fy-2023-snf-vbp-fact-sheet.pdf

Next steps

Plan . action

NEXT STEPS

Understand

Understand what the information represents

- CASPER QMs

https://qtso.cms.gov/reference-and-manuals/casper-reporting-users-guide-mds-providers

- Publicly Reported Data (Nursing Home Compare) and Five Star Quality Rating

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/usersguide.pdf

Identify

Use the data to identify trends to improve

- Comparison to self over time
- Comparison to State
- Comparison to National

Improve

Identify an area to improve and use the data to track the impact of your actions

- Monthly Comparison Report
- Facility QM Report
- Review and Correct

Understand

Know what the information represents

Understand MDS and Changes

- Understand the MDS items and coding rules for items that trigger the QM
- Prepare for the changes coming soon!

Identify Covariates

- Identify the co-variates that risk-adjust the QM

Know Exclusions

- Know the exclusions that keep resident's out of the QM

Inspect the Supporting Data

Is the MDS item coded according to the MDS manual?

- MDS CODING

Is the supporting chart information complete and timely?

- OBSERVATION PERIOD

Is the supporting chart information representative of the resident's status?

- ACCURACY
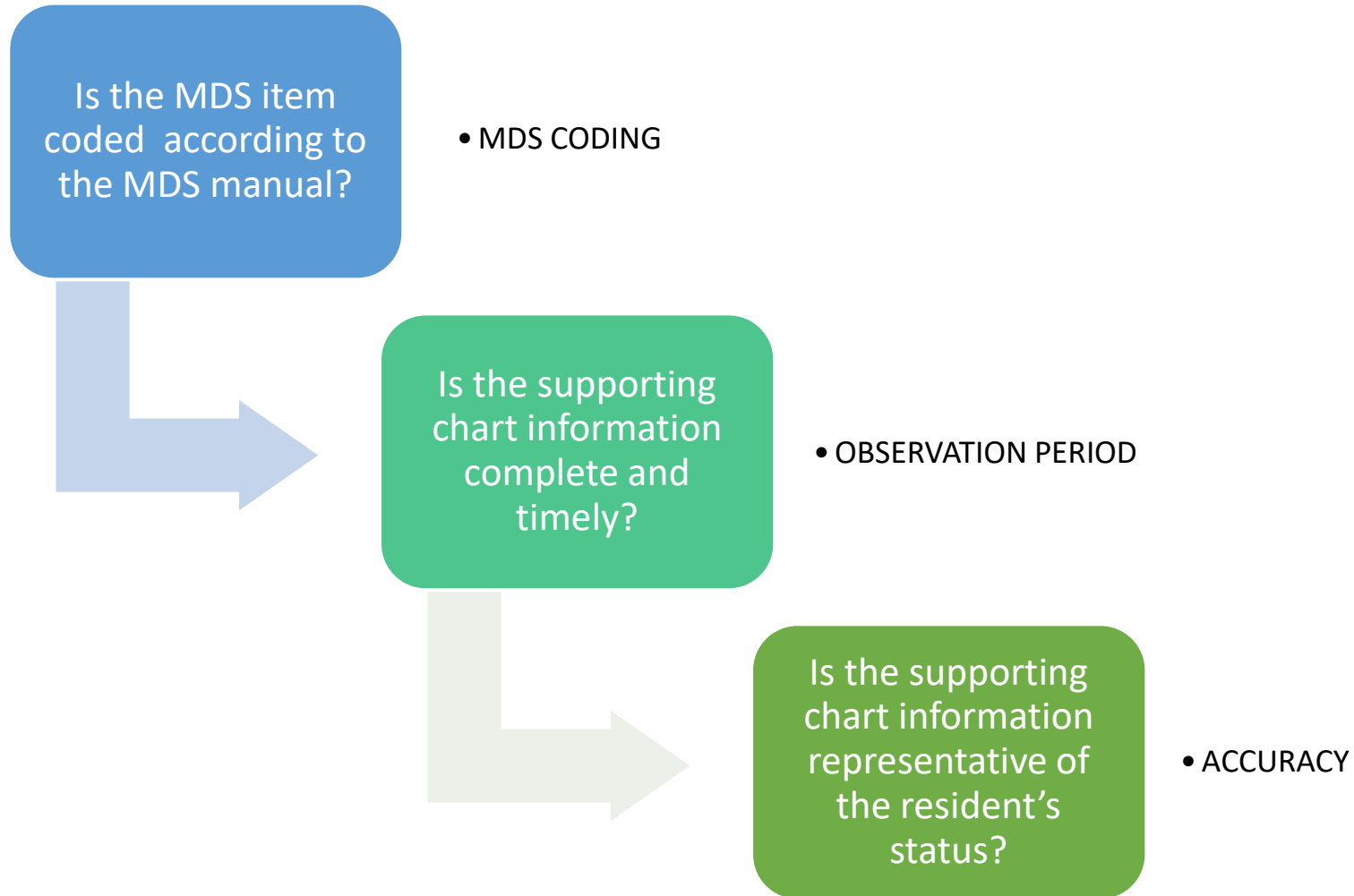
Remember…

ASSESSMENT

- Actual Problem
  - History
  - Impact on Health and Wellbeing
- Risk Factors
  - Extrinsic
  - Intrinsic
- Related/Contributing Issues
  - Comorbidities
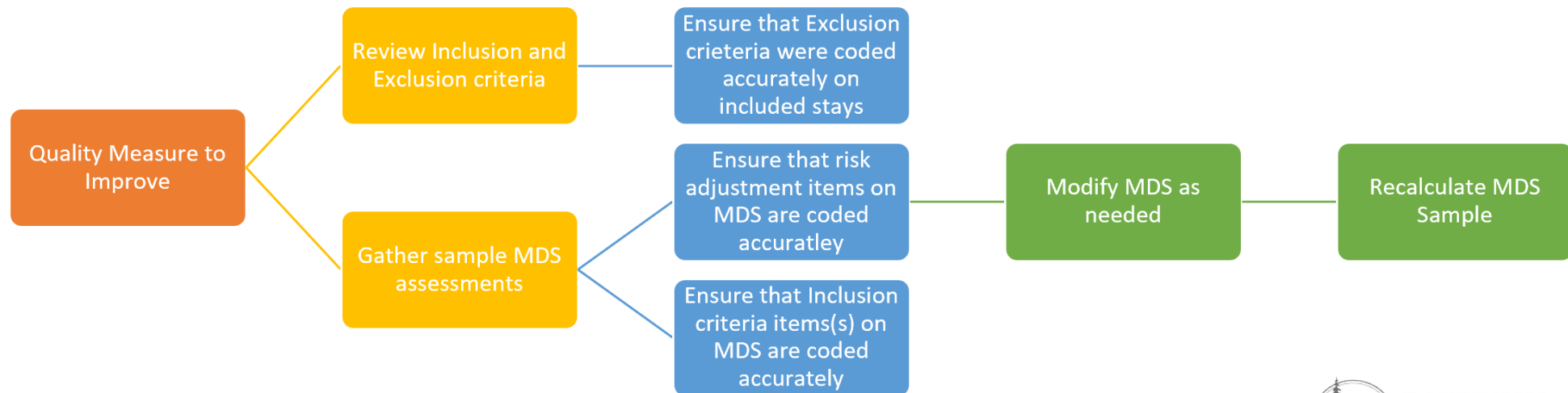
Identify

Use the data to identify trends to improve

Comparison State

- State comparison may represent local practice patterns, staffing and referrals

Comparison National

- National comparison represents a large pool of facilities

Comparison Internal

- Your own data reflects the facility resident and staff population and organizational practices

2

Improve

Identify an area to improve and use the data to track the impact of your actions

Comparison Monthly

Monthly Comparison Report - Comparison period is six months

Comparison Facility QM Report

State and national data calculated on first day of the month, two months prior to current month, *Facility data calculated weekly for MDS submitted since previous week's data collection*

Incorporate QAPI

Identify, determine, team, action plan (PIP), and report outcomes to QAPI

3

Leadership Data Strategy

MDS Process

Medicare & UB-04 Process

Data Knowledge

Other Data Sources

Data Knowledge

- Download the various SNF QM resources, learn them, and use them

- Establish a team to review the QMs on a regular basis – monthly, quarterly, annually

- Take advantage of preview reports to correct any discrepancies

- Review Facility Assessment

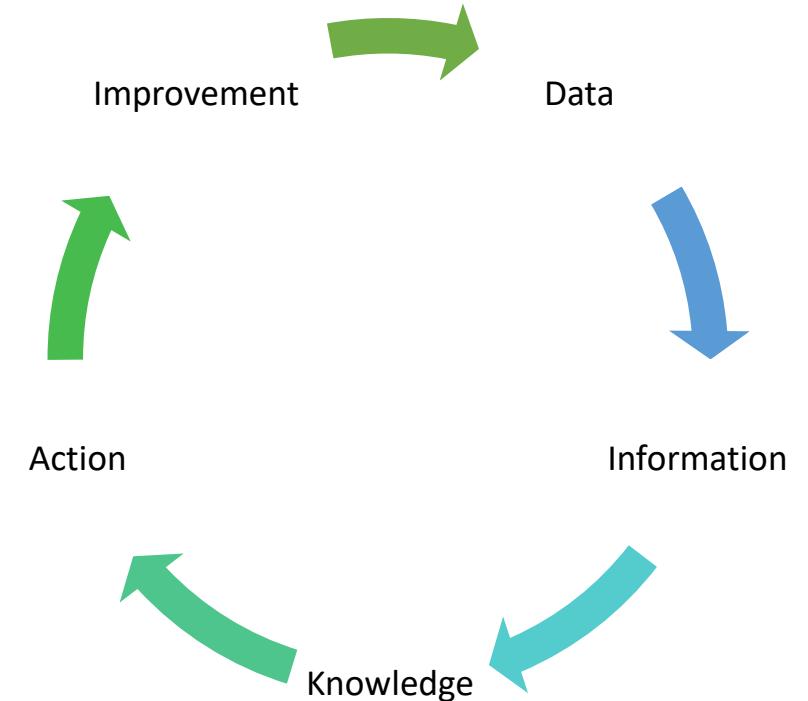- Fully implement QAPI

- Share the data internally and externally

- Team approach
- Standardize the process
- Cross sectional team
- Compare to FA
- Identify improvement
- Compliance
- Communicate
- Educate/Training Program
- Communicate
- QAPI/Compliance
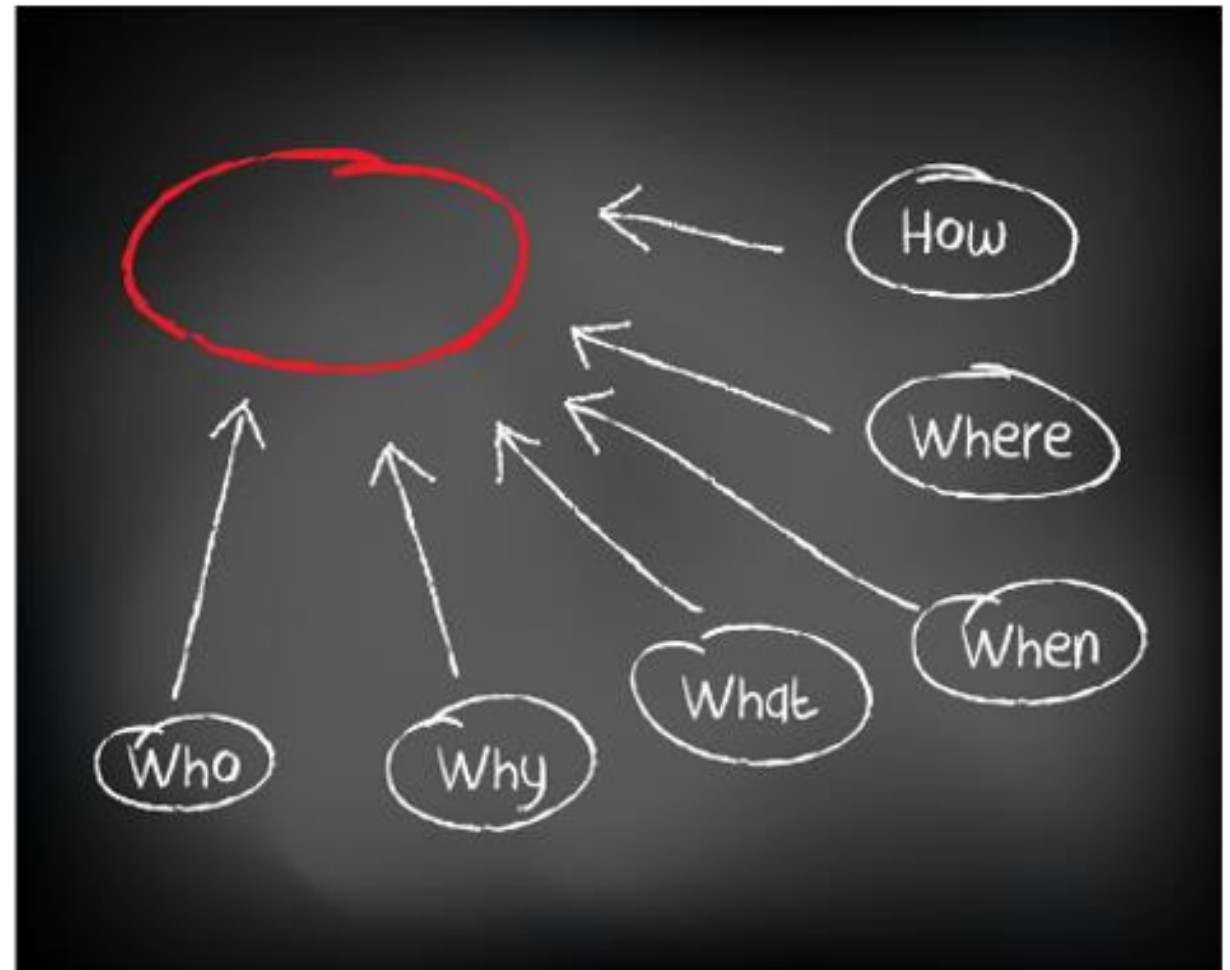
Summary

- Understand the details of included data for each quality measure
- MDS-based QMs
  - Review MDS coding and source documentation accuracy
  - Review clinical systems that impact that aspect of care or resident outcome
  - Observe care delivery
  - Use CASPER Monthly Comparison report to see changes
- Claims-based QMs
  - INTERACT – Interventions to Reduce Acute Care Transfers

Improvement → Data

Data → Information

Information → Knowledge

Knowledge → Action

Action → Improvement

"The goal is to turn data into information, and information into insight."

– Carly Fiorina, former executive, president, and chair of Hewlett-Packard Co.

Let's Get Back to Quality and Data Outcomes

www.pathwayhealth.com

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