



MOMENTUM

2023 ANNUAL MEETING & EXPO

MARCH 7-8, 2023

Renaissance Schaumburg
Convention Center - Schaumburg, IL

Let's Get Back to Quality and Data Outcomes

Lisa Thomson, BA, LNHA, HSE, CIMT

www.pathwayhealth.com

Objectives

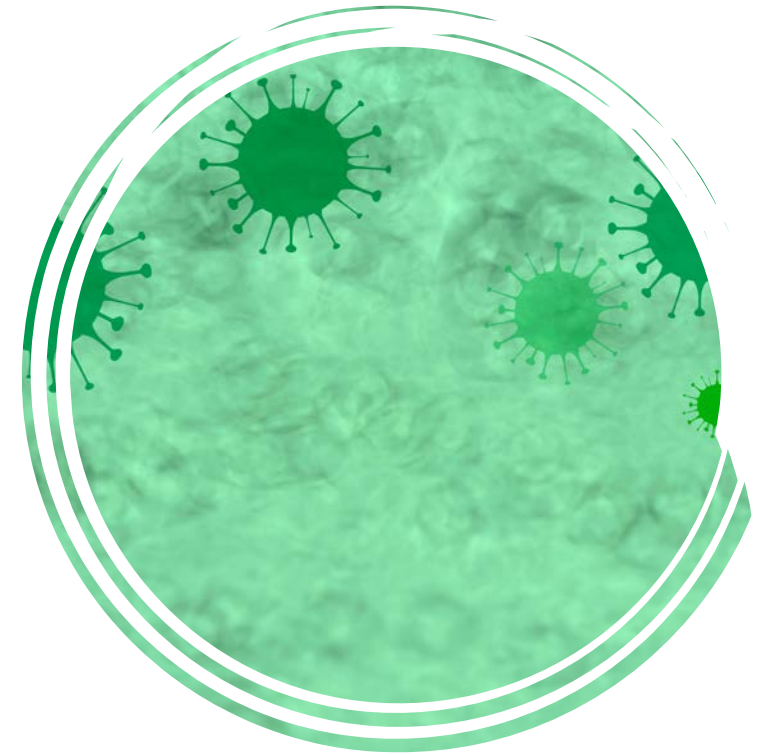
1. Identify what quality measure data represents now
2. Describe a process for analyzing data to select the most current information
3. Draft a plan for using quality data for one improvement project

Rapid Pace *Change*

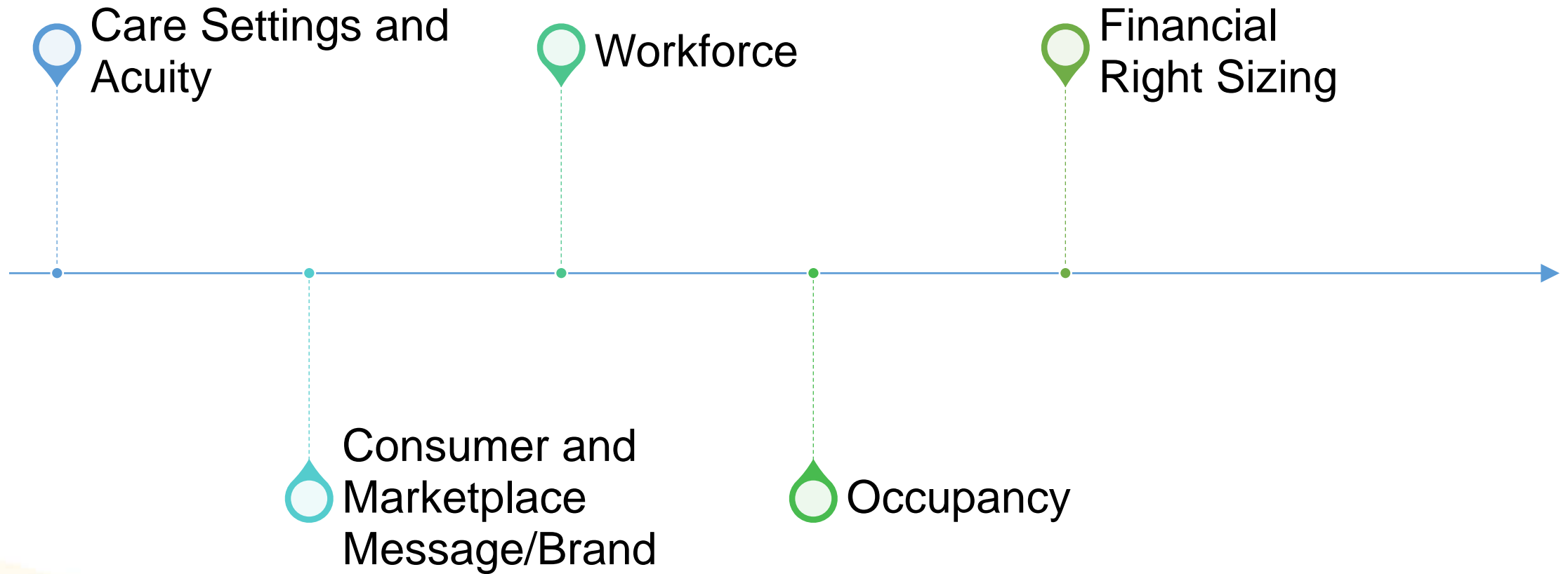


2022 – Whew!

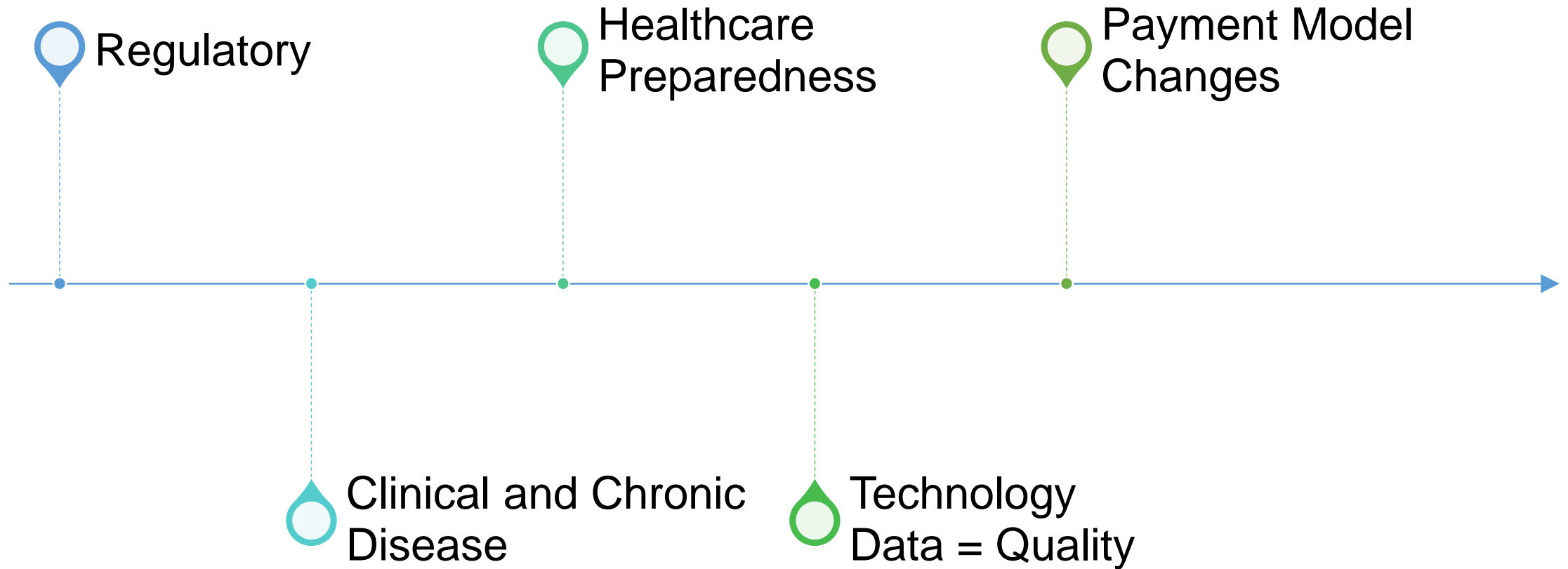
- New regulations and oversight - RoP Phase 3
- PDPM updates, rates and new MDS Changes 2023
- COVID-19 Continued
- Workforce Shortages
- State of Emergency and Waivers
- New Health Care Platforms
- The new virtual world – way of doing business
- Quality Measurement and Outcomes Changes
- VBP, VBC, APM growing quickly in 2022 and Beyond!



Trends

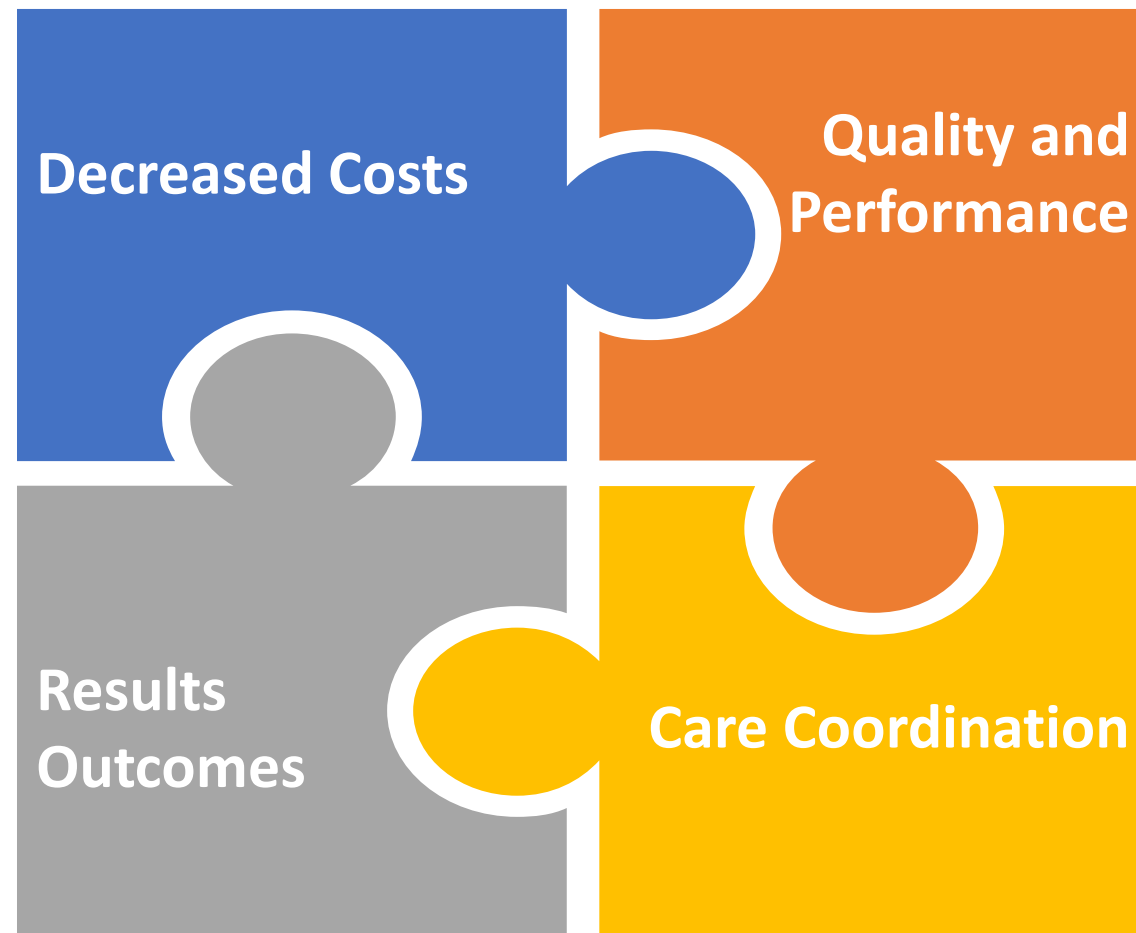


Trends

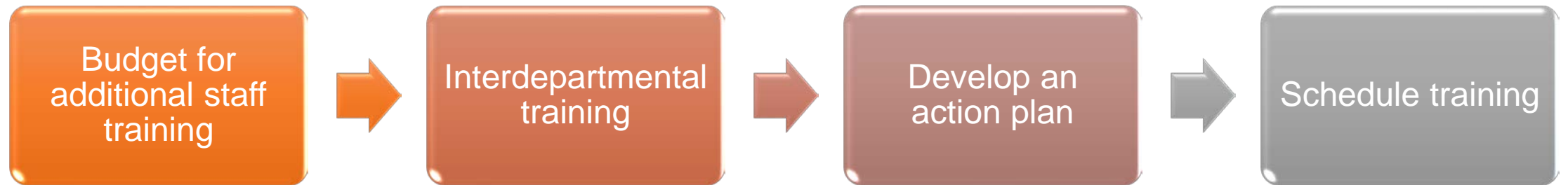


VBP/VBC and Payment Models

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

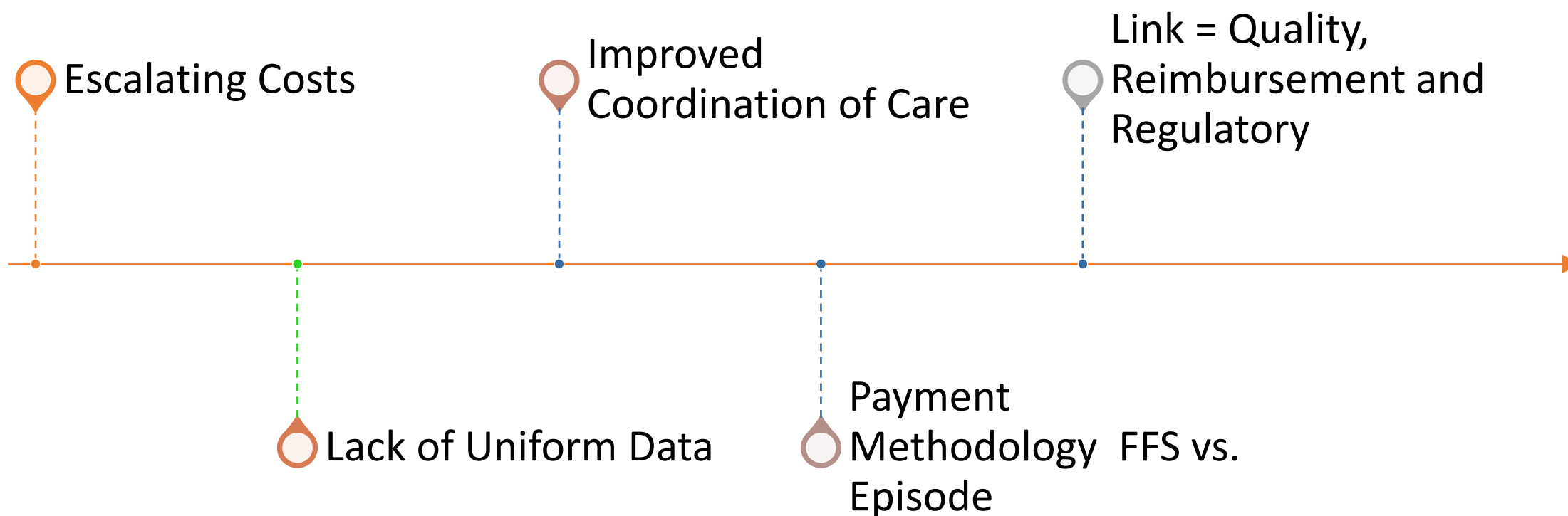


MDS Changes - Develop a Transition Plan



VBP/APM

(Pre COVID and Now)



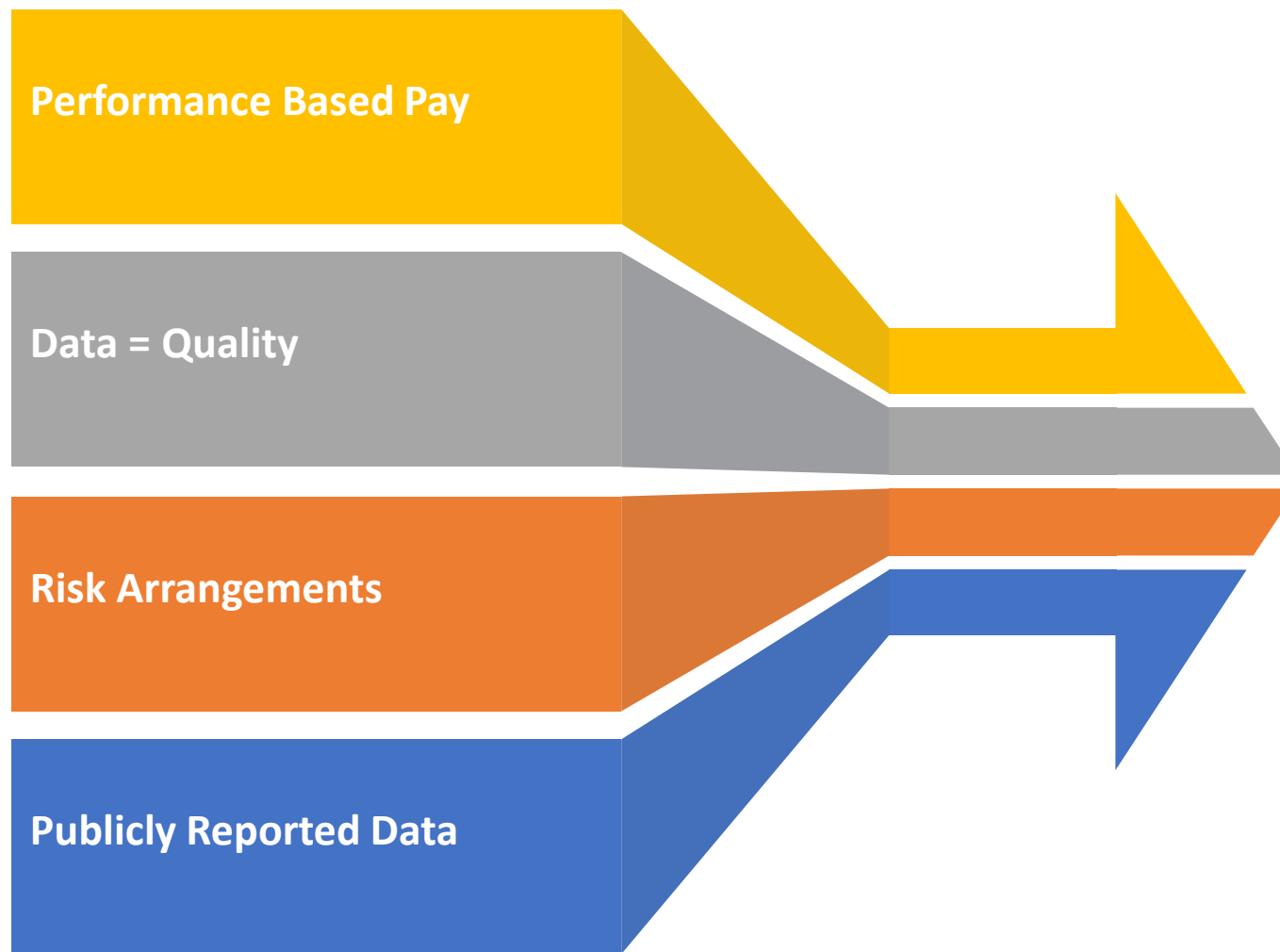
Payment Model Expectations

Performance Based Pay

Data = Quality

Risk Arrangements

Publicly Reported Data



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.**

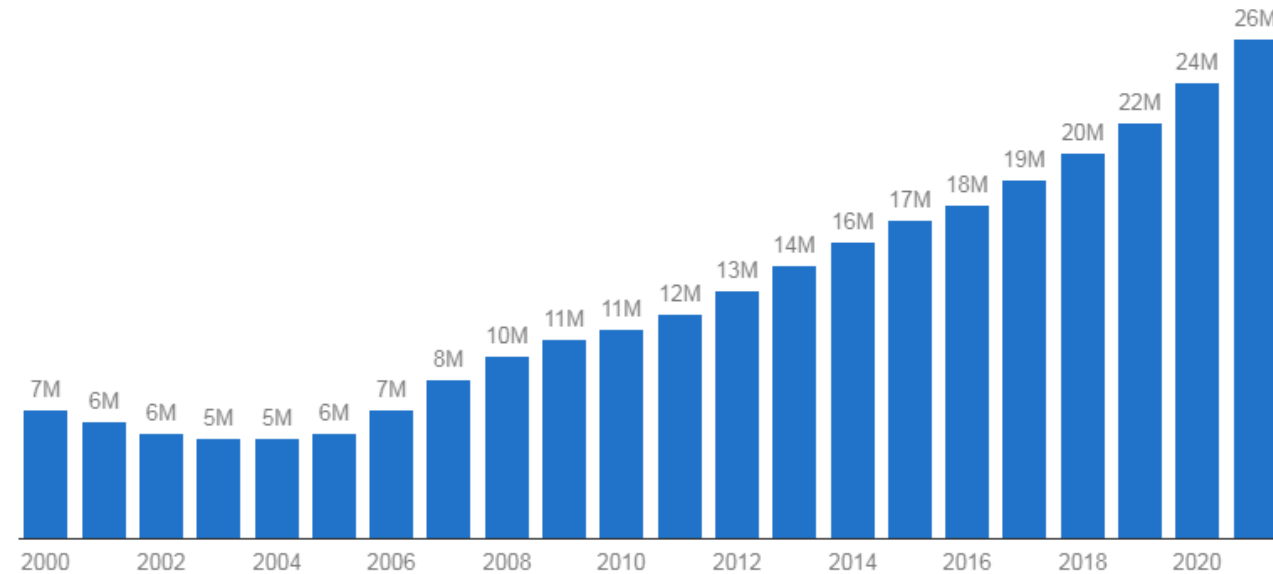
Medicare Advantage

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](#)

KFF

Data Source: [Kaiser Family Foundation \(KFF\) Medicare Advantage Update](#)

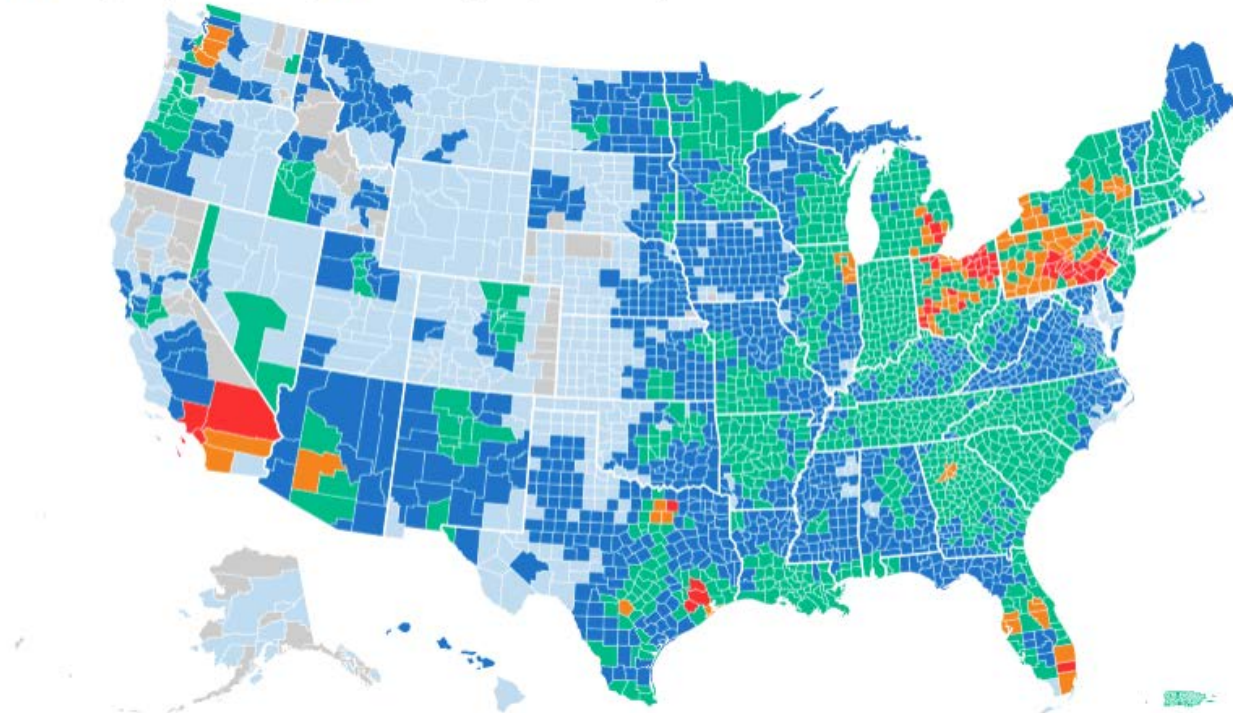
Medicare Advantage

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



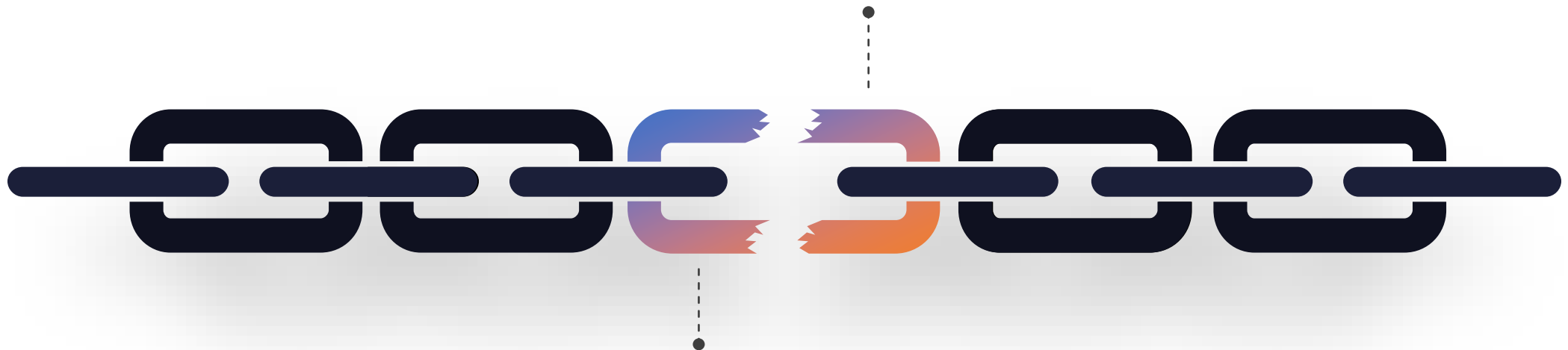
Information And Expectations

Rapid Pace . Data . Prioritize

THE LINK



Quality Measurement and Outcomes



Organization Data

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

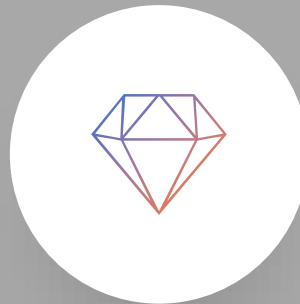


D a t a i n t o A c t i o n

Where to Start



Data
Internal and
External



Quality
Measurement



Action and
Opportunities

Organization Performance

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



Medicare.gov

Login About Glossary Español

Compare Website

compare nursing homes,
hospitals & other providers near you.

[Learn more about the types of providers listed here](#)

New – Care Compare

All provider types

Updates

MY LOCATION: Milwaukee, WI 532

PROVIDER TYPE: Select one

KEYWORDS (optional)

Search

Data.CMS.gov

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

Measure Description	CMS ID	Data	Num	Denom	Observed Percent	Adjusted Percent	State Average	National Average	National Percentile
Hi-risk/Unstageable Pres Ulcer (L)	N015.03	C	12	170	0.0%	0.0%	0.0%	0.0%	100 *
Phys restraints (L)	N027.02	C	6	351	0.0%	0.0%	0.0%	0.0%	100 *
Falls (L)	N032.02	C	20	306	0.0%	0.0%	0.0%	0.0%	100 *
Falls w/Maj Injury (L)	N013.02	C	3	354	0.0%	0.0%	0.0%	0.0%	100 *
Antipsych Med (S)	N011.02	C	21	23	91.3%	90.7%	90.7%	90.7%	99 *
Antipsych Med (L)	N031.03	C	301	352	99.7%	99.7%	99.7%	99.7%	100 *
Anxiety/Hypnotic Prev (L)	N033.02	C	30	351	99.7%	99.7%	99.7%	99.7%	100 *
Anxiety/Hypnotic % (L)	N036.02	C	34	348	99.7%	99.7%	99.7%	99.7%	100 *
Behav Sx affd Others (L)	N034.02	C	0	140	0.0%	0.0%	0.0%	0.0%	100 *
Depress Sx (L)	N030.02	C	353	353	100.0%	100.0%	100.0%	100.0%	100 *
UTI (L)	N024.02	C	1	141	0.0%	0.0%	0.0%	0.0%	100 *
Cath Insert/Left Bladder (L)	N026.03	C	7	178	0.0%	0.0%	0.0%	0.0%	100 *

Public data

Understanding the Impact

Compare Care Medicare

Medicare.gov [Login](#) [About](#) [Glossary](#) [Español](#)

Find & compare nursing homes, hospitals & other providers near you

[Learn more about the types of providers listed here](#)

MY LOCATION: Milwaukee, WI 532...

PROVIDER TYPE: Select one

KEYWORDS (optional):

Or, select a provider type to learn more:

Or, select a provider type to learn more:



Doctors & clinicians



Hospitals



Nursing homes including
rehab services



Home health services



Hospice care



Inpatient rehabilitation
facilities



Long-term care hospitals

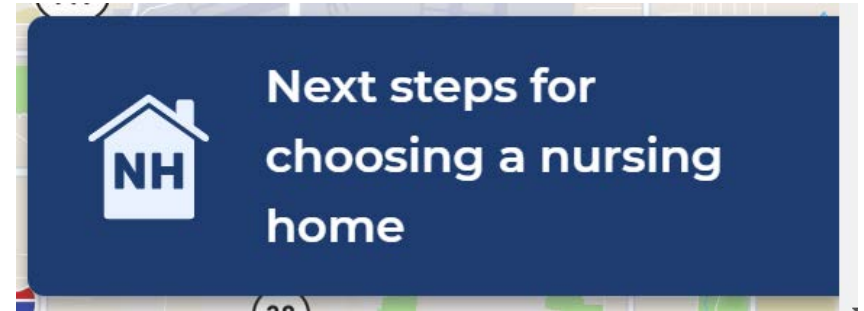
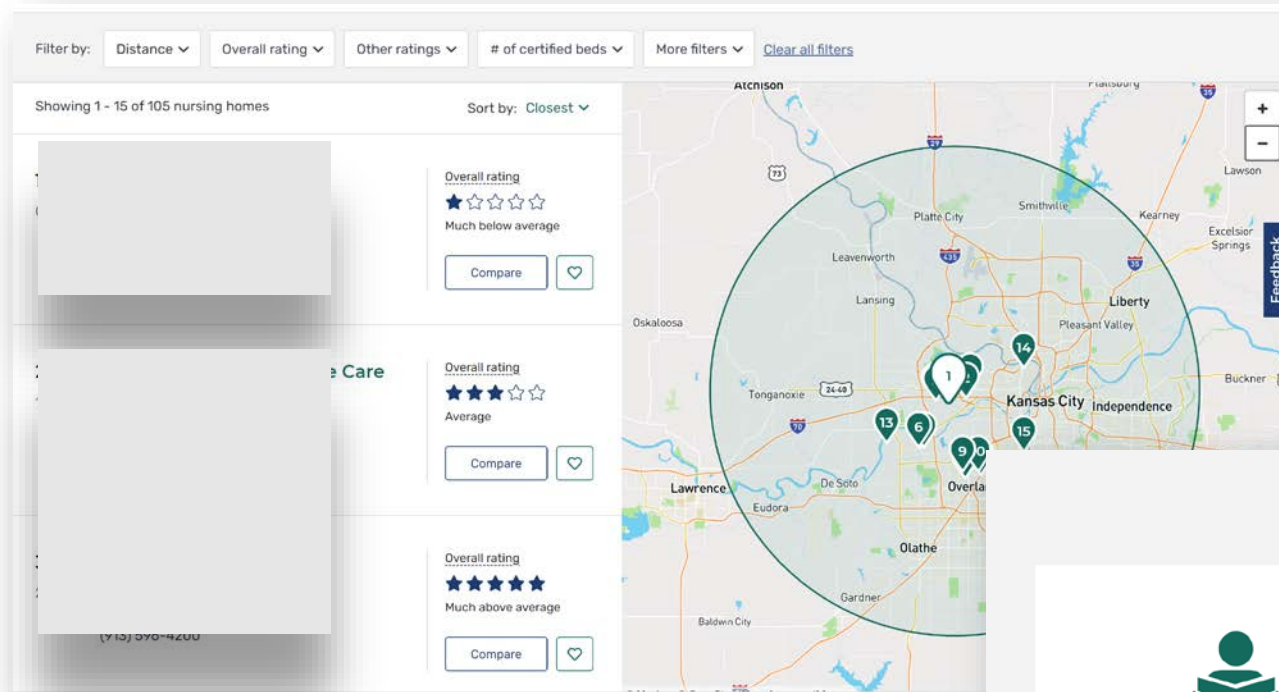


Dialysis facilities

Looking for medical supplies and equipment? [Visit the Supplier Directory.](#)

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

Compare Care Medicare



SFF Status and Ranking

Tips & Resources



About this tool

Learn more about this tool and what it can do for you.



Resources & information

Check out important things to consider when choosing a provider.



Info for health care providers

Find out how to keep your information up-to-date in our tools.

Looking to explore and download provider data? [Visit the data catalog on CMS.gov](#)

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

Compare Care Medicare

Nursing home

Jones Harrison Residence

Overall rating:
★★★★★

LOCATION
3700 Cedar Lake Avenue
Minneapolis, MN 55416

PHONE NUMBER
(612) 920-2030

Add to Favorites

Ratings Quality Details Location

RATINGS

Overall rating

★★★★★

Much above average

The overall rating is based on a nursing home's performance on 3 sources: health inspections, staffing, and quality of resident care measures.

[Learn how Medicare calculates this rating](#)

Health inspections

★★★★☆

Above average

[View Rating Details](#)

Staffing

★★★★★

Much above average

[View Rating Details](#)

Quality of resident care

★★★★★

Much above average

[View Rating Details](#)

QUALITY

Choose a category to see how this nursing home scores:

Fire safety >

Penalties >

Quality of resident care

[Learn more about quality of resident care](#)

[Find out why these short-stay measures are important](#)

[Find out why these long-stay measures are important](#)

[Get current data collection period](#)

Quality of resident care rating

★★★★★

Much above average

Medicare assigns the star rating based on data from a select set of clinical data measures. More stars means better quality of care.

Short-stay quality of resident care

★★★★☆

Above average

The short-stay quality of care rating reflects the quality of care delivered to temporary residents, and whose typical goal is to improve their health status so they can return to their previous setting, like their home.

Percentage of short-stay residents who were re-hospitalized after a nursing home admission ↓ Lower percentages are better	21.8%	National average: 20.8% Minnesota average: 20.1%
Percentage of short-stay residents who have had an outpatient emergency department visit ↓ Lower percentages are better	3.3%	National average: 10.3% Minnesota average: 10.5%
Percentage of short-stay residents who got antipsychotic medication for the first time ↓ Lower percentages are better	5.2%	National average: 1.8% Minnesota average: 1.6%
Percentage of residents with pressure ulcers/pressure injuries that are new or worsened ↓ Lower percentages are better	5%	National average: 2.5%
Percentage of short-stay residents who improved in their ability to move around on their own ↑ Higher percentages are better	69%	National average: 68% Minnesota average: 74.2%

Flu & pneumonia prevention measures - Short-stay residents

Percentage of short-stay residents who needed and got a flu shot	90.7%
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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



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/IDIR)
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 (IDIR). Currently, citations under IDR/IDIR 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

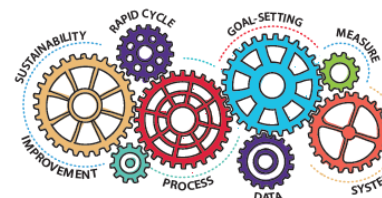
Effective with the October 2022 refresh, CMS is implementing the planned, regular increases to the Quality Measure (QM) rating thresholds, increasing each rating threshold by one-half of the average improvement in QM scores since the last time the thresholds were set. For the October 2022 refresh, the 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

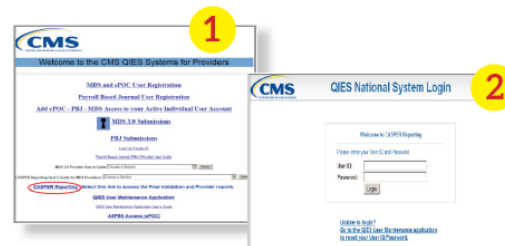
Effective with the July 2022 refresh, CMS revised the methodology for calculating the Staffing star rating. The new rating is based on six separate staffing measures. Similar to the Quality Measure (QM) rating, points are assigned based on the performance on each of these six measures. The points are 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:

Preview Report



How to Access the Nursing Home Five-Star Rating Preview Report

Nursing Home Compare Five-Star Ratings of Nursing Homes Provider Rating Report



STEP 1 | QIES System for Providers

Access the Centers for Medicare & Medicaid Services (CMS) Quality Improvement and Evaluation System (QIES) for providers and click CASPER Reporting on the left.

STEP 2 | Login

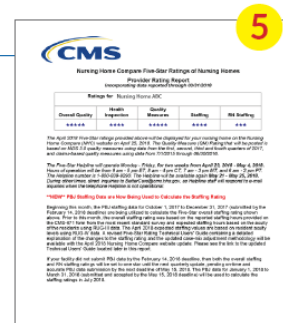
Use your User ID and Password to access the CASPER site.

STEP 3 | Folders

Click **Folders** at the top of your screen.

STEP 4 | Five-Star Report

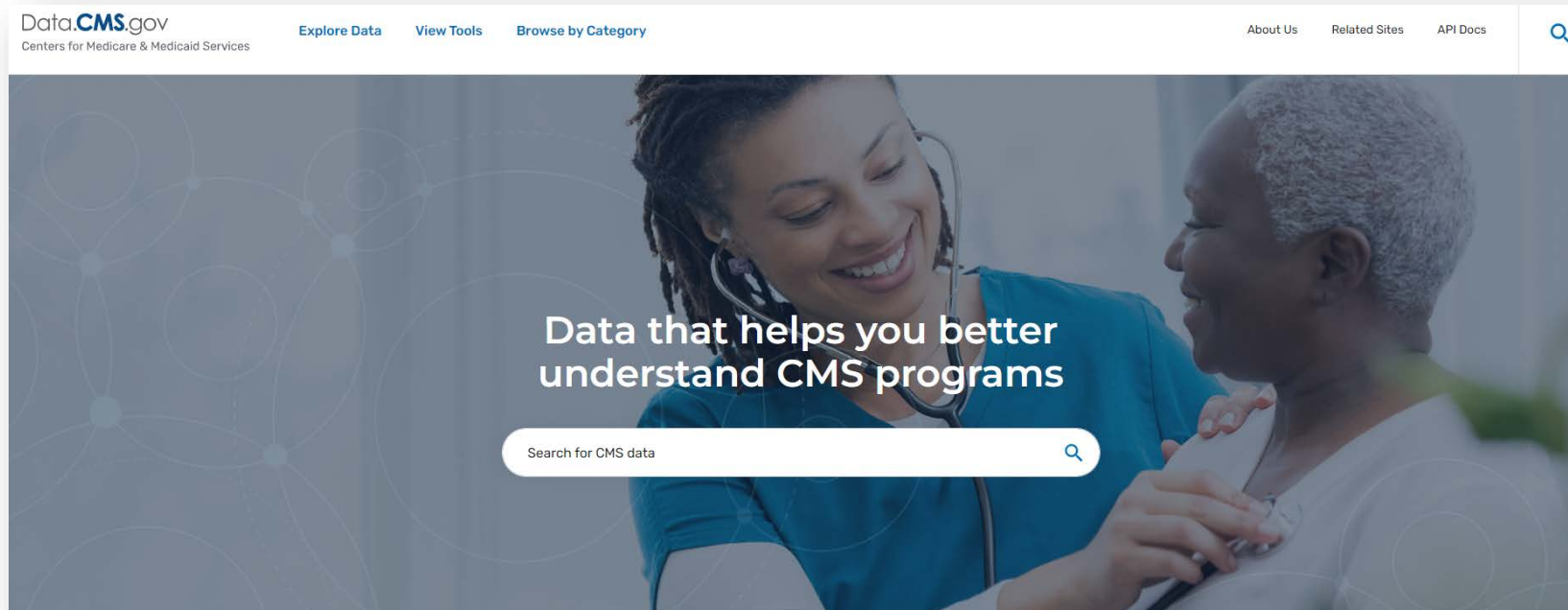
Click the first **Five-Star Report** PDF at the top of your screen.



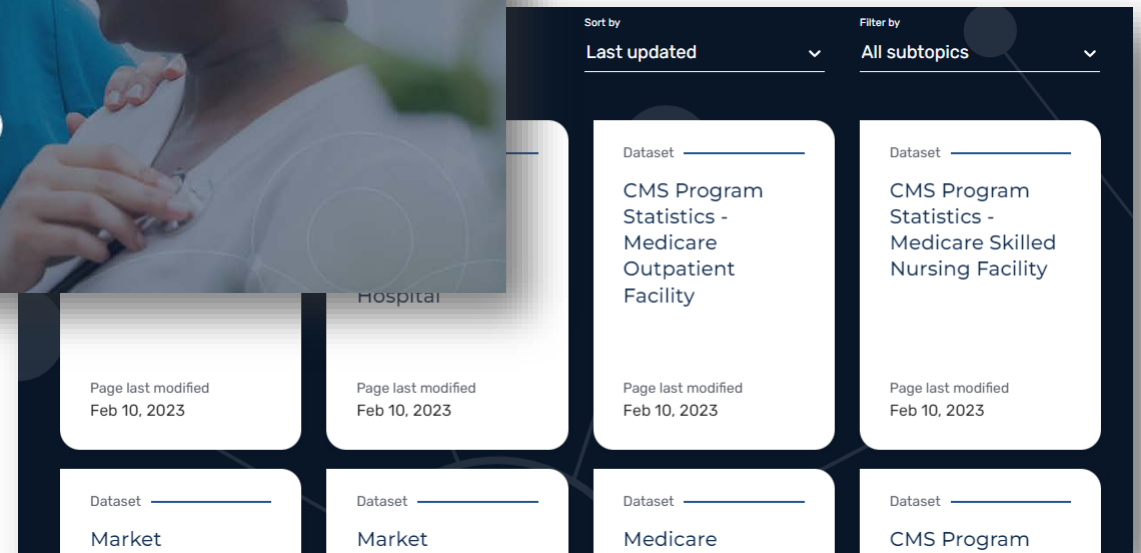
STEP 5 | View SNF Five-Star Report

Review the SNF (skilled nursing facility) Five-Star Report.

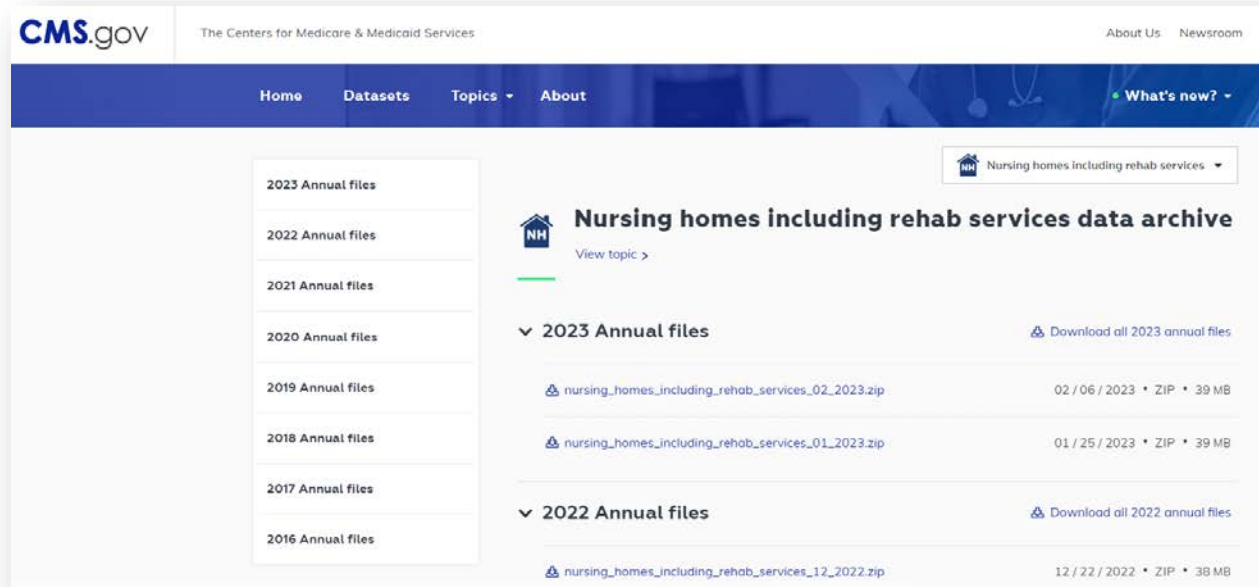
Public Data – Full Access!



<https://data.cms.gov/>

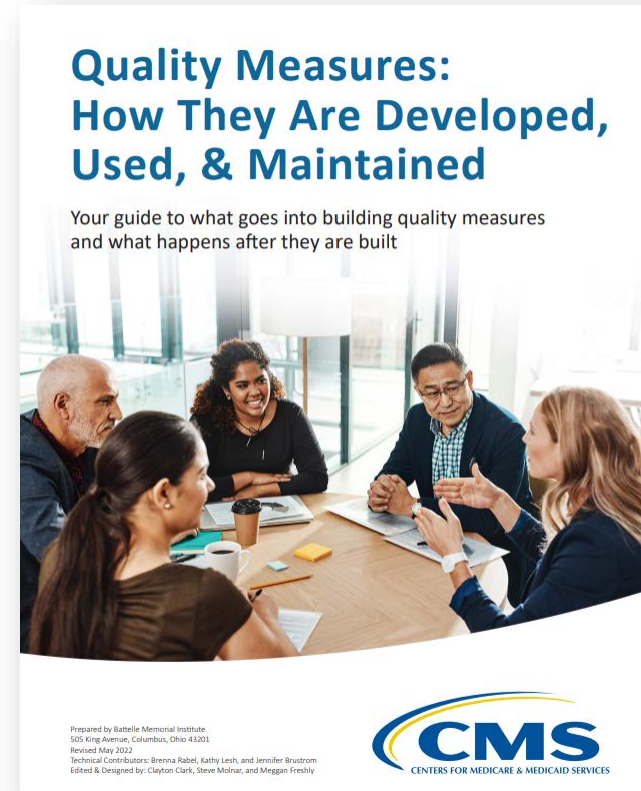


Public Data - There is More!!!!



The screenshot shows the CMS.gov website. The header includes the CMS.gov logo and navigation links: Home, Datasets, Topics, About, and What's new?. The main content area is titled 'Nursing homes including rehab services data archive'. It features a sidebar with a list of annual files from 2016 to 2023. The main content area shows the '2023 Annual files' section, which includes a download link for 'nursing_homes_including_rehab_services_02_2023.zip' (02 / 06 / 2023 • ZIP • 39 MB) and 'nursing_homes_including_rehab_services_01_2023.zip' (01 / 25 / 2023 • ZIP • 39 MB). Below this is the '2022 Annual files' section, which includes a download link for 'nursing_homes_including_rehab_services_12_2022.zip' (12 / 22 / 2022 • ZIP • 38 MB).

<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

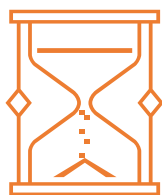
Prepared by Battelle Memorial Institute
505 King Avenue, Columbus, Ohio 43201
Revised May 2022
Technical Contributors: Brenna Rabel, Kathy Lech, and Jennifer Brostrom
Edited & Designed by: Clayton Clark, Steve Molnar, and Meggan Freshly

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

T o d a y a n d B e y o n d

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.



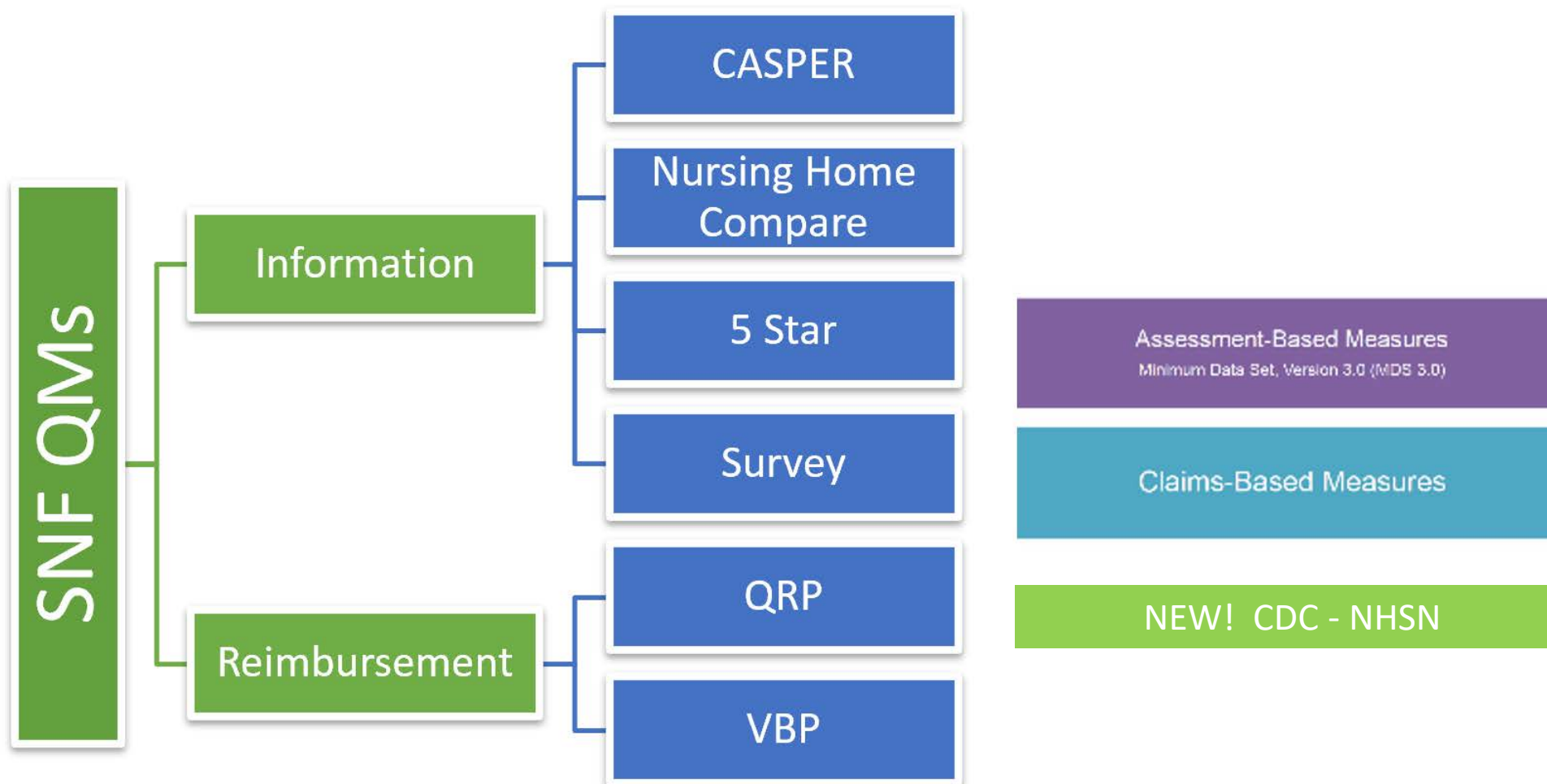
VBP and VBC

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

Quality Measures

CASPER, VBP, QRP and more!

UNDERSTAND QUALITY MEASURES



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

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

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 ↓	
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

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 themselves 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 ↓	↓ Enter Codes in Boxes ↓
<input type="text"/>	<input type="text"/>

[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.*

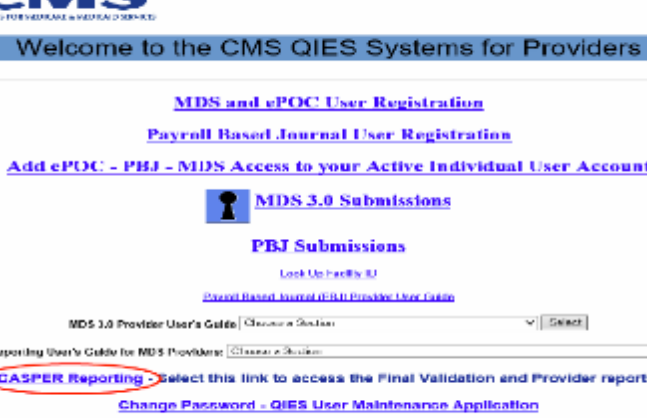
Current - Long Stay QUALITY MEASURES

- 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/NHQI/QualityMeasures>

Login




CMS
CENTRO FOR MEDICAL & HEALTH SERVICES

Welcome to the CMS QIES Systems for Providers

[MDS and ePOC User Registration](#)

[Payroll Based Journal User Registration](#)

[Add ePOC - PBJ - MDS Access to your Active Individual User Account](#)

 [MDS 3.0 Submissions](#)

[PBJ Submissions](#)

[Look Up Facility ID](#)

[Payroll Based Journal \(PBJ\) Provider User Guide](#)

MDS 3.0 Provider User's Guide

CASPER Reporting User's Guide for MDS Providers:

CASPER Reporting - Select this link to access the Final Validation and Provider reports.

[Change Password - QIES User Maintenance Application](#)

[QIES User Maintenance Application User's Guide](#)

[ASPEN Access \(ePOC\)](#)

The screenshot shows the login interface for the QIES National System. At the top left is the CMS logo. The main heading is "QIES National System Login". Below this, there's a section titled "WELCOME TO QIES NATIONAL SYSTEM LOGIN". It prompts the user to enter their User ID and Password. There are input fields for both, a "Login" button, and a "Forgot your password?" link. On the right side, there's a sidebar menu with options like "Home Page", "Change PDF Format", "Download Report", etc.

[illegible]

MDS 3.0 NH Assessment Print

Enter Criteria To Search For A Report:
(Hint: Leave blank to list all reports)

- Activity
- Admission and Reentry
- Assessments with Error Number XXXX
- Discharges
- Error Detail by Facility
- Error Number Summary by Facility by Vendor
- Errors by Field by Facility
- OBRA Missing Assessment
- NH Assessment Print

Pages **[1]** [2]

CASPER MDS 3.0 Facility Characteristics Report

- Facility Assessment Annual Update
- Survey Entrance Conference

Skip navigation links

CASPER Reports Submit Logout Folders MyLibrary Reports Queue Options Maint Home

Report: MDS 3.0 Facility Characteristics Report

Begin Date(mm/dd/yyyy): 08/01/2019
End Date(mm/dd/yyyy): 01/31/2020
Comparison Group: 05/01/2020-10/31/2020
Data Calculation Date: 02/15/2020

Template Folder: My Favorite Reports
Template Name: MDS 3.0 Facility Characteristics Report

Submit Back
Save & Submit Save

Figure 11-3. MDS 3.0 Facility Characteristics Report

CMS
CENTER FOR MEDICARE & MEDICAID SERVICES

CASPER Report
MDS 3.0 Facility Characteristics Report

Page 1 of 1

Facility ID: [REDACTED]
CCN: [REDACTED]
Facility Name: [REDACTED]
City/State: [REDACTED]

Report Period: 01/01/2020 - 06/30/2020
Comparison Group: 01/01/2020 - 06/30/2020
Report Run Date: 06/01/2020
Data Calculation Date: 10/02/2020
Report Version Number: 1.01

	Facility		Comparison Group		
	Num	Denom	Observed Percent	State Average	National Average
Gender					
Male	898	1,796	50.0%	50.0%	71.5%
Female	898	1,796	50.0%	50.0%	28.5%
Age					
<25 years old	5	1,796	0.3%	0.3%	2.2%
25-54 years old	12	1,796	0.7%	0.7%	0.2%
55-64 years old	57	1,796	3.2%	3.2%	13.5%
65-74 years old	1,558	1,796	86.7%	86.7%	56.8%
75-84 years old	147	1,796	8.2%	8.2%	27.0%
85+ years old	17	1,796	0.9%	0.9%	0.2%
Diagnostic Characteristics					
Psychiatric diagnosis	6	1,785	0.3%	0.3%	3.0%
Intellectual or Developmental Disability	371	371	100.0%	100.0%	75.0%
Hospice	3	1,788	0.2%	0.2%	0.0%
Prognosis					
Life expectancy of less than 6 months	3	1,788	0.2%	0.2%	0.0%
Discharge Plan					
Not already occurring	0	1,796	0.0%	0.0%	25.0%
Already occurring	1,796	1,796	100.0%	100.0%	75.0%
Referral					
Not needed	0	1,796	0.0%	0.0%	25.0%
Is or may be needed but not yet made	0	1,796	0.0%	0.0%	0.0%
Has been made	1,796	1,796	100.0%	100.0%	75.0%
Type of Entry					
Admission	1,795	1,796	99.9%	99.9%	100.0%
Reentry	1	1,796	0.1%	0.1%	0.0%
Entered Facility From					
Community	1,796	1,796	100.0%	100.0%	89.7%
Another nursing home	0	1,796	0.0%	0.0%	1.5%
Acute Hospital	0	1,796	0.0%	0.0%	0.0%
Psychiatric Hospital	0	1,796	0.0%	0.0%	0.0%
Inpatient Rehabilitation Facility	0	1,796	0.0%	0.0%	0.0%
ID/DD facility	0	1,796	0.0%	0.0%	0.0%

CASPER MDS 3.0 Facility Level Quality Measure Report

- Review Monthly with Your Team
- QAPI



CASPER Report MDS 3.0 Facility Level Quality Measure Report

Page 1 of 1

Facility ID: [REDACTED]
CCN: [REDACTED]
Facility Name: [REDACTED]
City/State: [REDACTED]

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

Figure 11-7. MDS 3.0 Resident Level Quality Measure Report*



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CASPER Report
MDS 3.0 Resident Level Quality Measure Report


Page 4 of 2785

Facility ID: [REDACTED]
Facility Name: [REDACTED]
CCN: [REDACTED]
City/State: [REDACTED]

Report Period: 01/01/2020 - 06/30/2020
Report Run Date: 10/01/2020
Data Calculation Date: 10/02/2020
Report Version Number: 3.02

Note: S = short stay, L = long stay, X = triggered, b = not triggered or excluded,
C = complete; data available for all days selected, I = incomplete; data not available for all days selected

Resident Name	Resident ID	Admission Date	Discharge Date	Pressure Ulcer (L)	Phys restraints (L)	Falls (L)	Falls w/ Maj Injury (L)	Antipsych Med (S)	Antipsych Med (L)	Antianxiety/Hypnotic Prev (L)	Antianxiety/Hypnotic (L)	Behav Sx Affect Others (L)	Depress Sx (L)	UTI (L)	Cath Insert/Left Bladder (L)	Lo-Risk Lose B/B Con (L)	Excess Wt Loss (L)	Incr ADL Help (L)	Move Indep Worsens (L)	Improvement in Function (S)	Quality Measure Count
Data				C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	0
Active Residents																					
[REDACTED]	48733332	05/99/99		b	b	b	b	b	X	X	X	b	X	b	X	b	X	b	b	b	6
[REDACTED]	48733505	03/99/99		b																	
[REDACTED]	48733333	05/99/99		b																	
[REDACTED]	48733506	03/99/99		b																	
[REDACTED]	48733511	04/01/99		b																	
[REDACTED]	48733512	04/01/99		b																	
[REDACTED]	48733517	04/99/99		b																	
[REDACTED]	48733518	04/99/99		b																	
[REDACTED]	48733523	05/01/99		b																	
[REDACTED]	48733524	05/01/99		b																	
[REDACTED]	48733529	05/99/99		b																	
[REDACTED]	48733530	05/99/99		b																	
[REDACTED]	48733535	02/01/99		b																	
[REDACTED]	48733536	02/01/99		b																	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

CASPER Report
MDS 3.0 Resident Level Quality Measure Report


Facility ID: [REDACTED]
Facility Name: [REDACTED]
CCN: [REDACTED]
City/State: [REDACTED]

Note: S = short stay, L = long stay, X = triggered, b = not triggered or excluded,
C = complete; data available for all days selected, I = incomplete; data not available for all days selected

Resident Name	Resident ID	Admission Date	Discharge Date	Pressure Ulcer/Injury
[REDACTED]	48203481	01/05/2021	01/12/2021	b

This report may contain privacy protected information.
Any alteration to this report is prohibited.

* Fictitious, sample data are depicted.



CENTERS FOR MEDICARE & MEDICAID SERVICES

CASPER Report
MDS 3.0 Resident Level Quality Measure Report

Page 453 of 498

Facility ID: [REDACTED]
Facility Name: [REDACTED]
CCN: [REDACTED]
City/State: [REDACTED]

Report Period: 04/01/2021 - 09/30/2021
Report Run Date: 10/07/2021
Data Calculation Date: 10/04/2021
Report Version Number: 3.03


Note: S = short stay, L = long stay, X = triggered, b = not triggered or excluded,
C = complete; data available for all days selected, I = incomplete; data not available for all days selected

Resident Name	Resident ID	Admission Date	Discharge Date	Pressure Ulcer/Injury ¹
[REDACTED]	48203481	01/05/2021	01/12/2021	b
[REDACTED]	48204570	08/12/2021	08/19/2021	b
[REDACTED]	48204852	11/23/2020	11/30/2020	b
[REDACTED]	48205443	08/25/2021	09/01/2021	b
[REDACTED]	48966432	01/05/2021	01/12/2021	b
[REDACTED]	48967513	11/23/2020	11/30/2020	b
[REDACTED]	48207689	04/23/2021	04/30/2021	b
[REDACTED]	48209303	01/08/2021	01/15/2021	b
[REDACTED]	48207789	08/11/2021	08/18/2021	X
[REDACTED]	48965807	01/08/2021	01/15/2021	b
[REDACTED]	48203482	01/06/2021	01/13/2021	b
[REDACTED]	48204571	08/13/2021	08/20/2021	b
[REDACTED]	48204853	11/24/2020	12/01/2020	b
[REDACTED]	48205444	08/26/2021	09/02/2021	b

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

Monthly Comparison Report

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



CENTERS FOR MEDICARE & MEDICAID SERVICES

CASPER Report

MDS 3.0 Quality Measure Monthly Comparison Report

Page 1 of 1

Facility ID: [REDACTED]
 CCN: [REDACTED]
 Facility Name: [REDACTED]
 City/State: [REDACTED]

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

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: N/A represents a value that could not be computed

Long Stay Measure (Sample size = 53)
 Short Stay Measure (Sample size = 1348)

CMS ID	Data	Measure Description	Facility Percent	State Percent	National Percent
N015.03	C	Hi-risk/Unstageable Pres Ulcer (L)	6.8%	6.8%	6.8%
N027.02	C	Phys restraints (L)	1.7%	1.7%	1.7%
N032.02	C	Falls (L)	5.6%	5.6%	5.6%
N013.02	C	Falls w/Maj Injury (L)	3.7%	3.7%	3.7%
N011.02	C	Antipsych Med (S)	>=90%	91.3%	91.3%
N031.03	C	Antipsych Med (L)	>=90%	99.7%	99.7%
N033.02	C	Antianxiety/Hypnotic Prev (L)	>=90%	99.7%	99.7%
N036.02	C	Antianxiety/Hypnotic % (L)	>=90%	99.7%	99.7%
N034.02	C	Behav Sx affect Others (L)	0.0%	0.0%	0.0%
N030.02	C	Depress Sx (L)	>=90%	100.0%	100.0%
N024.02	C	UTI (L)	0.6%	0.6%	0.6%
N026.03	C	Cath Insert/Left Bladder (L)	14.0%	14.0%	14.0%
N025.02	C	Lo-Risk Lose B/B Con (L)	0.0%	0.0%	0.0%
N029.02	C	Excess Wt Loss (L)	>=90%	98.8%	98.8%
N028.02	C	Incr ADL Help (L)	17.2%	17.2%	17.2%
N035.03	C	Move Indep Worsens (L)	40.1%	40.1%	40.1%
N037.03	C	Improvement in Function (S)	>=90%	100.0%	100.0%
S038.02	C	Pressure Ulcer/Injury ¹	1.8%	N/A	0.6%

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 QM Report Package

CASPER = Certification and Survey Provider Enhanced Reporting

Requested on-demand

Default timeline or 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 QRP Quick Reference Guide

Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Quick Reference Guide

The IMPACT Act of 2014 mandated the establishment of the SNF QRP. As finalized in the Fiscal Year (FY) 2016 SNF PPS final rule, beginning with FY 2018 and each subsequent FY, the Secretary shall reduce the market basket update (also known as the Annual Payment Update, or APU) by 2 percentage points for any SNF that does not comply with the quality data submission requirements with respect to that FY.

SNFs utilize the Minimum Data Set (MDS) 3.0 via the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system to collect patient assessment data. The implementation of the SNF QRP will not change requirements related to the submission of MDS 3.0 data through the Assessment Submission and Processing (ASAP) system to the Quality Improvement Evaluation System (QIES).

If the required quality data is not reported by each designated submission deadline, the SNF will be subject to a two (2)-percentage point reduction in their annual payment update (APU).

Frequently Asked Questions

Q: Where can I find more information about the SNF QRP requirements?
Providers should visit the SNF QRP webpages for more information on SNF QRP measures and requirements. This webpage will be frequently updated with announcements and resources including:

- [SNF QRP training materials](#)
- [Measures and technical information](#)
- [Program FAQs](#)

Q: How do I verify my MDS submission?
The best method to verify that your current MDS data submission has been accepted into QIES is by running final validation reports. Detailed guidance on how to run and interpret MDS reports can be found in the [CASPER Reporting User's Guide](#). Select "Section 7 – Final Validation Report" to open the PDFs. An additional resource is the MDS 3.0 Provider User's Guide, available on the same page. Refer to Section 4 for information on submission reports.


As you review your error messages, be sure to correct any instances where the value submitted for the quality measure item is a dash (-). Entering a dash as a response to a quality item may result in your facility not meeting the required threshold for that quality item.

Q: How are MDS QRP thresholds calculated?
The MDS threshold is calculated by taking the total number of assessments with 100% of the required MDS data elements (numerator) divided by the


Numerator		Assessments with 100% of the required MDS data elements
=		
Denominator		Assessments submitted successfully before the submission deadlines*

www.cms.gov/files/document/pac-snf-fy2022-quickreferenceguide-v12.pdf

Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Frequently Asked Questions (FAQs)



Current as of
10/01/2022



<https://www.cms.gov/files/document/fy2023-snf-grp-faqs.pdf>

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.

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

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

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.



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 qies@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](#).

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/CertificationandCompliance/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**

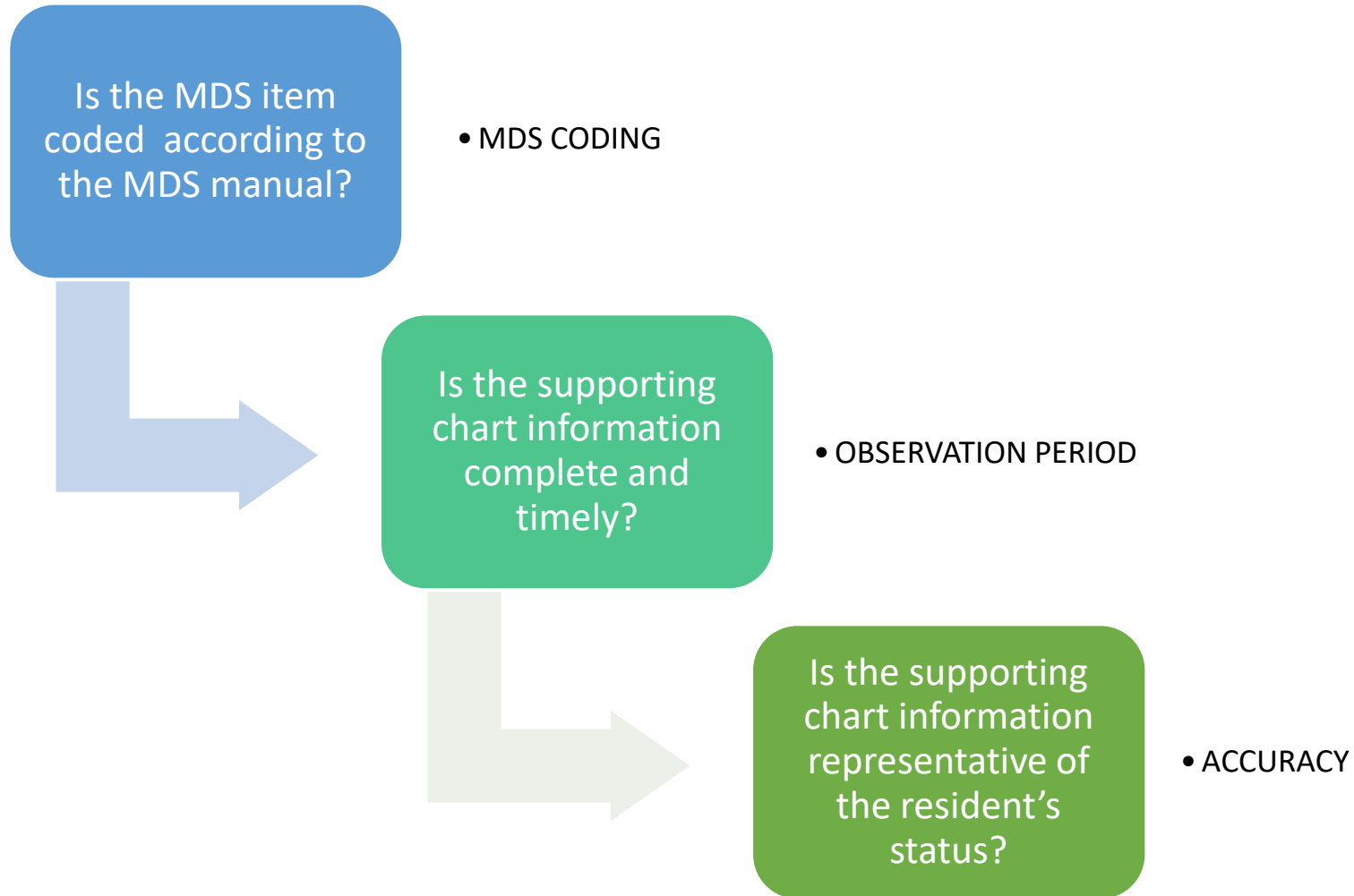
- Identify the co-variates that risk-adjust the QM



Know **Exclusions**

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

Inspect the Supporting Data

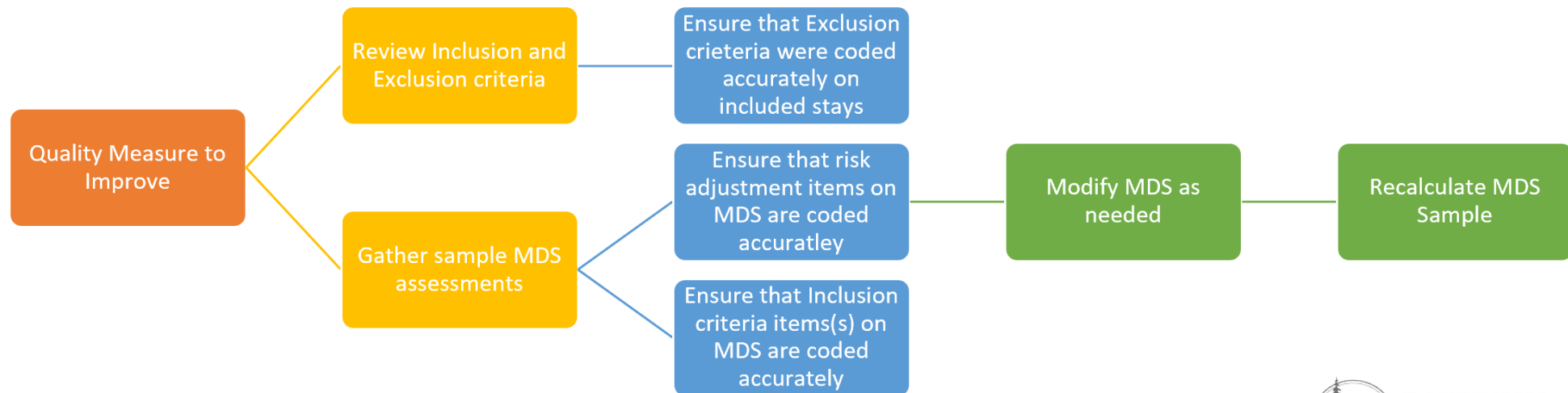


Remember...

ASSESSMENT

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

Validate the MDS assessments included in the
Quality Measure





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



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

Leadership Data Strategy

MDS
Process

Medicare
& UB-04
Process

Data
Knowledge

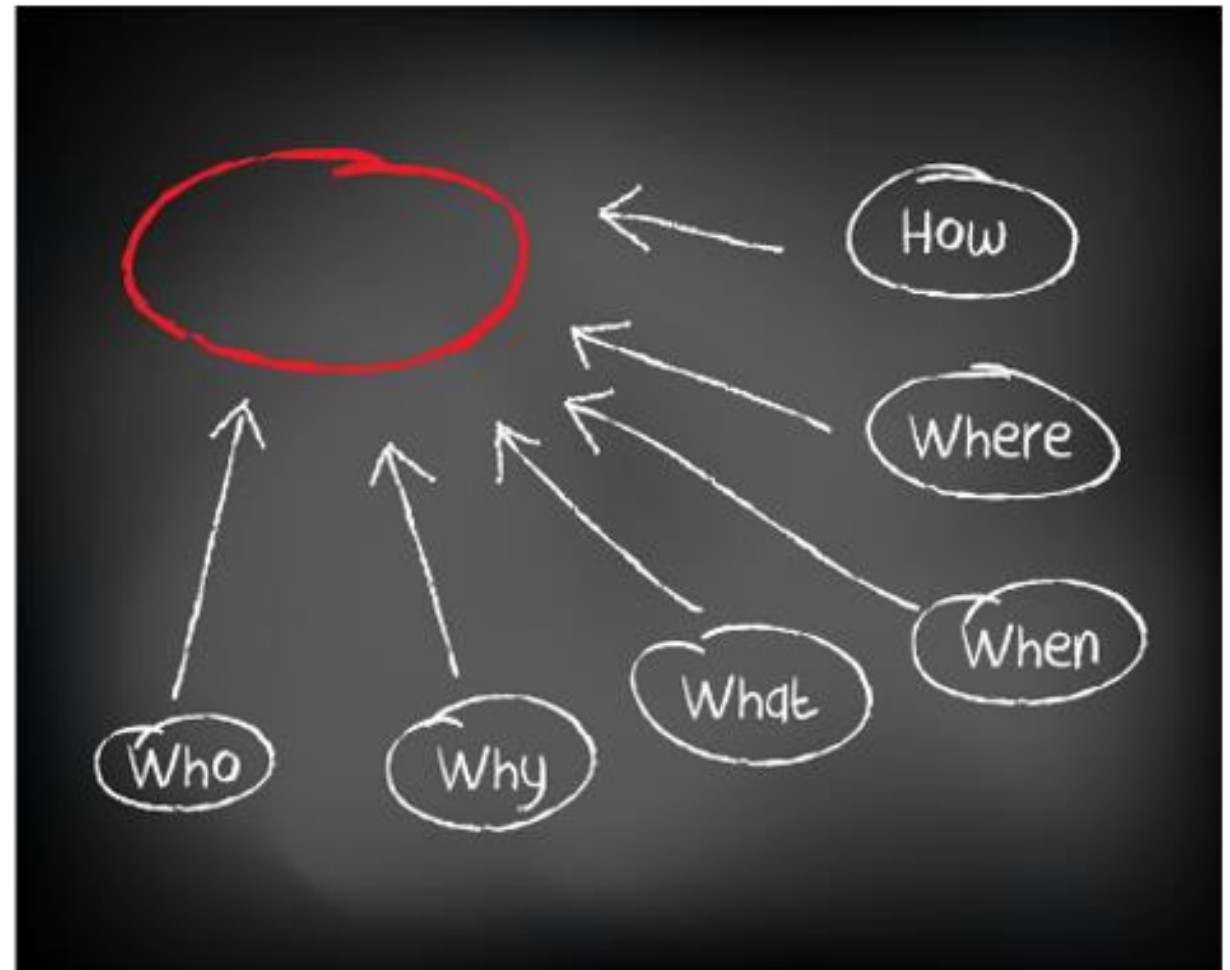
Other Data
Sources

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

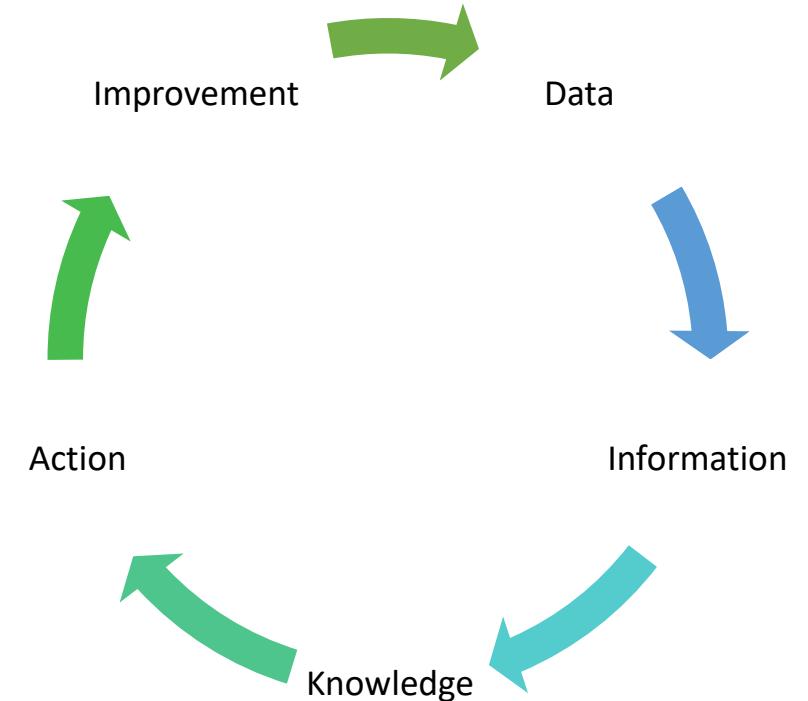



- Team approach
- Standardize the process
- Cross sectional team
- Compare to FA
- Identify improvement
- Compliance
- Communicate
- Educate/Training Program
- Communicate
- QAPI/Compliance



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





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

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



MOMENTUM

2023 ANNUAL MEETING & EXPO

MARCH 7-8, 2023

Renaissance Schaumburg
Convention Center - Schaumburg, IL

Let's Get Back to Quality and Data Outcomes

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