



LTC  2021

VIRTUAL SYMPOSIUM

THE WAY FORWARD

SEP 13-15, 2021

Future of Value-Based Purchasing

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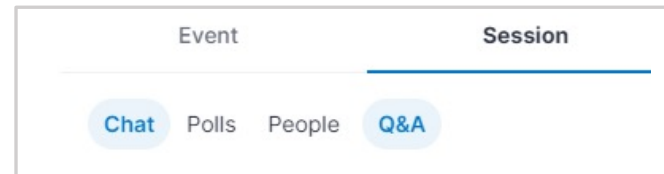
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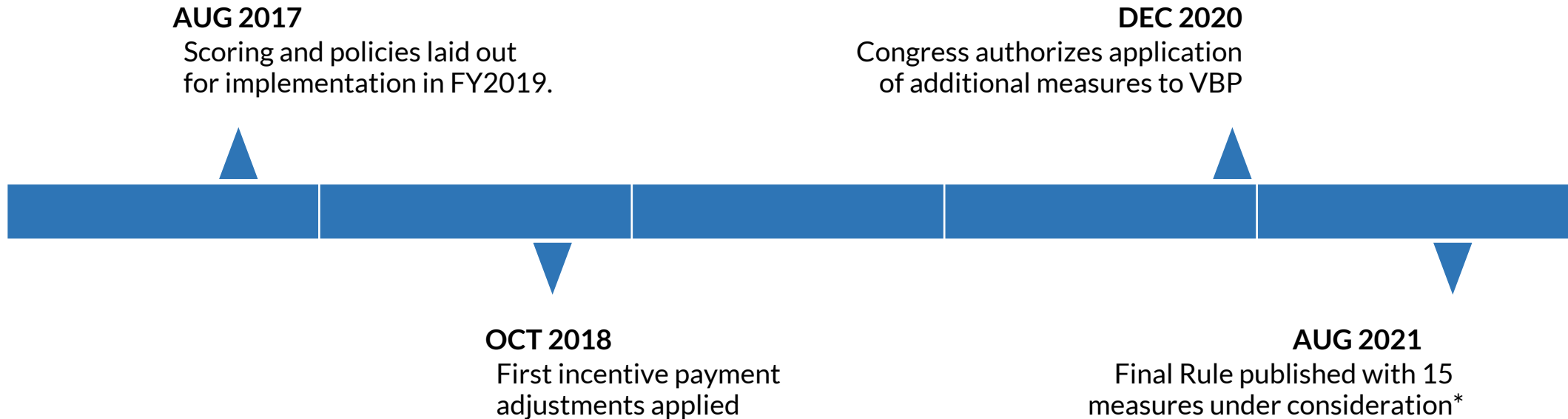
Session Agenda

- Current State of Value-Based Purchasing
- Future of Value-Based Purchasing
 - Proposed Measures
- Strategies to prepare for what is next



CURRENT STATE OF VBP

Legislative History

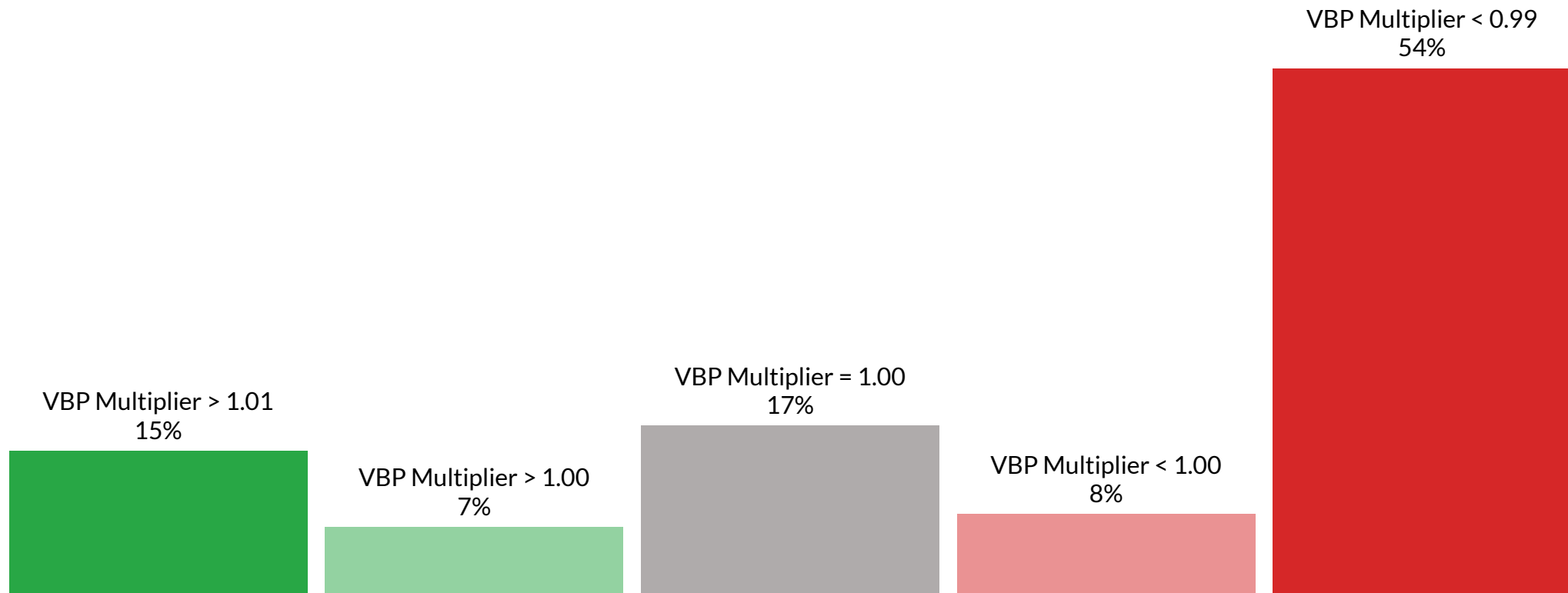


**For services furnished on or after October 1, 2023.*

How It Works

- CMS withholds 2% of SNFs' Medicare fee-for-service Part A payments.
- 60% of this withhold is then paid back to SNFs as incentive payments.
- Incentive Payment is determined based on provider performance on SNF 30-Day All-Cause Readmission Measure
 - This is a measure of unplanned readmissions to a hospital for SNF residents.
 - This performance is calculated using SNF and Hospital part A claims.

Who gets paid?





FUTURE OF VBP

Proposed Measures

TABLE 30: Quality Measures Under Consideration for an Expanded Skilled Nursing Facility Value-Based Purchasing Program

Meaningful Measure Area	NQF	Quality Measure
Minimum Data Set		
Functional Outcomes	A2635	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients*
Functional Outcomes	A2636	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients*
Preventable Healthcare Harm	0674	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)**
Preventable Healthcare Harm	0679	Percent of High Risk Residents with Pressure Ulcers (Long Stay)**
Functional Outcomes	N/A	Percent of Residents Whose Ability to Move Independently Worsened (Long Stay)**
Functional Outcomes	N/A	Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long Stay)**
Transfer of Health Information and Interoperability	N/A	Transfer of Health Information to the Provider-Post Acute Care *
Medication Management	N/A	Percentage of Long-Stay Residents who got an Antipsychotic Medication**

* Measures adopted in the SNF Quality Reporting Program (QRP).

** These measures are reported on the Nursing Home Care Compare website (<https://www.medicare.gov/care-compare/>).

~ Measure discussed in section VII.C.1 of this final rule for adoption in the SNF QRP.

Medicare Fee-For-Service Claims Based Measures		
Community Engagement	3481	Discharge to Community Measure-Post Acute Care Skilled Nursing Facility Quality Reporting Program*
Patient-focused Episode of Care	N/A	Medicare Spending per Beneficiary (MSPB)-Post Acute Care Skilled Nursing Facility Quality Reporting Program*
Healthcare-Associated Infections	N/A	Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization Measure~
Admissions and Readmissions to Hospitals	N/A	Number of hospitalizations per 1,000 long-stay resident days (Long Stay)**
Patient-Reported Outcome-Based Performance Measure		
Functional Outcomes	N/A	Patient-Reported Outcomes Measurement Information System [PROMIS]-PROMIS Global Health, Physical
Survey Questionnaire (similar to Consumer Assessment of Healthcare Providers and Systems (CAHPS))		
Patient's Experience of Care	2614	CoreQ: Short Stay Discharge Measure
Payroll Based Journal		
N/A	N/A	Nurse staffing hours per resident day: Registered Nurse (RN) hours per resident per day; Total nurse staffing (including RN, licensed practical nurse (LPN), and nurse aide) hours per resident per day**

<https://www.federalregister.gov/documents/2021/08/04/2021-16309/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities#h-100>

More Measures

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Functional Outcomes

Long Stay Indicators

Successful Discharge

More *Data Sources*

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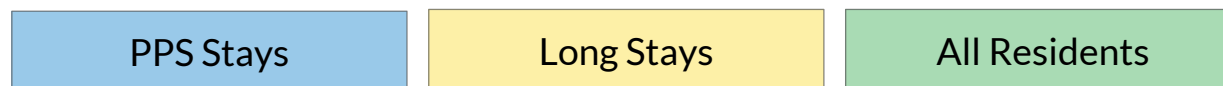


More Types of Stays

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STRATEGY #1

MASTER YOUR QUALITY MEASURES

Familiar Measures

- Five MDS Long-Stay measures currently reported in the Five-Star Ratings system.
 - N013 – 1+ Falls with Major Injury
 - N015 – High-Risk Pressure Ulcers
 - N028 – Help with ADLs Increased
 - N031 – Received Antipsychotic Medication
 - N035 – Locomotion Independently Worsened
- These five measures make up over half of our QM traffic.

	Page Title	% of Total QM Traffic
1.	Quality Measures - N015	13.53%
2.	Quality Measures - N035	13.44%
3.	Quality Measures - N028	11.19%
4.	Quality Measures - N031	8.70%
5.	Quality Measures - N013	7.61%
6.	Quality Measures - N024	7.11%
7.	Quality Measures - N011	5.62%
8.	Quality Measures - N037	5.22%
9.	Quality Measures - N026	4.72%
10.	Quality Measures - N025	2.49%



Take a team approach to quality assurance



Invest in training and technology



Develop a common language and rhythm

Best Practices



STRATEGY #2

SECURE SUCCESSFUL DISCHARGE

What is a successful discharge?

Functional Improvement

Discharge Self-Care Score

Discharge Mobility Score

Operational Efficiency

Transfer of Health Information

Medicare Spending per Beneficiary

Safe Transition

SNF 30-Day All-Cause Readmission

Hospitalizations per 1,000 long-stay resident days

Discharge to Community (QRP)

Healthcare-Associated Infections Requiring Hospitalization (QRP)

What is a successful discharge?

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Discharge to Community (QRP)

Healthcare-Associated Infections Requiring Hospitalization (QRP)

Functional Improvement

- These measures evaluate successful discharge by comparing a resident's *expected discharge score* to the resident's *observed discharge score*.

Expected Discharge Score is calculated using a set of 69 covariates across 17 categories as coded on the 5-Day assessment.

The 5-Day sets your baseline and expected scores.

Observed Discharge Score is calculated using the third column of responses in section GG as coded on the SNF PPS Discharge assessment.

Functional Improvement

- These measures evaluate successful discharge by comparing a resident's expected discharge score to the resident's observed discharge score.
 - Accurately capturing covariates on the 5-Day assessment is critical to managing performance for these measures.
 - Covariate categories include:
 - Age (A0900)
 - Admission Function Score (GG0130, GG0170)
 - Primary Medical Condition (I0020)
 - Prior Conditions
 - Prior Surgery (J2000)
 - Prior Functioning (GG0100)
 - Prior Device Use (GG0110)
 - Admission Conditions
 - Presence of Pressure Ulcers (M0300)
 - Cognitive Function (C0500)
 - Communication Impairment (B0700, B0800)
 - Continence (H0300, H0400)
 - Tube Feeding (K0510)
 - History of Falls (J1700)
 - 23 Categories of Comorbidities

Functional Improvement

Resident A		Resident B	
Admission Score	26	Admission Score	26
Baseline Score	59.0813	Baseline Score	59.0813
Age <i>81 years</i>	(0.6444)	Age <i>87 years</i>	(1.6103)
Primary Medical Condition <i>Non-Traumatic Brain Dysfunction</i>	(3.4806)	Primary Medical Condition <i>Medically Complex Conditions</i>	(3.1818)
Prior Conditions <i>(1) Some Help with Ambulation (2) Use of Wheelchair</i>	(8.9148)	Prior Conditions <i>NA</i>	(0.0000)
Status on Admission <i>(1) Severely Impaired Cognitive Function (2) Incontinence</i>	(6.4408)	Status on Admission <i>(1) Incontinence</i>	(4.6837)
Comorbidities <i>(1) Infectious Diseases (2) Cancer (3) Dementia (4) Mental Health Disorder</i>	(2.7192)	Comorbidities <i>(1) Infectious Diseases</i>	(0.2270)
Expected Discharge Score	36.8815	Expected Discharge Score	49.3785
<i>Expected Improvement</i>	<i>10.8815</i>	<i>Expected Improvement</i>	<i>23.3785</i>

What is a successful discharge?

Functional Improvement

Discharge Self-Care Score

Discharge Mobility Score

Operational Efficiency

Transfer of Health Information

Medicare Spending per Beneficiary

Safe Transition

SNF 30-Day All-Cause Readmission

Healthcare-Associated Infections Requiring Hospitalization (QRP)

Discharge to Community (QRP)

Hospitalizations per 1,000 long-stay resident days

Transfer of Health Information to the Provider

- New assessment-based measure included in the Quality Reporting Program.
- Effective “October 1st of the year that is at least one full FY after the end of the COVID-19 PHE.”
- QM Calculation Logic
 - **Numerator:** Stays where medication list was provided to subsequent provider at discharge
 - **Denominator:** Stays discharged to subsequent provider

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge At the time of discharge to another provider, did your facility provide the resident’s current reconciled medication list to the subsequent provider?	
Enter Code <input type="checkbox"/>	0. No – Current reconciled medication list not provided to the subsequent provider 1. Yes – Current reconciled medication list provided to the subsequent provider

[Measure Specifications](#)



Medicare Spending per Beneficiary

- Claims-based measure currently included in the Quality Reporting Program.
- Intended to evaluate a provider's resource use relative to the national median.
- QM Calculation Logic:
 - **Numerator:** Average risk-adjusted episode spending x National average episode spending
 - **Denominator:** Episode weighted national median

[Measure Specifications](#)

What is a successful discharge?

Functional Improvement

Discharge Self-Care Score

Discharge Mobility Score

Operational Efficiency

Transfer of Health Information

Medicare Spending per Beneficiary

Safe Transition

SNF 30-Day All-Cause Readmission

Healthcare-Associated Infections Requiring Hospitalization (QRP)

Discharge to Community (QRP)

Hospitalizations per 1,000 long-stay resident days

Healthcare-Associated Infections Requiring Hospitalization (QRP)

- Claims-based measure to be included in the Quality Reporting Program.

“SNF HAIs that are acquired during SNF care and result in hospitalization will be identified using the principal diagnosis on the Medicare hospital claims for SNF residents, during the time window beginning on day four after SNF admission and within day three after SNF discharge.”

Healthcare-Associated Infections Requiring Hospitalization (QRP)

- The HAI definition includes conditions that meet these criteria:
 - Infections that are likely to be acquired during SNF care and severe enough to require hospitalization.
 - Infections related to invasive (not implanted) medical devices such as catheters, insulin pumps, and central lines.
- See Appendix A of the Measure Specifications for a complete list of eligible HAI principal diagnoses.

[Measure Specifications](#)



Best Practices



STRATEGY #3
INVEST IN PEOPLE

Patient Reported Outcome Measures (PROMs)

- PROMIS Global Health, Physical survey questionnaire
 - Comprehensive questionnaire intended to be provided to all residents asking questions about the quality of care received and functional improvement over the course of their stay.
- CoreQ: Short Stay Discharge Measure
 1. In recommending this facility to your friends and family, how would you rate it overall?
 2. Overall, how would you rate the staff?
 3. How would you rate the care you received?
 4. How would you rate how well your discharge needs were met?

Payroll Based Journal

- Get the data right
- Know your data and what it means
- Know how CMS uses your data to tell the staffing story

Payroll Based Journal Proposed Measures

- RN and Nursing Hours per Resident Day
- Expect new Staff Turnover measures

“In addition to the staffing measures listed in Table 30 that focus on nurse staffing hours per resident day and that are currently reported on the Nursing Home Care Compare website, we indicated in the proposed rule that we are also interested in measures that focus on staff turnover.”

-FY 2022 SNF Final Rule



Develop a culture of quality care



Prioritize employees

Best Practices



Questions & Answers

PLEASE USE THE Q&A BUTTON TO
SUBMIT YOUR QUESTIONS



Thanks for attending!

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