VBP Success:

Navigating the Future of Value-Based Purchasing

NOV 9, 2021

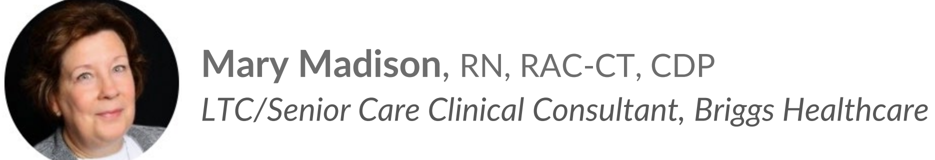
Upcoming webinar: Wed, Nov 17

What you'll learn:

- Infection Control and Emergency Preparedness tips
- Why data is king and always will be
- Taking care of your staff
- What to do when the waivers end
- How to prepare for upcoming regulatory change

Register at:

- simpleltc.com/training



Mary Madison, RN, RAC-CT, CDP
LTC/Senior Care Clinical Consultant, Briggs Healthcare

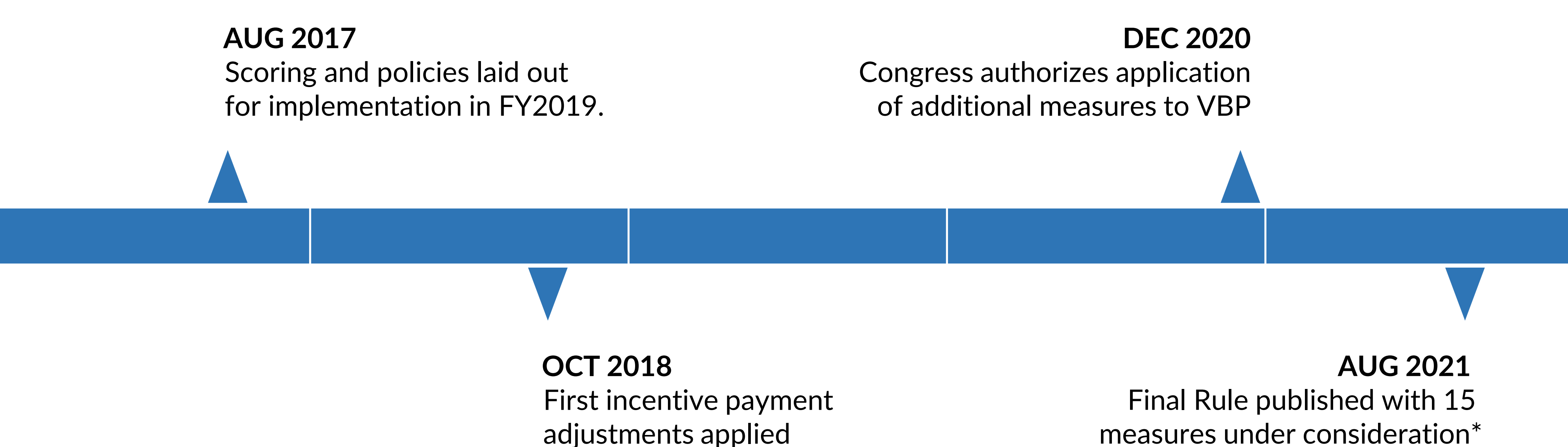
Live Poll

How familiar are you with the proposed changes to the Value-Based Purchasing program?

Current state of VBP

Where are we now?

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 It Works For

VBP Multiplier > 1.01
15%

VBP Multiplier > 1.00
7%

VBP Multiplier = 1.00
17%

VBP Multiplier < 1.00
8%

VBP Multiplier < 0.99
54%

Future of VBP

Where are we going?

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**
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**

** 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.

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 *Data Sources*

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MDS | FFS Claims | Patient Survey | PBJ

More *Measures*

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Functional Outcomes | Long Stay Indicators | Successful Discharge

More *Types of Stays*

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Medicare Stays

Long Stays

All Residents

Important Themes

Indicators of
Long Stay Quality of Care

Indicators of
Successful Discharge

Indicators of
Patient Satisfaction

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%

Example Company > Example Facility

	'19 Q1	Q2	Q3	Q4	'20 Q1	Q2	Q3	Q4	'21 Q1	Q2	Q3	Q4

5 Numerator Residents - 2021 Q4

Quarter: 2019 | 2020 | 2021 | Current CMS Quarter | 2021 Q3 Predicted | 2021 Q4 Predicted — Groups: All | Numerator | Denominator | Excluded — View: Quarterly | Four Quarters — Search — Columns

Name	Start Date	Latest Date	Quarter	Gender	Age	Group
Resident 2337259	2020-03-09	2021-10-17	2021-Q4	Male	73	Num Den

Target Assessment

Oct. 17th, 2021 — 204 — View

A0310A 02 — A0310F 99

Numerator Trigger

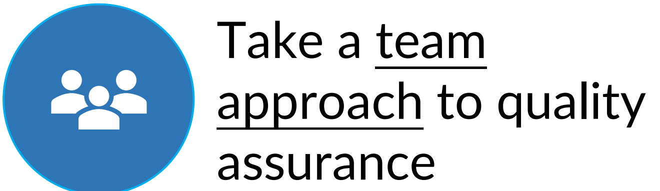
The resident's need for help score has increased by 2 points for the following late-loss ADL items: Eating (G0110H1).

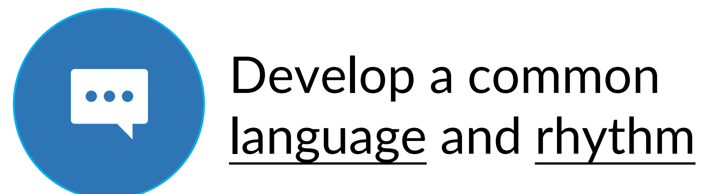
Jul. 17th, 2021 — ID: 74206115 — View

NC - Comprehensive

Admission PPS OBRA

A0310A	A0310B	A0310F
01	01	99





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)

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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

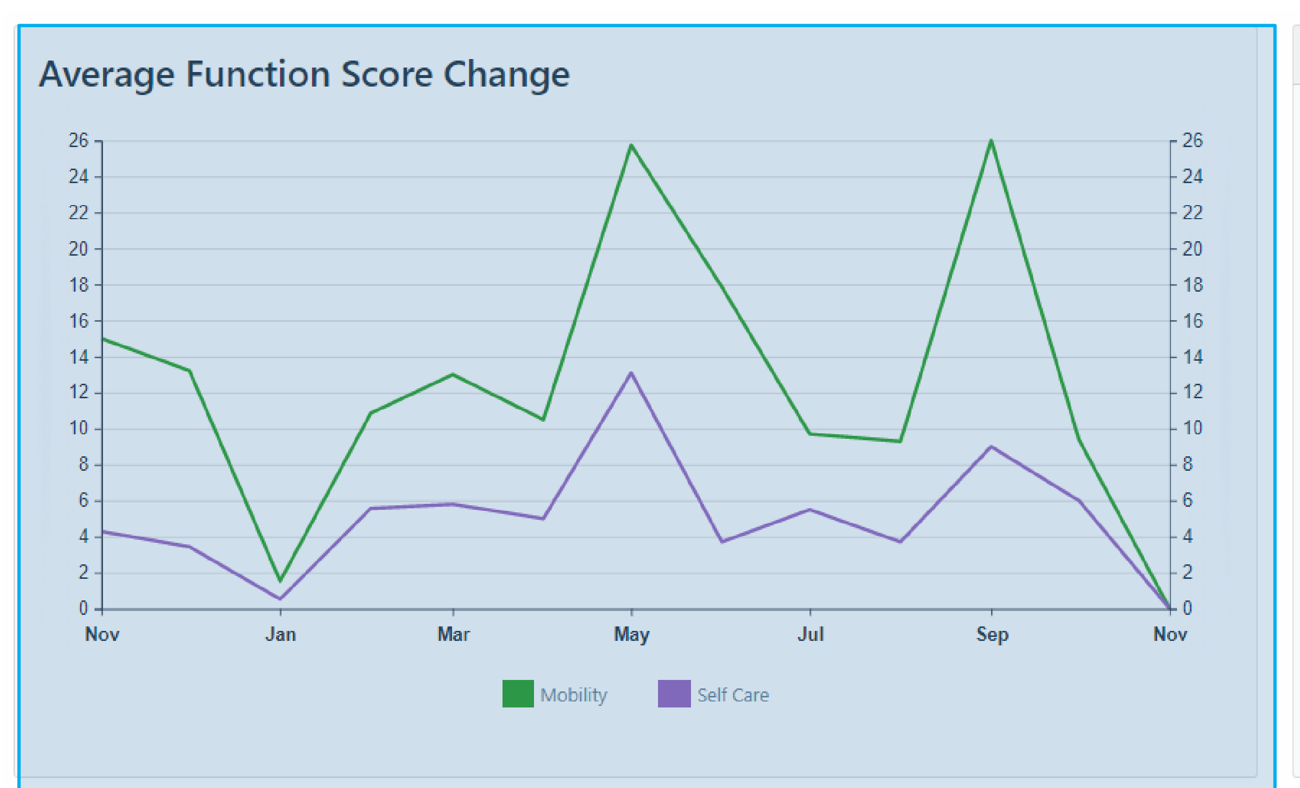
Functional Improvement

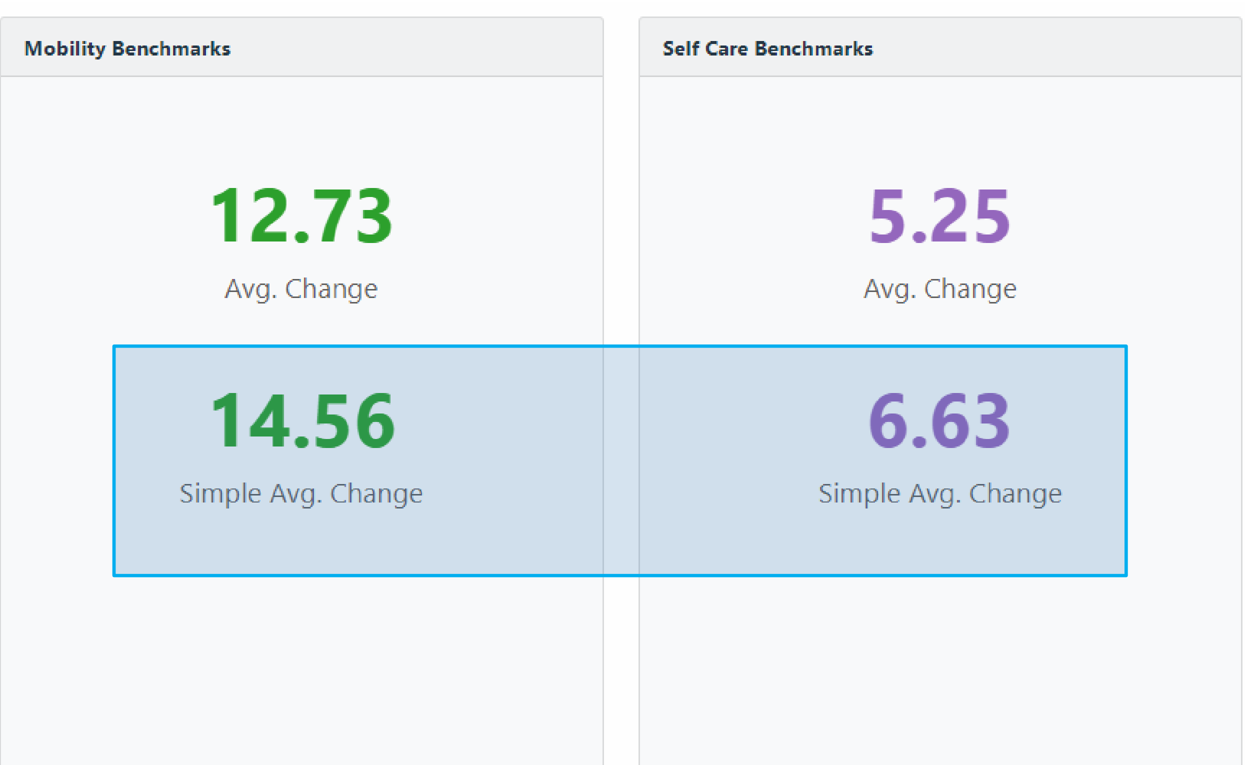
Resident A	
Admission Score	**26**
Baseline Score	59.0813
Age *81 years*	(0.6444)
Primary Medical Condition *Non-Traumatic Brain Dysfunction*	(3.4806)
Prior Conditions *(1) Some Help with Ambulation (2) Use of Wheelchair*	(8.9148)
Status on Admission *(1) Severely Impaired Cognitive Function (2) Incontinence*	(6.4408)
Comorbidities *(1) Infectious Diseases (2) Cancer (3) Dementia (4) Mental Health Disorder*	(2.7192)
Expected Discharge Score	**36.8815**
Expected Improvement	*10.8815*

Resident B	
Admission Score	**26**
Baseline Score	59.0813
Age *87 years*	(1.6103)
Primary Medical Condition *Medically Complex Conditions*	(3.1818)
Prior Conditions *NA*	(0.0000)
Status on Admission *(1) Incontinence*	(4.6837)
Comorbidities *(1) Infectious Diseases*	(0.2270)
Expected Discharge Score	**49.3785**
Expected Improvement	*23.3785*

Live Poll

How does your organization manage the CMS expected discharge scores for PPS stays?





Resident Function Scores

All Stays | Current Only | Discharged Only | Excluded Only | Search | Columns

Resident Name	Earliest Date	Latest Date	Length of Stay	Entry Mobility Score	Expected Mobility Score	Discharge Mobility Score	Mobility Score Delta	Entry Self Care Score	Expected Self Care Score	Discharge Self Care Score	Self Care Score Delta
Resident 2235244	2021-09-22	2021-09-22	46	30	38.68			19	24.13		
Resident 4497728	2021-08-30	2021-08-30	69	18	32.10			12	21.29		
Resident 4502064	2021-09-03	2021-09-03	65	25	49.57			26	36.09		

What is a successful discharge?

Functional Improvement

- Discharge Self-Care Score
- Discharge Mobility Score

Operational Efficiency

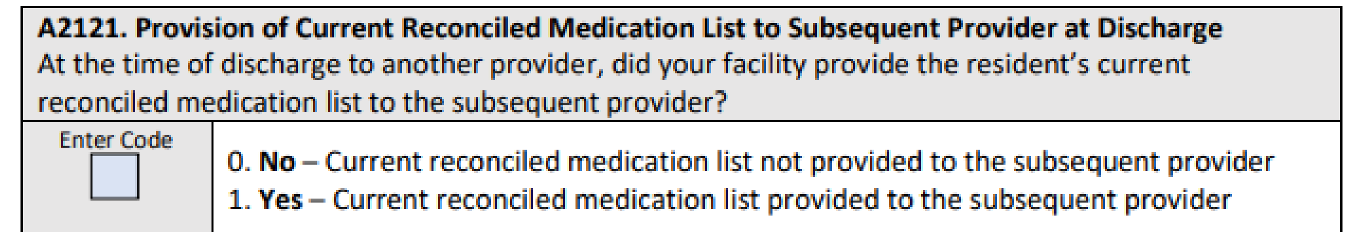
- Transfer of Health Information
- Medicare Spending per Beneficiary

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	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

Filters: All Facilities | Example Company > Choose a Facility... | Nov 6th 2020 - Nov 6th 2021

Diagnoses

Viral conjunctivitis ✕ | Exclude: Discharged Residents | Sum By: Residents | Rehospitalizations | Dx Count

Comorbidity Analyzer

Provider	Residents
Facility 6906	3
Facility 6913	3
Facility 6910	2
Facility 6895	1
Facility 6907	1
Facility 6914	1

0 Diagnoses Codes

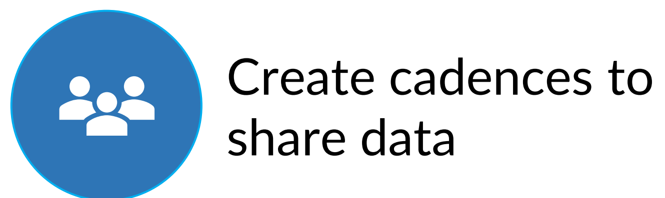
6 Facilities | 11 Residents

Filter/Search Comorbidities

Comorbidity Code	Description
No data to display	

Top

Diagnosis	%	Count
A00-B99 - Certain infectious and parasitic diseases		689
B25-B34 - Other viral diseases		11
B25 - Cytomegaloviral disease	0.3%	6
B34 - Viral infection of unspecified site	0.2%	4
B33 - Other viral diseases, not elsewhere classified	0.0%	1



Best Practices

Strategy #3

Invest in your 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?

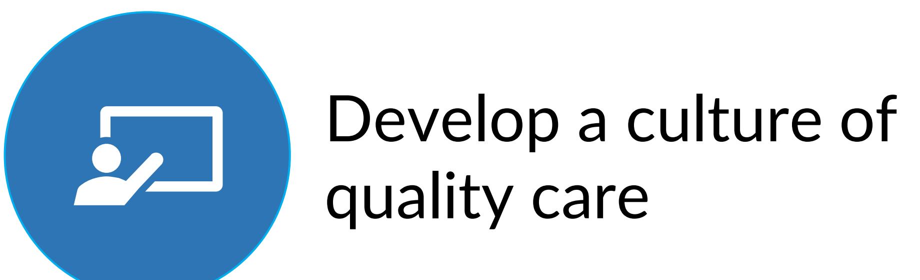
Payroll-Based Journal

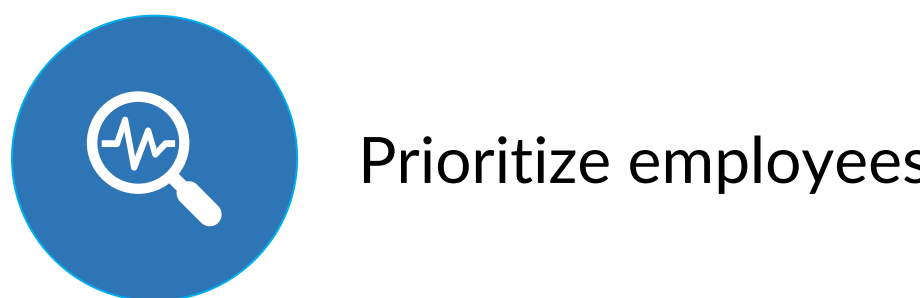
- Get the data right
- Know your data and what it means
- Know how CMS uses your data to tell the staffing story

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

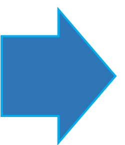




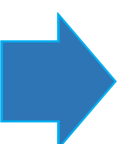
Best Practices

Conclusion

Master your Quality Measures



Secure Successful Discharge



Invest in People

Live Poll

Would you like a free demo of SimpleAnalyzer™ and its VBP functionality?

Q&A

What are your top VBP questions?

Thanks for attending!

Webinar recording and slides available at:

simpleltc.com/vbp-webinar