BKD National Health Care Group

BKD CPAs & Advisors

"HOW DOES YOUR COMMUNITY MEASURE UP?"

An Update on 5-Star and Quality Measures

Arkansas Health Care Association – Spring 2018

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OBJECTIVES:

1. Participant(s) will be able to state at least 3 different agencies/acts requiring the quality measures for Post Acute Care Providers.
2. Participant(s) will be able to state the quality measure(s) that will affect their APU (Annual Percentage Update).
3. Participant(s) will be able to quote specific “tools” that are available to assist in the management of their quality measures.

ALL QUALITY MEASURES (SNF TOTAL CURRENTLY…I COUNT 117!)

- MDS 3.0 QM **…(24)**
- QRP QM: Quality Reporting Program **= 12**
- VBP QM: Value-Based Purchasing (1)
- **Five-Star** QM **= 17**
- Publicly Reported QM on **Nursing Home Compare** **=25**
- Survey Measures…**17**
- QM Reported in **CASPER** **= 21**

- **JARGON:** SHORT STAY, LONG STAY, CLAIMS BASED MEASURES,
- DEFINITIONS OF WHAT CONSTITUTES A "STAY" OR AN "EPISODE" OR AN "ADMISSION" OR "REENTRY" WITH "CUMULATIVE DAYS IN FACILITY" **OR** THE (**CDIF**) & "TARGETED DATES" WITH "NUMERATORS & DENOMINATORS"
  & RISK ADJUSTMENTS WITH EXCLUSIONS, **STRATIFICATIONS & COVARIATES**

CAN FEEL VERY **OVERWHELMING**

WHO'S THE BOSS? ALL OVERSITE = CMS

- **CASPER** – "*come from resident assessment data*" that NH's routinely collect on the residents at specified intervals during their stay – overseen by **CMS**

  (Centers for Medicare & Medicaid Services)

- **Nursing Home Compare** – Designed by **CMS** for side-by-side facility comparison when choosing the best nursing home for their care.
- **5 Star** – found on Nursing Home Compare – web site features a quality rating system that gives each nursing home a rating of between 1 and 5 stars. Provides detailed information such as quality Ratings, Staffing Information, Health and Fire Safety Inspections, Nursing Home Complaints, and penalties. Was developed by **CMS** (Centers for Medicare & Medicaid Services)

- MDS 3.0 QM/Survey Measures – **CMS**
- **QRP QM** (**Quality Reporting Program**) – **The IMPACT Act of 2014** requires the Secretary to implement specified clinical assessment domains using standardized (uniform) data elements to be nested within the assessment instruments currently required for submission by LTCH, IRF, SNF, HHA providers. The Act further required: **CMS** develop & implement QMs from 5 domains using standardized assessment data, AND develop & report on measures pertaining to resource use, hospitalization, & discharge to the community with intent to enable interoperability & access to longitudinal information for such providers to **facilitate coordinated care**.
- **VBP QM** (**Value-Based Purchasing**) Originated from the **Protecting Access to Medicare Act (PAMA) of 2014** – **CMS** rewards SNFs with an **incentive payments** for the quality of care they give their residents. The SNF VBP Program started in FY 2019. **Promotes better clinical outcomes** for SNF patients & makes their care experience better during SNF stays.

CMS EXPLAINS THE **5 STAR** PURPOSE

- Primary Goal: to provide residents & their families with an easy way to understand assessing NH quality - making meaningful distinctions between high & low performing NH.
- The rating system looks at **3** Domains: **RECENT CHANGE!**
  - Health Inspections – current yr inspections will not effect 5 Star!
  - Staffing – changing: CMS forms 671 & 672 to PBJ soon!
  - Quality Measures – based on the MDS 3.0
- **Impact**: 22% of the nations centers have a "star change": 93% have a 1 star change & 7% = 2 or more star change!

5 STAR UPDATE: OVER ALL NH 22% CHANGE IN YOUR STAR RATING

1. Score frozen for one year – this year (2018)
   - **CMS will provide a summary of survey findings from 11/28/17 & after: total number of deficiencies cited, highest scope and severity level**, (but survey results will not affect your Five-Star rating while the freeze is in effect.)
   - Inform the public that these are calculation changes ONLY.
2. Third year survey results will no longer be part of your score. Most current survey (**2016**) will weigh **60%** and previous year's survey (**2015**) will weigh **40%**
   - **If 2016** survey was **NOT** a good survey it will now weigh **60%**

NEW CUT POINTS FOR

- Health Inspections Scores – recalibrated each month so that the distribution of star ratings within States remains relatively constant over time in an effort to reduce the likelihood that the rating process affects the health inspection process. (**OK about 10% (30) homes 5 Stars**)
- Oklahoma: Number of facilities = about **300** total nursing facilities

1 Star	2 Stars 5 Stars	3 Stars	4 Stars
>131.5 <24.800	<131.5->83.333	<83.333 >49.333	<49.333 >24.800

Top 10% in each State receive a 5-Star rating.

Middle (70% or approximately 161 facilities fall into =4 (**70**), =3 (**70**) & =2 (**70**) in each category.(**around 161 NH in each 2,3,4**)

The **Bottom** 20% (**60**)receive a 1 Star rating.

CMS UPDATES IN THE **5 STAR PROGRAM**

- Five-Star **HELPLINE**: **1-800-839-9290** (March 2-26 & March 30 – TIME available: 9 am to 5 pm EST.) or emailed questions:

  BetterCare@cms.hhs.gov

- REVIEW your December PREVIEW REPORT!!! It contains your PBJ data for 4 quarters and also has your DAILY MDS CENSUS. IF NOT CORRECT: ID ERROR & SUBMIT CORRECTLY
- **https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html**

NHC 5 STAR QUALITY RATING SYSTEM: TECHNICAL USERS' GUIDE

- December 2017 Updates Only
- Rest of User's Manual is January 2017
- Downloadable file containing the "expected", "reported" and "case-mix adjusted" hours used in the staffing calculations :
- **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html**

STAFFING DATA FILE DECEMBER 2017 (CASPER REPORT & PBJ)

- **CMS is saying there were over 3000 NH that did not have an RN 8 hr/day**
- **Stated this was found mostly in rural areas.**

- **Zero** facilities in Arkansas were **BLANK = meaning CMS has received PBJ data but not necessarily accurate data….**

- Technical User's Guide for Nursing Home Compare Five-Star Quality Rating System:
- January 2017

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

PBJ – CONCERNING RN'S & DIRECTORS OF NURSING SERVICE

- Remember:
- **FACT**: Job Title Code (JTC) does matter
  - JTC 5 = RN Director of Nursing (Do not additionally reflect these hours in any other category)
  - JTC 6 = RN with Administrative Duties: MDS, ADON, In-service Director
  - JTC 7 = RN – Includes nurse practitioners & clinical nurse specialists who primarily perform nursing – not physician-delegated tasks.

- Do not include Registered Nurses' hours reported elsewhere.

POSSIBILITY OF NO REGISTERED NURSE HOURS IN 24 HOURS??

- **Example**: Labor Classification/Job Title
- Reporting shall be based on the employee's "primary role & their official categorical title". It is understood that most roles have a *variety of non-primary duties* that are conducted throughout the day (e.g., helping out others when needed). Facilities shall still report just the total hours of that employee based on their primary role. **HOWEVER**….*If a nurse who spends the 1st 4 hours of a shift as the unit manager, & the last 4 hours of a shift as a floor nurse (Change in designated "job title"). Facilities should change the JTC &* ***report 4 hours as nurse with admin duties & 4 hours as nurse without admin duties.***

IMPACT ACT OF 2014 – IMPROVING POST-ACUTE CARE: SNFQRP

- **SNF QRP = Skilled Nursing Facility Quality Reporting Program**
- SNF QRP affects our Annual Percentage Update (or APU)$$$$$
- SNF, LTCH, IRF & HHA
- **Reporting requirements**:
  - **SNFs not submitting required data** may **receive a 2% reduction to their annual payment update (APU) for the applicable payment year.**
  - **??? Field many questions:** **BIG MISCONCEPTION!!!!**

APU REDUCTIONS

Question: I am trying to "fix" our Section GG issues in the MDSes. Some listed on the resident level don't seem to have any issue that I can find but some do. I am 83% on GG related issues & 5.8% on new/worsened pressure ulcers. I am afraid the combo might cause a problem. Can you help me? **What do my percentages need to be for pressure ulcers and falls with major injuries in order not to get hit with 2% reductions?**

Answer: The percentage of falls or pressure ulcers that worsen **do NOT affect the 2% payment update**. **Non-compliant assessments affect the annual payment update :** ***"This is a process driven quality measure". CMS is looking at your PROCESS!***

1. The use of dashes inappropriately in SNF QRP items or
2. Not coding admission & at least one discharge functional assessment &
3. A care plan that does NOT address function.

APU REDUCTION

- This potential reduction in APU does **NOT** have to do with
  - how many Falls with Major Injury or
  - how many pressure ulcers that are new or worsened
- but has "everything" to do with whether we coded the MDS accurately and submitted those assessments timely.
- **2% reduction in payment goes to SNFs who failed to report data necessary to calculate the QM under QRP for at least 80% of the assessments.**

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QM-Users-Manual-V10-FINAL-5-22-17.pdf
- Explains how these categories are measured, if there are any "**risk adjustments" and** also **how to correct your reports if completed in error**.
- CMS corresponds regularly through various venues concerning start & end of data collection, when all data "must" be submitted, & offer time for "corrections" of submitted data.
- **QIES** will inform providers if they did **not meet threshold**.

COMPLIANCE DETERMINATION FOR 2018

- **2018** SNF-QRP Measures: MDS Based

1. Application of % of residents experiencing **1 or more falls with major injury. (LS) (J1900)**.
2. **% of patients with pressure ulcers that are new or worsened**.(M0800)
3. Application of % of LTC Hospital patients with an **admission & discharge functional assessment & a care plan that addresses function**.

   (Section GG)

Date Collection Timeframe: 10/1 through 12/31/2016 **DONE**

Submission Deadline: June 1, 2017 **DONE**

Payment Reduction to APU for **Non-compliance**: 10/1/2017 **DONE**

J1900

- One or more falls with major injuries J1900 should **ONLY** be coded if:
  1. BONE FRACTURES,
  2. JOINT DISLOCATIONS,
  3. CLOSED HEAD INJURIES WITH ALTERED CONSCUOUSNESS
  4. SUBDURAL HEMATOMA

M0800

- M0800: Pressure Ulcer worsening defined as a pressure ulcer that has progressed to a deeper level of tissue damage & would be staged at a higher level, only looking back to your prior assessment ARD (sometimes see a wound that previously was not able to be staged but now it is and we will mark this as a new or worsened ulcer or vice versa.)
- **Remember**, do not include scheduled PPS assessments done for other than Medicare Part A & therefore not submitted.
- If an unstageable pressure ulcer that was present on admission/entry or re-entry is subsequently able to be numerically staged, do **NOT** consider it to be worsened because this would be the 1st X it was able to be staged.
- If a pressure ulcer was numerically staged & becomes unstageable due to slough or eschar, do **NOT** consider this pressure ulcer as worsened. You can only tell if it has worsened when enough slough or eschar is removed & the wound bed is visible.

M0800

- If a pressure ulcer was numerically staged & becomes unstageable, & is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before & after it was unstageable. If the pressure ulcer's current numerical stage has increased, ONLY THEN consider this pressure ulcer as worsened.
- If 2 pressure ulcers merge, do NOT code as worsened. Although two merged pressure ulcers might increase the overall surface area of the ulcer, there would need to be an increase in numerical stage in order for it to be considered as worsened.
- If a pressure ulcer is acquired during a hospital admission, its stage should be coded on admission and is considered as present on admission/entry or re-entry. It is not included or coded in this item. And what if they had a pu when they left your facility & went to the hospital - it worsens in the hospital…how do you code it when they return?

SECTION GG

- RAI Manual Refer to Section GG – Dashes cause problems **(Page GG-6)**

- ***Coding a dash*** *("-") in these items* ***indicates "No Information."*** *CMS expects dash use for SNFQRP items to be a rare occurrence.* ***Use of dashes for these items may result in a reduction in the APU (Annual Payment Update).*** *If the reason the item was not assessed was that* ***the resident refused (Code 07),.*** *Please note that a dash may be used for GG0130 Discharge goal item is NOT applicable because the resident did NOT perform this or safety concerns (Code 88), use these codes instead of a dash ("-")* *Discharge Goal items provided that* ***at least ONE Self-Care or ONE Mobility item has a Discharge Goal coded using the 6-point scale.*** *Using the dash in this allowed instance does not affect APU determination. Further information about the use of a dash for Discharge Goals is provided below under Discharge Goal(s): Coding Tips*

SECTION GG

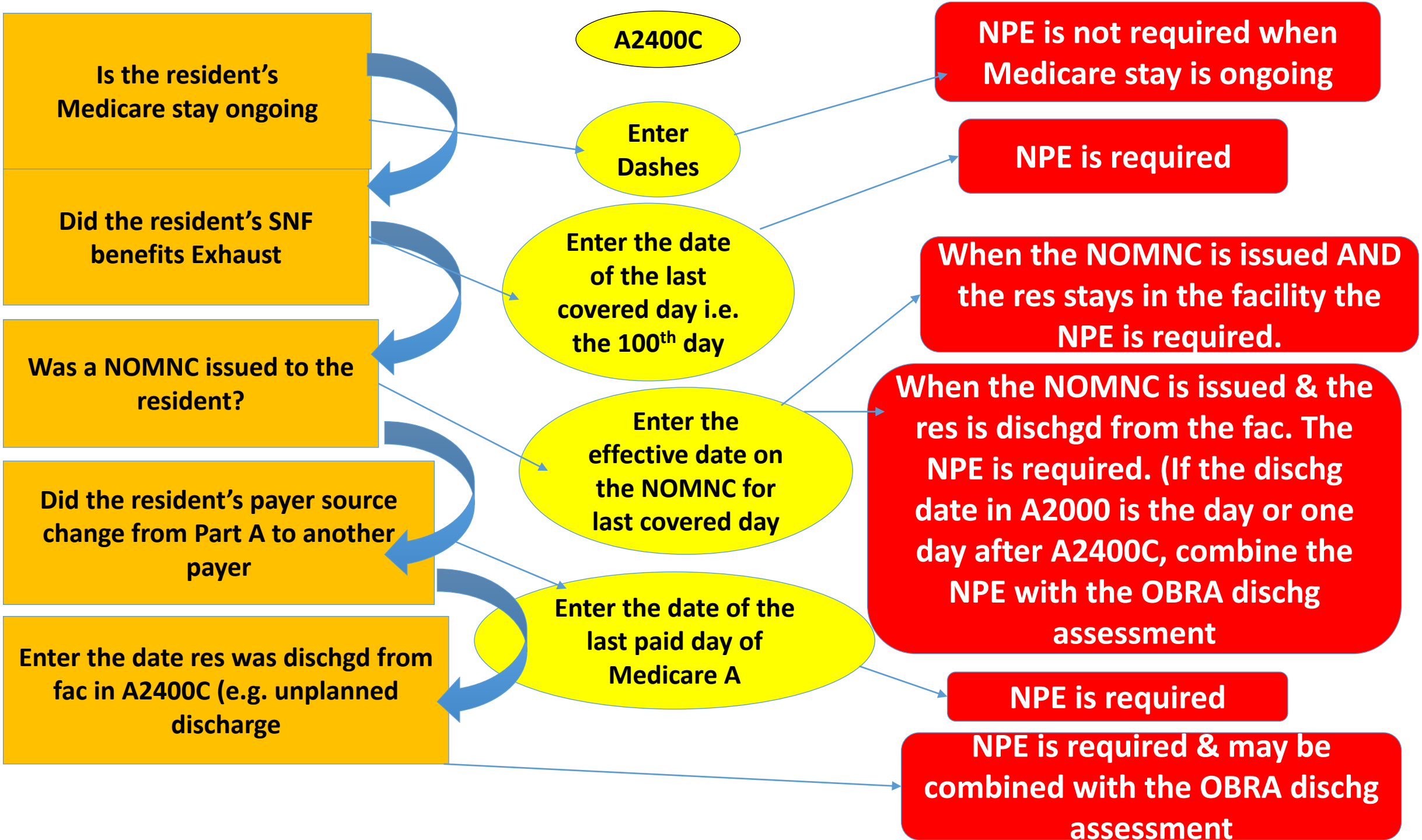
- *For the cross-setting quality measure, the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, a minimum of one Self-Care or Mobility Discharge Goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one Discharge Goal is required, the facility may choose to code more than one Discharge Goal for a resident.*

- Remember for this Quality Measure it is **critical** that you code your **MEDICARE PART A Residents.**
- Code **A2400** accurately and your SNF Part A Discharge Assessment (NPE) is completed when needed = AANAC Algorithm!

QRP QUESTION

Q: I thought it wasn't required to complete Section GG on a 5 Day assessment if the person was a "short stay" like 1-2 days. When is Section GG required to be completed? Thought if the person was in the facility for less than 3 days, and on discharge GG wasn't required if it was an "unplanned discharge."

A: Section GG is **always required on the 5-day** no matter how short the stay. Section GG is skipped on "unplanned discharges", stays less than 3 days & discharges to the hospital. The Part A PPS Discharge MDS is required even though Section GG is skipped.


A2400C
Is the resident's Medicare stay ongoing
Enter Dashes
NPE is not required when Medicare stay is ongoing
NPE is required
Did the resident's SNF benefits Exhaust
Enter the date of the last covered day i.e. the 100th day
When the NOMNC is issued AND the res stays in the facility the NPE is required.
Was a NOMNC issued to the resident?
Enter the effective date on the NOMNC for last covered day
When the NOMNC is issued & the res is dischgd from the fac. The NPE is required. (If the dischg date in A2000 is the day or one day after A2400C, combine the NPE with the OBRA dischg assessment
Did the resident's payer source change from Part A to another payer
Enter the date of the last paid day of Medicare A
NPE is required
Enter the date res was dischgd from fac in A2400C (e.g. unplanned discharge
NPE is required & may be combined with the OBRA dischg assessment

COMPLIANCE DETERMINATION FOR 2018

- **2018** SNF-QRP Measures: MDS Based

1. Application of % of residents experiencing **1 or more falls with major injury. (LS) (Section J1900)**
2. **% of patients with pressure ulcers that are new or worsened**.(**Section M800**)
3. Application of % of LTC Hospital patients with an **admission & discharge functional assessment & a care plan that addresses function**.

   (**Section GG**)

Date Collection Timeframe: 10/1 through 12/31/2016 **DONE**

Submission Deadline: May 15, 2017 **DONE**

Payment Reduction to APU for **Non-compliance**: 10/1/2017 **DONE**

Compliance determination for **FY 2019** will be based off of your data from this **past** year 1-1-17 through 12-31-17 **SNFQRP**

NQF NUMBER	MEASURE NAME	DATA SUBMISSION MECHANISM
NQF #0678	% Of Residents With Pressure Ulcers that are New or Worsened (Short Stay)	Minimum Data Set (MDS) 3.0
NQF #0674	Application of % of residents experiencing 1 or more FALLS with Major Injury (LS)	MDS 3.0
NQF #2631	Application of % of LTC Hospital patients with an Admission & Discharge Functional Assess. & ICP addressing Function	MDS 3.0

Done

PROPOSED: FY 2020 SNF QRP MEASURES ACTIVE

MEASURE	DATA COLLECTION X FRAME	SUBMISSION DEADLINES
% Res with Pressure Ulcers that are New or Worsened (SS) (NQF #0678)	January 1, 2018 – 6/30/18 1/1-3/31/2018 April 1 – June 30, 2018 July 1 – Sept 30, 2018	***** August 15, 2018 November 15, 2018 February 15, 2019
Change in Skin Integrity PAC: Pressure Ulcer/Injury (SS)	October 1 – Dec 31, 2018 **Replaces NQF #0678 on this date: 10/1/2018**	May 15, 2019
Application of % of Res. Experiencing One or More Falls with Major Injury (LS) (NQF #0674)	Oct 1-December 31, 2018 Jan 1 – March 31, 2018 April 1 – June 30, 2018 July 1 – Sept 30, 2018 Oct 1 – Dec 31, 2018	***** August 15, 2018 November 15, 2018 February 15, 2019 May 15, 2019

NOTE: 4 ADDITIONAL MEASURES BUT ALL IRF EXCEPT…..

Measure	Data Collection X Frame	Submission Deadlines
Application of % of LTC Hospital (LTCH) patients with an Admission & Discharge Functional Assessment & a Care Plan addressing it (NQF #2631)	Jan 1, 2018 – Dec 31, 2018 Jan 1 – March 31, 2018 April 1 – June 30, 2018 July 1 – Sept 30, 2018 Oct 1 – Dec 31, 2018	***** August 15, 2018 November 15, 2018 February 15, 2019 May 15, 2019
Drug Regimen Review Conducted with FU for Identified Issues – PAC SNF QRP	**Oct 1 – Dec 31, 2018 STARTS SOON!**	May 15, 2019
Medicare Spending Per Beneficiary (MSPB) – PAC Skilled Nursing	**********	Claims-based measure – No additional data submission required by SNF

REMAINING SNF QRP CLAIMS BASED

Measure	Data Collection X Frame	Submission Deadlines
Medicare Spending Per Beneficiary – PAC SNF Measure		Claims-based measure – No additional data submission required by SNFs
Discharge to Community – Post-Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)		Claims-based measure – No additional data submission required by SNFs
Potentially Preventable 30 Day Post-Discharge Readmission Measure for SNFQRP		Claims-based measure – No additional data submission required by SNFs

ALSO CLAIMS-BASED MEASURES SNFQRP RESOURCES

Measure	Data Source
Discharge to Community – Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)	UB-04s (how are our billers coding "locator 17" on the UB-04 – "Patient Discharge Status"?) *See MLN Matters: SE0801*
Potentially Preventable 30-Days Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)	Medicare FFS Claims – collecting data for "Potentially Preventable Readmissions" PPR within a 30-day window following discharge from the PAC or SNF **https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Measure-Specifications-for-FY17-SNF-QRP-Rinal-Rule.pdf**
Medicare Spending Per Beneficiary – Post-Acute Care (PAC) Skilled Nursing Facility Measure	(IMPACT Act of 2014) **https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-**

ASSESSMENTS USED IN THE SNF QRP

- **OBRA** – required assessments
- **Scheduled PPS** assessments
- **Discharge** assessments:
  - Discharge assessment: **RNA**
  - Discharge assessment: **RA**
  - **Part A PPS Discharge assessment**

ALL ASSESSMENTS ARE REVIEWED WITHIN THE TARGET DATES OF A MEDICARE PART A STAY FOR THE FOLLOWING DATA:

- Qualifying reasons for assessments:
  - **A0310A:** Type of Assessment:
    - **Federal OBRA Reason for Assessment**:
    - 01 Admission
    - 02 Quarterly
    - 03 Annual
    - 04 Significant Change in Status Assessment
    - 05 Significant Correction to prior comprehensive assessment
    - 06 Significant Correction to prior quarterly assessment
  - **A0310 B**. **PPS Assessment** (Scheduled Assessments for a Medicare Part A Stay)
    - 01 5 – day scheduled assessment
    - 02 14 day
    - 03 30 day
    - 04 60 day
    - **05 90 day**

TYPE OF ASSESSMENT CONTINUED

- **A0310F** Entry/Discharge reporting
  - 10 Discharge assessment – return not anticipated
  - 11 Discharge assessment – return anticipated **or**
- **A0310H** Is this a SNF Part A PPS Discharge Assessment?
  - 1 = Yes

SNF QRP INCOMPLETE STAYS

- Residents who have incomplete stays are defined as those residents:
  1. Who are discharged unexpectedly due to a *medical emergency*,
  2. Who *leave the SNF against medical advice* (UB-04 Locator 17=07), or
  3. Who *die* while in the SNF
- **ALL** Residents **NOT** meeting the criteria for incomplete stays will be considered **complete stays**.

FOR MORE INFORMATION SNF QRP

- 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.html

SNF QRP: CMS CONSIDERS

- If there are NO PPS 5-Day Assessments in the most recent 12 months, the Medicare Part A Admission record is considered "**missing**".

- If there is no Part A PPS Discharge assessment in the most recent 12 months, the Medicare Part A Discharge record is considered "**missing**".

- **Both of these assessments are required** when starting a patient's Medicare Part A stay in a facility and ending their Medicare Part A stay in a facility.
- MDS Coordinators and Management need to make certain that all required assessments are being completed and completed timely….**CASPER REPORTS!**

ACCESSING CASPER REPORTS TO ASSIST YOU IN VALIDATING QMS

https://www.aanac.org/docs/reference-documents/casper_reporting_guide_appendixa_final_validation_reports.pdf?sfvrsn=0

1. Do you request to see Validation Reports on a weekly basis from your MDS Coordinator?

2. Do you request to see that all new Medicare Part A patients have at least an "accepted" PPS 5 Day assessment and an "accepted" Medicare Discharge Assessment in the QIES? This should be a QIES generated report and can be provided to you by your MDS Coordinator.

//Instructions for accessing CASPER Reports to assist you in validation of quality of assessments submitted to QIES in regards to your Quality Measures

https://www.aanac.org/docs/reference-documents/casper_reporting_guide_section11_mds30qualitymeasurereports.pdf?sfvrsn=2

SKILLED NURSING FACILITY – VALUE BASED PURCHASING PROGRAM

- **Reward skilled nursing facilities with incentive payment for the quality of care they give to residents with Medicare.**
- **Skilled Nursing Facility 30-Day All-Cause Readmission Measure -**
- CMS will withhold 2% of the SNF Medicare payments starting 10/1/2018
- CMS will fund "incentive pay" & will redistribute 50-70% of the withheld moneys back to SNFs through this program.
  - FY 2018 PPS Final Rule determined 60% will be paid back to the SNFs FY2019 (10/1/2018)
  - Baseline period: CY 2015 (Used for benchmarking)
  - Performance period: CY 2017
  - Achievement threshold: 25th percentile of ALL SNF's performance during the baseline year
  - See SNF VBP Program & Quality Measure Report: http://www.leadingagewi.org/media/42111/SNF-VBPQMs.pdf

STATEMENT OF QUALITY MEASURE

SNF 30 Day **All Cause** Readmission Measure

- Rate of **unexpected** readmissions back to an IPPS hospital, CAH, or psychiatric hospital within 30 days of (for any reason) a discharge from a "hospital".

- **What is it that we do or produce that gives CMS this information?**

SNF VBP MEASURES

- Currently: Hospital readmission rates for SNFs are compared nationally-using the SNFs achievement score-50-70% of $ will be given back to **high performers = (SNFs who are in the top 60%)**

- SNF VBP program is to **promote better clinical outcomes for SNF patients & is to make their care experience better during the SNF stay.**

- Every year the SNF Prospective Payment System (PPS) rules outline what's required of the SNF VBP Program for that year.
- Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM): this estimates the risk-standardized rate of unplanned readmissions within 30 days for: "People with FFS Medicare who were inpatients at PPS, critical access, or psychiatric hospitals" **AND "**Any cause or condition".

UPCOMING CHANGE ?

Current:

SNFRM = 30-day SNF all cause Readmission Measure

Future: (FY2020?)

SNFPPR = Skilled Nursing Facility Potentially Preventable Readmission Measure

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

WHAT MEASURE WILL BE USED

SNF 30 Day All Cause Readmission Measure

- Rate of unexpected readmissions back to an IPPS hospital, CAH, or psychiatric hospital within 30 days of (for any reason) a discharge from a "hospital".
- Tracks hospital readmissions I'd through Medicare **Claims** (UB-04s from hospitals)
- Includes all Medicare Fee For Service SNF residents, with the exception of certain measure exclusions.

(5 Exclusions)

DON'T GET CONFUSED!!! VBP IS "ALL CAUSE"

- **Other** READMISSION MEASURES:
  - **Nursing Home Compare**:
    1. *"Percentage of residents who were re-hospitalized after a nursing home admission."*
    2. *"Percentage of residents who have had an outpatient emergency department visit."*
    3. *"Percentage of residents who were successfully discharged to the community.*
  - **SNF Quality Reporting Program:**
    1. *"Potentially Preventable 30-day post-discharge readmission measure for skilled nursing facility reporting program.":* measures potentially preventable re-admission within a 30 day window following discharge from PAC SNF.

THINGS TO KNOW:

- Tracks hospital readmissions NOT readmissions to the SNF
- Tracks these readmissions through Medicare claims (billing: UB-04s)
- Tracks readmissions within 30-days after discharge from a prior hospitalization NOT a discharge from a SNF.
- Prior Hospitalization calculation is defined as an admission to an inpatient prospective payment system hospital, CAH or psychiatric hospital
- This measure assesses the rate of readmission of SNF patients to an IPPS hospital or CAH, either before or after discharge from the SNF, within 30 days of discharge from a prior hospitalization. (**Unplanned readmissions**)
- Comorbidities are used when comparing facility readmission rates.
- CMS has proposed to adopt a SNF 30-Day Potentially "Preventable" Readmission Measure in future rulemaking.

SNF VALUE-BASED PURCHASING PROGRAM (VBP)

- Beginning 10/1/2018 – incentive payments based on performance will begin. (Readmission Rates from 2015 data for OK)
  - Oklahoma's readmission rates ranged from a low of 16.1% to a high of 28.134%
  - Meaning 89% of residents are not readmitted & 72% of res. Are not readmitted

- Achievement scoring: compares SNF's performance rate in a performance period against all SNF's performance during the baseline period.
  - **(FY2019 (Beginning 10/1/2018) will compare SNF's calendar year 2017 performance to the performance of all facilities during CY 2015)**
- Improvement scoring: Compares a SNF's performance during the performance period against its own prior performance during the baseline period
  - **Beginning 10/1/2016 SNFs have been receiving Quarterly feedback reports about your performance in SNF VBP via CASPER. Have you?**

ALL CAUSE READMISSION MEASURE (SNFRM) (2 OTHER SIMILAR QMS!)

- Estimates risk-standardized rate of all-cause, unplanned hospital readmissions of Medicare SNF beneficiaries within 30 days of discharge from their prior acute hospitalization.
- Hospital readmissions are identified through Medicare claims
- **Readmissions within 30-day window are counted regardless of whether the beneficiary is readmitted directly from the SNF or has been discharged from the SNF**
- Risk-adjusted based on patient demographics, principle diagnosis in prior hospitalization, comorbidities, & other health status variables that affect probability of readmission.
- **Excludes planned readmissions**
- **The SNFRM will be in use for the 1st year of the program, FY2019**

QUARTERLY REPORT MAY LOOK SOMETHING LIKE THIS

The Skilled Nursing Facility Value-Based Purchasing Program

Quarterly Confidential Feedback Report

March 2017 (Quarter 2, FY 2017)

Facility: YOUR SNF
CCN: 123456
City, State: WALTHAM, MASSACHUSETTS

Your SNF's Performance on the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) in 2014

Measure	Your SNF's Number of Eligible Stays	Your SNF's Number of Readmissions*	Your SNF's Risk-Standardized Readmission Rate**	National Average Readmission Rate***
SNFRM	25	4	18.76 %	19.09 %

Source: Medicare claims and eligibility data from CY 2014.

BKD CPAs & Advisors

Long Stay:

- Falls With Major Injury (QM)*
- Falls With Major Injury (QRP)*
- Self-Reported Mod/Severe Pain*
- High-Risk Pressure Ulcers*
- Urinary Tract Infection*
- Catheter*
- Lose Control of Bowel or Bladder*
- Physically Restrained*
- Need for Help with Daily* Activities Has Increased
- Lose Too Much Weight*
- Depressive Symptoms*
- Received an Antipsychotic Med*
- Ability to Move Ind. Worsened*
- Prevalence of Falls*
- Used Antianxiety or Hypnotic Medication (QM)*
- Prevalence of Antianxiety /Hypnotic Use (Surveyor)*
- Prevalence of Behavior Symptoms Affecting Others*
- Seasonal Influenza Vaccines*
- Pneumococcal Vaccines*
- Admission & Dischg Functional Assessment & Care Plan (QRP)*
- Drug Regimen Review (QRP)

LONG STAY: APPROVED MEASURES BEGIN DATA COLLECTION 10/1/18 & USED FOR APU DETERMINATION FY2020

- **Changes in Skin Integrity PAC: Pressure Ulcer/Injury (QRP)**
- Application of the Inpatient Rehab Facility (IRF) Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633) (QRP)
- Application of the Inpatient Rehab Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) (QRP)
- Application of the Inpatient Rehab Facility (IRF) Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635) (QRP)
- Application of the Inpatient Rehab Facility (IRF) Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636) (QRP)

- **SHORT STAY**
- Self-Report Moderate to Severe Pain *
- Pressure Ulcers That Are New or Worsened (QM) *
- Pressure Ulcers That Are New or Worsened (SNF QRP) *
- Newly Received an Antipsychotic Med *
- Made Improvements in Function *
- Seasonal Influenza Vaccines *
- Pneumococcal Vaccines *

- **Data Source**:
  - MDS *

CLAIMS BASED:

- Successfully Discharged to the Community* #
- Had Outpatient Emergency Department Visit* #
- Re-hospitalized After a Nursing Home Admission* #
- Discharge to Community – PAC SNF QRP # @ ^
- Potentially Preventable 30-Day Post-Discharge Readmission PAC SNF QRP # ~ ^
- Medicare Spending Per Beneficiary – PAC SNF QRP # ~ ^
- Skilled Nursing Facility 30-Day All-Cause Readmission Measure – (VBP)+

- **Data Source Key**:
  - MDS * // Medicare Denominator files ^
  - Inpatient Medicare Claims # // Index SNF Claims ~
  - Medicare Enrollment Database @ // Administrative claims +

FAQ FOR FALLS WITH MAJOR INJURY

Question: I am reviewing our 5 Star facility reports and we have a resident who is flagging for a fall with major injury. This resident had a fall with major injury on 9/7/2016 and has since passed away on 8/9/2017. She is still showing up on our 5 Star report for a major injury. My understanding is that she should be off by now, it has been 16 months since her fall. I feel like I'm missing something here. If it is a mistake, how do I fix it?

Answer: Fall with major injury is a look-back scan item. That means a fall coded on any MDS with 275 days of the most recent MDS would continue to trigger the QM. This fall should soon come off your QM Report. Look at the control group dates. Once the fall is a year before the latest date, it should stop triggering the QM. **"This means Falls with major injury will "trigger" for any "fall with major injury" that occurred any time during a one-year period."**

SUMMARY: HOW DO WE MANAGE ALL OF THESE QM?

- Nursing Home Compare – 5 Star – CASPER – SNF QRP – SNF VBP

*Know where to find their **User's Guides** – these explain exactly what is being reviewed

*Watch the **CMS communications** – **OAHCP/LeadingAge** keeps you abreast of changing QMs

*Review your **facility data on a weekly basis** – request the reports/compare against your census/identify any anomalies

***Train your MDS Coordinators and Others in your facility**

-MDS's control your $$$ and your Quality Measures which again control $$$

QUESTIONS

THANK YOU

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