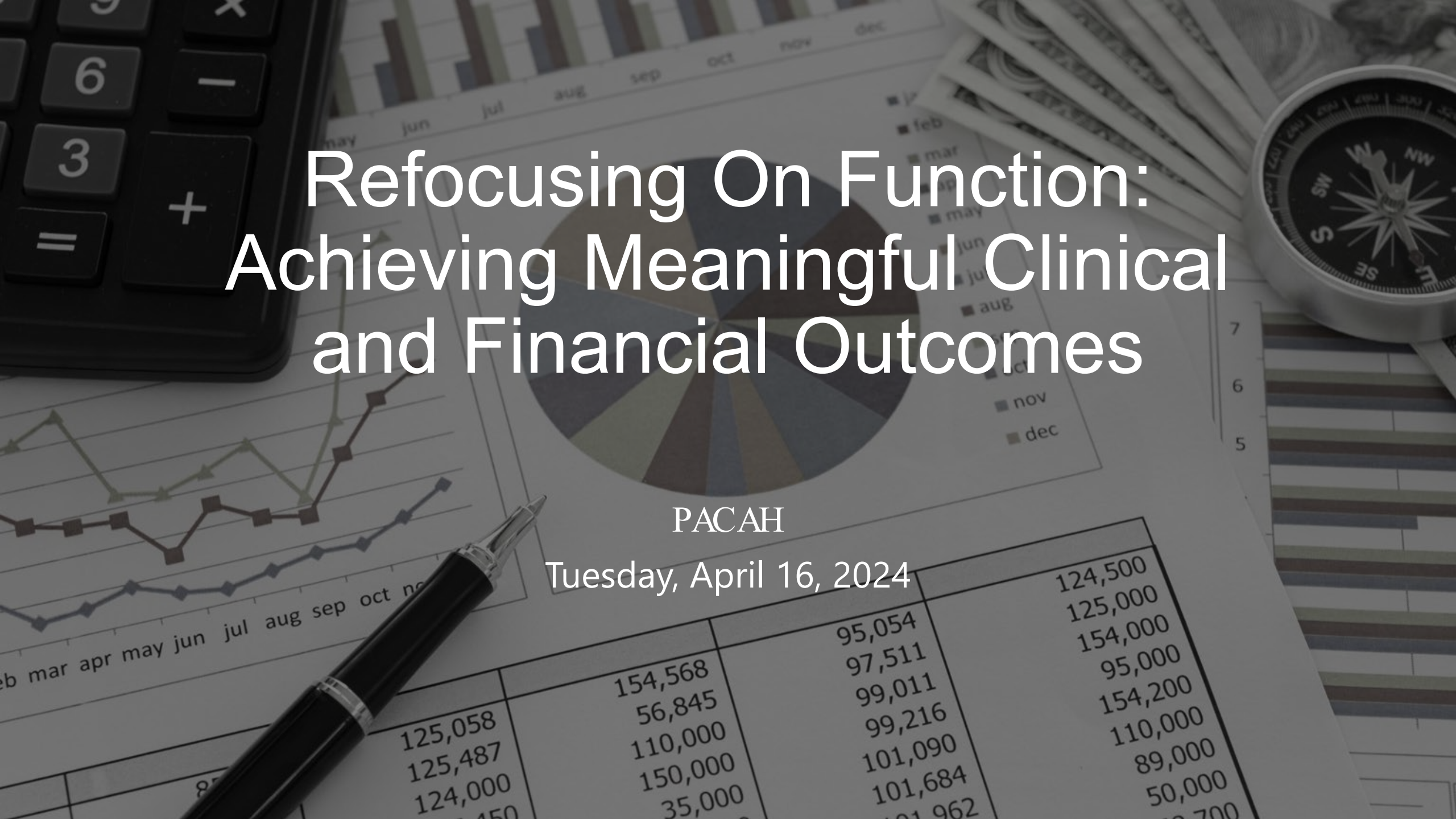

Refocusing On Function: Achieving Meaningful Clinical and Financial Outcomes

PACAH

Tuesday, April 16, 2024

Speakers:

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Objectives

- Upon completion, participants will be able to discuss the recent changes to the quality reporting and value-based purchasing (VBP) programs.
- Upon completion, participants will be able to discuss the function-based quality measures including coding instructions, roles of the IDT and reporting processes that will drive quality improvement efforts.

Measurement is the first step that leads to control and eventually to improvement. If you can't measure something, you can't understand it. If you can't understand it, you can't control it. If you can't control it, you can't improve it

– James Harrington

Quantity to Quality – Implications on Function and Therapy

Impact on Utilization

1960
- Social Security Act established Conditions of Participation to certify nursing homes to operate as Skilled Nursing Facilities (SNFs)
- Impact: Medicare reimburses rehabilitation in nursing homes

1983
- Prospective Payment System for Hospitals aims to control hospital costs
- Impacts: Reduced hospital length of stay, increased demand for SNF care for sicker patients

1987
- Omnibus Budget Reconciliation Act aims to improve quality of care in SNFs
- Impacts: Standards for staffing, medication administration, and improved clinical outcomes

1997
- Balanced Budget Act established Prospective Payment for SNFs with goal of reducing SNF costs
- Impacts: Immediate reduction in SNF spending, reduction in Medicare admissions, more in-house therapy services, and nurse staffing reductions

1999
- Balanced Budget Refinement Act increased payment rates for all patients in SNFs
- Impacts: Increased Medicare admissions, nurse staffing, and therapy provision, rising expenditures

2000
- Benefits Improved & Protection Act increased payment for rehabilitation and nursing case-mix compo9nsents of Resource Utilization Group case-mix system
- Impacts: Increased Medicare admissions, nurse staffing, and therapy provision, rising expenditures

2019
- Patient Driven Payment Model implemented to realign payment with patient characteristics and reduce unnecessary therapy provision
- Impacts: Therapy staffing declines, increased multi-participant therapy, higher overall fee-for-service reimbursement

Quality Legislation Timeline

OBRA – 1987 The Omnibus Budget Reconciliation Act

- Requires that a nursing home must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident
- Gave rise to the MDS and periodic review of patient diagnosis

BBA – 1997 Balanced Budget Act

- Moved us from a Cost based system to PPS RUGS and Therapy Cap

AAC – Affordable Care Act – March 2010

- The push for bundled payment – and paying for quality over quantity.

PAMA – 2014 Protecting Access to Medicare Act of 2014

- Added Value Based Purchasing

IMPACT ACT –2014

- Quality Reporting Program and Section GG

Changes to Therapy Minutes from RUGS to PDPM, SAMPLE – HIP FX

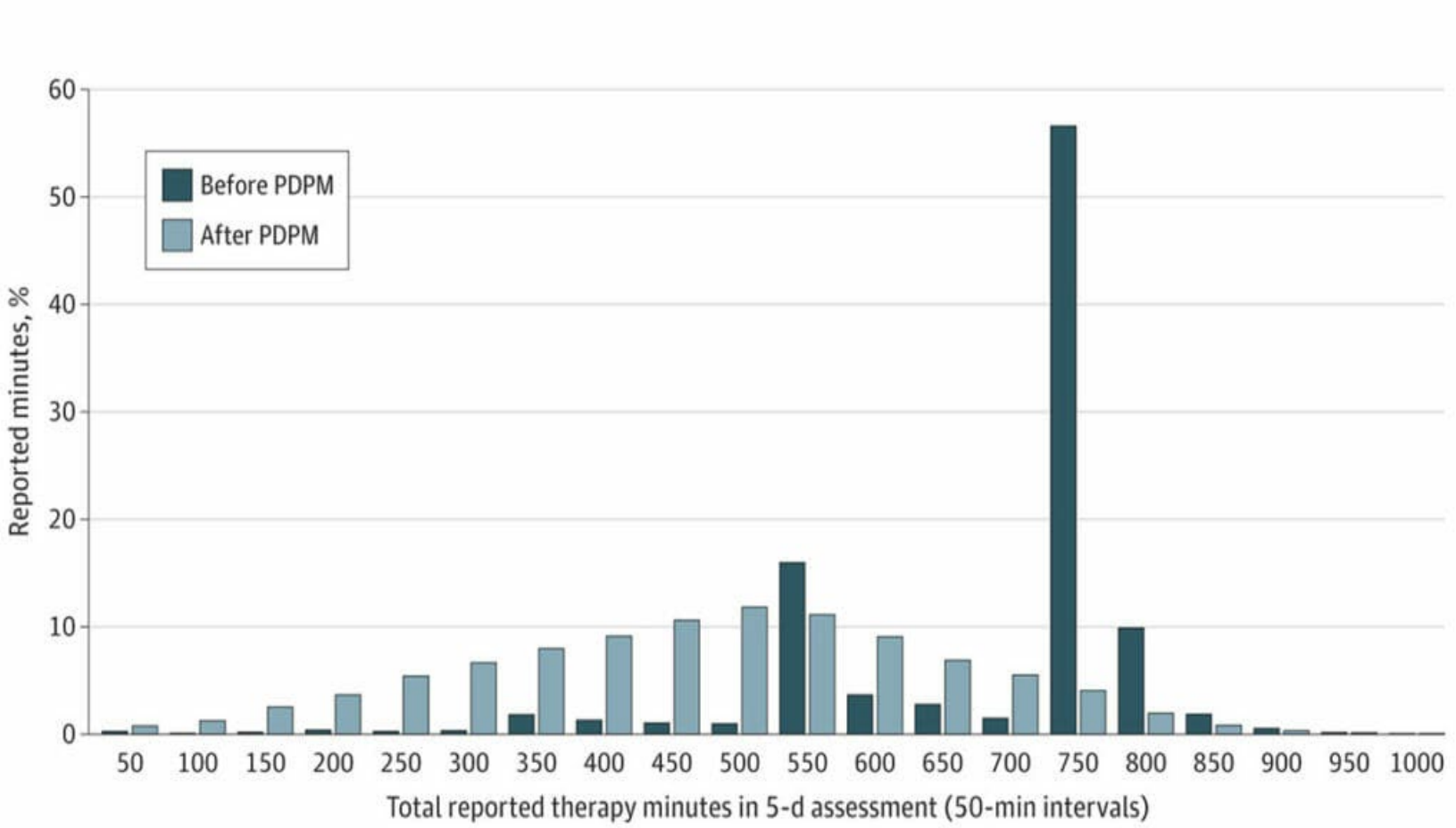
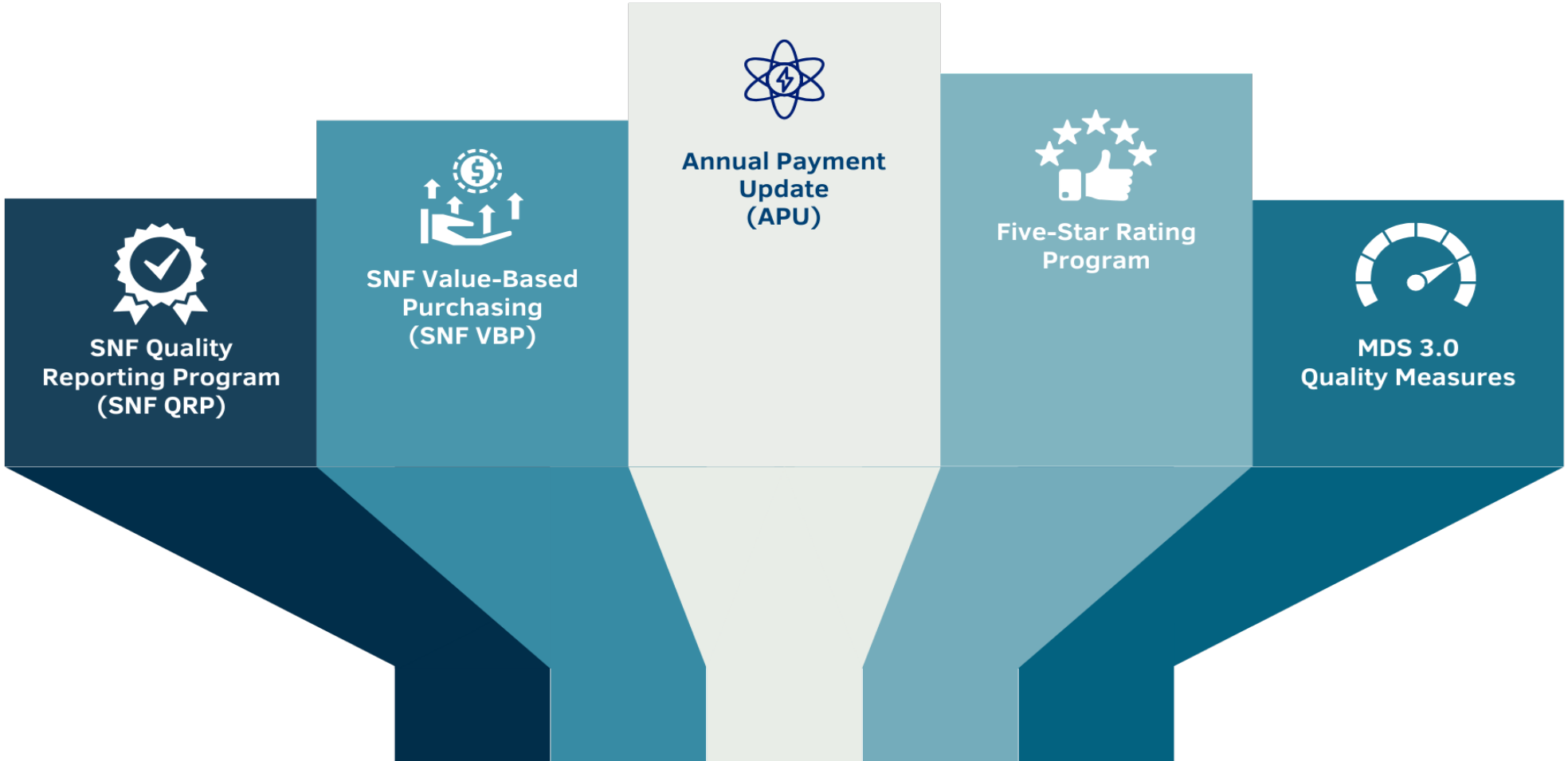


Figure Legend:

Distribution of Therapy Minutes Provided as Reported in 5-Day Scheduled Assessment for Patients With Hip Fracture Diagnosis Before and After the Patient Driven Payment Model (PDPM)Total therapy use is summation of 3 types of therapy (physical, occupational, and speech) provided at individual or nonindividual sessions. Therapy use is grouped into 50-minute intervals. The x-axis levels show the upper bound of the interval, ie, "50" means 0-50, "100" means 51-100, and so on.

Source: Rahman M, White EM, McGarry BE, et al. Association Between the Patient Driven Payment Model and Therapy Utilization and Patient Outcomes in US Skilled Nursing Facilities. JAMA Health Forum. 2022;3(1):e214366. doi:10.1001/jamahealthforum.2021.4366

“Quality of Care” Defining Programs



IMPACT Act Requirement

- The IMPACT Act requires assessment data to be standardized and interoperable to allow for exchange of the data among post-acute providers and other providers.
- The Act intends for standardized post-acute care data to improve Medicare beneficiary outcomes through shared-decision making, care coordination, and enhanced discharge planning.
- Examples of post-acute care providers include:
  - Long-Term Care Hospitals (LTCHs)
  - Skilled Nursing Facilities (SNFs)
  - Home Health Agencies (HHAs)
  - Inpatient Rehabilitation Facilities (IRFs).

What is the SNF Quality Reporting Program?

SNF QRP requires the reporting of standardized patient assessment data regarding quality measures and standardized patient assessment data elements (SPADES)

SNF QRP requires assessment data to be interoperable to allow for the exchange of data among post-acute providers and other providers

2% reduction in Med part A revenue

Found on review and correct reports

- Therapy is most involved when dashes are in Section GG
- Prior threshold was that 80% of data reported cannot be dashed

Changes to the SNF QRP

FY 2024: MDS Reporting Requirements

CMS is increasing the SNF QRP Data Completion thresholds for MDS Data Items beginning with the FY2026 SNF QRP.

- SNFs will need to report 100% of the required quality measure data and standardized resident assessment data collected using the MDS on at least 90% of the assessments they submit to CMS.
- Starting with data collected in CY2024, any SNF that does not meet the requirement will be subject to a reduction of 2 percentage points to the applicable FY annual payment update beginning with FY2026.

FY 2024: Adopting new measure

Discharge Function Score

- This measure assesses functional status by assessing the percentage of SNF residents who meet or exceed an expected discharge function score and uses mobility and self-care items already collected on the MDS.

FY 2024: Removed measures

Change in Self-Care Score and Mobility Score measures, and Patients with an Admission and Discharge Functional Assessment

- Will last appear in the April 2024 Provider Preview Reports for the July 2024 Refresh of SNF QRP data. Starting with the October 2024 Release, these measures will be removed from Care Compare and Provider Data Catalog.

SNF Quality Reporting Program – Measures			
Measure Name	**Data Source**	**Status**	**NOTES**
Potentially Preventable 30-day Post Discharge Readmission	Claims Based	Current	
SNF Healthcare-Associated Infections Requiring Hospitalization	Claims Based	Current	
Medicare Spending Per Beneficiary	Claims Based	Current	
Residents Experiencing One or More Falls with Major Injury (Short –Stay)	MDS Based	Current	
Discharge to Community-Post-Acute Care Measure for SNFs	Claims Based	Current	5 STAR
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	MDS Based	Current	5 STAR
Drug Regimen Review Conducted with Follow-Up for Identified Issues	MDS Based	Current	
Functional Outcomes Measure: Discharge Self Care Score	MDS Based	Current	
Functional Outcomes Measure Discharge Mobility Score	MDS Based	Current	
Patient and Provider Transfer of Health Information Measures (2)	MDS Based	FY 2025	
Discharge Function Score	MDS Based	FY 2025	5 STAR FY 2027
Influenza and COVID-19 Vaccination Measures (3)	MDS CDC - NHSN	Influenza – FY 2024 COVID- 19 - Staff current COVID – 19 Residents FY 2025	

MDS Data Submission Deadlines

To comply with the SNF QRP, individual MDS data submission deadlines must be met.

The data collection year runs from January to December, and the submission deadline for each quarter are as follows:

CY Data Collection Quarter	Data Collection Submission QRP	Submission Deadline
Quarter 1	January 1–March 31	August 15
Quarter 2	April 1–June 30	November 15
Quarter 3	July 1–September 30	February 15
Quarter 4	October 1–December 31	May 15

QRP Resources

- fy-2026-snf-qrp-apu-table-reporting-measures-and-data.pdf-0 (cms.gov)
- 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
- https://www.cms.gov/files/document/fy-2025-snf-qrp-apu-table-reporting-assessment-based-measures-and-standardized-patient-assessment.pdf
- snf-qrp-data-collection-submission-deadlines-fy-2026rev.pdf (cms.gov)

Function Related Measures – Falls with Major Injury

Description: Reports the percentage of Medicare Part A SNF stays where one or more falls with major injury (defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma) were reported during the SNF stay.

Numerator: The total number of Medicare Part A SNF stays (Type 1 SNF Stays only) in the denominator with one or more look-back scan assessments that indicate one or more falls that resulted in major injury (J1900C = [1, 2]).

Denominator: The total number of Medicare Part A SNF stays (Type 1 SNF Stays only) with one or more assessments that are eligible for a look-back scan (except those with exclusions).

Exclusions: -Medicare Part A SNF stays are excluded if:

1. The number of falls with major injury was not coded; i.e., J1900C (Falls with Major Injury) = [-].

2. The resident died during the SNF stay (i.e., Type 2 SNF Stays).

Covariates: None

Function Related Measures - Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

Description: This measure reports the percentage of Medicare Part A SNF stays with Stage 2-4 pressure ulcers, or unstageable pressure ulcers due to slough/eschar, non-removable dressing/device, or deep tissue injury, that are new or worsened since admission. The measure is calculated by reviewing a resident's MDS pressure ulcer discharge assessment data for reports of Stage 2-4 pressure ulcers, or unstageable pressure ulcers due to slough/eschar, non-removable dressing/device, or deep tissue injury, that were not present or were at a lesser stage at the time of admission.

Numerator: The number of Medicare Part A SNF stays (Type 1 SNF Stays only) in the denominator for which the discharge assessment indicates one or more new or worsened Stage 2-4 pressure ulcers, or unstageable pressure ulcers due to slough/eschar, non-removable dressing/device, or deep tissue injury, compared to admission.

Function Related Measures - Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

Denominator: The number of Medicare Part A SNF stays (Type 1 SNF Stays only) in the selected time window for SNF residents ending during the selected time window, except those that meet the exclusion criteria.

Exclusions:

- Data on new or worsened Stage 2, 3, 4, and unstageable pressure ulcers, including deep tissue injuries, are missing [-] at discharge
- The resident died during the SNF stay (i.e., Type 2 SNF Stays)

Covariates:

- Functional Mobility Admission Performance: Coding of dependent or substantial/maximal assistance for the functional mobility item Lying to Sitting on Side of Bed at admission
- Bowel Incontinence
- Peripheral Vascular Disease / Peripheral Arterial Disease or Diabetes Mellitus
- Low body mass index (BMI), based on height (K0200A) and weight (K0200B)

Functional Outcome Measure: Discharge Self Care Score

Description: Estimates the percentage of Medicare Part A SNF stays that meet or exceed an expected discharge self-care score

Section GG items: The Self-Care assessment items used for discharge Self-Care score calculations are:

- GG0130A3. Eating
- GG0130B3. Oral hygiene
- GG0130C3. Toileting hygiene
- GG0130E3. Shower/bathe self
- GG0130F3. Upper body dressing
- GG0130G3. Lower body dressing
- GG0130H3. Putting on/taking off footwear

- To obtain the discharge self-care score, use the following procedure:
  - If code is between 01 and 06, then use code as the value.
  - If code is 07, 09, 10, or 88, then recode to 01 and use this code as the value.
  - If the self-care item is skipped (^), dashed (-) or missing, recode to 01 and use this code as the value.
  - Sum the values of the discharge self-care items to create a discharge self-care score for each Medicare Part A SNF stay record. Scores can range from 7 to 42, with a higher score indicating greater independence.

Functional Outcome Measure: Discharge Self Care Score

Numerator: The total number of Medicare Part A SNF stays (Type 1 SNF Stays only) in the denominator, except those that meet the exclusion criteria, with a discharge self-care score that is equal to or higher than the calculated expected discharge self-care score.

Denominator: The total number of Medicare Part A SNF stays (Type 1 SNF Stays only), except those that meet the exclusion criteria.

Exclusions: Medicare Part A SNF stays are excluded if:

- The Medicare Part A SNF stay is an incomplete stay:
  - Unplanned discharge
  - Discharge to acute hospital, long-term care hospital, psychiatric hospital.
  - SNF PPS Part A stay less than 3 days.
- The resident died during the SNF stay (i.e., Type 2 SNF Stays).
- The resident has any of the following medical conditions at the time of admission (i.e., on the 5-Day PPS assessment): Coma, persistent vegetative state, complete tetraplegia, severe brain damage, locked-in syndrome, or severe anoxic brain damage, cerebral edema or compression of brain.
- The resident is younger than age 18.
- The resident is discharged to hospice or received hospice while a resident
- The resident did not receive OT or PT therapy at the time of admission (i.e., on the 5-Day PPS assessment)

Functional Outcome Measure: Discharge Self Care Score

Covariates: *(Data for each covariate are derived from the admission assessment included in the target Medicare Part A SNF stay.)*

- Age group
- Admission self-care – continuous form
- Admission self-care – squared form
- Primary medical condition category
- Interaction between primary medical condition category and admission self-care
- Prior surgery
- Prior functioning: self-care
- Prior functioning: indoor mobility (ambulation)
- Prior mobility device use
- Stage 2 pressure ulcer
- Stage 3, 4, or unstageable pressure ulcer/injury
- Cognitive abilities
- Communication Impairment
- Urinary Continence
- Bowel Continence
- Tube feeding or total parenteral nutrition
- Comorbidities

Functional Outcome Measure: Discharge Mobility Score

Description: This measure estimates the percentage of Part A SNF stays that meet or exceed an expected discharge mobility score.

Section GG items:

- GG0170A3. Roll left and right
- GG0170B3. Sit to lying
- GG0170C3. Lying to sitting on side of bed
- GG0170D3. Sit to stand
- GG0170E3. Chair/bed-to-chair transfer
- GG0170F3. Toilet transfer
- GG0170G3. Car transfer
- GG0170I3. Walk 10 feet
- GG0170J3. Walk 50 feet with two turns
- GG0170K3. Walk 150 feet
- GG0170L3. Walking 10 feet on uneven surfaces
- GG0170M3. 1 step (curb)
- GG0170N3. 4 steps
- GG0170O3. 12 steps
- GG0170P3. Picking up object

To obtain the discharge self-care score, use the following procedure: If code is between 01 and 06, then use code as the value.

- If code is 07, 09, 10, or 88, then recode to 01 and use this code as the value.
- If the self-care item is skipped (^), dashed (-) or missing, recode to 01 and use this code as the value.
- Sum the values of the discharge self-care items to create a discharge self-care score for each Medicare Part A SNF stay record. Scores can range from 7 to 42, with a higher score indicating greater independence.

Functional Outcome Measure: Discharge Mobility Score

Numerator: The total number of Med A SNF stays (Type 1 SNF Stays only) in the denominator, except those that meet the exclusion criteria, with a discharge mobility score that is equal to or higher than the calculated expected discharge mobility score.

Denominator: The total number of Med A SNF stays (Type 1 SNF Stays only), except those that meet the exclusion criteria.

Exclusions: Medicare Part A SNF stays are excluded if:

- The Medicare Part A SNF stay is an incomplete stay:
  - Unplanned discharge
  - Discharge to acute hospital, long-term care hospital, psychiatric hospital.
  - SNF PPS Part A stay less than 3 days.
- The resident died during the SNF stay (i.e., Type 2 SNF Stays).The resident has any of the following conditions at the time of admission (5-Day PPS assessment):Coma, persistent vegetative state, complete tetraplegia, severe brain damage, locked-in syndrome, or severe anoxic brain damage, cerebral edema or compression of brain.
- The resident is younger than age 18.
- The resident is discharged to hospice or received hospice while a resident
- The resident did not receive OT or PT services at the time of admission (i.e., on the 5-Day PPS assessment)

Functional Outcome Measure: Discharge Mobility Score

Covariates: (Data for each covariate are derived from the admission assessment included in the target Medicare Part A SNF stay.)Age group

- Admission mobility –continuous form
- Admission mobility –squared form
- Primary medical condition category
- Interaction between primary medical condition category and admission mobility
- Prior surgery
- Prior functioning: indoor mobility (ambulation)
- Prior functioning: stairs
- Prior functioning: functional cognition
- Prior mobility device use
- Stage 2 pressure ulcer
- Stage 3, 4, or unstageable pressure ulcer/injury
- Cognitive abilities
- Communication impairment
- Urinary Continence
- Bowel Continence
- History of falls
- Tube feeding or total parenteral nutrition
- Comorbidities

Discharge Function Score

Description: This measure estimates the percentage of Medicare Part A SNF stays that meet or exceed an expected discharge function score

Section GG assessment items used for discharge function score calculations are:

- GG0130A3. Eating
- GG0130B3. Oral hygiene
- GG0130C3. Toileting hygiene
- GG0170A3. Roll left and right
- GG0170C3. Lying to sitting on side of bed
- GG0170D3. Sit to stand
- GG0170E3. Chair/bed-to-chair transfer
- GG0170F3. Toilet transfer
- GG0170I3: Walk 10 Feet*
- GG0170J3: Walk 50 Feet with 2 Turns*
- GG0170R3. Wheel 50 feet with 2 Turns

Discharge Function Score

To obtain the discharge function score, use the following procedure:

- If code is between 01 and 06, use the code as the value.
- If code is 07, 09, 10, 88, dashed (-), then use statistical imputation to estimate the item value for that item and use this code as the value.
- If the item is skipped (^), dashed (-), or missing, then use statistical imputation to estimate the item value for that item and use this code as the value.
- Sum the values of the discharge function items to calculate the observed discharge function score for each Medicare Part A SNF stay. Scores can range from 10 to 60, with a higher score indicating greater independence.

Numerator: The total number of Medicare Part A SNF stays (Type 1 SNF Stays only) in the denominator, except those that meet the exclusion criteria, with an observed discharge function score that is equal to or greater than the calculated expected discharge function score.

Denominator: The total number of Medicare Part A SNF stays (Type 1 SNF Stays only), except those that meet the exclusion criteria.

Discharge Function Score

Exclusions: Medicare Part A SNF stays are excluded if:

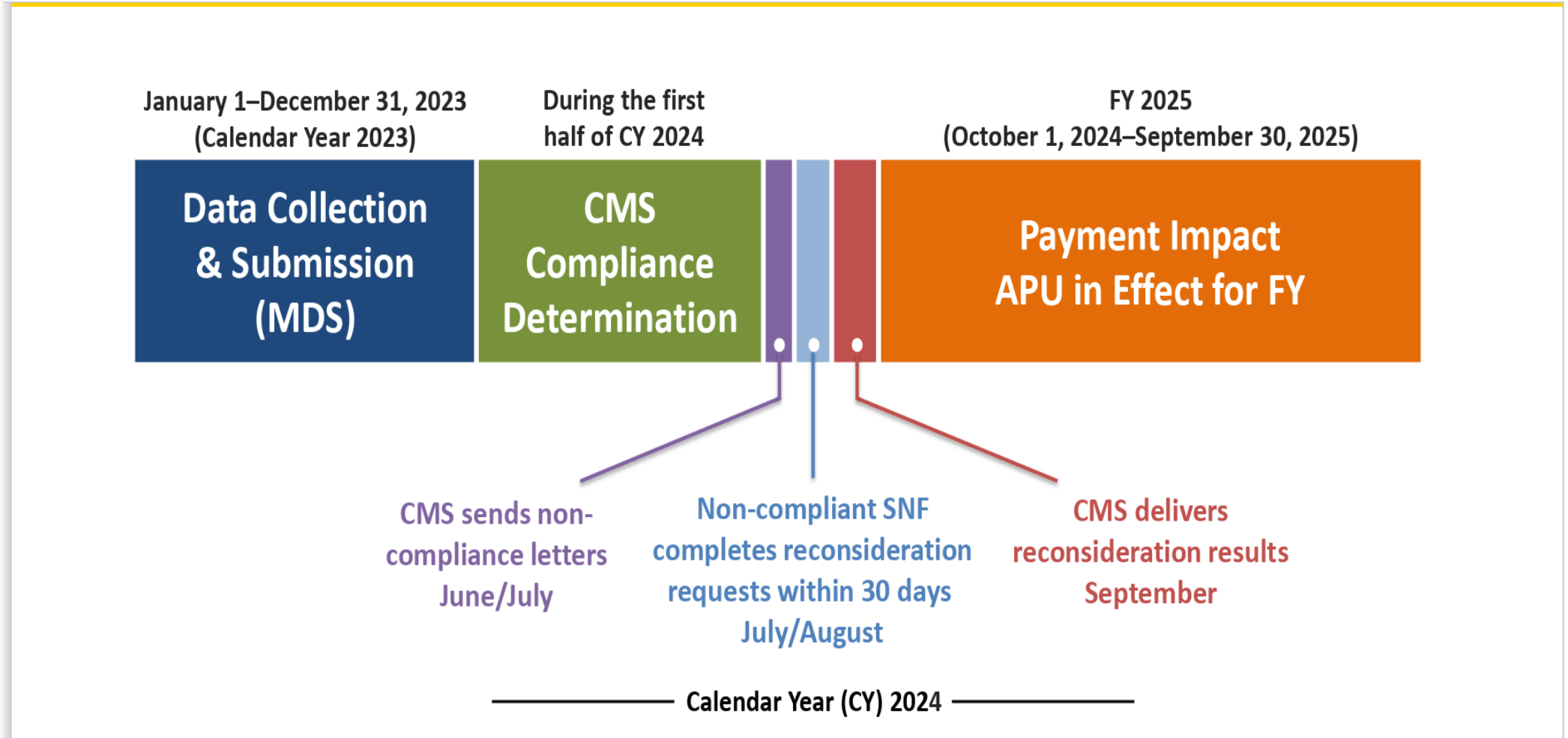
- The Medicare Part A SNF stay is an incomplete stay:
  - Unplanned discharge
  - Discharge to acute hospital, long-term care hospital, psychiatric hospital.
  - SNF PPS Part A stay less than 3 days.
  - The resident died during the SNF stay (i.e., Type 2 SNF Stays).
- The resident has any of the following medical conditions at the time of admission (i.e., on the 5-Day PPS assessment):Coma, persistent vegetative state, complete tetraplegia, severe brain damage, locked-in syndrome, or severe anoxic brain damage, cerebral edema or compression of brain.
- The resident is younger than age 18.
- The resident is discharged to hospice or received hospice while a resident
- The resident did not receive physical or occupational therapy services at the time of admission (i.e., on the 5-Day PPS assessment

Discharge Function Score

Covariates:

- Age group
- Admission function –continuous form
- Admission function –squared form
- Primary medical condition category
- Interaction between admission function and primary medical condition category
- Prior surgery
- Prior functioning: self-care
- Prior functioning: indoor mobility (ambulation)
- Prior functioning: stairs
- Prior functioning: functional cognition
- Prior mobility device use
- Stage 2 pressure ulcer/injury
- Stage 3, 4, or unstageable pressure ulcer/injury
- Cognitive abilities
- Communication impairment
- Urinary Continence
- Bowel Continence
- History of falls
- Nutritional approaches
- High BMI
- Low BMI
- Comorbidities

Relationship Between Quality Reporting and APU: SNF QRP Life Cycle



Feedback and Monitoring

iQIES Report

SNF QRP Facility-Level Quality Measure (QM) Report

Requested Report End Date: 03/31/2024
Report Run Date: 02/21/2024
Report Version Number: 2.5

Facility ID: **Facility Name:** I **CCN:** **City/State:**

Source: Minimum Data Set 3.0 (MDS 3.0)

Data Calculation Date: 02/15/2024

Table Legend
Dash (-): Data not available or not applicable

Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Numerator	Denominator	Facility Observed Percent	Facility Risk-Adjusted Percent	National Average
Pressure Ulcer/Injury	04/01/2023 - 03/31/2024	S038.02	04/01/2023 - 03/31/2024	3	49	6.1%	6.1%	2.7%

Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Numerator	Denominator	Facility Percent	National Average
Application of Falls	04/01/2023 - 03/31/2024	S013.02	04/01/2023 - 03/31/2024	1	49	2.0%	1.0%

Feedback and Monitoring

iQIES Report

SNF QRP Resident-Level Quality Measure (QM) Report

Requested Report End Date: 03/31/2024
Report Run Date: 02/21/2024
Data Calculation Date: 02/15/2024
Report Version Number: 2.4

SNF QRP Quality Measures Legend

QM #	Measure Name	Measure Interpretation	Report Period	CMS ID	CMS ID Discharge Dates
1	Pressure Ulcer/Injury	Undesirable Outcomes	04/01/2023 - 03/31/2024	S038.02	04/01/2023 - 03/31/2024
2	Application of Falls	Undesirable Outcomes	04/01/2023 - 03/31/2024	S013.02	04/01/2023 - 03/31/2024
3	Functional Status Outcome: Discharge Self-Care Score	Desirable Outcomes or Processes Performed	04/01/2023 - 03/31/2024	S024.04; S024.05	04/01/2023 - 09/30/2023; 10/01/2023 - 03/31/2024
4	Functional Status Outcome: Discharge Mobility Score	Desirable Outcomes or Processes Performed	04/01/2023 - 03/31/2024	S025.04; S025.05	04/01/2023 - 09/30/2023; 10/01/2023 - 03/31/2024
5	Discharge Function Score	Desirable Outcomes or Processes Performed	04/01/2023 - 03/31/2024	S042.01	04/01/2023 - 03/31/2024
6	DRR	Desirable Outcomes or Processes Performed	04/01/2023 - 03/31/2024	S007.02	04/01/2023 - 03/31/2024

Table Legend

Dash (-): Data not available or not applicable
X: Triggered (Bold indicates an undesirable outcome)
NT: Not Triggered (Bold indicates a desirable outcome did not occur or process was not performed)
E: Excluded from analysis based on quality measure exclusion criteria

Feedback and Monitoring

SNF QRP Resident-Level Quality Measure (QM) Report

iQIES Report

				Undesirable Outcomes		*Desirable Outcomes or Processes Performed*			
Resident Name	**Resident ID**	**Admission Date**	**Discharge Date**	**QM 1**	**QM 2**	**QM 3**	**QM 4**	**QM 5**	**QM 6**
		10/11/2023	10/31/2023	NT	NT	X	X	X	X
		08/19/2023	10/27/2023	NT	NT	NT	X	X	X
		10/02/2023	10/21/2023	NT	NT	NT	NT	NT	X
		09/19/2023	10/10/2023	NT	NT	NT	X	X	X
		08/25/2023	10/05/2023	NT	NT	X	X	X	X
		09/26/2023	10/01/2023	NT	NT	NT	X	X	X
		06/21/2023	09/07/2023	NT	NT	NT	NT	NT	X
		07/01/2023	09/03/2023	NT	NT	X	NT	X	X
		06/15/2023	08/28/2023	NT	NT	X	X	X	X
		07/01/2023	08/25/2023	NT	NT	X	X	X	X
		05/01/2023	07/22/2023	NT	NT	NT	X	X	X
		06/13/2023	07/16/2023	NT	NT	X	X	X	X
		07/02/2023	07/15/2023	NT	NT	NT	X	NT	X
		04/04/2023	07/12/2023	NT	NT	NT	NT	NT	X
		05/22/2023	06/20/2023	NT	NT	NT	NT	NT	X
		05/05/2023	06/19/2023	NT	NT	X	X	X	X
		06/02/2023	06/18/2023	X	NT	NT	NT	X	X

iQIES Report

SNF QRP Review and Correct Report

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

Requested Quarter End Date:	Q4 2023
Report Release Date:	01/01/2024
Report Run Date:	02/21/2024
Data Calculation Date:	02/19/2024
Report Version Number:	3.1

Definitions

Dash (-):	Data not available or not applicable
X:	Triggered (Bold indicates an undesirable outcome)
NT:	Not Triggered (Bold indicates a desirable outcome did not occur or process was not performed)
E:	Excluded from analysis based on quality measure exclusion criteria.

SNF QRP Review and Correct Report

iQIES Report

MDS 3.0 QUALITY MEASURE

Application of Falls

Reference page 1 of this report to locate the Table Legend

FACILITY-LEVEL DATA

Reporting Quarter	CMS ID	Start Date	End Date	Data Correction Deadline	Data Correction Period as of Report Run Date	Number of SNF Stays that Triggered the Quality Measure	Number of SNF Stays Included in the Denominator	Facility Percent
Q4 2023	S013.02	10/01/2023	12/31/2023	05/15/2024	Open	0	15	0.0%
Q3 2023	S013.02	07/01/2023	09/30/2023	02/15/2024	Closed	0	8	0.0%
Q2 2023	S013.02	04/01/2023	06/30/2023	11/15/2023	Closed	1	20	5.0%
Q1 2023	S013.02	01/01/2023	03/31/2023	08/15/2023	Closed	0	22	0.0%
Cumulative	-	**01/01/2023**	**12/31/2023**	-	-	**1**	**65**	**1.5%**

iQIES Report

FY 2026 SNF QRP Provider Threshold Report

CCN		**Report Run Date**	02/21/2024
Facility Name		**Data Collection Start Date**	01/01/2024
City/State		**Data Collection End Date**	12/31/2024

# of MDS 3.0 Assessments Submitted: 19

# of MDS 3.0 Assessments Submitted Complete: 19

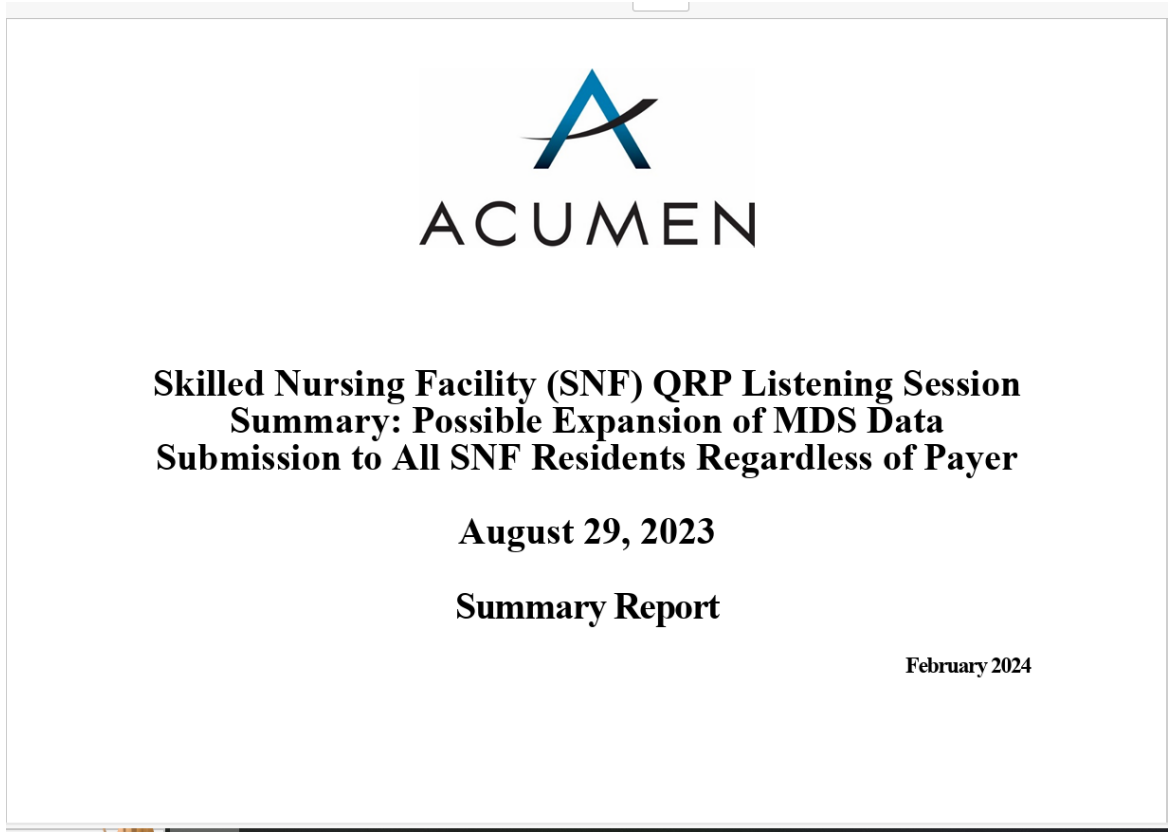
% of MDS 3.0 Assessments Submitted Complete: 100%*

* FY 2026 SNF QRP Annual Payment Update (APU) Determination Table is limited to the data elements that are used for determining SNF QRP compliance and are included in the APU submission threshold. There are additional data elements used to risk adjust the quality measures used in the SNF QRP. It should be noted that failure to submit all data elements used to calculate and risk adjust a quality measure can affect the quality measure calculations that are displayed on the Compare website.

Keys to Success

- Understand your measures
- Be aware of what is triggering while you're completing the MDS
- Keep track of your data
- Run your threshold reports frequently
- Know the review and correct deadlines
- Make corrections as necessary
- Care Compare is your reflection.

Possible Future of Quality Reporting



ACUMEN

Skilled Nursing Facility (SNF) QRP Listening Session Summary: Possible Expansion of MDS Data Submission to All SNF Residents Regardless of Payer

August 29, 2023

Summary Report

February 2024

Value Based Purchasing

The Protecting Access to Medicare Act of 2014 (PAMA), required the Department of Health and Human Services to establish a SNF VBP Program. The Program began affecting SNF payments on October 1, 2018.

PAMA specifies that under the SNF VBP Program, SNFs:

- Are evaluated by their performance on a hospital readmission measure;
- Are assessed on 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.
- All SNFs paid under the Medicare PPS program are included in the SNF VBP Program. This does not require any action on the part of SNFs.

Value Based Purchasing

- As required by statute, CMS withholds 2% of SNFs' Medicare fee-for-service (FFS) Part A payments to fund the program.
- CMS is required to redistribute between 50% and 70% as incentive payments. CMS currently redistributes 60% of the withhold to SNFs as incentive payments, and the remaining 40% of the withhold is retained in the Medicare Trust Fund.
- Congress amended Section 1888(h) of the Social Security Act to allow the HHS Secretary to apply up to nine additional measures to the SNF VBP Program for payments for services furnished on or after October 1, 2023 (FY2024). Eight additional measures have been approved so far.

SNF VALUE BASED PURCHASING - Measures by Program Years						
Measure Name	Data Source	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028
SNF 30-Day All-Cause Readmission	Claims Based	X	X	X	X	
SNF Healthcare-Associated Infections Requiring Hospitalization*	Claims Based			X	X	X
Total Nurse Staffing Hours per Resident Day*	PBJ System			X	X	X
Total Nursing Staff Turnover+	PBJ System			X	X	X
Discharge to Community-Post-Acute Care Measure for SNFs*	Claims Based				X	X
Residents Experiencing One or More Falls with Major Injury (Long-Stay)+	MDS				X	X
Discharge Function Score for SNFs+	MDS				X	X
Number of Hospitalizations per 1,000 Long Stay Resident Days+	Claims Based				X	X
SNF Within-Stay Potentially Preventable Readmissions+	Claims Based					X

*New SNF VBP measure finalized in the FY2023 SNF Prospective Payment System (PPS) Final Rule +New SNF VBP measure finalized in the FY2024 SNF Final Rule

SNF VALUE BASED PURCHASING - Measure Baseline and Performance Periods			
Measure Name	First Program Fiscal Year (FY)	First Performance Period	First Baseline Period
SNF 30-Day All-Cause Readmission	FY2019	Calendar Year (CY) 2017	CY2015
SNF Healthcare-Associated Infections Requiring Hospitalization	FY2026	FY2024	FY2022
Total Nurse Staffing Hours per Resident Day	FY2026	FY2024	FY2022
Total Nursing Staff Turnover	FY2026	FY2024	FY2022
Discharge to Community-Post-Acute Care Measure for SNFs	FY2027	FY2024 and FY2025	FY2021 and FY2022
Residents Experiencing One or More Falls with Major Injury (Long-Stay)	FY2027	FY2025	FY2023
Discharge Function Score	FY2027	FY2025	FY2023
Number of Hospitalizations per 1,000 Long Stay Resident Days	FY2027	FY2025	FY2023
SNF Within-Stay Potentially Preventable Readmissions	FY2028	FY2025 and FY2026* (10/1/24 - 9/30/26)	FY2022&2023 10/1/21 - 9/30/23
SNF 30-Day All-Cause Readmission	LAST PROGRAM YEAR - FY2027	LAST PERF. PERIOD FY2025* 10/1/24 - 9/30/25	LAST BASELINE FY2023* 10/1/22 - 9/30/23

*The SNF WS PPR measure is a 2-year measure. The SNFRM is a 1-year measure. The data used to calculate the baseline and performance period for the SNF WS PPR measure for the FY2028 program year will include data that are also used to calculate the baseline and performance period for the SNFRM for the FY2027 program year.

Value Based Purchasing Resources

FY2024-SNF-VBP-Fact-Sheet.pdf (cms.gov)

The Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program | CMS

Discharge to Community (DTC)

Description: This measure reports a SNF's risk-standardized rate of Medicare FFS residents who are discharged to the community following a SNF stay, do not have an unplanned readmission to an acute care hospital or LTCH in the 31 days following discharge to community, and remain alive during the 31 days following discharge to community. Community, for this measure, is defined as home or selfcare, with or without home health services.

Claims based – also QRP measure

- 2-year **baseline period:** FY 2021 through FY 2022 (October 1, 2020, through September 30, 2022)
- 2-year **performance period:** FY 2024 through FY 2025 (October 1, 2023, through September 30, 2025)
- **Achievement Threshold:** 0.42946, **Benchmark:** 0.66370
- **Program year impact:** 2027
- **Case Minimums:** SNFs must have a minimum of 25 eligible stays during the applicable 2-year performance period to be eligible to receive a score on the measure

Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

This measure assesses the falls with major injury rates of long-stay residents (All payers)

1 year baseline period: FY2023 (October 1, 2022, through September 30, 2023)

1 year performance period: FY2025 (October 1, 2024, through September 30, 2025)

Program Year Impact: FY2027

Case Minimum: minimum of 20 residents in the measure denominator during the 1-year performance period in order to be eligible to receive a score on the measure for the applicable fiscal program year.

Various Re-hospitalization Measures

Long Stay Hospitalization Measure per 1000 long-stay resident days

This measure assesses the hospitalization rate of long-stay residents (Part A and Part B only)

- 1 year **baseline period:** FY 2023 (October 1, 2022, through September 30, 2023)
- 1 year performance period: FY 2025 (October 1, 2024, through September 30, 2025)
- **Program Year Impact:** FY 2027
- **Case Minimum:** minimum of 20 eligible stays during the 1-year performance period in order to be eligible to receive a score on the measure for the applicable fiscal program year.

Skilled Nursing Facility Within Stay Potentially Preventable Readmissions (SNF WS PPR) (replacement of the SNFRM)

This potentially preventable readmission (PPR) measure estimates the risk-standardized rate of unplanned, potentially preventable readmissions that occur during skilled nursing facility (SNF) stays among Medicare fee-for-service (FFS) beneficiaries.

- 2-year **baseline period:** FY 2022 and FY 2023 (October 1, 2021, through September 30, 2023)
- 2-year performance period: FY 2025 and 2026 (Oct. 1, 2024 – Sept. 30, 2026)
- **Program Year Impact:** FY 2028
- **Case Minimum:** minimum of 25 eligible stays during the 2-year performance period in order to be eligible to receive a score on the measure for the applicable fiscal program year

QRP and VBP Health Equity program

CMS is committed to developing approaches to meaningfully incorporate the advancement of HealthEquity into both the SNF QRP and VBP programs. This is one of the reasons why the SDOH data items were added to the MDS.

For the QRP program confidential feedback reports are available on IQIES for two measures, Medicare spending per beneficiary and discharge to community

For the VBP program, CMS has adopted a HealthEquity adjustment that will reward SNF's that perform well and whose resident population during the performance. Includes 20% of residents with dual eligibility status. Adjustment will begin in the FY2027

The Function or Function Based Measures – Key Components

QMs

QRP

VBP

5- STAR

CARE COMPARE

PDPM

PDPM MEDICAID RATE SETTING

Functional Quality Measures Most Impacted By Therapy							
Functional Measures	**iQIES**	**Care Compare**	**5 Star**	**VBP**	**QRP**	**5 Star points**	**MDS Contributing Items**
Residents whose ability to walk independently worsened	✓	✓	✓			150	GG0170I Walk 10 ft.
Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (LS)	✓	✓	✓			150	GG0170B Sit to Lying GG0170D Sit to Stand GG0130A Eating GG0170F Toilet Transfer
Discharge Function Score (Short Stay)	✓	✓	✓	✓	✓	150	GG0130A Eating GG0130B Oral hygiene GG0170A Roll left and right GG0170C Lying to sitting on side of bed GG0170D Sit to stand GG0170E Chair/bed-to-chair transfer GG0170F Toilet transfer GG0170I Walk 10 ft GG0170J Walk 50 Ft with 2 Turns*
Discharge Self-Care Score for Medical Rehabilitation patients meets or exceeds expected dc score	✓	✓			✓		GG0130 A,B,C,E,F,G,H except personal hygiene
Discharge Mobility Score for Medical Rehabilitation Patients	✓	✓			✓		All mobility items GG0170A - P
Discharge to Community	✓	✓	✓	✓	✓	150	Claims Based

SNFs in precarious position moving to GG

Percentage of residents who are at or above an expected ability to care for themselves at discharge *Higher percentages are better*	**35.4%** National average: 50.5%
Percentage of residents who are at or above an expected ability to move around at discharge *Higher percentages are better*	**16.7%** National average: 46.3%
Change in residents' ability to care for themselves *Higher scores are better*	**5.8** National average: 7.9
Change in residents' ability to move around *Higher scores are better*	**9.4** National average: 18.7

If therapy outcomes look like this

Treatment Statistics

Avg Daily Tx	Avg Tx Days	Avg Total Tx
74.20	30.71	1,420.54
Natl Daily	Natl Tx Days	Natl Total Tx
50.05	29.75	629.21

Outcome Statistics

Avg Outcome	Avg Start	Avg End
0.78	2.10	2.88
Natl Outcome	Natl Start	Natl End
0.32	1.98	2.30

SNFs well positioned for transition???

Percentage of residents who are at or above an expected ability to care for themselves at discharge

Higher percentages are better

64.2%

National average: 50.5%

Percentage of residents who are at or above an expected ability to move around at discharge

Higher percentages are better

65.7%

National average: 46.3%

Change in residents' ability to care for themselves

Higher scores are better

10.3

National average: 7.9

Change in residents' ability to move around

Higher scores are better

25.2

National average: 18.7

CMS had frozen all measures utilizing section GG starting with October 1st of last year. Providers were guessing on how well they did with the transition and how much it impacted their quality measures…

Until now

The Big Reveal

Keys to Survival - IDT

Section GG Training – CNA on up

Consistent, Accurate Capture of Patient Performance – no holes in patient data

Team Collaboration and Culture Development

Effective Functional Communication – Change in Condition

Planning for the Future – Who has been in the CMI driver's set?

PDPM Nursing Clinical Heirarchy

Nursing Category	Extensive Services	Clinical Conditions	Depression	Restorative	Function Score	Nursing Case Mix Group	Nursing Case Mix Index
Extensive Services	Trach & Vent	Infection Isolation			**0-14**	**ES3**	**4.06**
	Trach or Vent				**0-14**	**ES2**	**3.07**
	Infection				**0-14**	**ES1**	**2.93**
Special Care High		**Serious Medical Conditions** (Comatose and completely dependent, septicemia, diabetes w/Insulin injections & 2 or more days of Insulin order changes, quadriplegia, asthma or COPD w/SOB while lying flat, fever w/pneumonia or vomiting, parental/IV feedings, respiratory therapy)	Yes		0-5	HDE2	2.40
			No		0-5	HDE1	1.99
			Yes		6-14	HBC2	2.24
			No		6-14	HBC1	1.86
Special Care Low		**Serious Medical Conditions** (CP, MS, Parkinson's Disease, respiratory failure & O2 therapy, pressure ulcers, foot infection, diabetic foot ulcers, radiation therapy, dialysis)	**Yes**		**0-5**	**LDE2**	**2.08**
			No		**0-5**	**LDE1**	**1.73**
			Yes		**6-14**	**LBC2**	**1.72**
			No		**6-14**	**LBC1**	**1.43**
Clinically Complex		**Conditions Requiring Complex Medical Care** (Pneumonia, hemiplegia/hemiparesis, surgical wounds, burns chemotherapy, Oxygen therapy , IV medications, transfusions)	Yes		0-5	CDE2	1.87
			No		0.5	CDE1	1.62
			Yes		6-14	CBC2	1.55
			Yes		15-16	CA2	1.09
			No		6-14	CBC1	1.34
			No		15-16	CA1	0.94
Behavioral Symptoms or Cognitive Performance		**Behavioral Symptoms (BIMS score of 9 or less and Function score of ≥ 11, hallucinations, delusions, wandering, behaviors directed at others)**		**2 or more**	**11-16**	**BAB2**	**1.04**
				0-1	**11-16**	**BAB1**	**0.99**
Reduced Physical Function		**Assistance with Daily Living and General Supervision** (Residents who do not meet the conditions of any previous categories or who would meet the criteria of behavior symptoms and cognition performance but have a Function Score less than 11)		2 or more	0-5	PDE2	1.57
				0-1	0-5	PDE1	1.47
				2 or more	6-14	PBC2	1.22
				2 or more	15-16	PA2	0.71
				0-1	6-14	PBC1	1.13
				0-1	15-16	PA1	0.66

A Re-Focus on True Therapy Value


OBRA '87
The Nursing Home Reform Act

A GENTLE REMINDER FROM CMS

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE

MEDICARE ENROLLMENT & APPEALS GROUP

DATE: February 13, 2024

TO: All Medicare Advantage Organizations

FROM: Jerry Mulcahy
Director, Medicare Enrollment and Appeals Group

SUBJECT: **REMINDER:** Jimmo Settlement Coverage and Training Policies

This memorandum is to remind Medicare Advantage Organizations ("MAOs") of certain skilled therapy coverage and training policies related to the *Jimmo v. Sebelis* Settlement Agreement. CMS is supplying the following information and links to materials for MAOs to use to refresh and/or train staff and contracted providers to ensure Medicare Advantage services are provided – and organization determinations and reconsiderations are adjudicated accurately and appropriately – in accordance with existing Medicare policy.

The Centers for Medicare & Medicaid Services (CMS) reminds MAOs of the Jimmo Settlement Agreement (January 2013), which clarified that the Medicare program covers skilled nursing care and skilled therapy services under Medicare's skilled nursing facility, home health, and outpatient therapy benefits when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met). Specifically, the Jimmo Settlement required manual revisions to restate a "maintenance coverage standard" for both skilled nursing and therapy services under these benefits:

- Skilled nursing services are covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration, so long as the beneficiary requires skilled care for the services to be safely and effectively provided.

- Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program.

The Jimmo Settlement may have reflected a change in practice for those providers, adjudicators, and contractors who may have erroneously believed that the Medicare program covers nursing and therapy services under these benefits only when a beneficiary is expected to improve. The Settlement is consistent with the Medicare program's regulations governing maintenance nursing and therapy in

Keys to Survival – Therapy Expectation

- Function Based Treatment that meets the needs of the resident
- Caregiver Training and Return Demonstration
- Quarterly Screen Timing
- Competency Hand Off Training
- Revisit a true FMP Focus
- Restorative Nursing – Combatting PAIs
- Participate in QAPI

It takes a village…..
Any questions?