



How Quality, Value and Managed Care are Impacting Your Bottom Line

Presented by

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Post-Acute Care Advisors of Clinical Operations and Regulatory Compliance

Post-Acute Care Operations

- ✓ Reimbursement & Regulatory Advisory Services
- ✓ PDPM/MDS/CMI Expertise

Quality Improvement

- ✓ 5-Star Rating/Quality Improvement Strategies
- ✓ Payroll Based Journal Reporting Guidance

Provider Litigation Support for Post-Acute Care

- ✓ Independent Review Organization (IRO)
- ✓ Mergers and Acquisitions Due Diligence

Compliance Solutions

- ✓ Medicare Compliance Auditing

Clinical Care Management

- ✓ Survey Preparedness
- ✓ Infection Prevention Protocols

Medical Coding and Billing



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MDSRescue steps in remotely for facilities anywhere in the country. Subject matter experts ensure assessment completion conforms to regulations, is accurate and timely, which improves 5-Star ratings. MDSRescue alleviates the financial burdens of traditional hiring process, and reports MDS hours for Payroll-Based Journals when applicable.

REMOTE PRN SERVICE

- Flexible coverage
- Support during rise in caseload, staff vacations
- Avoid traditional hiring costs

SKILLED STAFF

- High level, qualified staff, many RAC-Certified nurses
- Continually educated to attain the most up-to-date information

REVENUE INTEGRITY

- Maintaining quality documents supports compliance, contributing to peace of mind and payment retention

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Objectives

- Discuss the FY24 CMS changes to revenue calibration
- Explain the impact to the PDPM rates
- Illustrate increased Managed Care beneficiary penetration
- Display the impact on revenue that Managed Medicare has
- Review the new quality measures in both SNFQRP and SNFVBP
- Identify overlaps between the QM programs



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Reimbursement Changes for FY24

Rate Calibration



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Parity Adjustment Delay FY22

- Increase in aggregate spending of 5.3%
- Delayed for FY22, similar outcome to the 2012 reduction of 12.5%
- Due to an increase in CMIs from 2017 estimates to 2020 actual
- Estimated an increase of 1.46 (46%) actual increase higher, CMS proposing a reduction of CMIs to 37%
- Parity adjustment of \$1.7 billion proposed resulting in a 5% reduction to PPS rates over 2 years



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Table 13: Average Case-Mix Index, Expected and Actual, by PDPM Component

Component	Expected Average CMI (FY 2019 Estimate, Subject Population)	Actual CMI per Stay (Control, Period, Subset, Population)	Percentage Difference
PT	1.51	1.52	0.4%
OT	1.51	1.52	0.4%
SLP	1.40	1.66	18.6%
Nursing	1.45	1.60	10.8%
NTA	1.16	1.20	3.0%



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Base Rates FY 24

TABLE 3: FY 2024 Unadjusted Federal Rate Per Diem—URBAN

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	\$70.08	\$65.23	\$26.16	\$122.15	\$92.16	\$109.39

TABLE 4: FY 2024 Unadjusted Federal Rate Per Diem—RURAL

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	\$79.88	\$73.36	\$32.96	\$116.71	\$88.05	\$111.41

2023 proposed rule p.6

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PT 2022 vs. 2023 Impact of CMI Changes

URBAN

RURAL

	PT 2023 Base Rate	PT CMI-2022	PT CMI-2023	CMI Difference	% CMI decline	\$ difference	% \$ difference
A	\$66.06	1.53	1.49	0.04	2.61%	-\$2.64	-2.61%
B	\$66.06	1.70	1.65	0.05	2.94%	-\$3.30	-2.94%
C	\$66.06	1.88	1.83	0.05	2.66%	-\$3.30	-2.66%
D	\$66.06	1.92	1.87	0.05	2.60%	-\$3.30	-2.60%
E	\$66.06	1.42	1.38	0.04	2.82%	-\$2.64	-2.82%
F	\$66.06	1.61	1.57	0.04	2.48%	-\$2.64	-2.48%
G	\$66.06	1.67	1.62	0.05	2.99%	-\$3.30	-2.99%
H	\$66.06	1.16	1.13	0.03	2.59%	-\$1.98	-2.59%
I	\$66.06	1.13	1.10	0.03	2.65%	-\$1.98	-2.65%
J	\$66.06	1.42	1.38	0.04	2.82%	-\$2.64	-2.82%
K	\$66.06	1.52	1.48	0.04	2.63%	-\$2.64	-2.63%
L	\$66.06	1.09	1.06	0.03	2.75%	-\$1.98	-2.75%
M	\$66.06	1.27	1.24	0.03	2.36%	-\$1.98	-2.36%
N	\$66.06	1.48	1.44	0.04	2.70%	-\$2.64	-2.70%
O	\$66.06	1.55	1.51	0.04	2.58%	-\$2.64	-2.58%
P	\$66.06	1.08	1.05	0.03	2.78%	-\$1.98	-2.78%
AVERAGES	66.06	1.46	1.43	0.04	2.69%	-\$2.60	-2.69%

	PT 2023 Base Rate	PT CMI- 2022	PT CMI-2023	CMI Difference	% CMI decline	\$ difference	% \$ difference
A	\$75.30	1.53	1.45	0.08	5.23%	-\$6.02	-5.23%
B	\$75.30	1.70	1.61	0.09	5.29%	-\$6.78	-5.29%
C	\$75.30	1.88	1.78	0.10	5.32%	-\$7.53	-5.32%
D	\$75.30	1.92	1.82	0.10	5.21%	-\$7.53	-5.21%
E	\$75.30	1.42	1.34	0.08	5.63%	-\$6.02	-5.63%
F	\$75.30	1.61	1.52	0.09	5.59%	-\$6.78	-5.59%
G	\$75.30	1.67	1.58	0.09	5.39%	-\$6.78	-5.39%
H	\$75.30	1.16	1.10	0.06	5.17%	-\$4.52	-5.17%
I	\$75.30	1.13	1.07	0.06	5.31%	-\$4.52	-5.31%
J	\$75.30	1.42	1.34	0.08	5.63%	-\$6.02	-5.63%
K	\$75.30	1.52	1.44	0.08	5.26%	-\$6.02	-5.26%
L	\$75.30	1.09	1.03	0.06	5.50%	-\$4.52	-5.50%
M	\$75.30	1.27	1.20	0.07	5.51%	-\$5.27	-5.51%
N	\$75.30	1.48	1.40	0.08	5.41%	-\$6.02	-5.41%
O	\$75.30	1.55	1.47	0.08	5.16%	-\$6.02	-5.16%
P	\$75.30	1.08	1.02	0.06	5.56%	-\$4.52	-5.56%
AVERAGES	75.30	1.46	1.39	0.08	5.39%	-\$5.93	-5.39%

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FY24 Urban CMI

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.45	\$101.62	1.41	\$91.97	0.64	\$16.74	ES3	3.84	\$469.06	3.06	\$282.01
B	1.61	\$112.83	1.54	\$100.45	1.72	\$45.00	ES2	2.90	\$354.24	2.39	\$220.26
C	1.78	\$124.74	1.60	\$104.37	2.52	\$65.92	ES1	2.77	\$338.36	1.74	\$160.36
D	1.81	\$126.84	1.45	\$94.58	1.38	\$36.10	HDE2	2.27	\$277.28	1.26	\$116.12
E	1.34	\$93.91	1.33	\$86.76	2.21	\$57.81	HDE1	1.88	\$229.64	0.91	\$83.87
F	1.52	\$106.52	1.51	\$98.50	2.82	\$73.77	HBC2	2.12	\$258.96	0.68	\$62.67
G	1.58	\$110.73	1.55	\$101.11	1.93	\$50.49	HBC1	1.76	\$214.98	-	-
H	1.10	\$77.09	1.09	\$71.10	2.7	\$70.63	LDE2	1.97	\$240.64	-	-
I	1.07	\$74.99	1.12	\$73.06	3.34	\$87.37	LDE1	1.64	\$200.33	-	-
J	1.34	\$93.91	1.37	\$89.37	2.83	\$74.03	LBC2	1.63	\$199.10	-	-
K	1.44	\$100.92	1.46	\$95.24	3.5	\$91.56	LBC1	1.35	\$164.90	-	-
L	1.03	\$72.18	1.05	\$68.49	3.98	\$104.12	CDE2	1.77	\$216.21	-	-
M	1.20	\$84.10	1.23	\$80.23	-	-	CDE1	1.53	\$186.89	-	-
N	1.40	\$98.11	1.42	\$92.63	-	-	CBC2	1.47	\$179.56	-	-
O	1.47	\$103.02	1.47	\$95.89	-	-	CA2	1.03	\$125.81	-	-
P	1.02	\$71.48	1.03	\$67.19	-	-	CBC1	1.27	\$155.13	-	-
Q	-	-	-	-	-	-	CA1	0.89	\$108.71	-	-
R	-	-	-	-	-	-	BAB2	0.98	\$119.71	-	-
S	-	-	-	-	-	-	BAB1	0.94	\$114.82	-	-
T	-	-	-	-	-	-	PDE2	1.48	\$180.78	-	-
U	-	-	-	-	-	-	PDE1	1.39	\$169.79	-	-
V	-	-	-	-	-	-	PBC2	1.15	\$140.47	-	-
W	-	-	-	-	-	-	PA2	0.67	\$81.84	-	-
X	-	-	-	-	-	-	PBC1	1.07	\$130.70	-	-
Y	-	-	-	-	-	-	PA1	0.62	\$75.73	-	-

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FY 24 Proposed Rule

Market Basket and Adjustments	Figures
Unadjusted	2.7%
Forecast Error Remains Helpful	3.6%
MFP Decrease of 0.2%	-0.2%
Year 2 of 2-Year Parity Adjustment Phase-in Decrease of 2.3%	-2.3%
Net Final Market Basket	3.7%



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High Risk Areas for Revenue Recoupment

- Diagnostic Assignment
 - Primary and other
- Supportive documentation- Skilled services, no hospital stay
- Signatures and dates
- Coding
 - MDS
 - Claims



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Managed Care/Medicare Advantage



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Medicare Advantage Is On the Rise

- CMS is encouraging beneficiaries to enroll in managed care plans
 - Marketing efforts increased for seniors, or those approaching
 - More and more beneficiaries are choosing MA plans



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MAO Denials on the Rise

- Light needs to be shed on provider issues involving MA plan denials
 - Case managers 'choosing' PDPM scores and requiring MDSC to falsify MDS coding to match their PDPM scores
 - Misinterpretation of RAI guidelines to deny coding, assessment types, ARDs, completion dates, and submission dates
- **Managed Care Final Rule published 4/12/23 addresses these issues!**



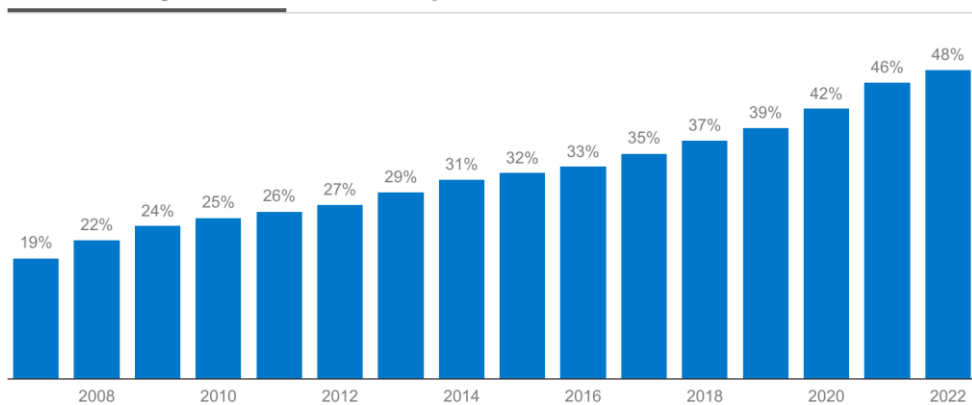
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Figure 1

Total Medicare Advantage Enrollment, 2007-2022

Medicare Advantage Penetration

Medicare Advantage Enrollment



NOTE: Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 58.6 million people are enrolled in Medicare Parts A and B in 2022.

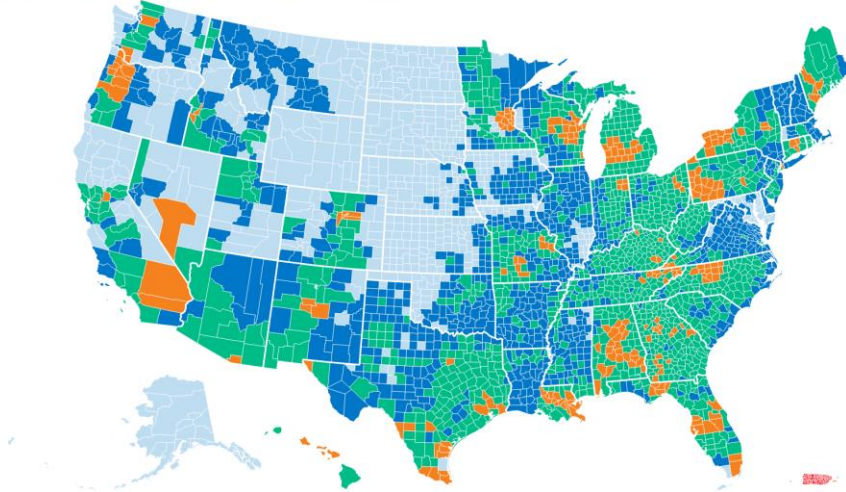
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2022; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2017; CCW data from 20 percent of beneficiaries, 2018-2020; and Medicare Enrollment Dashboard 2021-2022.



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Figure 7
Medicare Advantage Penetration, by County, 2022

■ < 20%
 ■ 20%–40%
 ■ 40%–60%
 ■ 60%–80%
 ■ ≥ 80%

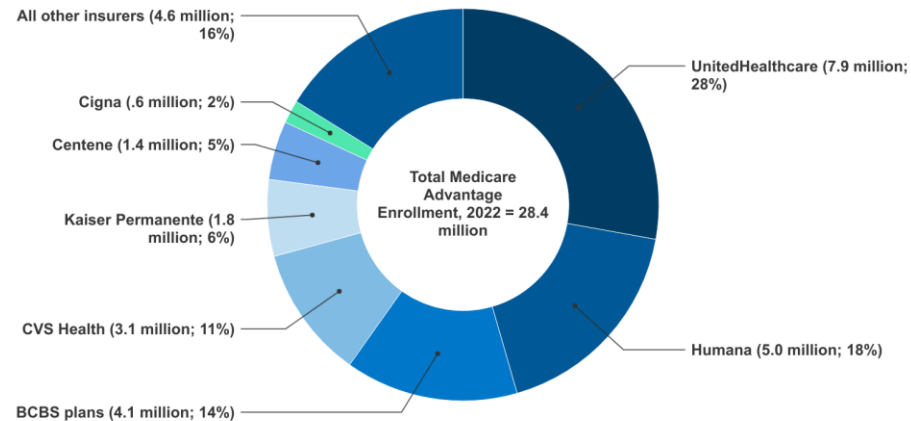


NOTE: Includes only Medicare beneficiaries with Part A and B coverage.
 SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2022 and March Medicare Enrollment Dashboard, 2022.



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Figure 8
Medicare Advantage Enrollment by Firm or Affiliate, 2022



NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and includes Anthem BCBS plans. Anthem non-BCBS plans are about 2% of total enrollment.
 SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2022.



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Office of Evaluations and Inspections (OEI) 4/27/22 Report Finds Delays and Denials of Medicare Covered Services

- Medicare Advantage Organizations (MAO) are incentivized to deny beneficiaries access to care and deny payments to providers to increase profit margins
- CMS audits have revealed widespread and persistent problems related to inappropriate denials of service and payment



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What the Study Showed

- 250 cases of denied care and 250 payment denials by 15 of the largest MAOs were audited
- Claims review period (6/1/19- 6/7/19)
 - Claims for services that meet Medicare coverage and regulatory guidelines were denied
 - Claims that met both Medicare and MAO billing regulations were denied
 - Additional administrative burden was created by the MAO that required the provider to perform 'extra steps'



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What the Study Showed

- 13% of denied prior authorization requests met coverage guidelines and would have been paid for under FFS Medicare
- 18% of denied payments met Medicare coverage regulations
 - MAOs payment systems were not updated causing system processing errors
 - Manual claims reviews “missing documents” included for review by the provider



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Common Causes Identified for Denials

- MAOs using clinical criteria not contained in Medicare coverage rules
 - ‘Making up their own rules’
- Denying based on ‘lack of supportive documentation’, which was included as part of the medical record
 - Medical necessity was clearly present, yet payment denied
 - Not accepting the documentation provided



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OEI Recommendations to CMS

- CMS to issue guidance to MA plans on appropriate use of clinical criteria to meet medical necessity
- MAOs to update protocols on auditing claims particularly for post acute facility stays, which had been one of the two top providers for denied care
- MAO to take additional step to identify and address the issues found in the report



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MAO Changes effective 6/5/2023

- Prior Authorization will be used only to confirm a diagnosis or other medical condition and once granted, will remain valid as long as medically necessary based on:
 - Past medical history of resident
 - Recommendations of the treating physician



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MAO Changes effective 6/5/2023

- Coverage must be based on LCDs, NCDs and benefits included in traditional Medicare
 - If no LCD or NCD, may create internal coverage guidelines, which must be posted and publicly accessible
 - If coverage criteria is unspecified, the internal guidelines must be based on current evidence-based criteria
 - Must be widely used treatment guidelines or clinical literature
 - Must provide evidence that was considered during the development of the internal criteria to make medical decisions



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MAO Changes effective 6/5/2023

- Must establish a Utilization Review Committee to review all criteria annually to ensure the criteria remains consistent with coverage requirements
 - Utilization management
 - Coverage criteria
 - Prior Authorization process
 - Policies
- Marketing to seniors will also be limited and waiting periods enforced



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Managed Care Impact on Revenue

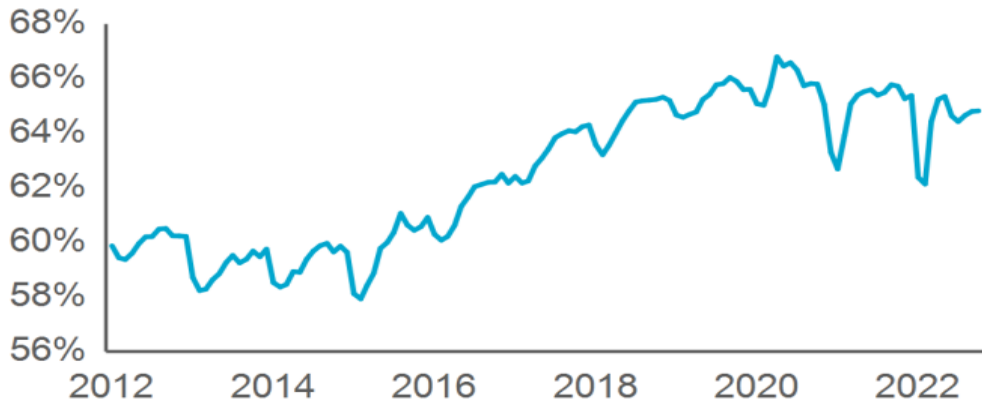
Rate Reduction Effects



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Patient Day Mix

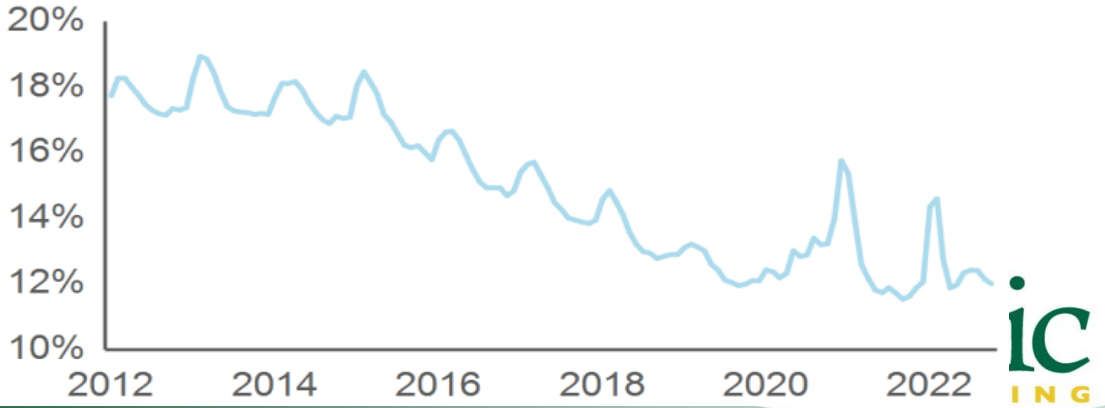
— Medicaid



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Patient Day Mix

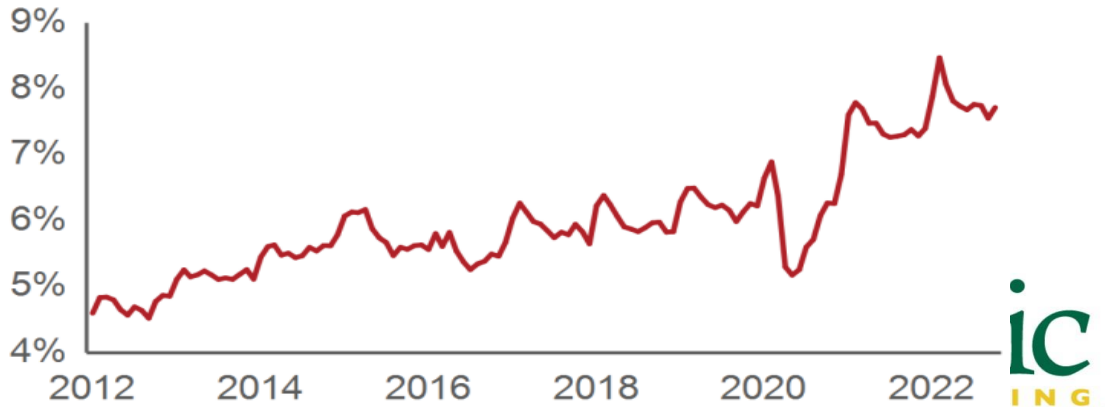
— Medicare



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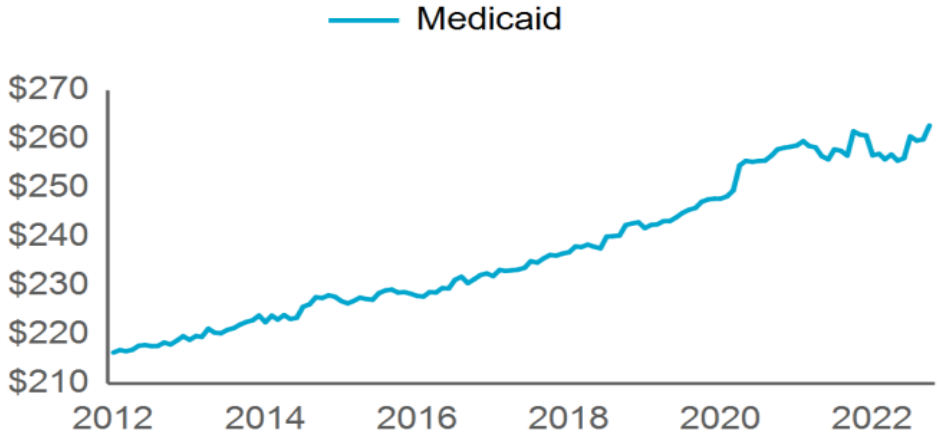
Patient Day Mix

— Managed Medicare



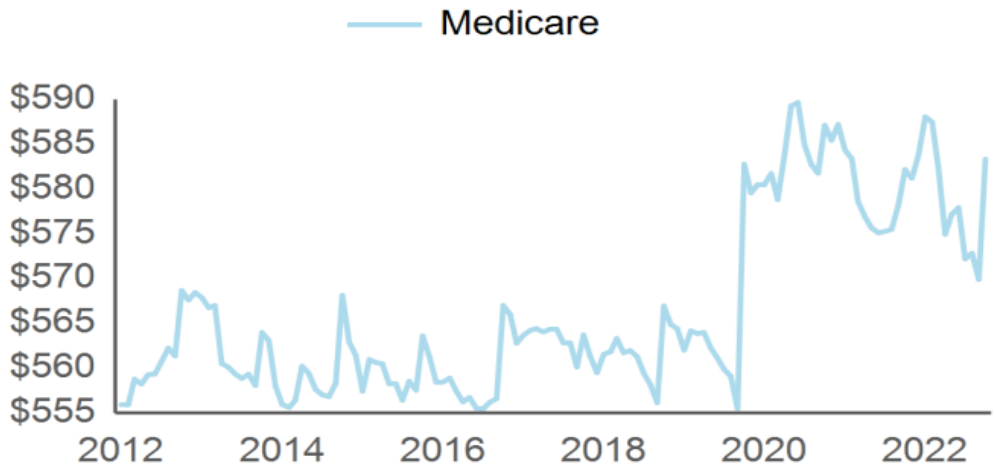
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Revenue Per Patient Day



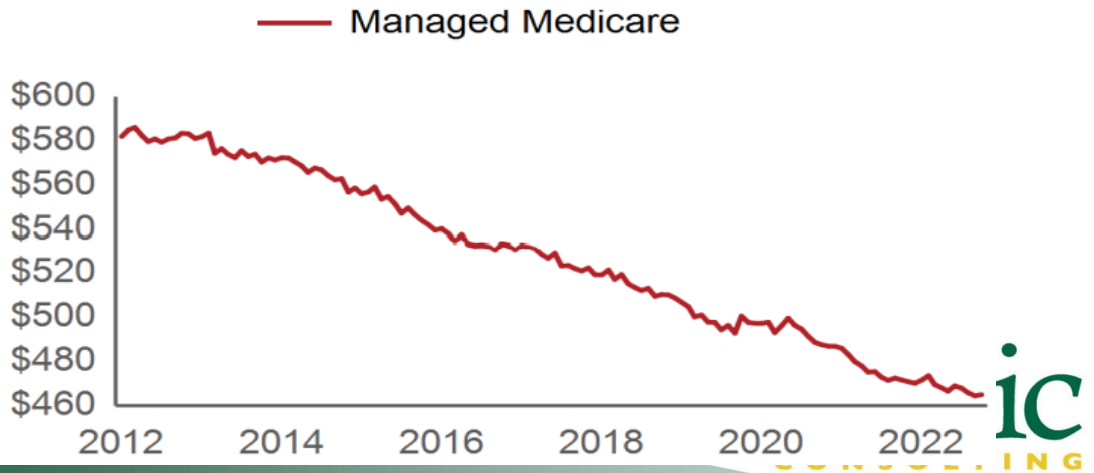
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Revenue Per Patient Day



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Revenue Per Patient Day



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Average Reimbursement per Payer (through January 2023) \$124/\$119 (22)/\$101 (21)

Revenue Per Patient Day								
Medicaid	\$269	0.5%	\$256	0.2%	\$271	0.0%	\$270	0.7%
Medicare	\$592	-0.4%	\$589	0.0%	\$590	-0.1%	\$593	-0.5%
Managed Medicare	\$468	0.3%	\$431	0.3%	\$469	0.6%	\$472	0.3%
Private	\$321	1.3%	\$291	1.1%	\$303	1.8%	\$334	1.1%

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Best Practices for Billing Staff

- Become familiar with CMS regulations for Medicare HMOs
- Understand the importance of developing a system of Case Management for SNF providers
- Identify Billing challenges and coverage for Medicare HMO and Insurance companies
- Keep track of percentage of MA denials



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2023 Quality and Value: CMS Updates SNFVBP & SNFQRP

Measures Under Consideration



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Current CMS Measurement Reporting

- Reporting structure
 - Quality measures
 - CASPER reporting
 - 5-star rating system
 - PEPPER reports
 - SNF Value Based Purchasing
 - SNF Quality Reporting Program
- Medical record reviews (ADR) through the MAC/RAC or others



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Quality Measure Reporting

Quality Indicators



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What is Being Reported?

Quality Measure (QM) Label	Short or Long Stay	CMS ID	NQF ID	Effective Date	CASPER	NHC	Five-Star	Provider Preview
SHORT STAY QMs								
Percent of Residents or Patients with Pressure Ulcers That are New or Worsened	Short	N002.04	0678 (with-drawn)	10/1/12	YES	YES	YES	YES
Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine	Short	N003.03	0680	10/1/12	NO	YES	NO	YES
Percent of Residents Who Received the Seasonal Influenza Vaccine	Short	N004.03	0680A	10/1/12	NO	NO	NO	YES
Percent of Residents Who Were Offered and Declined the Seasonal Influenza Vaccine	Short	N005.03	0680B	10/1/12	NO	NO	NO	YES
Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine	Short	N006.03	0680C	10/1/12	NO	NO	NO	YES
Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine	Short	N007.02	0682 (with-drawn)	10/1/12	NO	YES	NO	YES
Percent of Residents Who Received the Pneumococcal Vaccine	Short	N008.02	0682A (with-drawn)	10/1/12	NO	NO	NO	YES

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What is Being Reported?

Quality Measure (QM) Label	Short or Long Stay	CMS ID	NQF ID	Effective Date	CASPER	NHC	Five-Star	Provider Preview
Percent of Residents Who Were Offered and Declined the Pneumococcal Vaccine	Short	N009.02	0682B (with-drawn)	10/1/12	NO	NO	NO	YES
Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Pneumococcal Vaccine	Short	N010.02	0682C (with-drawn)	10/1/12	NO	NO	NO	YES
Percent of Residents Who Newly Received an Antipsychotic Medication	Short	N011.02	NA	4/1/12	YES	YES	YES	YES
Percentage of Residents Who Made Improvements in Function	Short	N037.03	NA	10/1/16	YES	YES	YES	YES

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What is Being Reported?

Quality Measure (QM) Label	Short or Long Stay	CMS ID	NQF ID	Effective Date	CASPER	NHC	Five-Star	Provider Preview
LONG STAY QMs								
Percent of Residents Experiencing One or More Falls with Major Injury	Long	N013.02	0674	10/1/10	YES	YES	YES	YES
Percent of High-Risk Residents with Pressure Ulcers	Long	N015.03	0679	10/1/18	YES	YES	YES	YES
Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine	Long	N016.03	0681	10/1/10	NO	YES	NO	YES
Percent of Residents Who Received the Seasonal Influenza Vaccine	Long	N017.03	0681A	10/1/10	NO	NO	NO	YES
Percent of Residents Who Were Offered and Declined the Seasonal Influenza Vaccine	Long	N018.03	0681B	10/1/10	NO	NO	NO	YES
Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine	Long	N019.03	0681C	10/1/10	NO	NO	NO	YES
Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine	Long	N020.02	0683 (with-drawn)	10/1/10	NO	YES	NO	YES



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What is Being Reported?

Quality Measure (QM) Label	Short or Long Stay	CMS ID	NQF ID	Effective Date	CASPER	NHC	Five-Star	Provider Preview
Percent of Residents Who Received the Pneumococcal Vaccine	Long	N021.02	0683A (with-drawn)	10/1/10	NO	NO	NO	YES
Percent of Residents Who Were Offered and Declined the Pneumococcal Vaccine	Long	N022.02	0683B (with-drawn)	10/1/10	NO	NO	NO	YES
Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Pneumococcal Vaccine	Long	N023.02	0683C (with-drawn)	10/1/10	NO	NO	NO	YES
Percent of Residents with a Urinary Tract Infection	Long	N024.02	0684	10/1/10	YES	YES	YES	YES
Percent of Low Risk Residents Who Lose Control of Their Bowels or Bladder	Long	N025.02	0685 (with-drawn)	10/1/10	YES	YES	NO	YES
Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder	Long	N026.03	0686	10/1/10	YES	YES	YES	YES
Percent of Residents Who Were Physically Restrained	Long	N027.02	0687	10/1/10	YES	YES	NO	YES
Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased	Long	N028.02	0688	10/1/10	YES	YES	YES	YES
Percent of Residents Who Lose Too Much Weight	Long	N029.02	0689	10/1/10	YES	YES	NO	YES



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What is Being Reported?

Quality Measure (QM) Label	Short or Long Stay	CMS ID	NQF ID	Effective Date	CASPER	NHC	Five-Star	Provider Preview
Percent of Residents Who Have Depressive Symptoms	Long	N030.02	0690 (with-drawn)	10/1/10	YES	YES	NO	YES
Percent of Residents Who Received an Antipsychotic Medication	Long	N031.03	NA	4/1/12	YES	YES	YES	YES
Percent of Residents Who Have Had a Fall	Long	N032.02	NA	10/1/10	YES	NO	NO	NO
Percent of residents who used Antianxiety or Hypnotic Medication without a Psychotic or Related Condition	Long	N033.02	NA	10/1/10	YES	NO	NO	NO
Percent of Residents Who Have Behavior Symptoms Affecting Others	Long	N034.02	NA	10/1/10	YES	NO	NO	NO
Percent of Residents Whose Ability to Move Independently Worsened	Long	N035.03	NA	10/1/16	YES	YES	YES	YES
Percent of Residents Who Used Antianxiety or Hypnotic Medication	Long	N036.02	NA	4/27/16	YES	YES	NO	YES

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SNF Quality Reporting Program

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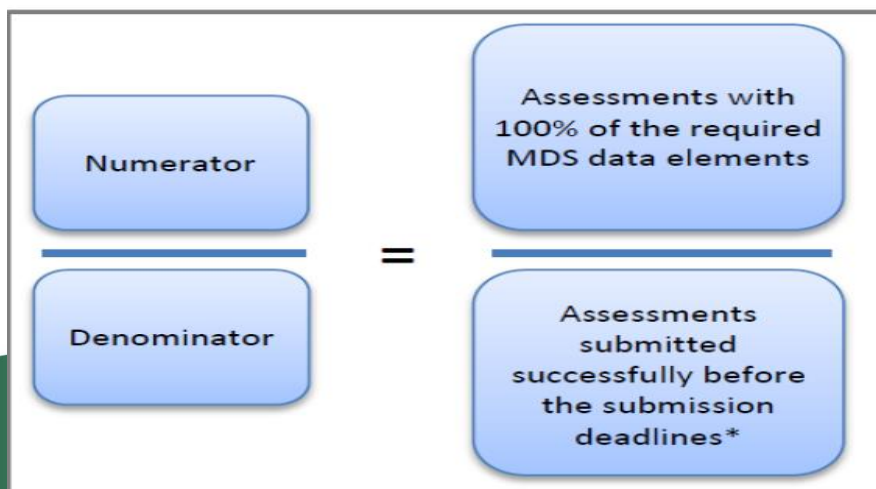
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IMPACT Act & Quality Reporting Program

- The Improving Medicare Post-Acute Care Transformation (IMPACT) Act was passed by Congress in 2014 to improve the overall quality of healthcare across post-acute care settings
- As of October 2016, PAC providers must submit standardized assessments for data collection upon residents' admissions and discharges
 - 55.5 data points for SNFQRP
 - **Failure to complete at least 80% of the MDS data points will result in a 2% reduction in Medicare Part A reimbursement**
 - **Threshold will increase to 90% for FY24**

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Penalty Threshold for SNFQRP



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Data Points

What is Being Collected



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QMs for SNF QRP Under IMPACT

- **2016 MDS-Based Measures:**
 - Functional status and cognition changes from admit to d/c (10-1-16)
 - Skin integrity and changes: *added unstageable pressure ulcers **10-1-18**
 - Falls with major injury (10-1-16)
- **2017 Claims-Based Measures**
 - MSPB-Medicare Spending per Beneficiary
 - Discharge to Community
 - Potentially Preventable Re-hospitalizations
- **2018 Additions**
 - Medication reconciliation/Drug Regimen Review
 - Change in Self-Care Score for Medical Rehab Patients
 - Change in Mobility Score for Medical Rehab Patients
 - Discharge Self-Care Score for Medical Rehab Patients
 - Discharge Mobility Score for Medical Rehab Patients
- Care Plan- transfer of health info/med reconciliation (**10-1-23**) **Delayed**

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QRP MDS Measures FY 23

Short Name	Measure Name & Data Source
Resident Assessment Instrument Minimum Data Set (Assessment-Based)	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).
Application of Functional Assessment/Care Plan	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).
Change in Mobility Score	Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634).
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).
Change in Self-Care Score	Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633).
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635).
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
TOH-Provider*	Transfer of Health (TOH) Information to the Provider Post-Acute Care (PAC).
TOH-Patient*	Transfer of Health (TOH) Information to the Patient Post-Acute Care (PAC).

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SPADE/TOH Delay in Reporting

- Delay in the Compliance Date of the Transfer of Health Information Measures and Certain SPADEs Adopted for the SNF QRP
- CMS will require SNFs to begin collecting data on the two TOH Information Measures beginning with discharges on October 1st of the year that is at least 2 full fiscal years after the end of the COVID–19 PHE
- NPRM proposes, SNFs will be required to begin collecting data on these measures beginning with patients discharged on October 1, 2023, on the MDS 1.18.11.

SPADES (Standardized Patient Assessment Data Elements)



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QRP Claims Based Measures FY23

Claims-Based	
MSPB SNF	Medicare Spending Per Beneficiary (MSPB)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
DTC	Discharge to Community (DTC)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) (NQF #3481).
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).
SNF HAI	SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization

CONSULTING

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QRP NHSN Measure

NHSN	
HCP COVID-19 Vaccine	COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)



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SPADES

- **Standardized Patient Assessment Data Elements**
 - Assessment data elements standardized for all PAC Providers
- Expansion of 5 new SPADES for 10/1/23 MDS 1.18.11
 - Race, ethnicity, preferred language, health literacy, social isolation
 - Outcomes can be measured regarding Health Equity
- Data collected on Admission and Discharge Assessments



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MUC for Future SNFQRP Updates

TABLE 16: Future Measures and Measure Concepts Under Consideration for the SNF QRP

Quality Concepts
Cross-Setting Function
Health Equity Measures
PAC – COVID-19 Vaccination Coverage among Patients



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Section GG Data Collection SNFQRP

- Admission Performance, 5-day PPS MDS
- Discharge Goal, 5-day PPS MDS
- Discharge Performance, DRA, DRNA or End of PPS Stay for planned discharges only
- Interim performance required for IPA completion
- 7 functional items for nursing function score (late loss ADLs)
- 11 items for PT/OT function score
- **Will be used for 5-star as Section G sunsets.**



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SNF QRP Claims-Based Measures

Potentially Preventable Readmissions –

- Slight variation on the rehospitalization QM reported in Five Star
- Only Medicare Part A
- Time period = 1st 30 days following Discharge from SNF, excluding day of Discharge
- Measures readmission rates for those readmitted to a hospital or LTCH who have a principal diagnosis considered to be unplanned & potentially preventable.



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Exclusions to PPR

- Discharge to another SNF/IRF/LTCH
- Residents who expire during their Medicare covered episode
- Discharges AMA (against medical advice)
- Acute care stay for cancer treatment or pregnancy
- Residents who exhaust their Medicare benefits
- Residents who were not Medicare beneficiaries for 12 months prior or 3 months after the stay
- Transfers to federal hospitals
- ESRD



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Most Common Reasons for Readmissions

1. Inadequate management of chronic conditions
2. Inadequate management of infections
3. Inadequate management of other unplanned events
4. Inadequate injury prevention

*multiple SNF admissions during a 12 month period will all count



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SNF QRP Discharge to Community

- Slight variation on the DC to community QM reported in Five Star
- Only Medicare Part A
- Time period = 31 days post discharge to community
- Measures SNF rate of successful discharge through no unplanned rehospitalizations nor death in the 31 days (includes day of discharge)
- Discharge status codes on the SNF claim are important here
 - Only these four codes are considered - O1, 02, 81, 86 (82-planned d/c Acute)
 - Does your team communicate with finance on this?

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SNF QRP Exclusions for Discharge to Community

- Discharge to a psych hospital
- Discharge to Hospice facility, or community hospice
- Discharge to law enforcement
- Discharge AMA (against medical advice)
- Discharge to another SNF
- Acute care stays for cancer treatment
- Planned discharges
- Benefits exhaust



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SNF QRP Medicare Spending per Beneficiary (MSPB)

- Also claims-based, Part A only but includes spending for both A&B
- CMS Goals for this measure include:
 - Improve care coordination & efficiency of care
 - Facilitate comparisons while accounting for case mix
 - Create accountability amongst providers for quality & value by measuring resource use for an entire “episode” of care
- Calculates both Attributor Provider & other Provider services costs throughout the episode which begins on admit & for 30 days after discharge
- Episodes are only compared to other episodes of like providers

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SNF QRP Medicare Spending per Beneficiary (MSPB)

- Exclusions of Clinically unrelated services including:
 - Planned hospital admissions
 - Routine management of certain preexisting chronic conditions
 - Some routine screening and health care maintenance
 - Immune modulating medications
- Beneficiary must have been enrolled in Medicare Part A for the entire 90-day period prior to admission date for episode & for entire episode window (Part A stay through 30 days from discharge.)
- Will have risk-adjustments r/t prior care/services, age, clinical categories, etc.

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MSPB Example

	Episode 1	Episode 2	Episode 3	Episode 4	Episode 5	Episode 6	
Observed Spending /	\$3,300 /	\$4,890 /	\$4,020 /	\$5,270 /	\$6,850 /	\$5,460 /	
Expected Spending	\$4,000 =	\$4,100 =	\$3,700 =	\$6,200 =	\$5,900 =	\$5,000 =	
Ratio of Obs/Exp	0.825	1.193	1.086	0.850	1.161	1.092	= 6.207

Provider's Average
Obs/Exp Ratio

6.207 / 6 episodes = 1.035

MSPB PAC Amount
(Provider's Average Obs/Exp Ratio
* National Avg Observed Spending)

National Average Observed Episode Spending = \$5,325

1.035 * \$5,325 = \$5,509

Provider Score
(MSPB PAC Amount/
National Median MSPB PAC Amount)

National Median MSPB PAC Amount = \$5,700

\$5,509 / \$5,700 = 0.966

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Source: Minimum Data Set 3.0 (MDS 3.0)

Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Numerator	Denominator	Facility Observed Percent	Facility Risk-Adjusted Percent	National Average
Pressure Ulcer	10/01/2018 - 09/30/2019	S002.01	10/01/2018 - 09/30/2019	133	670	19.9%	75.4%	1.7%
Pressure Ulcer/Injury	10/01/2018 - 09/30/2019	S038.01	10/01/2018 - 09/30/2019	141	677	20.8%	75.7%	2.6%

Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Numerator	Denominator	Facility Percent	National Average
Application of Falls (NQF #0674)	10/01/2018 - 09/30/2019	S013.01	10/01/2018 - 09/30/2019	71	972	7.3%	1.1%
Application of Functional Assessment/Care Plan (NQF #2631)	10/01/2018 - 09/30/2019	S001.02	10/01/2018 - 09/30/2019	499	1,018	49.0%	98.4%

Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Average Observed Discharge Score	Average Expected Discharge Score	Numerator	Denominator	Facility Percent	National Average
Functional Status Outcome: Discharge Self-Care Score (NQF #2635)	10/01/2018 - 09/30/2019	S024.01	10/01/2018 - 09/30/2019	18.0	27.0	78	622	12.5%	52.0%
Functional Status Outcome: Discharge Mobility Score (NQF #2636)	10/01/2018 - 09/30/2019	S025.01	10/01/2018 - 09/30/2019	35.4	67.8	14	622	2.3%	43.3%

Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Numerator	Denominator	Facility Percent	National Average
DRR	10/01/2018 - 09/30/2019	S007.01	10/01/2018 - 09/30/2019	924	1,002	92.2%	41.0%

Measure Name	Report Period	CMS ID	CMS ID Discharge Dates	Denominator	Average Observed Admission Score	Average Observed Discharge Score	Average Observed Change	Average Risk-Adjusted Change	National Average
Functional Status Outcome: Change in Self-Care (NQF #2633)	10/01/2018 - 09/30/2019	S022.01	10/01/2018 - 09/30/2019	619	14.8	17.9	3.2	1.6	11.2
Functional Status Outcome: Change in Mobility (NQF #2634)	10/01/2018 - 09/30/2019	S023.01	10/01/2018 - 09/30/2019	622	49.2	35.4	-13.8	-10.3	22.7

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Facility ID:
 CCN:
 Facility Name:
 City/State:
 Requested Report End Date: 09/30/2019
 Report Run Date: 08/08/2019
 Data Calculation Date: 08/08/2019
 Report Version Number: 2.00

SNF ORP Quality Measures Legend

QM #	Measure Name	Measure Interpretation	Report Period	CMS ID	CMS ID Discharge Dates
1	Pressure Ulcer	Undesirable Outcomes	10/01/2018 - 09/30/2019	S002.01	10/01/2018 - 09/30/2019
2	Pressure Ulcer/Injury		10/01/2018 - 09/30/2019	S038.01	10/01/2018 - 09/30/2019
3	Application of Falls (NQF #0674)		10/01/2018 - 09/30/2019	S013.01	10/01/2018 - 09/30/2019
4	Application of Functional Assessment/Care Plan (NQF #2631)	Desirable Outcomes or Processes Performed	10/01/2018 - 09/30/2019	S001.02	10/01/2018 - 09/30/2019
5	Functional Status Outcome: Discharge Self-Care Score (NQF #2635)		10/01/2018 - 09/30/2019	S024.01	10/01/2018 - 09/30/2019
6	Functional Status Outcome: Discharge Mobility Score (NQF #2636)		10/01/2018 - 09/30/2019	S025.01	10/01/2018 - 09/30/2019
7	DRR		10/01/2018 - 09/30/2019	S007.01	10/01/2018 - 09/30/2019
8	Functional Status Outcome: Change in Self-Care (NQF #2633)	Change in Function Scores	10/01/2018 - 09/30/2019	S022.01	10/01/2018 - 09/30/2019
9	Functional Status Outcome: Change in Mobility (NQF #2634)		10/01/2018 - 09/30/2019	S023.01	10/01/2018 - 09/30/2019

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
 Change in Function Scores: Values are observed change in function scores from admission to discharge

Resident Name	Resident ID	Admission Date	Discharge Date	Undesirable Outcomes			Desirable Outcomes or Processes Performed				Change in Function Scores		
				QM 1	QM 2	QM 3	QM 4	QM 5	QM 6	QM 7	QM 8	QM 9	
	45428987	05/01/2019	07/08/2019	E	E	E	X	E	E	E	E	E	E
	45429228	06/30/2019	07/07/2019	NT	NT	X	NT	NT	NT	X	-7	-41	
	45428996	05/01/2019	07/07/2019	X	X	X	X	NT	NT	X	4	9	
	45428995	05/01/2019	07/07/2019	X	X	X	X	NT	NT	X	4	9	
	45428994	05/01/2019	07/07/2019	X	X	X	X	NT	NT	X	4	9	



Newer Items/Data Points

What is coming down the pike



COVID Vaccinated HCP FY24

- SNF PPS Final Rule FY 22 added 1 measure- HCP COVID19 Vaccine
- FY24 reporting SNFQRP data on this measure
- Data reported through NHSN by facility
- Must achieve 100% reporting threshold, not 80% like MDS items

*will be modified in FY25



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HAI

- HAI-Infection acquired during SNF stay, or related to an invasive device, severe enough to require hospitalization
 - Catheters, Lines
- Data updated once annually
- Claims based measure- hospital and SNF
- Principal Dx and Present on Admission (POA) determining factors
- Baseline year FY22 (10/1/21-9/30/22)



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HAI Criteria

- Measures from day 4 of admission through day 3 post SNF discharge
 - Includes deaths
- **Excludes**: LOS less than 4 days, non-PPS stays, no hospital stay, D/C to federal hospital, foreign hospital stay, missing data
- **Excluded Infections**: diagnosed at ER or in Observation stay, chronic infections, long acting/presenting diagnoses, related to prior hospital stay, sequela, secondary infections, community or animal acquired, acquired outside US, pre-existing (repeat) infections
- “In diseases classified elsewhere”

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HAI Risk Adjustment

- Age
- Sex
- Procedure in hospital
- Principal diagnosis/ HCC code
- LOS
- Number of hospital stays in 12 months
- ICU/CCU



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Future QRP Measures Approved By CMS

- Flu Vaccination HCP FY25
 - Measured 10/1-3/31, reported once annually
 - Utilize NHSN to report the data
 - HCP- all paid and unpaid, direct and indirect who worked at least 1 day
- Transfer of health information FY24 to begin with MDS 1.18.11
 - Delayed from 10/1/20 due to PHE, CMS proposing 10/1/23 start date
 - Reconciled medication list transferred to patient, downstream provider
 - Collected on Discharge MDS



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QRP Measures CMS Exploring

- Cross-setting function FY25
 - Combine Self Care and Mobility measures into one functional measure
- Health Equity Measures (collect FY24 report FY26)
 - Disparities
- COVID Booster measure for Residents FY26
- CoreQ Pt Satisfaction Survey Results FY26
 - Rate the facility, Rate the staff, rate the care, whether discharge needs met
 - 1-5 Poor, Average, Good, Very Good, Excellent



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Health Equity

- Evidence that a treatment or outcome is affected by underlying healthcare disparities
- Considers Social Risk Factors (SFR)
- SPADES will be expanded 10/1/23 to add this information to MDS
 - Race, ethnicity, preferred language, transportation, health literacy, social isolation



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CoreQ FY26

- Separate Vendor to perform the survey
- Discharges of 100 days or less in last 6 months
- Must answer within 2 months of receiving survey
- Exclusions: Expired, Discharged to another SNF, hospital, Psych hospital, IRF, LTCH, or AMA. Hospice, those with legal guardians or dementia



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SNF Value Based Purchasing



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SNF VBP

Result of PAMA of 2014 enacted 4-1-14 under Social Security Act

- Focus of the program:
 - Performance standards including 'achievement' and 'improvement' ratings
 - Rank SNFs for from low to high based on performance
 - 2% of PPS/Medicare payment withheld to fund program
 - Incentive payments to providers must total 50-70% of amount withheld
 - Incentive payments=buying your money back
- Both measures are based on hospital readmissions
 - SNF RM- all-cause/condition, original measure (began 1-1-17)
 - Payments affected as of 10/1/18
 - Transition to SNF PPR- potentially preventable



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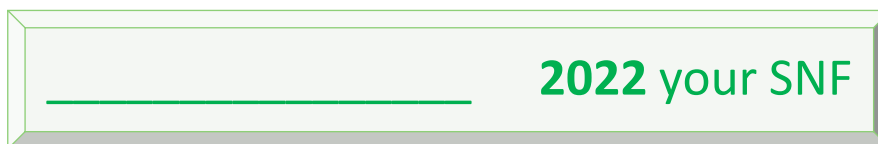
SNFRM VBP Measure

- Results in achievement rating score based on percentage of residents that were not readmitted during the window
- Compares value rating scores between providers
- How did you do in 2022 compared to all SNFs nationwide in 2019?
 - If you did better than benchmarks (100 points, or 10 pts)
 - If you did worse than achievement threshold (0 points)
 - All facilities in between points assigned based on “Achievement Score”
- Second score “Improvement Score” based on how well your facility did in 2022 compared to your 2019 data
 - Above benchmark (90, or 9 points)
 - If worse than 2019 (0 points)

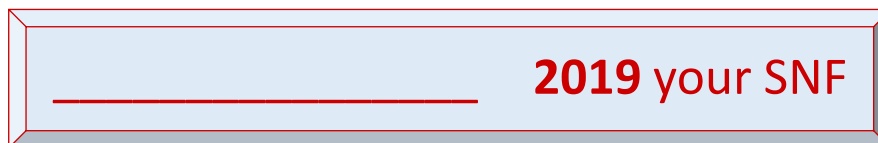


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SNFRM Improvement Rating



‘Improvement’ Rating up to **90, or 9** points



Better of the two, *Improvement* Rating or *Achievement* Rating

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SNF VBP RM Achievement Rating

Benchmark: Average top 10% performing SNFs in FY25 (83.028)

_____ **2022 your SNF**

↑ Achievement Rating: SNF reaches 25% threshold (79.270)

_____ **2019 ALL SNFs**

- If your SNF meets the BENCHMARK, then your rating is 100 or 10.
- If your SNF doesn't meet at least the 25th percentile, then your rating is 0.
- Remainder will be disbursed, 1-100, or 1-10 when all measures are included.
- Rehospitalizations less than 20.73% for achievement score of 0.



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Performance Scores for FY25

The lower the readmission rate, the better.

Since a lower readmission rate is better, CMS has inverted every SNF's readmission rate using $(1 - \text{readmission rate})$ for the purposes of the performance standards (i.e., benchmark and achievement threshold) and performance scoring.

• Standard	2019
• 25th Percentile	20.73%
• Achievement Threshold	79.270%
• Mean of the Best Decile	16.972%
• Benchmark	83.028%



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Performance Standards FY25 baseline 2019

TABLE 18: Proposed Estimated FY 2025 SNF VBP Program Performance Standards

Measure ID	Measure Description	Achievement Threshold	Benchmark
SNFRM	SNF 30-Day All-Cause Readmission Measure (NQF #2510)	0.79270	0.83028



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Performance Standards FY26 proposed

- Rebase to FY22 for baseline comparison
- Adjust point rating from 0-100 for **Achievement** Score to 0-10
- Adjust point rating from 0-90 for **Improvement** Score to 0-9



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Future Measures

Measure Name	Measure Short Name	Measure Status	First Program Year	First Performance Period*
SNF 30-Day All-Cause Readmission Measure	SNFRM	Adopted, implemented	FY 2017**	FY 2015
SNF Healthcare-Associated Infections Requiring Hospitalization Measure	SNF HAI Measure	Adopted, not implemented	FY 2026	FY 2024
Total Nurse Staffing Hours per Resident Day Measure	Total Nurse Staffing Measure	Adopted, not implemented	FY 2026	FY 2024
Total Nursing Staff Turnover Measure	Nursing Staff Turnover Measure	Proposed	FY 2026 ⁺	FY 2024
Discharge to Community – Post-Acute Care Measure for SNFs	DTC PAC SNF Measure	Adopted, not implemented	FY 2027	FY 2024 and FY 2025
Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) Measure	Falls with Major Injury (Long-Stay) Measure	Proposed	FY 2027 ⁺	FY 2025
Discharge Function Score for SNFs Measure	DC Function Measure	Proposed	FY 2027 ⁺	FY 2025
Number of Hospitalizations per 1,000 Long Stay Resident Days Measure	Long Stay Hospitalization Measure	Proposed	FY 2027 ⁺	FY 2025
SNF Within-Stay Potentially Preventable Readmissions Measure	SNF WS PPR Measure	Proposed	FY 2028 ⁺	FY 2025 and FY 2026



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Questions?

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