The Times They Are A Changin’

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Objectives

At the end of this session participants will be able to:

• Identify key initiatives that have penetrated their geographic service areas
• Understand the specific facility operational impact of the key initiatives that are active in their geographic service areas
• Identify three key strategies for dealing with the key initiatives that will help minimize any negative effect on facility operations

If you’re here...

Please Come Join Us!
New Models
- New models require care coordination across the continuum
  - Capitation/Shared Savings/Risk
  - Bundled payments
  - Accountable care organizations
  - Condition-based and site neutral reimbursement changes
  - Fee for service—the good old days
  - Managed care
    - Optimal care measured through financial outcomes
  - Preferred Provider Networks
  - QRP—Quality Reporting Program and IMPACT ACT 2014
  - Five Star
    - Hospital value-based purchasing—PAMA 2014
  - 3 days pre-acute care episode through 30 days post-acute care

Capitation/Shared Savings/Risk
Bundled payments
Accountable care organizations
Condition-based and site neutral reimbursement changes

Bundled Payment
- Affordable Care Act calls for the Department of Health and Human Services' to shift Medicare payments from the traditional fee-for-service model to Alternative Payment Model’s (APM’s).
- DHS set a goal of reaching 30% of Medicare payments to be made through APM’s by 2016 increasing to 50% by 2018.
- In March of this year DHS announced it had achieved the 30% APM goal in January 2016 a full year ahead of schedule.
Bundled Payment

Comprehensive Care for Joint Replacement (CJR):
• Created to test bundled payment for lower extremity joint replacement (LEJR) - DRG 469 & 470.
• Under the program, the hospital is responsible for all Part A & B services associated with the LEJR procedure - both acute and 90 days post-discharge.
• 67 Metropolitan Statistical Areas (MSAs) were selected for the participation encompassing approximately 800 hospitals.
• CJR went into effective April 1, 2016 as a 5 year pilot.
Bundled Payment

July 25, 2016

• CMS releases a proposed rule to expand CJR and introduce a new Bundle payment model for Cardiac Care.

• Proposed Rule:
  – Extend CJR bundled payment to cover other hip procedures (DRG 480 & 481).
  – Development of a new Bundled Payment for Acute Myocardial Infarction (AMI) and Coronary Artery Bypass (CABG) – would extend to 98 MSA’s. Will launch July 1, 2017.
  – Implementation of a Cardiac Rehabilitation Incentive Payment model
  – Introduce a new incentive for Physicians through a Quality Payment Program.
Bundled Payment

Components of Bundled Payment

- DRG
- Bundle
- Episode of Care

Bundled Payment

Creation of the Bundles:

CMS took the 181 individually priced Condition Related DRG's.
Consolidated them into 48 individual Bundles.
Essentially, a Bundle is a compilation of multiple Diagnostic Related DRG's.
Facilities were able to choose individual Bundles for participation in BPCI.
Bundled Payment

PAC - Episode of Care Defined:

- An episode is initiated when an eligible beneficiary (Medicare A & B patient) is admitted to or initiates services with a BPCI provider within 30 days after discharge from an inpatient stay at an acute care hospital for one of the included DRGs.
- The stay is billed to Medicare Part A or B.
- The Episode of care lasts for the pre-determined Risk Period (30, 60 or 90 days).
- Contains all cost billed under Part A & B within the Risk Period.

Bundle Coverage:

- All services billed to Med A & B within the Risk Period are counted in bundle cost.
- Key to success - Reduce Cost.
- Exclusions exist for specific conditional: ACT’s, Procedures and Readmissions to SNF.
- Patient can experience multiple bundles within 100 covered days and each year.
- Bundle cost continues to accumulate as the patient transitions through care settings.

5 Keys to Success for Bundlers

- Must Identify Patients who are inside the Bundle and appropriately target them for intervention.
- Must Manage and Structure Patients for the Duration of the Episode (30, 60 or 90 Days).
- Must Manage the Location and Utilization of Services for the Bundled Patients and to the Best of their ability Centralize Cost even where services are delivered outside their organization.
- Must Have Strong Data Analytics.
- Must Have the Right Technology to Help them Manage Transitions and Effectively Coordinate Care.
Bundled Payment

Additional Keys for PAC Providers:
- Know clearly residents End-Of-Life Preferences (utilization of Palliative and Hospice care).
- Organize Hospital and SNF communication protocol on Model 2 and Model 3 patient transfers to and from the hospital.
- Align Physicians and N/P’s understanding of the BPCI initiative. Assure understanding of cost saving initiative.
- Expand Clinical Competency (Specialty’s).

Bundled Payment

Additional Keys to Success for PAC Providers Only:
- Consider Warm Handoff admission methods.
- Manage avoidable readmissions - consider SNFist or enhanced N/P services to cover off hour and weekend acute changes in condition.
- Use of INTERACT tools.
- Longitudinal Care Planning.
- Consider how to manage your Post Discharge Risk Period

Bundled Payment
Managed care
Preferred Provider Networks

Optimal care measured through financial outcomes

Managed Care

• A variety of techniques intended to reduce the cost of providing health benefits and improve the quality of care to health care plan enrollees
  • Used to be…..
    • Paid by levels
    • Paid by RUGS
  • Now…..
    • Partnering with post-acute care management companies
    • Partnering with hospital systems and establishing preferred provider networks

Preferred Provider Networks

• A provider network is a list of the doctors, other health care providers, and hospitals that a plan or organization has contracted with to provide care to its members
  • Managed Care
  • Hospital Systems
    • Bundle Conveners
    • ACOs
  • Physician Practices
    • Bundle Conveners
    • ACOs
Operational Impact Of New Models

- Narrowing of provider networks
  - Right Care
  - Right Place
  - Right Time
  - Right Cost
- Payment schedules with deep cuts to provider payments
  - Promises of volume to preferred providers

Operational Impact of New Models, cont.

- Expected performance
  - Reduced readmissions
  - Reduced SNF length of stay
  - Therapy hours per patient day
  - Functional outcomes
- Substitute lower cost settings
  - Divert to Home Health and Outpatient Therapy
  - SNFs with best cost outcomes
    - What about quality?
    - What about the patient’s choice?
    - Patient/resident satisfaction

Strategies For Dealing With New Models

- Cost Management
  - Length of stay
  - Hospital readmission performance
  - Cost tracking per episode
- Quality Outcomes
  - Five Star
  - Clinical care pathways
    - Nursing
    - Therapy
    - Integrated
  - Hospital readmission performance
  - Physician integration
  - Functional Outcomes
  - Post-discharge management
    - Preferred Provider Networks Downstream
Strategies For Dealing With New Models

- Electronic Health Records
  - Interoperability and interfaces
  - Physician integration
  - Ability to track and analyze metrics
- Marketing Initiatives
  - Specialty Niches
- Patient Satisfaction
  - Education regarding types of benefits available
  - Post-discharge management

Cost Management

Pre-Admission Process

- Determine coverage eligibility
  - Verify coverage days
- Determine clinical and therapy needs
  - Co-morbidity/course of stay
  - Too medically unstable to admit—probability of hospital readmission
- Anticipate course of stay
  - Longer is not always better
    - FFS—28 days
    - MA—11-14 days
    - ACO—7-10 days
- Determine costs
- Compare costs to reimbursement
  - Compare to anticipated RUGS
  - Compare to anticipated MCO contract level
- Managed Care
  - Authorization obtained
Case Management

• Consider designated case manager position—RN
• Responsibilities:
  • Provide single point of contact for health plan to ensure consistent communication
  • Build strong relationships with health plan creating climate of trust
  • Verifies eligibility and payer on admission
  • Ensures correct level of initial authorization and monitors levels of care throughout resident’s stay
  • Advocates for the most appropriate level of care and facility reimbursement
  • Coordinates admissions and communicates with Business Office Manager for appropriate billing
  • Coordinates ancillary services with contracted vendors to avoid paying for these services
  • Negotiates Letter of Agreement with health plans you are not contracted with
  • Obtains authorizations for additional skilled days as needed
  • Develop and lead a clear and efficient system of communication with facility team

Cost Tracking Per Episode

• What Is An Episode
  • Bundles
  • Quality Measures
  • Medicare Spending Per Beneficiary
    • Hospital Value-Based Purchasing Initiative
      • 3 days pre-acute care episode through 30 days post-acute care
        » Length of stay
        » Hospital readmissions
  • Post-discharge management
    • Transition Coordinators

Quality Outcomes
Quality Outcomes

- Medicare Nursing Home Compare five-star ratings are a routine point of reference
  - Pressure ulcers
  - Urinary tract infections
  - Weight loss
  - Falls
  - Fractures
  - Decline in activities of daily living
  - Rehospitalization
  - Improvement in Function since Admission
  - Decline in Mobility
  - Discharge to community
  - Outpatient ED visits
  - Discharge to community
  - Observation stays

- Short-term post-acute rehab stays
  - Functional gain outcomes
  - Therapy performance
  - Section 56

Quality, cont.

- Clinical and Rehab care pathways
  - Rehab
    - Orthopedic Recovery
    - Fractures
    - Cardiac rehab
  - Pulmonary rehab
  - Post-surgery rehabilitation
  - Stroke
  - Complex wound care
  - Palliative care
  - Oncology
  - Medically complex

- Lengths of stay
  - Discharge to community
  - Hospital readmission rates

- Post discharge management
  - Transition Coordinator
  - Preferred Provider Networks Downstream

Electronic Health Records
What Can You Do Now?

- Interoperability and interfaces
  - IMPACT timeframes
    - October 1, 2016—reporting of quality measures, resource use and other measures
    - October 1, 2018—reporting standardized patient assessment data requirements
- Engage in cross-continuum dialogue with other PAC providers to understand care similarities and differences
- Post-discharge management
  - Establish transfer communication and coordination methods with tracking and accountability reporting

What Can You Do Now?, cont.

- Ability to track and analyze metrics
  - Adopt systems to standardize measurement and documentation and reporting requirement
    - Quality outcomes
    - Lengths of stay
      - Clinical care pathways
      - Discharge to community
    - Readmission performance
    - Cost tracking per episode
      - Identify cost of care variables, quantify and record
      - Anticipate the requirement to report patient specific resource costs and begin integrating into clinical decisions
    - Resident satisfaction

Marketing Initiatives
Marketing to Managed Care

Who are the potential referral sources?
- Medical Director
- Hospitalist
- Hospital Case Manager
- HMO Case Manager
  - Hospital
  - SNF
  - Ambulatory

Track Key statistics and data to present to referral sources
- Hospital readmissions
  - Length of Stay
    - By Clinical Condition
    - By Payer Source and Contract
  - Utilization of Ancillary Services
  - VBP

Marketing to Managed Care

How do you become a preferred SNF for the HMO?
- Accept and manage complex patients
- Treat in place – manage changes in condition at SNF
- Specialty Programs
- Data on preferred outcomes
- Be a ONE STOP shop
- Health plan wants:
  - 24/7 admission
  - Admissions from ER/Admissions from home
  - Shorter length of stay
  - A discharge plan within 24-48 hours of admission
  - A single contact
  - Low percentages of hospital re-admissions

Patient Satisfaction
Patient Preference

- Post-discharge client satisfaction scores
  - Facility length of stay
  - Clinical outcomes
  - Hospital readmission rates
- Post-discharge management
  - Discharge setting
  - Hospital readmission rates
- Resident advocacy
  - Resident rights
  - Education regarding types of plans and benefits available
  - Center for Medicare Advocacy
    - Jimmo vs. Sibelius
    - Medicare appeal process—unjust and inefficient

Bracing for IMPACT!
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The FY16/17 Final Rules

- SNF Value based Purchasing (VBP) PAMA
  - CMS is moving from a passive payer of services to an active purchaser of quality.
  - CMS believes that the implementation of the SNF Value Based Purchasing (VBP) Program is an important step toward transforming how care is paid for, moving increasingly toward rewarding better value, outcomes, and innovation instead of merely volume.
  - The SNF FY 2016 final rule finalizes the implementation of the SNF Rehospitalization Measure or SNFRM initiated by PAMA
  - This is NQF #2510 – All Cause Risk Standardized Readmission Measure.

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The FY16/17 Final Rules

- SNF Value based Purchasing (VBP) PAMA
  - The SNFRM estimates the risk-standardized rate of all-cause, unplanned hospital readmissions for SNF Medicare FFS beneficiaries within 30 days of discharge from their prior proximal short-stay acute hospital discharge.
  - The SNF admission must have occurred within 1 day after discharge from the prior proximal hospital stay. The prior proximal hospital stay is defined as an inpatient admission to an inpatient prospective payment system (IPPS) hospital, critical access hospital (CAH), or PPS-exempt psychiatric or cancer hospitals.

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- SNF Value based Purchasing (VBP) PAMA
  - This measure is based on data for 12 months of SNF admissions.
  - Because the measure denominator is based on SNF admissions, it is possible that Medicare beneficiaries with more than one eligible admission may be included in the measure multiple times within a given year.
  - Hospital readmissions that occur within the stay or after discharge from the SNF stay but within 30 days of the proximal hospitalization are included in the numerator.
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• SNF Value based Purchasing (VBP) PAMA
  • The numerator is more specifically defined as the risk-adjusted estimate of the number of SNF stays with unplanned (2) readmissions that occurred within 30 days of discharge from the prior proximal acute hospitalization.
  • The denominator includes all patients who have been admitted to a SNF within 1 day of discharge from a prior proximal hospitalization, taking denominator exclusions (9) into account.
  • The measure is further risk adjusted by several covariates (11) or elements that would make a readmission more likely to occur.

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• SNF Value based Purchasing (VBP)
  • The implementation of a SNF VBP Program is a central step in revamping Medicare’s payments for health care services to reward better value, outcome, and innovations, rather than the volume of care.
  • The intent of the SNFRM is to encourage SNF providers to monitor and reduce hospital readmissions, thereby reducing costs and improving the quality of care Medicare beneficiaries receive during their SNF stay.

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• SNF Value based Purchasing (VBP)
  • SNF providers may use the SNFRM to track their readmissions to the hospital to enhance internal quality improvement efforts.
  • Public reporting of this measure will provide information about facilities’ readmission rates, allowing beneficiaries and their families to make informed choices about their SNF care.
  • The SNFRM data will be based on Hospital claims data so no additional reporting will be required by SNFs.
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The FY16/17 Final Rules

• SNF Value based Purchasing (VBP)
  • Public reporting of this measure will provide information about facilities’ readmission rates, allowing beneficiaries and their families to make informed choices about their SNF care.

TimeLine:

• FY 2016 (Oct. 1 2015)
  • An all condition, risk adjusted, hospital readmission rate for SNFs will have been developed by HHS.

• FY2017 (Oct. 1, 2016)
  • Beginning with the first quarter of FY 2017 and for every quarter thereafter, SNFs will receive reports from HHS on their performance based on the rehospitalization measure.

• FY 2018 (Oct. 1, 2017)
  • Individual SNF rehospitalization rates, will be posted to Nursing Home Compare or other website for public viewing. SNFs will have the opportunity to view this information prior to public posting, and work with CMS to make any corrections.

• FY 2019 (Oct. 1, 2018)
  • Beginning FY 2019, all SNFs will receive a 2% reduction in their rates.
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- SNF Value based Purchasing (VBP)
  - Performance based on a prior year's performance will have been established based on SNF's higher of performance and improvement relative to their rehospitalization rate (CY 2015 baseline CY 2017 Performance).
  - The performance scores that have been achieved by each SNF, based on these standards, will then be ranked from lowest to highest using one of 4 currently proposed Scoring curves.
  - Not less than 50% but no greater than 70% of the savings realized by the 2% rate reduction that began this FY will be applied as incentives. Those SNFs who receive the highest rankings will receive the highest value-based incentive payments and those with the best will receive lower incentive payments. Those SNFs in the lowest 40% may receive incentive payments but these will not be enough to overcome the 2% rate reduction, so their rates will always be below what the rates would have been prior to the application of the 2% reduction.

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The FY16/17 Final Rules

- SNF Value based Purchasing (VBP)
  - Basics:
    - PAMA indicates that, for purposes of the SNF VBP Program, the Secretary shall apply the a SNF Potentially Preventable Readmission (PPR) measure instead of the SNFRM soon as practicable.
    - This measure has been finalized in the SNF PPS FY 2017 Final Rule to be applicable at a future date, to replace the current VBP NQF 2510 measure.

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

Bracing for IMPACT!
Bracing for IMPACT!

**IMPACT ACT**
The Improving Medicare Post-Acute Care Transformation Act of 2014
- Prior to IMPACT, the House Ways and Means and Senate Finance Committees invited Medicare post-acute care (PAC) stakeholders to provide ideas for post-acute care reform. The result was the need for standardized post-acute assessment data across Medicare PAC provider settings. The IMPACT Act creates the necessary assessment instruments that move toward the modernization of Medicare payments to PAC providers and a more accountable, quality-driven PAC benefit.

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**IMPACT ACT**
- The challenge is that there is substantial variation in spending, quality, and margins within the post-acute sector. This provides strong motivation for payment reform ideas including expansion of bundled payments, site neutral payments, and value based purchasing.
- Standardized post-acute assessment data is the necessary building block for any subsequent payment reform across post-acute care settings and providers.

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**IMPACT ACT**
- The lack of comparable information across PAC settings undermines the ability of policymakers to evaluate and providers to determine appropriate care settings for patients based on clinical evidence and quality metrics and differentiate between PAC providers. Absent this information, it is difficult to move forward with PAC payment reform.
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**IMPACT ACT**

- The IMPACT Act is an attempt to address this information gap and would require collection and analyses of data that will enable Medicare to:
  - (1) compare quality across PAC settings;
  - (2) improve hospital and PAC discharge planning; and
  - (3) use this information to reform PAC payments (via site neutral or bundled payments, for example) while ensuring continued beneficiary access to the most appropriate setting of care.

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**IMPACT ACT**

- Highlights of the IMPACT Act:
  - Requires Post-Acute Providers to Report Standardized Assessment Data—Builds on existing PAC assessment tools, and requires the reporting of common data across PAC providers for purposes of:
    - patient assessment,
    - quality comparisons,
    - resource use measurement, and
    - payment reform, i.e. establishing payment rates according to the individual characteristics of the patient, not the care setting.

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**IMPACT ACT**

- Highlights of the IMPACT Act (cont.):
  - Provides Congress with New Payment Models to Consider for Future Reforms—Requires reports to Congress from MedPAC and the Department of Health and Human Services that will utilize the PAC assessment data to:
    - build actual payment prototypes that,
    - Congress can use to consider for future PAC payment reforms.
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IMPACT ACT
• Highlights of the IMPACT Act (cont.):
  • Protects Beneficiary Choice and Access to Care – Directs the Secretary to develop regulations:
    • That encourages the use of quality data in patient discharge planning while continuing to take into account patient preferences.
    • That provide for collection of comparable information across PAC settings so that any future PAC payment reforms have the data needed to identify and ensure continued patient access to appropriate settings of care.

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IMPACT ACT
• Highlights of the IMPACT Act (cont.):
  • The Act requires that CMS make interoperable standardized patient assessment and quality measures data, and data on resource use and other measures to allow for the exchange of data among PAC and other providers to facilitate coordinated care and improved outcomes.
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IMPACT ACT

• Highlights of the IMPACT Act (cont.):
  • Achieving standardization (i.e., alignment/harmonization) of clinically relevant data elements improves care and communication for individuals across the continuum: Enables shared understanding and use of clinical information
  • Enables the re-use of data elements (e.g., for transitions of care, care planning, referrals, decision support, quality measurement, payment reform, etc.)
  • Supports the exchange of patient assessment data across providers
  • Influences and supports CMS and industry efforts to advance interoperable health information exchange and care coordination

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The FY16/17 Final Rules

• SNF Quality Reporting Program (QRP)
  • QMs:

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Bracing for IMPACT!

The FY16/17 Final Rules

• SNF Quality Reporting Program (QRP)
  • Basics:
    • Beginning with the FY 2018 (October 2017) payment determination, SNFs must report all of the data necessary to calculate the proposed quality measures on at least 80% of the MDS assessments that they submit.
    • Any SNF that does not meet the proposed requirement that 80 percent of all MDS assessments submitted contain 100 percent of all data items necessary to calculate the SNF QRP measures would be subject to a reduction of 2% to its FY 2018 market basket percentage.

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The FY16/17 Final Rules

• SNF Quality Reporting Program (QRP)
  • Basics:
    • CMS will collect a single quarter of data for FY 2018, October 1, 2016, through December 31, 2016, to remain consistent with the usual October release schedule for the MDS, to give SNFs a sufficient amount of time to update their systems so that they can comply with the new data reporting requirements, and to give CMS a sufficient amount of time to determine compliance for the FY 2018 program.
    • CMS has finalized that following the close of the reporting quarter, for the FY 2018 payment determination, SNFs would have an additional 4½ months to correct and/or submit their quality data. And that the final deadline for submitting data for the FY 2018 payment determination would be May 15, 2017.
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• SNF Quality Reporting Program (QRP)

  Basics:
  • After the initial reporting period, in the FY 2017 proposed rule, CMS is proposing to
    follow a CY schedule for measure and data submission requirements that includes
    quarterly deadlines following each quarter of data submission, beginning with data
    reporting for the FY 2019 payment determinations.
  • Each quarterly deadline will occur approximately 4.5 months after the end of a given
    calendar quarter as outlined below in Table 15. This timeframe will give SNFs enough
    time to submit corrections to the assessment data, as discussed below.
  • Thus, if finalized, the FY 2019 payment determination would be based on 12
    consecutive months of data beginning on January 1, 2018, and ending on December 31, 2018.
  • This approach would enable CMS to move to a full 12 months of data reporting
    immediately following the first 3 months of reporting (October 1, 2016 through
    December 31, 2016) for the FY 2018 payment determination; rather than an interim
    approach, which would use only 9 months of FY data reporting following the initial reporting for the FY 2018 payment determination.

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TABLE 14: Finalized Measures, Data Collection Source, Data Collection Period and Data Submission Deadlines Affecting the FY 2018 Percent Determination

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Data Collection</th>
<th>Data Collection Period</th>
<th>Data Submission Deadline for FY 2018 Percent Determination</th>
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</thead>
<tbody>
<tr>
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<td>QD</td>
<td>July 1, 2016 - December 31, 2016</td>
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<tr>
<td>NSQ H-73: Application of Place or śląże Residency with Licensed Clinician (Not Required)</td>
<td>QD</td>
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</tr>
</tbody>
</table>

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TABLE 15: Proposed Data Collection Period and Data Submition Deadlines Affecting the FY 2019 Percent Determination and Subsequent Years

<table>
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</table>
Bracing for IMPACT!
The FY16/17 Final Rules
• SNF Quality Reporting Program (QRP)
  • Basics:
    • Participation/Timing for New SNFs: Beginning with the submission of data required for the FY 2018 payment determination, CMS has finalized that a new SNF would be required to begin reporting data on any quality measures finalized for that program year by no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter.
    • For example, for FY 2018 payment determinations, if a SNF received its CCN on August 28, 2016, and 30 days are added (for example, August 28 + 30 days = September 27), the SNF would be required to submit data for residents who are admitted beginning on October 1, 2016.

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• SNF Quality Reporting Program (QRP)
  • Basics:
    • CMS has finalized a process by which a facility may request an extension related to QRP data submission when there are circumstances present that would preclude timely submission like man made or natural disasters.

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• SNF Quality Reporting Program (QRP)
  • (NQF #2631) Cross-setting Function Quality Measure: Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
    This quality measure reports the percent of patients/residents with an admission and a discharge functional assessment and a treatment goal that addresses function. The treatment goal provides evidence that a care plan with a goal has been established for the patient/resident.
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• SNF Quality Reporting Program (QRP)
  • QMs: (NQF #2631 cont.)
    • This process quality measure requires the collection of admission and discharge functional status data by clinicians using standardized clinical assessment items or data elements that assess specific functional activities, that is, self-care and mobility activities.
    • The self-care and mobility function items are coded using a 6-level rating scale that indicates the patient’s/resident’s level of independence with the activity. A higher score indicates greater independence. If an activity is not attempted, the reason that the activity did not occur is coded.

  • For this quality measure, documentation of a goal for one of the function items reflects that the patient’s/resident's care plan addresses function.
  • The functional goal is recorded at admission for at least one of the standardized self-care or mobility function items using the 6-level rating scale.
  • Subsequent to the admission assessment, goal setting and establishment of a care plan to achieve the goal, at the time of discharge the self-care and mobility functional performance is reassessed using the same 6-level rating scale, enabling the ability to re-assess the patient’s/resident’s functional abilities.

• MDS Revisions FY 2016 and FY2017
  • In FY 2017, this fall, there will be at least two major revisions to the RAI to accommodate the SNF QRP measures NQF 2631.
    • Chapter 3 Section A will be amended to accommodate a new data set and Section GG instructions will be added to accommodate NQF 2631.
    • A new data set will be added, Nursing Home and Swing Bed PPS Part A Discharge (End of Stay) (NPE/SPE) Item Set. This will be required for residents who discharge from Part A and remain in the SNF under custodial type care levels.
  • Draft RAI Manual v1.14:
  • Draft MDS 3.0 v1.14.0:
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• MDS Revisions FY 2016 and FY2017
  • Other significant RAI Manual and Data Set Revisions for FY 2017 (DRAFT Manual has 72 pages of change documents. Final version of the revised Manual due out any time)
  • New MCR A PPS Discharge data set.
  • Changes to section A to accommodate the new data set.
  • Revisions to section C items for coding delirium.
  • Revisions to the Delirium CAA.
  • Revisions to the Confusion Assessment Method (CAM).
  • Requirements for both the new section G6 as well as requirements for the new Part A PPS discharge data set have been issued.
  • Clarifications to the instructions for coding falls with major injury.
  • Clarifications to the instructions for coding pressure ulcer present on admission.

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The FY16/17 Final Rules

• SNF Quality Reporting Program (QRP)
  • QMs: (NQF #2631 cont.)
    ▪ The denominator is the number of Medicare Part A covered resident stays.
    ▪ The numerator is the number of patient/resident stays with functional assessment data for each self-care and mobility activity and at least one self-care or mobility goal.
    ▪ To the extent that a patient/resident has an incomplete stay (for example, for the purpose of being admitted to an acute care facility), collection of discharge functional status data might not be feasible. Therefore, for patients/residents with incomplete stays, admission functional status data and at least one treatment goal would be required. Discharge functional status data would not be required to be reported.
    ▪ Patient/residents with complete and incomplete stays are included in the numerator for this quality measure.

• (NQF #0678) Cross-Setting Pressure Ulcer Measure: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened
  ▪ This quality measure reports the percent of patients/short-stay residents with Stage 2-4 pressure ulcers that are new or worsened since admission. For residents in a SNF, the measure is calculated by examining all assessments during an episode of care (Remember 8.3% and 18.3% r/t the MDS focused survey demonstration).
  ▪ This measure is intended to encourage SNFs/Nursing Homes (NHs), LTCHs, and IRFs to prevent pressure ulcer development or worsening, and to closely monitor and appropriately treat existing pressure ulcers.
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The FY16/17 Final Rules

• SNF Quality Reporting Program (QRP)
  • QMs: (NQF #0678 cont.)
    • The denominator is the number of short-stay residents with one or more MDS 3.0 assessments that are eligible for a look-back scan (except those with exclusions). All assessments with target dates within the episode are examined to determine whether the event or condition of interest occurred at any time during the episode.
    • A look-back scan is a review of all qualifying assessments within the resident’s current episode to determine whether events occurred during the look-back period.
    • All assessments with target dates within the episode are examined to determine whether the event or condition of interest occurred at any time during the episode. Assessment types include:
      – admission, quarterly, annual, significant change/correction OBRA assessment; or a PPS 5-, 14-, 30-, 60-, or 90-day; or discharge with or without return anticipated; or SNF PPS Part A Discharge Assessment.

  • The numerator is the number of short-stay residents with an MDS 3.0 assessment during the selected time window who have one or more Stage 2-4 pressure ulcers, that are new or worsened, based on examination of all assessments in a resident’s episode for reports of Stage 2-4 pressure ulcers that were not present or were at a lesser stage on prior assessment or last admission/entry or reentry as recorded at items M0800 A-C in the MDS 3.0 data set.
  • Assessments may be discharge, PPS 5-, 14-, 30-, 60-, 90-day, SNF PPS Part A Discharge Assessment or OBRA admission, quarterly, annual or significant change assessments.

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The FY16/17 Final Rules

• SNF Quality Reporting Program (QRP)
  • (NQF #0674) Cross-Setting Falls with Major Injury Measure: Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674)
    • This quality measure reports the percentage of SNF patients/residents who experience one or more falls with major injury (defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma) during the SNF stay (Remember 25.5% discrepancy in MDS Focus Survey demonstration).
The FY16/17 Final Rules

• SNF Quality Reporting Program (QRP)
  • QMs: (NQF #0674 cont.)
  • This quality measure is based on data reported for two items. The first item (J1800) is a gateway item that asks whether the patient/resident has experienced any falls since admission/entry (or reentry or prior assessment).
  • If the answer to J1800 is no, the next item (J1900) is skipped.
  • If the answer to J1800 is yes, the next item (J1900) asks for the number of falls with a) no injury, b) injury (except major), and c) major injury. The measure is calculated using data reported for J1900C (number of falls with major injury).
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The FY16/17 Final Rules

- SNF Quality Reporting Program (QRP)
  - IMPACT Act Resource Use and other measures finalized in the FY 2017 SNF PPS Final Rule.
    - Total estimated Medicare spending per beneficiary – 10/1/2016
    - Discharge to Community – 10/1/2016
    - Measure to reflect all-cause risk adjusted potentially preventable hospital readmission rates – 10/1/2016
    - Medication Reconciliation – 10/1/2018

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The FY16 Final/17 Proposed Rule

- SNF Quality Reporting Program (QRP)
  - IMPACT Act Resource Use and other measures finalized in the FY 2017 SNF PPS Final Rule.
    - Total estimated Medicare spending per beneficiary – 10/1/2016
    - The MSPB-PAC measures evaluate PAC providers’ resource use relative to the resource use of the national median PAC provider of the same type. There is a separate MSPB-PAC measure for SNF, HHA, LTCH, and IRF providers; within each measure, a given PAC provider is only compared to other providers in the same setting (i.e., in the MSPB-PAC SNF measure, a SNF provider is compared to all SNF providers). Specifically, the measures assess the Medicare spending performed by the PAC provider and other healthcare providers during an MSPB-PAC episode.

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The FY16/17 Final Rules

- SNF Quality Reporting Program (QRP)
  - IMPACT Act Resource Use and other measures finalized in the FY 2017 SNF PPS Final Rule.
    - Total estimated Medicare spending per beneficiary – 10/1/2016
    - The proposed MSPB-PAC SNF episode-based measure will provide actionable and transparent information to support SNF providers’ efforts to promote care coordination and deliver high quality care at a lower cost to Medicare. The MSPB-PAC SNF measure holds SNF providers accountable for the Medicare payments within an “episode of care” (episode), which includes the period during which a patient is directly under the SNF’s care, as well as a defined period after the end of the SNF treatment, which may be reflective of and influenced by the services furnished by the SNF.
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The FY16/17 Final Rules

- SNF Quality Reporting Program (QRP)
- IMPACT Act Resource Use and other measures finalized in the FY 2017 SNF PPS Final Rule.

  - Total estimated Medicare spending per beneficiary – (Cont.)
  
    - An MSPB-PAC episode includes all Medicare Part A and Part B services with a start date in the episode window, except for a limited set of services that are excluded for being clinically unrelated to PAC treatment. The episode window is opened by a trigger event, which is a billing submission to the facility.
  
    - IMPACT Act Resource Use and other measures finalized in the FY 2017 SNF PPS Final Rule.

- Discharge to Community

  - This trigger event marks the first day of the PAC treatment period. The treatment period is the time during which the patient receives treatment from the provider for whom the measure is being calculated (the "attributed PAC provider") and all services related to that provider's services. The treatment period includes all Medicare Part A and Part B services provided by the attributed PAC provider, excepting a limited set of services that are determined to be clinically unrelated to PAC treatment. The treatment period ends at discharge for SNF.

- Discharge to Community

  - The associated services period is the time during which any Medicare Part A and Part B services other than those in the treatment period are counted towards the episode spending, again excepting a limited set of services that are clinically unrelated to PAC treatment. For each type of MSPB-PAC episode, the associated services period starts at the episode trigger and ends 30 days after the last day of the episode’s treatment period.

- Discharge to Community – (Cont.)

  - Discharge to community is an actionable health care outcome, as targeted interventions have been shown to successfully increase discharge to community rates in a variety of post-acute settings. Many of these interventions involve discharge planning or specific rehabilitation strategies, such as addressing discharge barriers and improving medical and functional status. The effectiveness of these interventions suggests that improvement in discharge to community rates among post-acute care residents is possible through modifying provider-led processes and interventions.
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The FY16/17 Final Rules

• SNF Quality Reporting Program (QRP)
  • IMPACT Act Resource Use and other measures finalized in the FY 2017 SNF PPS Final Rule.
  • Measure to reflect all-cause risk adjusted potentially preventable hospital readmission rates – 10/1/2016
    1. This proposed measure assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for Medicare FFS beneficiaries in the 30 days post SNF discharge. The SNF admission must have occurred within up to 30 days of discharge from a prior proximal hospital stay which is defined as an inpatient admission to an acute care hospital (including IPPS, CAH, or psychiatric hospital). Hospital readmissions include readmissions to a short-stay acute care hospital or an LTCH, with a diagnosis considered to be unplanned and potentially preventable.
    2. This proposed measure is claims-based, requiring no additional data collection or submission burden for SNFs. Because the measure denominator is based on SNF admissions, each Medicare beneficiary may be included in the measure multiple times within the measurement period.

• Medication Reconciliation: Drug Regimen Review Conducted with Follow-Up for Identified Issues - Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program – 10/1/2018 (Affecting 2020 payment determinations) Cont.
  • Additionally, for this proposed quality measure, drug regimen review is defined as the review of all medications or drugs the patient/resident is taking to identify any potentially clinically significant medication issues.
  • This proposed quality measure utilizes both the processes of medication reconciliation and a drug regimen review, in the event an actual or potential medication issue occurred.
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The FY16/17 Final Rules

- SNF Quality Reporting Program (QRP)
  - IMPACT Act Resource Use and other measures finalized in the FY 2017 SNF PPS Final Rule.
    - This proposed measure informs whether the PAC facility identified and addressed each clinically significant medication issue and if the facility responded or addressed the medication issue in a timely manner. Of note, drug regimen review in PAC settings is generally considered to include medication reconciliation and review of the patient’s drug regimen to identify potential clinically significant medication issues. This measure is applied uniformly across the PAC settings.
    - For SNFs, this measure applies to resident stays covered by Medicare Part A.

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**ADMISSION (START OF SNF PPS STAY)**

- Medications
  - Medication Reconciliation
    - Initial medication reconciliation performed within 3 days of admission
    - Subsequent reconciliation performed every 30 days
  - Medication Reconciliation performed within 3 days of admission
  - Medication Reconciliation performed every 30 days

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**DISCHARGE (END OF SNF PPS STAY)**

- Medications
  - Medication Reconciliation
    - Discharge medication reconciliation performed within 24 hours of discharge
    - Medication Reconciliation performed within 24 hours of discharge

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TABLE 15: Proposed New QIP Assessment-Based Quality Measures: Data Collection Period and Data Submission Deadline: Affecting the FY 2020 Payment Determination

| Quality Measure | Data Collection Source | Proposed Data Collection Period | Proposed Data Submission Deadline | Payment Determination
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Pregnancy</td>
<td>Concurrent and Follow-Up Assessment from PAC QIP</td>
<td>March 15 - December 31</td>
<td>April 15</td>
<td>May 15, 2020</td>
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</tbody>
</table>

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TABLE 16: Proposed Data Collection Period and Data Submission Deadline: Affecting the FY 2019 Payment Determination and Subsequent Years

<table>
<thead>
<tr>
<th>CV Data Collection Quarter</th>
<th>Data Collection/Collection Period</th>
<th>Quarterly Review and Correction Period</th>
<th>Payment Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>January 1 - March 31</td>
<td>April 1 - August 31</td>
<td>FY 2019</td>
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<tr>
<td>Quarter 2</td>
<td>April 1 - June 30</td>
<td>July 1 - November 15</td>
<td>FY 2019</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>July 1 - September 30</td>
<td>October 1 - February 28</td>
<td>FY 2019</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>October 1 - December 31</td>
<td>January 1 - May 15</td>
<td>FY 2019</td>
</tr>
</tbody>
</table>
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In April 2016, CMS began posting data for six new quality measures (QMs) on Nursing Home Compare:

- Percentage of short-stay residents who were successfully discharged to the community
- Percentage of short-stay residents who have had an outpatient emergency department visit
- Percentage of short-stay residents who were re-hospitalized after a nursing home admission
- Percentage of short-stay residents who made improvements in function
- Percentage of long-stay residents whose ability to move independently worsened
- Percentage of long-stay residents who received an antianxiety or hypnotic medication
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• Measures 1-5 are being factored into the Nursing Home Compare 5-star rating system via a phase-in process beginning July, 2016.
  – 50% in July and full weight January 2017.
  – CASPER Preview reports have been posted each month since April 2016.
  – Nursing Home Compare was to be updated in July. CMS found errors in their calculations. Revised CASPER preview reports were posted on August 4th. Nursing Home Compare 5-Star Ratings will be updated August 10th.
  – All material related to the revised 5-star system, including the technical specifications and Technical user’s guide that was updated in July can be found at the following website:

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• 1. The Percentage of Short-Stay Residents Who Were Re-Hospitalized after a Nursing Home Admission. (Claims based with claims and MDS based exclusions and risk adjustments)
  – Purpose of Measure: If a nursing home sends many residents back to the hospital, it may indicate that the nursing home is not properly assessing or taking care of its residents who are admitted to the nursing home from a hospital.

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– Measure Description and Specifications: The short-stay re-hospitalization measure determines the percentage of all new admissions or readmissions to a nursing home from a hospital where the resident was re-admitted to a hospital for an inpatient or observations stay within 30 days of entry or reentry. Planned inpatient readmissions are excluded. Note that higher values of the short-stay re-hospitalization measure indicate worse performance on the measure.
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– **Numerator**: The numerator for the measure is the number of nursing home stays where the resident had one or more unplanned inpatient admissions or one or more outpatient claims for an observation stay within 30 days of entry/reentry. This includes inpatient or observation stays occurring after discharge from the nursing home but within the 30 day timeframe.

– **Denominator**: The measure includes Medicare fee-for-service enrollees who entered or reentered the nursing home from a hospital, were not enrolled in hospice during their nursing home stay, and who were not identified as comatose based on the MDS admission assessment.

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2. Percentage of Short-Stay Residents Who Have had an Outpatient Emergency Department Visit. (Claims based with claims and MDS based exclusions and risk adjustments)

– **Purpose of Measure**: If a nursing home often sends many of its residents to the emergency department (ED), it may indicate that the nursing home is not properly assessing or taking care of its residents who are admitted to the nursing home from a hospital. Better preventative care and access to physicians and nurse practitioners in an emergency may reduce rates of ED visits.

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**Measure Description and Specifications**: The short-stay outpatient ED visit measure determines the percentage of all new admissions or readmissions to a nursing home from a hospital where the resident had an outpatient ED visit (i.e., an ED visit not resulting in an inpatient hospital admission) within 30 days of entry or reentry. Note that higher values of the short-stay outpatient ED visit measure indicate worse performance on the measure.
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- **Numerator:** The numerator for the measure is the number of nursing home stays where the resident had one or more outpatient claims for an ED visit within 30 days of entry/reentry. This includes outpatient ED visits occurring after discharge from the nursing home but within the 30 day timeframe. Note that outpatient ED visits are included in the measure regardless of their diagnosis.

- **Denominator:** The measure includes Medicare fee-for-service enrollees who entered or reentered the nursing home from a hospital, were not enrolled in hospice during their nursing home stay, and who were not identified as comatose based on the MDS admission assessment.

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- 3. **Percentage of Short-Stay Residents who were Successfully Discharged to the Community.**
  
  (Claims based with claims and MDS based exclusions and risk adjustments.)

  - **Purpose of Measure:** Many nursing home residents enter skilled nursing facilities for rehabilitation services. For many short-stay patients, return to the community is the most important outcome associated with nursing home care. If a nursing home discharges few residents back to the community successfully, it may indicate that the nursing home is not properly assessing its residents who are admitted to the nursing home from a hospital or not adequately preparing them for transition back to the community.

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**Measure Description and Specifications:** The short-stay successful community discharge measure determines the percentage of all new admissions to a nursing home from a hospital where the resident was discharged to the community within 100 calendar days of entry and for 30 subsequent days, they did not die, were not admitted to a hospital for an unplanned inpatient stay, and were not readmitted to a nursing home. Note that lower values of the short-stay successful community discharge measure indicate worse performance on the measure.
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- **Numerator:** The numerator for the measure is the number of nursing home episodes where the resident was discharged to the community within 100 calendar days of entry, and the resident did not die, did not have a claim for an unplanned inpatient admission, and did not enter/reenter a nursing home within 30 days of discharge to the community.

- **Denominator:** The measure includes Medicare fee-for-service enrollees who entered the nursing home from a hospital, were not a resident of the nursing home in the previous 30 days, were not enrolled in hospice during their nursing home stay, and were not identified as comatose based on the MDS admission assessment.

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4. **Percentage of Short-stay Residents Who Made Improvements in Function.** (MDS based with MDS based exclusions and risk adjustments)

- **Purpose of Measure:** Short-stay residents frequently have limitations in their physical functioning because of factors including but not limited to illness, hospitalization, or surgery. The purpose of the Percentage of Short-stay Residents Who Made Improvements in Function measure is to determine, among short-stay nursing home residents who are discharged from the nursing home, the percentage of residents who gain more independence in transfer, locomotion, and walking during their episodes of care.

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**Measure Description and Specifications:** The short-stay improvements in function measure assesses the percentage of short-stay nursing home residents of all ages with improved independence on these mobility functions (transfer: self-performance; locomotion on unit: self-performance; walk in corridor: self-performance) from the earliest initial assessment (admission or 5-day assessment) to the discharge assessment (specifically, the discharge assessment when return to the nursing home is not anticipated).
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- **Numerator:** The numerator for the measure is the number of nursing home episodes where the resident had a negative mid-loss activities of daily living (MLADL) change score; where the MLADL score is defined as the sum of transfer: self-performance G1b(A), locomotion on unit: self-performance G1e(A), and walk in corridor: self-performance G1d(A).

- **Denominator:** The measure includes all short-stay residents who have a valid discharge (return not anticipated) assessment and a valid preceding 5-day assessment, who were not identified as comatose, as having a prognosis of less than 6 months, in hospice care, or as having a MLADL score greater than or equal to 1 based on the 5-day or admission assessment, and who did not have an unplanned discharge during the care episode.

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- **5. Percentage of Long-stay Residents Whose Ability to Move Independently Worsened or the long-stay locomotion measure.** (MDS based with MDS based exclusions and risk adjustments)

  - **Purpose of Measure:** The long-stay locomotion measure evaluates the quality of nursing home care with regard to the loss of independence in locomotion among individuals who have been residents of the nursing home for more than 100 days. Loss of independence in locomotion is itself an undesirable outcome. Additionally, it increases risks of hospitalization, pressure ulcers, musculoskeletal disorders, pneumonia, circulatory problems, constipation, and reduced quality of life. Residents who have declined in independence in locomotion also require more staff time than those who are more independent.

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**Measure Description and Specifications:** The long-stay locomotion measure assesses the percentage of long-stay residents who experienced a decline in independence in locomotion. The measure includes all long-stay residents except those for whom the measure cannot be calculated, and those for whom a decline in independence in locomotion does not necessarily indicate poor quality of care.
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- **Numerator**: The numerator for the measure is the number of long-stay residents who had a decline in locomotion on unit: self-performance since their prior MDS assessment.

- **Denominator**: The measure includes all long-stay residents who have a qualifying MDS assessment during the target period (e.g., calendar quarter) and at least one qualifying prior assessment. Qualifying assessments include: annual, quarterly, significant change, significant correction, PPS (14-, 30-, 60-, or 90-day), or discharge assessment with or without return anticipated. A discharge assessment does not count as a qualifying prior assessment.

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- **6. Not Part of the Revised 5-Star Calculation** - Percentage of Long-stay Residents Who Received an Antianxiety or Hypnotic Medication. (MDS based with MDS based exclusions.)
  - **Purpose of Measure**: The use of antianxiety and hypnotic medications among older adults has been linked to increased risk of adverse outcomes such as cognitive impairment, delirium, falls, and fractures. The long-stay antianxiety or hypnotic medication use measure assesses the percentage of long-stay residents in a nursing home who receive antianxiety or hypnotic medications. The measure is intended to prompt nursing homes to re-examine their prescribing patterns in order to encourage practice consistent with clinical recommendations and guidelines (i.e., preventing and stopping long-term use of benzodiazepine).

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- **Primary Scoring Changes**
  - Data uses four quarters of data now instead of three.
  - The scoring tables reduce the minimum denominator to 20 for all measures. This will be more inclusive for facilities with small samples. Prior to this long stay measures could only be calculated for at least 30 resident assessments and the short stay QMs had to have a minimum of 20.
  - Revised imputation methodology for low-denominator QMs. CMS has revamped the imputation methodology, using a combination of the facility’s own available data and the state average to reach the minimum denominator. For facilities with missing data or an inadequate denominator size for one or more QMs, all available data from the facility are used. The remaining assessments (or stays) are imputed to get the facility to the minimum required sample size of 20, i.e., assessments would be imputed using the state average to get to the minimum sample size as well as missing values are imputed based on the statewide average for the measure.
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Primary Scoring Changes

- Uses national cut points for the ADL QM. The scoring rules for the ADL QM (aka the long-stay QM, Percentage of Residents Whose Need for Help with Activities of Daily Living Has Increased) have changed. Previously, the scoring grouped all facilities into quintiles based on the national distribution for each QM—except for the ADL measure, which used state-specific quintiles using state distributions. Now, all of the measure groupings are based on the national distribution of the QMs, prior to any imputation.
- For each of the MDS-derived QMs, the cut points are based on the QM distributions averaged across the four quarters of 2015.
- For the claims-based QMs, the cut points are based on the national distribution of the measures calculated for the period of Quarter 3 of 2014 through Quarter 2 of 2015.
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How to Prepare

• Stay up to date. Things are changing at a rapid pace (FY 2016 Final and FY 2017 Proposed Rules, FY 2017 and FY 2018 MDS changes, SNF VBP and QRP technical Specifications)
• Pay attention to your rehospitalization Data.
• Adopt processes that reduce rehospitalizations.
• Adapt to the changing payment landscape.
• Increase your ability to care for medically complex patients.
• Partnerships, Partnerships, Partnerships…
• Buzz Word Realities: Opportunity, Efficiency, Collaboration, Innovation, Quality, Outcomes…

Questions?

Questions

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