Clinical Performance Measurement in LTC

- CMS Nursing Home Compare 5 Star Rating System
  - Electronic Staffing Data Submission - Payroll Based Journal (PBJ)
- SNF Quality Reporting Program (SNFQRP)
  - Data collection starts October 1, 2016
- SNF Value Based Purchasing Program (SNFVBP)
  - Affects Medicare Fee for Service Payment FY 2019
Use of Data in Long Term Care

- Quality Improvement
  - Internal use of data to identify problems or opportunities for improvement

- Accountability
  - Nursing Home Quality Indicator Survey Process (QIS)
  - Consumer decision making
  - Criteria for waiver of 3 day Hospital stay for bundled payments
  - Value based Payment Systems
    - Transitioning payment based on "quantity" to "quality"

Sources of Data in Long Term Care

- Clinical Data
  - Minimum Data Set (MDS)

- Staffing Data
  - CMS 671 Form
  - PBJ Staffing Data

- Transitions in Care Data
  - Medicare Fee for Service Claims Data

- Financial Data
  - Medicare Fee for Service Claims Data
**Electronic Staffing Data Submission**  
**Payroll Based Journal**

- Mandated under the Affordable Care Act of 2010
  - Requires Facilities to electronically submit direct care staffing information based on payroll and other auditable data
- Final rule published August 2015
- Voluntary submission period
  - October 1, 2015 – July 1, 2016
- Mandatory submission
  - Quarterly starting July 1, 2016
- Goal
  - Report on the level of staffing in each nursing home
  - Report on employee turnover and tenure

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**Electronic Staffing Data Submission**  
**Payroll Based Journal**

- Regulatory Requirements
  - Complete and accurate direct care staffing data
    - Direct Care Staff including agency and contract staff
      - “Individuals who through direct contact with residents or resident care management, provide care and services to allow resident to attain or maintain their highest practicable physical, mental, psychosocial well-being”
  - Submitted at a minimum quarterly
    - Based on Fiscal year quarters
    - Due 45 days after the end of the fiscal quarter
  - Staffing data must be auditable
  - Failure to submit is considered as noncompliant and subject to enforcement actions by CMS
Electronic Staffing Data Submission
Payroll Based Journal

Data Submission elements
- Employee ID Number
  - No names
- Hire Date
- Termination Date
- Pay type code
  - Exempt/Non-exempt/Contract
- Staffing hours per day by date
  - Hours paid (excluding meal/breaks/leave)
  - Day- Calendar day period
- Job Title Code
  - Based on employees primary role

Census – last day of the month
- Medicare
- Medicaid
- Other
Facility Challenges

- Method of submission decision
  - Manual submission into system vs. software that generates data file
- Mapping Facility job descriptions to CMS Job Title Code
  - Use PBJ definitions not “671” definitions
    - May include licensure/certification credentials for the job title code
- Capturing staffing data for contract staff
  - Medical Director’s time vs. attending physician time
  - Agency nurses, therapists
- Segregating time that is billed to 3rd party payer
  - Do not count hours that is billed directing by practitioner to 3rd party
    - Only count hours paid by Facility
    - Example: Dentist, Podiatrist, Nurse Practitioner

Facility Challenges

- Designing the workflow for data collection and review
  - Identifying staff member responsible to oversee/coordinate the process
  - Defining the workflow elements
    - Collection
    - Review
    - Adjust
    - Finalize
    - Submit
- Identify frequency of submission
  - Quarterly/monthly/payroll period
CMS Staffing Star Rating Calculation

- Current process based on staffing submitted at time of survey
  - CMS-671 completed at time of annual certification survey
  - Includes staffing hours reflective of the most recent completed payroll period
  - Hours are reflective of 14 day period only

- Weakness of current process
  - Not auditable
  - May not reflect staffing year round
    - Negatively – if survey during high vacation or holiday periods
    - Positively – notion of “staffing up” during survey picture dates

CMS Staffing Star Rating Calculation Components

- RN Hours Per Resident Day (HPRD)
  - Director of Nursing
  - RN
  - Licensed Nurses with Administrative Duties
    - Supervisors/Unit Managers
    - ADON
    - MDS Coordinators
    - Case Managers (if licensed nurse)
    - Staff Development/Infection Control/Wound Care

- Total Nursing Staff Hours Per Resident Day (HPRD)
  - RN
  - LPN
  - CNA
**CMS Staffing Star Rating Calculation**

- **Reported Hours**
  - Based on Hours indicated on 671

- **Expected Hours**
  - Based on MDS data submitted during the last full quarter closest to survey

- **Adjusted Hours**
  - \( \text{Reported Hours/Expected Hours} \times \text{National Average} = \text{Adjusted} \)
  - Adjusted Hours are what decides the star rating

**CMS Staffing Star Rating Calculation**

- **Reported Hours**
  - Current Reporting System
    - Hours reported on the 671 divided by 14 = Hours per day
    - Census reported on 672
    - Hours per day/Census = NHPRD
**CMS Staffing Star Rating Calculation**

**Expected Hours**
- Hours per day for RN/LPN/NA for each RUG III version 53 group
- Most recent MDS information for each resident in the facility on the last day of the quarter closest to survey
  - Composite profile from resident if they have both OBRA and PPS assessments
- Calculate NHPRD for each resident/census = expected hours

**Adjusted Hours**
- Reported /Expected x National Average = Adjusted
- National Averages
  - Total nursing staff (Aides + LPNs + RNs) = 4.0309
  - Registered nurses = 0.7472
# CMS Staffing Star Rating Calculation

<table>
<thead>
<tr>
<th></th>
<th>CNA</th>
<th></th>
<th>LPN</th>
<th></th>
<th>RN</th>
<th></th>
<th>Total Nursing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported Staffing</td>
<td>2.58368</td>
<td></td>
<td>0.78836</td>
<td></td>
<td>0.88037</td>
<td></td>
<td>4.25241</td>
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<tr>
<td>Expected Staffing</td>
<td>2.596073003</td>
<td></td>
<td>0.768677422</td>
<td></td>
<td>1.223398364</td>
<td></td>
<td>4.58148789</td>
<td></td>
</tr>
<tr>
<td>Adjusted Staffing</td>
<td>2.44198665</td>
<td></td>
<td>0.85125279</td>
<td></td>
<td>0.537692777</td>
<td></td>
<td>3.73593812</td>
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</tr>
<tr>
<td>Star Rating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RN</td>
<td>****</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total Nursing</td>
<td>****</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Overall Staffing</td>
<td>****</td>
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</tr>
</tbody>
</table>

## CMS Staffing Star Rating Calculation

**Table 5**

<table>
<thead>
<tr>
<th>RN rating and hours</th>
<th>Total nurse staffing rating and hours (RN, LPN and nurse aide)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>0.283</td>
</tr>
<tr>
<td>3</td>
<td>0.379 – 0.512</td>
</tr>
<tr>
<td>4</td>
<td>0.513 – 0.709</td>
</tr>
<tr>
<td>5</td>
<td>≥0.710</td>
</tr>
</tbody>
</table>

Note: Adjusted staffing values are rounded to three decimal places before the cut points are applied.
Electronic Staffing Data Submission
Payroll Based Journal

What does it really mean??
  - CMS equates availability of staff as an indicator of quality
    - Volume
    - Tenure
    - Turnover
  - CMS believes that staffing should be based on resident acuity
    - No industry standard for acuity based staffing
    - Facility will be required to identify staffing needs based on the resident population in the Facility Assessment (required by November 2017)
  - CMS wants to report Facility staffing on an ongoing basis
    - Updated more frequently than annually
    - Quarterly ???

Electronic Staffing Data Submission
Payroll Based Journal

What does it really mean for Nursing Leadership
  - Identify your staffing needs based on acuity
    - Evaluate your resident acuity over time using the CMS methodology
    - Identify your fluctuations quarter to quarter
  - Identify your staffing based on acuity and 5 Star staffing goal
    - Identify your daily staffing pattern
    - Review budgeted positions not just FTEs.
  - Identify and monitor your NHPRD
    - Establish system to calculate daily
    - Look at your fluctuations
      - Weekends
      - Vacation/Holiday
SNF Quality Reporting Program (SNFQRP)

IMPACT Act Requirements

- Reporting of Quality Measures across all Post Acute Providers
  - Long Term Acute Care Hospital (LTACH)
  - Inpatient Rehabilitation Facilities/Units (IRF)
  - Skilled Nursing facilities (SNF)
  - Certified Home Health Agencies (CHHA)
- Measures being developed are both clinical and claims based
  - Clinical measures will use data from Provider specific assessments
    - Skilled Nursing facilities - MDS

SNF Quality Reporting Program (SNFQRP)

Comparison between SNFQRP and CMS 5 Star QM

- Data is collected on Medicare Part A FFS admissions only
- Measures will be based on a smaller population
- Residents may be at higher risk
  - Recent medical episode
SNF Quality Reporting Program (SNFQRP)

SNFQRP – FY 2017

- Clinical Measures Only
  - Percent with 1 or more falls with major injury while in SNF Part A stay
  - Percent of residents with new or worsening Pressure Ulcers
  - Percent with Admission & Discharge Functional Assessment and a care plan that addresses function
    - Prevalence only
    - No comparison of functional improvement between admission/discharge

SNF Quality Reporting Program (FY 2017 SNFQRP)

  - Data must be reported by May 15, 2017
  - Potential 2% penalty reduction to market basket index for not submitting data
    - Requires all data elements to calculate QM in 80% of MDS submitted
    - Use of a (-) in any data element is considered not submitted
SNF Quality Reporting Program (SNFQRP)

- SNFQRP FY 2018 additional measures for collection
  - Medicare Spending per Beneficiary
  - Successful Discharge to the Community
    - Being reported as of April 2016 on Nursing Home Compare
  - Potentially Preventable 30-day Post Discharge Readmission

SNF Quality Reporting Program (SNFQRP)

- SNFQRP FY 2019 additional measures for collection
  - Drug Regimen Review with Follow Up
    - Includes both Medication reconciliation and Drug Regimen Review
    - Includes those with clinically significant medication issues
    - Requires response from physician by midnight of the next calendar day
SNF Quality Reporting Program (SNFQRP)

What does this mean??

- CMS is focused on value and quality
  - Comparative data about outcomes for Post Acute Providers
  - Available to both CMS and Consumers
  - Facilities with low Medicare Part A Fee for service at a disadvantage

What does this mean for now??

- Know the submission, quarterly reporting and correction timeframes

<table>
<thead>
<tr>
<th>CY Data Collection Quarter</th>
<th>Data Collection/submission Quarterly Reporting Period</th>
<th>Quarterly Review and Correction Periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>January 1 – March 31</td>
<td>April 1 – August 15</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>April 1 – June 30</td>
<td>July 1 – November 15</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>July 1 – September 30</td>
<td>October 1 – February 15</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>October 1 – December 31</td>
<td>January 1 – May 15</td>
</tr>
</tbody>
</table>
SNF Quality Reporting Program (SNFQRP)

What does this mean for now??

- Identify staff person/team responsible to monitor and oversee the process
  - Clinical MDS measures
  - Claims based measures
- Review MDS process to assure that assessments are completed accurately and with no dashes
  - Verify that all new sections (GG) and assessments (Medicare discharge) are being completed when required
  - Look at all data elements required for the SNFQRP measures and identify any work flow issues

What does this mean to prepare for 2018??

- Expand Hospital readmission prevention initiative to include analysis by payer mix
  - Causes for readmission may be different between Medicare Part A FFS and other payers
- Monitor the MDS changes in 2017 related to Drug Regimen Review
SNF Value Based Purchasing Program (SNFVBP)

Overview of SNFVBP

- Establishes a 2% withhold to Medicare Part A payments FY2019
  - Starts October 1, 2018
- SNFs can earn back dollars based on SNF VBP Measure score
  - Earn back is between 50 – 70 % of total amount of reductions in total
  - Facilities can earn back more than the 2% reduction

SNF Value Based Purchasing Program (SNFVBP)

SNF VBP Re-hospitalization Measure – FY 2019

- 30 day all cause all condition Readmission Measure (SNFRM)
  - 30 days of discharge from Hospital inpatient stay
- Medicare Fee for Service claims based measure
- Risk adjusted
  - co morbidities,
  - specific diagnosis which have a higher readmission rate
  - Long Hospital LOS indicating more complex care
- Does not include planned admissions
Methodology for calculating score

- Performance period will be based on calendar year
  - 1st performance period will be January 1, 2017 to December 31, 2017
- Achievement score will be based on ranking on their performance year rate
  - Score will be 0 – 100 points
  - Bottom 25% = 0
  - Top 5% = 100

- Improvement Score is based on improvement over a 2 year period
  - 1st improvement period will be CY 2015 and CY2016
  - Improvement range is based on difference between baseline period score and national benchmark
  - If performance period score is ≤ improvement threshold = 0 points
  - If performance period score is ≥ national benchmark = 90 points
  - Is performance period score ≥ improvement threshold but < national benchmark then would be awarded points between 0 and 90.
- Re-hospitalization score is the higher of Achievement score or Improvement score
SNF Value Based Purchasing Program (SNFVBP)

Proposed new measures – FY 2020
- Potentially Preventable re-hospitalization measure (SNFPPR)
  - Medicare Part A claims based measure
  - Only includes claims with Hospital diagnosis that are identified as preventable
    - Inadequate management of chronic conditions
    - Inadequate management of infections
    - Inadequate management of other unplanned events

What does this mean??
- CMS is focused on value and quality
  - Payment based on outcomes of care not volume of care
- Facility’s outcomes can negatively affect all Medicare Part A FFS rates
  - 2% reduction is automatic
  - Facility can recoup all or more depending on their performance
**SNF Value Based Purchasing Program (SNFVBP)**

- **What does this mean??**
  - Clinical assessment & lack of care can negatively affect payment
    - Not just to the individual but to all Medicare FFS Part A residents
  - Reevaluate ability to provide higher level of care/services to prevent Hospitalization
    - Nursing Assessment
    - Medical Staff/NP assessment
    - Program Development
  - Need to monitor your outcomes
    - Need to identify the Hospital discharge diagnosis and include in your data analysis
    - Monitor outcomes post discharge from nursing facility

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**Clinical Performance Data..... What Does it Really Mean?**

*You can’t build a reputation on what you are going to do.*

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*The Proof is in the Data*
Clinical Performance Data.....
What Does it Really Mean?

Questions

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