Avoiding the Medicare Readmissions Penalty

Welcome!

- All lines are muted, so please ask your questions in Q&A
- For technical issues, chat to the 'Technical Support' Panelist
- Please actively participate in polling questions that will pop up on the lower righthand side of your screen

ALLIANT QUALITY

The Quality Improvement Services Group of
ALLIANT HEALTH SOLUTIONS

We will get started shortly!

Kimberly Rask, MD PhD

CHIEF DATA OFFICER

Kimberly J. Rask, MD PhD is Chief Data Officer at Alliant Health Group, providing analytic support to Medicare, Medicaid, ESRD and private health care program partners. Since 2008 she has provided clinical and analytic direction at Alliant for economic evaluations, patient safety initiatives including healthcare associated infections, quality data reporting and community-based interventions.

A primary care physician and health economist, she also holds joint appointments as Associate Professor of Health Policy and Management and Associate Professor of Medicine at Emory University where her research and teaching focus on quality improvement and outcomes measurement with a particular focus on rural and underserved populations.

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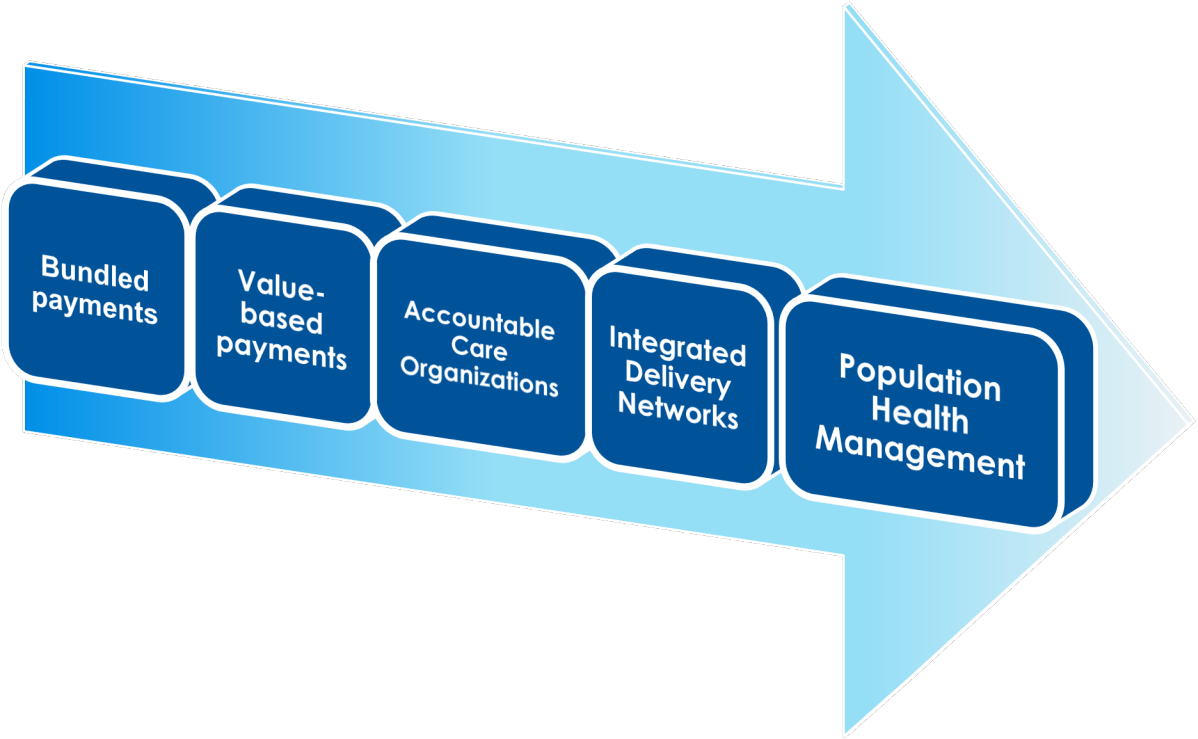
Objectives

- Learn Today:
  - Understand how the Skilled Nursing Facility (SNF) VBP Program affects Medicare payments to SNFs
  - Review the SNF 30 Day All-Cause Readmission Measure (SNFRM)
  - Learn how CMS translates SNF performance scores into incentives or penalties

- Use Tomorrow:
  - Review the interim quarterly confidential feedback reports that are distributed to SNFs
  - Use findings to guide improvement activities

One of Many Initiatives that Promote Care Coordination



- Align physician, hospital, post-acute care provider incentives
- Financial integration so entity can accept bundled payments and distribute them amongst providers
- Ability to organize care in ways not paid for under traditional fee-for-service payment models

Medicare Cost Drivers

- Most (75%) of the variation in Medicare spending per beneficiary is from post-acute care – home health, skilled nursing, rehabilitation facilities, long-term care hospitals, hospice
  - 40% of Medicare beneficiaries discharged from an acute care hospital receive post-acute care from SNFs, HHAs, IRFs or LTCHs (2016)
  - These patients account for 20% of all Medicare spending

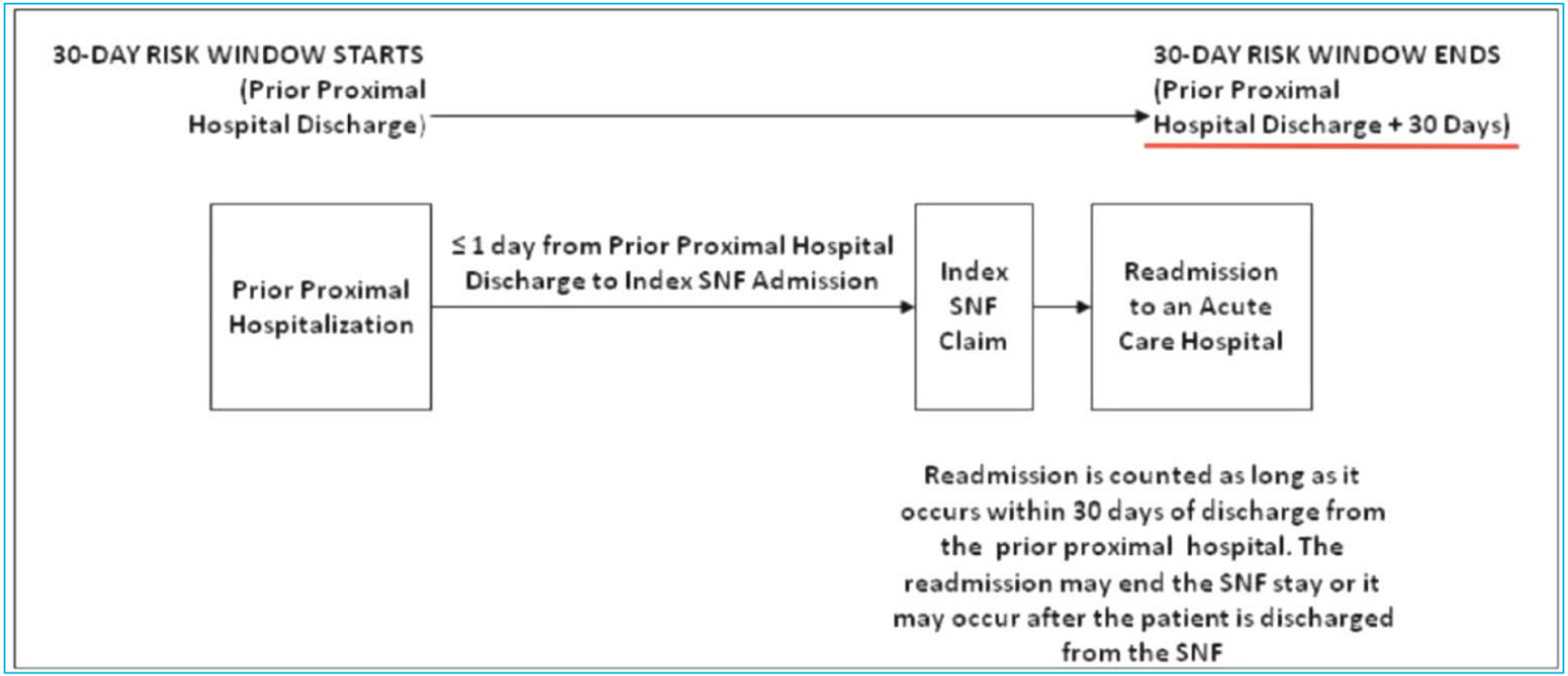
What is the Skilled Nursing Facility Value-Based Purchasing Program?

- The Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program offers Medicare incentive payments to SNFs based on their performance on readmissions
  - Provides incentives for facilities to coordinate care
  - Aims to protect patients from potential harms or adverse events associated with hospital readmissions
- Began in FY 2019 (October 2018)
- Builds on previous quality improvement efforts
  - Nursing Home Compare
  - SNF Quality Reporting Program

Only One Quality Measure… the SNFRM

- The SNF 30-Day All Cause Readmission Measure (SNFRM) estimates risk-standardized rate of all-cause, unplanned hospital readmissions of Medicare SNF beneficiaries within 30 days of discharge from their prior proximal acute hospitalization.
- SNFRM tracks hospital readmissions NOT readmissions to the SNF
- CMS calculates the data, excluding planned readmissions
- Readmissions within 30-day window are counted regardless of whether the beneficiary is readmitted to the hospital directly from the SNF or has been discharged from the SNF

SNFRM

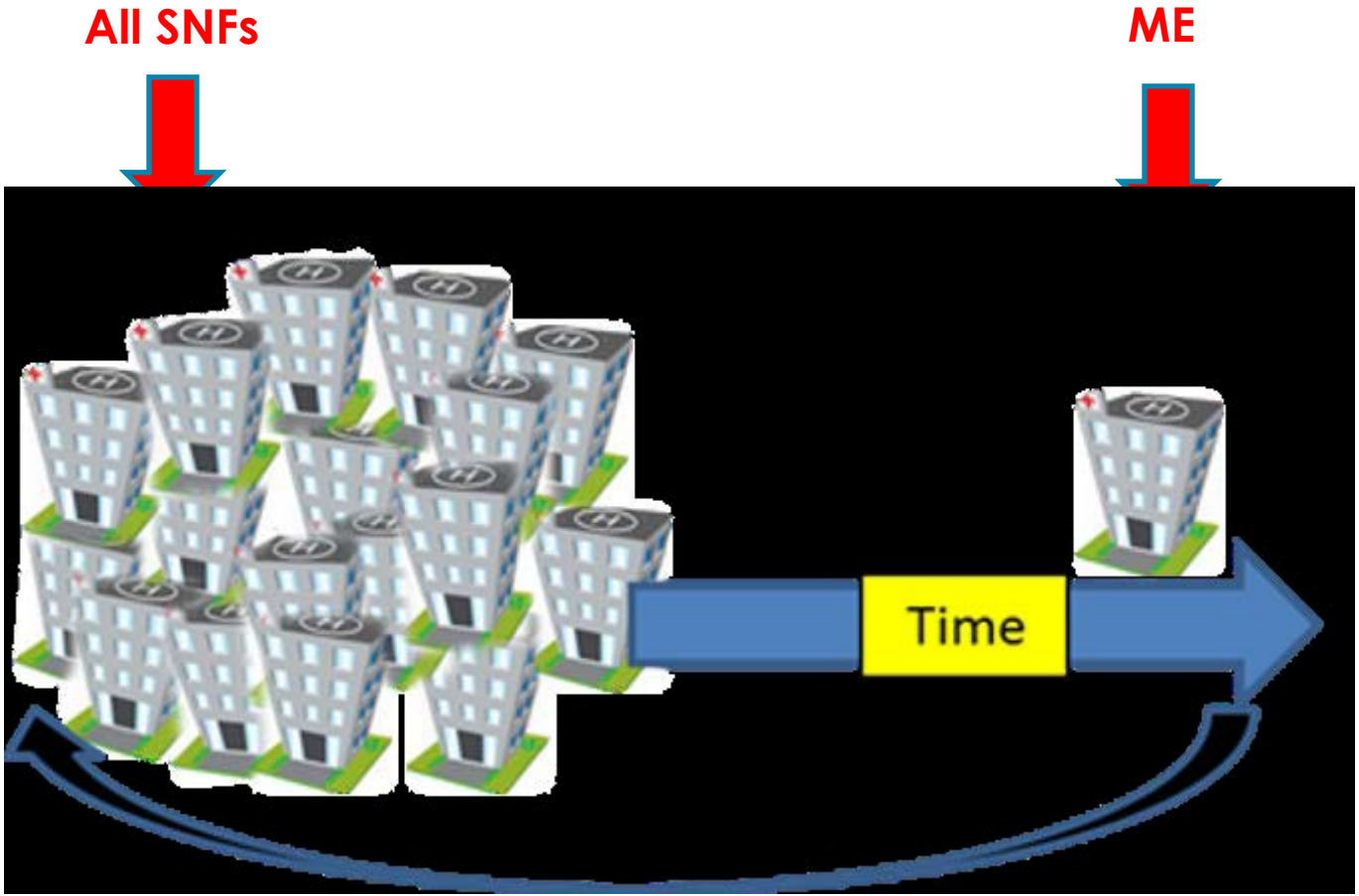

30-DAY RISK WINDOW STARTS
(Prior Proximal
Hospital Discharge)
30-DAY RISK WINDOW ENDS
(Prior Proximal
Hospital Discharge + 30 Days)
Prior Proximal
Hospitalization
≤ 1 day from Prior Proximal Hospital
Discharge to Index SNF Admission
Index
SNF
Claim
Readmission
to an Acute
Care Hospital
Readmission is counted as long as it
occurs within 30 days of discharge from
the prior proximal hospital. The
readmission may end the SNF stay or it
may occur after the patient is discharged
from the SNF

SNF Readmission Measure Calculation

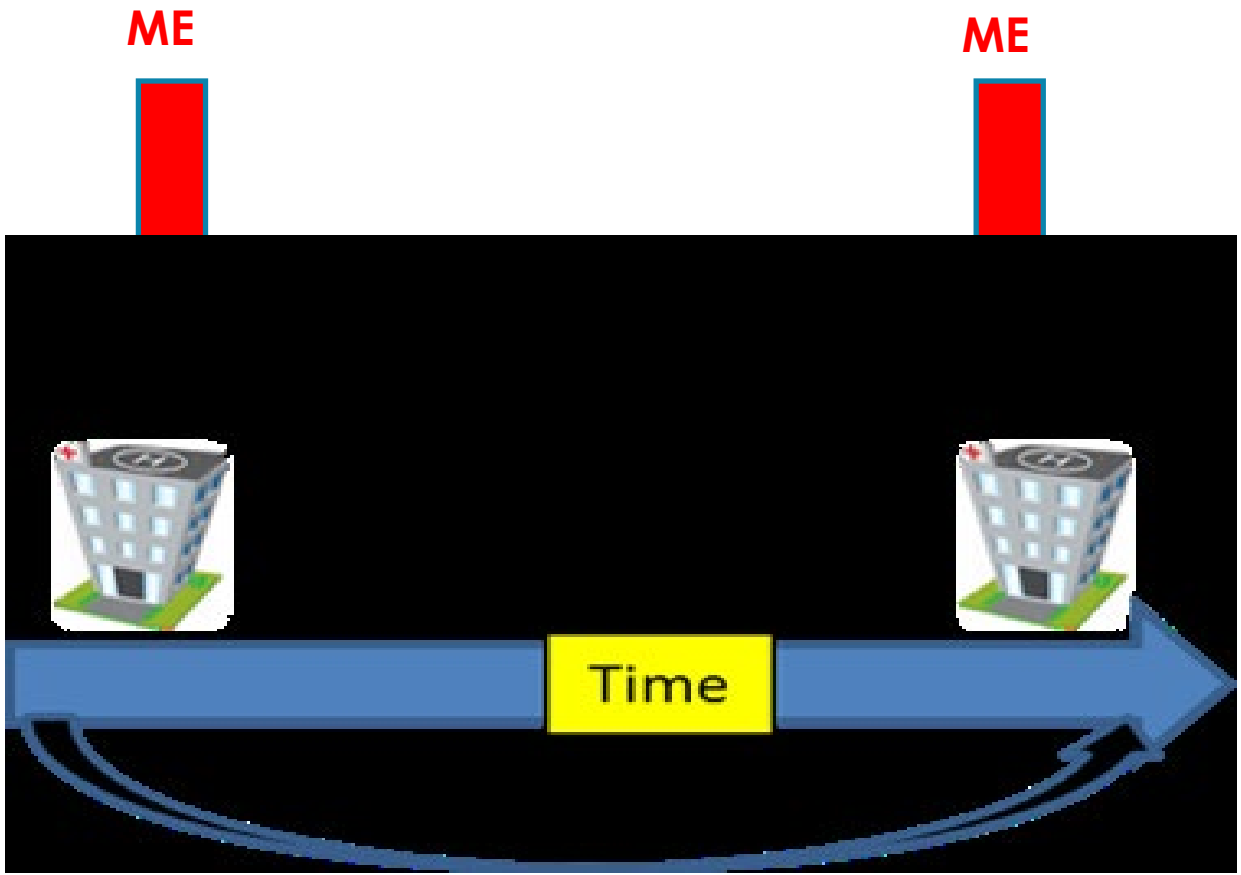
- The SNFRM's outcome is a risk-standardized readmission rate (RSRR) adjusted for resident severity.
  - patient demographics (e.g., age and sex)
  - principal diagnosis in the prior hospitalization and comorbid conditions
  - disability as the original reason for Medicare coverage
  - health service factors (e.g., length of stay and any time spent in intensive care unit during the patient's prior proximal hospitalization)
- The RSRR = ratio of the risk-adjusted predicted number of unplanned readmissions to the expected number of unplanned readmissions.
- for FY 2020 Program Year: Baseline = FY 2016

  Performance Period = FY 2018

Achievement Score



Improvement Score



Receive the Higher of the Two Scores

- Achievement Points:
  - Max = 100 points
  - Performance compared to:
    - Threshold (minimum performance level)
    - Benchmark (high attainment level)

Below threshold	Between threshold & benchmark	At or above benchmark
0 pts.	1-99 pts.	100 pts.

- Improvement Points:
  - Max = 90 points
  - Performance compared to:
    - Prior performance (from baseline period)
    - Benchmark (high attainment level)

At or below baseline period score	Above baseline period score
0 pts.	1-90 pts.

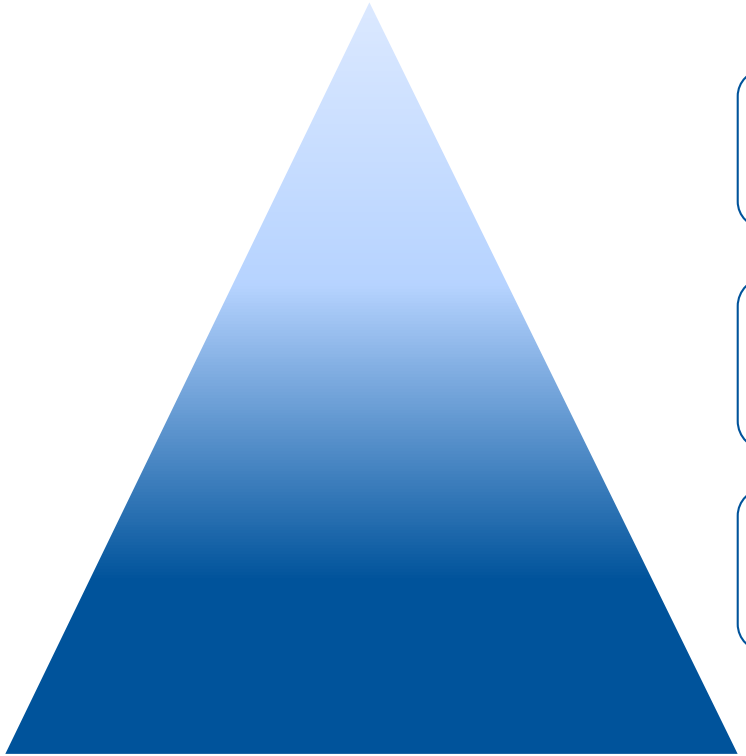
Translating Performance into Payments

Funds at Risk
All SNF Part A fee-for-service (FFS) Medicare Payments

Withhold
CMS withholds 2% of these payments

Redistribution
60% of withhold funds are redistributed to SNFs as incentive payments for good performance

Less Than 30% Get a Neutral or Positive Payment



2% of all SNFs receive the full 2% back

26% of SNFs receive more than 2% back

72% of SNFs receive less than 2% back

How Can I Find Out How My Facility is Doing? QIES and CASPER

The Skilled Nursing Facility Value-Based Purchasing Program
Quarterly Confidential Feedback Report

March 2017 (Quarter 2, FY 2017)

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

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

Measure	Your SNF's Number of Eligible Stays	Your SNF's Number of Readmissions*	Your SNF's Risk-Standardized Readmission Rate**	National Average Readmission Rate***
SNFRM	23	4	18.76 %	19.09 %

Source: Medicare claims and eligibility data from CY 2014.

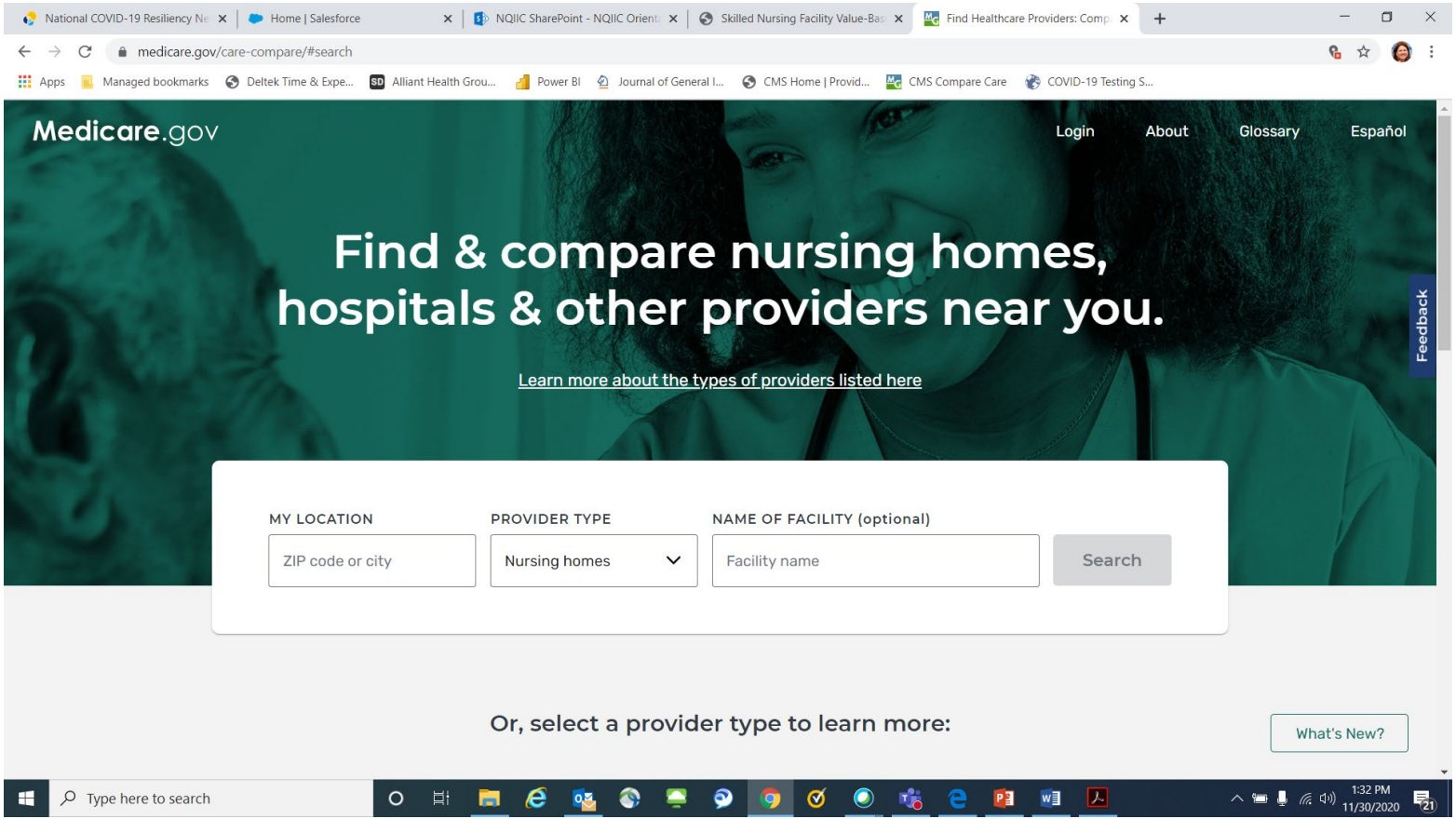
CMS Shares 3 Different Types of Reports

Interim Workbooks	Full-Year Workbooks	Performance score Report
Less than full year data	Full year of data	60 days prior to payment impact
Stay-level information	Stay-level and facility level information	Scoring and payment information
Data is not final	Data is final	Data is final
Generally December and March Reports	Generally June Report	Generally August Report

COVID Impact

- CMS announced a nationwide extraordinary circumstance exception (ECE); qualifying claims from January 1-June 30, 2020 will be excluded from the claims-based SNFRM calculations.
- This policy will automatically apply to all SNFs, and no action is required.
- ECE falls within the performance period of the FY 2022 SNF VBP Program. CMS to communicate any further policy adjustments to the SNF VBP Program.

Performance Scores Posted



New Measure Coming….

SNF Potentially Preventable Readmissions (SNFPPR) Measure

- The SNFPPR assesses the risk-standardized rate of unplanned, potentially preventable readmissions (PPRs) for Medicare FFS SNF patients within 30 days of discharge from a prior proximal hospitalization.
- CMS will propose to replace the SNFRM with the SNFPPR in future rulemaking.

Contact Information:

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Complete this sentence in Chat: *I will…*

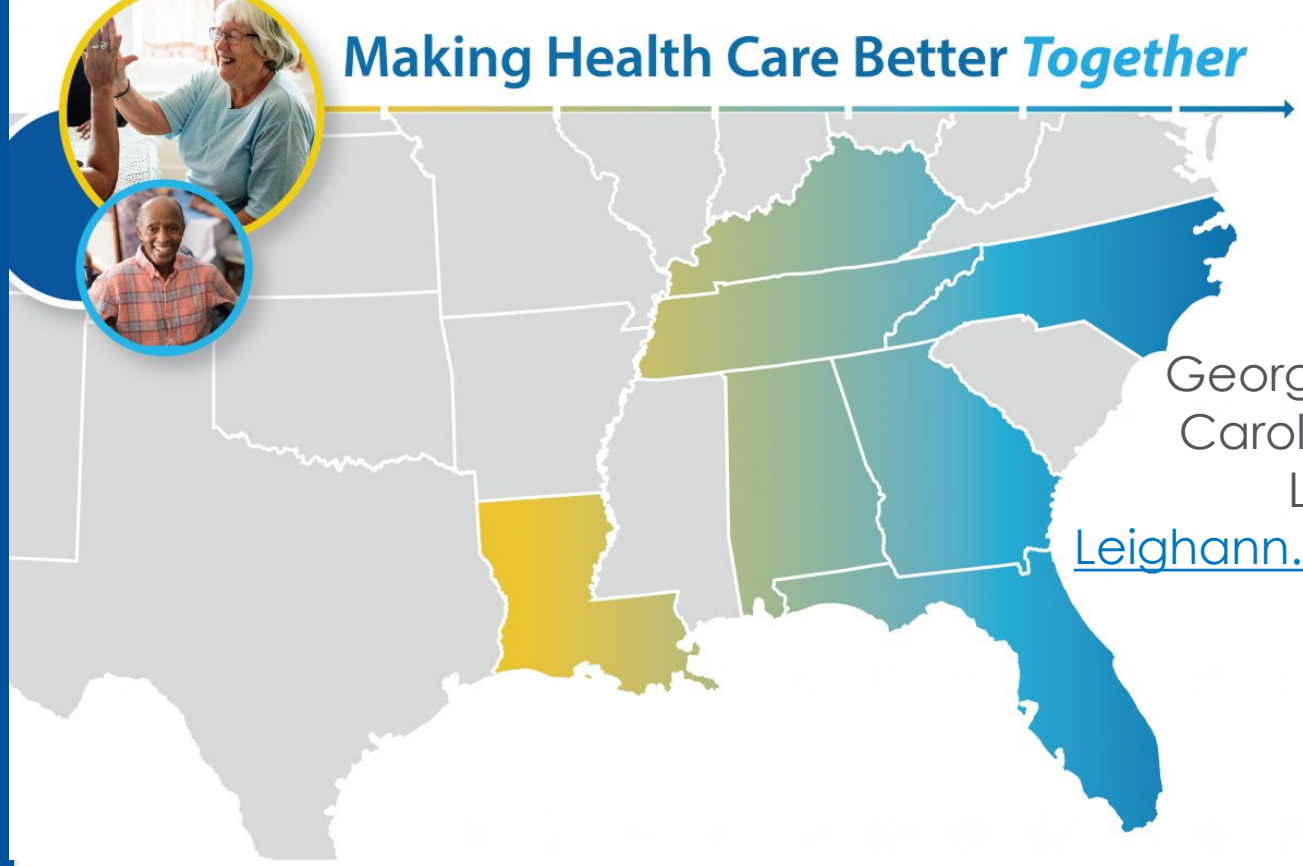
Closing Survey

Help Us Help You!

- Please turn your attention to the poll that has popped up in your lower right-hand side of your screen
- Completion of this survey will help us steer our topics to better cater to your needs

CMS 12th SOW Goals

Behavioral Health Outcomes & Opioid Misuse	✓ Promote opioid best practices ✓ Decrease high dose opioid prescribing and opioid adverse events in all settings ✓ Increase access to behavioral health services
Patient Safety	✓ Reduce risky medication combinations ✓ Reduce adverse drug events ✓ Reduce C. diff in all settings
Chronic Disease Self-Management	✓ Increase performance on ABCS clinical quality measures (i.e., aspirin use, blood pressure control, cholesterol management, cardiac rehab) ✓ Identify patients at high-risk for developing kidney disease & improve outcomes ✓ Identify patients at high risk for diabetes-related complications & improve outcomes
Quality of Care Transitions	✓ Convene community coalitions ✓ Identify and promote optical care for super utilizers ✓ Reduce community-based adverse drug events
Nursing Home Quality	✓ Improve the mean total quality score ✓ Develop national baselines for healthcare related infections in nursing homes ✓ Reduce emergency department visits and readmissions of short stay residents



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Program Directors

Upcoming Events

Learning and Action Webinars

Nursing Homes Tuesdays, 2pm ET/1pm CT	Community Coalitions Thursdays, 12:30 pm ET/11:30am CT
February 16th, 2021: Immunizations Fears, Myths & Truths	January 28th, 2021: Put A Little Love in Your Heart: Strategies for Reducing Heart Failure
March 16th, 2021: TBD	February 25th, 2021: Increasing Vaccine Acceptance Rates from a Community Perspective

Shop Talk: NHSN Updates & Technical Assistance

Thursday, January 21st , 2021 2:00 pm

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