CMS Quality 2023 Conference

Building Resilient Communities:

Having an Equitable Foundation for Quality Healthcare

Building a Stronger Long-term Care System That's Equitable












AGENDA

- CMS/CCSQ Authorities and Programs
- Skilled Nursing Facility Quality Reporting Program and the IMPACT Act of 2014
- Social Determinant Assessment Data in Post-Acute Care Settings
- Skilled Nursing Facility Quality Reporting Program Health Equity Update
- Skilled Nursing Facility Value-Based Purchasing Proposed Rule
- Skilled Nursing Facility Quality Improvement Organizations Health Equity Update
- Culturally Competent and Person-Centered Requirements to Increase Access to Care and Improve Quality for All proposed rule

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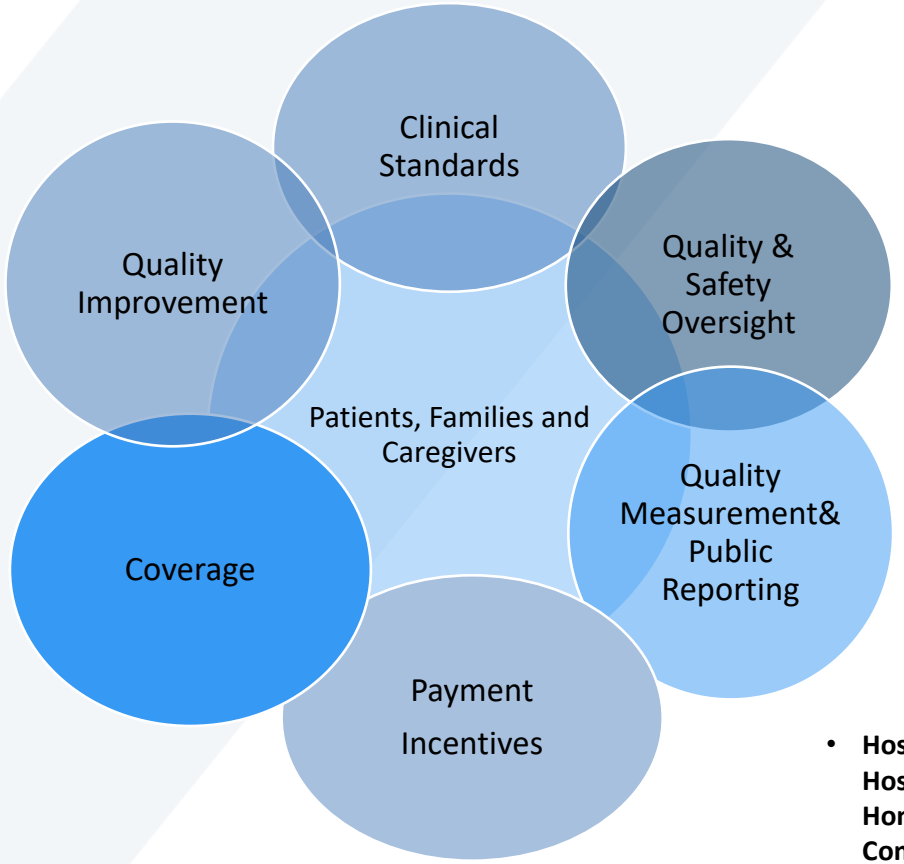
CMS/CCSQ Authorities & Programs

- **Quality Improvement Organizations**
- **Hospital Innovation & Improvement Networks**
- **Rapid Cycle Evaluation**



- **Hospital Inpatient Quality**
- **Hospital Outpatient**
- **In-patient psychiatric hospitals**
- **Cancer hospitals**
- **Nursing homes**
- **Home Health Agencies**
- **Long-term Care Acute Hospitals**
- **In-patient rehabilitation facilities**
- **Hospices**
- **Other facilities**

- **CLIA Program**
- **Clinical Laboratories**
- **Target surveys**
- **Quality Assessment & Performance Improvement**

- **National & Local policies**
- **Mechanisms to support innovation (CED, parallel review, other)**

- **Hospitals, Home Health Agencies, Hospices, ESRD facilities, Nursing Home, Clinician and other Care Compare**

- **VBP hospitals, SNF, HHA, ESRD**
- **Payment adjustments HAC, hospital RRP**
- **Physician Quality Payment Program (QPP)**

IMPACT Act of 2014 and the Skilled Nursing Facility Quality Reporting Program

- Bi-partisan bill passed on September 18, 2014, and signed into law October 6, 2014
- The Act requires *standardized* patient assessment data elements for:
  - Long-term Care Hospitals (LTCHs)
  - Skilled Nursing Facilities (SNFs)
  - Home Health Agencies (HHAs)
  - Inpatient Rehabilitation Facilities (IRFs)
- The Act specifies the data "… be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes…".
- Standardized patient assessment data element Clinical Categories:
  - Functional status
  - Cognitive function and mental status
  - Special services, treatments, and interventions
  - Medical conditions and co-morbidities
  - Impairments
  - Other categories required by the Secretary

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

Social Determinant Assessment Data in PAC Settings

Added through IMPACT Act as standardized data elements to HHA, IRF, LTCH, and SNF Assessment Instruments

- A1005. Ethnicity
- A1010. Race
- A1110. Language
  - A1110A. Preferred Language
  - A1110B. Need for an Interpreter
- B1300. Health Literacy
- D0700. Social Isolation
- A1250. Transportation

When added to assessments:
OASIS-E 1/1/23
IRF-PAI 10/1/22
LCDS 10/1/22
MDS 10/1/23

Skilled Nursing Facility Quality Reporting Program Health Equity Update (1 of 5)

- Confidential Feedback Reports that stratify some quality measures by race/ethnicity and income
- Considering health equity measures used in other settings but using SDOH data items collected in PAC Programs.
- Aligning SDOH data items across all care settings as they apply to PAC settings.
  - SDOH Data Items in Acute Care Settings:
    - housing instability, food instability, transportation needs, utility difficulties, and interpersonal safety

Skilled Nursing Facility Value Based Purchasing Program Health Equity Update (2 of 5)

- Protecting Access to Medicare Act of 2014 authorized the SNF VBP Program. The program was restricted to one measure; Skilled Nursing Facility 30-Day All-Cause Readmission Measure.
- Similar to HVBP, funding was based on a 2% withhold from Medicare FFS Payments but includes a provision that CMS was only to payback 50-70% of the withhold of which CMS currently redistributes 60% to SNFs
- Consolidated Appropriations Act, 2021 (CAA) authorized the Secretary to apply up to 9 measures that may include measures of function, care coordination, safety, patient satisfaction and measures of the IMPACT Act and added Measure Validation Requirement.

Skilled Nursing Facility Value Based Purchasing Program Health Equity Update (3 of 5)

Current Measure

1) Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNF RM)(Statutory)

Added Measures Beginning FY 2024 Performance Year (For a total of 4 Measures)

2) SNF Healthcare Acquired Infection (Program Year 2026) (Finalized FY 2025 PPS Rule)
3) Discharge to Community (Program Year 2027) (Finalized FY 2025 PPS Rule)
4) Total Staff Nursing (Program Year 2026) (Finalized FY 2025 PPS Rule)
5) Nursing Turnover (Program Year 2026) (Proposed FY 2024 PPS Rule)

Added Measures Beginning FY 2025 Performance Year (For a total of 8 Measures)

6) Percent of Residents Experiencing One or More Falls with Major Injury (Proposed FY 2024 PPS Rule)
7) Number of Hospitalizations per 1,000 Long-Stay Resident Days (Proposed FY 2024 PPS Rule)
8) Discharge Function (Proposed FY 2024 PPS Rule)

Replacement of SNF RM with SNF WS PPR Beginning FY 2025 Performance Year (Statutory)

Skilled Nursing Facility Within Stay Potentially Preventable Readmissions (SNF WS PPR) (Program Year 2027 Proposed FY 2024 PPS Rule)

Skilled Nursing Facility Value Based Purchasing Program Health Equity Update (4 of 5)

- We proposed to adopt a scoring methodology change to reward excellent care for vulnerable populations by the healthcare system in the SNF VBP Program. Specifically, we recommend proposing to award bonus points to high performing higher dual SNFs
- SNF VBP Health Equity Adjustment is an application of Rewarding Excellent Care for Underserved Populations (RECUP) to the SNF VBP Program
- The Health Equity Adjustment (HEA) will begin in Performance Year 2025 and impact FY 2027 Program Year Payments

Skilled Nursing Facility Value Based Purchasing Program Health Equity Update (5 of 5)

- Health Equity Adjustment will have 2 points are allocated for each of the 8 measures where the SNF is in the top tier of performance for that measure compared to all SNFs
- The points are aggregated and then multiplied by an underserved multiplier (underserved multiplier is defined by proportion of duals served by the SNF) to determine the amount of bonus points that are added to the total performance score that is used to calculate the payment adjustment.
- The underserved multiplier is based on the adjusted proportion of duals that a SNFs provides are for where higher dual proportions will receive a higher proportion of points using a logistic exchange function
- SNFs whose proportion duals is under 20% are assigned 0 for the underserved multiplier and do not receive bonus points
- The application of the logistic exchange function and the 20% minimum underserved adjustment requirement ensures that the majority of the bonuses goes to SNFs that serve the highest proportion of underserved
- CMS is proposing to increasing the payback so the bonuses provided to the high performing high duals SNFs do not come at the expense of the other SNFs

Skilled Nursing Facility Quality Improvement Organizations (QIOs) Health Equity Update (1 of 2)

The CMS Framework for Health Equity serves as the foundation for Nursing Home Health Equity Disparities Reduction work in the QIO program

- Nursing home beneficiaries are stratified by race/ethnicity and gender, with actions implemented for all beneficiaries in the cohort
- National Culturally and Linguistically Appropriate Services (CLAS) standards were implemented through education, resources and direct consultation
- Communication to Medicare beneficiaries in areas with low health literacy is tailored to enhance equitable community responses
- Progress of health disparity reductions are tracked using qualitative data such as stakeholder feedback and quantitative data through established metrics

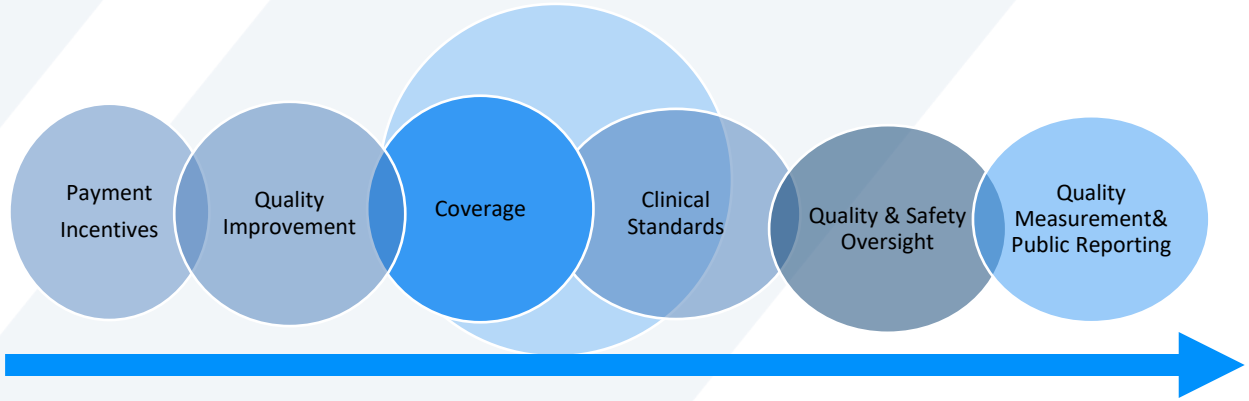
Skilled Nursing Facility Quality Improvement Organizations (QIOs) Health Equity Update (2 of 2)

- Social determinants of health screening questions are embedded into healthcare provider electronic medical records
- Special codes allow provider reporting of social determinants of health. This allows identification of the most common risk factors in their locations
- Disparities in care are addressed during regional nursing home collaborative meetings, with aggregate data provided to identify gaps and monitor progress toward decreasing any disparities
- Non-clinical entities are engaged in efforts to reduce disparities, which may include services such as transportation and on-site health fairs

Culturally Competent and Person-Centered Requirements to Increase Access to Care and Improve Quality for All proposed rule

- Proposed rule would establish culturally competent and person-centered requirements for all provider and supplier types (including LTC facilities).
- Proposed revisions to the Conditions of Participation/Conditions of Coverage (CoPs/CfCs) pertaining to:
  - Governance
  - Resident rights (nondiscrimination and accessibility)
  - Clinical quality standards
  - Quality Assessment and Performance Improvement
  - Staff Training
  - Care planning and discharge planning
- Culturally competent and person-centered focused health and safety requirements could lead to improved access to care, improved quality of care and better health outcomes for all
- Estimated Publication Date: Spring 2023

Aligning on the Journey Towards Equity



Journey Toward an Equitable System of Health

What are some of the policy/program issues to address?
What are we doing now?
What are some outstanding policy/program questions?