DATA SPEAKS

CMS Claims Data 101: How it is used and What you should track?

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AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

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Speakers:

Dr. Kendall Brune, PhD, CPH, MBA, LNHA, Fellow District 6 Governor, American College of Healthcare Administrators (ACHCA)

Renee Kinder MS, CCC-SLP, RAC-CT, EVP of Clinical Services Broad River Rehab

Joel VanEaton BSN, RN, RAC-CT, RAC-CTA, Master Teacher, EVP of Compliance and Regulatory Affairs Broad River Rehab

Faculty Disclosure

- I have no financial relationships to disclose
- I have no conflicts of interests to disclose
- I will not promote any commercial products or services

Requirements for Successful Completion

- 1.5 contact hours will be awarded for this continuing nursing education activity
- Criteria for successful completion includes attendance for at least 80% of the entire event. Partial credit may not be awarded
- Approval of this continuing education activity does not imply endorsement by AAPACN or ANCC (American Nurses Credential Center) of any commercial products or services

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What is DATA SPEAKS?

A collaborative learning series between AAPACN, ACHCA, and Broad River Rehab.

Course 1: CMS Claims Data 101: How it is used and What you should track

Course 2: What is my niche? Data Driven Decision Making

Course 3: What's my PDPM Primary Category? Does I0020B make sense for my residents?

Course 4: How are my NTAs? A Nationwide look at where NTA Points Stack Up.

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Course Overview

- Today's session will overview how CMS has used data to inform regulatory reform in the past, how they may use data in the future, and what attendees can do immediately to begin tracking and trending within their own communities.

Current State

Description of current state:

- Currently providers, beneficiaries and care teams have limited access to CMS data aside from what is analyzed internally within their communities and publicly reported on CMS.GOV and Nursing Home Compare.

Description of desired/achievable state:

- Attendees will achieve an increased understanding of national and regional based trends allowing for improved decision-making capabilities internally and for strategic partnerships with acute care hospitals and providers in their communities.

Learner Objectives

1. Explain current metrics used by CMS including Nursing Home Compare; CPT Coding development; PEPPER Reports; IMPACT Act and PCP accountability; Rehospitalization Rates and Bundled Payments
2. Define data points and purpose of ResDAC
3. Describe integration of data into the RAI Process including importance of coding accuracy

Speaker: Dr. Kendall Brune

Dr. Kendall Brune has thirty plus years of experience in senior executive capacities in the development, construction and operation of ambulatory, pharmacy, senior housing, and care facilities. He earned a BHS in Healthcare Administration from the University of MO – Columbia, an MBA from William Woods University, a Graduate Certificate in Health Policy from Meharry Medical College and PhD from Kennedy Western University. He owns and operates assisted living and memory care facilities in Missouri, Tennessee and Florida.

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Speaker: Renee Kinder

Renee Kinder, MS, CCC-SLP, RAC-CT is Executive Vice President of Clinical Services for Broad River Rehab. Additionally, she authors McKnight's Long Term Care News Rehab Realities Blog, serves as Gerontology Professional Development Manager for the American Speech Language Hearing Association's (ASHA) gerontology special interest group, is the ASHA STAMP for Kentucky, a member of the University of Kentucky College of Medicine community faculty, and is an alternate advisor to the American Medical Association's Relative Value Update Committee (RUC) Health Care Professionals Advisory Committee (HCPAC)

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Speaker: Joel VanEaton

Joel VanEaton, BSN, RN, RAC-CT, RAC-CTA, MT is Executive Vice President of Compliance and Regulatory Affairs for Broad River Rehab serving facilities in TN, KY, NC, SC, OH, MD and RI. Joel began his career in LTC as an MDS coordinator and worked for many years as the Director of Clinical Reimbursement and RAI for a group of nursing facilities in Tennessee and Kentucky. Joel has contributed to McKnight's LTC News and the AANAC LTC Leader. He currently serves as a board member on the AAPACN Education Foundation

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CMS Defining Quality

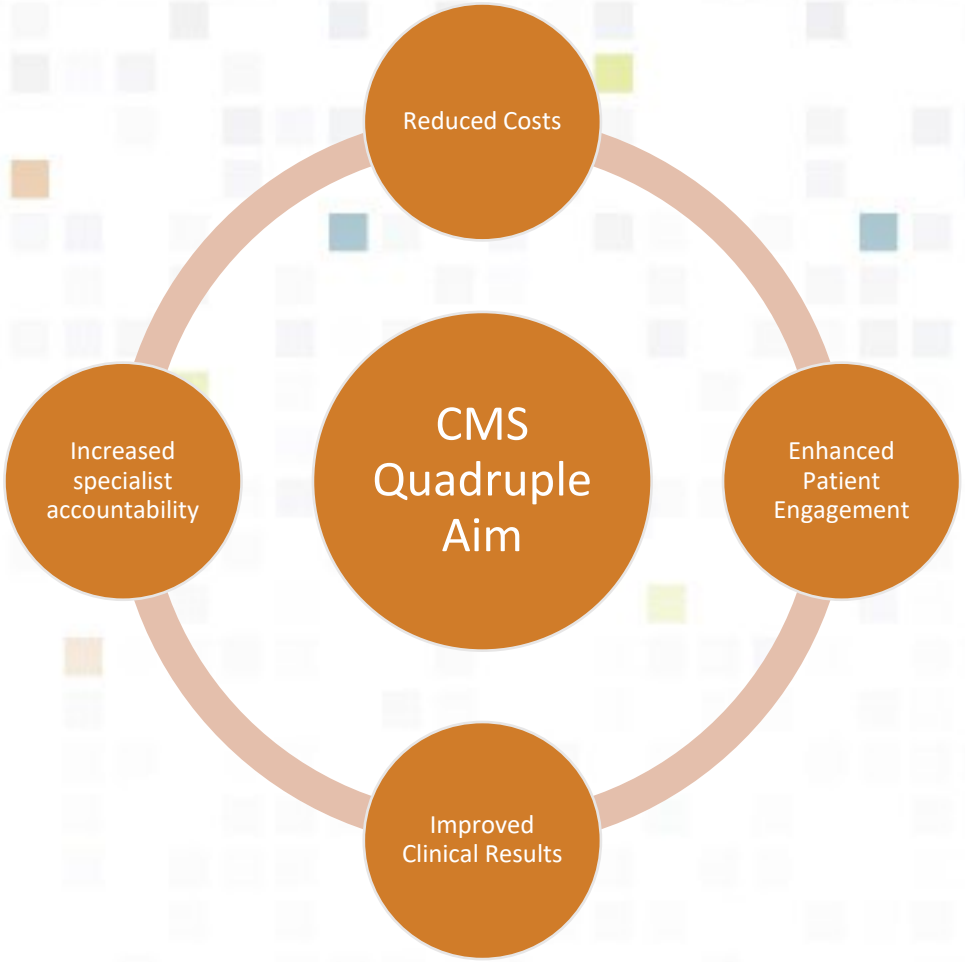
CMS Quality Strategy

Better Care: Improve the overall quality of care by making health care more person-centered, reliable, accessible, and safe.

Smarter Spending: Reduce the cost of quality health care for individuals, families, employers, government, and communities.

Healthier People, Healthier Communities: Improve the health of Americans by supporting proven interventions to address behavioral, social, and environmental determinants of health, and deliver higher-quality care.

CMS Quadruple Aim



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Administrators Strategic Role

- Clinical Care Path Engagement prior to facility admission and during the post acute phase
- Interoperability is not just an “IT” term
- Appreciating the role of the care continuum
- What is the ultimate goal and outcome of the multi-disciplinary team

CMS- How is data used?

CMS and Shared Data

IMPACT Act

Payment Reform

Care Compare

PEPPER Reports

CPT Code Updates

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IMPACT Act

The Improving Medicare Post-Acute Care Transformation Act of 2014

The IMPACT Act is an attempt to address the PAC information gap and would require collection and analyses of data that will enable Medicare to:

- Compare quality across PAC settings;
- Improve hospital and PAC discharge planning; and
- 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.

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

IMPACT Act

Provides Congress with New Payment Models to Consider for Future Reforms –Requires reports to Congress from Med PAC 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 (ex. PDPM, PDGM).

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.

IMPACT Act

- 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***
- 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*** (ex. Care Compare)
- Influences and supports CMS and industry efforts to advance ***interoperable health information exchange and care coordination***
- SNF QRP - CMS believes that the QRP will, ***"…promote higher quality and more efficient health care for Medicare Beneficiaries"***

SNF QRP

Skilled Nursing Facility (SNF) Quality Reporting Program (SNF QRP)

- The Improving Medicare Post-Acute Care Transformation Act (IMPACT) Act of 2014 requires the Secretary to implement specified clinical assessment domains using ***standardized (uniform) data elements*** to be nested within the assessment instruments currently required for submission by Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF), and Home Health Agency (HHA) providers.
- The Act further requires that the Centers for Medicare and Medicaid Services (CMS) develop and implement quality measures using standardized assessment data.
- In addition, the Act requires the development and reporting of measures pertaining to resource use, hospitalization, and discharge to the community.
- Through the use of standardized quality measures and standardized data, the intent of the Act, among other obligations, is to enable ***interoperability*** and access to ***longitudinal information*** for such ***providers to facilitate*** coordinated care, improved outcomes, and overall quality comparisons.
- Click CMS SNF QRP for access to the most up to date information on the SNF QRP
- Click Quality Reporting Manuals Manuals for access to all quality measure user's manuals. (Addendum, v3.0.1)

SNF QRP

Skilled Nursing Facility (SNF) Quality Reporting Program (SNF QRP)

- The IMPACT Act of 2014 mandated the establishment of the SNF QRP. As finalized in the Fiscal Year (FY) 2016 SNF PPS final rule, beginning with FY 2018 and each subsequent FY, the Secretary shall reduce the market basket update (also known as the **Annual Payment Update, or APU**) by two percentage points for any SNF that does not comply with the **quality data submission requirements** with respect to that FY.
- SNFs utilize the Minimum Data Set (MDS) 3.0 via the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system to collect patient assessment data. The implementation of the SNF QRP will not change requirements related to the submission of MDS 3.0 data through CMS' QIES ASAP system.
- The FY 2021 reporting year is based on four quarters of data from 01/01/2019 – 12/31/2019. This means that FY 2021 compliance determination will be based on data submitted for admissions to the SNF on and after January 1, 2019 and discharged from the SNF up to and including December 31, 2019.
- See Memo QSO 21-06-NH for updates to the QRP data reporting related to the upcoming Jan. 27, 2021 refresh to the Care Compare site.

SNF QRP

Current SNF QRP Measures

MDS Based

FY 2016

- Application of Percent of Residents Experiencing One or More Falls with Major Injury
- Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function

FY 2017

- Drug Regimen Review Conducted with Follow-Up for Identified Issues—PAC SNF QRP

FY 2018

- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury P - (PU new or worsening)
- Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients
- Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients
- Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients
- Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients

SNF QRP

October 2020 :

- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (Replacing the Pressure Ulcer New or worsening measure
- Drug Regimen Review Conducted with Follow-Up for Identified Issues
- Application of IRF Functional Outcome Measure: Change in Self-Care
- Application of IRF Functional Outcome Measure: Change in Mobility
- Application of IRF Functional Outcome Measure: Discharge Self-Care Score
- Application of IRF Functional Outcome Measure: Discharge Mobility Score

Claims Based

FY 2017

- Medicare Spending Per Beneficiary – Post-Acute Care (PAC) SNF QRP FY 2017
- Discharge to Community - PAC SNF QRP FY 2017
- Potentially Preventable 30-Day Post-Discharge Readmission Measure – SNF QRP FY 2017

SNF QRP

New Project: Development of the Skilled Nursing Facility (SNF) Healthcare-Associated Infections (HAIs) Requiring Hospitalizations Measure for the Skilled Nursing Facility Quality Reporting Program (SNF QRP). New measure is being developed as a healthcare-associated infections quality measure for the SNF QRP under the Meaningful Measure domain : Making Care Safer by Reducing Harm Caused in the Delivery of Care.

- Measure specifications: this new measure, "…will estimate the risk-standardized rate of HAIs that are acquired during SNF care and result in hospitalization. SNF HAIs that are acquired during SNF care and result in hospitalization will be identified using the principal diagnosis on the Medicare hospital claims for SNF residents, during the time window beginning on day four after SNF admission and within day three after SNF discharge. The measure is risk adjusted to "level the playing field" to allow comparison based on residents with similar characteristics between SNFs."

SNF QRP

- "Meaningful Measures" framework is the Centers for Medicare and Medicaid Services' new initiative which identifies the highest priorities for quality measurement and improvement.
- It involves only assessing those core issues that are the most critical to providing high-quality care and improving individual outcomes.
- The Meaningful Measure Areas serve as the connectors between CMS strategic goals and individual measures/initiatives that demonstrate how high-quality outcomes for our beneficiaries are being achieved.
- They are concrete quality topics, which reflect core issues that are most vital/meaningful to high quality care and better patient outcomes.
- Meaningful Measures is not intended to replace any existing programs but will help programs identify and select individual measures.
- Meaningful Measure areas are intended to increase measure alignment across CMS programs and other public and private initiatives. Additionally, it will point to high priority areas where there may be gaps in available quality measures while helping guide CMS's effort to develop and implement quality measures to fill those gaps.

SNF QRP

Promote Effective Communication & Coordination of Care

Meaningful Measure Areas:

- Medication Management
- Admissions and Readmissions to Hospitals
- Transfer of Health Information and Interoperability

Promote Effective Prevention & Treatment of Chronic Disease

Meaningful Measure Areas:

- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality

Work with Communities to Promote Best Practices of Healthy Living

Meaningful Measure Areas:

- Equity of Care
- Community Engagement

Make Care Affordable

Meaningful Measure Areas:

- Appropriate Use of Healthcare
- Patient-focused Episode of Care
- Risk Adjusted Total Cost of Care

Make Care Safer by Reducing Harm Caused in the Delivery of Care

Meaningful Measure Areas:

- Healthcare-associated Infections
- Preventable Healthcare Harm

Strengthen Person & Family Engagement as Partners in their Care

Meaningful Measure Areas:

- Care is Personalized and Aligned with Patient's Goals
- End of Life Care according to Preferences
- Patient's Experience of Care
- Functional Outcomes

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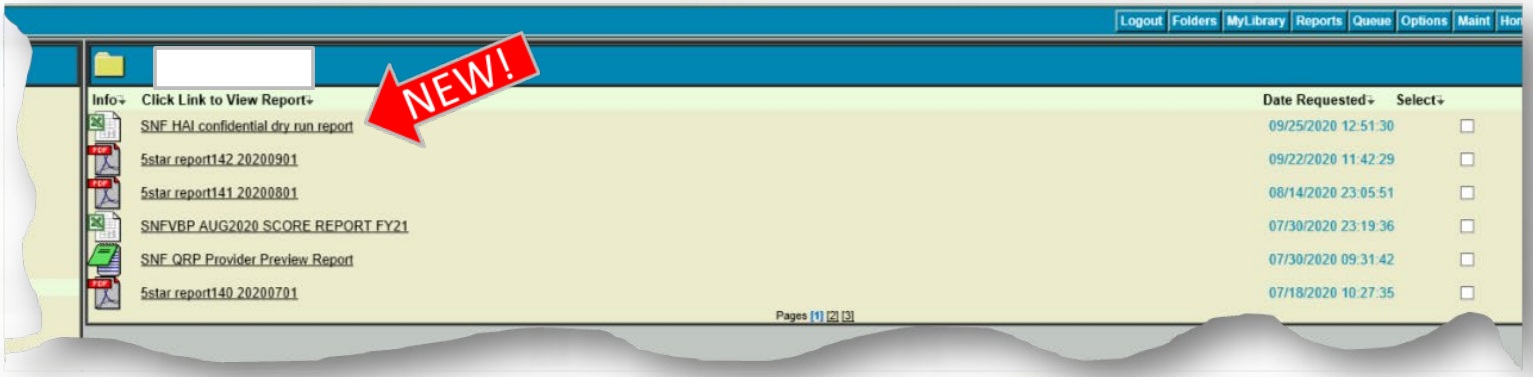
SNF QRP

SNF HAI Confidential dry run report: The purpose of the provider report is to inform SNFs of their performance in comparison to their peers. It is important to recognize that HAIs in SNFs are not considered "never-events." The goal of this risk-adjusted measure is to identify SNFs that have notably higher rates of HAIs and to statistically distinguish between SNFs that are either better than or worse than their peers in infection prevention and in infection management.



HAI Performance Report

Provider	Facility ID	State	Performance Year	Data Collection Period	# of Stays	# of HAI Cases	Observed HAI Rate	Risk Adjusted HAI Rate	95% CI Lower Bound	95% CI Upper Bound	Comparative Performance Category	Observed National Average	# of Providers Better than National Average	# of Providers No Different than National Average	# of Providers Worse than National Average	# of Providers Too Small to Report
XXXXX	XXXXXXXXX	XX	FY2018	10/01/2017-09/30/2018	158	14	8.86%	7.25%	4.63%	10.35%	No Different than National Average	5.96%	294	12,185	770	1,790
XXXXX	XXXXXXXXX	XX	FY2019	10/01/2018-09/30/2019	170	18	10.59%	9.27%	6.02%	13.42%	Worse than National Average	5.68%	292	12,175	650	1,983

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CMS and the Research Data Assistance Center (ResDAC)

ResDAC
RESEARCH DATA ASSISTANCE CENTER

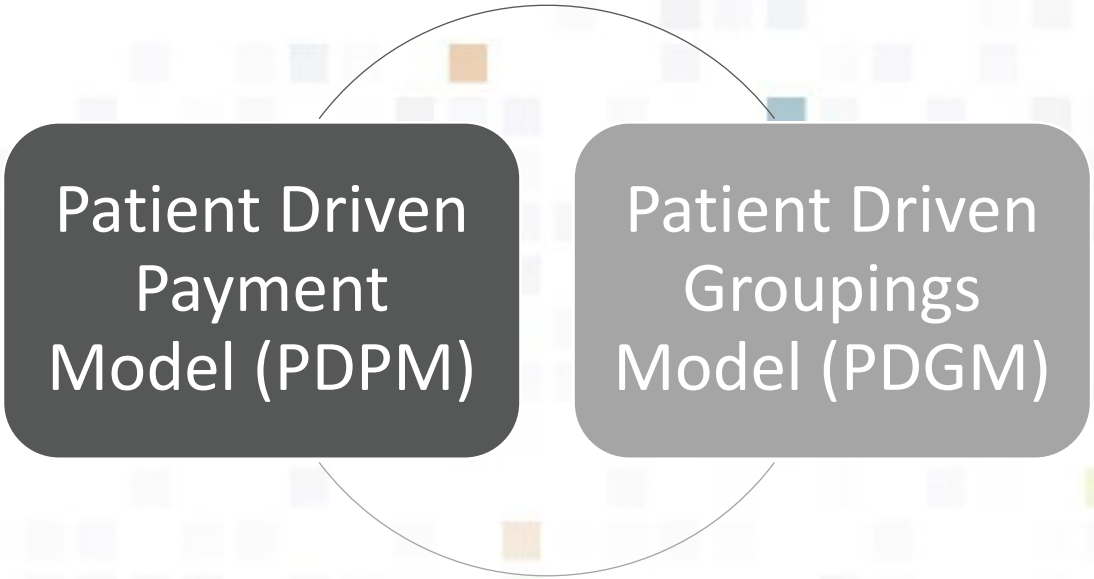
Your source for CMS data support

- ResDAC assists researchers with requesting data for two large insurance programs administered by the Centers for Medicare and Medicaid Services (CMS).
- **Medicare** is a federal health insurance program for those aged 65 and older, certain people under 65 with disabilities, and people of any age with End Stage Renal Disease. Medicare covers about 96% of all US citizens aged 65 and older.
- **Medicaid** is a joint federal/state health insurance program, providing coverage to low-income children, pregnant women, people with disabilities, some elderly and non-elderly adults. While the federal government defines broad national guidelines of eligibility and services, each state's program establishes its own eligibility standards and determines the scope of services.
- **Dual Eligibles** are individuals who are enrolled in both Medicare and Medicaid.

Research Data Assistance Center

- The Research Data Assistance Center (ResDAC) provides free assistance to academic and non-profit researchers interested in using Medicare, Medicaid, SCHIP, and Medicare Current Beneficiary Survey (MCBS) data for research. Primary funding for ResDAC comes from a CMS research contract. ResDAC is a consortium of faculty and staff from the University of Minnesota, Boston University, Dartmouth Medical School, and the Morehouse School of Medicine.

- ResDAC offers a number of services for researchers with all levels of experience using or planning to use CMS data. Services include technical data assistance, information on available data resources, and training



CMS- How is data used to shape PAC Models?

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"A *Knowledgeable* and *Compassionate* partner"

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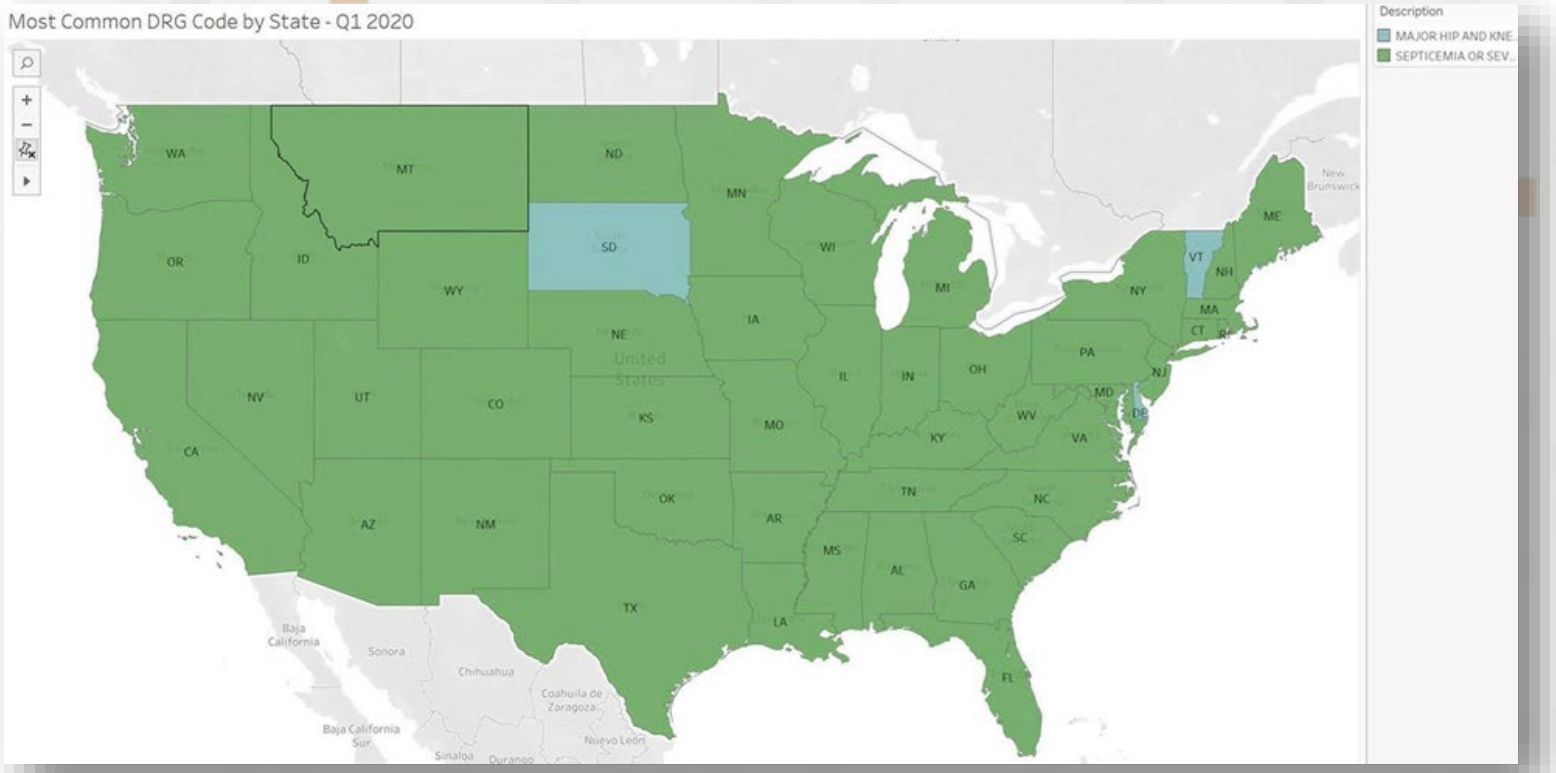
Hospital Relationships and DRGs

- A DRG, or diagnostic related group, is how Medicare and some health insurance companies categorize hospitalization costs and determine how much to pay for a patient's hospital stay.
- Rather than paying the hospital for each specific service that was provided, Medicare or a private insurer will pay the hospital a predetermined amount based on the patient's Diagnostic Related Group.
- This encompasses a variety of metrics designed to classify the resources needed to care for a given patient based on diagnosis, prognosis, and various other factors.

ResDAC Hospital DRG

Nationwide, Septicemia is the number 1 hospital recorded DRG



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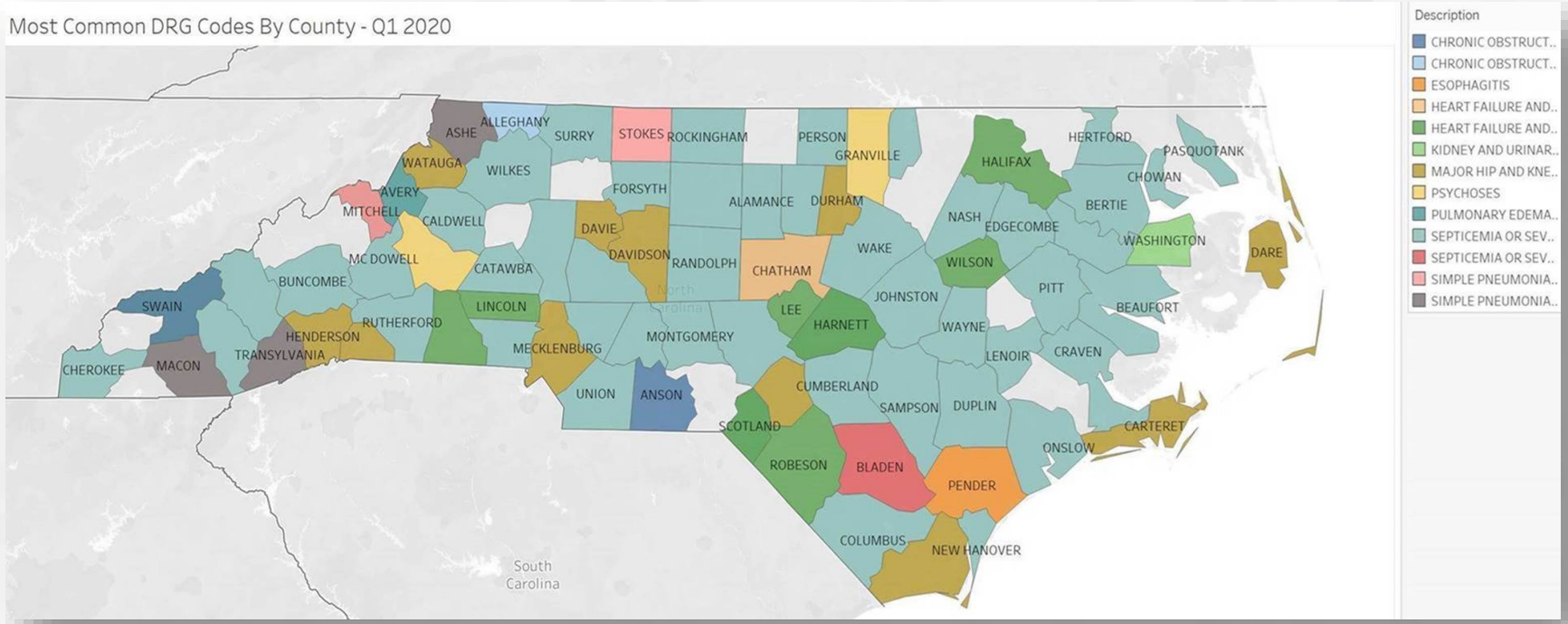
ResDAC Hospital DRG

State Example: North Carolina



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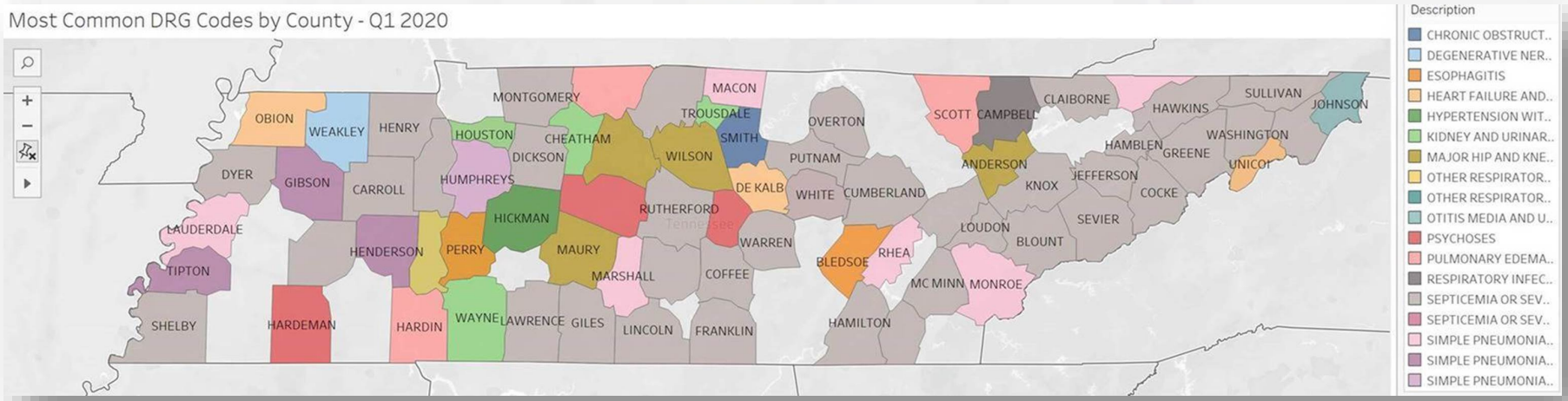
ResDAC Hospital DRG



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ResDAC DRG and Re-admissions

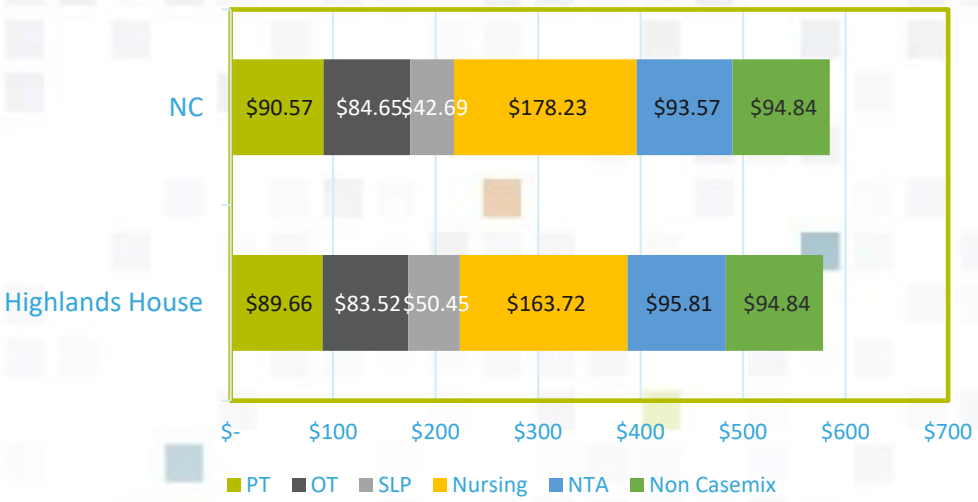
- Interesting from ResDAC:
  - Nationally for residents that were admitted to SNFs, after a hospital stay for any diagnosis other than septicemia, and then readmitted to a hospital in that same episode with a diagnosis of septicemia;
    - In the top 25% of SNF primary diagnosis 13% were respiratory related, 6% were Renal Related, 4% were related to encephalopathy, 1% were surgical related and 1% related to arterial occlusion.
  - Facilities can use this data to facilitate processes to prevent residents from developing septicemia and partner with hospitals to create care flow pathways that help residents achieve their goals while limiting Healthcare-Acquired Infections and rehospitalizations.

Hospital Relationships with Admin

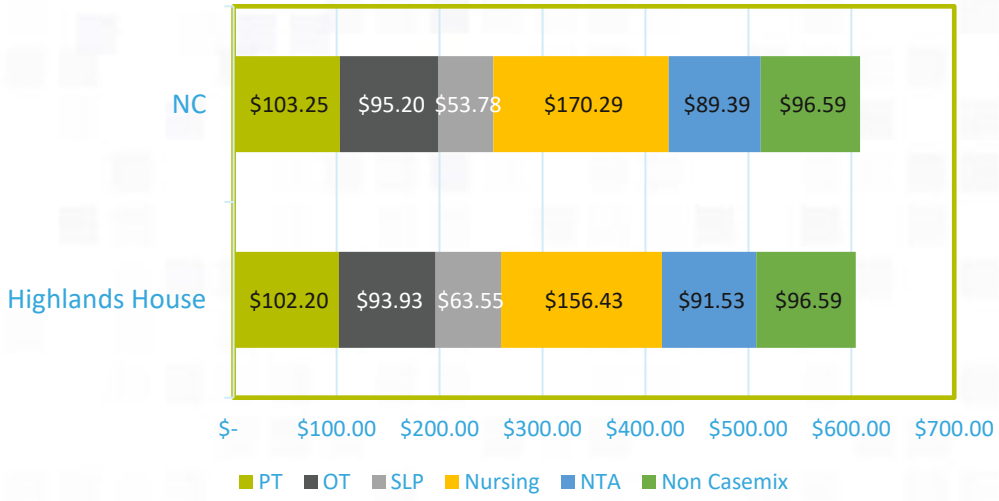
- DRG versus Re-admission potential
- Be aware of risks for penalty to the hospital
- Consider partnership specific to clinical characteristics
- What are the clinical care path of the hospital?
  - Where are your staff in their clinical care path and their accessibility

SNF DATA: PDPM Q2 2020 Urban and Base Rate Trends

Composite Rate (Urban)



Composite Rate (Rural)



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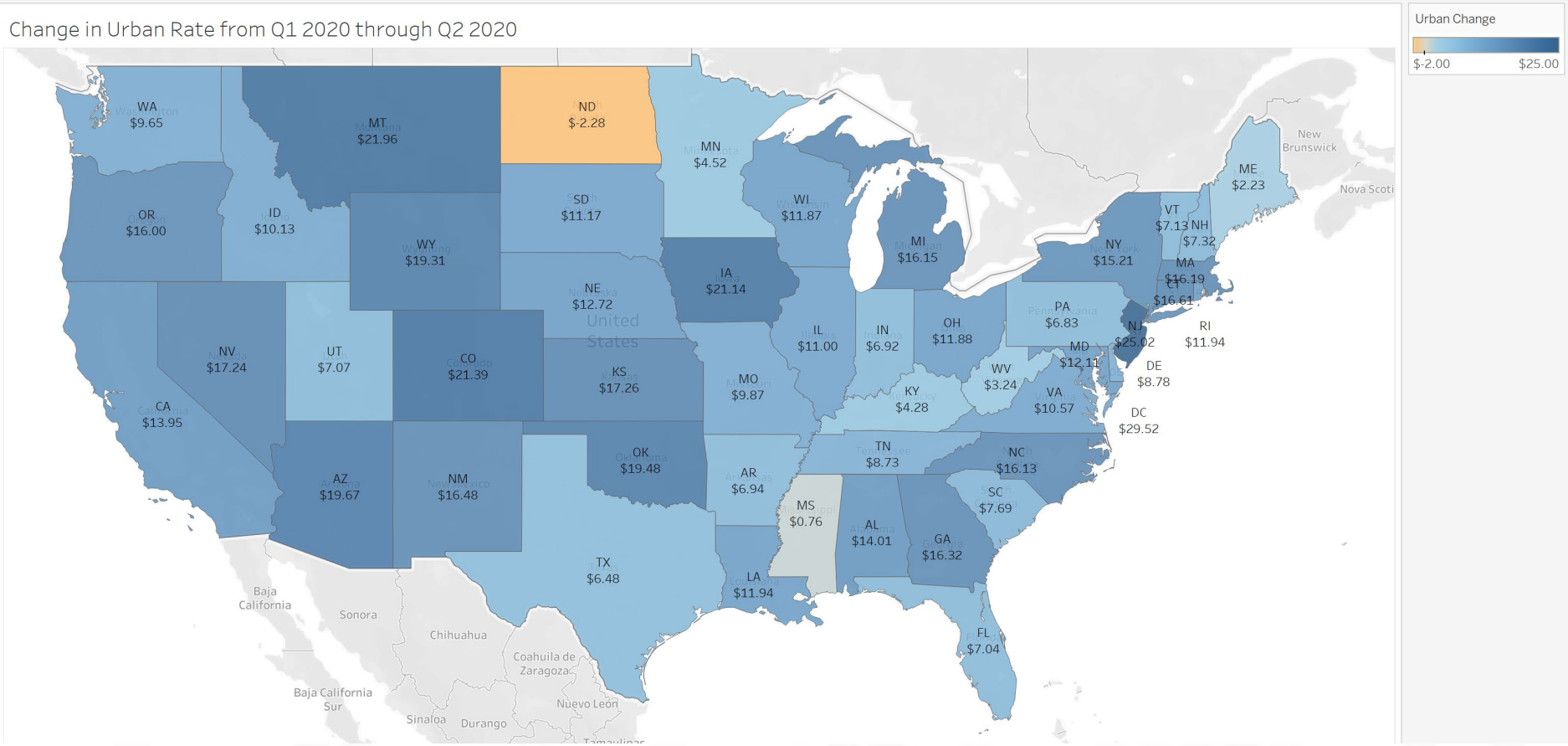
Change in Urban Rate from Q1 2020 through Q2 2020



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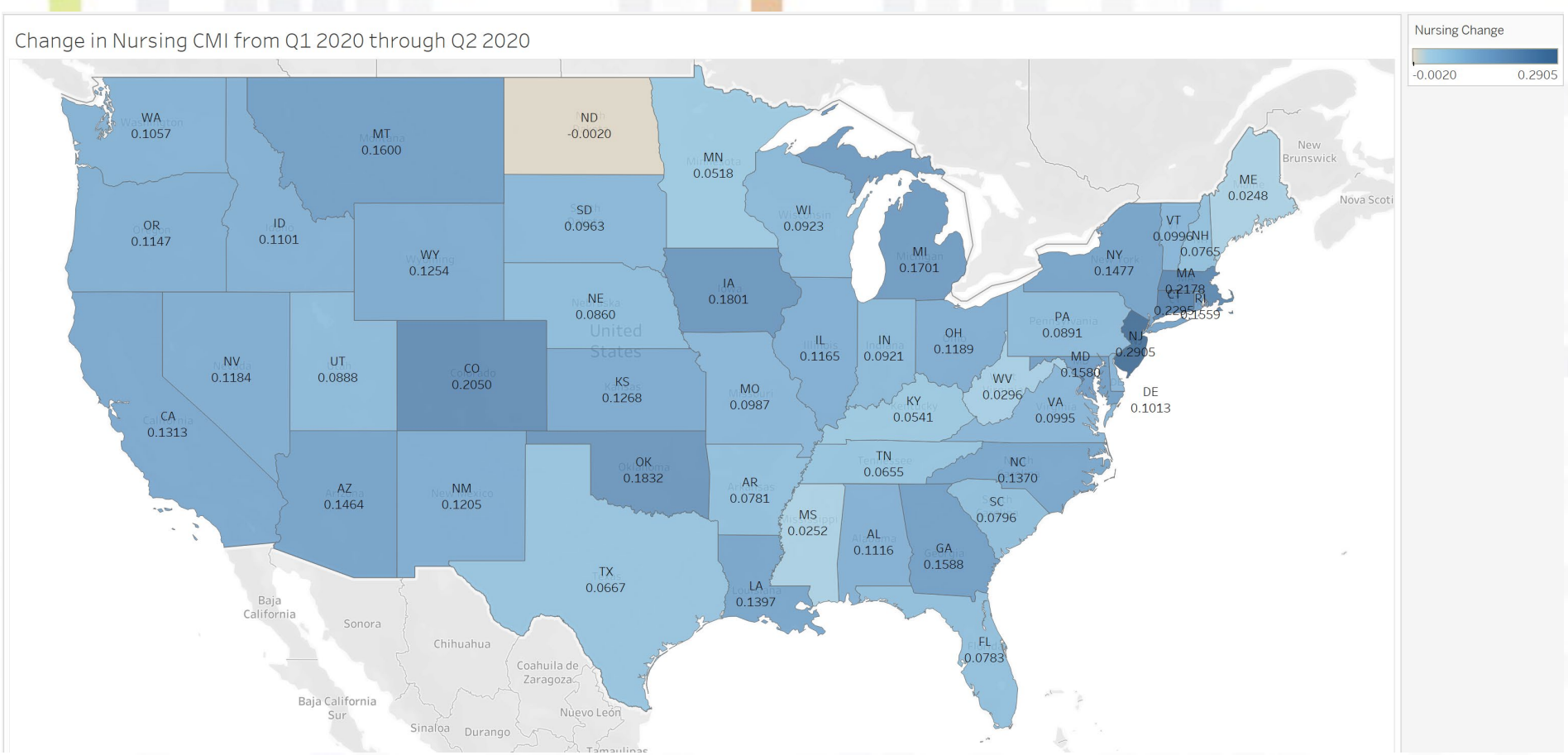
Change in Nursing CMI from Q1 2020 through Q2 2020



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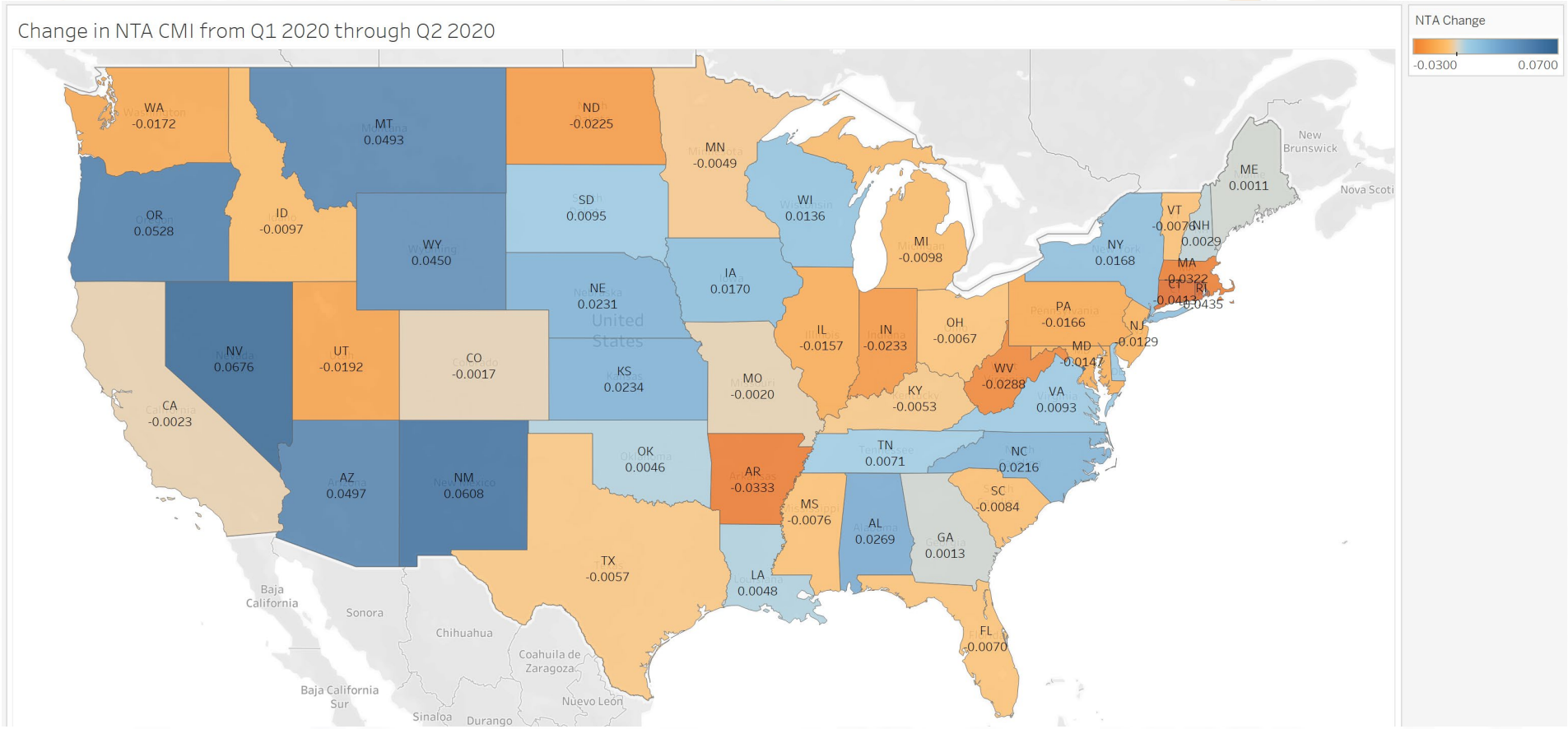

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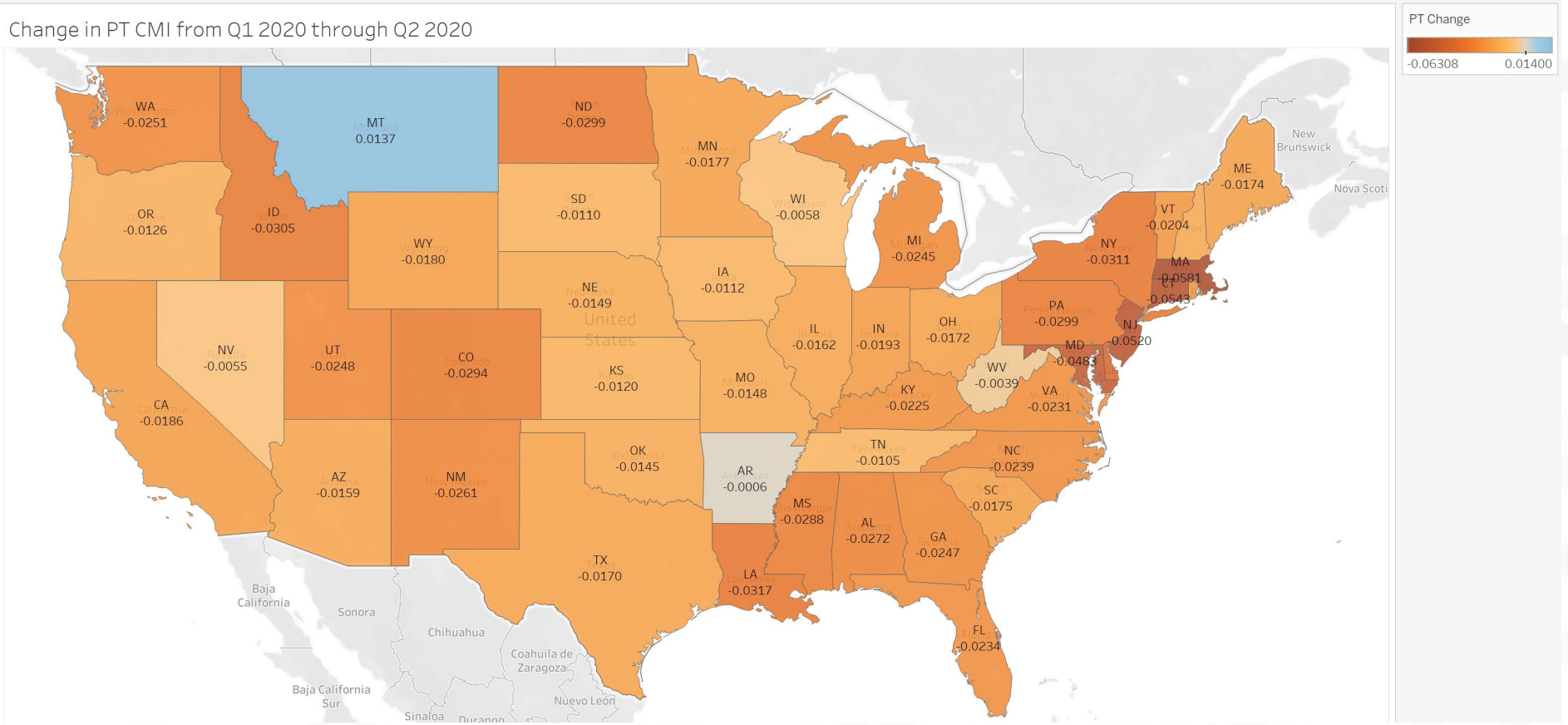

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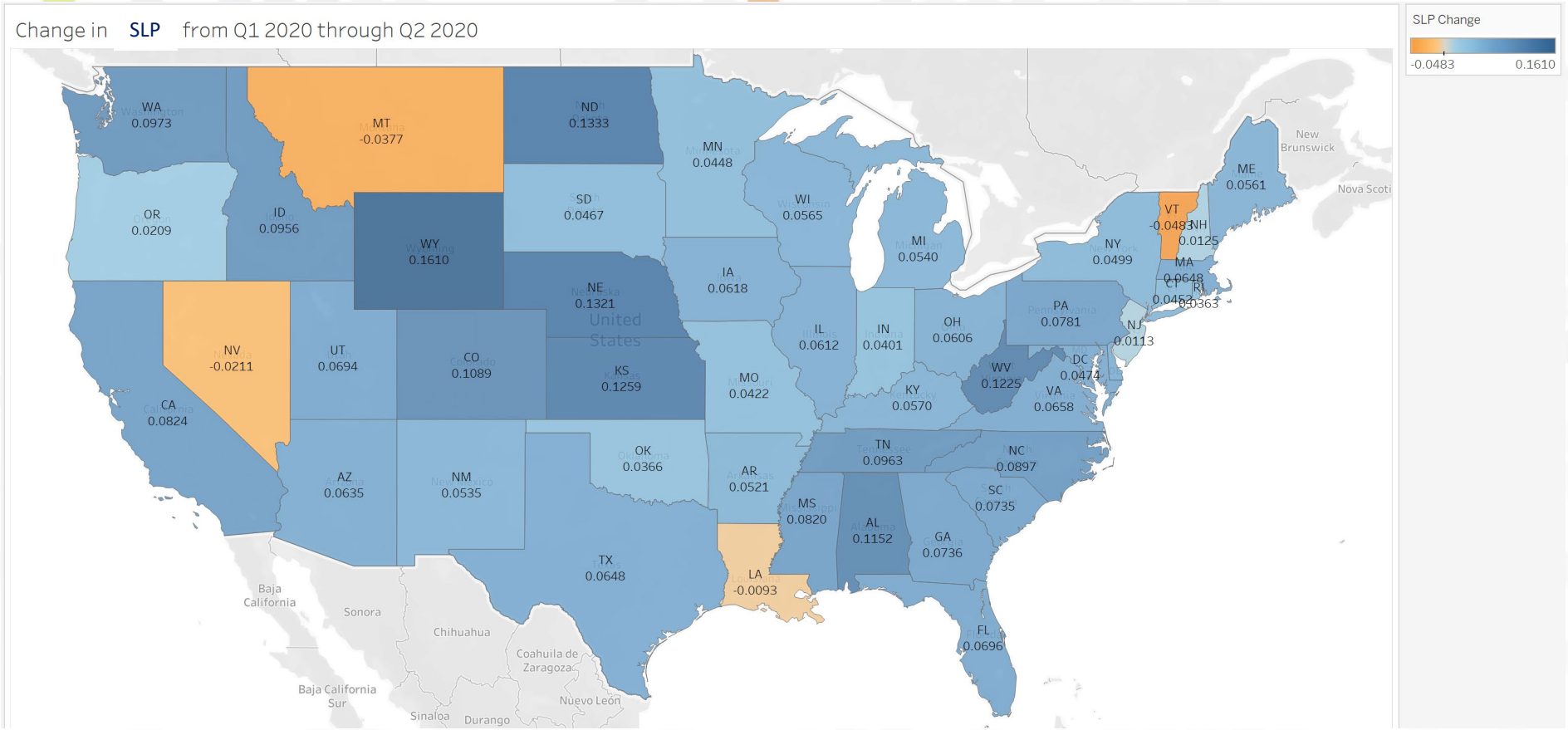

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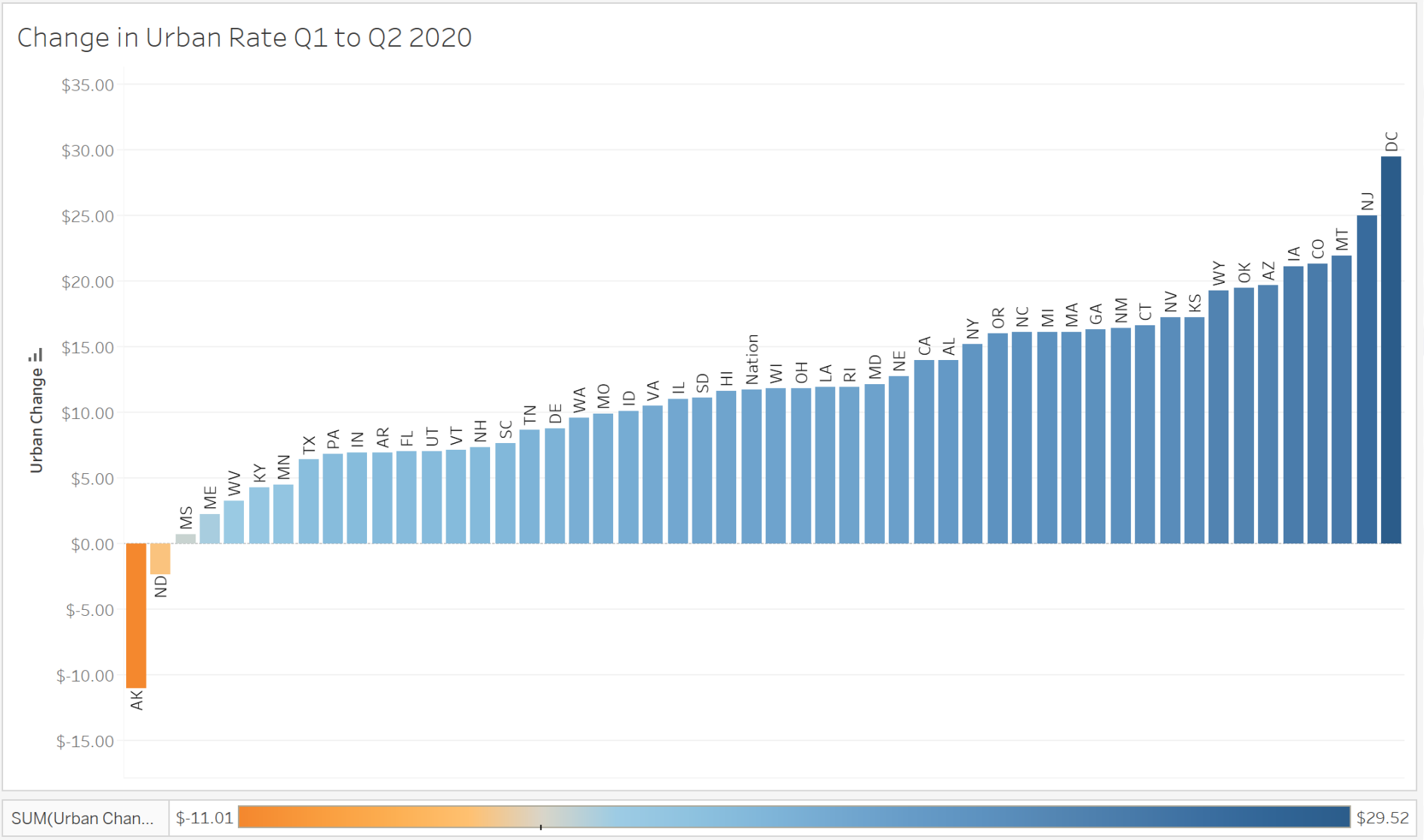

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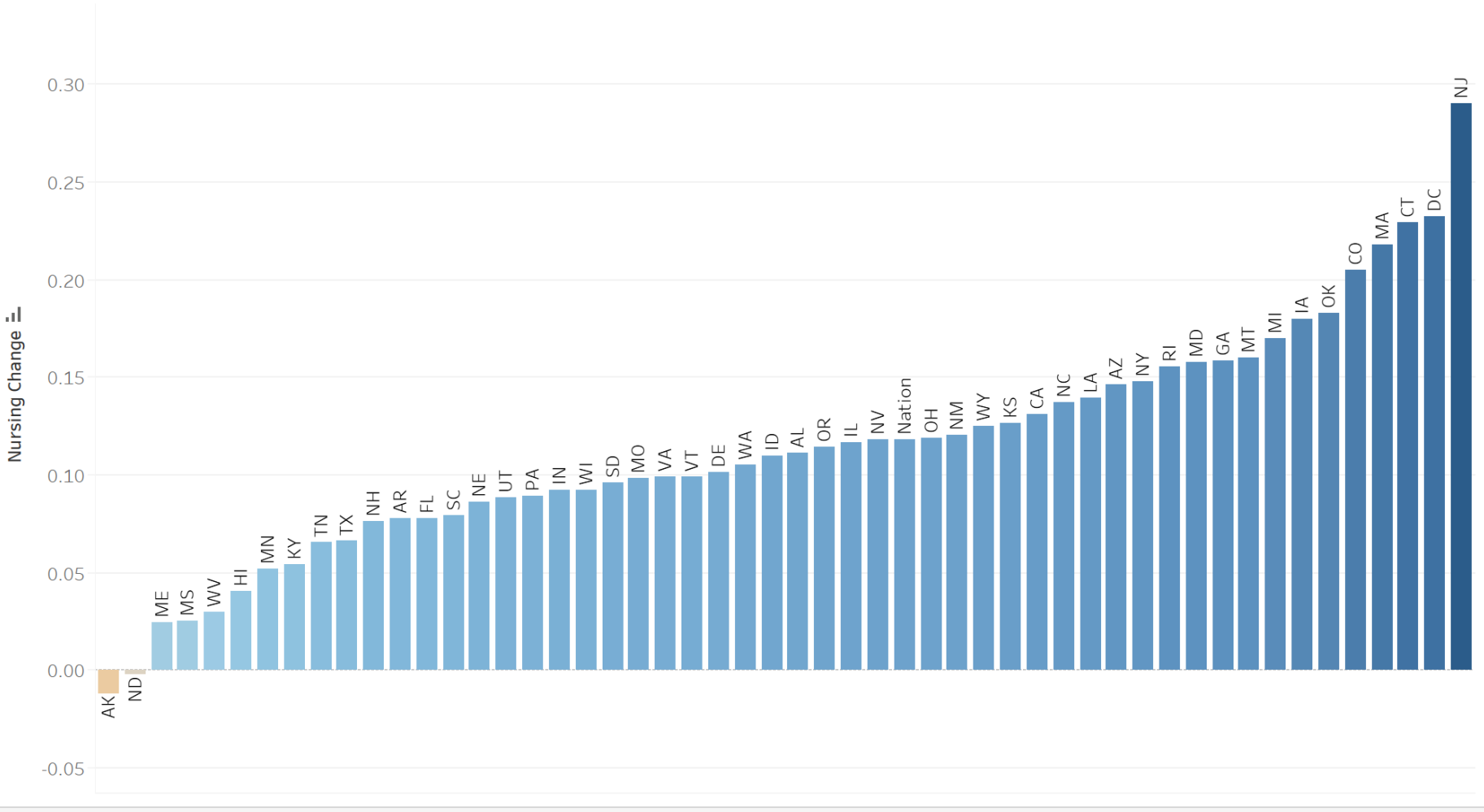
Change in Nursing CMI Q1 to Q2 2020



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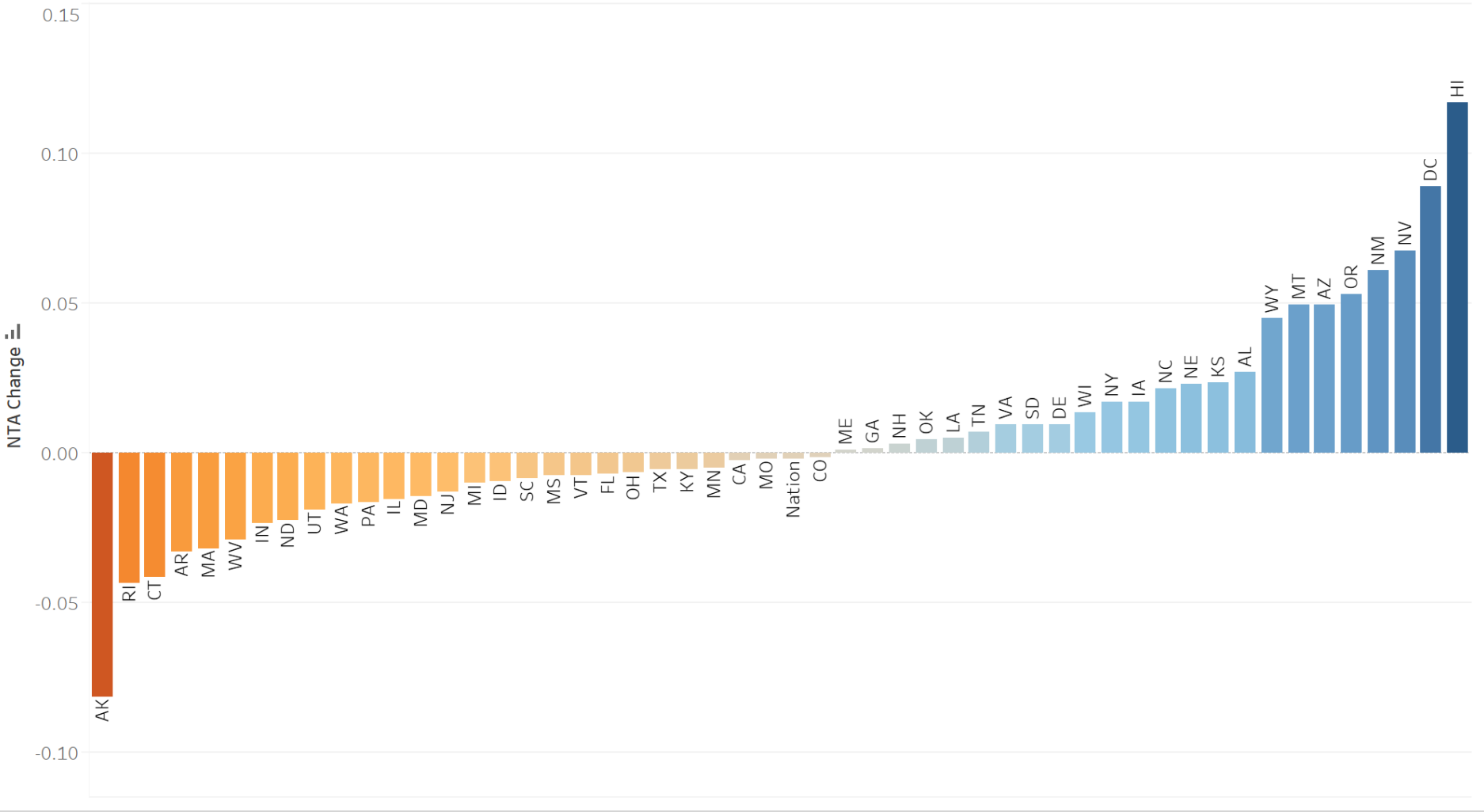
Change in NTA CMI Q1 to Q2 2020



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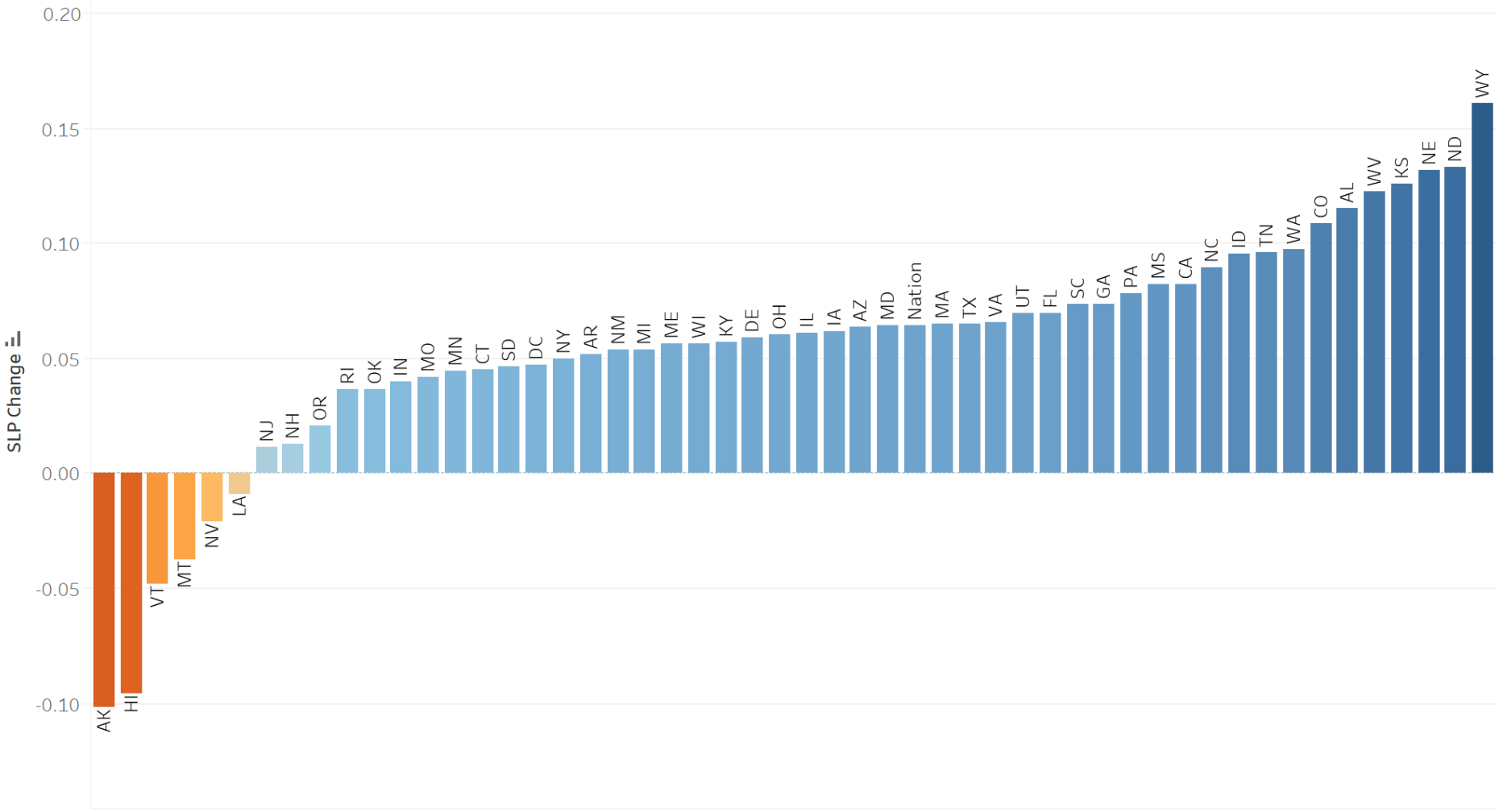
Change in SLP CMI Q1 to Q2 2020



SUM(SLP Change) -0.1017 0.1610

DATA SPEAKS

AAPACN AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

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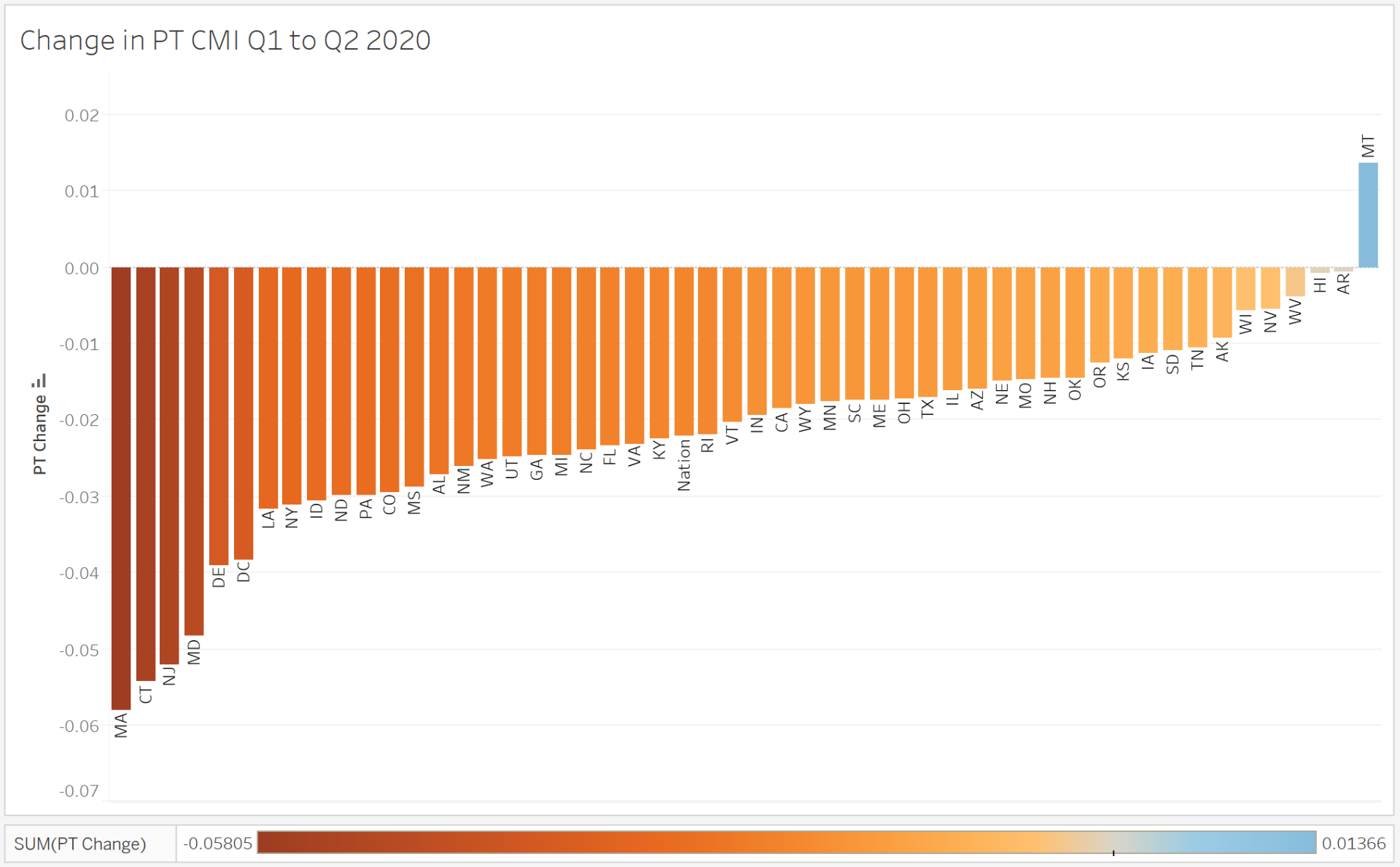
Change in PT CMI Q1 to Q2 2020



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DATA SPEAKS

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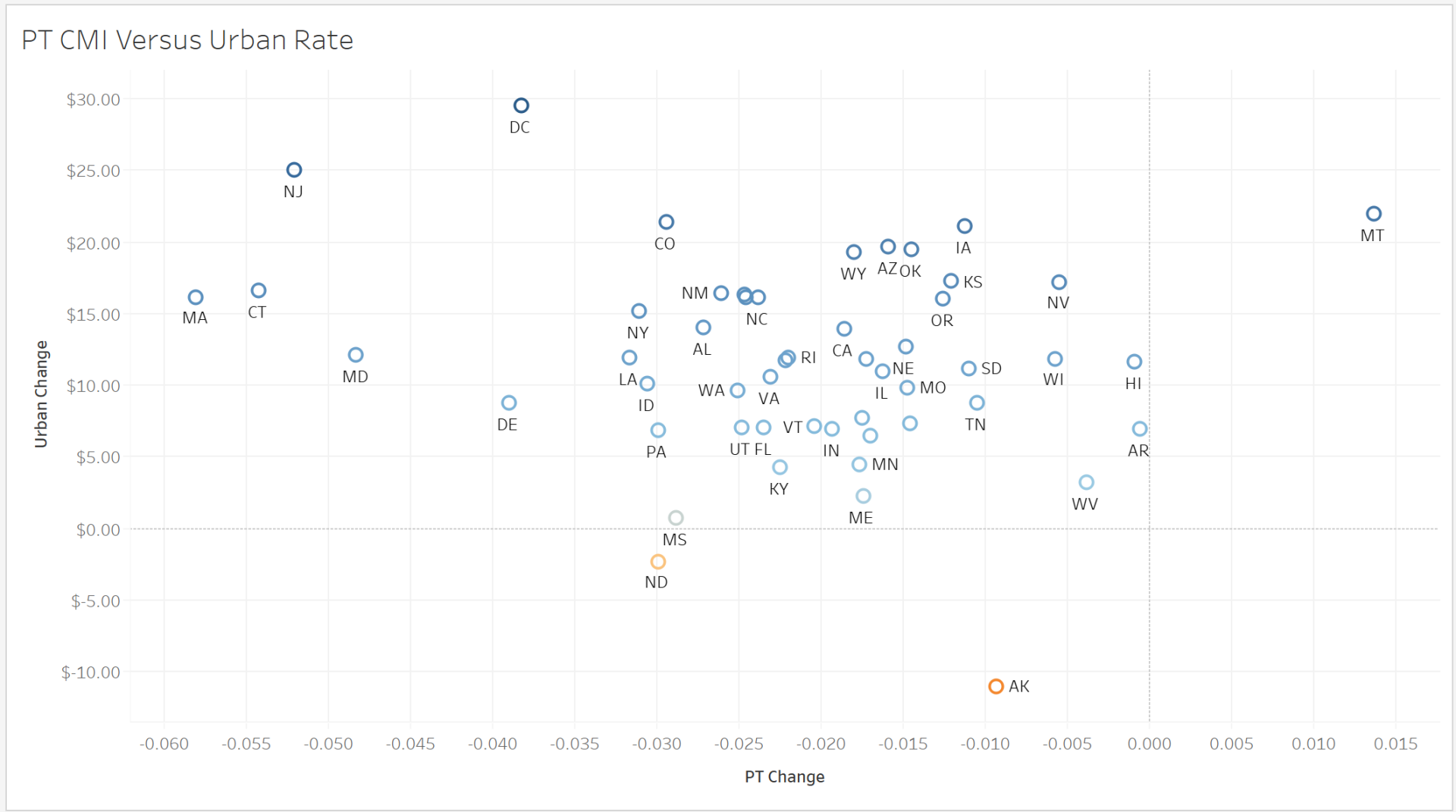

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Take Home Points for Administrators

- Economic Impact- we are all accountable
- Technical Issues- It might not be your fault; It might be your fault
  - Systems, paper driven, clinically driven, discharge process
- What are your indicators?
- What are your systems for review?

Take Home Points for Administrators

- Resident Centered Care
- Strategic partnerships
- Continuum of care
- Safe and least restrictive environment

CEU Reminders

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