

“A Knowledgeable and Compassionate partner”



SNF Quality Reporting Program QM's:

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- This nursing continuing professional development activity was approved by Broad River Rehab, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- This course has been approved for 1.5 contact hours.

CONFLICT OF INTEREST DISCLOSURE

- Broad River Rehab is not charging for this educational offering and has no financial or other conflicts of interest regarding this program.

SUCCESSFUL COMPLETION REQUIREMENTS

- **Live, in-person**
 - In order to obtain nursing contact hours, you must attend the entire activity, participate in case study analysis, and complete the evaluation.
- **Live, virtual**
 - In order to obtain nursing contact hours, you must participate in the entire program, participate in audience polling and/or Q&A and complete the evaluation.
- **Web-Based/On-Demand**
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DISCLOSURE OF THE EXPIRATION DATE FOR AWARDING CONTACT HOURS FOR ENDURING PROGRAMS

- Contact hours for this program will not be awarded after May 13th, 2023



SNF Quality Reporting Program: Quality Measures

Agenda

- SNF Quality Reporting Program (QRP) review
- SNF QRP Quality Measures
- What's Changing, a peek at the SNF FY 2024 proposed rule
- Health Equity and SNF QRP
- Resident Reported Outcomes
- Q&A

Agenda

SNF Quality Reporting Program (SNF QRP)

- **SNF QRP Resources:**

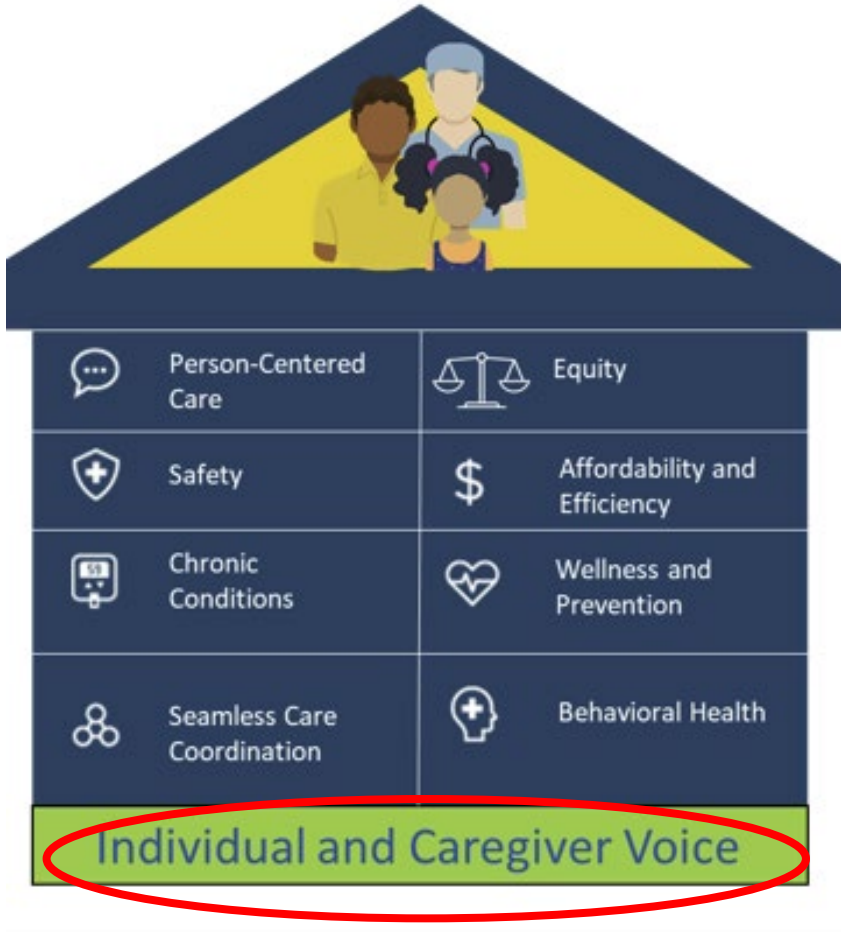
Resources

- [SNF QRP](#)
- [Reporting tables for FY 2024](#)
- [Reporting tables for FY 2025](#)
- [SNF QRP Technical Specifications](#) and [Addendum](#)
- [HAI Draft Specifications](#)
- [COVID-19 Vaccination Among HCP Specifications](#)
- [Influenza Vaccination Coverage Among HCP](#)
- [TOH Measures and SPADEs](#)
- [Claims Based Measures DTC and PPR](#)
- [MSPB](#)
- [Unified PAC Report to Congress](#)
- [MDS 3.0 v1.18.11](#)

IMPACT Act

- On October 6, 2014, the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) was signed into law.
- The Act requires the submission of standardized data by Long-Term Care Hospitals (LTCHs), **Skilled Nursing Facilities (SNFs)**, Home Health Agencies (HHAs) and Inpatient Rehabilitation Facilities (IRFs).
- Standardized data are to be collected by the commonly used assessment instruments: The Long-Term Care Hospital CARE Data Set (LCDS) for LTCHs, **the Minimum Data Set (MDS) for SNFs**, the Outcome and Assessment Information Set (OASIS) for HHAs, and the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) for IRFs.
- The IMPACT Act requires the reporting of standardized patient assessment data with regard to quality measures and standardized patient assessment data elements (SPADEs).
- The Act also requires the submission of data pertaining to measure domains pertaining to resource use, and other domains.
- In addition, the IMPACT Act requires assessment data to be **standardized** and **interoperable** to allow for **exchange of the data among post-acute providers and other providers**.
- The Act intends for standardized post-acute care data to **improve Medicare beneficiary outcomes through shared-decision making, care coordination, and enhanced discharge planning**.

Building Value-Based Care and Promoting Health Equity



Meaningful measures 2.0

- **Meaningful Measures 2.0 supports five interrelated goals.**
 - Empower consumers to make good health care choices through patient-directed quality measures and public transparency.
 - Leverage quality measures to promote health equity and close gaps in care.
 - Use the Meaningful Measures Initiative to streamline quality measurement.
 - Leverage measures to drive outcome improvement through public reporting and payment programs.
 - Improve quality measure efficiency by transitioning to digital measures and using advanced data analytics.

CMS National Quality Strategy goals

- **Embed Quality into the Care Journey:** Incorporate quality as a foundational component to delivering value as a part of the overall care journey. Quality includes ensuring optimal care and best outcomes for individuals of all ages and backgrounds as well as across service delivery systems and settings. Quality also extends across payer types.
- **Advance Health Equity:** Address the disparities that underlie our health system, both within and across settings, to ensure equitable access and care for all.
- **Promote Safety:** Prevent harm or death from health care errors.
- **Foster Engagement:** Increase engagement between individuals and their care teams to improve quality, establish trusting relationships, and bring the voices of people and caregivers to the forefront.
- **Strengthen Resilience:** Ensure resilience in the health care system to prepare for, and adapt to, future challenges and emergencies.
- **Embrace the Digital Age:** Ensure timely, secure, seamless communication and care coordination between providers, plans, payers, community organizations, and individuals through interoperable, shared, and standardized digital data across the care continuum.
- **Incentivize Innovation & Technology:** Accelerate innovation in care delivery and incorporate technology enhancements (e.g. telehealth, machine learning, advanced analytics, new care advances) to transform the quality of care and advance value.
- **Increase Alignment:** Develop a coordinated approach to align performance metrics, programs, policy, and payment across CMS, federal partners, and external stakeholders to improve value. Strive to create a simplified national picture of quality measurement that is comprehensible to individuals, their families, providers, and payers.



IMPACT Act

- The Improving Post-Acute Care Transformation (IMPACT) Act of 2014 also requires a [report to Congress on unified payment for Medicare post-acute care \(PAC\)](#).
- Medicare PAC services are provided to beneficiaries by PAC providers defined as skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and home health agencies (HHAs).
- Each PAC provider setting has a separate Medicare fee-for-service (FFS) prospective payment system (PPS).
- A goal of unified PAC payment is to base the payment on patient characteristics instead of the PAC setting.
- This framework applies a uniform approach to case-mix adjustment across Medicare beneficiaries receiving PAC services for different types of PAC providers while accounting for factors independent of patient need that are important drivers of cost across PAC providers.
- The unified approach to case-mix adjustment includes **standardized patient assessment data** collected by the four PAC providers.

IMPACT Act

- There are 16 quality measures that have been developed for SNFs as a result with more to come, some filtered through the [Meaningful Measures Framework](#), with multiple of Standardized Patient Assessment Data Elements or SPADES in MDS 3.0 v1.18.11.
- The SNF QRP is currently driven by 14 quality measures. 8 of these measures derive from the Minimum Data Set, 4 from Medicare claims and 2 are reported through NHSN. Only 2 of these measures currently affect a facility's 5-star rating.
- **Quality Measure Domains:** - Skin integrity and changes in skin integrity; - Functional status, cognitive function, and changes in function and cognitive function; - Medication reconciliation; - Incidence of major falls; - Transfer of health information and care preferences when an individual transitions;
- **Resource Use and Other Measure Domains:** - Resource use measures, including total estimated Medicare spending per beneficiary; - Discharge to community; and All-condition risk-adjusted potentially preventable hospital readmissions rates.
- **SNF QRP compliance thresholds** are 100% of MDS data elements (**including SPADEs**) on at least 80% of MDS submissions **and** 100% of NHSN data submission requirements. Noncompliance with either threshold equals a 2% reduction to the Market Basket Update.

IMPACT Act QMs

IMPACT Act Domain	IMPACT Act Measure	Source	PAC Setting Adopted
Skin Integrity and Changes in Skin Integrity 	Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) replaced with Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.	Assessment	IRF, LTCH, SNF, HH
Functional Status, Cognitive Function, and Changes in Function and Cognitive Functiony	Application of Percent of LTCH Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	Assessment	IRF, LTCH, SNF, HH
	Change in Self-Care Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
	Change in Mobility Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
	Change in Discharge Self-Care Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
	Change in Discharge Mobility Score for Medical Rehabilitation Patients	Assessment	IRF, SNF
Medication Reconciliation	Drug Regimen Review	Assessment	IRF, LTCH, SNF, HH
Incidence of Major Falls	Application of the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	Assessment	IRF, LTCH, SNF, HH
Transfer of Health Information and Care Preferences when an Individual Transitions	Transfet of Health Information to Provider Transfer of health Information to Patient	Assessment Assessment	IRF, LTCH, SNF, HH
Resource Use Measures, including Total Estimated Medicare Spending Per Beneficiary	Medicare Spending Per Beneficiary	Claims	IRF, LTCH, SNF, HH
Discharge to Community 	Discharge to Community	Claims	IRF, LTCH, SNF, HH
All-Condition Risk-Adjusted Potentially Preventable Hospital Readmissions Rates	Potentially Preventable 30-Day Post-Discharge Readmission	Claims	IRF, LTCH, SNF, HH
Meaningful Measure Domain	IMPACT Act Measure		PAC Setting Adopted
Patient Safety (Meaningful Measures 2.0)	SNF Healthcare Associated infections	Claims	SNF
Patient Safety (Meaningful Measures 2.0)	Influenza vaccination HCP	NHSN	IRF, LTCH, SNF
Patient Safety (Meaningful Measures 2.0)	COVID-19 Vaccination HCP	NHSN	IRF, LTCH, SNF

SNF Quality Reporting Program (QRP)

- **Additional MDS Based QMs**

- Transfer of Health Information to the Provider–Post-Acute Care (PAC): This measure assesses for and reports on the timely transfer of health information, specifically transfer of a reconciled medication list.
 - This measure evaluates for the transfer of information when a patient/resident is transferred or discharged from their current setting to a subsequent provider.
 - For this measure, the subsequent provider is defined as a **short-term general hospital, a SNF, intermediate care, home under care of an organized home health service organization or hospice, hospice in an institutional facility, an IRF, an LTCH, a Medicaid nursing facility, an inpatient psychiatric facility, or a critical access hospital.**
- Transfer of Health Information to the Patient–Post-Acute Care (PAC): This measure, the Transfer of Health Information to the Patient, assesses for and reports on the timely transfer of health information, specifically transfer of a medication list.
 - This measure evaluates for the transfer of information when a patient/resident is discharged from their current setting of PAC to a **private home/apartment, board and care home, assisted living, group home, transitional living, or home under the care of an organized home health service organization or hospice.**

SNF Quality Reporting Program (QRP)

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires CMS to develop, implement, and maintain standardized patient assessment data elements (SPADEs) for PAC settings (SNF, HH, LTCH, IRF).
- The goals of implementing cross-setting SPADEs are to facilitate care coordination and interoperability and to improve Medicare beneficiary outcomes.
- The IMPACT Act further requires that the assessment instruments for each PAC setting (MDS, OASIS, LCDS, IRF PAI) be modified to include core data elements on health assessment categories and that such data be standardized and interoperable. HH, IFF and LTCH tools have already been modified to report these SPADEs. **MDS 3.0 v1.18.11 contains the data elements necessary to comply with this mandate.**
- CMS has adopted SPADEs for five categories specified in the IMPACT Act:
 - **Cognitive function** (e.g., able to express ideas and to understand normal speech) and mental status (e.g., depression and dementia)
 - **Special services, treatments, and interventions** (e.g., need for ventilator, dialysis, chemotherapy, and total parenteral nutrition)
 - **Medical conditions and comorbidities** (e.g., diabetes, heart failure, and pressure ulcers)
 - **Impairments** (e.g., incontinence; impaired ability to hear, see, or swallow)
 - **Other categories** as deemed necessary by the Secretary (Social Determinants of Health)

MDS 3.0v1.18.11 and S.P.A.D.Es

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires CMS to develop, implement, and maintain standardized patient assessment data elements (SPADEs) for PAC settings (SNF, HH, LTCH, IRF).
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 - **Other categories** as deemed necessary by the Secretary (Social Determinants of Health)

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Cognitive Function: Brief Interview for Mental Status (BIMS)**
 - The following MD items have been retained in MDS 3.0v1.18.11 to assess for cognitive function.
 - **C0100 Should Brief Interview for Mental Status (C0200-C0500) be Conducted?**
 - **C0299 Repetition of Three Words**
 - **C0300 Temporal Orientation**
 - **C0400 Recall**
 - **C0500 BIMS Summary Score**

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Cognitive Function (cont.)**

- **Confusion Assessment Method (CAM©):** The following MDS will be retained in MDS v1.18.11 to assess delirium.
 - **C1310 Signs and Symptoms of Delirium (from CAM©)**
 - **C1310 A. Acute Onset Mental Status Change**
 - **C1310 B. Inattention**
 - **C1310 C. Disorganized Thinking**
 - **C1310 A. Altered Level of Consciousness**

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Cognitive Function (cont.)**

- **Patient Healthcare Questionnaire (PHQ-2 to 9):** The PHQ-2 to 9 data elements use a summed-item scoring approach to first screen for signs and symptoms of depressed mood in patients and residents by assessing the two cardinal criteria for depression: depressed mood and anhedonia (inability to feel pleasure).
- At least one of the two must be present for a determination of probable depression, which signals the need for continued assessment of the additional seven PHQ symptoms. Specifically, If either D0150A2 or D0150B2 is coded 2 (7-11 days) or 3 (12-14 days), CONTINUE asking the questions below. If not, END the PHQ interview.
- The interview is concluded if a respondent screens negative for the first two symptoms.
- The following MDS items have been revised on MDS 3.0v1.18.11 to accommodate this data
 - **D0150 Resident Mood Interview (PHQ-2 to 9)** (Replaces D0200)
 - **D0160. Total Severity Score** (Replaces D0300)

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Special Services, Treatments, and Interventions (Including Nutritional Approaches) (Cont.)**
- MDS item **O0110 Special Treatments, Procedures, and Programs**, has been added to MDS 3.0 v1.18.11. This is a significant revision to O0100. Multiple items for the following are now required to be coded on admission (column a), while a resident (column b) and at discharge (column c). **Note** that the column, “While NOT a Resident”, has been removed.
 - **A1. Chemotherapy (A2. IV, A3. Oral, A10. Other),**
 - **B1. Radiation,**
 - **C1. Oxygen therapy (C2. Continuous, C3. Intermittent, C4. High-concentration oxygen delivery system)**
 - **D1. Suctioning (D2. Scheduled, D3. As needed),**
 - **E1. Tracheostomy Care,**
 - **F1. Invasive mechanical ventilator**
 - **G1. Non-invasive mechanical ventilator (G2. BiPAP, G3. CPAP)**
 - **H1. IV medications (H2. vasoactive medications, H3. antibiotics, H4. anticoagulants, H5. other)**
 - **I1. Transfusions**
 - **J1. Dialysis (J2. hemodialysis, J3. peritoneal dialysis)**
 - **O1. IV access (O2. peripheral IV, O3. midline, O4. central line)**

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Special Services, Treatments, and Interventions (Including Nutritional Approaches)** (cont.)
- **MDS item K0520, Nutritional Approaches**, has been added to MDS 3.0v1.18.11. This is a revision to K0510. MDS items for the following are now required to be coded on admission (3-day window days 1-3 of the stay), while not a resident, while a resident and at discharge (3-day window last 3 days of the stay).
 - **A. Parenteral/IV feeding**
 - **B. Feeding tube**
 - **C. Mechanically altered diet** (not coded while not a resident)
 - **D. Therapeutic diet** (not coded while not a resident)

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Special Services, Treatments, and Interventions (Including Nutritional Approaches)** (cont.)
- **MDS item N0415, High-risk drug classes: use and indication**, has been added to MDS 3.0v1.18.11. This is a significant revision to N0410. MDS items for the following are now required to be coded when taken (Column 1) and that there is an indication for use (Column 2).
- Assessing use of high-risk medications by SNF residents and indications for each medication would provide important information related to resident safety in SNFs and care transitions between SNFs and other settings
 - **A. Antipsychotic**
 - **B. Antianxiety**
 - **C. Antidepressant**
 - **D. Hypnotic**
 - **E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin)**
 - **F. Antibiotic**
 - **G. Diuretic**
 - **H. Opioid**
 - **I. Antiplatelet (new item)**
 - **J. Hypoglycemic (including insulin) (new item).**

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Medical Conditions and Co-Morbidities**
- **Pain Interference**: (cont.)
- **J0400 Pain Frequency** is now numbered J0410
- The following MDS Items have been added to MDS 3.0v1.18.11(Revised J0500) to address pain in PAC settings
 - **J0510. Pain Effect on Sleep**
 - **J0520. Pain Interference with Therapy Activities**
 - **J0530. Pain Interference with Day-to-Day Activities**
- The order of the frequency intervals for all pain items (Rarely, Occasionally, Frequently and Almost Constantly) have been reversed.

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Impairments**

- **Hearing and Vision Impairments (cont.)**

- The following MDS items have been retained in MDS 3.0v1.18.11 to address impairments

- **B0200 Hearing**
- **B1000 Vision**



MDS 3.0v1.18.11 and S.P.A.D.Es

- **New Category: Social Determinants of Health**

- CMS has identified data elements for cross-setting standardization of assessment for seven social determinants of health (SDOH).
- **Healthy People 2020 defines SDOH** as, “...the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”
- **World Health Organization** – “Social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. The SDH have an important influence on Health Inequities - the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.”
- Examples of the social determinants of health, which can influence health equity in positive and negative ways: - Income and social protection – Education - Unemployment and job insecurity – Working life conditions - Food insecurity – Housing, basic amenities and the environment - Early childhood development - Social inclusion and non-discrimination - Structural conflict - Access to affordable health services of decent quality.

MDS 3.0v1.18.11 and S.P.A.D.Es

- **New Category: Social Determinants of Health (cont.)**
- MDS items have been added and or revised to assess for SDOH:
 - **Ethnicity – MDS item A1005**
 - **Race – MDS item A1010**
 - **Preferred Language – MDS item A1110**
 - **Interpreter Services – MDS item A1110**
 - **Transportation – MDS item A1250**
 - **Health Literacy – MDS item B1300**
 - **Social Isolation – MDS item D0700**

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Health Equity Update (SNF PPS FY 2024 proposed Rule)**
- In the FY 2023 SNF PPS proposed rule CMS included an RFI entitled “Overarching Principles for Measuring Equity and Healthcare Quality Disparities Across CMS Quality Programs.
- CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by CMS’ programs and models, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that beneficiaries need to thrive.
- This initiative is guided by 5 priorities
- **Priority 1:** Expand the Collection, Reporting and Analysis of Standardized Data
- **Priority 2:** Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps
- **Priority 3:** Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities
- **Priority 4:** Advance Language Access, Health Literacy and the Provision of Culturally Tailored Services
- **Priority 5:** Increase All Forms of Accessibility to Health Care Services and Coverage

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Health Equity Update (SNF PPS FY 2024 proposed Rule cont.)**
- CMS' National Quality Strategy identifies a wide range of potential quality levers that can support CMS' advancement of equity, including:
 - (1) establishing a standardized approach for resident-reported data and stratification;
 - (2) employing quality and value-based programs to address closing equity gaps; and
 - (3) developing equity-focused data collections, analysis, regulations, oversight strategies, and quality improvement initiatives.

MDS 3.0v1.18.11 and S.P.A.D.Es

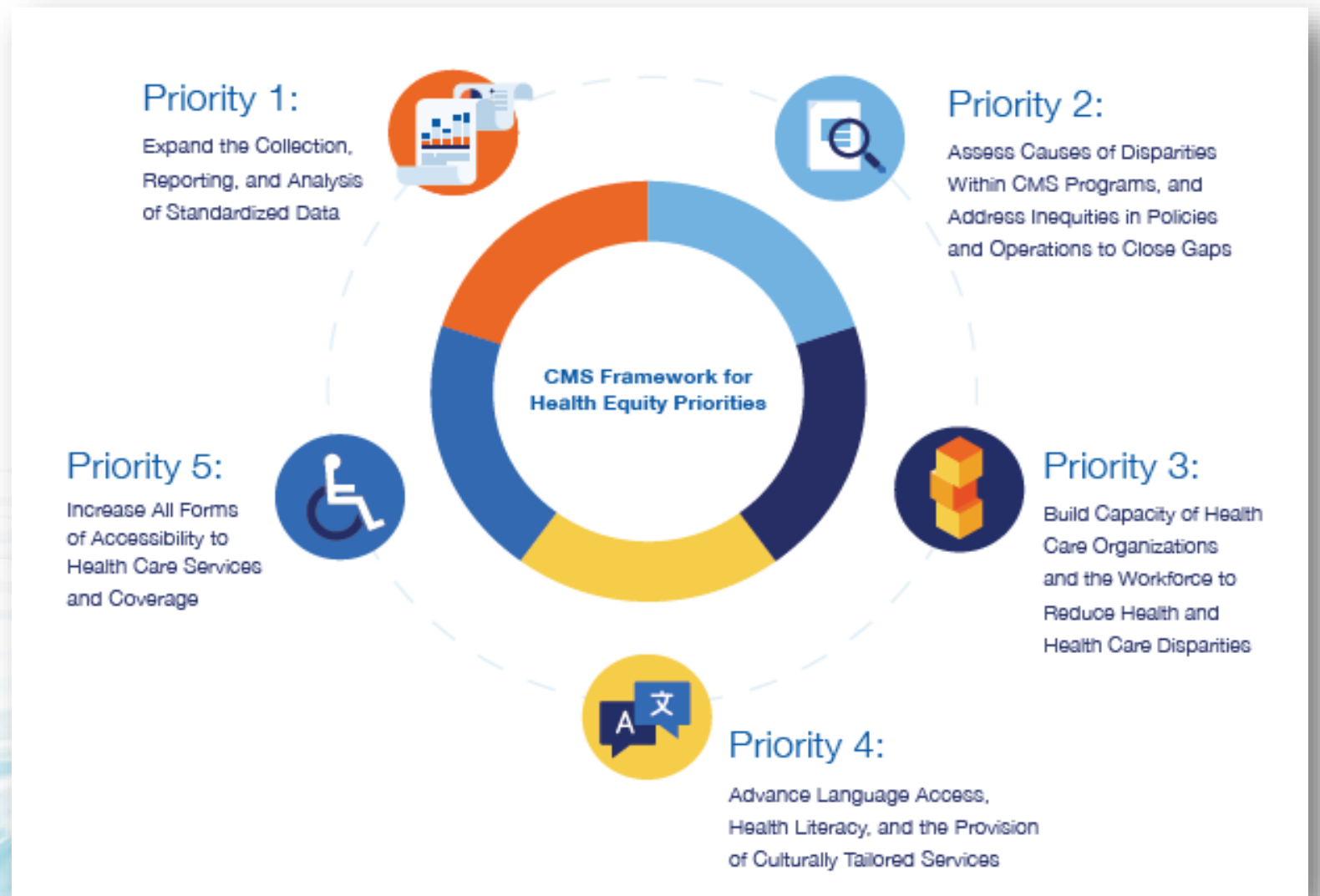
- **Health Equity Update (SNF PPS FY 2024 proposed Rule cont.)**
- CMS is committed to developing approaches to meaningfully incorporate the advancement of health equity into the SNF QRP. One option CMS is considering is including social determinants of health (SDOH) as part of new quality measures.
- CMS is considering whether health equity measures we have adopted for other settings, such as hospitals, could be adopted in post-acute care settings.
- CMS is exploring ways to incorporate SDOH elements into the measure specifications. For example, CMS is considering a future health equity measure like screening for social needs and interventions.
- With 30 percent to 55 percent of health outcomes attributed to SDOH, a measure capturing and addressing SDOH could encourage SNFs to identify residents' specific needs and connect them with the community resources necessary to overcome social barriers to their wellness.

MDS 3.0v1.18.11 and S.P.A.D.Es

- **Health Equity Update (SNF PPS FY 2024 proposed Rule cont.)**
- CMS could specify a health equity measure using the same SDOH data items that are and will be collected as standardized patient assessment data elements under the SNF.
- These SDOH data items assess health literacy, social isolation, transportation problems, and preferred language (including need or want of an interpreter).
- CMS also sees value in aligning SDOH data items across all care settings as they develop future health equity quality measures under SNF QRP statutory authority.
- This would further the NQS to align quality measures across our programs as part of the Universal Foundation.

Health Equity Resource

CMS Framework for Health Equity 2022–2032



FY 2023 SNF PPS Proposed Rule Updates to SNF QRP

- **Proposed Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP)**
 - CMS is proposing the adoption of three measures in the SNF QRP,
 - the removal of three measures from the SNF QRP, and
 - the modification of one measure in the SNF QRP. In addition,
 - the proposed rule would also make policy changes to the SNF QRP, and
 - begin public reporting of four measures.

FY 2023 SNF PPS Proposed Rule Updates to SNF QRP

- **Proposed Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP)**
 - CMS is proposing the adoption of the Discharge Function Score (DC Function) measure beginning with the FY 2025 SNF QRP.
 - This measure assesses functional status by assessing the percentage of SNF residents who meet or exceed an expected discharge function score and uses mobility and self-care items already collected on the Minimum Data Set (MDS).
 - This measure would replace the topped-out process measure – the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment/a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) measure.

FY 2023 SNF PPS Proposed Rule Updates to SNF QRP

- **Proposed Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP)**
 - CMS is proposing the adoption of the **CoreQ: Short Stay Discharge (CoreQ: SS DC) measure** beginning with the FY 2026 SNF QRP.
 - This measure calculates the percentage of individuals discharged from an SNF, within 100 days of admission, who are satisfied with their SNF stay.
 - The questionnaire that would be administered under the CoreQ: SS DC measure asks individuals to rate their overall satisfaction with their care using a 5-point Likert scale.
 - The areas of care include: staff, the care received, recommending the facility to friends and family, and how well their discharge needs were met.

FY 2023 SNF PPS Proposed Rule Updates to SNF QRP

- **Proposed Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP)**
- CMS is proposing that each SNF must contract with an independent CMS-approved CoreQ survey vendor to administer the CoreQ: SS DC measure questionnaire, and report the results to CMS, on behalf of the SNF

TABLE 13: CoreQ: Short Stay Discharge Primary Questions

Primary questions used in the CoreQ: Short Stay Discharge Questionnaire	Response options for the four CoreQ primary questions
1. In recommending this facility to your friends and family, how would you rate it overall?	Poor (1)
2. Overall, how would you rate the staff?	Average (2)
3. How would you rate the care you received?	Good (3)
4. How would you rate how well your discharge needs were met?	Very Good (4)
	Excellent (5)

FY 2023 SNF PPS Proposed Rule Updates to SNF QRP

- **Proposed Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP)**
 - CMS is proposing the adoption of the **COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID-19 Vaccine) measure** beginning with the FY 2026 SNF QRP.
 - This measure reports the percentage of stays in which residents in an SNF are up to date with recommended COVID-19 vaccinations in accordance with the Centers for Disease Control and Prevention's (CDC's) most recent guidance.
 - Data would be collected using a new standardized item on the MDS.

FY 2023 SNF PPS Proposed Rule Updates to SNF QRP

- **Proposed Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP)**
 - CMS is proposing to modify **the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) measure** beginning with the FY 2025 SNF QRP.
 - This measure tracks the percentage of healthcare personnel (HCP) working in SNFs who are considered up to date with recommended COVID-19 vaccination in accordance with the CDC's most recent guidance.
 - The prior version of this measure reported only on whether HCP had received the primary vaccination series for COVID-19.
 - The proposed modification would require SNFs to report the cumulative number of HCP who are up to date with recommended COVID-19 vaccinations in accordance with the CDC's most recent guidance.

FY 2023 SNF PPS Proposed Rule Updates to SNF QRP

- **Proposed Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP)**
 - CMS is proposing to remove the **Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan)** measure beginning with the FY 2025 SNF QRP.
 - CMS is proposing this measure removal for two reasons.
 - First, the Application of Functional Assessment/Care Plan measure meets the conditions for measure removal factor one: measure performance among SNFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.
 - Second, this measure meets the conditions for measure removal factor six: there is an available measure (the proposed DC Function measure, discussed above) that is more strongly associated with desired resident functional outcomes.

FY 2023 SNF PPS Proposed Rule Updates to SNF QRP

- **Proposed Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP)**
 - CMS is proposing to remove the **Application of the IRF Functional Outcome Measures: Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Care Score)** measure; and the **Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score)** measure beginning with the FY 2025 SNF QRP.
 - CMS proposes to remove these two measures because these measures meet the condition for measure removal factor eight: the costs associated with a measure outweigh the benefits of its use in the program.
 - Additionally, these measures are similar or duplicative of other measures within the SNF QRP.

FY 2023 SNF PPS Proposed Rule Updates to SNF QRP

- **Proposed Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP)**
 - CMS is proposing to increase the SNF QRP Data Completion thresholds for the Minimum Data Set (MDS) Data Items beginning with the FY 2026 SNF QRP.
 - CMS proposes SNFs must report 100% of the required quality measure data and standardized resident assessment data collected using the MDS on at least 90% of the assessments they submit to CMS.
 - Any SNF that does not meet the proposed requirement that 90% of all MDS assessments submitted contain 100% of required data items, will be subject to a reduction of 2 percentage points to the applicable FY annual payment update beginning with FY 2026.

FY 2023 SNF PPS Proposed Rule Updates to SNF QRP

- **Proposed Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP)**
 - CMS is proposing to begin the public reporting of the **Transfer of Health Information to the Provider—PAC Measure** and the **Transfer of Health Information to the Patient—PAC Measure** beginning with the October 2025 Care Compare refresh or as soon as technically feasible.
 - The measures report the percentage of patient stays with a discharge assessment indicating that a current reconciled medication list was provided to the subsequent provider and/or to the patient/family/caregiver at discharge or transfer.

Conclusion

- QRP/SPADEs are here to stay for both QRP, VBP and Payment (UPAC)
- Don't procrastinate your engagement of these concepts
- MDS Accuracy is PARAMOUNT! Future QMs and Payment are at stake.
- Engage the updated MDS and RAI Manual as if you never read it before. It's that important!
- Have a resource library (Slide 5). Essential documents necessary for engagement and Understanding are crucial to have at your fingertips.
- Resident centered care is always the end goal.

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QUESTIONS?