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Nursing Home Compare Updates

Long-Stay Hospitalization Quality Measure
CMS continues to focus on reducing hospitalizations to improve the health and safety of nursing home residents. Over the last several years, CMS has launched several initiatives aimed at reducing hospitalizations, such as the Skilled Nursing Facility Value Based Purchasing program and the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents.

In 2015, CMS added a quality measure to the Nursing Home Compare website and Five Star Quality Rating System, which reported the percentage of short-stay residents who were re-hospitalized. Posting this quality measure was aimed at informing stakeholders about the rates of re-hospitalizations for each nursing home, and incentivizing nursing homes to implement interventions to reduce these instances and improve quality.

In July 2018, CMS will provide rates of hospitalizations for long-stay residents in each facility's confidential "Nursing Home Compare Five-Star Ratings of Nursing Homes Provider Rating Report." In October 2018, the long-stay hospitalization measure will be posted on the Nursing Home Compare website as a long-stay quality measure. In the spring of 2019, this quality measure will be included in the Five Star Quality Rating System. Additionally, in July 2018 CMS will update the other claims-based quality measures reported on the Nursing Home Compare website.

Payroll-Based Journal Data
In 2017, CMS began posting the number of hours worked by nursing staff submitted through the Payroll-Based Journal (PBJ) system on data.cms.gov. To increase transparency, CMS will begin posting the number of hours worked by other staff (non-nursing) in July 2018. CMS will also distinguish between hours submitted for direct employees and contract staff. CMS encourage stakeholders to use this information to learn how different categories of staff can improve quality and outcomes for residents. The information will be posted on data.cms.gov and will include the total number of hours submitted for each staff category.

In April 2018, CMS announced the use of PBJ data to calculate staffing measures and facilities' five star quality ratings.

Health Inspection Rating Freeze
In February 2018, CMS implemented a temporary "freeze" of the health inspection domain of the Nursing Home Five Star Quality Rating System by holding each facility's health inspection rating constant for approximately one year. During the freeze, inspections conducted after November 28, 2017, are not included in facility's star ratings calculation. This action is part of CMS's implementation of a new inspection process and Phase Two of the revised Requirements for Participation for Long Term Care Facilities. In October 2019, CMS will resume posting the average number of citations per inspection for each state and nationally. CMS is monitoring outcomes of the new inspection process and plans to resume health inspection rating calculations in the spring of 2019. CMS will communicate more details about this prior to its implementation.

June 2018 OIG Updates

National Background Check Program: Assessment of Concluded State Grant Programs in 2017
The Patient Protection and Affordable Care Act (ACA) authorizes CMS to provide grants to States to implement background check programs for prospective employees and providers of long-term-care services. The ACA requires the OIG to evaluate this grant program, known as the National Background Check Program, after its completion. For States that closed their grants in the preceding year, The OIG will review the procedures States implemented for long-term care facilities and providers to conduct background checks on prospective employees who would have direct access to patients. The OIG will determine the outcomes of the States' programs and whether the checks led to any unintended consequences.

Inappropriate Denial of Services and Payment in Medicare Advantage
Capitated payment models are based on payment per person rather than payment per service provided. A central concern about the capitated payment model used in Medicare Advantage is the incentive to inappropriately deny access to, or reimbursement for, health care services in an attempt to increase profits for managed care plans. The OIG will conduct medical record reviews to determine the extent to which beneficiaries and providers were denied preauthorization or payment for medically necessary services covered by Medicare. To the extent possible, we will determine the reasons for any inappropriate denials and the types of services involved.

Accountable Care Organizations' Strategies Aimed at Reducing Spending and Improving Quality
The Medicare Shared Savings Program (MSSP) introduced

accountable care organizations (ACOs) into the Medicare Program to promote accountability of hospitals, physicians, and other providers for a patient population; coordinate items and services; encourage investment in infrastructure; and redesign care processes for high-quality and efficient service delivery. The OIG will identify ACOs' strategies aimed at reducing spending and improving quality. Specifically, the OIG will describe ACOs' strategies intended to reduce spending and improve care in different service areas, such as hospitals and nursing homes. The OIG will also describe strategies ACOs are using to work with physicians and engage beneficiaries; manage the care of beneficiaries needing high-cost, complex care; address behavioral health and social needs; and use data and technology.

State and Territory Response and Recovery Activities for the 2017 Hurricanes

The OIG will conduct reviews of selected States' and one territory's hurricane preparedness and response activities to provide the necessary resources to ensure the safety of HHS beneficiaries affected by the 2017 Hurricanes Harvey, Irma, and Maria. The OIG will determine the extent to which State and territory emergency preparedness plans included necessary activities to enhance ongoing response and recovery operations and strengthen public health and medical response capabilities. The OIG will also assess the effectiveness of State and territory implementation of emergency preparedness response and recovery activities related to the 2017 Hurricane.

CMS Launches Data Element Library

The CMS Data Element Library (DEL) is the centralized resource for CMS assessment instrument data elements (e.g. questions and responses) and their associated health information technology (IT) standards.

The mission of the Data Element Library (DEL) is to create a comprehensive, electronic, distributable, and centralized resource of CMS assessment instrument content.

In support of the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act), the goals of the DEL are to:

- Serve as a centralized resource for CMS assessment data elements (questions and response options)
- Promote the sharing of electronic CMS assessment data sets and health information technology standards;
- Influence and support industry efforts to promote Electronic Health Record (EHR) and other health IT interoperability

The DEL will initially contain data elements from the patient assessment instruments for the following PAC settings:

- Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
- Long-Term Care Hospital Continuity Assessment Record & Evaluation (CARE) Data Set (LCDS)
- Resident Assessment Instrument (RAI) Minimum Data Set (MDS)
- Outcome and Assessment Information Set (OASIS)
- Hospice Item Set (HIS)
- Functional Assessment Standardized Items (FASI) (In Progress)

Through the DEL application, providers, vendors, researchers, and other stakeholders will be able search the database and generate reports on CMS assessment contents, including questions, response options, relevant details, and their associated health IT standards, in one location.

The DEL does not contain any patient-level data. The DEL is limited to CMS assessment questions and response options, as well as their associated attributes including the assessment version, item labels, item status, copyright information, CMS item usage, skip pattern information, look-back periods, and related health IT standards.

CMS anticipates that the DEL will make it easier for IT vendors to incorporate data elements adopted by CMS into provider EHRs, thereby reducing burden, improving interoperable data exchange, and facilitating care coordination.

In addition, the DEL provides a centralized location for providers, states, researchers, or others to obtain the most up to date information on CMS assessment content.

The CMS Data Element Library may be viewed: https://DEL.cms.gov

Deadline to Contest Inaccuracies in SNF QRP QM Provider Preview Reports

Providers have until June 30, 2018 to review their performance data prior to public display on the Nursing Home Compare site. Corrections to the underlying data will not be permitted during this time. However, providers can request a CMS review during the preview period if they believe their data scores displayed are inaccurate.

The SNF Provider Preview Report includes performance data on the following quality measures based on the subsequent Quarterly data:

Quarter 1 – 2017 to Quarter 4 – 2017 data
- Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (#0674)

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- Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)
- Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (#2631).

Quarter 4 – 2016 to Quarter 3 – 2017 data

- Medicare Spending Per Beneficiary – Post-Acute Care (PAC) Skilled Nursing Facility Measure
- Discharge to Community- Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

Quarter 4 – 2015 to Quarter 3 – 2017 data

- Potentially Preventable 30-Days Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

**Polaris Group Solution Center
Hotline Q&A
"Where No Question Goes Unanswered!"**

Question:
If a resident has a Deep Tissue Injury should I code M0210 (Does this resident have one or more unhealed pressure ulcers at stage 1 or higher) a yes or no?

Answer:
Yes. According to the RAI direction for M0210 if the resident had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period the MDS Coordinator should code a yes.

Question:
If a new resident is admitted from an ER would you code them under Section A1800 admitted from acute hospital or would it be coded from the community?

Answer:
Code acute hospital. The RAI says under acute hospital: Code 03, acute hospital: if the resident was admitted from an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.

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August 21-23 Las Vegas, NV
October 16-18 Orlando, FL

SNF Medicare & PPS Compliance
November 13-15 New Orleans, LA

SNF Billing Training
September 18-20 Dallas/Ft. Worth, TX

For more information, please contact your Polaris Group representative.