Technical Expert Panel (TEP) for the Measurement Gaps and Measure Development Priorities for the Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) Program

March 9, 2022

Summary Report

December 2022

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Contents

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1 INTRODUCTION

Section 215 of the *Protecting Access to Medicare Act of 2014* (PAMA) added sections 1888(g) and (h) to *the Social Security Act*, requiring the Secretary to establish a Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) program: a CMS program that applies payment adjustments for SNFs through incentive payments or penalties based on the quality of care a facility provides to Medicare beneficiaries.[1] Section 111 of the *Consolidated Appropriations Act, 2021* (CAA) amendment to Section 1888(h) of the SSA allowed the Secretary to apply nine additional measures to the SNF VBP program for payments for services furnished on or after October 1, 2023.[2] The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC (hereafter referred to as Acumen) to expand the Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) program. The contract name is "*Quality Measure & Assessment Instrument Development & Maintenance & QRP Support for the Long Term Care Hospital, Inpatient Rehabilitation Facility, Skilled Nursing Facility, Quality Reporting Programs, & Nursing Home Compare*." The contract number is 75FCMC18D0015, Task Order 75FCMC19F0003.

This report provides a summary of the feedback shared by panelists during the March 9, 2022 Technical Expert Panel (TEP) meeting, which focused on the identification of measurement gaps and measure development priorities for the SNF VBP Program. The remainder of Section 1 briefly introduces the SNF VBP Program (Section 1.1) and the panel composition (Section 1.2). Section 2 outlines the structure of the TEP meeting and supplemental materials. Section 3 summarizes the meetings that occurred prior to the TEP meeting, including the Patient and Family Engagement (PFE) focus group held on February 22, 2022 and TEP orientation meeting held on February 25, 2022. Section 4 summarizes the presentation, panelist discussion, and key findings for each session within the March 9, 2022 TEP meeting. Finally, Section 5 outlines the next steps for this project based on TEP feedback.

1.1 Project Context

Under the aforementioned contract, Acumen has an ongoing project to support CMS in the development and maintenance of quality and cost measures for Post-Acute Care (PAC) settings. Within PAC, the SNF VBP Program aims to improve care in the SNF setting by rewarding or penalizing SNFs via payment adjustments, based on their performance. The current SNF VBP Program assesses facility performance based on one hospital readmission measure, which started affecting payments as of October 1, 2018. There is potential for improving the

[1] U.S. Congress, House, *Protecting Access to Medicare Act, 2014*, H.R.4302, 113th Cong., introduced in the House March 26, 2014, https://www.congress.gov/bill/113th-congress/house-bill/4302/text.
[2] U.S. Congress, House, *Consolidated Appropriations Act, 2021*, H.R.133, 116th Cong., introduced in the House January 3, 2019, https://www.congress.gov/bill/116th-congress/house-bill/133/text.

SNF VBP Program by expanding from a single measure to a more diverse measure set covering several quality domains. CMS is investigating measures for use in the SNF VBP Program to affect Medicare fee-for-service (FFS) claims paid under the SNF Prospective Payment System (PPS) starting October 1, 2023. To ensure measures meet CMS program requirements and goals while maintaining high levels of scientific acceptability, Acumen convened a TEP and sought guidance on the current SNF VBP Program's measurement gaps and priorities for measure development.

1.2 TEP Panelists

The SNF VBP Measurement Gaps and Measure Development Priorities TEP comprised 15 stakeholders with diverse perspectives and areas of expertise, as shown in Table 1-1. The panelists included stakeholders representing clinical, policy and program, measure development, and technical expertise.

Table 1-1. TEP Membership List[3]

Name, Credentials, Professional Role	Organizational Affiliation, City, State	Consumer/ Patient/ Family/ Caregiver Perspective	Performance Measurement	Skilled Nursing Facility (SNF)	SNF Value-Based Purchasing (VBP)	Post-Acute Care (PAC) / Long-Term Care (LTC)	Quality Improvement	Conflict of Interest Disclosure
Amy Stewart, MSN, RN, RAC-MT, RAC-MT, DNS-MT, QCP-MT, Vice President of Education and Certification Strategy	American Association of Post-Acute Care Nursing, Ely, MN	-	X	X	X	X	X	None
Andrea Jersey, BSN, RN, RAC-CTA, RAC-CT, CDP, Sr. Director Clinical Reimbursement – SNF Consultant	Ethica, Louisville, GA	-	-	X	X	-	-	None
Brian Isetts, RPh, PhD, BCPS, Geriatric Pharmacist, Professor, Health Policy Analyst, Person & Family Engagement and Quality Improvement Researcher	University of Minnesota College of Pharmacy, Spring Valley Health and Rehabilitation Center, Redwing, MN	X	X	X	-	X	X	None
David Fielding, MPH, BCPA, PFE Focus Group Representative[4]	PFCCpartners, Engage Caring Solutions, Rockville Centre, NY	X	-	-	-	-	-	None

[3] "X" indicates area of expertise, while "-" indicates no data.

[4] Acumen partnered with Patient & Family Centered Care Partners (PFCCpartners) to hold a PFE Focus Group to identify indicators of quality important to SNF residents, family members, and caregivers. Acumen and PFCCpartners then selected two focus group members to participate in the TEP.

Name, Credentials, Professional Role	Organizational Affiliation, City, State	Consumer/ Patient/ Family/ Caregiver Perspective	Performance Measurement	Skilled Nursing Facility (SNF)	SNF Value-Based Purchasing (VBP)	Post-Acute Care (PAC) / Long-Term Care (LTC)	Quality Improvement	Conflict of Interest Disclosure
Dheeraj Mahajan, MD, MBA, MPH, FACP, CIC, CMD, CHCQM, Long-term Care Medical Director, President & CEO, Physician	CIMPAR Consulting, Oak Park, IL	-	X	X	X	X	X	None
Dorothy Winningham, PCA, PFE Focus Group Representative	PFCCpartners, Health Quality Innovators Patient & Family Advisory Council, Warner Robins, GA	X	-	X	-	X	X	None
Jennifer Hefele, PhD, MA, Independent Researcher, Senior Scientist	Booz Allen Hamilton, Brandeis University, UMB Gerontology Institute, Hollis, NH	X	X	X	X	X	-	Dr. Hefele is an employee of Booz Allen, which engages in government contract work not related to the SNF VBP program.
Mark Besch, PT, Caregiver, Physical Therapist	American Physical Therapy Association, Aegis Therapies, Inc., Waunakee, WI	-	X	X	-	X	-	None
Maureen McCarthy, BS, RN, RAC-MT, QCP-MT, DNS-MT, RAC-MTA, Consultant	Celtic Consulting, LLC, Torrington, CT	-	X	X	X	X	X	None

Name, Credentials, Professional Role	Organizational Affiliation, City, State	Consumer/ Patient/ Family/ Caregiver Perspective	Performance Measurement	Skilled Nursing Facility (SNF)	SNF Value-Based Purchasing (VBP)	Post-Acute Care (PAC) / Long-Term Care (LTC)	Quality Improvement	Conflict of Interest Disclosure
Robin Hillier, CPA, LNHA, RAC-MT, Licensed Nursing Home Administrator, Co-Owner of Nursing Home	American Health Care Association and National Center for Assisted Living, Welcome Nursing Home, Westerville, OH	-	X	X	X	X	X	None
Sabrena McCarley, MBA-SL, OTR/L, CLIPP, RAC-CT, QCP, FAOTA, Occupational Therapist, Director of Clinical Reimbursement	National Association of Rehabilitation Providers and Agencies, Napa, CA	-	X	X	X	-	-	None
Stephanie DeWees, BS, HSE, LNHA, LPN, Quality & Regulatory Specialist	Leading Age Ohio, Squared Business Solutions, London, OH	-	X	X	X	X	X	Ms. DeWees provides consulting services to LeadingAge Ohio members as the Quality & Regulatory Specialist and as owner of Squared Business Solutions consulting services.
Terry O'Malley, MD, CMD, Geriatric Physician, Professor	Harvard Medical School, Winchester, MA	-	X	X	-	X	X	None
Toby Edelman, JD, Senior Policy Attorney	Center for Medicare Advocacy, Washington, DC	X	-	X	-	-	-	None

Name, Credentials, Professional Role	Organizational Affiliation, City, State	Consumer/ Patient/ Family/ Caregiver Perspective	Performance Measurement	Skilled Nursing Facility (SNF)	SNF Value-Based Purchasing (VBP)	Post-Acute Care (PAC) / Long-Term Care (LTC)	Quality Improvement	Conflict of Interest Disclosure
Tracy Fritts, PT, MSPT, CEEAA, Vice President of Quality and Outcomes	National Association for the Support of Long Term Care, Consonsus Healthcare, Marquis Companies, Milwaukie, OR	-	X	X	X	X	X	None

2 MEETING OVERVIEW

This section provides an overview of the overall TEP meeting structure and sessions (Section 2.1) and lists the meeting materials provided to the panelists (Section 2.2).

2.1 Structure

The SNF VBP Measurement Gaps and Measure Development Priorities TEP encompassed three separate meetings. First, Acumen partnered with Patient & Family Centered Care Partners (PFCCpartners) to hold a Patient and Family Engagement (PFE) focus group to identify indicators of quality important to SNF residents, family members, and caregivers. Acumen then held a one-hour TEP orientation to provide panelists with an overview of the current SNF VBP Program, measurement gaps, and measure expansion and development efforts. During the four-hour TEP meeting, Acumen sought feedback on a framework for identifying measurement gaps, measures suggested to fill gaps, and alternative data sources. Table 2-1 provides the agenda for the PFE focus group, TEP orientation, and TEP meeting.

Table 2-1. TEP Agenda

Session	Topic	Section
	PFE Focus Group (February 22nd, 2022)	
1-A	PFE Focus Group with PFCCpartners	3.2
	TEP Orientation (February 25th, 2022)	
2-A	Welcome and Introductions	-
2-B	Overview of the SNF VBP Program, Measurement Gaps, and Measure Development	3.1
2-C	Next Steps and Closing Remarks	-
	TEP Meeting (March 9th, 2022)	
3-A	Overview of the SNF VBP Program	-
3-B	Framework for Identifying Measurement Gaps	4.1
3-C	Filling Measurement Gaps	4.2
3-D	Considerations for Alternative Data Sources	4.3
3-E	Wrap Up and Next Steps	-

Acumen presented targeted questions to facilitate the discussion and solicit feedback to inform next steps for the expansion of the SNF VBP Program. Bulleted highlights of those discussions are presented at the end of each section in this report.

2.2 Meeting Materials

Prior to the TEP orientation, panelists reviewed the TEP Charter which outlined the purpose of the TEP and level of commitment expected for participation. The TEP Charter was posted to the CMS.gov *Measures Management System (MMS) Current TEP Opportunities webpage*: https://mmshub.cms.gov/get-involved/technical-expert-panel/current. Acumen also provided panelists with the applicable slide decks in advance of the TEP orientation and meeting. The TEP orientation slide deck provided some resources for panelists to review in preparation for the TEP meeting with additional background on the current SNF VBP Program measurement gaps and measure development efforts:

- CMS SNF VBP Program Website[5]
- Chapter 4 of the June 2021 MedPAC Report to Congress[6]
- 2021-2022 Final MAP Recommendations[7]

The TEP meeting slide deck included a list of references with additional information on the specific measures and data sources introduced in the presentation:

- FY2022 SNF PPS Final Rule[8]
- Measure Specification Documents (Appendix B: Background Materials, Table B-1)
- CMS Measures Inventory Tool (CMIT) Webpages (Table B-2)
- Data Source Websites (Table B-3)
- Journal Articles (Table B-4)

Following the TEP orientation and four-hour meeting, Acumen shared information with panelists regarding patient-reported outcome measures as requested.[9] Specifically, panelists expressed interest in the details of the CoreQ Short Stay Discharge questionnaire[10] and Patient-Reported Outcome Measurement Information System (PROMIS) tool.[11]

[5] CMS. (2022). *The Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program*. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page.
[6] MedPAC. (2021). *Mandated Report: Evaluating the Skilled Nursing Facility Value-Based Purchasing Program*. Chapter 4. https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-default-document-library-jun21_ch4_medpac_report_to_congress_sec-pdf/.
[7] National Quality Forum. (2022) *2021-2022 MAP Final Recommendations*. https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=96698.
[8] 86 FR 42424
[9] CMS Measures Management System. (2021). *CMS MMS Blueprint: Patient Reported Outcome Measures.* https://www.cms.gov/files/document/blueprint-patient-reported-outcome-measures.pdf.
[10] CoreQ. (2019) *What are the Questions?* http://coreq.org/.
[11] HealthMeasures. (2022). *PROMIS.* https://www.healthmeasures.net/index.php?option=com_content&view=category&layout=blog&id=147&Itemid=806.

3 SUMMARY OF PRE-TEP MEETINGS

This section reviews the two meetings held before the SNF VBP Measurement Gaps and Measure Development Priorities TEP meeting. Section 3.1 summarizes Session 2-B, a component of the TEP Orientation held on February 25, 2022, in which Acumen reviewed the TEP logistics and agenda, TEP Charter, and background information on the SNF VBP Program. Section 3.2 summarizes the PFE focus group convened with PFCCpartners on February 22, 2022, which was used to inform subsequent TEP discussions on patient and family perspectives.

3.1 Session 2-B: Overview of the SNF VBP Program, Measurement Gaps, and Measure Development

The one-hour orientation meeting on February 25, 2022 opened with the TEP formally approving the TEP Charter. Acumen then provided panelists with a brief overview of the current SNF VBP Program (Section 3.1.1), measurement gaps (Section 3.1.2), and measure expansion and development efforts (Section 3.1.3) in preparation for the TEP meeting.

3.1.1 Overview of the SNF VBP Program

Section 215 of PAMA added sections 1888(g) and (h) to the SSA, requiring the Secretary to establish a SNF VBP program. The SNF VBP Program is a mandatory program for all SNFs paid under the PPS that applies incentive payments based on the quality of care provided to Medicare beneficiaries. [12] To fund the SNF VBP Program, CMS withholds two percent of all SNF Medicare fee-for-service (FFS) Part A payments. This two percent is referred to as the "withhold." CMS is required to distribute 50 to 70 percent of the withhold annually. Currently, CMS distributes 60 percent of the withhold as payment incentives and retains 40 percent of the withhold as Program savings under the Medicare Trust Fund.[13]

Under the current scoring methodology, SNFs are evaluated relative to each other. CMS calculates a SNF performance score for each facility, taking the highest of either the achievement or improvement score. CMS then uses this performance score to determine payment adjustments to reward or penalize the facility. However, the SNF VBP Program scoring methodology is currently being re-evaluated. Further scoring methodology discussions occurred during the TEP for the *Scoring Methodology for the Expansion of the Skilled Nursing Facility Value-Based Purchasing Program*, convened by CMS, Mathematica, and RTI International on May 19, 2022 under the Division of Value, Incentives, and Quality Reporting (DVIQR) Program Support (DPS) contract.

[12] CMS.gov. (2022). *The Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program.* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page.
[13] 82 FR 36530

The current SNF VBP Program includes a single hospital readmission measure, the *SNF 30-Day All-Cause Readmission Measure* (SNFRM) (NQF #2510),[14] to assess quality as related to payment.[15] CMS plans to replace the SNFRM with the *SNF Potentially Preventable Readmission after Hospital Discharge* measure (SNFPPR) through future rulemaking. While the SNFRM evaluates the risk-standardized rate of unplanned, all-cause hospital readmissions, the SNFPPR measure focuses on potentially preventable hospital readmissions. Additionally, Section 111 of the CAA of 2021 allowed the Secretary to apply nine additional measures to the SNF VBP Program for payments for services furnished on or after October 1, 2023, including those for functional status, patient safety, care coordination, or patient experience. [16]

3.1.2 Overview of Measurement Gaps

The SNF VBP Program has several measurement gaps as it currently only implements one measure assessing hospital readmissions. Although the SNFRM touches on multiple components of care, such as medication management, fall prevention, infection control, skin integrity, and hydration, it falls short of a comprehensive assessment of all domains of the quality of care provided in the SNF.[17] Further, relying on a single measure may encourage providers to focus on aspects of care tied to payment while neglecting others. Lastly, any flaws within the sole measure in a single-measure program are amplified, as that measure is the only determinant of reimbursement.

Medicare FFS payment systems, such as the Prospective Payment System (PPS) for SNFs, can also induce responses by providers that negatively affect quality of care (see 4.1.1). Potential provider responses to the PPS also indicate measurement gaps within the SNF VBP Program. For example, concerns with the SNF PPS resident characteristic-based payment model may influence the reduction of service provisions to reduce costs. The addition of quality measures to the SNF VBP may help to monitor a sufficient and appropriate level of core services being provided against the influence of responses to the payment system.

3.1.3 Overview of Measure Expansion and Development

The Consolidated Appropriations Act (CAA) of 2021 authorized the Secretary to add up to nine additional measures to the SNF VBP program.[18] CMS is considering existing measures and newly developed measures. Four measures were submitted to the SNF VBP 2021 Measures

[14] This measure is NQF-endorsed for use in the SNF setting and finalized for reporting by SNFs under the SNF VBP: 80 FR 46419.
[15] At the time that this TEP took place, the SNF VBP Program only encompassed one quality measures. Three additional measures were finalized into the SNF VBP Program through the FY2023 SNF PPS Final Rule: 87 FR 47502.
[16] U.S. Congress, House, *Consolidated Appropriations Act, 2021*, H.R.133, 116th Cong., introduced in the House January 3, 2019, https://www.congress.gov/bill/116th-congress/house-bill/133/text.
[17] MedPAC. (2021). *Mandated Report: Evaluating the Skilled Nursing Facility Value-Based Purchasing Program*. Chapter 4. https://www.medpac.gov/document/june-2021-report-to-the-congress-medicare-and-the-health-care-delivery-system/.
[18] U.S. Congress, House, *Consolidated Appropriations Act, 2021*, H.R.133, 116th Cong., introduced in the House January 3, 2019, https://www.congress.gov/bill/116th-congress/house-bill/133/text.

Under Consideration (MUC) List, and were discussed during the 2021-2022 Measure Application Partnership (MAP) workgroups.[19] These measures and their MAP recommendations displayed in Table 3-1 below.

Table 3-1. Measures that Underwent Pre-Rulemaking

#	Measure name	Measure description	NQF endorsement	Measure data source	MAP recommendation
1	Skilled Nursing Facility Healthcare-Associated Infections (HAI) Requiring Hospitalization	This measure estimates the risk-standardized rate of HAIs acquired during SNF care and result in hospitalization	Pending initial endorsement submission	Medicare FFS claims	Conditional support for rulemaking
2	Discharge to Community (DTC)	This measure estimates the risk-adjusted rate of successful discharge to community from a SNF, with successful discharge to the community including no unplanned re-hospitalizations and no death in the 31 days following discharge	Endorsed: NQF #3481	Medicare FFS claims	Support for rulemaking
3	Total Nursing Hours per Resident Day	This structural measure uses auditable electronic data reported to CMS's Payroll-Based Journal system to calculate total nursing hours (registered nurse + licensed practical nurse + nurse aide hours) per resident day	Not yet endorsed	Payroll-Based Journal	Conditional support for rulemaking
4	CoreQ Short Stay Discharge	This measure calculates the percentage of individuals discharged in a six-month time period from a SNF, within 100 days of admission, who are satisfied (scoring three or above on the CoreQ patient satisfaction survey)	Endorsed: NQF #2614	CoreQ questionnaire	Support for rulemaking

[19] Following the TEP, the SNF HAI, DTC, and Total Nursing Hours per Resident Day measures were finalized into the SNF VBP Program through the FY2023 SNF PPS Final Rule: 87 FR 47502. The SNF HAI and Total Nursing Hours per Resident Day Staffing measures will be implemented in the Program in FY2026, while DTC will be implemented in FY2027.

3.2 Session 1-A: PFE Focus Group with PFCCpartners

Acumen partnered with PFCCpartners to hold a one-hour and fifteen-minute PFE Focus Group on February 22, 2022 to identify indicators of quality important to SNF residents, family members, and caregivers. PFCCpartners collaborates with healthcare organizations and the public to promote the development of sustainable patient and family engagement structures across the healthcare continuum. Table 3-2 lists the supporting PFCCpartners staff and the assembled focus group members, a mixture of TEP nominees and PFCCpartners Patient Family Advisors Network (PFAnetwork) members.

Table 3-2. Focus Group Members and Supporting Staff

Name	Role
Libby Hoy	PFCCpartners Founder and Chief Executive Officer
Laura Jackson	PFCCpartners Director of Community
Arlene Salamendra	Focus Group Member
David Fielding	Focus Group Member, TEP Participant[20]
Dorothy Winningham	Focus Group Member, TEP Participant
Janice Tufte	Focus Group Member
Phil Posner	Focus Group Member
Rosie Bartel	Focus Group Member

Section 3.2.1 provides details on the PFE focus group discussion, and Section 3.2.2 lists the key findings from this discussion that were used to inform subsequent TEP discussions on patient and family perspectives.

3.2.1 Focus Group Discussion

PFCCpartners and Acumen posed a series of four questions to the PFE focus group, with a short discussion after each.

1. *What is important to you when choosing a skilled nursing facility for you or a family member to receive care from?*

PFE focus group members identified a range of criteria for evaluating and selecting a SNF to receive care from. Focus group members first consider impressions during initial phone calls and facility visits. Characteristics that members notice in these first moments include the facility's location, accessibility, maintenance, and safety. Additionally, focus group members consider the quality of interactions between staff/administrators and residents, family, and caregivers. For example, they consider whether staff express compassion and respect towards residents or recognize if residents seem neglected and over-crowded. Members emphasized the

[20] After the PFE Focus Group held on February 22, 2022, Acumen and PFCCpartners selected two focus group members to attend the TEP Orientation on February 25, 2022 and participate in the TEP Meeting discussions on March 9, 2022: David Fielding and Dorothy Winningham.

importance of the number, quality, and morale of staff. Beyond these first impressions, members consider the services a SNF provides in terms of cost and affordability, culturally appropriate accommodations, and specialty programs (e.g., ventilator-dependent care or dementia care). Members also review the SNF's Five-Star Ratings, although they noted that these metrics are often difficult for family members to understand.

2. *What criteria are important to you when evaluating the quality of care that you or a family member receives during a stay at a skilled nursing facility?*

Focus group members expanded on a few criteria introduced in response to the first question, including potential publicly reported metrics to evaluate staffing and specialty programs. One focus group member suggested consideration of a measure of staffing ratios per shift on weekdays and weekends by education level to disincentivize facilities from "short-staffing" and ensure the care needs of all residents are met. This focus group member also expressed support for a staff turnover measure as it can be indicative of the quality of facility leadership. Another focus group member recommended the development of measures to assess the quality of specialty programs beyond availability, for example, considering ventilator-associated pneumonia (VAP) rates, other infection rates, weaning rates, and the percentage of residents receiving specialty services that are discharged.

Focus group members also introduced additional criteria for evaluating the quality of care received during a stay at a SNF, including adherence to infection prevention and control protocol and avenues for capturing the resident's voice. Focus group members highlighted the role of family members and caregivers to identify infections, poor management of infections, and lack of staff adherence to health and safety protocols (e.g., hand hygiene, use of gowns and masks). Further, since visitation has been limited during the COVID-19 Public Health Emergency (PHE), focus group members emphasized the importance of facility leadership to hold their staff to high standards of care. Focus group members also valued structures for collecting resident, family member, and caregiver feedback on the delivery of SNF services (e.g., responsiveness to call bells, food quality, and activity options). These platforms may include publicly reported patient satisfaction surveys.

3. *What are some important criteria, when evaluating the quality of care that you or a family member received, that may not be apparent until after discharge from the skilled nursing facility?*

Focus group member responses primarily centered around communication, specifically the sharing of information with family members and caregivers throughout the course of the stay. Many focus group members acknowledged that the delayed sharing or omission of information regarding the details and extent of a resident's condition on admission; the goals of the SNF stay; any changes to the resident's condition, care, or behavior during the stay (e.g., room placement,

medication management, weight loss, compliance to rehabilitation exercises, falls, restraint use, emergency room visits, re-hospitalizations); and resident care needs at discharge may not be apparent until after discharge.

In turn, focus group members provided some suggestions to facilitate transparency and collaboration among staff, administrators, residents, family members, and caregivers. Focus group members recommended the collection of metrics to monitor what occurred during the stay, both at the resident-level (e.g., reason for admission, daily services, negative health events, improvement at discharge, length of stay) and facility-level (e.g., policies, changes in staffing, resident room changes). These metrics could be documented in electronic health record (EHR) systems, similar to MyChart, where family members may access the information from the resident and family portal. Focus group members also emphasized the importance of family members requesting care plan meetings, care navigators, and copies of a resident's records.

4. *Which outcome(s) do you think are the most important for patients to report to skilled nursing facilities and/or CMS to evaluate quality of care?*

   CMS defines a patient-reported outcome as any report of the status of a patient's health condition or health behavior that comes directly from the patient, without interpretations of the patient's response by a clinician or anyone else.

Focus group members provided suggestions for measurement areas to include in publicly reported surveys that capture the resident, family member, and caregiver voice. Focus group members recommended the inclusion of items related to pressure ulcers, wounds, and infections (e.g., Clostridium difficile (C. diff), methicillin-resistant staphylococcus aureus (MRSA), carbapenem-resistant enterobacteriaceae (CRE)). One focus group member suggested that these surveys include items for resident comfort and pain levels. A few focus group members recommended the inclusion of items to assess effective and frequent communication across staff teams as well as between staff and residents, family, and caregivers.

However, focus group members also acknowledged concerns with a lack of accountability and follow-up by facilities as well as retaliation by staff towards residents as a result of the feedback collected in patient-reported surveys. In turn, focus group members supported the establishment of an independent family council to manage these implications and enforce change.

3.2.2 Key Findings

- A recurring criterion for evaluating the quality of a SNF included the assessment of staff and administrator engagement and compassion with residents, family members, and caregivers in daily interactions, care planning, and care transitions.

- Focus group members also emphasized the need for other staffing metrics, such as staff-to-resident ratios per shift by education level, staff turnover rates, and staff adherence to facility protocols.
- Additional areas highlighted for measurement included cost, quality of specialty programs, rates of negative health events (e.g., infection, falls, emergency department visits, and re-hospitalizations), patient satisfaction, and improvement at discharge.

4 SUMMARY OF THE TEP PRESENTATION AND DISCUSSION

This section summarizes feedback shared by TEP panelists during the TEP meeting on March 9, 2022 and is organized into three subsections. Section 4.1 explores an Acumen-developed framework for identifying measurement gaps within the current[21] SNF VBP Program, Section 4.2 summarizes various measures and approaches to fill the Program's measurement gaps, and Section 4.3 delves into data source options for potential SNF VBP measures. Each subsection summarizes the material presented to the TEP, discussions among TEP panelists in response to the material presented and guiding questions, and the key findings from the discussion.

4.1 Session 3-B: Framework for Identifying Measurement Gaps

Acumen presented a framework for identifying measurement gaps to the TEP (Section 4.1.1). Panelists offered their feedback and suggestions to this framework and to guiding questions that Acumen posed (0), from which Acumen extracted key findings from the discussion (Section 4.1.3).

4.1.1 Summary of Presentation

Acumen presented a conceptual framework for identifying measurement gaps within the current SNF VBP Program. To view a visual application of this framework, refer to Appendix C:. The five core principles encompassing this framework are listed below:

- **Principle 1:** The measure set should include the smallest number of measures that comprehensively assess the value of all services expected from SNF providers. Potential measures should comprehensively assess SNF core services while limiting duplication of measure concepts. Examples of SNF core services include (i) comprehensive assessment and planning, (ii) nursing services, (iii) physical therapy (PT), (iv) occupational therapy (OT), (v) speech-language pathology (SLP), (vi) medication management (oral and intravenous), (vii) skin/wound care, and (viii) respiratory care.
- **Principle 2:** Cost measurement should be a major component of VBP programs, and integration of complementary quality measures may assess important health care outcomes not included in cost measures. Value may be measured as cost relative to quality. Therefore, the SNF VBP measure set should address both cost and quality.
- **Principle 3:** The measure set should meet priorities laid out in CMS's Meaningful Measures Initiative 2.0, which prioritizes outcome and patient-reported measures.[22] The Meaningful Measures Initiative 2.0 aims to build value-based care through several domains of care, such as (i) person-centered care, (ii) safety, (iii) chronic conditions, (iv)

[21] Refers to the SNF VBP Program as of March 9, 2022
[22] CMS. (2022, June 17). *Meaningful Measures 2.0: Moving from Measure Reduction to Modernization*. https://www.cms.gov/medicare/meaningful-measures-framework/meaningful-measures-20-moving-measure-reduction-modernization.

seamless care coordination, (v) equity, (vi) affordability and efficiency, (vii) wellness and prevention, (viii) behavioral health, and (ix) consumer and caregiver voice. SNF VBP-associated measures, which either exist in the current Program or have completed CMS pre-rulemaking processes as of March 2022, reflect Meaningful Measure domains as outlined in Table 4-1.

- **Principle 4:** The measure set should incorporate patient and caregiver perspectives, as summarized in Section 3.2.
- **Principle 5:** The measure set should prioritize measures that focus on quality areas most likely to be affected by potential provider responses to the SNF Prospective Payment System (PPS). Payment systems and VBP Programs play complementary roles. Medicare FFS payment systems are designed to ensure payment accuracy (i.e., payments should reflect average cost of care), while VBP Programs are designed to reward high value care. However, any payment system has the potential to induce potential response from providers that can affect value of care. Examples of provider responses to SNF PPS are listed below:
    - Insufficient service provision due to resident characteristics-based payment system: Most Medicare Prospective Payment Systems pay a prospective amount to cover care, with direct reimbursement of services occurring rarely. In 2019, the SNF PPS began basing payment on resident characteristics rather than service provisions. However, this focus on resident characteristics may influence SNFs to provide insufficient services, such as reduced therapy, which has the potential to adversely impact health outcomes (e.g., reduce patient function, increase falls and pressure ulcers, etc.). An analysis comparing FY2020 service provision to that of FY2018 found that patients admitted in FY2020 received less therapy minutes on 5-day assessments than those admitted in FY2018, when therapy minutes affected reimbursement.[23] Measures of functional status, falls, skin integrity, infection control, emergency department visits, discharge to community, and/or of hospital readmissions should be considered for SNF VBP Program adoption as they may mitigate the insufficient service provision provider response to the SNF payment system.
    - Untimely care planning due to reduced assessment frequency: The current SNF payment system reduces SNFs' administrative burden by simplifying the PPS assessment schedule. For example, Interim Payment Assessment (IPA) is an optional assessment that may be completed by providers to report a change in the resident's Patient-Driven Payment Model (PDPM) classification. In FY2020, less than 5% of stays submitted an IPA. However, provider response to reduced assessment frequency may influence the development of untimely care plans for residents. Adverse health outcomes resulting from an untimely care plan include delayed detection of falls, increased emergency department visits and hospitalization, insufficient or delayed wound and respiratory care, increased use

[23] Kane, J. (2021, September 13-15). *LTCH 2021 Virtual Symposium-Patient Driven Payment Model: Understanding the Impacts.* https://www.simpleltc.com/wp-content/uploads/2021/09/18.-LTC-Virtual-Symposium-Speaker_Kane.pdf.

of restraints, and increased feelings of patient neglect. Measures of functional status, falls, emergency department visits, discharge to community, hospital readmissions, healthcare-associated infections, and patient reported outcomes should be considered for SNF VBP Program adoption as they may mitigate the untimely care plan provider response to the reduced assessment frequency component of SNF PPS.

- Premature discharges due to variable per diem payment schedule: Shortened lengths of stay are a historic concern across Medicare payment systems for institutional settings. The current SNF payment model includes a "Variable Per Diem (VPD) adjustment" that adjusts the per diem rate over the course of the stay to track costs of care. The decreasing nature of payment could result in increases in early discharge. Premature discharges can lead to an increase in hospitalization and emergency department visits. Measures of successful discharge to community, potentially preventable readmissions, healthcare-associated infections, and patient satisfaction at discharge should be considered for SNF VBP Program adoption as they may mitigate premature discharges resulting from SNF PPS's VPD adjustment.
- Delayed SNF readmissions due to interrupted stay policy: An "interrupted" SNF stay is defined as a stay in which a patient is discharged from Part A covered SNF care and is subsequently readmitted to Part A covered SNF care in the same SNF during the three-day interruption window. The subsequent stay is considered a continuation of the previous "interrupted" stay for the purposes of both the variable per diem schedule and the assessment schedule. The three-day interrupted stay policy may influence providers to delay SNF readmission to day four or later to reset the variable per diem schedule in an effort to receive higher payments. However, delayed readmission may result in adverse outcomes for residents and increase healthcare resource use. Measures of resource use (such as *Medicare Spending per Beneficiary* or a more narrowly focused episode-based resource use measure), patient experience, and emergency department visits should be considered for SNF VBP Program adoption as they may mitigate the effects of delayed readmissions due to the SNF PPS interrupted stay policy.
- Increased antidepressant reporting due to nursing payment component: Nursing is an essential payment component under the current SNF PPS. Beginning October 2019, the SNF PPS payment model started using extensive services, clinical conditions, depressive symptoms, function, and restorative nursing services to group patients into 25 nursing case-mix groups. However, reporting of these nursing payment items has changed over time, with the percentage of stays with depression increasing ~5% beginning October 2019.[24] Historically, there has been concern regarding upcoding in Medicare Prospective Payment Systems and Medicare Advantage. Similar to other prospective payment systems, SNF PPS ties payment to resident characteristics, such as depression. However, payment

[24] Kane, J. (2021, September 13-15). *LTCH 2021 Virtual Symposium-Patient Driven Payment Model: Understanding the Impacts.* https://www.simpleltc.com/wp-content/uploads/2021/09/18.-LTC-Virtual-Symposium-Speaker_Kane.pdf.

systems focus on resident characteristics may influence upcoding of certain conditions. Measures of antidepressant use or patient experience should be considered for SNF VBP Program adoption to mitigate the effects of upcoding or increased condition reporting due to a resident characteristic-based payment system.

Principles 1 through 5 constitute the framework with the conditions a measure set should satisfy. As such, the framework can be operationalized to identify where a measure is necessary in SNF VBP but where one does not currently exist. SNF VBP can create new measures, use existing measures, or re-work existing measures to fill measurement gaps within the Program. Refer to Appendix C: for a list of measures that may be suited to fill measurement gaps within the Program based on Principle 1 through 5.

Table 4-1. SNF VBP- Associated Measures by Meaningful Measures Initiative Domain[25]

SNF VBP-Associated Measures	Meaningful Measures Initiative Domain	Measure Type
Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	Seamless Care Coordination	Outcome
Skilled Nursing Facility Potentially Preventable Readmission After Hospital Discharge (SNFPPR)	Seamless Care Coordination	Outcome
Discharge to Community (DTC) – Post Acute Care (PAC) Measure for Skilled Nursing Facilities	Seamless Care Coordination	Outcome
Skilled Nursing Facility Healthcare-Associated Infections (HAI) Requiring Hospitalization	Safety	Outcome
CoreQ: Short Stay Discharge Measure	Person-Centered Care	Patient-Reported Outcome Measure
Total Nursing Hours per Resident Day Payroll-Based Journal (PBJ)	Person-Centered Care	Structural

4.1.2 Panelist Discussion

Acumen posed three questions to the TEP to welcome discussion for identifying measurement gaps within the current SNF VBP Program.

1. *Are there any additional principles that should be incorporated into the conceptual framework? If so, how could these additions shape SNF VBP?*

Panelists discussed aspects of SNF quality of care that the aforementioned principles do not completely capture, such as patient-centered care, equity, and balancing cost and quality.

[25] Table 4-1 lists SNF VBP-associated measures as of March 9, 2022

Panelists highlighted that some of the Meaningful Measures Initiative 2.0 domains deserve a more prominent role in the framework. Three panelists recommended prioritizing patient perspectives beyond mention in Principle 3 and Principle 4. One panelist suggested the provision of real-time patient and caregiver surveys to improve the accuracy of feedback. Another panelist recommended measuring the ability of a SNF to meet a resident's specific needs. The third panelist noted the importance of capturing resident quality of life. Several panelists recommended elevating health equity as a primary consideration, rather than a sub-point within Principle 3. Finally, one panelist mentioned that cost and quality are both important, and that low cost should not be conflated with high quality. This panelist recommended that an individual measure should contain both components of quality and of cost, so as to not overvalue cost savings at the expense of quality of care.

Panelists also generally supported the addition of a staffing component to the framework. One panelist recommended measuring staff satisfaction along with patient/family/caregiver satisfaction to incentivize management to treat staff well and promote continuity of care. In addition, two panelists stressed the importance of evaluating characteristics of all facility staff, including availability of shifts, expertise, and quality of interactions with residents. One of these panelists noted that contracted staff should be included in staffing measures for consistency with hospital staffing measures. One panelist recommended that a staffing measure must directly correlate to the value of care.

2. *Should any of Principles 1-5 be changed or removed? If so, why?*

In alignment with Principle 1, one panelist recommended a method for reducing the number of overlapping measures that may be considered for Program adoption. This panelist proposed for CMS to assess correlations between potential measures. In cases where potential measures are highly correlated, CMS may select the most relevant measure for Program consideration. Another panelist agreed with a data-driven approach and recommended utilizing an evidence-based method to select measures for the SNF VBP Program.

Additional panelists noted that the measure set should avoid strictly evaluating improvement in patient condition from admission to discharge in residents. One panelist stressed that measures in the SNF VBP Program should also evaluate maintenance of function and the prevention of deterioration. Another panelist advised against creating expectations of linear rehabilitation processes, which may lead to fraud in reporting.

3. *Are there specific ways in which the design of the SNF VBP measurement set can best align with other Medicare VBP programs?*

Panelists offered recommendations for the alignment of the SNF VBP Program measure set with other Medicare VBP programs. One panelist emphasized the importance of capturing

shared responsibility across settings and providers during an episode of care. This panelist suggested grouping measure performance for a resident's common episode of care across providers of different settings. Providers would then share rewards and penalties, which could incentivize improved care coordination, information-sharing, and prioritization of the patient's needs. Panelists noted that care coordination may be captured in re-hospitalization and/or total cost measures. One other panelist recommended greater integration of the clinician-level measures in Merit Based Incentive Payments Systems (MIPS) and Alternative Payment Models (APMs) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) with the potential SNF VBP facility-level measures to promote collaboration. Additionally, two panelists voiced their support for all-payer measures that would balance care stinting and providing more care than is necessary.

Finally, one panelist suggested general considerations for the design of the SNF VBP measure set. This panelist recommended incorporation of managed care into SNF VBP measurement to account for the lack of control that SNFs often experience when care plan decisions are made based on costs of services rather than patient conditions. The panelist also recommended the addition of a measure that evaluates downstream spending and over-coding at the next facility a resident receives care from (e.g., home health) if applicable.

4.1.3 Key Findings

- Panelists expressed general support for this framework with several suggestions. Panelists recommended the frameworks' prioritization of health equity approaches and patient perspectives. Panelists also recommended that the Program captures resident quality of life, staffing (i.e., availability of shifts, staff expertise, quality of staff and resident interactions), maintenance of function, and prevention and deterioration.
- Additional recommendations include the Program's avoidance of measures that overlap in concept, evaluation of SNF improvement in patient condition from admission to discharge, and creation of expectations for linear rehabilitation processes.
- Lastly, panelists recommended the Program aligns with other VBP Programs, emphasizes integration and collaboration with MIPS measures, and incorporates aspects of managed care.

4.2 Session 3-C: Filling Measurement Gaps

During this session, Acumen presented and solicited feedback on five existing measure concepts for SNF VBP consideration (Sections 4.1.1 through 4.2.5). The session concluded with a discussion of the operationalization of Principle 1 from the framework presented in Section 4.1 and consideration of a request for information (Section 4.2.6), and a discussion of strategies for health equity inclusion in the SNF VBP measurement set (Section 4.2.7).

4.2.1 Medicare Spending per Beneficiary

Acumen presented the existing *Medicare Spending per Beneficiary* (MSPB) measure for possible inclusion in the SNF VBP measure set.

Summary of Presentation

The MSPB measure exists in several quality reporting programs (QRPs), including the SNF QRP, and is recommended for SNF VBP Program adoption by MedPAC. This measure utilizes Medicare FFS claims to assesses the cost to Medicare for services provided by SNFs and other providers during a SNF Part A stay and 30 days post-discharge. MSPB is NQF-endorsed for the inpatient rehabilitation facility (IRF) (#3561), long-term care hospital (LTCH) (#3562), and hospital (#2158) settings. This measure satisfies all five principles from the measurement gaps framework, as it captures several SNF core services, assesses cost and efficiency, emphasizes affordability and care coordination, and accounts for inadequate care provision as a response to the SNF PPS.

Adoption of this measure would fill an important resource use gap within the current SNF VBP Program. MSPB is a cost measure with aspects of quality influencing the measure score, such as re-hospitalizations and the intensity of subsequent PAC care. Additionally, the MSPB measure includes costs of health outcomes associated with downstream providers in an episode of care, as referenced by panelists in the framework discussion (0). The measure also has the potential to serve as a proxy for a SNF's ability to accurately determine the appropriate type and intensity of services, as well as their coordination and timing. Finally, the measure identifies providers with low cost but who also deliver low-quality care, and thus avoids conflation of cost with quality.

Panelist Discussion

1. *Given the cost and resource use measurement gap within the current SNF VBP Program, what are the advantages and disadvantages of including the existing MSPB-PAC for Skilled Nursing Facilities measure in the SNF VBP Program?*

Panelists expressed various suggestions for improvement of the MSPB measure. One panelist noted that the measure's NQF endorsement for other settings is an advantage, while another panelist was concerned with the lack of endorsement for the SNF setting. Another panelist expressed concern over potential overlap between MSPB with SNFRM and recommended for SNF VBP measures to capture different domains of care. Another panelist felt that the measure does not align with CMS's Meaningful Measures Initiative 2.0's prioritization of outcome measures and patient-reported measures, as it is a cost measure. Another panelist suggested incorporation of the costs for pharmaceutical services, drugs, and medication management into the measure. Two panelists were concerned with the 30-day post discharge

period, as a non-Medicare-covered portion of a stay can last much longer than 30 days and as it ignores the possibility that further skilled care for a resident may occur at the same facility.

Two panelists spoke on the downstream and cross-setting aspect of the measure. One appreciated that the measure assesses downstream spenders compared to what is in the control of the SNF. This participant also encouraged CMS to assess how Accountable Care Organizations (ACOs) may influence an MSPB measure. Another panelist recommended that the measure account for facilities with limited resources. Additionally, two panelists raised the question of expanding this measure to represent all-payers.

Panelists further debated the merits of the data source for the MSPB measure. One panelist noted that while claims data is available with no additional burden to the provider, the measure is only a proxy for value of care and while it may be driven by quality variation, it does not evaluate quality directly. Three other panelists agreed and were concerned that adoption of the MSPB measure may incentivize providers to prioritize efficiency over patient-satisfaction.

Key Findings

- Panelists appreciated the measure's assessment of downstream spenders, and the measure's NQF endorsement for other PAC settings.
- Panelists expressed concerns regarding the measure's lack of NQF endorsement for the SNF setting, misalignment with CMS's Meaningful Measure Initiative 2.0 as it is neither an outcome measure nor a patient-reported outcome measure, potential to incentivize providers to prioritize efficiency over patient satisfaction, confusion surrounding the 30-day post discharge period, ability to evaluate quality directly, and potential overlap with other quality measures.

4.2.2 Falls

Acumen presented a falls measure concept for SNF VBP Program consideration.

Summary of Presentation

Falls are a common event in SNFs, however injurious falls are largely preventable. Injurious falls are one of the leading causes of disability and death in nursing home residents, and account for a significant portion of medical expenses among the elderly.[26] A falls measure should be considered for SNF VBP Program adoption as it may capture several quality domains, including medication management, staff levels and staff competency, adherence to safety guidelines, and adequacy of facility equipment. Additionally, a falls measure satisfies Principles 1, 3, 4, and 5 from the measurement gaps framework presented in Section 4.1, as it captures SNF core services, fulfills the safety Meaningful Measure 2.0 domain, addresses

[26] 80 FR 46440

patient/family/caregiver concerns (Section 3.2.1), and assesses potential responses to the SNF PPS such as insufficient service provision or untimely care plans.

Occurrence of falls may be measured in several ways. Measures for SNF VBP consideration may assess the percent of residents experiencing (i) general falls, (ii) falls with major injury, or (iii) falls with injury. The existing *Prevalence of Falls (Long Stay)* measure, within the Nursing Home Quality Initiative (NHQI), assesses all falls that occurred during an episode of care regardless of whether or not the fall resulted in injury.[27,28] Additionally, both the NHQI and SNF QRP programs measure falls with major injury through respective use of the *Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)* and the *Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)* measures.[29,30] The NHQI and SNF QRP falls measures utilize the Minimum Data Set (MDS) 3.0 as a data source, which has been shown to underreport falls.[31] Lastly, the Hospital Inpatient Quality Reporting program houses an inactive *Falls with Injury* measure which captures all injurious falls rather than only those that resulted in major injury.[32,33]

Panelist Discussion

2. *Given the current falls measurement gap within the current SNF VBP Program, what are the advantages and disadvantages of including a falls with major injury, falls with injury, or all-encompassing falls measure in the SNF VBP Program?*

Panelists debated the merits of a general falls measure as compared to one tied to injury. Most panelists supported a falls with major injury measure in comparison to a general falls measure or a falls with injury measure. Three panelists supported the former while one supported a more general falls measure. One panelist noted that it is common for events to be labeled as a fall due to the broad "changing of planes" fall definition in the Resident Assessment Instrument (RAI) manual. Residents may decide to behave in a way that changes a plane, for example sitting down. Therefore, this panelist supported adoption of a falls with major injury measure rather than a more general falls measure. This panelist also noted that a falls with major injury measure may better capture the quality of facilities care plans as well as resident pain. Another panelist

[27] Prevalence of Falls reports the percentage of long-stay residents who have had an MDS-documented fall during their stay.
[28] CMS. (2022). *MDS 3.0 Quality Measures User's Manual v15.0*. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.
[29] Falls with Major Injury reports the percentage of residents who have experienced one or more MDS-documented falls with major injury (defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma).
[30] CMS. (2022). *MDS 3.0 Quality Measures User's Manual v15.0*. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.
[31] MedPAC. (2021). *Mandated Report: Evaluating the Skilled Nursing Facility Value-Based Purchasing Program*. Chapter 4. https://www.medpac.gov/document/june-2021-report-to-the-congress-medicare-and-the-health-care-delivery-system/.
[32] Falls with Injury captures all documented patient falls with an injury level of minor or greater and is reported as such falls per 1000 Patient Days.
[33] National Quality Forum. (2011). *Falls with Injury*. https://www.qualityforum.org/QPS/0202.

conditionally supported the *Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)* measure for SNF VBP consideration as it is NQF endorsed in the nursing home setting. However, this panelist also raised the concern that long-stay measures are not suitable for a Medicare Part A reimbursement program

Panelists provided general feedback for the consideration of falls measures. One panelist recommended the inclusion of an investigation into drug-related causes of falls whenever one occurs, and added that many classes of drugs can have this effect beyond opioids and psychotropic medications. Another panelist suggested the use of a patient satisfaction survey to provide greater insight into fall events. Lastly, one panelist recommended utilizing a proxy measure to capture the downstream effects of a fall instead of measuring falls directly, since falls appear to be reported at similarly low rates across SNFs. The panelist noted that this is indicative of flawed measurement through the MDS.

Key Findings

- Panelists largely supported consideration of a falls with major injury measure in comparison to a general falls measure or a falls with injury measure for several reasons such as, (i) the broad definition of falls and (ii) noting the NQF endorsement of the *Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)* in the NHQI program.
- One panelist raised the concern that long-stay measures are not suitable for a Medicare Part A reimbursement program.
- Panelists recommended investigations of drug-related fall causes, and utilization of patient satisfaction surveys to provide greater insight to fall events.
- Panelists were also concerned with use of the MDS as a data source for a falls measure.

4.2.3 Function Measure(s)

Acumen presented four existing SNF QRP Functional Outcome Measures for SNF VBP consideration.

Summary of Presentation

The following SNF Functional Outcome Measures: *Discharge Self-Care Score for Skilled Nursing Facility Residents* (NQF #2635),[34] *Change in Self-Care Score for Skilled Nursing Facility Residents* (NQF #2633*),*[35] *Discharge Mobility Score for Skilled Nursing Facility*

[34] Discharge Self-Care Score reports the percentage of Medicare Part A SNF stays that meet or exceed an expected discharge self-care score.
[35] Change in Self-Care Score reports the risk-adjusted mean change in self-care score between admission and discharge for Medicare Part A SNF stays.

Residents (NQF #2636),[36] and *Change in Mobility Score for Skilled Nursing Facility Residents* (NQF #2634) [37] are active measures in the SNF QRP,[38] and may be considered for SNF VBP adoption. Each of these functional outcome measures use the MDS as a data source, though MedPAC has expressed concerns about the accuracy of this provider-reported assessment data.[39] The functional outcome measures satisfy Principles 1, 3, and 4 from the measurement gaps framework summarized in Section 4.1, as the measures assess SNF core services, fulfill the person-centered care domain of CMS's Meaningful Measure Initiative 2.0, and address insufficient service provision and untimely care plans as responses to the SNF PPS.

Functional outcome measures provide a window into the comprehensive care SNFs provide, and should be considered for Program adoption. For example, since the primary care goal of many SNF residents is improvement in function, the functional outcome measures evaluate the effectiveness of SNF rehabilitative care through clinical assessments of residents' functional status at admission and discharge. These functional outcomes are often correlated with the type and amount of therapy services SNFs provide. Additionally, functional outcome measures evaluate the important opportunities beyond therapy sessions to improve resident function during a SNF stay, including interactions with nurses, nurse practitioners, aides, dieticians, etc.

Panelist Discussion

3. *Given the functional assessment measurement gap within the current SNF VBP Program, what are the advantages and disadvantages of including the existing SNF QRP Mobility or Self-Care function measures in the SNF VBP Program?*

Similar to MedPAC's recommendation, four panelists did not support adoption of the four functional outcome measures into the SNF VBP Program due to concerns about inaccuracies in provider-reported assessment data. One panelist recommended the measures for SNF VBP consideration only after providers have had enough time to thoroughly understand Section GG coding following the removal of Section G in the MDS. Another panelist suggested the implementation of data validation processes to evaluate the accuracy of SNFs' reporting of functional status. For example, the functional status reporting of one SNF may be compared to that of the next PAC provider a patient receives care from. However, a separate panelist noted that this data validation technique would be dependent upon the next PAC provider's Section GG

[36] Discharge Mobility Score reports the percentage of Medicare Part A SNF stays that meet or exceed an expected discharge mobility score.
[37] Change in Mobility Score reports the risk-adjusted mean change in mobility score between admission and discharge for Medicare Part A SNF Stays.
[38] CMS (2019). *Skilled Nursing Facility Quality Reporting Program Measure Calculations and Reporting User's Manual Version 4.0*. https://www.cms.gov/files/document/snf-quality-measure-calculations-and-reporting-users-manual-v40.pdf.
[39] MedPAC. (2021). *Mandated Report: Evaluating the Skilled Nursing Facility Value-Based Purchasing Program*. Chapter 4. https://www.medpac.gov/document/june-2021-report-to-the-congress-medicare-and-the-health-care-delivery-system/.

coding accuracy, and whether or not the patient required additional PAC care after discharge from the SNF. Another panelist further suggested that functional outcome measures should not use facility-reported data as a data source. One panelist recommended the sharing of MDS assessments with residents, family members, and caregivers to increase transparency and discourage facilities from misrepresenting functional status.

Panelists also shared suggestions on measure performance expectations. One panelist recommended that expected discharge scores be shared with providers so that they have a threshold to aim for. Acumen noted that the measure specifications in the SNF QRP Quality Measure Calculations and Reporting User's Manual include the steps to calculate expected scores. However, a separate panelist expressed that the complex specifications may influence providers to spend too much time focusing on the calculation of measure scores rather than strategies to improve patient-centered care. A different panelist disagreed and suggested that because the calculations are so complicated, gaming is not feasible for facilities and that they would be more likely to code according to guidelines.

Two panelists supported filling the SNF VBP measurement gap with functional outcome measure(s). One suggested incorporating these measures following the end of the COVID-19 PHE as the PHE has impacted SNFs' abilities to complete some of the assessment items. Another supported the four measures and noted that imperfection should not impede progress. This panelist noted that facilities will become more familiar with Section GG of the MDS in the future and that there will always be a chance for gaming, but that the measures can still be valuable.

Key Findings

- Some panelists supported adoption of the functional outcome measures into the SNF VBP.
- Other panelists expressed concern regarding the functional outcome measures' data source (i.e., Section GG learning curve, inaccurate reporting) and requested data validation efforts, recommended performance thresholds and transparency in measure calculation, and requested delay in implementation until the end of the PHE.

4.2.4 Emergency Department Visit

Acumen presented the *Short-Stay Residents Who Have had an Outpatient Emergency Department Visit* measure for possible inclusion in the SNF VBP Program.

Summary of Presentation

Short-Stay Residents Who Have had an Outpatient Emergency Department Visit is a non-NQF-endorsed active measure in NHQI that may be suitable for filling the emergency department visit measurement gap within the current SNF VBP Program. The measure uses

Medicare FFS claims data to capture the percentage of new nursing home admissions or readmissions from a hospital who had an outpatient emergency department visit within 30 days of entry or reentry. This measure satisfies Principles 1, 3, 4, and 5 from the measurement gaps framework summarized in Section 4.1 as it assesses SNF core services, captures Meaningful Measure 2.0 domains of care-coordination and safety, emphasizes measure concepts discussed during the PFE focus group (Section 3.2.1), and accounts for a range of potential responses to the PPS (i.e., insufficient service provision, untimely care plans, premature discharge, delayed SNF readmission).

Consideration of an emergency department visit measure, such as the *Short-Stay Residents Who Have had an Outpatient Emergency Department Visit* measure, for SNF VBP Program adoption is warranted for the following reasons. First, addition of an emergency department visit measure to the SNF VBP would fill a measurement gap that is distinct from that of the Program's current measure, SNFRM, which captures hospital readmission instead of emergency department visits. Additionally, the measure would capture SNFs that often send its residents to the emergency department, which may be indicative of a facility's failure to properly assess or care for admitted SNF residents. For example, one study demonstrated that nursing homes with higher quality ratings had a 13% lower risk of emergency department visits for residents.[40] Furthermore, emergency department visits should be monitored through a SNF VBP measure as they are associated with excessive costs. Finally, emergency department visits should be monitored in SNFs as Medicare/Medicaid dually-enrolled patients and those with multiple chronic conditions have higher rates of unscheduled emergency department visits.[41]

Panelist Discussion

4. *Given the emergency department visit measurement gap within the current SNF VBP Program, what are the advantages and disadvantages of including the existing Short-Stay Residents Who Have had an Outpatient Emergency Department Visit measure in the SNF VBP Program?*

Panelists expressed concerns about the ability of the *Short-Stay Residents Who Have had an Outpatient Emergency Department Visit* measure to assess health equity. One panelist noted that there is overutilization of emergency department visits in rural areas, compared to urban areas. Another panelist suggested for the measure to be risk-adjusted for comorbidities that may cause an increased risk for emergency department visits. This panelist also recommended risk

[40] Bartley, M. M., Rahman, P. A., Storlie, C. B., Takahashi, P. Y., & Chandra, A. (2020). Associations of Skilled Nursing Facility Quality Ratings With 30-Day Rehospitalizations and Emergency Department Visits. *The annals of long-term care: the official journal of the American Medical Directors Association*, *28*(1), e11–e17. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8025962/.

[41] Venkatesh, A. K., Mei, H., Shuling, L., D'Onofrio, G., Rothenberg, C., Lin, Z., & Krumholz, H. M. (2020). Cross-sectional Analysis of Emergency Department and Acute Care Utilization Among Medicare Beneficiaries. *Academic emergency medicine : official journal of the Society for Academic Emergency Medicine*, *27*(7), 570–579. https://doi.org/10.1111/acem.13971.

adjustment or stratification of measure results by Medicare/Medicaid dual enrollment status. Acumen noted that the measure could be modified to account for social risk factors since it has not undergone SNF VBP rulemaking.

A few panelists raised concerns regarding unintended consequences of the measure. Two panelists expressed concern about the measure capturing emergency department visits that are out of the SNF's control, such as patient- or family-initiated visits. One of these panelists mentioned that, in New York, the MDS has an item in Section S for denoting emergency department visits that the patient requested, and recommended expanding this practice. Two panelists also mentioned that this measure could potentially discourage SNFs from sending residents to the emergency department even when doing so is appropriate. One panelist disagreed with this notion, and suggested that the risk for SNFs not sending residents to emergency departments even when appropriate already exists with the presence of a hospital readmission measure. Further, two panelists expressed concern over the measure numerator's exclusion of observation stays, as this exclusion criterion may incentivize hospitals to increase the use of observation stays to reduce hospital readmissions. One of these panelists also noted that emergency department visits occurring on the same day as SNF admission may suggest that the hospital discharged the patient too soon, a decision outside of the control of the SNF. Similarly, another panelist emphasized that there are several factors contributing to emergency department visits from SNFs that the measure does not capture.

One panelist supported the measure to fill the emergency department visit measurement gap in the SNF VBP Program, and suggested it would pair strongly with a hospital readmission measure. However, this panelist and one other expressed concern with the claims data delay due to the data reporting of the *Short-Stay Residents Who Have had an Outpatient Emergency Department Visit* measure. A claims data delay may impact the actionability of the measure as measure scores may not always reflect the current state of the facility. One panelist recommended the use of admission, discharge, transfer (ADT) messages as a data source for an emergency department visits measure rather than claims data while noting that ADT messages are only useful for counting visits and would not necessarily capture services and outcomes.

Key Findings

- Panelists recommended considerations for the incorporation of health equity approaches into the *Short-Stay Residents Who Have had an Outpatient Emergency Department Visit* measure.
- Panelists expressed concerns regarding unintended consequences and actionability of the measure.

4.2.5 Patient-Reported Outcome-Based Performance Measurement Information System (PROMIS)

Acumen presented the measure concept of the Patient-Reported Outcome-Based Performance Measurement Information System (PROMIS) tool for SNF VBP consideration.

Summary of Presentation

Utilization of the Patient-Reported Outcome-Based Performance Measurement Information System (PROMIS) tool within the SNF VBP Program may serve as a valuable patient-reported outcome quality indicator for the SNF VBP Program. The PROMIS tool is a questionnaire used to measure patient self-reported health status. A quality measure using the PROMIS tool would satisfy Principles 1, 3, and 4 from the measurement gaps framework in Section 4.1 by assessing SNF core services of comprehensive assessment and planning, fulfilling the person-centered care domain of CMS's Meaningful Measures Initiative 2.0, and touching upon the measure concept of patient-family satisfaction surveys as discussed during the PFE focus group (Section 3.2.1).

The PROMIS tool measures several aspects of resident health status, including physical, mental, and social health. The tool can measure overall/global health, cognitive function, dyspnea, gastrointestinal health, pain, and various social factors of health. Further, stakeholders have considered this tool for use as a quality indicator. Commenters on the FY2022 SNF PPS Proposed Rule's Request for Information (RFI) regarding an expanded SNF VBP measure set supported the inclusion of a patient-reported outcome measure in the SNF VBP Program measure set.[42] One commenter supported the use of the PROMIS questionnaire. Commenters noted that use of a PROMIS measure may impose additional patient and provider burdens and noted that additional resources would be needed for implementation. One commenter recommended that any PROMIS measure considered for adoption should be reviewed by NQF.

Panelist Discussion

Acumen posed two questions to the TEP regarding the PROMIS tool.

5. *Given the patient-reported outcome measure gap within the current SNF VBP Program, what are the advantages and disadvantages of including a PROMIS measure in the SNF VBP Program?*

Five panelists agreed that patient-reported outcome measures are a critical gap in the SNF VBP Program. One panelist noted that the PROMIS tool, which contains a diverse set of questions, would only be as good as the reliability and relevance of the questions used. This

[42] 86 FR 42508

panelist suggested that survey responses collected during, as opposed to at the conclusion of a SNF stay would be most effective.

6. *How would the expanded SNF VBP measure set benefit from the inclusion of two patient-reported outcome measures (e.g., PROMIS, CoreQ)?*

Note: The CoreQ Short-Stay Discharge Measure has completed SNF VBP pre-rulemaking requirements.

One panelist supported pairing a PROMIS tool measure with the *CoreQ Short-Stay Discharge Measure*. The panelist noted that the two measures may complement each other as CoreQ survey questions are fairly non-specific, while PROMIS questions are more detailed. However, another panelist noted that adding two patient-reported outcome measures to the Program may increase provider burden and potentially divert staffing resources away from patient care and towards data monitoring. Two other panelists expressed concerns with CoreQ as a data source. Panelists took issue with the survey's exclusion of (i) responses from residents who may be dissatisfied with care, such as those who left the facility against medical advice or changed facilities, and (ii) responses from residents with dementia or those who did not fill out their own survey as this exclusion is discriminatory. One panelist found the five-point method for scoring in CoreQ problematic as respondents may be frequently tempted to choose the neutral option. Another panelist noted that the collection of survey responses should be entirely independent of facility staff oversight to ensure the accuracy of survey responses. Acumen highlighted that the CAA requires data validation processes to be implemented within the SNF VBP Program. See Section 4.3.2 for further discussion of CoreQ and the PROMIS tool.

Key Findings

- Panelists largely supported patient-reported outcome measure(s) to fill SNF VBP measurement gaps.
- One panelist noted that a measure using the PROMIS tool and the *CoreQ Short-Stay Discharge Measure* may complement each other, while others expressed concern over provider burden related to implementation of two patient-reported outcome measures.
- Panelists expressed concern over the exclusions and scoring of the CoreQ data source.

4.2.6 Utilizing Principle 1 and Stakeholder Feedback from Requests for Information as Guidance for Developing a Measure Set

In an effort to limit duplication of measure concepts in a potential SNF VBP measure set, Acumen conducted a correlation analysis to assess overlap between existing quality measures. Additionally, Acumen presented stakeholder feedback from the FY2022 SNF PPS Final Rule Request for Information for potential future SNF VBP measures.

Summary of Presentation

As described in Principle 1 of Section 4.1 and echoed through panelist feedback, the SNF VBP measure set should avoid adoption of measures with duplicate measure concepts. Acumen conducted a correlation analysis to investigate potential overlap in measure concept between existing measures that may be considered for SNF VBP Program adoption. Correlations between existing measures indicate the extent to which a measure is either redundant or captures a distinct dimension of care. Measure correlations closer to zero indicate less duplication of measure concepts, while a correlation closer to one indicates higher measure concept redundancy. Since functional outcome measures pose a measurement gap within the current SNF VBP Program, Acumen first assessed the correlations between the four existing SNF functional outcome measures as depicted in Table 4-2. Results of the analysis indicated that the four functional outcome measures are highly correlated. Therefore, one or two functional outcome measures should be considered for SNF VBP Program adoption rather than all four measures as their measure concepts are duplicative of one another. Additionally, Acumen conducted a correlation analysis between measures assessing hospital readmission, successful discharge to community, healthcare-associated infections, emergency department visits, falls with major injury, staffing, and resource use as illustrated in Table 4-3. Results of the analysis reveal that the aforementioned measures may fit well together in one Program as measures had small correlations indicating minimal overlap in measure concept.

Table 4-2. Correlations of Existing SNF Functional Outcome Measures[43]

	Change in Self-Care Score	Change in Mobility Score	Discharge Self-Score	Discharge Mobility Score
Mean	6.88	14.39	47.16	39.27
Standard Deviation	2.16	4.95	15.19	15.51
N Providers	10,200	10,237	10,242	10,242
Change in Self-Care Score	1.00	0.68**	0.92**	0.63**
Change in Mobility Score	0.71*	1.00	0.63**	0.94**
Discharge Self-Score	0.90*	0.66*	1.00	0.62**
Discharge Mobility Score	0.64*	0.93*	0.65*	1.00

Table 4-3. Correlations of Existing Measures Suitable for SNF VBP Adoption[44]

	SNFRM	DTC	MSPB	Falls with Major Injury	Short-Stay Residents Without Outpatient ED visit	Total Nursing Hours per Resident Day	HAI
Mean	0.20	52.97	1.06	0.91	10.49	3.76	0.06
Standard Deviation	0.02	10.97	0.24	1.51	5.49	1.02	0.02
N Providers	10,707	12,972	14,072	12,530	12,450	14,724	14,102
SNFRM	1.00	-0.13**	0.06**	0.01**	0.07**	-0.04**	0.24**
DTC	-0.12*	1.00	-0.41**	-0.03**	-0.01**	0.30**	-0.35**
MSPB	0.06*	-0.43*	1.00	0.04**	-0.02**	-0.20**	0.39**
Falls with Major Injury	0.00*	-0.09*	0.03*	1.00	0.06**	-0.04**	0.00**
Short-Stay Residents Without Outpatient ED visit	0.07*	-0.02*	-0.02*	0.07*	1.00	-0.05**	0.03**
Total Nursing Hours per Resident Day	-0.04*	0.30*	-0.21*	-0.06*	-0.06*	1.00	-0.17**
HAI	0.24*	-0.34*	0.39*	0.03*	0.04*	-0.19*	1.00

*Pearson correlation results

**Spearman correlation results

[43] Nursing Home Public Reporting Data from February 2022 were used for this analysis.
[44] Nursing Home Public Reporting Data from February 2022 were used for this analysis

In addition to establishing a concise measure set with limited measure concept duplication, Acumen urged panelists to consider stakeholder comments from the FY2022 SNF PPS Final Rule RFI. The RFI requested feedback regarding measures discussed in Sections 3.1.3 and 4.2, as well as measures assessing pressure ulcers, activities of daily living, transfer of health information, number of hospitalizations among long-stay residents, use of antipsychotic medication, and staff turnover. Rule commenters responding to the RFI assessed measures based on the following criteria: (i) NQF endorsement status, (ii) measure type, (iii) measure concept duplication, (iv) risk-adjustment for social risk factors, (v) provider performance variation, and (vi) PHE considerations. Overall, rule commenters supported inclusion of several measure concepts, but were against Program adoption of the *Percentage of Long-Stay Residents who got an Antipsychotic Medication* measure. In regard to a measure of staff turnover, Acumen noted that beginning January 2022, CMS publicly reports the percent of nursing staff and number of administrators that stopped working at the nursing home over a 12-month period.

Panelist Discussion

Acumen posed several questions to the TEP.

7. *Should any of these existing measures discussed in the RFI be considered for SNF VBP program adoption?*
    a. *Are there any existing measures from other quality reporting programs or CMS quality initiatives that should be considered for SNF VBP program adoption?*

One panelist was in favor of the Merit-based Incentive Payment System (MIPS) Medication Reconciliation Post-Discharge measure for SNF VBP consideration.

8. *Are there existing measures that cover important measure concepts, but should be reevaluated for potential inclusion into the SNF VBP program adoption?*

Panelists offered suggestions for reevaluating existing measures that may not be entirely suitable for SNF VBP Program inclusion at this time. One panelist emphasized the distinction between measure recommendation for SNF QRP and those recommended for the SNF VBP Program. This panelist also raised the concern that long-stay measures are not suitable for a Medicare Part A reimbursement program. One panelist recommended re-specifying the *Percentage of Long-Stay Residents who got an Antipsychotic Medication* measure to distinguish between approved and non-approved FDA indications of psychosis. This panelist recommended including a broader scope of clinician types in the *Total Nursing Hours per Resident Day* staffing measure beyond nursing (e.g., pharmacists). Two panelists recommended expanding patient-reported outcome measures to include end-of-life or palliative care.

9. *Are there any new measures that should be developed for potential SNF VBP program adoption?*

First, panelists debated the merits of a staff turnover measure. One panelist supported such a measure noting a lack of sufficient staffing due to the COVID-19 PHE. The panelist additionally supported a staff turnover measure to assess capabilities of SNF leadership to retain staff. However, three panelists were concerned with such a measure due to (i) its impact on Program scoring methodology, (ii) whether or not a staff turnover measure is suitable for assessment in a short-stay population, and (iii) the definition of staff turnover as 60-days between shifts since medical leaves, pregnancy, or extended trips frequently require absences longer than 60-days. Lastly, two panelists supported a measure to evaluate the efficacy of care transition, particularly the investment, implementation, and transferability of electronic health record (EHR) platforms to share information across providers.

Key Findings

- Panelists generally supported Acumen recommendations to combine certain duplicative measures and use non-duplicative measures to form a comprehensive measure set.
- Panelists provided suggestions to enhance the suggested SNF VBP Program dataset, particularly surrounding medication management measures and staff turnover.

4.2.7 CMS Health Equity Initiatives

Acumen presented existing CMS health equity initiatives and raised the possibility of including equity provisions in SNF VBP Program measures.

Summary of Presentation

Acumen presented existing CMS health equity initiatives to spark ideas for health equity inclusion in the SNF VBP. Health equity refers to the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.[45] Currently, CMS has various health equity initiatives in effect. First, the MIPS program accounts for equity through the inclusion of a complex patient bonus, with two components for medical and societal complexity. Second, the Hospital Readmissions Reduction Program (HRRP) accounts for equity by providing hospitals with stratified confidential measure performance results by Medicare/Medicaid dual-eligibility. Lastly, CMS accounts for health equity through the Office of Minority Health's (OMH) development of a Health Equity Summary Score (HESS), which provides a summary of equitable care delivery by combining performance and improvement across multiple measures and multiple at-risk groups.

[45] CMS. (2022). *Health Equity*. https://www.cms.gov/pillar/health-equity.

Panelist Discussion

10. *How can health equity be accounted for in SNF VBP measure expansion?*
    - *Should a health equity measure be developed for the program (e.g., Health Equity Summary Score (HESS))?*
    - *Should SNF VBP measure(s) be stratified by social risk factor in public reporting?*
    - *Are there other mechanisms for achieving health equity goals in the SNF setting?*

Panelists offered suggestions for encompassing health equity within a SNF Program. One panelist suggested that summary scores are the most valuable approach to account for health equity. This panelist noted that summary scores stratify measures by groups and indicate the extent to which care is consistently or differentially delivered across those groups. This panelist also emphasized the importance of publicly reporting measure performance by stratified groups. Another panelist acknowledged that incorporating concepts of equity into a value-based purchasing program is difficult. This panelist supported MedPAC's recommendation to implement payment adjustments for groups with disproportionate risk, using, for example, dual-eligibility as a proxy for high-risk groups. The panelist noted that this would encourage SNFs to provide high-quality care to residents from populations with limited resources and/or worse health outcomes.

Key Findings

- Panelists supported the incorporation of health equity into the SNF VBP and offered numerous suggestions for implementation including, development of a health equity summary score, stratified reporting, and payment adjustments.

4.3 Session 3-D: Considerations for Alternative Data Sources

Acumen presented data source options for measures that may be considered for SNF VBP Program adoption (Section 4.3.1). Panelists then discussed the various data sources (Section 4.3.2) from which Acumen drew key findings (Section 4.3.3).

4.3.1 Summary of Presentation

When considering measures for the SNF VBP Program, assessing potential data sources serves importance. Assessing data sources' feasibility (i.e., availability, data collection or submission burdens, etc.), reliability, and validity determines suitability for use. Acumen presented six potential data sources to the group and discussed the advantages and disadvantages of using them in a SNF VBP measure set. Data sources discussed include (i) Medicare FFS claims data, (ii) MDS 3.0 assessments, (iii) NHSN surveillance, (iv) Payroll-based Journal (PBJ), (v) CoreQ Patient Satisfaction Survey, and (vi) the Patient-Reported Outcomes Measurement Information System (PROMIS) tool. Descriptions of each data source as well as advantages and disadvantages of their use are summarized in Appendix D:. Furthermore, Acumen emphasized the CAA's SNF VBP data validation requirement, as the Secretary must apply a process to validate the measures and data submitted under the SNF VBP, as appropriate.[46]

4.3.2 Panelist Discussion

Acumen posed the following question to the TEP:

1. *What types of data sources should be considered for measures adopted into the SNF VBP program?*

- *Can include measure domains that we have or have not already discussed.*
- *Can include data sources that we have not yet discussed.*

Panelists discussed the usefulness of different data sources. First, one panelist recommended further validation of the MDS as opposed to excluding MDS assessment-based measures from the Program due to concerns about the accuracy of reporting. Next, regarding use of NHSN surveillance, one panelist raised concern with different state-based reporting requirements and recommended standardization at a national level. In terms of the Payroll-based Journal, one panelist expressed concern that the data source differentiates between staff on the facility's payroll and those who are contracted, and recommends that measures using the PBJ should be encompassing of all staff types.

When comparing data sources that can be used for patient-reported outcome measure(s), one panelist favored the PROMIS tool while three preferred the CoreQ survey. Another panelist

[46] U.S. Congress, House, *Consolidated Appropriations Act, 2021*, H.R.133, 116th Cong., introduced in the House January 3, 2019, https://www.congress.gov/bill/116th-congress/house-bill/133/text.

more broadly favored alternative data sources to CoreQ survey. Panelists that were unsupportive of the CoreQ survey found it to be vague, and noted that survey questions with high levels of specificity are more equipped to accurately reflect provider performance, patient satisfaction, and quality of life. One panelist emphasized that targeted questions may incentivize providers to improve their care. Another panelist noted potential biases within the CoreQ survey. Conversely, those who supported the CoreQ survey preferred its general, simpler questions as they are easier for residents to answer. One panelist recommended the use of a third party to conduct the data collection, processing, and delivery of survey feedback to providers. One panelist emphasized that addition of a patient-reported outcome measure to the SNF VBP would increase provider burden no matter which data source is used as SNFs are not currently required to report resident, family, and/or caregiver feedback at the national level. Panelists noted that the quality of questions, and timeliness of response were important aspects to consider.

Furthermore, one panelist posed a question for the group regarding whether the data for the measures discussed are easier to collect with an established EHR system. This panelist noted that the burden of EHR platforms and technologies for small and rural facilities must be considered in measure development. Another panelist acknowledged that EHRs are usually curated purely for billing and regulatory purposes rather than documenting clinical or practitioner workflow. This panelist noted the challenges associated with EHRs such as transferring data from the EHR or a lab automatically into a system such as the NHSN rather than manually. This panelist further noted that there have been efforts to minimize burden by building Application Programming Interfaces (APIs). The panelist emphasized the development of measures to incentivize this type of technological progress, such as building data reporting structures within EHR platforms. Another panelist clarified that a majority of the data is similar for established and "home-grown" EHR systems; the difference is the functionality and reporting. One panelist noted that smaller facilities might actually be better equipped to transfer information. Acumen noted that there have been conversations within CMS regarding the adoption of health records and interoperability in PAC. Preliminary discussion has considered the creation of codes to expedite this process. However, the timeline has yet to be determined.

A final panelist posed a general recommendation that the current data collection system among SNFs should be completely overhauled to streamline information from a variety of sources in a standardized nomenclature.

4.3.3 Key Findings

- Panelists largely recommended consideration of provider burden, data validation, and collection/reporting interoperability for future SNF VBP Program measure data sources.

5 NEXT STEPS

The input provided by this TEP meeting will provide guidance to CMS and the SNF VBP Program support teams throughout the measure set expansion effort. This will entail:

- Utilizing the composite framework to identify and fill Program measurement gaps;
- Considering measures to submit to future Measures Under Consideration (MUC) Lists, and to propose for adoption into the Program; and
- Prioritizing SNF VBP data validation efforts

APPENDIX A: ACUMEN SNF VBP MEASURE EXPANSION CCSQ SUPPORT TEAM

The Acumen SNF VBP Measure Expansion CCSQ Support team is multidisciplinary and includes individuals with knowledge and expertise in the areas of measure development, clinician payment policy, health economics, clinical practice, public reporting, pay-for-performance, and value-based purchasing and quality improvement. The following individuals from the project team attended the TEP:

- Rebecca Clearwater, TEP Moderator
- Sriniketh Nagavarapu, Co-Project Director
- Stephen McKean, Co-Project Director
- Cheng Lin, Co-Project Manager
- Ellen Strunk, Clinical Lead
- Serena Master, Data and Policy Analyst
- Julia Lo, Data and Policy Analyst
- Kaitlin Frangione, Data and Policy Analyst
- Prabana Mendis, Data and Policy Analyst
- Samuel Wands, Data and Policy Analyst

APPENDIX B: BACKGROUND MATERIALS

The following tables present the background materials provided to the TEP panelists for review prior to the TEP meeting, with additional information on the specific measures and data sources introduced in the presentation. Materials include measure specification documents (Table B-1), CMS Measures Inventory Tool (CMIT) webpages (Table B-2), data source websites (Table B-3), and journal articles (Table B-4).

Table B-1. Measure Specification Documents

Document Name	URL
Minimum Data Set (MDS) 3.0 Quality Measures (QM) User's Manual V15.0	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures
Nursing Home Compare Claims-Based Quality Measure Technical Specifications (September 2018)	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/Nursing-Home-Compare-Claims-based-Measures-Technical-Specifications.pdf
SNF QRP Measure Calculations and Reporting User's Manual Version 3.0	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-Measure-Calculations-and-Reporting-Users-Manual-V30_FINAL_508C_081419-002.pdf

Table B-2. CMIT Webpages

Measure Name	URL
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	https://cmit.cms.gov/cmit/#/MeasureView?variantId=1003&sectionNumber=1
Discharge to Community (DTC) – Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)	https://cmit.cms.gov/cmit/#/MeasureView?variantId=1985&sectionNumber=1
Falls with Injury	https://cmit.cms.gov/cmit/#/MeasureView?variantId=3799&sectionNumber=1
Skilled Nursing Facility (SNF) Healthcare-Associated Infections (HAIs) Requiring Hospitalizations	https://cmit.cms.gov/cmit/#/MeasureView?variantId=5146&sectionNumber=1

Table B-3. Data Source Websites[47]

Data Source	URL
Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN)	https://www.cdc.gov/nhsn/index.html

[47] Copy and paste URLs into web browser.

Data Source	URL
CoreQ Short Stay Discharge Questionnaire	http://coreq.org/
Minimum Data Set (MDS) 3.0 for Nursing Homes and Swing Bed Providers	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30
Nursing Home Staff Turnover and Weekend Staffing Levels	https://www.cms.gov/files/document/qso-22-08-nh.pdf
Staffing Data Submission Payroll Based Journal (PBJ)	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ

Table B-4. Journal Articles[48]

Title, Author, Year	URL
Associations of Skilled Nursing Facility Quality Ratings With 30-Day Rehospitalizations and Emergency Department Visits (Bartley et al., 2020)	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8025962/
Cross-Sectional Analysis of Emergency Department and Acute Care Utilization Among Medicare Beneficiaries (Venkatesh et al., 2020)	https://doi.org/10.1111/acem.13971

[48] Copy and paste URLs into web browser.

APPENDIX C: CONCEPTUAL FRAMEWORK TO FILL MEASUREMENT GAPS

	Potential Responses to SNF Payment System				
SNF Core Services	Insufficient Service Provision	Untimely Care Plan	Premature Discharge	Delayed Readmissions back to SNF	Increased Depression Reporting
Nursing	**RM/PPR**, **DTC**, **HAI**, **PBJ**, ED,	**RM/PPR**, **DTC**, **HAI**, Ulcers, ED	**RM/PPR**, **DTC**, **HAI**, ED	ED	
Comprehensive assessment and planning	**RM/PPR**, **DTC**, Restraints, MSPB	**RM/PPR**, **DTC**, **CoreQ**, Restraints	**RM/PPR**, **DTC**, **CoreQ**	**CoreQ**, ED	**CoreQ**
Physical Therapy	**RM/PPR**, **DTC**, **PBJ**, Mobility, Falls*, ED	**RM/PPR**, **DTC**, Mobility, Falls*, ED	**RM/PPR**, **DTC**, ED	MSPB, ED	
Occupational Therapy	**RM/PPR**, **DTC**, **PBJ**, Self-care, Falls*, ED	**RM/PPR**, **DTC**, Self-care, Falls*, ED	**RM/PPR**, **DTC**, ED	MSPB, ED	
Speech Therapy	**RM/PPR**, **DTC**, **HAI**, **PBJ**, ED	**RM/PPR**, **DTC**, **HAI**, ED	**RM/PPR**, **DTC**, **HAI**, ED	MSPB, ED	
Skin Wound Care	**RM/PPR**, **DTC**, **HAI**, **PBJ**, Ulcers, ED	**RM/PPR**, **DTC**, **HAI**, Ulcers, ED	**RM/PPR**, **DTC**, **HAI**, ED	MSPB, ED	
Respiratory Care	**RM/PPR**, **DTC**, **HAI**, **PBJ**, ED	**RM/PPR**, **DTC**, **HAI**, ED	**RM/PPR**, **DTC**, **HAI**, ED	MSPB, ED	
Medication Management		Drug Regiment Review (DRR)			DRR, Anti-depressants

Legend: **Bolded** measures are in the Program or completed pre-rulemaking processes as of March 2022. Underlined measures currently exist in the SNF QRP, and may be suitable for SNF VBP consideration. All other measures are concepts that exist in other quality programs/initiatives and should be assessed for SNF VBP consideration.

*The falls measure refers to a general falls measure, including falls with or without major injury. A general falls measure does not currently exist in the SNF QRP.

APPENDIX D: CONSIDERATIONS FOR ALTERNATIVE DATA SOURCES

Type	Description of data source	Advantages	Disadvantages
Medicare fee-for-service (FFS) claims	Medicare FFS SNF claims contain information from paid bills submitted by SNF institutional facility providers.	- No additional data collection burden - Use of this data source in SNF VBP measure expansion is supported by MedPAC as it does not introduce provider burden[1]	- Claims data may miss some information that could be useful in quality measurement - Some claims-based measures are designed with a multiyear lag between when claims are submitted and when data are used to inform measure performance
Minimum Data Set (MDS) 3.0	The MDS is part of the federally mandated process for clinical assessment of all residents in Medicare- and Medicaid-certified nursing homes. The MDS provides a comprehensive assessment of residents' functional capabilities.[49]	- All Medicare-certified nursing homes are required to use the MDS; therefore, it is comprehensive - Assesses residents on a regular basis (i.e., on admission, every three months after admission, quarterly)	- Data is self-reported; MDS items may be underreported or over-reported based on incentives - Can lead to additional provider burden if a new measure requires a new item to be added to the assessment
National Healthcare-Safety Network (NHSN) Surveillance	The Centers for Disease Control's NHSN is the nation's most widely used HAI tracking system. The NHSN also allows facilities to track blood safety errors and healthcare process measures such as healthcare personnel influenza and COVID-19 vaccine status and infection control adherence rates.[50]	- Provides facilities, states, regions, and the nation with data needed to identify problem areas and measure progress of prevention efforts	- Additional data collection burden placed on SNF - Does not report patient-level information

[49] CMS. (2022). *Minimum Data Set (MDS) 3.0 for Nursing Homes and Swing Bed Providers*. CMS.gov. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30.
[50] CDC. (2021). *National Healthcare Safety Network (NHSN)*. CDC.gov. https://www.cdc.gov/nhsn/index.html.

Type	Description of data source	Advantages	Disadvantages
Payroll-based Journal (PBJ)	CMS developed the PBJ system for facilities to submit staffing information. The PBJ allows for staffing information to be collected on a quarterly basis. The PBJ fulfills the Section 6101 requirement of the Affordable Care Act, which requires facilities to electronically submit direct care staffing information based on payroll and other auditable data.[51]	- All long-term care facilities have access to the PBJ system at no cost - PBJ data is auditable - No additional data collection burden as providers are required to submit direct care staffing information	- A few commenters in the FY 2022 SNF PPS Final Rule express burden concerns for reporting.[15]
CoreQ Patient Satisfaction Survey	The CoreQ questionnaire is a patient satisfaction survey that uses a five-point Likert Scale: Poor (1), Average (2), Good (3), Very Good (4), Excellent (5).[52]	- The CoreQ survey is short, which reduces burden on residents and their families, and allows for organizations to benchmark their results with consistent questions and a comparable response scale	- Survey does not provide granular-level detail and may not fully reflect the patient experience - Some survey questions may be open to interpretation
Patient-Reported Outcomes Measurement Information System (PROMIS)	The tool is used to measure patient self-reported health status. [53]	- Addresses several quality domains across different patient populations - Measures are available in several languages - Free tool, which can be administered in several ways - Addresses domains discussed in patient/family focus group (i.e., patient/family communication, pain management, etc.)	- May increase provider burden as data collection of PROMIS measures are not currently mandated

[51] CMS. (2022). *Staffing Data Submission Payroll Based Journal (PBJ)*. CMS.gov. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.
[52] CoreQ. (2019) *What are the Questions?* http://coreq.org/.
[53] HealthMeasures. (2022). *PROMIS.* https://www.healthmeasures.net/index.php?option=com_content&view=category&layout=blog&id=147&Itemid=806.