


Readmission and Incentive Penalty Programs: HRRP, VBP, and WQIP

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Objectives

- Discuss the:
  - Hospital Readmission Reduction Program (HRRP).
  - Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP).
  - Workforce Quality Incentive Program (WQIP).
- Define the measures for each of the programs.
- Describe tools and resources facilities can use to improve program performance.

HRRP

HRRP Overview

- A Medicare value-based purchasing program set forth under Section 1886(q) of the Social Security Act.
- CMS reduces payments to hospitals with excess readmissions.
- The FY 2024 program includes condition/ procedure-specific, 30-day, risk-standardized, unplanned readmission measures:
  - Acute myocardial infarction (AMI)
  - Chronic obstructive pulmonary disease (COPD)
  - Heart failure (HF)
  - Pneumonia
  - Coronary artery bypass graft surgery (CABG)
  - Elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)

CMS = Centers for Medicare & Medicaid Services
FY = fiscal year

HRRP Payment Reduction Methodology

- Evaluates a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full Medicaid benefits.
- Hospitals are divided into 5 similarly sized groups based on their dual proportion.
  - 1 is the lowest, 5 is the highest.
- CMS calculates excess readmission ratios (ERRs) to measure hospital performance. The ERR is the risk-adjusted ratio of predicted readmission rate to expected readmission rate.

Changes in HRRP From FY 2013 to FY 2024

Program year	Readmission measures	Maximum payment reduction	Payment reduction methodology
FY 2013	AMI HF Pneumonia	Up to 1 percent	**Non-peer grouping methodology**
FY 2014	No change in measures	Up to 2 percent	Non-peer grouping methodology
FY 2015	AMI HF Pneumonia COPD (added) THA/TKA (added)	Up to 3 percent	Non-peer grouping methodology
FY 2016	No change in measures	Up to 3 percent	Non-peer grouping methodology
FY 2017	AMI HF Pneumonia (expanded cohort) COPD THA/TKA CABG (added)	Up to 3 percent	Non-peer grouping methodology
FY 2018	No change in measures	Up to 3 percent	Non-peer grouping methodology
FY 2019 to FY 2022	No change in measures[a]	Up to 3 percent	**Peer grouping methodology**[b,c]
FY 2023	Pneumonia paused[a,d]	Up to 3 percent	Peer grouping methodology
FY 2024	Pneumonia resumed[a,d]	Up to 3 percent	Peer grouping methodology

CMS Quality Net HRRP. https://qualitynet.cms.gov/inpatient/hrrp.
HRRP FAQs download: https://qualitynet.cms.gov/files/64cbd7649631f9001cc7dc12?filename=FY2024_HRRP_FAQs.pdf

SNF VBP

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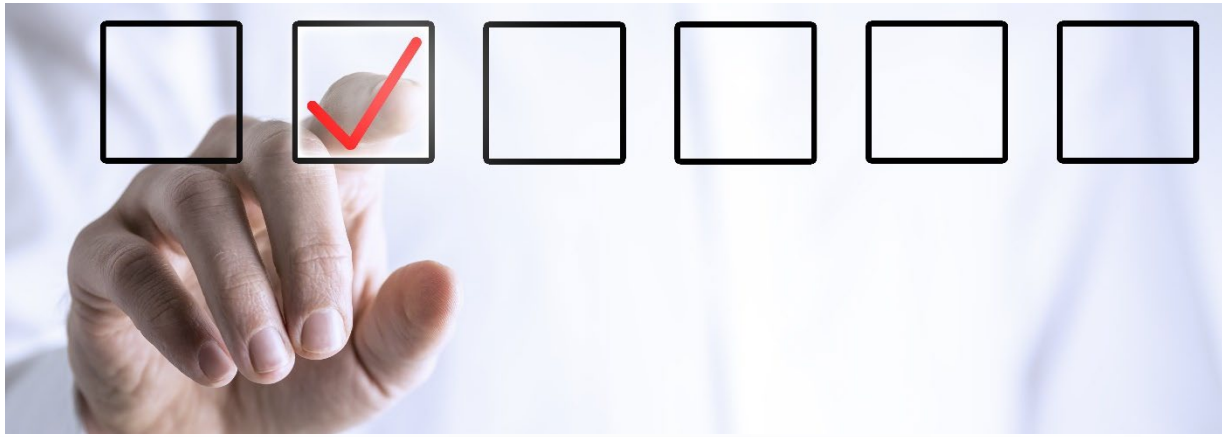
SNF VBP Program

- Established by the Protecting Access to Medicare Act (PAMA) of 2014.
- Rewards SNFs with incentive payments based on the quality of care they provide.
- All SNFs paid under Medicare's SNF Prospective Payment System (PPS) are included in the SNF VBP Program.

Program Framework

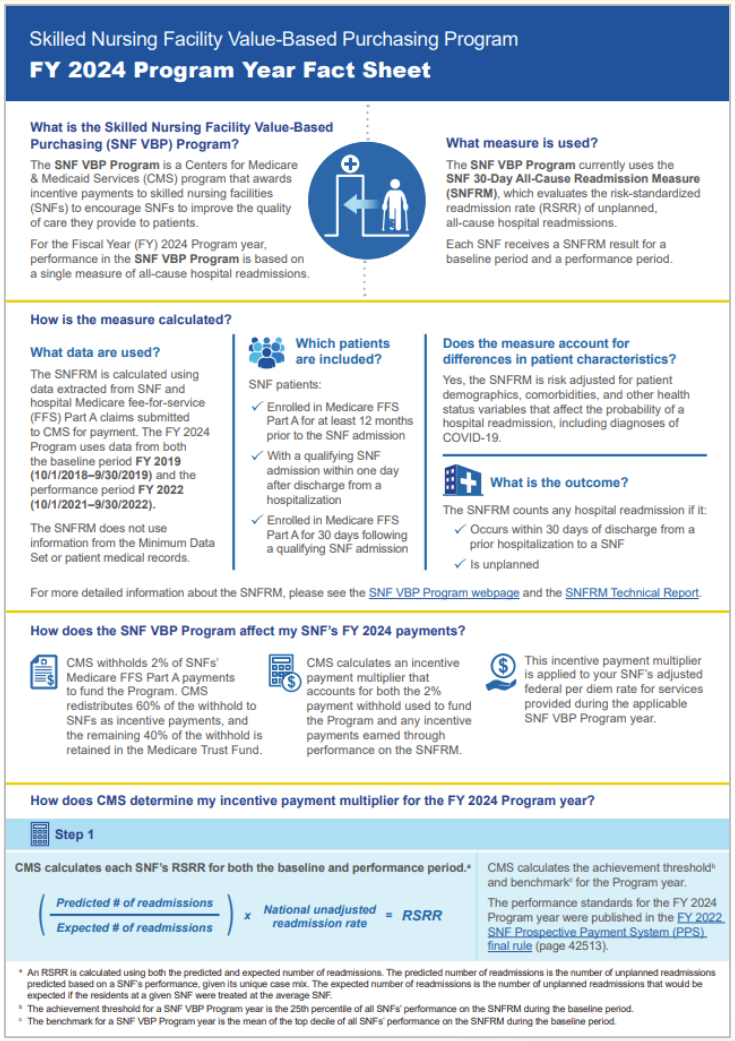
- PAMA specifies that, under the SNF VBP Program, SNFs:
  - Are evaluated by their performance on a hospital readmission measure.
  - Are scored on both improvement and achievement.
  - Receive quarterly, confidential feedback reports containing information about their performance.
  - Earn incentive payments based on their performance.



SNF Readmissions Measure (RM) FY 2024

- The SNF RM assesses the rate of all-cause, unplanned, hospital readmissions for SNF residents within 30 days of discharge from a prior hospital stay.
- Risk adjusted based on:
  - Patient demographics.
  - Comorbidities.
  - Other health status variables that affect the probability of a hospital readmission, including diagnoses of COVID-19.

SNF FY 2024 VBP Fact Sheet



Skilled Nursing Facility Value-Based Purchasing Program

FY 2024 Program Year Fact Sheet

What is the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program?

The **SNF VBP Program** is a Centers for Medicare & Medicaid Services (CMS) program that awards incentive payments to skilled nursing facilities (SNFs) to encourage SNFs to improve the quality of care they provide to patients.

For the Fiscal Year (FY) 2024 Program year, performance in the **SNF VBP Program** is based on a single measure of all-cause hospital readmissions.

What measure is used?

The **SNF VBP Program** currently uses the **SNF 30-Day All-Cause Readmission Measure (SNFRM)**, which evaluates the risk-standardized readmission rate (RSRR) of unplanned, all-cause hospital readmissions.

Each SNF receives a SNFRM result for a baseline period and a performance period.

How is the measure calculated?

What data are used?

The SNFRM is calculated using data extracted from SNF and hospital Medicare fee-for-service (FFS) Part A claims submitted to CMS for payment. The FY 2024 Program uses data from both the baseline period **FY 2019 (10/1/2018–9/30/2019)** and the performance period **FY 2022 (10/1/2021–9/30/2022)**.

The SNFRM does not use information from the Minimum Data Set or patient medical records.

Which patients are included?

SNF patients:

- ✓ Enrolled in Medicare FFS Part A for at least 12 months prior to the SNF admission
- ✓ With a qualifying SNF admission within one day after discharge from a hospitalization
- ✓ Enrolled in Medicare FFS Part A for 30 days following a qualifying SNF admission

Does the measure account for differences in patient characteristics?

Yes, the SNFRM is risk adjusted for patient demographics, comorbidities, and other health status variables that affect the probability of a hospital readmission, including diagnoses of COVID-19.

What is the outcome?

The SNFRM counts any hospital readmission if it:

- ✓ Occurs within 30 days of discharge from a prior hospitalization to a SNF
- ✓ Is unplanned

For more detailed information about the SNFRM, please see the SNF VBP Program webpage and the SNFRM Technical Report.

How does the SNF VBP Program affect my SNF's FY 2024 payments?

CMS withholds 2% of SNFs' Medicare FFS Part A payments to fund the Program. CMS redistributes 60% of the withhold to SNFs as incentive payments, and the remaining 40% of the withhold is retained in the Medicare Trust Fund.

CMS calculates an incentive payment multiplier that accounts for both the 2% payment withhold used to fund the Program and any incentive payments earned through performance on the SNFRM.

This incentive payment multiplier is applied to your SNF's adjusted federal per diem rate for services provided during the applicable SNF VBP Program year.

How does CMS determine my incentive payment multiplier for the FY 2024 Program year?

Step 1

CMS calculates each SNF's RSRR for both the baseline and performance period.[a]

$$\left(\frac{\text{Predicted \# of readmissions}}{\text{Expected \# of readmissions}}\right) \times \text{National unadjusted readmission rate} = \text{RSRR}$$

CMS calculates the achievement threshold[b] and benchmark[c] for the Program year.

The performance standards for the FY 2024 Program year were published in the FY 2022 SNF Prospective Payment System (PPS) final rule (page 42513).

[a] An RSRR is calculated using both the predicted and expected number of readmissions. The predicted number of readmissions is the number of unplanned readmissions predicted based on a SNF's performance, given its unique case mix. The expected number of readmissions is the number of unplanned readmissions that would be expected if the residents at a given SNF were treated at the average SNF.

[b] The achievement threshold for a SNF VBP Program year is the 25th percentile of all SNFs' performance on the SNFRM during the baseline period.

[c] The benchmark for a SNF VBP Program year is the mean of the top decile of all SNFs' performance on the SNFRM during the baseline period.

Step 2

CMS determines the performance scores for all SNFs. SNFs' RSRRs in the performance period are compared to two metrics to determine the performance score:

- SNFs' own past performance during the baseline period, used to calculate an improvement score (scores range from 0 to 90)[a]
- National SNF performance during the baseline period, used to calculate an achievement score (scores range from 0 to 100)

CMS compares a SNF's achievement and improvement scores; whichever score is higher becomes the SNF's performance score.[b]

[a] SNFs with fewer than 25 eligible stays during the baseline period (FY 2019) are included in the SNF VBP Program for FY 2024 but are scored on achievement only. These SNFs will not receive a baseline period RSRR or improvement score, so their achievement score will equal their performance score.

[b] SNFs that did not meet the SNFRM's case minimum (25 or more eligible stays) in the performance period (FY 2022) are excluded from the SNF VBP Program for FY 2024. Payments to these SNFs in FY 2024 will not be affected by the SNF VBP Program; instead, these SNFs will receive their adjusted federal per diem rate.

Step 3

CMS transforms performance scores for all SNFs using the logistic exchange function.

Logistic Exchange Function

Using the transformed performance scores, CMS calculates each SNF's incentive payment adjustment and incentive payment multiplier. This multiplier is applied to each SNF's adjusted federal per diem rate.

When payments are made for a SNF's Medicare FFS Part A claims in FY 2024, the adjusted federal per diem rate is multiplied by the SNF's incentive payment multiplier.

For more information on the methodology for calculating performance scores and incentive payment multipliers, see the SNF VBP Program: FY 2024 Incentive Payment Multiplier Calculation Infographic on the CMS.gov website, the SNF VBP Program Exchange Function Methodology Report, and the FY 2018 SNF PPS final rule (pages 36616–36621).

How can SNFs review their results?

CMS provides confidential feedback reports to SNFs on a quarterly basis through the Internet Quality Improvement and Evaluation System (iQIES).

- CMS distributes four reports each year: an Interim (Partial-Year) Workbook, two Full-Year Workbooks (one each for the baseline period and performance period), and a Performance Score Report. For more information on the distribution timing of the quarterly confidential feedback reports, see the FY 2024 SNF VBP Program Timeline on the CMS.gov website.
- SNFs that have problems accessing their reports can contact the QIES/iQIES Service Center by phone at (800) 339-9313 or by email at iqies@cms.hhs.gov.

The SNF VBP Program's Review and Correction (R&C) process has two phases. CMS considers Phase 1 and 2 correction requests for up to 30 calendar days after dissemination of the applicable report.

- Phase 1: review and submit corrections to readmission measure rates for the baseline and performance periods (applies to Full-Year Workbooks only)
- Phase 2: review and submit corrections to the performance score and ranking (applies to Performance Score Reports only)

Where does CMS publicly report SNF VBP Program results?

CMS publicly reports facility-level and national, aggregate-level results generally in the fall following distribution of the Performance Score Reports on a CMS-specified website.

Historical SNF VBP Program data are also publicly available on the CMS-specified website.

Where can I go for more information?

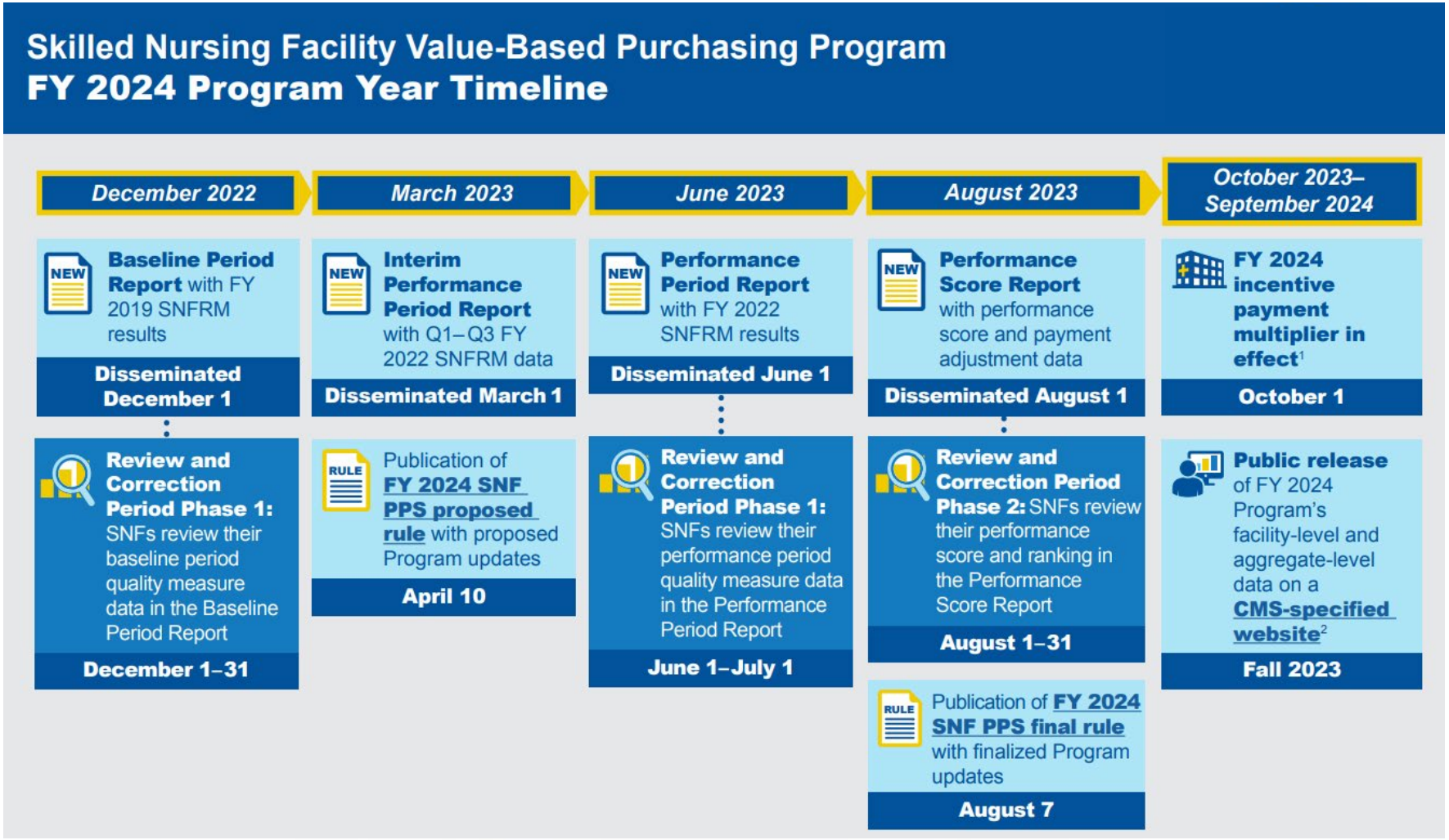
For more information about the SNF VBP Program, visit the SNF VBP Program webpage on CMS.gov.

For questions about the SNF VBP Program, email the SNF VBP Program Help Desk at SNFVBP@rti.org.

For help obtaining access to quarterly reports in iQIES, contact the QIES/iQIES Service Center by phone at (800) 339-9313 or by email at iqies@cms.hhs.gov.

CMS. Skilled Nursing Facility Value-Based Purchasing Program FY 2024 Fact Sheet. https://www.cms.gov/sites/default/files/2023-08/FY2024-SNF-VBP-Fact-Sheet.pdf

SNF VBP FY 2024 Timeline



CMS. Skilled Nursing Facility Value-Based Purchasing Program FY 2024 Timeline. https://www.cms.gov/files/document/fy2024-snf-vbp-timeline.pdf

California WQIP
Claims-Based Quality Metrics

WQIP Overview

- The WQIP will provide directed payments to SNFs through the managed care delivery system.
  - Succeeds the former fee-for-service Quality and Accountability Supplemental Payment (QASP) program, effective for calendar year (CY) 2023.

DHSC. https://www.dhcs.ca.gov/services/Pages/SNF-WQIP.aspx

WQIP Design Objectives

DHCS key objectives for nursing facility financing reform:

- Better incentivize and hold SNFs accountable for quality patient care.
  - Emphasize the critical role of workforce.
  - Better balance distribution of annual rate increases.
  - Result in the long-term financial viability of SNFs in the Medi-Cal managed care environment.
- WQIP will account for approximately 4% of Medi-Cal reimbursement to SNFs.
- WQIP is intended to distribute funding to incentivize workforce and quality improvement as a core part of facilities' reimbursements, compared to QASP, which provided a smaller bonus only to the highest performing facilities.

DHCS = Department of Health Care Services
https://www.dhcs.ca.gov/services/Documents/WQIP-PY1-TechnicalProgramGuide-F3.pdf

Program Components

Program Component	Development Timeline	Implementation Timeline
Workforce & Quality Incentive Program (WQIP). DHCS will provide directed payments to facilities to incentivize workforce and quality. This program succeeds the former Quality and Accountability Supplemental Payment (QASP) program.	September 2022–December 2022	Payments made to facilities in early 2024 based on CY 2023 utilization.
Workforce Standards Program (WSP). DHCS will establish workforce standards such as maintain a collective bargaining agreement or paying prevailing wage. DHCS will provide facilities that meet these standards with a workforce augmentation to base their per diem rate effective for CY 2024.	December 2022–November 2023	Rate augmentation effective for CY 2024.
Accountability Sanctions Program (ASP). DHCS is authorized to sanction facilities that do not meet quality standards established by DHCS on a per Medi-Cal bed basis.	July 2023–November 2023	Quality standards will be effective for CY 2024.

CA DHCS. Nursing Facility Financing Reform AB 186. https://www.dhcs.ca.gov/services/medi-cal/Pages/Nursing-Facility-Financing-Reform-AB-186.aspx

WQIP at a Glance

Domain	Measurement Area	# of Measures	% of Final Score
Workforce	PBJ Staffing Hours	5	35%
	PBJ Turnover	1	15%
Clinical	MDS Clinical Measures	3	20%
	Claims-Based Measures	**3**	**20%**
Equity	Medi-Cal Disproportionate Share	1	7%
	Racial & Ethnic Data Completeness	1	3%

PBJ = Payroll Based Journal
MDS = Minimum Data Set

CMS. Nursing Home Quality Initiative.
www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits

Claims-Based Quality Measures

CMS Metrics

- Outpatient Emergency Department (ED) Visits per 1,000 Long-Stay Resident Days
- Healthcare-Associated Infections (HAIs) Requiring Hospitalization
- Potentially Preventable 30-Day Post-Discharge Readmissions

Claims-Based Definition—ED Visits

- Medi-Cal members or dual-eligible members
- Long-stay residents who reside in a SNF
- ED visits that did not result in an outpatient observation stay or inpatient hospital stay
- All-cause outpatient ED visits
- Hospital outpatient claims during the 2023 calendar year

Claims-Based Definition—HAI Rate

- Medi-Cal and dual-eligible SNF stays that do not meet an exclusion criterion
- HAIs acquired during SNF care and resulting in hospitalization
- Hospitalization must occur during the period beginning between the 4th day after the SNF admission and within 3 days after the SNF discharge
- Identified using the principal diagnosis of the hospital readmission inpatient claim

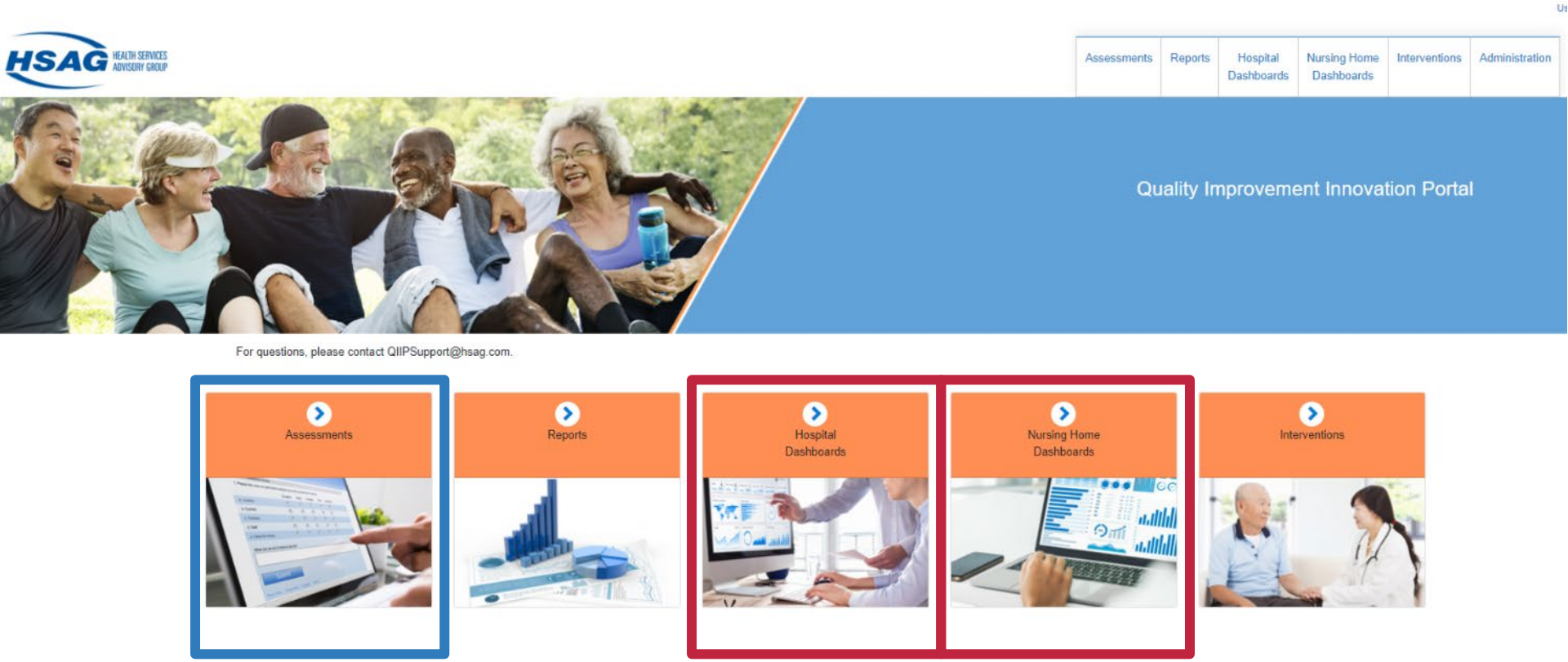
Claims-Based Definition—Potentially Preventable 30-Day Post-Discharge Readmissions

- Medi-Cal and dually eligible members
- SNF patients who are readmitted to the hospital or LTCH within 30 days following discharge from a SNF
- Unplanned inpatient admissions
- Principle diagnosis considered to be unplanned or preventable:
  - UTI, septicemia, *C. difficile*
  - Pneumonia, asthma, COPD, influenza, CHF, hypertension
  - Pressure ulcers

LTCH = long-term care hospital
UTI = urinary tract infection
CHF = chronic heart failure

Tools to Support Readmission and HAI Initiatives

Quality Improvement Innovation Portal (QIIP): Assessments and Data Dashboard



www.hsag.com/qiip-start

QIIP Monthly Infection and Readmission Data

QIIP Care Transitions Assessment

SNF Pain/Opioids | SNF Care Transitions | SNF ADE | SNF Quality Score | SNF Antibiotics

Care Transitions

Work with your department leadership team to complete the following assessment. Each item relates to care transition elements that should be in place for a program to improve care transitions within your facility. This Care Transitions Implementation Assessment is supported by published evidence and best practices including, but not limited to, The Joint Commission (TJC), National Quality Forum (NQF), Project RED (Re-Engineered Discharge from the Agency for Healthcare Research and Quality [AHRQ]), Project BOOST (Better Outcomes to Optimize Safe Transitions from the Society of Hospital Medicine), and the Care Transitions Model ([CTM®] also known as the Coleman Model). Select the level of implementation status on the right for each assessment item.

Download Assessment

To understand the rationale and references for each question, click

- **A. Care Continuum**
- **B. Discharge Planning**
- **C. Quality Improvement of Care Transitions**
- **Open Response**

Care Transitions

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Skilled Nursing Facility (SNF) Care Transitions Assessment

Facility Name: _____ **CCN:** _____ **Assessment Date:** _____ **Completed by:** _____

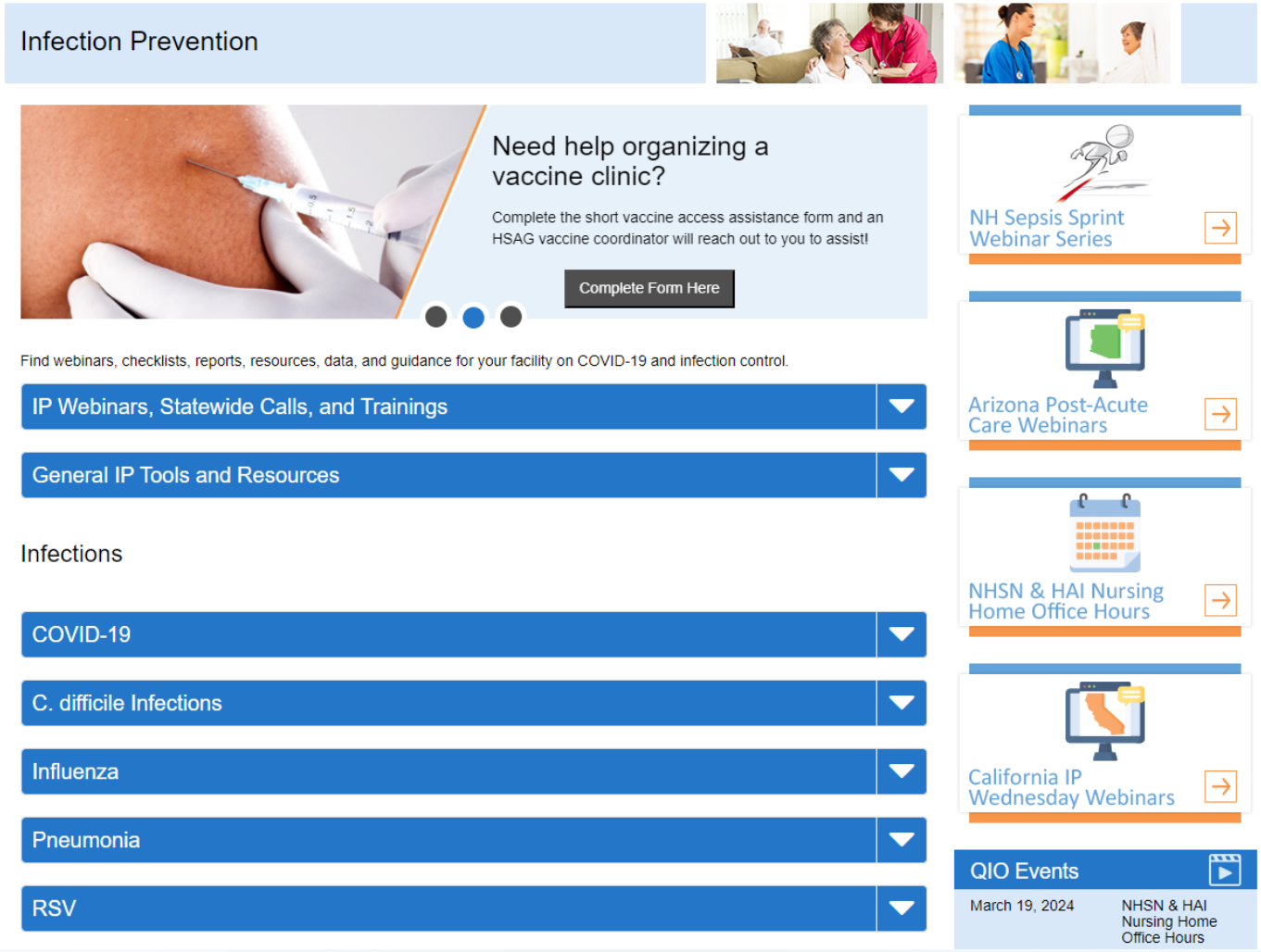
Work with your department leadership team to complete the following assessment. Each item relates to care transition elements that should be in place for a program to improve care transitions within your facility. This Care Transitions Implementation Assessment is supported by published evidence and best practices including, but not limited to, the Joint Commission (TJC), National Quality Forum (NQF), Project RED (Re-Engineered Discharge from the Agency for Healthcare Research and Quality [AHRQ]), Project BOOST (Better Outcomes to Optimize Safe Transitions from the Society of Hospital Medicine), and the Care Transitions Model ([CTM®] also known as the Coleman Model). Select the level of implementation status on the right for each assessment item. Once this form is complete, please go online and enter your answers.

Assessment Items	Not implemented/ no plan	Plan to implement/no start date set	Plan to implement/ start date set	In place less than 6 months	In place 6 months or more
A. Care Continuum					
1. Your facility uses a mechanism for bi-directional feedback with acute care partners to address transition communication gaps of key clinical information during resident transfers (e.g., discharge summary, outstanding tests/lab results, medication list discrepancies).[i]	☐	☐	☐	☐	☐
2. Your facility regularly meets with acute care partners to identify and review care transition plans of: [ii]					
a. Super-utilizers (residents with four admissions in one year—**or**—six emergency department visits within one year).	☐	☐	☐	☐	☐
b. 30-day acute care readmissions of residents on high-risk medications (anticoagulants, opioids, antidiabetics, and antipsychotics)	☐	☐	☐	☐	☐
3. Your facility monitors the timeliness of provider (medical director, SNFist, etc.) response for resident change-of-condition events.[iii]	☐	☐	☐	☐	☐
4. Your facility uses a risk stratification tool to identify residents who are high risk for readmission to the hospital.[iv]	☐	☐	☐	☐	☐
B. Discharge Planning					
5. Your facility provides focused case management for residents at high risk for readmissions to coordinate care addressing: [v]					
a. Ability to pay for medications.	☐	☐	☐	☐	☐
b. Scheduling of physician follow-up visits.	☐	☐	☐	☐	☐
c. Transportation to follow-up visits.	☐	☐	☐	☐	☐

HSAG Care Coordination Webpage

https://www.hsag.com/cc-resources

HSAG Infection Prevention Webpage



https://www.hsag.com/nh/infection-prevention

Our Next Care Coordination Quickinar

Readmission and Post Discharge Follow Up

Tuesday, May 7, 2024 | 11 a.m. PT

bit.ly/cc-quickinars3

www.hsag.com/cc-quickinars

Questions?

Thank you!

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