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The Leaders Top 10

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Objectives

- Understand the CMS reports available for SNF leaders
- Identify the Top 10 reports for operational use
- Describe the key leadership strategies related to the Top 10 reports for positive operational outcomes

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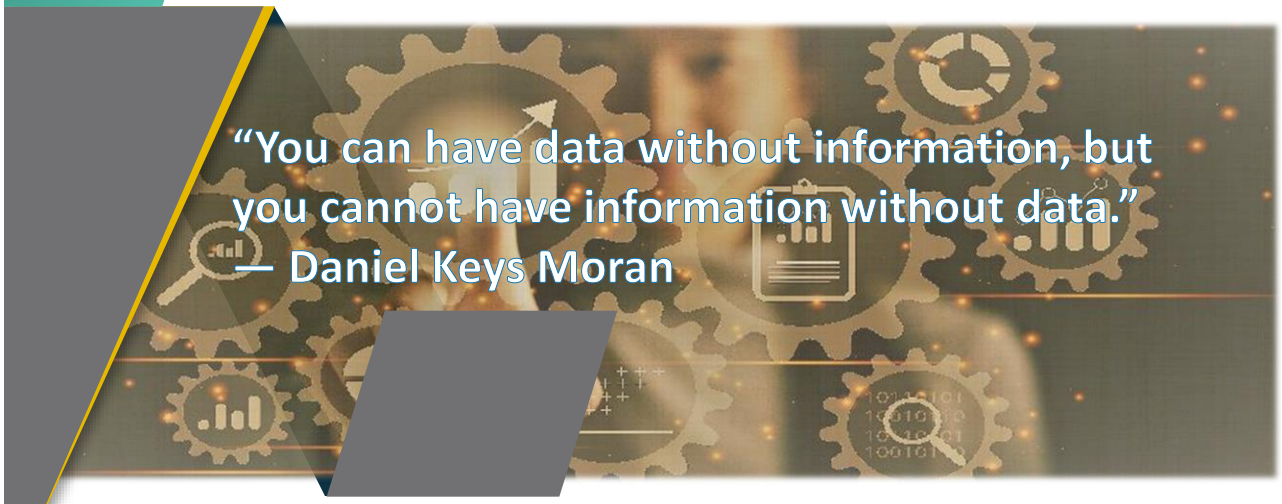
Data Driven Decisions



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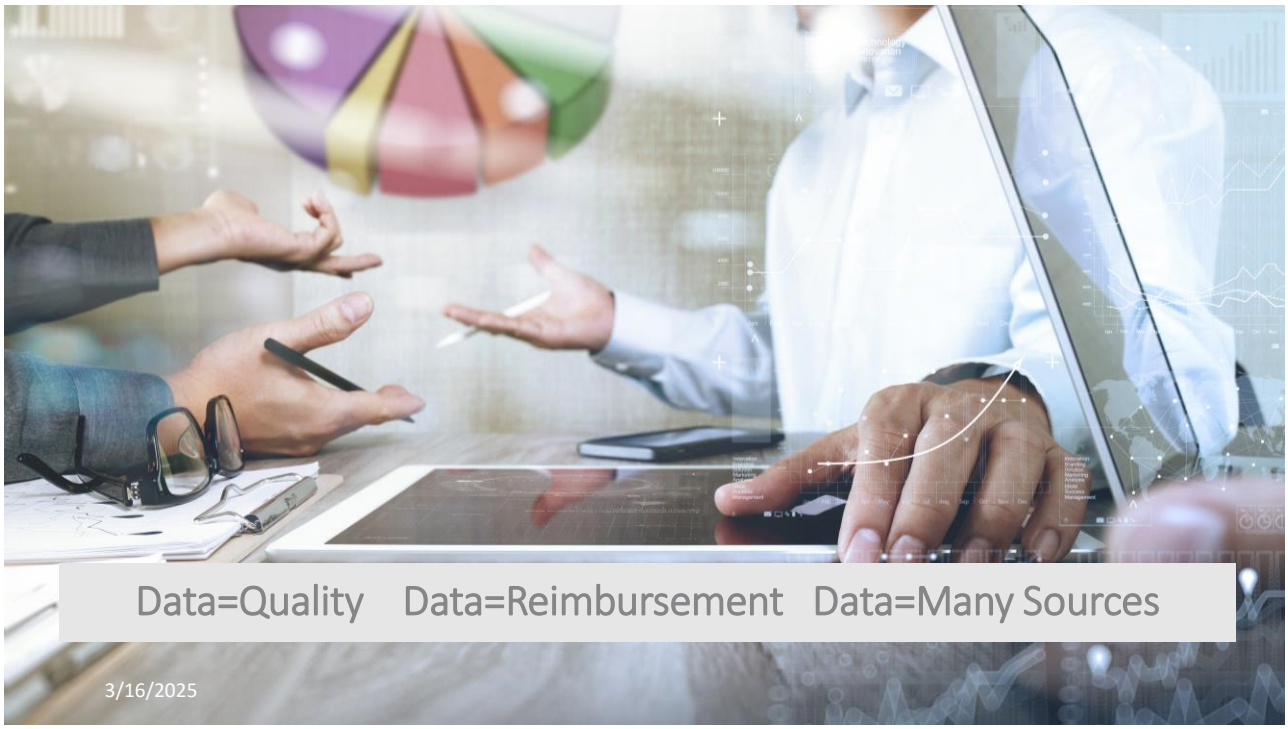
Data=Quality Data=Reimbursement Data=Many Sources
3/16/2025

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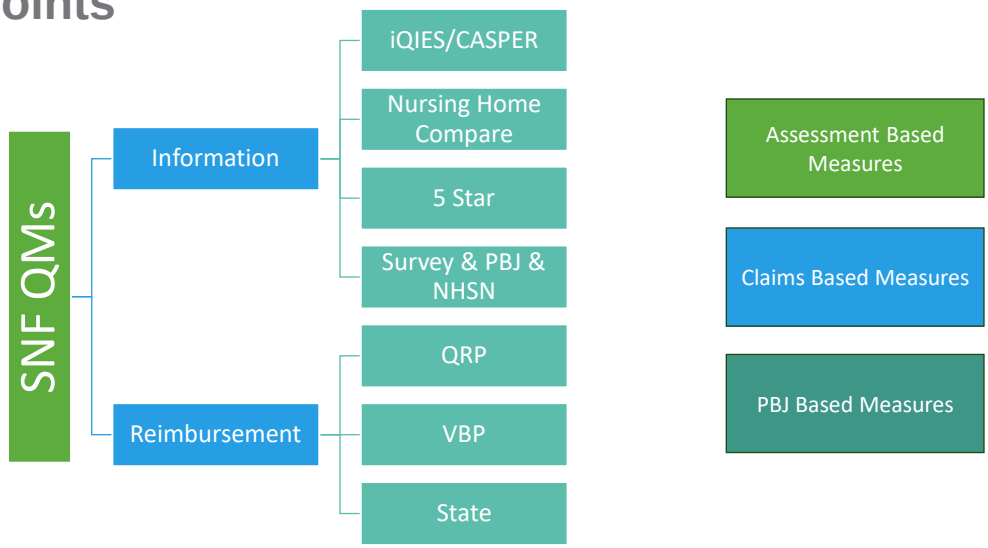
Data Points



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SNF Quality Measures – Impacting Outcomes

Quality Measure Group	Payor	Data Source(s)	Residents
iQIES/CASPER	All	MDS, Claims, PBJ, NHSN	All
Nursing Home Compare	All	MDS, Claims, PBJ, NHSN	All
5 Staff	All	MDS, Claims, PBJ	All
Survey	All	MDS & PBJ	All
Quality Reporting Program (QRP)	Medicare Part A	MDS & Claims	Short Stay Only (<101 Days)
Value Based Purchasing	Medicare Part A	Claims Only	Short Stay Only (<101 Days)

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Leadership Data Needs
• Internal/Operational/ Financial
• Quality/Clinical
• Workforce
• Public
• Compliance
• Reimbursement
• Strategy/Marketplace
data analysis
modeling
processing
decision-making
inspecting
aggregation
time-series
data mining
science
quality
presentation
experimental
cleaning
clustering
pattern
field data
sequence
extraction
causation
analytics
complexity
innumeracy
sorting
database
integrity
ranking
business intelligence
visualization
statistics
information
geographic
geospatial
correlation
deviation
structure
nominal
part-to-whole
research
storage
product
social

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Leadership Data Strategy
How
Where
When
What
Why
Who
3/16/2025

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CMS Data and Reports

Strategies for Leaders

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Where to Begin?

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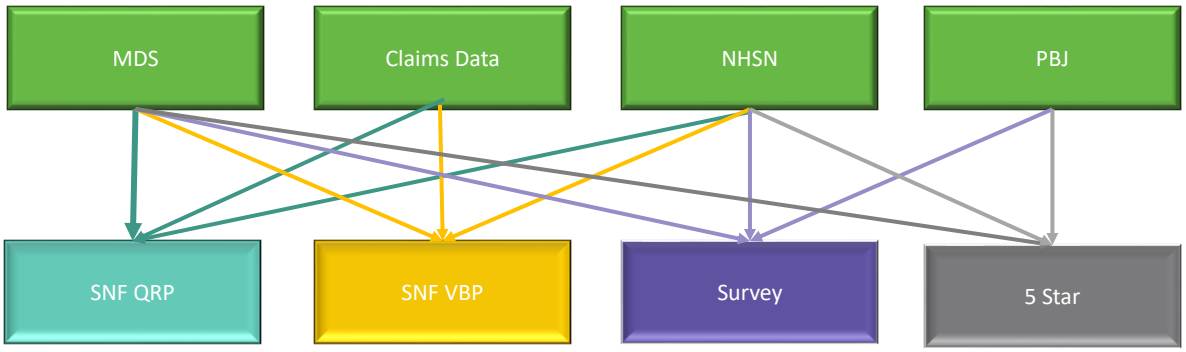
Organization Data Trail and Impact



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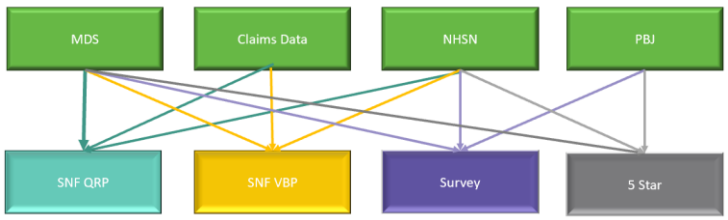
CMS Reports

- NHSN
- Quality Measures
- PBJ
- SNF QRP
- SNF VBP

- Weekly
- Monthly
- Quarterly
- Annual



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Weekly CMS Reports

For Leaders

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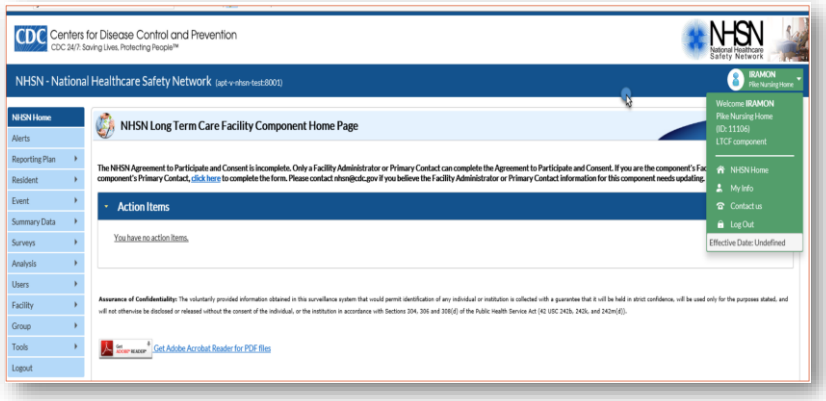
Weekly - NHSN

Weekly Reporting/Reports
COVID
RSV
Influenza
Vaccination
Cases
Hospitalizations

Monthly
HCP Vaccination

Annual
Influenza



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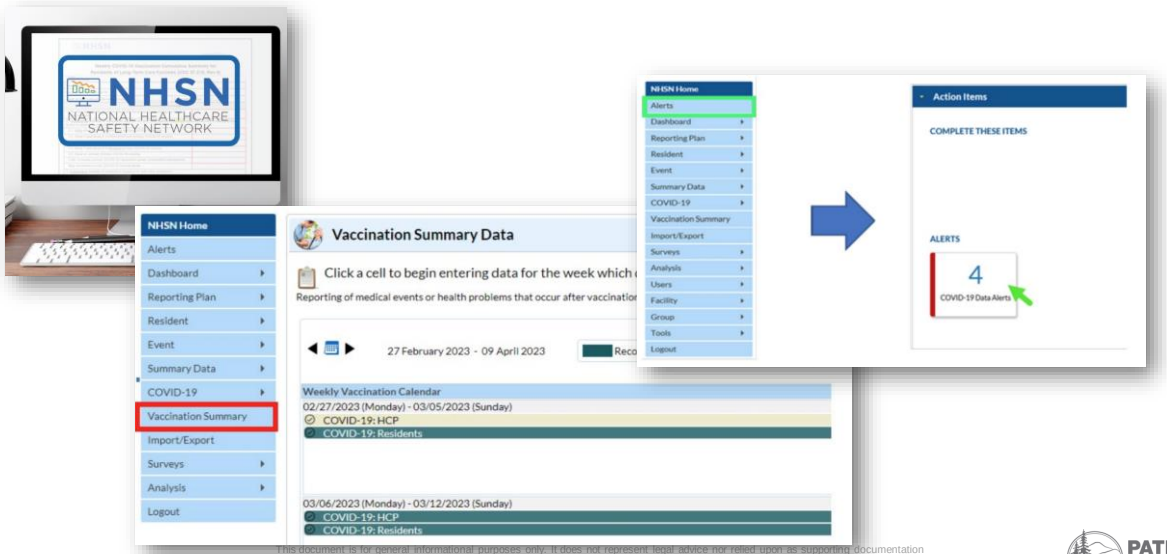
Check for Data Corrections and Timeliness



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Purpose and Reminders

- Check for errors or incompletion
- Review weekly every Friday
- NHSN Facility Administrator (for login) should stay up to date with requirements.
- Have at least one backup reporter for NHSN with Level 3 SAMS access.
- Have a designated day for weekly reporting.
- If an NHSN reporter is leaving, have a succession plan in place before their last day.

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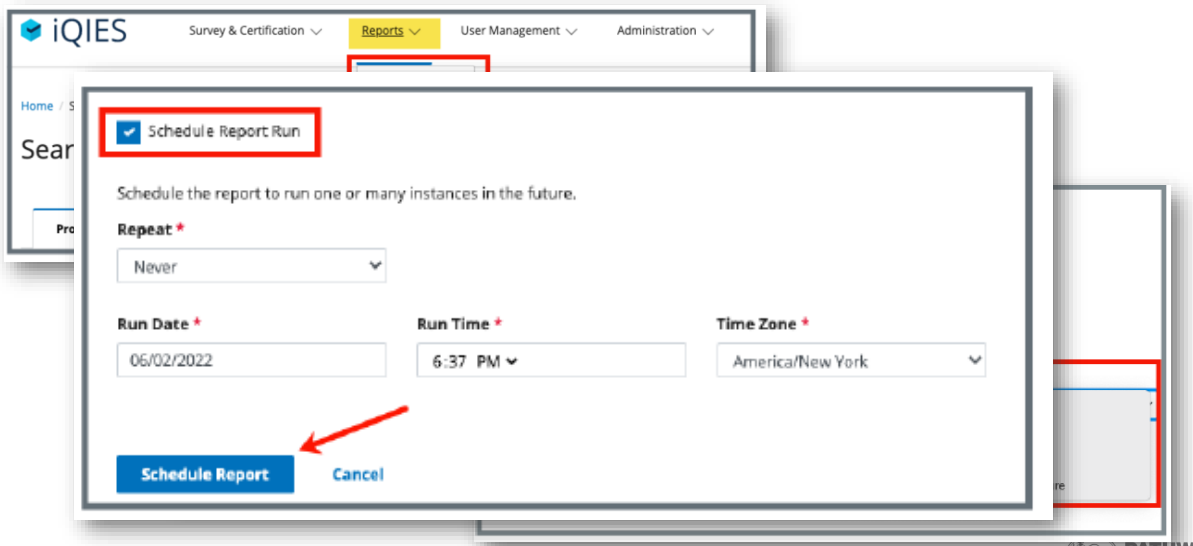
iQIES – Reports



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Weekly

- Schedule Weekly

MDS				
	MDS 3.0 QM Package	Package Reports	Quality Measure	Allows users to run one or multiple MDS 3.0 Quality Measure reports using the same report criteria selections for one or more providers in a single report request. All data for the selected reports will be returned in files separated by provider.
	MDS 3.0 Activity	Provider	Submission	Displays a list of accepted assessments, tracking records and inactivation requests that were submitted by the requested facility(ies) for the time frame selected.
	MDS 3.0 Admissions/ Reentry/ Discharges Report	Provider	Admission/ Discharge	Provides information about the residents who were admitted to and/or discharged from the selected facility during the specified period.
	MDS 3.0 Missing OBRA Assessment	Provider	Submission	Displays the residents for whom the target date of the most recent OBRA assessment (other than a discharge or death record) is more than 138 days prior to the report run date. The report also includes residents for whom no OBRA record was submitted for a current episode that began more than 60 days prior to the report run date.

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Weekly

- Schedule Weekly

Report Name	Report Category	Report Type	Report Purpose
MDS 3.0 NH Error Detail Report	Provider	Error	Displays assessment information and error details for user selected error numbers and submission date within the requested date range where selected errors were encountered in successful submissions made by or on behalf of the selected provider. Included in the report are the assessment items and submitted data that caused the selected error to occur.
MDS 3.0 NH Final Validation Report	Provider	Validation	Displays detailed information regarding the records contained in the submission file for the facility. The report indicates whether the records were accepted or rejected and displays the warning and fatal errors for the records.

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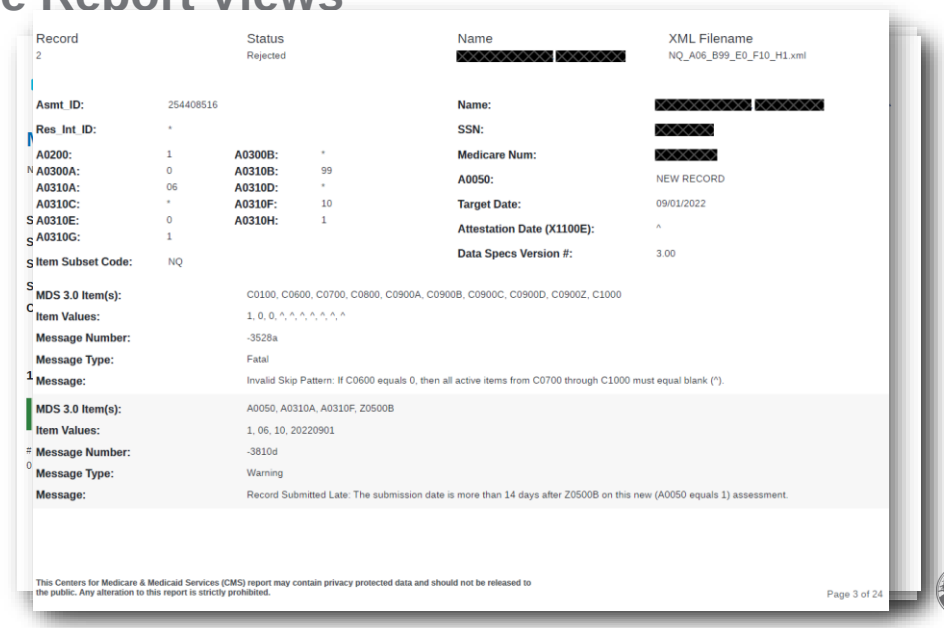
Sample Report Views



Record	Status	Name	XML Filename
2	Rejected	[redacted]	NQ_A06_B99_E0_F10_H1.xml

Asmt_ID:	254408516			**Name:**	[redacted]
Res_Int_ID:	*			**SSN:**	[redacted]
A0200:	1	**A0300B:**	*	**Medicare Num:**	[redacted]
A0300A:	0	**A0310B:**	99	**A0050:**	NEW RECORD
A0310A:	06	**A0310D:**	*	**Target Date:**	09/01/2022
A0310C:	*	**A0310F:**	10	**Attestation Date (X1100E):**	^
A0310E:	0	**A0310H:**	1	**Data Specs Version #:**	3.00
A0310G:	1				
Item Subset Code:	NQ				

MDS 3.0 Item(s):	C0100, C0600, C0700, C0800, C0900A, C0900B, C0900C, C0900D, C0900Z, C1000
Item Values:	1, 0, 0, ^, ^, ^, ^, ^, ^, ^
Message Number:	-3528a
Message Type:	Fatal
Message:	Invalid Skip Pattern: If C0600 equals 0, then all active items from C0700 through C1000 must equal blank (^).
MDS 3.0 Item(s):	A0050, A0310A, A0310F, Z0500B
Item Values:	1, 06, 10, 20220901
Message Number:	-3810d
Message Type:	Warning
Message:	Record Submitted Late: The submission date is more than 14 days after Z0500B on this new (A0050 equals 1) assessment.

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Goal

- Ensure all MDS assessments are accepted into the CMS database, no default rates
  - MDS 3.0 Final Nursing Home Validation Report
    - Generated within 24 hours of submission
    - Report indicates if the records were accepted, rejected, warnings, and fatal errors
  - MDS Error Detail Report
    - Outlines specific details
  - MDS Activity Report
    - Outlines all MDS activity during a specific time range
    - Important if a high number of admissions/DC
- MDSs align with business office census records
  - MDS 3.0 Admission/Discharge/Reentry Report

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Monthly Quality Measures Reports

Leaders Reports

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Short Stay

Quality Measure (QM) Label
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine
Percent of Residents Who Received the Seasonal Influenza Vaccine
Percent of Residents Who Were Offered and Declined the Seasonal Influenza Vaccine
Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine
Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine
Percent of Residents Who Received the Pneumococcal Vaccine
Percent of Residents Who Were Offered and Declined the Pneumococcal Vaccine
Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Pneumococcal Vaccine
Percent of Residents Who Newly Received an Antipsychotic Medication
Discharge Function Score

Long Stay

Quality Measure (QM) Label
Percent of Residents Experiencing One or More Falls with Major Injury
Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine
Percent of Residents Who Received the Seasonal Influenza Vaccine
Percent of Residents Who Were Offered and Declined the Seasonal Influenza Vaccine
Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine
Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine
Percent of Residents Who Received the Pneumococcal Vaccine
Percent of Residents Who Were Offered and Declined the Pneumococcal Vaccine
Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Pneumococcal Vaccine

Quality Measure (QM) Label
Percent of Residents with a Urinary Tract Infection
Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder
Percent of Residents Who Were Physically Restrained
Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased
Percent of Residents Who Lose Too Much Weight
Percent of Residents Who Have Depressive Symptoms
Percent of Residents Who Received an Antipsychotic Medication
Percent of Residents Whose Ability to Walk Independently Worsened
Percent of Residents Who Used Antianxiety or Hypnotic Medication
Percent of Residents with Pressure Ulcers
Percent of Residents With New or Worsened Bowel or Bladder Incontinence
Prevalence of Falls
Prevalence of Antianxiety/Hypnotic Use
Prevalence of Behavior Symptoms Affecting Others

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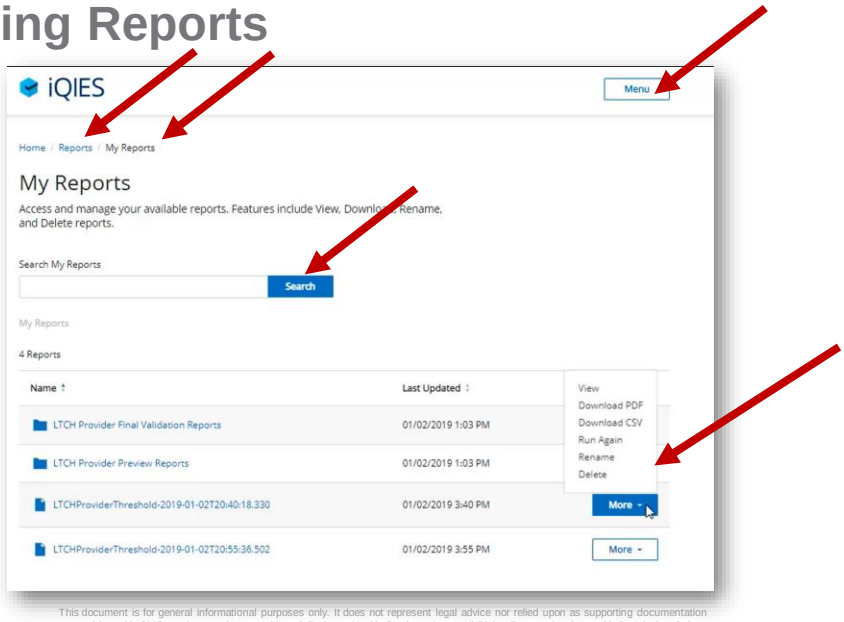
Accessing Reports

Date Range
Searchability
Saving options
Formatting Options
Graphs



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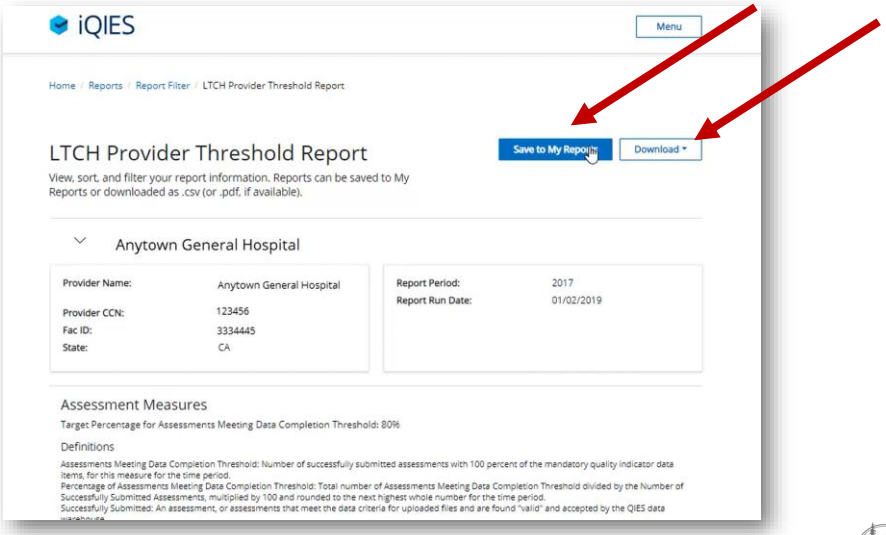
Accessing Reports



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Monthly MDS Reports

Quality Measure Reports

Report	Overview	Purpose
MDS 3.0 Facility Characteristics Report	• Displays facility demographic information based upon data submitted in the MDS 3.0 records and includes comparison state and national percentages for a specified timeframe. • By comparing the facility percentages with the state and national average percentages, you can determine whether the facility's demographic characteristics differ from the norm. • Facility characteristics may indicate a need to concentrate a review on certain resident groups.	• Review facility compared to state and national data • Determine any trends • Do the facility characteristics align with the current Facility Assessment demographics • Data gives the facility the opportunity to ensure that care and services are aligned with the needs of the demographic. • Determine areas for competencies and improvement • Review admissions and readmissions

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Monthly MDS Reports

Quality Measure Reports

Report	Overview	Purpose
MDS 3.0 Resident-Level Quality Measure (QM) Report	• Displays the residents (active and discharged) who were included in the calculations for the selected facility and period that were used to produce the MDS 3.0 Facility- Level Quality Measure (QM) Report. • The report lists the residents by name and indicates the measures, if any, triggered by each.	Identifies any residents triggered, 75% or above Use this information to review specific residents triggered (will be reviewed by surveyors). Does the data accurately reflect the resident current status.
MDS 3.0 Facility- Level Quality Measure (QM) Report	• Displays the facility percentage and how the facility compares with other facilities in their state and in the nation for each quality measure. • This report helps facilities identify possible areas for further emphasis in facility quality improvement activities or investigation during the survey process.	Review for QM's over 75% national percentile Determine trends – month to month, quarter to quarter Review comparison to the state and national levels Determine outliers

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Next - Quality Reporting Program

CMS.gov Centers for Medicare & Medicaid Services

- IMPACT Act - 2014
- Standardization of quality measures
- Medicare beneficiaries across settings

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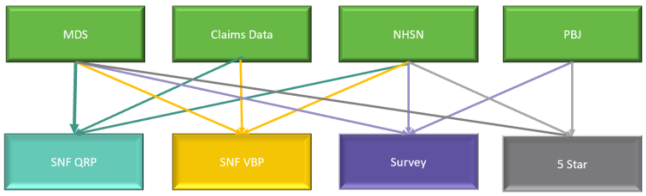
SNF QRP Reports

- Leader's review SNF QRP reports monthly for:
  - Compliance to avoid 2% payment reduction
  - Trend clinical performance affecting regulatory, financial, clinical, and public-facing outcomes
  - Benchmark performance nationally, like CMS



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Data Elements

Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Overview of Data Elements Used for Reporting Assessment-Based Quality Measures and Standardized Patient Assessment Data Elements Affecting FY 2025 Annual Payment Update (APU) Determination

Page 3 of 15

MDS Data Elements Used for FY 2025 SNF QRP APU Determination		MDS 3.0 Assessment Type		Data Collection Periods (CY 2023)	
MDS Section & Number	Data Element Label/Description	PPS 5-Day A0310B=[01]	Part A PPS Discharge A0310H=[1]	Q1, Q2, Q3 2023 MDS 3.0 Version 1.17.2	Q4 2023 MDS 3.0 Version 1.18.11
A1005*	Ethnicity	X			X
A1010*	Race	X			X
A1110A	Language: What is your preferred language?	X			X
A1110B	Language: Need or want an interpreter to communicate with a doctor or health care staff?	X			X
A1250	Transportation	X	X		X
A2105*	Discharge Status		X		X
A2121*	Provision of Current Reconciled Medication List to Subsequent Provider at Discharge		X		X
A2122*	Route of Current Reconciled Medication List Transmission to Subsequent Provider		X		X
A2123*	Provision of Current Reconciled Medication List to Resident at Discharge		X		X
A2124*	Route of Current Reconciled Medication List Transmission to Patient		X		X
B0200	Hearing	X			X
B1000	Vision	X			X
B1300	Health Literacy	X	X		X

SNF QRP FY2025 APU Table for Reporting Assessment Based Measures and Standardized Patient Assessment Data Elements (cm.gov)

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Monthly Reports for Leaders

SNF QRP Measure Reports

Report	Overview	Purpose
SNF QRP Facility Level Quality Measure (QM) Report	• Provides facility-level quality measure results for a select 12- month period. • Quality measure results are computed from the data submitted in the Minimum Data Set (MDS), Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN), and Medicare Fee-For-Service (FFS) Claims data sources.	• Determine if QM's reported for SNF QRP are improving or declining • Compare to national average (MDS, NHSN, Claims)
SNF QRP Provider Threshold Report	• Allows providers to monitor their compliance status of the required data submission for the SNF Quality Reporting Program (QRP) for the Annual Payment Update (APU) by Fiscal Year (FY).	• Details the status of the measures required for the Annual Payment Update (APU) 2% • 100% of data elements must be completed on 80% of MDS submissions

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Monthly Reports for Leaders

SNF QRP Measure Reports

Report	Overview	Purpose
SNF QRP Resident Level Quality Measure (QM) Report	• Lists each resident with a qualifying Minimum Data Set (MDS 3.0) record used to calculate the assessment-level quality measure values for a select 12-month period. • Calculates the facility-level quality measure values for a select 12-month period. • The report displays each resident's name and indicates how/if the resident's stay affected the SNF's quality measure scores.	• Part A SNF stays • Displays each resident's name and indicates how or if the resident's assessment affects the SNF's QMs.

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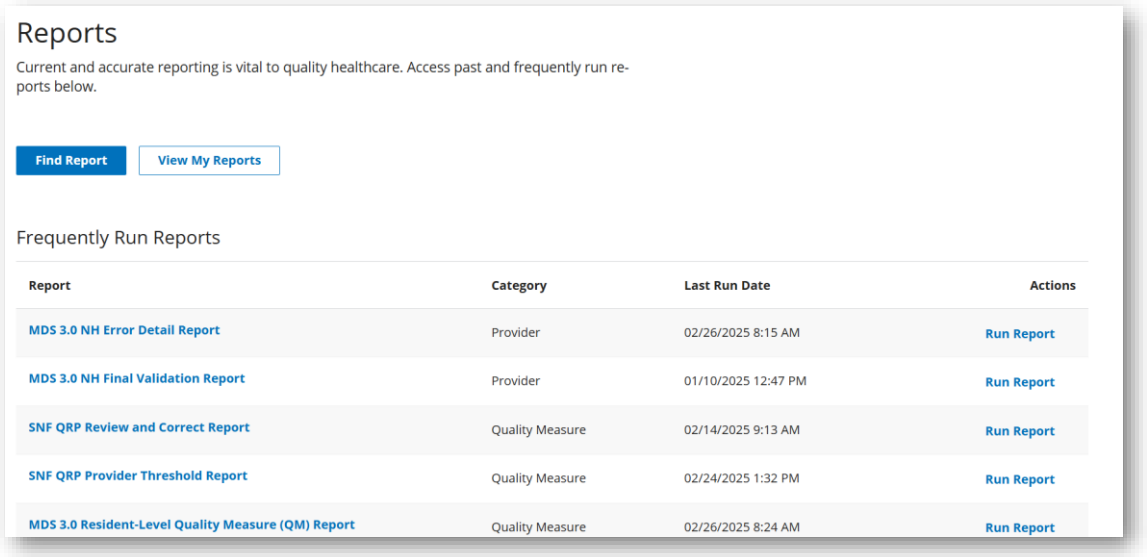
Reports
Current and accurate reporting is vital to quality healthcare. Access past and frequently run reports below.
Find Report
View My Reports
Frequently Run Reports
Report
Category
Last Run Date
Actions
MDS 3.0 NH Error Detail Report
Provider
02/26/2025 8:15 AM
Run Report
MDS 3.0 NH Final Validation Report
Provider
01/10/2025 12:47 PM
Run Report
SNF QRP Review and Correct Report
Quality Measure
02/14/2025 9:13 AM
Run Report
SNF QRP Provider Threshold Report
Quality Measure
02/24/2025 1:32 PM
Run Report
MDS 3.0 Resident-Level Quality Measure (QM) Report
Quality Measure
02/26/2025 8:24 AM
Run Report

iQIES Report

CMS

FY 2026 SNF QRP Provider Threshold Report

CCN		Report Run Date	08/09/2024
Facility Name		Data Collection Start Date	01/01/2024
City/State		Data Collection End Date	12/31/2024

# of MDS 3.0 Assessments Submitted:	104
# of MDS 3.0 Assessments Submitted Complete:	92
% of MDS 3.0 Assessments Submitted Complete:	89%*

* FY 2026 SNF QRP Annual Payment Update (APU) Determination Table is limited to the data elements that are used for determining SNF QRP compliance and are included in the APU submission threshold. There are additional data elements used to risk adjust the quality measures used in the SNF QRP. It should be noted that failure to submit all data elements used to calculate and risk adjust a quality measure can affect the quality measure calculations that are displayed on the Compare website.

*Disclaimer: The SNF Provider Threshold Report is available for the convenience of the provider. Extensions and exceptions approved according to CMS policy have not been applied in the score calculations. The score in this report is considered preliminary, and is not the final CMS calculation of SNF compliance with the requirements set out in 42CFR 413.360(b)(2).

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SNF QRP Compliance Report

iQIES Report

CMS

MDS 3.0 NH Error Detail Report

Note:* indicates an empty value

Facility ID:		**Report Period:**	01/01/2024 - 08/09/2024
Facility Name:		**Report Run Date:**	08/09/2024
City/State:		**Error Numbers Selected:**	-3891, -3897, -3908

Error Number	Error Type	Error Message
-3891	Warning	Discharge Goal Not Identified: If A0310B equals 01, then at least one of the items GG0130A2 through GG0130C2, GG0130E2 through GG0130H2, GG0170A2 through GG0170G2, GG0170I2 through GG0170P2, GG0170R2, or GG0170S2 should equal 01, 02, 03, 04, 05, 06, 07, 09, 10, or 88. Submitting dash (-) in the Discharge Goal items may result in a payment reduction of two percentage points for the affected payment determination.

Submission Date	Last Name	First Name	Assessment ID	Field in Error	Value in Error

No Data Returned for Selected Criteria

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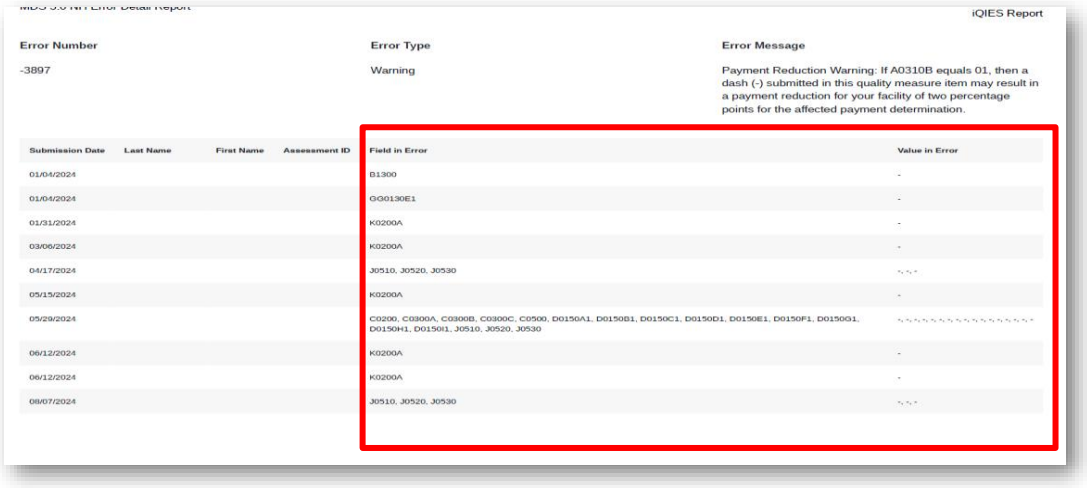
SNF QRP Compliance Report



MDS 3.0 NHI Error Detail Report — iQIES Report

Error Number	Error Type	Error Message
-3897	Warning	Payment Reduction Warning: If A0310B equals 01, then a dash (-) submitted in this quality measure item may result in a payment reduction for your facility of two percentage points for the affected payment determination.

Submission Date	Last Name	First Name	Assessment ID	Field in Error	Value in Error
01/04/2024				B1300	-
01/04/2024				GG0130E1	-
01/31/2024				K0200A	-
03/06/2024				K0200A	-
04/17/2024				J0510, J0520, J0530	-, -, -
05/15/2024				K0200A	-
05/29/2024				C0200, C0300A, C0300B, C0300C, C0500, D0150A1, D0150B1, D0150C1, D0150D1, D0150E1, D0150F1, D0150G1, D0150H1, D0150I1, J0510, J0520, J0530	-, -, -, -, -, -, -, -, -, -, -, -, -, -, -, -, -, -, -
06/12/2024				K0200A	-
06/12/2024				K0200A	-
08/07/2024				J0510, J0520, J0530	-, -, -

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Goal

- Review of organization data for accuracy
- Impacts
  - Medicare A reimbursement
  - Medicaid – PDPM/Case mix
  - Clinical trends
  - Reimbursement
  - Partnerships/relationships
  - Regulatory
- Identify trends and implement actions for improvement
- Proactive vs. reactive
- The reports need to become routine

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Quarterly CMS Reports

Leaders Reports

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Quarterly Reports for Leaders

MDS Quality Measures

Report	Overview	Purpose
MDS 3.0 QM Package Reports	• Set of reports that can be run simultaneous within customized date ranges • Included are: Facility Level Quality Measures Resident Level Listing Monthly Comparison Facility Characteristics	• Use to compare organization data to national and state benchmarks • Identify triggers above 75% • Review trends for increase or decline in outcomes • Report findings and actions to QAPI

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Quarterly Reports for Leaders

SNF QRP

Report	Overview	Purpose
SNF QRP Review & Correct Report	• Allows providers to review their QM data to identify if there are any corrections or changes needed to the assessment-based data prior to the quarter's data submission deadline, which is 4.5 months following the end of the reporting quarter. • The report will provide a breakdown by measure and by quarter, of the SNF's assessment-based QM data for four rolling quarters. • The report also identifies whether each quarter's data correction period is open or closed as of the report run date.	• Quarterly review and correction periods and data submission quarterly deadlines for payment determination are: Aug 15 November 15 February 15 May 15

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Quarterly Reports for Leaders

Payroll Based Journal - PBJ

Report	Overview	Purpose
Job Title Report	• Report details organization payroll data by work date and staffing hours submitted for PBJ specific job titles	• Review in detail for staffing hours and correlation to job roles in alignment with PBJ requirements
PBJ Submitter Final Validation Report	• Provides detailed status submission file outcomes – errors, missing data • Indicates submission outcome –accepted, rejected, warnings and fatal errors	• Impacts regulatory, five-star • Quarterly reporting deadlines: Feb 14 May 15 Aug 14 Nov 14

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Quarterly Reports for Leaders

Nursing Home Compare

Report	Overview	Purpose
Five Star – Nursing Home Compare Preview (Review and Correct)	• Report outlines a preview of data for each Five Star domain – health inspection, quality, and staffing. • Provides preview of rating for each domain and overall star rating	• Review in detail with the team • Identify areas of concern and improvement • Send in corrections prior to the final date. • Impacted by PBJ, MDS, NHSN data.

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Annual CMS Reports

Leaders Reports

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Provider Survey Report

Survey Reports

Report	Overview	Purpose
Provider Survey History Reports	• Report outlines the organization's deficiencies cited on the most recent four surveys, three years of complaint surveys • Deficiency trends • Scope and severity trends	• Download report 3 months prior to opening of survey window for survey preparation. • Review facility survey data and trends • Can use as comparison • Use to review with team for opportunities for improvement

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Health Equity

CMS defines **health equity** as 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.

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Health Equity Reports

- Confidential reports to identify individuals who are at risk for increased poor health outcomes due to social risk factors (SRFs) including low-income status or being from a certain race/ethnicity.
- The Stratified Health Equity Confidential Feedback Reports provide data on whether difference in measure outcomes is present for individuals in their facility.
- Data
  - Medicare Part A claims
  - Medicare part B claims
  - Medicare enrollment data
  - Medicare Bayesian Improved Surname Geocoding method (used to estimate beneficiaries' race and ethnicity).

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Quarterly Reports for Leaders

Confidential Feedback – Health Equity

Report	Overview	Purpose
Discharge to Community (DTC) Health Equity Confidential Feedback Report	• Captures the successful discharge to the community from the given post-acute setting meaning no unplanned rehospitalizations' or deaths in the 31 days post-discharge	• Link to readmissions (SNFVBP). • Across provider comparison to national performance • Comparison to national performance among same population • Within provider comparison
Medicare Spending Per Beneficiary (MSPB) Health Equity Confidential Feedback Report	• captures the efficiency of care per post-acute care treatment period and for 30 days after including the costs of emergency room or hospital admissions	• Link to readmissions (SNFVBP). • Across provider comparison to national performance • Comparison to national performance among same population • Within provider comparison

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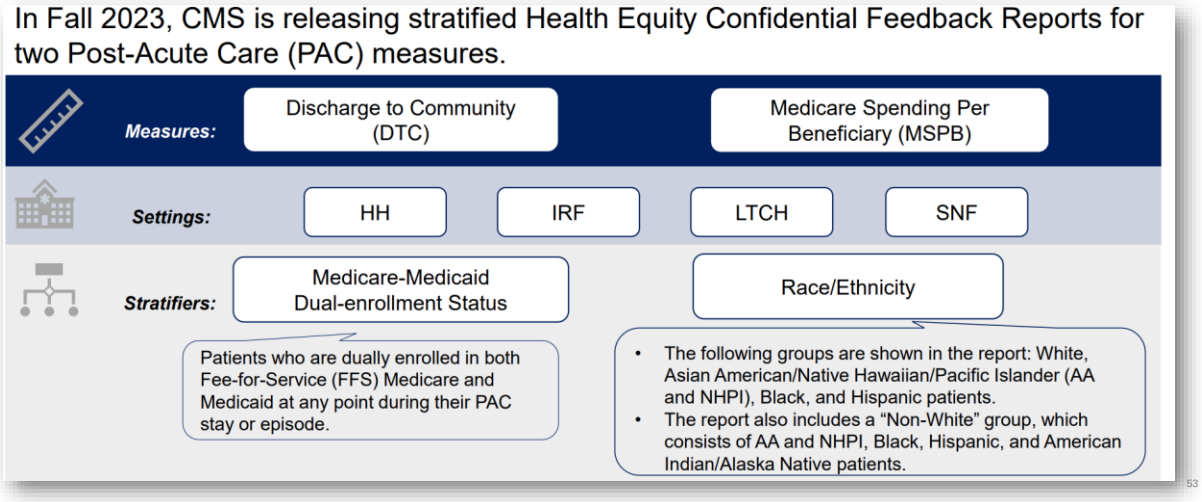
PAC Measures



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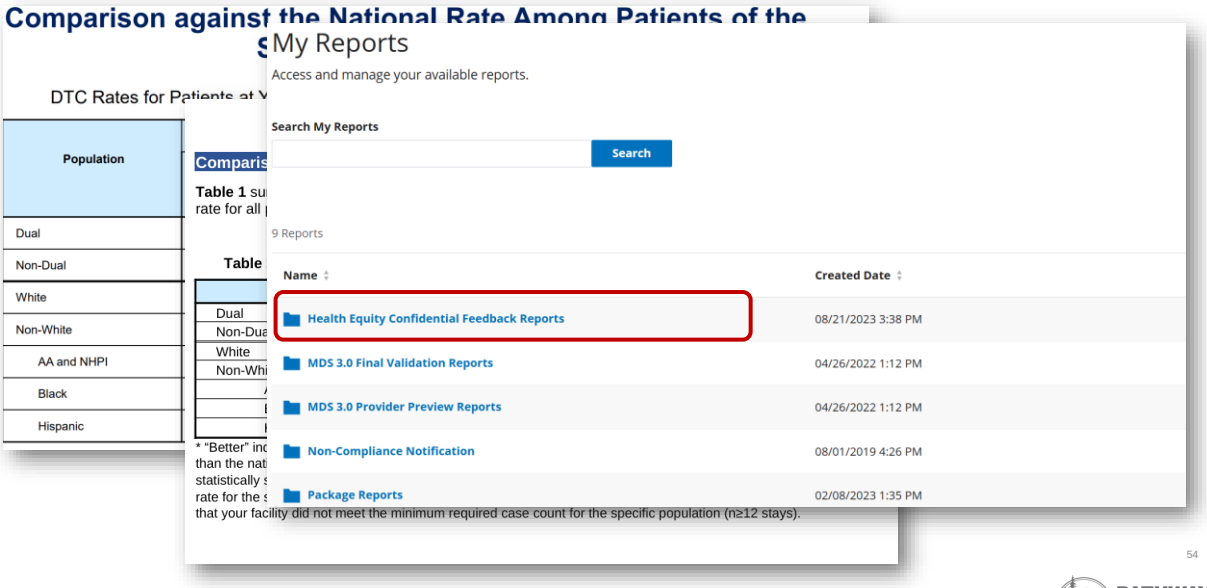

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SNF VBP Reports

Skilled Nursing Facility Value-Based Purchasing Program

FY 2025 Program Year Fact Sheet

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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) 2025 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 annual 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.

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SNF VBP Measures

Four additional CMS skilled nursing facility value-based purchasing (SNF VBP) measures went into **effect October 1, 2024**, to determine Medicare Part A rates beginning October 1, 2026.

- Hospital Readmissions-SNF 30 Day All Cause (2016)
- Healthcare Acquired Infection Hospitalizations
- Long-stay Hospitalizations
- Discharge to Community
- Discharge Function Score
- Total Nurse Turnover
- Total Nurse Hours Per Resident Day
- Long-stay Falls with Major Injury

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Measure and Link to Technical Report	Adopted in SNF PPS Final Rule	FY 2025 Program Year	FY 2026 Program Year	FY 2027 Program Year	FY 2028 Program Year
SNF 30-Day All-Cause Readmission Measure (SNFRM)	FY 2016	✓	✓	✓	–
Skilled Nursing Facility Healthcare-Associated Infections (SNF HAI) Requiring Hospitalization	FY 2023	–	✓	✓	✓
Total Nurse Staffing Hours per Resident Day (including Registered Nurse [RN], Licensed Practical Nurse [LPN], and Nurse Aide hours)	FY 2023	–	✓	✓	✓
Total Nursing Staff Turnover	FY 2024	–	✓	✓	✓
Discharge to Community—Post-Acute Care (DTC-PAC) Measure for SNFs	FY 2023	–	–	✓	✓
Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)	FY 2024	–	–	✓	✓
Discharge Function Score for SNFs	FY 2024	–	–	✓	✓
Number of Hospitalizations per 1,000 Long Stay Resident Days	FY 2024	–	–	✓	✓
Skilled Nursing Facility Within-Stay Potentially Preventable Readmission (SNF WS PPR) Measure	FY 2024	–	–	–	✓

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SNF VBP Report Examples

Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization (SNF HAI)	47 eligible stays	Yes	43 eligible stays	Yes	A lower (↓) result indicates better performance	5.82%	5.59%
Total Nursing Staff Turnover	107 eligible nursing staff	Yes	91 eligible nursing staff	Yes	A lower (↓) result indicates better performance	73.83%	80.22%
Total Nursing Hours per Resident Day	66 average residents per day	Yes	59 average residents per day	Yes	A higher (↑) result indicates better performance	4.20 nursing hours per resident day	3.96 nursing hours per resident day

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SNF VBP Report Examples

Table 4. Your SNF's Measure Score Calculations

Measure	Your SNF's Baseline Period Measure Result [a]	Your SNF's Performance Period Measure Result [a]	Your SNF's Achievement Score (0 - 10; higher is better)	Your SNF's Improvement Score (0 - 9; higher is better)	Your SNF's Measure Score (0 - 10; higher is better)
Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	17.88%	19.37%	4.90838	0.00000	4.90838
Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization (SNF HAI)	5.82%	5.59%	8.51902	3.35009	8.51902
Total Nursing Staff Turnover	73.83%	80.22%	0.00000	0.00000	0.00000
Total Nursing Hours per Resident Day	4.20 nursing hours per resident day	3.96 nursing hours per resident day	2.65529	0.00000	2.65529

SNF VBP Report Examples

Table 2. Measure Performance and Scores

Measure	Your SNF's Baseline Period Measure Result	Your SNF's Performance Period Measure Result	Compared to the Baseline Period, Your SNF's Performance Period Measure Result is... [a]	Your SNF's Measure Score (0 - 10; higher is better)	Your SNF's Measure Score is...
Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	17.88%	19.37%	worse	4.90838	equal to or better than 61% of SNFs nationwide
Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization (SNF HAI)	5.82%	5.59%	better	8.51902	equal to or better than 84% of SNFs nationwide
Total Nursing Staff Turnover	73.83%	80.22%	worse	0.00000	equal to or better than 23% of SNFs nationwide
Total Nursing Hours per Resident Day	4.20 nursing hours per resident day	3.96 nursing hours per resident day	worse	2.65529	equal to or better than 67% of SNFs nationwide

Notes:
[a] Comparison of your SNF's baseline and performance period measure results was conducted on unrounded numbers and may indicate a difference even if the displayed, rounded numbers do not.

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SNF VBP Report Examples

Table 6. Your SNF's Performance Score Calculation

Measure	Your SNF's Measure Score (0 - 10; higher is better)	Maximum Possible Score	Contribution to Performance Score [b,c]
Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	4.90838	10.00000	12.27094
Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization (SNF HAI)	8.51902	10.00000	21.29755
Total Nursing Staff Turnover	0.00000	10.00000	0.00000
Total Nursing Hours per Resident Day	2.65529	10.00000	6.63822
Sum of All Eligible Measures	**16.08269**	**40.00000**	**40.20672**

SNF VBP Report Examples

Table 8. Your SNF's Performance Score and Incentive Payment Multiplier

Program Year	FY 2026
Your SNF's Performance Score (0 - 100; higher is better) [a]	40.20672
Your SNF's Incentive Payment Multiplier (IPM) [a,b]	**0.9909452354**

Notes:

[a] If your SNF does not meet the measure minimum, your SNF will receive "measure minimum not met" for your SNF's performance score and incentive payment multiplier.

[b] When payments are made for a SNF's Medicare FFS Part A claims, CMS would multiply the adjusted federal per diem rate by this multiplier. If your incentive payment multiplier is <1, your SNF will earn less than it would have in the absence of the SNF VBP Program. If your incentive payment multiplier is >1, your SNF will earn more than it would have in the absence of the SNF VBP Program. If your incentive payment multiplier is equal to 1, your SNF will earn the same amount it would have in the absence of the SNF VBP Program.

Determining the incentive payment Example 1.09 – X 100= Incentive payment

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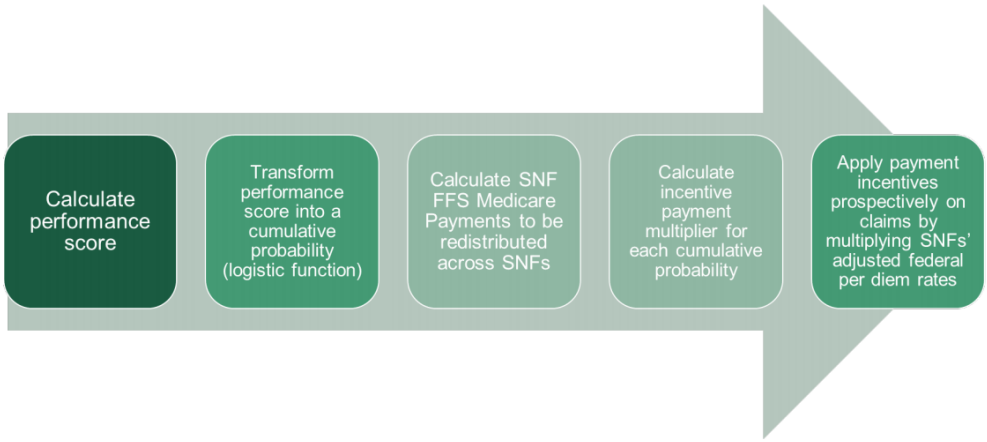
SNF VBP

Incentive Payment Calculation



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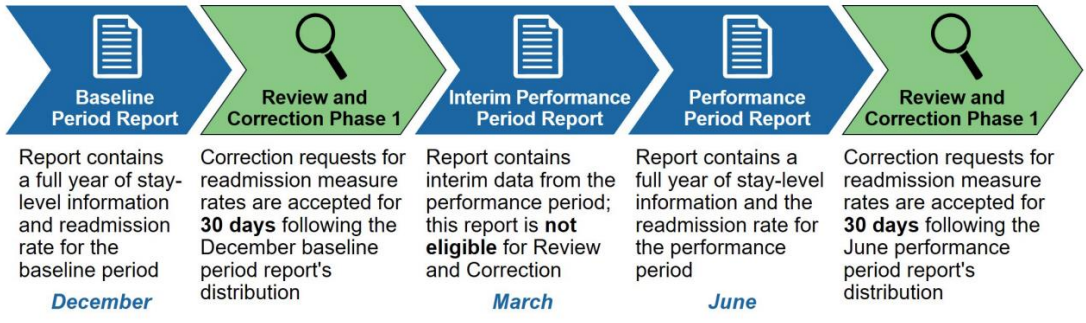
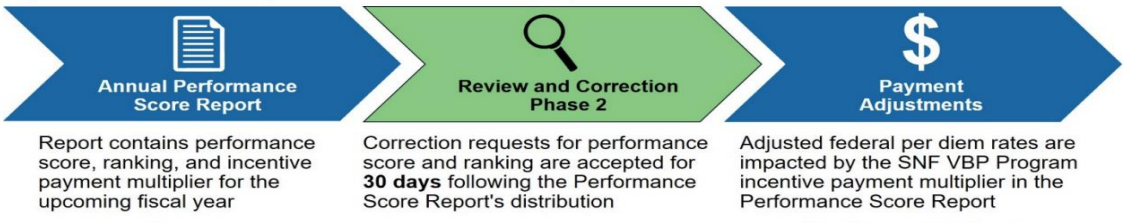


Interim Workbook Full Year Workbook Performance Score



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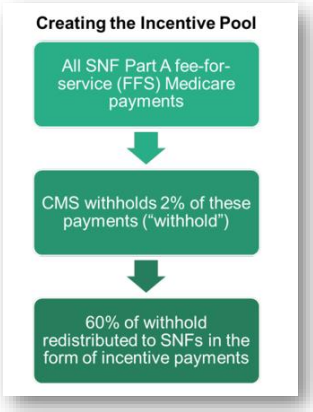
Value Based Purchasing Program



SNF VBP P	Footnote --	CMS Certification Number (CCN)	Baseline P	Performan	Achievement Sco	Improvement Score	Performance Scor	Incentive Payment Multiplier
7275		010007	0.20018	0.23768	0	0	0	0.980253876
602		010044	0.17051	0.1707	92.53589	0	92.53589	1.017400809
712		010045	0.18901	0.1724	88.4689	80.88418	88.4689	1.017139608
2966		010058	0.18295	0.18755	52.22488	0	52.22488	1.001067411
791		010065	0.19672	0.1732	86.55502	81.95009	86.55502	1.016976601
653		010125	0.187	0.17149	90.64593	84.49798	90.64593	1.017292087
7200		010158	0.22835	0.223	0	4.11725	4.11725	0.980381903
2104		015009	0.17921	0.18308	62.91866	0	62.91866	1.009756552
7275		015010	0.20903	0.23358	0	0	0	0.980253876
4644		015012	0.22385	0.20281	15.7177	33.83352	33.83352	0.986284171
1411		015016	0.2086	0.17865	73.51675	71.93296	73.51675	1.014634825
1357		015019	0.17671	0.17825	74.47368	0	74.47368	1.014911788
7275		015024	0.2121	0.22338	0	0	0	0.980253876
7147		015027	0.21242	0.20801	0	5.31579	5.31579	0.98042998
7275		015028	0.21721	0.21704	0	0	0	0.980253876
3792		015031	0.17182	0.19134	43.15789	0	43.15789	0.992719569
2239		015032	0.23601	0.19194	41.72249	61.43051	61.43051	1.008761832

FY_2024_SNF_VBP_Facility_Perfor

FY 2024 SNF VBP Facility-Level Dataset | Provider Data Catalog (cms.gov)

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Resource

Value-Based Purchasing (SNF VBP) Program *Quick*TIP©

Quality Measures Impacting Organizational Outcomes

SNF VBP Measure		FY 2024	FY 2025	FY 2026	FY 2027	FY 2028	Performance Period Begins	Data/ Measure	Risk Adjust
SNFRM – All-cause readmission	All-cause rehospitalizations during 30-day window from admission to SNF During & after SNF stay (if DC home prior to 30 days) Excludes planned readmits and observation stays	X	X	X	X	-	CY2017 1 year measurement	Claims	X
Skilled Nursing Facility Healthcare-Associated Infections (SNF HAI) Requiring Hospitalization *(See link page 2 for ICD-10 Codes for HAI Conditions)*	Likely SNF-acquired infections that require hospitalization Invasive medical device infections (catheters, insulin pumps, central lines, trachs, etc.)			X	X	X	FY2024 Oct 2023-Sept 2024	Claims SNF QRP	X
Total Nurse Staffing Hours per Resident Day (includes RN, LPN, Nurse Aide hours)	Includes C.N.A., LPN, and RN hours across 4 quarters PBJ Job Codes 5-12			X	X	X	FY2024 Oct 2023-Sept 2024	PBJ Five Star	
Total Nurse Staff Turnover	Includes C.N.A., LPN, and RN hours across 4 quarters for the numerator PBJ Job Codes 5-12			X	X	X	FY2024 Oct 2023-Sept 2024	PBJ Five Star	
Discharge to Community – Post Acute Care (DTC-PAC) Measure for SNFs	Residents discharged to community following SNF stay and do not have an unplanned readmission to hospital or LTCH or die in 31 days following DC				X	X	FY2024 – FY2025 Oct 2023-Sept 2025	Claims Five Star/ SNF QRP	X

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Resource

SNF VBP Measure		FY 2024	FY 2025	FY 2026	FY 2027	FY 2028	Performance Period Begins	Data/ Measure	Risk Adjust
	Community = DC to home or home with home health services						2 year measurement		
Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)	LS residents with one or more falls with major injury J1900C = 1,2 LS: >100 days				X	X	FY2025 1 year measurement	MDS Five Star	
Discharge Function Score for SNFs *(See link below for DC Function Score Technical Report)*	Percent of Med A SNF residents who achieve an expected function score at DC Based on Admission Function Score, age, and resident clinical characteristics				X	X	FY2025 1 year measurement	MDS SNF QRP	X
Number of Hospitalizations per 1000 Long Stay Resident Days	Unplanned hospitalizations for every 1000 days that the LS residents were in the SNF Includes inpatient & outpatient observation stays Planned admissions identified via hospital dc claim				X	X	FY2025 1 year measurement	Claims Five Star	X
Skilled Nursing Facility Within-Stay Potentially Preventable Readmission (SNF WS PPR)	Preventable rehospitalizations during 30 day window from admission to SNF Only during SNF stay					X	FY2026-FY2027 2 year measurement	Claims	X

Resource: https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing

See Appendix A: ICD-10 Codes for HAI Conditions: www.cms.gov/files/document/snf-hai-technical-report.pdf - 52 pages of possible ICD-10 codes

DC Function Score: www.cms.gov/files/document/snf-discharge-function-score-technical-report-february-2023.pdf-0

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Leadership Strategies

Prepare Plan Implement

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Prepare | Plan | Implement

- Team approach (Cross sectional)
- Data Strategy Plan
- Determine CMS and Other Reports
- Standardize the process
- Align with organization priorities
- Compare to Facility Assessment
- Communicate
- Evaluate and Monitor
- QAPI

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Resource

Leaders Guide

CMS Report Utilization

Report	Frequency				Responsible	What *(Generate reports, review/trends, audit, benchmark)*	Actions/Outcomes
	Wk.	Mon	Qtr.	Yr.			
NHSN Reports							
MDS NH Error Detail Report							
MDS NH Final Validation Report							
MDS Missing OBRA Assessments							
MDS Facility Characteristics Report							
MDS Facility Level Quality Measure Report							
MDS Resident Level Quality Measure Report							
SNF QRP Resident Level Quality Measure Report							
SNF QRP Facility Level Quality Measure Report							
SNF QRP Provider Threshold Report							

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Prepare | Plan | Implement

MDS Process

- Identify the processes for MDS data collection, coding, scheduling, and validation.
- Educate all persons collecting and coding data about MDS definitions and instructions for coding.
- Competency checks!
- Audit MDS-based QM data monthly, quarterly, annually

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Prepare | Plan | Implement

Data Knowledge

- Download the various SNF QM resources, learn them, and use them
- Establish a team to review the QMs on a regular basis – monthly, quarterly, annually
- Take advantage of preview reports to correct any discrepancies
- Fully implement QAPI
- Share the data internally and externally

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Prepare | Plan | Implement

Data → Trends

- Comparison to self over time
- Comparison to State
- Comparison to National
  - State comparison may represent local practice patterns, staffing, and referrals
  - National comparison represents a large pool of facilities
  - Your data reflects the facility resident and staff population and organizational practices.

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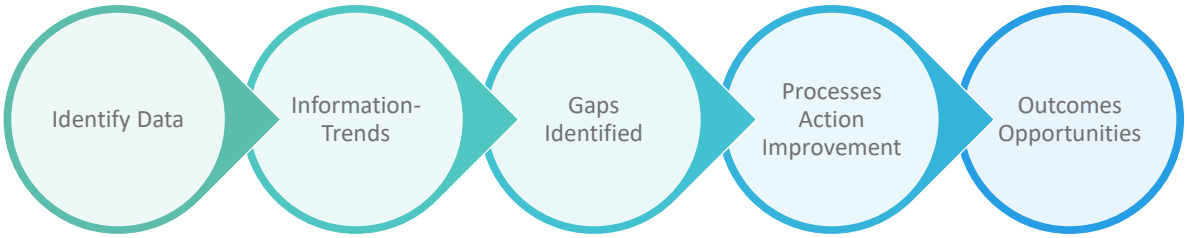
Strategies for Success



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"The goal is to turn data into information, and information into insight."
– Carly Fiorina, former executive, president, and chair of Hewlett-Packard Co.

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PATHWAY HEALTH
Insight | Expertise | Knowledge

Consulting | Education | Interim | Resources

The Leaders Top 10

Lisa Thomson, BA, LNHA, LALD, HSE, CIMT
Chief Operating Officer
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