
"A *Knowledgeable* and *Compassionate* partner"
BROAD RIVER REHAB
Health Equity and Social Determinants of Health
The Changing Face of Patient Care
MHCA Convention 08/27/2024
Joel VanEaton, BSN, RN, RAC-CT, RAC-CTA, Advanced Master Teacher:
Executive Vice President of PAC Regulatory Affairs and Education

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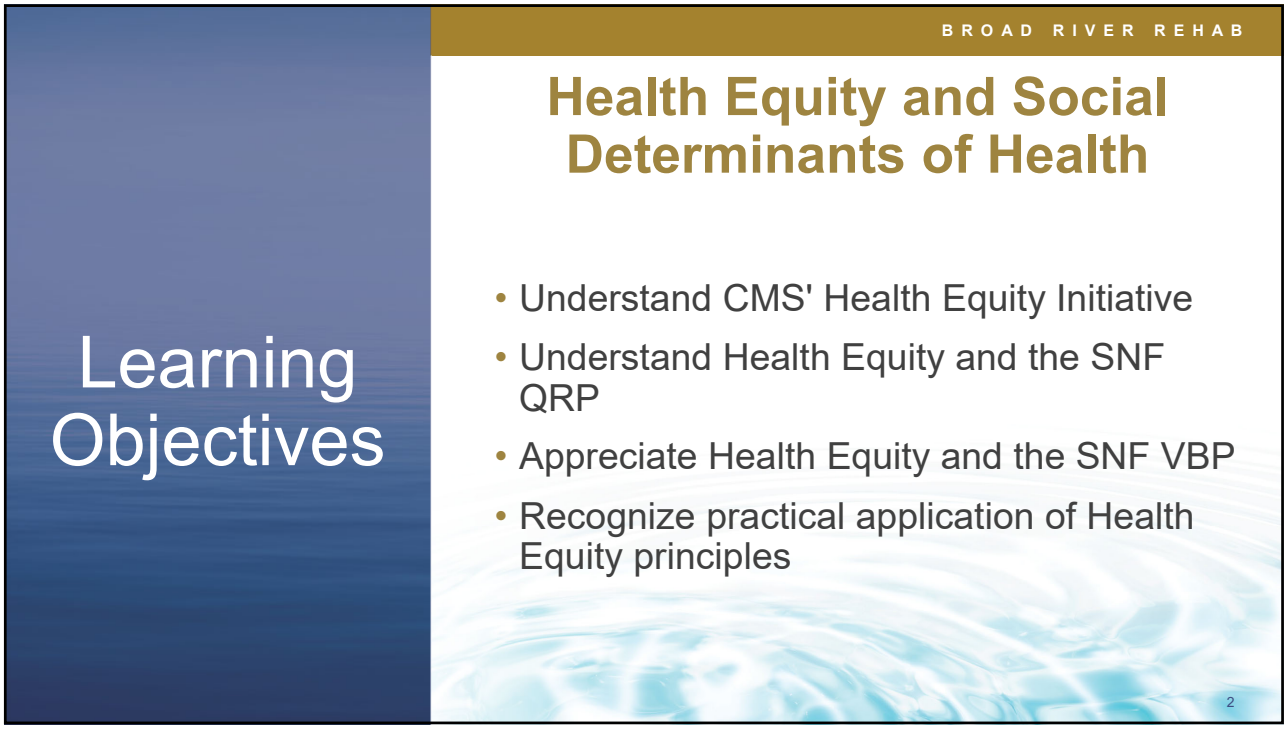
BROAD RIVER REHAB
Learning Objectives
Health Equity and Social Determinants of Health
• Understand CMS' Health Equity Initiative
• Understand Health Equity and the SNF QRP
• Appreciate Health Equity and the SNF VBP
• Recognize practical application of Health Equity principles
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Skilled Nursing Facility Quality Reporting Program (SNF QRP)

- **SNF QRP and VBP Resources:**
  - SNF QRP
  - SNF QRP Technical Specifications
  - Reporting tables for FY 2026
  - SNF QRP Data Submission Deadlines
  - Health Equity Confidential Feedback Report educational Material
  - SNF VBP
  - CMS National Quality Strategy
  - CMS Health Equity Framework
  - Area Deprivation Index Neighborhood Atlas

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IMPACT Act

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

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IMPACT Act QMs

TABLE 28: Quality Measures Currently Adopted for the SNF QRP

Short Name	Measure Name & Data Source
Resident Assessment Instrument Minimum Data Set (Assessment-Based)	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
TOH-Provider	Transfer of Health (TOH) Information to the Provider Post-Acute Care (PAC)
TOH-Patient	Transfer of Health (TOH) Information to the Patient Post-Acute Care (PAC)
DC Function	Discharge Function Score
Patient/Resident COVID-19 Vaccine	COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
Claims-Based	
MSPB SNF	Medicare Spending Per Beneficiary (MSPB)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
DTC	Discharge to Community (DTC)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
SNF HAI	SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization
National Healthcare Safety Network	
HCP COVID-19 Vaccine	COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (HCP)

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SNF Quality Reporting Program (QRP)

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

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SNF Quality Reporting Program (QRP)

- **New Category: Social Determinants of Health** MDS items have been added and or revised to assess for SDOH:
  - **Ethnicity – MDS item A1005**
  - **Race – MDS item A1010**
  - **Preferred Language – MDS item A1110**
  - **Interpreter Services – MDS item A1110**
  - **Transportation – MDS item A1250**
  - **Health Literacy – MDS item B1300**
  - **Social Isolation – MDS item D0700**
  - **New FY 2026 – Living Situation**
  - **New FY 2026 – Food (x 2 items)**
  - **New FY 2026 – Utilities**
  - **Revised FY 2026 – Transportation**

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SNF Quality Reporting Program (QRP)

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

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SNF VBP/QRP Connection: Health Equity

CMS Framework for Health Equity 2022–2032

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SNF VBP/QRP Connection: Health Equity

- The CDC defines health equity as, "…the state in which everyone has a fair and just opportunity to attain their highest level of health." "Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable **health disparities**."
- The CDC also indicated that, "Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities." "Achieving health equity also requires addressing **social determinants of health** and **health disparities**."

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SNF VBP/QRP Connection: Health Equity

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

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SNF VBP/QRP Connection: Health Equity

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

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SNF VBP/QRP Connection: Health Equity

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

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SNF VBP/QRP Connection: Health Equity

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

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SNF QRP Updates – New MDS Items

- CMS has finalized a requirement to require SNFs to collect and submit four new items in the MDS as standardized patient assessment data elements under the SDOH category because these items would collect information not already captured by the current SDOH items.
- These item will begin to be collected for residents admitted on October 1, 2025 through December 31, 2025 for purposes of the FY 2027 SNF QRP, excluding any SNF residents who, immediately prior to their hospitalization that preceded a new SNF stay, resided in a NF for at least 366 continuous days.
- Specifically, CMS believes the ongoing identification of SDOH would have three significant benefits.
  - First, promoting screening for these SDOH could serve as evidence-based building blocks for supporting healthcare providers in actualizing their commitment to address **disparities that disproportionately impact underserved communities**.
  - Second, screening for SDOH **improves health equity** through identifying potential social needs so the SNF may address those with the resident, their caregivers, and community partners during the discharge planning process, if indicated.
  - Third, these SDOH items could support CMS' ongoing SNF QRP initiatives by providing data with which to **stratify SNF's performance on measures and or in future quality measures**.

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SNF QRP Updates – New MDS Items

- CMS' definition of SDOH: SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
- According to the World Health Organization, research shows that the SDOH can be more important than health care or lifestyle choices in influencing health, accounting for between 30 to 55 percent of health outcomes.
- Access to standardized data relating to SDOH on a national level permits us to conduct periodic analyses, and to assess their appropriateness as risk adjustors or in future quality measures.
- These items have the capacity to take into account treatment preferences and care goals of residents and their caregivers, to inform CMS' understanding of resident complexity and SDOH that may affect care outcomes and ensure that SNFs are in a position to impact them through the provision of services and supports, such as connecting residents and their caregivers with identified needs with social support programs.

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SNF QRP Updates – New MDS Items

- **Health-related social needs (HRSNs)** are individual-level, adverse social conditions that negatively impact a person's health or health care and are the resulting effects of SDOH.
- Examples of HRSNs include lack of access to food, housing, or transportation, and have been associated with poorer health outcomes, greater use of emergency departments and hospitals, and higher health care costs.
- Certain HRSNs can directly influence an individual's physical, psychosocial, and functional status. This is particularly true for food security, housing stability, utilities security, and access to transportation.
- Additional collection of SDOH items would permit CMS to continue developing the statistical tools necessary to maximize the value of Medicare data and improve the quality of care for all beneficiaries.
- As CMS continues to standardize data collection across PAC settings, they believe using common standards and definitions for new items is important to promote interoperable exchange of longitudinal information between SNFs and other providers to facilitate coordinated care, continuity in care planning, and the discharge planning process.

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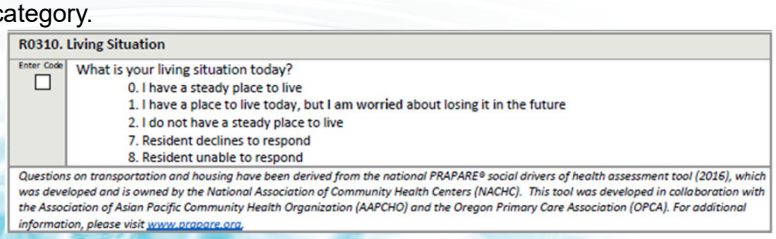
SNF QRP Updates – New MDS Items

- **Living Situation**
  - Lack of housing stability encompasses several challenges, such as having trouble paying rent, overcrowding, moving frequently, or spending the bulk of household income on housing.
  - These experiences may negatively affect one's physical health and access to health care.
  - Housing instability can also lead to homelessness, which is housing deprivation in its most severe form. People who are homeless have an increased risk of premature death and experience chronic disease more often than among the general population.
  - CMS believes that SNFs can use information obtained from the Living Situation item during a resident's discharge planning.
  - Due to the potential negative impacts housing instability can have on a resident's health, CMS is adopting the Living Situation item as a new standardized patient assessment data element under the SDOH category.



R0310. Living Situation

Enter Code ☐

What is your living situation today?

0. I have a steady place to live
1. I have a place to live today, but I am worried about losing it in the future
2. I do not have a steady place to live
7. Resident declines to respond
8. Resident unable to respond

Questions on transportation and housing have been derived from the national PRAPARE® social drivers of health assessment tool (2016), which was developed and is owned by the National Association of Community Health Centers (NACHC). This tool was developed in collaboration with the Association of Asian Pacific Community Health Organization (AAPCHO) and the Oregon Primary Care Association (OPCA). For additional information, please visit www.nrapare.org.

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SNF QRP Updates – New MDS Items

- **Food (2 items)**
  - The U.S. Department of Agriculture, Economic Research Service defines a lack of food security as a household-level economic and social condition of limited or uncertain access to adequate food.
  - Adults who are food insecure may be at an increased risk for a variety of negative health outcomes and health disparities like obesity, and higher probability of death from any cause or cardiovascular disease.
  - Having enough food is one of many predictors for health outcomes, a diet low in nutritious foods is also a factor.
  - CMS believes that adopting items to collect and analyze information about a resident's food security at home could provide additional insight to their health complexity and help facilitate coordination with other healthcare providers, facilities, and agencies during transitions of care, so that referrals to address a resident's food security are not lost during vulnerable transition periods.
  - CMS is adopting two Food items as new standardized patient assessment data elements under the SDOH category.

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SNF QRP Updates – New MDS Items

- **Food (2 items) cont.**

R0320. Food

Enter Code ☐

A. Within the past 12 months, you worried that your food would run out before you got money to buy more.
0. Often true
1. Sometimes true
2. Never true
7. Resident declines to respond
8. Resident unable to respond

Enter Code ☐

B. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
0. Often true
1. Sometimes true
2. Never true
7. Resident declines to respond
8. Resident unable to respond

Hager, E. R., Quigg, A. M., Black, M. M., et al. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146.

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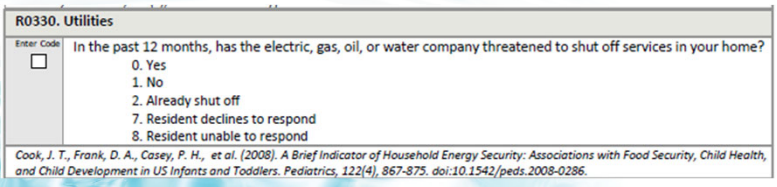
SNF QRP Updates – New MDS Items

- **Utilities**
  - A lack of energy (utility) security can be defined as an inability to adequately meet basic household energy needs.46 According to the United States Department of Energy, one in three households in the U.S. are unable to adequately meet basic household energy needs.
  - The consequences associated with a lack of utility security are represented by three primary dimensions: economic; physical; and behavioral. The effects of a lack of utility security include vulnerability to environmental exposures such as dampness, mold, and thermal discomfort in the home, which have a direct impact on a person's health.
  - CMS believes that adopting an item to collect information about a resident's utility security would facilitate the identification of residents who may not have utility security and who may benefit from engagement efforts.
  - CMS is adopting a new item, Utilities, as a new standardized patient assessment data element under the SDOH category



R0330. Utilities

Enter Code ☐

In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?

0. Yes
1. No
2. Already shut off
7. Resident declines to respond
8. Resident unable to respond

Cook, J. T., Frank, D. A., Casey, P. H., et al. (2008). A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers. Pediatrics, 122(4), 867-875. doi:10.1542/peds.2008-0286.

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SNF QRP Updates – New MDS Items

- **Transportation (Revised)**
  - Beginning October 1, 2023, SNFs began collecting seven items adopted as standardized patient assessment data elements under the SDOH category on the MDS. One of these items, A1250. Transportation, collects data on whether a lack of transportation has kept a resident from getting to and from medical appointments, meetings, work, or from getting things they need for daily living.
  - First, the modification of the Transportation item will use a defined 12-month look back period, while the current Transportation item uses a look back period of six to 12 months. CMS believes the distinction of a 12-month look back period would reduce ambiguity for both residents and clinicians, and therefore, improve the validity of the data collected.
  - Second, CMS is simplifying the response options, as shown below, as they believe reliable transportation services are fundamental to a person's overall health, and as a result, the burden of collecting this information separately outweighs its potential benefit.

Current

A1250. Transportation (from NACHC©) QRP

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

Complete only if A0310B = 01 or A0310G = 1 and A0310H = 1

↓ Check all that apply

☐ A. Yes, it has kept me from medical appointments or from getting my medications ♠

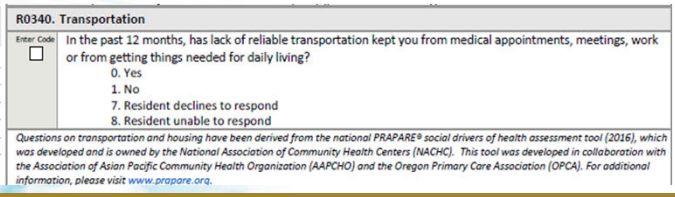
☐ B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need ♠

☐ C. No ♠

☐ X. Resident unable to respond ♠

☐ Y. Resident declines to respond ♠

Finalized



R0340. Transportation

Enter Code ☐

In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

0. Yes
1. No
7. Resident declines to respond
8. Resident unable to respond

Questions on transportation and housing have been derived from the national PRAPARE® social drivers of health assessment tool (2016), which was developed and is owned by the National Association of Community Health Centers (NACHC). This tool was developed in collaboration with the Association of Asian Pacific Community Health Organization (AAPCHO) and the Oregon Primary Care Association (OPCA). For additional information, please visit www.prapare.org.

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SNF QRP Updates – New MDS Items Timing

- SNFs will be required to report these new SDOH items and the modified Transportation item using the MDS beginning with residents admitted on October 1, 2025 through December 31, 2025 for purposes of the FY 2027 SNF QRP.
- Starting in CY 2026, SNFs would be required to submit data for the entire calendar year for each program year.
- SNFs will be required to submit the Living Situation, Food, and Utilities items as standardized patient assessment data elements under the SDOH category at admission only (and not at discharge) because it is unlikely that the assessment of those items at admission would differ from the assessment of the same item at discharge.
- SNFs will be required to collect and submit the modified standardized patient assessment data element, Transportation, at admission only.

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Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

- **Value Based Purchasing**
  - The Centers for Medicare & Medicaid Services (CMS) awards incentive payments to skilled nursing facilities (SNFs) through the SNF VBP Program to encourage SNFs to improve the quality of care they provide to Medicare beneficiaries. Performance in the SNF VBP Program is currently based on a single measure of all-cause hospital readmissions.
  - In Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA), Congress added sections 1888(g) and (h) to the Social Security Act, which required the Secretary of the Department of Health and Human Services (HHS) to establish a SNF VBP Program. The Program began affecting SNF payments on October 1, 2018.
  - PAMA specifies that under the SNF VBP Program, SNFs:
    - Are evaluated by their performance on a hospital readmission measure;
    - Are assessed on both improvement and achievement, and scored on the higher of the two;
    - Receive quarterly confidential feedback reports containing information about their performance; and
    - Earn incentive payments based on their performance.
    - All SNFs paid under Medicare's SNF Prospective Payment System (PPS) are included in the SNF VBP Program. Inclusion in the SNF VBP Program does not require any action on the part of SNFs.
  - As required by statute, CMS withholds 2% of SNFs' Medicare fee-for-service (FFS) Part A payments to fund the program. This 2% is referred to as the "withhold".
  - CMS is required to redistribute between 50% and 70% of this withhold to SNFs as incentive payments. 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.

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Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

- **Value Based Purchasing (Cont.)**
  - In Section 111 of the Consolidated Appropriations Act, 2021, Congress amended Section 1888(h) of the Social Security Act to allow the HHS Secretary to apply up to nine additional measures to the SNF VBP Program for payments for services furnished on or after October 1, 2023 (fiscal year [FY] 2024).

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Current SNF VBP Measures

TABLE 30: SNF VBP Program Measures and Timeline for Inclusion in the Program

Measure	FY 2025 Program Year	FY 2026 Program Year	FY 2027 Program Year	FY 2028 Program Year
Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	Included	Included	Included	
Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization (SNF HAI) measure		Included	Included	Included
Total Nursing Hours per Resident Day (Total Nurse Staffing) measure		Included	Included	Included
Total Nursing Staff Turnover (Nursing Staff Turnover) measure		Included	Included	Included
Discharge to Community – Post-Acute Care Measure for Skilled Nursing Facilities (DTC PAC SNF measure)			Included	Included
Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) (Falls with Major Injury (Long-Stay)) measure			Included	Included
Discharge Function Score for SNFs (DC Function Measure)			Included	Included
Number of Hospitalizations per 1,000 Long Stay Resident Days (Long Stay Hospitalization) measure			Included	Included
Skilled Nursing Facility Within-Stay Potentially Preventable Readmissions (SNF WS PPR) measure				Included

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Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

- **Value Based Purchasing FY 2024 SNF PPS**
  - To prioritize the achievement of **health equity** and the reduction of disparities in health outcomes in SNFs, CMS is adopting of a Health Equity Adjustment in the SNF VBP Program that rewards SNFs that perform well and whose resident population during the applicable performance period includes at least 20% of residents with dual eligibility status.
  - This adjustment would begin with the **FY 2027 program year and FY 2025 performance year**.
  - CMS is adjusting the scoring methodology to provide bonus points to high-performing facilities (CMS is defines a top tier performing SNF, as a SNF whose score on the measure for the program year falls in the top third of performance, or greater than or equal to the 66.67th percentile) that provide care to a higher proportion of duals.
  - In the FY 2024 SNF PPS rule, CMS is requesting comments about possible future methodologies for selecting and prioritizing quality measures to focus on underserved populations.

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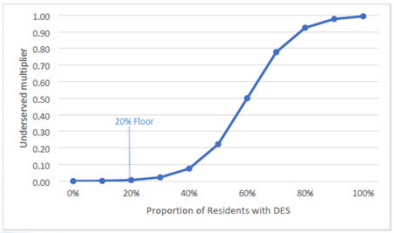
Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

- **Value Based Purchasing FY 2024 SNF PPS**
  - In addition, CMS will increase the payback percentage policy under the SNF VBP program from current 60% to a level such that the bonuses provided to the high performing, high duals SNFs do not come at the expense of the other SNFs. The estimates for FY 2027 program year is 66.02%.
  - Bonus Scoring Methodology (if 20% DES):
    - **Measure Performance Scaler**: 2 bonus points for each VBP measure scoring in the top 66.67th percentile.
    - **Underserved Multiplier**: the number representing the SNF's proportion of residents with DES out of its total resident population in the applicable program year, translated using a logistic exchange function
    - **HEA bonus points** = measure performance scaler × underserved multiplier



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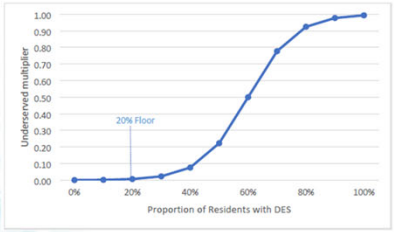
Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

TABLE 20: Example of the HEA Bonus Points Calculation

Example SNF	Measure Performance Scaler [A]	Proportion of Residents with DES (%) [B]	Underserved Multiplier [C]	HEA bonus points [D] ([A]*[C])
SNF 1	16	50	0.22	3.52
SNF 2	14	70	0.78	10.92
SNF 3	10	10	0	0
SNF 4	2	80	0.92	1.84

TABLE 21: Example of the HEA Bonus Points Calculation

Example SNF	Normalized Sum of all Points Awarded for each Measure [A]	HEA Bonus Points (Step 3, Column [D]) [B]	SNF Performance Score ([A] + [B])
SNF 1	80	3.52	83.52
SNF 2	65	10.92	75.92
SNF 3	42	0	42.00
SNF 4	10	1.84	11.84



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VBP Updates – National Quality Strategy

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SNF VBP Updates – Future Measure Considerations and Health Equity

- As part of the National Quality Strategy, CMS has stated in previous rule making that the goal of explicitly incorporating **health equity-focused components** into the Program was to both measure and incentivize equitable care in SNFs.
- Although the Health Equity Adjustment rewards high performing SNFs that care for high proportions of SNF residents with underserved populations, it **does not explicitly measure or reward** high provider performance among the disadvantaged or underserved population.
- CMS remains committed to achieving equity in health outcomes for residents by promoting SNF **accountability for addressing health disparities**, supporting SNFs' quality improvement activities to reduce these disparities, and incentivizing better care for all residents.

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SNF VBP Updates – National Quality Strategy

- CMS selects measures for the Universal Foundation that are:
  - of high national impact,
  - can be benchmarked nationally and globally,
  - are applicable to multiple populations and settings,
  - are appropriate for stratification to identify disparity gaps,
  - have scientific acceptability,
  - support the transition to digital measurement, and
  - have no anticipated unintended consequences with widespread measure implementation.

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SNF VBP Updates – Future Measure Considerations and Health Equity

- CMS is currently exploring the feasibility of future health equity-focused metrics for the Program.
- Specifically, CMS is considering different ways of measuring health equity that could be incorporated into the program as either a new measure, combined to form a composite measure, or as an opportunity for SNFs to earn bonus points on their SNF performance score.
- These performance metrics would utilize the existing SNF HAI, DC Function, DTC PAC SNF, and SNF WS PPR measures that have been adopted in the Program.
- CMS is considering the development of health-equity-focused versions of these measures because they are either cross-setting or could be implemented in multiple programs.

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SNF VBP Updates – Future Measure Considerations and Health Equity

- The health-equity focused measures or metrics for bonus points could include:
  - **A high-social risk factor (SRF) measure** that utilizes an existing Program measure where the denominator of the measure only includes residents with a given SRF, which would allow for comparisons of care for underserved populations across SNFs;
  - **A worst-performing group measure** that utilizes an existing Program measure and compares the quality of care among residents with and without a given SRF on that measure and places greater weight on the performance of the worst-performing group with the goal of raising the quality floor at every facility; **and**
  - **A within-provider difference measure** that assesses performance differences between residents (those with and without a given SRF) within a SNF on an existing Program measure, creating a new measure of disparities within SNFs.

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SNF VBP Updates – Future Measure Considerations and Health Equity

- CMS is testing these various measure concepts to determine:
  - where current across- and within-provider disparities exist in performance,
  - how to best incentivize SNFs to improve their quality of care for all residents, including those who may be underserved, **and**
  - the feasibility of incorporating a health equity-focused measure into the Program.
- As CMS explores these and other options, they will be focusing on approaches that:
  - Include as many SNFs as possible and are feasible to implement;
  - Integrate feedback from interested parties;
  - Encourage high quality performance for all SNFs among all residents and discourage low quality performance;
  - Are simple enough for SNFs to understand and can be used to guide SNFs in improvement; **and**
  - Meet the goal of incentivizing equitable care to ensure all residents in all SNFs receive high quality care
  - Display opportunities to align with other CMS programs to minimize provider burden.

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Health Equity/Social Determinants of Health in Practice

- **Health Equity/Social Determinants of Health Application**
  - In a recent column in McKnight's LTC News, it was noted that, "According to the Centers for Disease Control and Prevention"
  - "social isolation can increase a person's risk of premature death from all causes and increases the risk of dementia by 50%."
  - "Social isolation is a lack of social connections. Social isolation can lead to loneliness in some people, while others can feel lonely without being socially isolated."
  - **"Health Risks of Loneliness:** Although it's hard to measure social isolation and loneliness precisely, there is strong evidence that many adults aged 50 and older are socially isolated or lonely in ways that put their health at risk. Recent studies found that:
    - Social isolation **significantly increased a person's risk of premature death** from all causes, a risk that may rival those of smoking, obesity, and physical inactivity.[1]
    - Social isolation was associated with about a **50% increased risk of dementia**.[1]
    - Poor social relationships (characterized by social isolation or loneliness) was associated with a **29% increased risk of heart disease** and a **32% increased risk of stroke**.[1]
    - Loneliness was **associated with higher rates of depression, anxiety, and suicide**.
    - Loneliness among heart failure patients was **associated with a nearly 4 times increased risk of death, 68% increased risk of hospitalization, and 57% increased risk of emergency department visits**.[1]

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Health Equity/Social Determinants of Health in Practice

- **Health Equity/Social Determinants of Health Application**
  - Black Americans' High Gout Rate Stems From Social Causes (Medscape): Gout prevalence is more common in Black Americans than white Americans, and the disparity in prevalence is attributable to social determinants of health, according to a recently published article in *JAMA Network Open.*
  - Age-standardized prevalence of gout:
    - 3.5% in Black women and 2.0% in white women.
    - 7.0% in Black men and 5.4% in white men
    - Similar differences were found in the prevalence of hyperuricemia between Black and white Americans.
  - This research concluded that the increased prevalence of gout in Black Americans, compared with white Americans, does not arise from genetics. The conclusion was that it was due to social determinants of health. "When we adjusted for all socio-clinical risk factors, the racial differences in gout and hyperuricemia prevalence disappeared. Importantly, stepwise regression analysis showed **the two biggest drivers of the racial difference in gout prevalence among women were poverty itself, and excess BMI, which can be influenced by poverty.**"
  - The authors suggested that Primary care providers need to adopt a holistic approach to gout management that involves counseling about good nutrition, smoking cessation, regular exercise, and limiting alcohol consumption, in addition to medication adherence.

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Health Equity/Social Determinants of Health in Practice

- **Health Equity/Social Determinants of Health Application**
  - This research discovered that significantly more black women and men were currently taking diuretics, compared with their white counterparts and therefore, clinicians should give more thought to medical therapies prescribed for conditions like high blood pressure to patients with gout or at risk for gout.
  - One author indicated that diuretic use is a driver of gout and stated, a prescriber "may want to consider different therapies that present a lower risk of gout if someone has hypertension. There could be greater consideration for prescribing alternatives to diuretics."

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Health Equity/Social Determinants of Health in Practice

- **Health Equity/Social Determinants of Health Application**
  - Study: Socioeconomic factors influence stroke outcomes: A new study published in *Neurology* reveals that how well you fare after a stroke or other neurological event may come down to where you live.
    - Researchers used three years' worth of Medicare claims to identify nearly a million people aged 65 and older who had been hospitalized for various neurologic conditions like stroke, Alzheimer's disease, Parkinson's disease, epilepsy, coma, multiple sclerosis
    - The address of each of these patients was reviewed using a measurement called the **Area Deprivation Index (ADI)** to determine whether or not they lived in a socioeconomically disadvantaged neighborhood. The ADI takes things like the **housing quality**, **education**, **income** and **employment of neighborhood residents** to assign a score, and neighborhoods that score higher on the index are at a greater disadvantage. The study team then used these scores to look at which Medicare recipients died within a month after their hospitalization for one of the neurological conditions listed.
    - According to the report, 14.6% of stroke victims in the most disadvantaged neighborhoods died within the first month after their stroke, compared to 14.1% in advantaged neighborhoods.
    - For degenerative conditions like Alzheimer's disease and Parkinson's, 9.7% of the patients studied died within a month of hospitalization compared to 8.7% in advantaged neighborhoods.
    - Another 7.7% died within a month of hospitalization for epilepsy in disadvantaged neighborhoods compared to 6.8% in advantaged neighborhoods.
    - The study authors suggest that these results highlight the need for healthcare providers to examine neighborhood level access to care and how it can impact patient outcomes.

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Health Equity/Social Determinants of Health in Practice

- "Living in a disadvantaged neighborhood has been linked to a number of healthcare outcomes, including higher rates of diabetes and cardiovascular disease, increased utilization of health services, and earlier death. Health interventions and policies that don't account for neighborhood disadvantage may be ineffective." https://www.neighborhoodatlas.medicine.wisc.edu/
- **The Area Deprivation Index (ADI) …**allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest (e.g., at the state or national level). It includes factors for the theoretical domains of income, education, employment, and housing quality. It can be used to inform health delivery and policy, especially for the most disadvantaged neighborhood groups.

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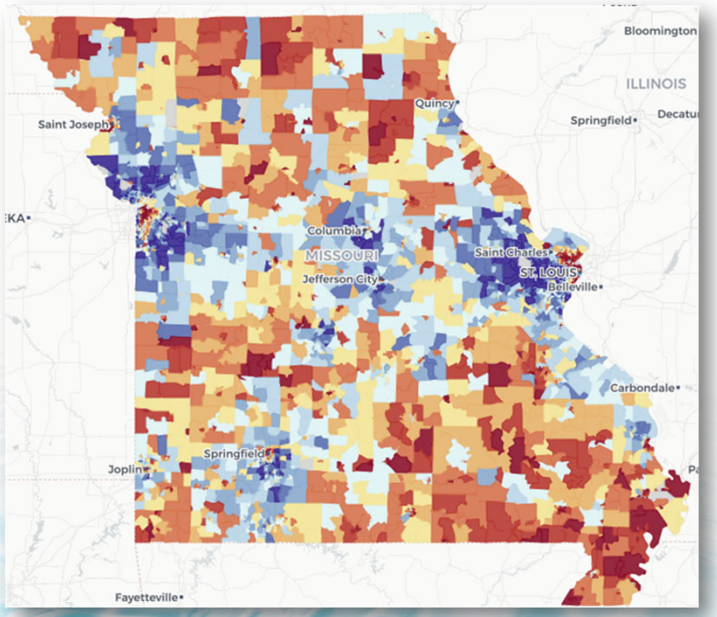

Area Deprivation Index
South Carolina

The Area Deprivation Index (ADI) …allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest (e.g., at the state or national level).

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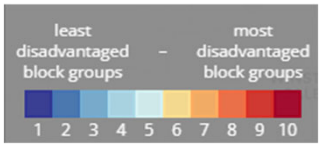

Center for Health Disparities Research
University of Wisconsin School of Medicine and Public Health

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Health Equity Confidential Feedback Reports

- The goal of the Health Equity Confidential Feedback Reports is to compare measure outcomes between Fee-for-Service Medicare-Medicaid dually enrolled patients (duals) and non-duals, as well as between Non-White and White patients.
  - Non-White patients" include patients of the following races/ethnicities: AA and NHPI, Black, Hispanic, and American Indian/Alas ka Native. AA and NHPI: Asian American and Native Hawaiian or other Pacific Islander.
- The current reports measure population outcomes for these populations related to the two SNF QRP PAC measures, **Discharge to Community (DTC)** and **Medicare Spend Per Beneficiary (MSPB)**.
- Data is for these measures stratified. Stratification involves the calculation of certain outcomes separately for different populations. Stratified measure outcomes can provide valuable insight on how different patient populations perform on a given measure.
- The PAC Health Equity Confidential Feedback Reports will stratify the DTC and MSPB measures by dual-enrollment status and race/ethnicity.

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Health Equity Confidential Feedback Reports

- For each of the comparisons, your facility/agency will receive a categorization to describe whether your patient populations are performing statistically significantly "Better than," "No different from," or "Worse than" the following comparison groups.
- **ACROSS-PROVIDER COMPARISONS**
  - COMPARISON TO THE NATIONAL PERFORMANCE AMONG ALL PATIENTS: Compares the measure outcome for your facility/agency's patient population to the national performance across all patients in your care setting. (e.g., your SNF's duals' DTC rate versus the national DTC rate across all SNF patients).
  - COMPARISON TO THE NATIONAL PERFORMANCE AMONG THE SAME POPULATION: Compares the measure outcome for your facility/agency's patient population to the national performance among the same population in your care setting. (e.g., your SNF's duals' DTC rate versus the national DTC rate among all duals in SNF's nationwide).

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Health Equity Confidential Feedback Reports

- **WITHIN-PROVIDER COMPARISONs**
  - Compare measure outcomes between patient populations within the same facility/agency. (e.g., your SNF's duals' DTC rate versus your SNF's non-duals' DTC rate).
- **Measure performance period for Fall 2023 reports**: Fiscal Year (FY) 2021-2022.
- Health Equity Confidential Feedback Reports will be updated annually.
- Medicare Part A and B claims are used to calculate measure outcomes and conduct risk-adjustment.

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Health Equity Confidential Feedback Reports

Table 1- Comparison Against the National Rate for All Patients (Summary): Shows how the average DTC and MSPB Amounts for your patient populations differ from the national average DTC and MSPB Amount for all patients in your care setting.

Population	Difference from National Rate
Dual	Worse Outcome than National Rate
Non-Dual	Outcome is No Different than National Rate
White	Outcome is No Different than National Rate
Non-White*	Worse Outcome than National Rate
AA and NHPI	Better Outcome than National Rate
Black	Worse Outcome than National Rate
Hispanic	Worse Outcome than National Rate

Health Equity Confidential Feedback Reports

Table 2 - Patient Composition at Your Facility and Similar Geographic Locations: Provides your patient composition (dual non-dual, white, non-white) and the patient composition (dual non-dual, white, non-white) among facilities in similar geographic locations as you.

Population	Your Facility	Same Rural/ Urban Location	Your CBSA	Your State	Your Region	National
		Urban	Washington-Arlington-Alexandria, DC-VA-MD-WV	District of Columbia	South Atlantic	
Total Number of Stays	300	72,00	5,000	3,200	17,300	97,500
Dual	20.0%	13.0%	20.0%	25.0%	21.0%	35.0%
Non-Dual	80.0%	87.0%	80.0%	75.0%	79.0%	65.0%
White	43.0%	80.0%	43.0%	82.0%	80.0%	68.0%
Non-White	57.0%	20.0%	57.0%	18.0%	20.0%	31.0%
AA and NHPI	11.0%	7.0%	11.0%	5.0%	8.0%	2.0%
Black	24.0%	7.0%	24.0%	9.0%	9.0%	20.0%
Hispanic	17.0%	5.0%	17.0%	3.0%	2.0%	7.0%

Health Equity Confidential Feedback Reports

Table 3 - Comparison of Performance Against the National Rate for All Patients (Detail): Shows the average MSPB Amount and DTC rates for Patients at Your Facility, Compared to All Patients Nationwide.

Population		DTC Rate	Performance Relative to National Rate		
			Difference (Your Facility - National Rate)	Confidence Interval	Category of the Difference
Comparison Points (All Patients)	National Rate	20.00%	--	--	--
	90th Percentile Facility	28.00%	--	--	--
Your Facility	Dual	10.00%	-10.00%	[-13.00%, -7.00%]	Worse Outcome than National Rate
	Non-Dual	17.00%	-3.00%	[-7.00%, 1.00%]	Outcome is No Different than National Rate
	White	16.00%	-4.00%	[-10.00%, 2.00%]	Outcome is No Different than National Rate
	Non-White	13.00%	-7.00%	[-10.00%, -3.00%]	Worse Outcome than National Rate
	AA and NHPI	27.00%	7.00%	[6.00%, 8.00%]	Better Outcome than National Rate
	Black	12.00%	-8.00%	[-12.00%, -4.00%]	Worse Outcome than National Rate
	Hispanic	6.00%	-14.00%	[-20.00%, -8.00%]	Worse Outcome than National Rate

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Health Equity Confidential Feedback Reports

Table 4 - Comparison against the National Rate among Patients of the Same Population: Compares the average MSPB Amount and DTC rate of each of your patient populations with their national average amount.

Population	DTC Rate		Performance Relative to National Rate among the Same Population		
	Your Facility	National Rate	Difference (Your Facility - National Rate)	Confidence Interval	Category of the Difference
Dual	10.00%	19.00%	-9.00%	[-11.00%, -7.00%]	Worse Outcome than National Rate for Dual Patients
Non-Dual	17.00%	20.00%	-3.00%	[-6.00%, 0.00%]	Outcome is No Different than National Rate for Non-Dual Patients
White	16.00%	22.00%	-6.00%	[-13.00%, 1.00%]	Outcome is No Different than National Rate for White Patients
Non-White	13.00%	18.00%	-5.00%	[-12.00%, 2.00%]	Outcome is No Different than National Rate for Non-White Patients
AA and NHPI	27.00%	21.00%	6.00%	[-2.00%, 14.00%]	Outcome is No Different than National Rate for AA and NHPI Patients
Black	12.00%	5.00%	7.00%	[-4.00%, 18.00%]	Outcome is No Different than National Rate for Black Patients
Hispanic	6.00%	19.00%	-13.00%	[-27.00%, 1.00%]	Outcome is No Different than National Rate for Hispanic Patients

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Health Equity Confidential Feedback Reports

Tables 5 and 6 - Within-Facility Comparison: Show the differences in Average MSPB Amount and DTC rates Within Your Facility for both Dual Status and Race/Ethnicity characteristics.

Table 5

	DTC Rate		Difference in DTC Rate		
	Duals	Non-Duals	Difference (Duals – Non-Duals)	Confidence Interval	Category of the Difference
National Rate	19.00%	20.00%	-1.00%	--	--
Your Facility	10.00%	17.00%	-7.00%	[-11.00%, -4.00%]	Worse Outcome for Dual Patients at Your Facility

Table 6

	DTC Rate		Difference in DTC Rate		
	Non-White	White	Difference (Non-White – White)	Confidence Interval	Category of the Difference
National Rate	18.00%	22.00%	-4.00%	--	--
Your Facility	13.00%	16.00%	-3.00%	[-7.00%, 1.00%]	Outcomes are No Different for Non-White and White Patients at Your Facility

Health Equity Confidential Feedback Reports

Table 7 - Patient Outcomes among Facilities in Similar Geographic Location: Provides the average MSPB Amount and DTC rates of your patient populations and the average MSPB Amount and DTC rates for the same populations among patients in similar geographic locations.

Population	Your Facility	Your Rural/ Urban Location Category	Your CBSA	Your State	Your Region	National
Dual	10.00%	17.00%	10.00%	13.00%	11.00%	19.00%
Non-Dual	17.00%	18.00%	17.00%	23.00%	16.00%	20.00%
White	16.00%	15.00%	16.00%	19.00%	21.00%	22.00%
Non-White	13.00%	12.00%	13.00%	15.00%	10.00%	18.00%
AA and NHPI	27.00%	20.00%	27.00%	19.00%	23.00%	21.00%
Black	12.00%	6.00%	12.00%	11.00%	7.00%	5.00%
Hispanic	6.00%	11.00%	6.00%	20.00%	15.00%	19.00%

Health Equity Confidential Feedback Reports

Table 8 - Patient Outcomes among Facilities with Similar Patient Composition: Provides the average MSPB Amount and DTC rates of your patient populations and the average MSPB Amount and DTC rates for the same populations among patients at facilities with similar patient composition. (Risk brackets (1-10) are calculated based on your average expected DTC rate across all your stays, and average expected MSPB amount across all your episodes, as predicted through risk adjustment.)

Population	Your Facility	Facilities with:			National
		Same Risk Bracket: Bracket #3	Similar Proportion of Duals	Similar Proportion of Non-White Patients	
Dual	10.00%	11.00%	9.00%	13.00%	19.00%
Non-Dual	17.00%	16.00%	19.00%	17.00%	20.00%
White	16.00%	16.00%	21.00%	18.00%	22.00%
Non-White	13.00%	12.00%	8.00%	10.00%	18.00%
AA and NHPI	27.00%	25.00%	19.00%	29.00%	21.00%
Black	12.00%	9.00%	8.00%	12.00%	5.00%
Hispanic	6.00%	5.00%	13.00%	6.00%	19.00%

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Conclusion

- Health equity and Social determinants of health are now embedded into CMS' expectations for how we care for our residents.
- New MDS items have been added to begin the conversation, don't ignore them!
- New Quality measures for both SNF QRP and SNF VBP are also resident focused and can be used to address SDOH and Health Equity.
- Include a focus on SDOH and Health Equity in your CAAs, care pathway development and discharge planning (ex. social isolation in CAA 4, 5, 7 and 18).
- Consider that this is a significant opportunity to approach our residents from a new perspective.
- Take a look at the area deprivation index
- Spend some time with your confidential feedback reports.

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Final Thoughts

"Twice I've needed to be rescued. The first time it was Mamaw who saved me. The second, it was what she taught me. That where we come from is who we are, but we choose every day who we become."

J.D. Vance in Hillbilly Elegy

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QUESTIONS?

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Find Out More

Contact Us:

Tricia Wood: Vice President, Business Development
twood@broadriverrehab.com
(919) 844-4800

Sign up for our Blog www.broadriverrehab.com

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