Skilled Nursing Facility (SNF) QRP Listening Session Summary: Possible Expansion of MDS Data Submission to All SNF Residents Regardless of Payer

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Chapter 1: Introduction

The Centers for Medicare & Medicaid Services (CMS) has contracted with RTI International (RTI) to develop and maintain measures for the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP). RTI operates under the Development, Maintenance, and Support for Quality Reporting and Value-Based Purchasing Programs and Nursing Home Care Compare contract (75FCMC18D0012/Task Order 75FCMC24F0121).

On October 1, 2024, RTI hosted a listening session, which was held to seek SNFs' input on the possible expansion of requirements for collecting and submitting Minimum Data Set (MDS) assessment data used for the SNF QRP. This session expanded on a previous listening session held on August 29, 2023, on the same topic.[1] Registration to attend the listening session was open to the public through CMS's SNF QRP webpage. Approximately eight hundred participants registered and approximately 350 participants attended. This report provides a summary of the participants' feedback during the listening session. The remainder of this introduction provides the rationale for expanding MDS data collection and submission, and an overview of discussion from the August 2023 listening session. **Sections 2 through 5** present a summary of the presentation provided during the October 2024 listening session for each discussion topic, stakeholder input received for each discussion question, and key findings. Specifically, **Section 2** covers application of the SNF interrupted stay policy to a potential all-payer MDS data collection and submission policy for SNFs. **Section 3** discusses the application of the current definition of a leave of absence to a potential all-payer MDS data collection and submission policy for SNFs. **Section 4** covers other issues CMS should consider for a potential all-payer MDS data collection and submission policy for SNFs, including the review of a few specific issues shared during the listening session to obtain participants' feedback. Finally, **Section 5** summarizes considerations for how data collected and submitted under a potential all-payer policy might be used by SNFs.

CMS also invited participants to provide additional feedback on these topics via email for up to 30 days following the listening session using a dedicated email inbox, SNF-Listening-Session-2024@rti.org. In total, four emailed comments were received by the November 1st at 5pm ET deadline. Feedback received via email is summarized and addressed in the applicable discussion topic sections of this report. CMS also received several comments during the listening session and subsequently via email that were unrelated to the questions asked at the listening session; therefore, they are not incorporated in this report.

Section 1.1: Rationale for all-payer data collection and submission.

The session began with a summary of the rationale for possibly expanding MDS data collection and submission to include all residents regardless of payer given the possibility that attendees joining the October 1, 2024, listening session may not have attended the August 29, 2023, listening session.

[1] A summary of this August 29, 2023, SNF Listening Session is available on CMS's website: https://www.cms.gov/files/document/snf-listening-session-2023-summary-report.pdf

Requiring quality data reporting on all patients/residents regardless of payer is not a new concept. For the past 10 years, CMS has received public input on the need to standardize measurement data collection across all payers in the post-acute care settings. A summary of this public input can be found in the August 29, 2023, SNF Listening Session Summary Report.[1]

CMS is currently collecting quality data on all patients regardless of payer as part of the Inpatient Rehabilitation Facility (IRF) QRP, the Long-Term Care Hospital (LTCH) QRP, and the Hospice Quality Reporting Program (HQRP). Beginning January 1, 2025, home health agencies will also begin collecting quality data on all patients regardless of payer for the home health (HH) QRP. In addition, eligible clinicians participating in the Merit-based Incentive Payment System (MIPS) who submit quality measure data on Qualified Clinical Data Registry measures, MIPS clinical quality measures (CQMs) or electronic clinical quality measures (eCQMs) are required to submit data on a percentage of all patients, regardless of payer.

Collecting quality data on all residents in the SNF setting, regardless of payer, would also provide the most robust and accurate representation of the quality of care being provided in SNFs. As of February 2024, 54 percent[2] of Medicare beneficiaries were enrolled in a Medicare Advantage coverage plan[3] and are therefore not captured in the SNF QRP which only requires MDS data collection and submission on Medicare fee-for-service (FFS) residents. Furthermore, the data would promote higher quality and more efficient health care for all patients/residents through the exchange of information and longitudinal analysis of that data. Despite the importance of quality data reporting on all SNF residents regardless of payer, implementation of a policy change presents unique challenges for CMS that have not been encountered in other settings. These challenges are related to the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) initial and periodic assessment requirements, the use of the MDS by non-critical access hospitals (non-CAHs) with a swing bed agreement, and the use of MDS assessment data in the Medicare SNF Prospective Payment System (PPS) and many state Medicaid reimbursement systems. MDS assessment data is also used to calculate a number of quality measures for purposes of the SNF Value-Based Purchasing (VBP) Program, the SNF QRP, and the Nursing Home Quality Initiative (NHQI). Therefore, CMS is eager to hear from interested parties on certain topics related to the possible expansion of MDS data collection and submission to all SNF residents regardless of payer.

Section 1.2: Overview of points we heard in August 2023 listening session.

As mentioned previously, a report of the August 2023 listening session is available on the SNF QRP Measures and Technical Information webpage.[4] A key takeaway from this earlier listening session was that participants generally supported of the idea of a standardized definition of skilled services across all payers. However, there were a number of concerns raised regarding Medicare Advantage Organizations' (MAOs) interpretation of CMS' definition of skilled care as

[2] Note that the rate of Medicare Advantage enrollment is even higher in some geographic areas of the country.

[3] Medicare Payment Advisory Commission. Health Care Spending and the Medicare Program: A Data Book. https://www.cms.gov/files/document/snf-listening-session-2023-summary-report.pdf. July 2024, page 127.

[4] https://www.cms.gov/files/document/snf-listening-session-2023-summary-report.pdf

provided in section §30 of the Medicare Benefit Policy Manual and the misalignment between this definition and how other payers, including MAOs, define skilled care.[5]

In addition, listening session participants generally agreed it would be helpful to add an item to the MDS that collects more information about payer types than is captured by the current MDS item set, including adding an item to capture residents' secondary payers. Participants were generally split on whether they are already completing a 5-day PPS assessment for residents receiving care under a non-Medicare FFS benefit. Some participants noted that, in addition to the OBRA required MDS assessments, other payers may require the SNF to complete their own proprietary forms or the SNF is required to collect and submit state-required forms, both of which would add to the burden created by a potential expansion of MDS data collection and submission to all residents regardless of payer.

Chapter 2: Interrupted Stay Policy

For the listening session's first discussion topic CMS was interested in hearing from interested parties whether utilizing the SNF PPS interrupted stay policy for completing MDS assessments on all residents, regardless of payer, may be beneficial to providers. This section summarizes participants' feedback on the topic and is organized into five subsections. **Section 2.1** provides background information on CMS's interrupted stay policy, and **Sections 2.2** introduces the questions asked on this topic and summarizes participants' comments in response to the questions during the October 1, 2024, meeting. Finally, **Section 2.3** presents the key takeaways extracted from that discussion.

Section 2.1: Background

Beginning with the fiscal year (FY) 2020 implementation of the SNF Patient Driven Payment Model (PDPM), CMS implemented an interrupted stay policy as part of the SNF PPS. In Chapter 2 of the Resident Assessment Instrument Manual,[6] an interrupted stay is defined as:

- A Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the same SNF for a Medicare Part A-covered stay during the interruption window.

Specifically, when a resident is discharged from a SNF and returns to the same SNF by 12:00 a.m. at the end of the third day of the interruption window, the resident's stay is treated as a continuation of the previous stay. In other words, the 3-day interruption window refers to three calendar days, which is two overnights. In cases where the resident's absence from the SNF exceeds this 3-day interruption window or in any case where the resident is readmitted to a different SNF, the readmission is considered a new stay. The reason the resident was discharged is not considered for purposes of defining an interrupted stay. As long as a resident resumes SNF

[5] Medicare Benefits Policy Manual (100-2); Chapter 8 – Coverage of Extended Care (SNF) Services Under Hospital Insurance. §30. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf

[6] https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf

care within that 3-day interruption window, MDS assessment completion depends on whether the resident is resuming skilled care in the same SNF or a different SNF.

For example, if the resident is discharged from a Medicare Part A SNF stay, remains in the same SNF, and then resumes skilled care within the 3-day interruption window, then neither a tracking form nor a new MDS assessment is required. If the resident leaves the facility (planned or unplanned), the SNF completes a nursing discharge assessment. If the resident returns within the 3-day interruption window and resumes skilled Part A services, the SNF completes an entry tracking form, and if indicated, an Interim Payment Assessment.

Section 2.2: Questions

Question 1. Using this definition of an interrupted stay, do you think it would be feasible to identify non-Part A SNF residents requiring an MDS assessment for purposes of the SNF QRP? If not feasible, what are the problems you would encounter?

Several participants stated it would be feasible to use this definition of an interrupted stay to identify non-Part A SNF residents requiring a new MDS for purposes of the SNF QRP. These and other participants expressed concern, however, that managed care payers have their own definitions and would need to have extensive education to avoid potential confusion and ensure consistent application.

Another participant agreed that application of the definition would be feasible, since this participant's SNF was already completing assessments for non-Medicare FFS residents that were not being submitted to CMS. This participant and others acknowledged, however, that there might be resistance from MAOs, given that many have their own definitions, but that having consistent definitions across all payers would help SNFs.

Two participants noted that while SNFs make skilled care determinations for residents with Medicare Part A FFS benefits, they do not have control to make those determinations for residents in the facility who do not have traditional Medicare Part A FFS benefits. Applying the SNF PPS interrupted stay definition to these non-Part A SNF residents would add complexity. This participant also expressed concern about the additional complexity that may be introduced due to the prior authorization requirements from MAOs. Three participants echoed that the payers, and not the SNF providers, functionally have control over when residents are discharged and may discharge the resident before the SNF feels is appropriate. The participants felt these discharges could negatively impact SNFs.

Question 2. Do plans other than Medicare utilize a "window" of interruption when a resident is discharged and returns within a defined time period?

Multiple participants stated that payers define interruptions in resident stays. One participant had experience with some MAOs implementing the CMS definition of a three-day interrupted window. Finally, another noted that applying this interrupted stay definition may require collecting and submitting additional PPS assessments and would therefore increase the burden on SNFs.

Question 3. Are there are other considerations we should be aware of?

Multiple participants reiterated the fact that utilizing this definition for all residents regardless of payer would promote consistency in MDS data collection and submission. However, they also stated that some MAOs and other payers currently use other defined windows of time to determine when a new stay occurs, such as 12 hours, over a midnight, or four days. These participants were cautious stating that if MAOs do not adopt the definition in practice, then it would create additional confusion and complexity for SNFs. Some of these participants also noted that they believe MAOs are supposed to be following traditional Medicare rules as of January 1, 2024, but they have not observed that happening yet.

Finally, one participant noted that item sets would need to be updated to transition to this type of data collection.

Section 2.3: Key takeaways

- Participants generally agreed that it would be feasible to identify non-Part A SNF residents using CMS' current definition of an interrupted stay, but SNFs and MAOs would need extensive education to consistently apply it. Additionally, there would be challenges for SNFs if MAOs did not adopt the definition in practice.
- Some participants have experience with MAOs utilizing a "window" of interruption but note that the timeframe for this "window" is diverse and not standardized. There was also agreement that MDS assessments are already being completed for residents with non-traditional Medicare payers, though there is variation in the interrupted stay policy implementation
- Participants agreed that a standardized interrupted stay window across payers would be beneficial for SNFs but were skeptical about whether standardization could be achieved.

Chapter 3:
Leave of Absence Policy

For the listening session's second discussion topic, CMS was interested in hearing from participants whether utilizing the CMS leave of absence policy for completing MDS assessments for all residents, regardless of payer, may be beneficial to providers. This section summarizes participants' feedback and is organized into five subsections. **Section 3.1** provides background information on CMS's leave of absence policy, and **Sections 3.2** introduces the questions asked on this topic and summarizes the information received from participant's feedback during the October 1, 2024, meeting. **Section 3.3** presents the key takeaways extracted from that discussion.

Section 3.1: Background

CMS defines a "leave of absence" as either (1) a temporary home visit of at least one night, (2) a therapeutic leave of at least one night, or (3) a hospital observational stay less than 24 hours and

the hospital does not admit the resident.[7] The policy applies to all residents in a skilled stay as well as those residing in the nursing facility.

When a resident returns to the facility, SNFs are expected to make appropriate documentation in the medical record regarding any changes in the resident's status. If there are significant changes in status, as defined by OBRA guidelines, then a Significant Change in Status Assessment may be necessary. SNFs may also have state-specific leave of absence policies to follow.

Section 3.2: Questions

Question 1. Using this definition of a leave of absence, do you think it would be feasible to utilize this definition for non-Part A SNF residents? If not feasible, what are the problems you would encounter?

Several participants agreed that using CMS' definition of a leave of absence for non-Part A SNF residents would be feasible. However, they also raised concerns about MAO adoption of the definition.

Question 2. Do plans other than Medicare utilize a "leave of absence" policy when a resident has a temporary home visit or therapeutic leave of at least one night?

One participant said they had experience with a leave of absence definition used by some state Medicaid Managed Care policies, but in their experience, MAOs were not utilizing it. This participant also noted that if CMS were to utilize this definition to apply to MDS data collection and submission for all residents regardless of payer, then there would need to be extensive education and reinforcement.

Question 3. Are there other considerations we should be aware of?

One participant suggested CMS should consider that resident characteristics may influence the frequency of their leaves of absence. Another participant echoed this concern and noted that in their state of Florida, they have a significant number of residents with substance abuse problems and some MAOs only make exceptions to allow for a leave of absence in very narrow situations (e.g., funerals, weddings), indicating a belief that if a resident can leave the SNF, they do not require skilled care.

Section 3.3: Key takeaways

- Participants generally agreed that using CMS' definition of leave of absence for non-Part A SNF residents would be feasible but were skeptical about whether the definition could be standardized across payers in application.
- Three participants provided examples of MAO leave of absence policies that varied from the SNFs own policies including not recognizing any form of leave of absence for residents/residents receiving skilled care.

[7] Resident Assessment Instrument Manual. Chapter 2. Available at: https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf

Chapter 4:
Other Issues CMS Should Consider

For the listening session's third topic area, CMS presented some issues and specific examples to participants for their consideration and requested feedback. This section summarizes participants' input on each discussion topic and is organized into four subsections. **Section 4.1** introduces the questions asked on this topic and summarizes the information received during the October 1, 2024, meeting. **Section 4.2** presents the key takeaways extracted from the discussions.

Section 4.1: Questions

Question 1. What are your thoughts on the following example? A long-stay resident discharges to the hospital and returns on the same calendar day and is determined to need skilled services as defined by §30.2 of the Medicare Benefit Policy Manual. How often do you encounter this current scenario? Under a SNF QRP all-payer data collection policy, do you think CMS should collect QRP data on these residents? Should the collection be driven by a particular length of stay or intensity of service delivery?

One participant voiced concerns about SNFs' and other payers' interpretation and understanding of what constitutes a skilled level of care and that this would require education. This participant and another one also questioned how this type of scenario would affect a resident's 100-day extended care (SNF) services benefit. These participants also raised concerns about this type of scenario stating that many of the SNF QRP measures do not apply to long-stay residents, and mixing the data could skew the results of the SNF QRP measures.

One participant also raised questions about how the requirements for beneficiary notices and appeal rights would be handled in this scenario, since the facility could make the decision to end the skilled services at any time, resulting in potential positive or negative impacts on their measures. This participant provided an example scenario of a facility in appropriately keeping a resident on a skilled stay for the duration of a pressure ulcer so the ulcer would be healed by the time the resident ended their period of skilled care.

One participant did state that trying to manage a same day change in skill would be difficult and add confusion to what assessments would need to be submitted and would increase the number of assessments SNF would have to complete.

Question 2. We understand that SNF's encounter a variety of residents and payers as they deliver skilled services. Are there other scenarios you encounter that might impact a policy to collect QRP data on all residents?

One participant said that other payers have different criteria and billing practices and brought up the Veterans Administration as an example.

Another participant added that if states have long-term care quality incentive payment programs, then additional assessments on long-stay residents could also impact their long-term Medicaid rates. For example, if one of the Medicaid quality incentive program measures were Falls with Major Injury, there would be overlap with the assessment data sources used for payment.

Another participant added that variable MAO practices could skew MDS data and impact interpretation of quality, as there is a high degree of variation in what MAOs expect to be coded on assessments. This may include only using specific criteria during the assessment to code section GG that varies from others. This participant expressed concern that these practices may make it difficult to meet the 90 percent reporting threshold, and that this penalty would impact the Medicare payment and not the MAOs themselves.

Question 3. CMS recognizes that collecting MDS data on all residents regardless of payer would increase the burden on SNF's. Other than burden, are there other ways your workflows or systems would be impacted? For example, how might all-payer affect workflow related to electronic health records?

One participant said that the result of moving to collecting MDS data on all residents regardless of payer would be ultimately beneficial for SNFs and provided the following example. When a resident changes payer, the SNFs are usually required to complete a new assessment. The resident's start-to-end trajectory may be skewed in the QRP if the resident has already been in the facility for several days at the time of payer change. Revising the process to require an MDS for all residents would therefore be beneficial.

Two participants noted that a policy to collect and submit MDS data on all residents regardless of payer could potentially decrease SNF burden because they are completing 5-day assessments for MAOs already, but not submitting them to CMS.

One participant added that these assessments that are not transmitted to iQIES may have lower accuracy, and that some facilities may prefer to admit residents with payers other than non-traditional Medicare due to their lack of participation in the QRP program. This participant stressed that measurement of quality of care needs to be reflective of the entire SNF population rather than only those with traditional Medicare and supports the all-payer data collection and requiring submission as a way to do improve this. Another participant noted that the 5-day MDS includes items not utilized by the QRP and suggested that this would be a barrier to data collection.

One participant said that the MDS completion requirements are so specialized that it would be difficult and unfair to expect SNFs to ensure other payers follow these requirements.

Section 4.2: Key takeaways

- Two participants stated that collecting and submitting MDS data on all residents regardless of payer would be ultimately beneficial because they are completing 5-day assessments for MAOs already, but not submitting them to CMS. They agreed that standardization across all payers would be helpful.
- Other participants noted that variable practices among non-Part A payers and overlapping quality programs may make standardized implementation difficult.
- Another participant raised concerns that the 5-day MDS includes items collected for purposes other than the SNF QRP and questioned how CMS would account for this.

Chapter 5:
Considerations for How the Data Would be Used

The listening session's fourth and final discussion topic centered around CMS's interest in knowing how participants might utilize the additional information they collect through the MDS on a potentially new resident population. This section summarizes participants' feedback and is organized into four subsections. **Section 5.1** introduces the questions asked on this topic and summarizes the information received during the October 1, 2024, meeting. **Section 5.2** presents the key takeaways extracted from that discussion.

Section 5.1: Questions

Question 1. Would having QRP information on all residents regardless of payer assist you in achieving your organizational clinical and quality goals?

Two participants said that data for all residents regardless of payer would only assist in achieving clinical and quality goals if data were standardized and that if MAOs have different quality metric requirements, this information would not be actionable. Several participants said that the SNF QRP measure results are not particularly actionable because their payment is based on data completion rather than measure performance. These participants added that they don't use SNF QRP measure performance rates for quality improvement efforts due to the age of the measure data.

One of these participants also noted that many SNF QRP claims-based measures exclude MAOs from results and there would then be a disconnect between some QRP and MDS measures.

Question 2. If CMS were to calculate the SNF QRP measure results for all payers, would that be beneficial to you?

One participant also reiterated the concern that MAOs dictating discharge date may affect SNF QRP measures such as the Discharge Function Score measure, but if measure results were stratified by payer, it would be beneficial.

Question 3. However, CMS is aware that SNF's already obtain a variety of robust reports from their electronic health record vendors. Do you currently have access to reports that provide item-level information for all residents you complete an MDS on, even if you do not submit it? How do you utilize those reports in your workflows?

One participant confirmed that they had MDS item-level reports with software that allowed them to query any desired data that is more current and useful for their quality improvement purposes. This data pulls information on all residents regardless of payer.

Section 5.2: Key takeaways

- Participants agreed that SNF QRP information on all residents regardless of payer would only be actionable if there was confidence that the underlying data were standardized. Individual participants also noted that there are currently different resident populations represented in different CMS programs and that would need to be addressed.

- Some participants agreed that the CMS' QRP measure results were not useful for their clinical quality improvement efforts due to the age of the data, and that internal software that allows for querying of more current data was more useful for accessing actionable MDS item-level data.