Nursing Facility Quality Payment Program Guidelines

2023 - Program Year 4

Quality Measurement Period: **01/01/2023 – 12/31/2023**

We value your feedback

Help us improve the program guidelines by sending us your questions or comments on this document.

Email PSInquiries@hpsm.org

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Program Overview

Health Plan of San Mateo's Nursing Facility Quality Payment Program (NF QPP) offers quality bonus payments to contracted nursing facilities providing skilled and/or long-term care services to HPSM Medi-Cal and CareAdvantage members. HPSM uses facilities' standard claims reporting to assess performance in select quality metrics against designated full and partial credit benchmarks. The program also provides performance monitoring reports to each facility designed to help track and improve HPSM member access, utilization, and quality outcomes.

These Program Guidelines offer comprehensive information about the program structure and quality metrics. See Quality Metric Summaries below for a complete list of quality metrics and benchmarking targets. For additional questions about the NF QPP, please contact HPSM Provider Services at PSinquiries@hpsm.org.

Eligibility

All contracted facilities are automatically opted into this upside-only program. Facilities must have a contract with HPSM Medi-Cal and CareAdvantage lines of business beginning at least six months prior to the program year (PY) end date AND active as of the lump sum payment date no later than six months following the close of the PY.

To qualify for bonus payments for skilled nursing services, facilities must also meet a minimum number of HPSM admissions during the PY. For more information, see "Access Gate" metric below. Facilities that do not meet the Access Gate may not receive a bonus payment for skilled services.

Important Dates – PY4

Period	Dates	Description
Quality Measurement Period	01/01/2023 – 12/31/2023	Performance is assessed for all dates of service (DOS) occurring within the measurement period timeframe.
Claims Submission Deadline	01/30/2024	All HPSM claims and qualifying reporting codes must be submitted by this date to quality for payment credit.
Bonus Payment Distribution	Q1 2024	Incentive payments are distributed in a lump sum via paper check mailed to the facility's primary mailing address on file.

Bonus Payments

Beginning PY4, bonus payments are distributed in a lump sum no later than six months after the close of the measurement period. A facility's lump sum augments total payments for DOS in the quality measurement period to the equivalent of the bonus-adjusted rate. As of 01/01/2023, standard network rates are as follows:

SKILLED SERVICES: 85% of Medicare Patient-Driven Payment Model (PDPM) base rate, with up to 10% additional quality bonus (95% total bonus-adjusted rate)

LONG-TERM CARE SERVICES: 100% of Medi-Cal per diem base rate, with up to 5% additional quality bonus (105% total bonus-adjusted rate).

Bonus-adjusted rates are derived from quality score points where 1 quality score point equals a 1% increase to base reimbursement.

Performance Monitoring Reports

All contracted facilities receive access to HPSM eReports, HPSM's data-sharing portal that hosts Microsoft Excel-based quality performance monitoring reports. **Reports are published at the beginning of every calendar month** and report performance in the quality metrics based on process claims as of the report date. Facilities may sign up for eReports and request login credentials for individual staff by emailing PSInquiries@hpsm.org.

HPSM offers two types of performance reports to all facilities:

1. **NF Benchmark Progress Report**: A "scorecard" of current performance rates and denominators in all quality metrics included in the program. Additional information includes prior year rates, benchmarking information, and average performance from all facilities in the HPSM network.
2. **NF Benchmark Member Detail Report**: A list of all HPSM patients admitted for skilled nursing or long-term care services during the measurement period. Columns indicate patient identifying data (HPSM Member ID, HPSM line of business, member date of birth), utilization data (dates of admission and discharge, number of Emergency Department visits and inpatient readmissions, etc.), and other information pertaining to the quality metrics.

Quality Metric Summaries

Skilled Care Quality Metrics Summary

Performance Metric	Full Credit Benchmark	Full Credit Quality Score Points	Partial Credit Benchmark	Partial Credit Quality Score Points
Access Gate	20 admissions	N/A	N/A	N/A
Average Length of Stay*	20 days or fewer	4	25 days or fewer	2
Medicare Stars Rating	5	2	3 - 4	0.5 - 1
Readmissions to Acute Care*	17% or lower	4	20% or lower	2

***For this metric, a **lower rate is better**

Total Possible Quality Score Points (Skilled) = 10

Long-Term Care Quality Metrics Summary

Performance Metric	Full Credit Benchmark	Full Credit Quality Score Points	Partial Credit Benchmark	Partial Credit Quality Score Points
Total Access	Scored on a curve across the network	≤1	N/A	N/A
New Access	Scored on a curve across the network	≤1	N/A	N/A
Inpatient Utilization*	2% fewer admissions compared to 2022 OR rate below 1.5% admissions	1.5	Any improvement compared to 2022 OR rate below 3% admissions	0.75
Emergency Department Utilization*	2% fewer ED visits compared to 2022 OR rate below 1.5% ED visits	1.5	Any improvement compared to 2022 OR rate below 3% ED visits	0.75

***For this metric, a **lower rate is better**

Total Possible Quality Score Points (Long-Term Care) = 5

Skilled Care Metrics

Access Gate

Metric Definition: The number of HPSM Medi-Cal and CareAdvantage admissions over the 12-month measurement period. Admissions do **NOT** need to be unique members. Any member who is readmitted after 3 days or longer outside of the facility will count as a new admission.

Facilities must meet this benchmark in order to qualify for any bonus payment for skilled services.

Average Length of Stay

Metric Definition: The average length of stay of HPSM Medi-Cal and CareAdvantage members in the facility.

Metric Calculation: The number of paid days in the facility divided by the total number of admissions to the facility.

Benchmarks: Facilities with an average of 20 paid days or fewer for HPSM members receive 4 quality score points. Facilities with an average of 25 paid days or fewer for HPSM members receive 2 quality score points.

Readmissions to Acute Care

Metric Definition: The percentage of HPSM Medi-Cal and CareAdvantage members who were discharged from an acute care facility and readmitted to acute care for any cause within 30 days of discharge.

Metric Calculation: The number of readmissions within 30 days of discharge divided by the total number of discharges.

Benchmarks: Facilities with 17% or fewer HPSM members who were readmitted to acute care within 30 days receive 4 quality score points. Facilities with 20% or fewer HPSM members who were readmitted to acute care within 30 days receive 2 quality score points.

Medicare Stars Rating

Metric Definition: The facility's Medicare Stars Overall rating as of December of the quality measurement period.

Benchmarks: Facilities with a Medicare Stars rating of 5 receive 2 quality score points**.** Facilities with a Medicare Stars rating of 3 or 4 receive 0.5 or 1 quality score points, respectively. A Medicare Stars rating of 1 or 2 stars is not eligible for credit.

Long-Term Care Quality Metrics

Total HPSM Bed Access

Metric Definition: The percentage of total bed days filled by HPSM members, out of the total bed days available in the measurement period.

Benchmarks: This metric will be scored on a curve across the network, with 0.5 – 1 quality score points available.

New HPSM Bed Access

Metric Definition: The percentage of new bed days filled by HPSM members, out of the total bed days available in the measurement period. A new admission is defined as a member who had no claims for long-term care by the admitting facility submitted in the prior 31 calendar days.

Benchmarks: This metric will be scored on a curve across the network, with 0.5 – 1 quality score points available.

Inpatient Utilization

Metric Definition: The number of inpatient admissions resulting from an Emergency Department (ED) visit in the eligible population in the measurement period. Exclude pre-scheduled inpatient procedures and stays.

Metric Calculation: The number of inpatient admissions resulting from an ED visit per 1000 member months. The number of admissions is pulled from all SNF and LTC claims.

Benchmarks: Facilities with 2% or fewer inpatient admissions compared to prior year will receive 1.5 quality score points. Facilities showing any improvement compared to prior year will receive at least 0.75 quality score points.

Emergency Department Utilization

Metric Definition: The number of Emergency Department (ED) visits in the eligible population in the measurement period. Exclude ED visits that resulted in an inpatient stay.

Metric Calculation: The number of ED visits per 1000 member months. The number of ED visits is pulled from all SNF and LTC claims data.

Benchmarks: Facilities with 2% or fewer ED visits compared to prior year will receive 1.5 quality score points. Facilities showing any improvement compared to prior year will receive at least 0.75 quality score points.

Terms & Conditions

Participation in Health Plan of San Mateo's Nursing Facility Quality Payment Program, as well as acceptance of performance bonus payments, does not in any way modify or supersede any terms or conditions of any agreement between HPSM and participating providers. There is no guarantee of future funding or payment under any HPSM Quality Payment Program. HPSM's NF QPP and/or its terms and conditions may be modified or terminated at any time, with or without notice, at HPSM's sole discretion.

In consideration of HPSM's offering of its NF QPP, provider agrees to fully and forever release and discharge HPSM from any and all claims, demands, causes of action, and suits, of any nature, pertaining to or arising from the offering by HPSM of the NF QPP. Any monies paid under the NF QPP for services deemed inappropriately submitted will be recouped from future payment. All cases of suspected fraud or abuse will be investigated thoroughly and reported to the appropriate authorities.

HPSM reserves the right to audit medical records to validate services have been completed as billed. If there is evidence of fraud, waste, or abuse, HPSM can recoup NF QPP payments found to be invalidly billed and the provider could lose privileges to participate in future HPSM quality payment programs.

Participating providers must be in good standing with all contract and compliance requirements in order to receive HPSM NF QPP payments. If any participating providers are not in good standing, NF QPP payments will not be made until such time that providers are meeting all contract and compliance requirements.