Nursing Facility Quality Payment

2021 Program Guidelines

Measurement Period: **10/1/2020 - 9/30/2021**

We value your feedback

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Program Overview

Health Plan of San Mateo's Nursing Facility Quality Payment Program offers performance bonus payments to in-network nursing facilities providing skilled and/or custodial services to HPSM Medi-Cal and CareAdvantage members. The program is also designed to share data with our facilities on quality metric performance. The targeted quality measure set focuses on member access and designated healthcare service utilization and outcome targets. Facilities that meet designated full or partial credit benchmarks receive quality score points that are used to determine the amount of bonus payments. See Measures Summary for a list of benchmarks and corresponding quality scores.

If you would like to participate in the program evaluation and update process in partnership with HPSM, or if you have questions about the program, please contact the HPSM Provider Services Department at PSinquiries@hpsm.org.

Provider Participation Eligibility

For skilled rate adjustments, providers must be reimbursed under MC PDPM payment method for any applicable lines of business. The agreement must be active on the date of payment for any quality payments made under this program.

Eligible Population

HPSM Medi-Cal and CareAdvantage members served by a facility are eligible to participate during the measurement period.

Reports

Performance bonus payment in the Nursing Facility Quality Payment Program is contingent on meeting the specified measure benchmarks for assigned patients who meet the measure criteria. Monthly member benchmark progress reports are available to providers through the HPSM eReports portal at https://reports.hpsm.org.

If you are unsure whether your organization has access, who in your organization has access, or would like to set up a login to access the HPSM eReports system, please contact HPSM Provider Services at PSinquiries@hpsm.org.

Payment Schedule

Base rate adjustments will be applied January 1st following the current measurement period. Quality metric performance will be measured from Oct. 1 to Sept. 30 of the measurement year. The deadline for submission of claims and other data will be November 30th of the measurement year to allow for a 2-month claims lag prior to base rate adjustments the following calendar year. Base rates will be applicable for the full calendar year following the measurement period (pending provider eligibility, please see Terms and Conditions for additional information). If a facility is not in the program for the entire measurement period, adjustments will be pro-rated based on the facility's length of time in the program. Retroactive adjustments will not be made. Payment will be adjusted based on quality score points. The points are representative of percent adjustments to the base rates.

Skilled Care Quality Measures Summary

Performance Measure	Full Credit Benchmark	Full Credit Quality Score	Partial Credit Benchmark	Partial Credit Quality Score
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 measure, a **lower rate is better**

Total Possible Quality Score Points (Skilled Care) = 10

Custodial Care Quality Measures Summary

Performance Measure	Full Credit Benchmark	Full Credit Quality Score	Partial Credit Benchmark	Partial Credit Quality Score
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 2020	1.5	Any improvement compared to 2020	0.75
Emergency Department Utilization*	2% fewer ED visits compared to 2020	1.5	Any improvement compared to 2020	0.75
Successful Discharge to Community	6 months	N/A	N/A	N/A

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

Total Possible Quality Score Points (Custodial Care) = 5

Skilled Care Measures

Access Gate

Measure 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 quality payments.

Average Length of Stay

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

Measure 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

Measure 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.

Measure 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

Measure Definition: The facility's Medicare Stars rating as of November 30th of the measurement year.

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.

Custodial Care Measures

Access Metrics

Total Access

Measure Definition: The percentage of total bed days filled by HPSM members, out of the total bed days available in the measurement period. This measure will be scored on a curve across the network.

New Access

Measure 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 custodial care by the admitting facility submitted in the prior 31 calendar days. This measure will be scored on a curve across the network.

Utilization Metrics

Eligible Population: CareAdvantage and Medi-Cal members residing in the facility for whom HPSM is the primary payer.

Inpatient Utilization

Measure 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.

Measure 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 2020 will receive 1.5 quality score points. Facilities showing any improvement compared to 2020 will receive at least 0.75 quality score points.

Emergency Department Utilization

Measure 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.

Measure 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 2020 will receive 1.5 quality score points. Facilities showing any improvement compared to 2020 will receive at least 0.75 quality score points.

Successful Discharge to Community

Measure Definition: The number of members who have had successful community placement without any return to the facility for 6 months from discharge.

Facilities will receive a bonus of 2-months PMPM (60 days of current custodial rate) for each member who qualifies for this metric. No retro-active adjustments will be made based on changing rate status from state adjustments.

Terms & Conditions

Participation in Health Plan of San Mateo's Nursing Facility Quality Payment Program (NFQPP), 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 NFQPP 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 NFQPP, 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 NFQPP. Any monies paid under the NFQPP 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 NFQPP 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 NFQPP payments. If any participating providers are not in good standing, NFQPP payments will not be made until such time that providers are meeting all contract and compliance requirements.