# The Open Arms for Nursing Facilities Value-Based Program

## Improving the cost of quality care and health outcomes

2024

Keystone First

Community HealthChoices

# Contents

Keystone First
Community HealthChoices

200 Stevens Drive
Philadelphia, PA 19113-1570

Dear Nursing Facility Provider:

Keystone First Community HealthChoices (CHC) proudly presents our Open Arms for Nursing Facilities program. The program is structured to reward Nursing Facility Providers for high-quality and cost-effective care specific to the services delivered to CHC Participants.

Keystone First CHC is excited about our enhanced incentive program and will work with your facility so you can maximize your revenue while providing quality and cost-effective care to our Participants. Thank you for your continued participation in our network and for your commitment to our Participants. If you have any questions, please contact your Provider Account Executive.

Sincerely,

Frank Santoro
Director, LTSS Plan Operations and Administration

# Introduction

The Open Arms for Nursing Facilities value-based program is an incentive program developed by Keystone First Community HealthChoices (CHC) for participating Nursing Facility Providers.

The Open Arms for Nursing Facilities value-based program provides incentives for high-quality and cost-effective care, Participant service and convenience, and submission of accurate and complete health data. Quality performance is the most important determinant of the additional compensation. As additional meaningful measures are developed and improved, the quality indicators contained in this Open Arms program will be refined. Keystone First CHC reserves the right to make changes to this program at any time and shall provide written notification of any changes.

# Program overview

The Quality Performance component of the program represents a Nursing Facility Provider-focused quality model covering availability and accountability of continuity care, improved health outcomes, and reduced re-hospitalizations. The quality score is calculated according to the total overall performance of each measure ranked among the network of Nursing Facility Providers.

The Total Cost of Care component rewards Nursing Facility Providers who performed above their peers in the quality measures of the program and whose actual medical costs were lower than expected medical costs.

# Performance incentive payment (PIP)

A performance incentive payment (PIP) may be paid in addition to a Nursing Facility Provider's base per diem, room and board compensation rate. The payment amount is calculated based on how well a Nursing Facility Provider scores in the Quality Performance component relative to other qualifying Keystone First CHC participating Nursing Facility Providers participating in the program.
The performance components are:

1. Quality Performance
2. Efficient Use of Services/Total Cost of Care

## 1. Quality Performance

This component includes six National Quality Forum (NQF) metrics.

These measures are based on services rendered during the reporting period and require accurate and complete encounter reporting.

| The Quality Performance measures are: | |
|---|---|
| Percentage of short-stay residents who were rehospitalized after a Nursing Facility admission | **Measure description:** The percentage of short-stay residents who entered or reentered the nursing home from a hospital and were readmitted to a hospital for an unplanned inpatient stay or observation stay within 30 days of the start of the nursing home stay.<br>**Numerator:** The numerator includes nursing home stays for beneficiaries who:<br>a) Met the inclusion and exclusion criteria for the denominator; **and**<br>b) Were admitted to a hospital for an inpatient stay or outpatient observation stay within 30 days of entry/reentry to the nursing home, regardless of whether they were discharged from the nursing home prior to the hospital readmission.<br>Note that inpatient hospitalizations and observation stays are identified using Medicare claims; **and**<br>c) The hospital readmission did not meet the definition of a planned hospital readmission (identified using principal discharge diagnosis and procedure codes on Medicare claims for the inpatient stay).<br>**Denominator:** Included in the measure are stays for residents who:<br>a) Entered or reentered the nursing home within one day of discharge from an inpatient hospitalization. (Note that inpatient rehabilitation facility and long-term care hospitalizations are not included.) These hospitalizations are identified using Medicare Part A claims; **and**<br>b) Entered or reentered the nursing home within the target 12-month period.<br>**Source data:** Centers for Medicare & Medicaid Services (CMS) data and claims data |

| The Quality Performance measures are: | |
|---|---|
| Percentage of long-stay residents with pressure ulcers | **Measure description:** This measure captures the percentage of long-stay residents with Stage II-IV or unstageable pressure ulcers.<br><br>**Numerator:** All long-stay residents with a selected target assessment that meet the following conditions:<br><br>Stage II-IV or unstageable pressure ulcers are present, as indicated by **any** of the following six conditions:<br><br>(M0300B1 = [1, 2, 3, 4, 5, 6, 7, 8, or 9]) **or**<br><br>(M0300C1 = [1, 2, 3, 4, 5, 6, 7, 8, or 9]) **or**<br><br>(M0300D1 = [1, 2, 3, 4, 5, 6, 7, 8, or 9]) **or**<br><br>(M0300E1 = [1, 2, 3, 4, 5, 6, 7, 8, or 9]) **or**<br><br>(M0300F1 = [1, 2, 3, 4, 5, 6, 7, 8, or 9]) **or**<br><br>(M0300G1 = [1, 2, 3, 4, 5, 6, 7, 8, or 9]).<br><br>**Denominator:** All long-stay residents with a selected target assessment, except those with exclusions.<br><br>**Source data:** Completed Minimum Data Set (MDS) |
| Percentage of long-stay residents experiencing one or more falls with major injury | **Measure description:** This measure reports the percentage of long-stay residents who have experienced one or more falls with major injury reported in the target period or look-back period compared to all visits billed within the reporting period.<br><br>**Numerator:** Long-stay residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury (J1900C = [1, 2]).<br><br>**Denominator:** All long-stay nursing home residents with one or more look-back scan assessments except those with exclusions.<br><br>**Source data:** Completed Minimum Data Set (MDS) |

| The Quality Performance measures are: | |
|---|---|
| Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine | **Measure description:** The measure reports the percentage of long-stay residents who are assessed and/or given, appropriately, the influenza vaccination during the most recent influenza season.<br><br>**Numerator:** Residents meeting any of the following criteria on the selected influenza vaccination assessment:<br><br>1. Resident received the influenza vaccine during the most recent influenza season, either in the facility (O0250A= [1]) or outside the facility (O0250C = [2]); or<br><br>2. Resident was offered and declined the influenza vaccine (O0250C = [4]); or<br><br>3. Resident was ineligible due to medical contraindication(s) (O0250C = [3]) (e.g., anaphylactic hypersensitivity to eggs or other components of the vaccine, history of Guillain-Barre syndrome within six weeks after a previous influenza vaccination, bone marrow transplant within the past six months).<br><br>**Denominator:** All long-stay residents with a selected influenza vaccination assessment. This includes all residents who have an entry date (A1600) on or before March 31 of the most recently completed influenza season and have an assessment with a target date on or after October 1 of the most recently completed influenza season (i.e., the target date must fall on or between October 1 and June 30), except those with exclusions.<br><br>**Source data:** Completed Minimum Data Set (MDS) |
| Percentage of long-stay residents assessed and appropriately given the pneumococcal vaccine | **Measure description:** This measure reports the percentage of long-stay residents whose pneumococcal vaccine status is up to date.<br><br>**Numerator:** Residents meeting any of the following criteria on the selected target assessment:<br><br>1. Have an up-to-date pneumococcal vaccine status (O0300A = [1]); or<br><br>2. Were offered and declined the vaccine (O0300B = [2]); or<br><br>3. Were ineligible due to medical contraindication(s) (e.g., anaphylactic hypersensitivity to components of the vaccine; bone marrow transplant within the past 12 months; or receiving a course of chemotherapy within the past two weeks) (O0300B = [1]).<br><br>**Denominator:** All long-stay residents with a selected target assessment.<br><br>**Source data:** Completed Minimum Data Set (MDS) |

| The Quality Performance measures are: | |
|---|---|
| Percentage of long-stay residents who received an antipsychotic medication | **Measure description:** This measure reports the percentage of long-stay residents who are receiving antipsychotic drugs in the target period.<br><br>**Numerator:** Long-stay residents with a selected target assessment where the following condition is true: antipsychotic medications received. This condition is defined as follows:<br><br>For assessments with target dates on or after 10/01/2023: (N0415A1 = [1]).<br><br>**Denominator:** Long-stay nursing home residents with a selected target assessment except those with exclusions.<br><br>**Source data:** Completed Minimum Data Set (MDS) |
| Percentage of long-stay residents with a urinary tract infection | **Measure description:** The measure reports the percentage of long-stay residents who have a urinary tract infection.<br><br>**Numerator:** Long-stay residents with a selected target assessment that indicates urinary tract infection within the last 30 days (I2300 = [1]).<br><br>**Denominator:** All long-stay residents with a selected target assessment, except those with exclusions.<br><br>**Source data:** Completed Minimum Data Set (MDS) |
| Staffing ratios (CMS Star Rating) | **Measure description:** This staffing measure is derived from data submitted each quarter through the Payroll-Based Journal (PBJ) system, along with daily resident census derived from Minimum Data Set, Version 3.0 (MDS 3.0) assessments, and will be represented by the CMS Star Rating.<br><br>Ratings for the staffing domain are based on six measures. This includes three nurse staffing level measures (hours per resident per day) and three measures of staff turnover.<br><br>**Source data:** PBJ, Completed Minimum Data Set (MDS), and CMS<br><br>*More detailed information about the PBJ system is available at:<br><br>**https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html** |

### Quality Performance score calculation

Results will be calculated for each of the above listed quality performance measures as specified by their specific numerator and denominator criteria.

These results will then be compared to the results for all of the eligible Nursing Facility Providers to determine the provider's percentile ranking for each of the quality performance measures. Then, the overall score will be the average percentile ranking across all included quality performance measures. This incentive is paid annually and is based on the provider's average ranking and the number of billed units for the provider's respective Keystone First CHC Participants.

## 2. Efficient Use of Services/ Total Cost of Care Component

The Total Cost of Care component for the program represents an actual versus expected medical cost analysis that determines an efficient use of services based on the population being served. This efficient use of services calculation is what ultimately establishes a shared savings pool that is then made available to providers based on their quality performance across the measures in the program.

### Total Cost of Care — efficient use of services calculation

Efficient use of services is defined as having an actual medical and pharmacy spend that is less than the expected medical and pharmacy spend (as determined using the 3M™ Clinical Risk Groups [CRG]) in the measurement year. By comparing the actual cost to the expected cost, Keystone First CHC calculates an actual versus expected cost ratio.

The actual versus expected cost ratio is the ratio of the actual medical and pharmacy cost to the expected cost. A provider whose actual medical cost is exactly equal to the expected medical cost would have an actual versus expected cost ratio of 1, or 100%, indicating that the cost is exactly as expected for the health mix of the attributed population. An actual versus expected cost ratio of less than 100% indicates a lower-than-expected spend and therefore a savings. The savings percentage is then calculated using the difference between 100% and the provider's actual versus expected cost ratio. This savings percentage is capped at 10%. If the result of this calculation is greater than 10%, 10% will be used. The shared savings pool will be equal to the savings percentage multiplied by the provider's reimbursement for services rendered during the claims period and then multiplied by a factor to increase the earning potential for high performers.

**Note:**
**The submission of accurate and complete encounters is critical to make sure your agency receives the correct calculation, based on the services performed for Keystone First Community HealthChoices Participants.**

**Note:**
**If you do not submit encounters reflecting the measures shown starting on page 4 (where applicable), your ranking will be adversely affected, thereby reducing your incentive payment.**

### Total Cost of Care — provider performance earnings example

For example, Provider X had an actual medical cost of $950,000 versus an expected medical cost of $1,000,000. This results in a 95% efficient use of services score, with a margin of 5%. The provider also billed $100,000 in claims during this time, which would result in establishing a shared savings pool of $5,000 [provider spend × margin × factor] available to the provider to earn through this program.

The amount of dollars earned from this shared savings pool is then determined by how well the provider performed across the quality measures in the program when compared to their peers. Points are earned per measure based on the percentile ranking achieved for the year:

- 60th percentile and higher = 3 points
- 55th – 59th percentile = 2 points
- 50th – 54th percentile = 1 point

The total earned points across all eligible measures divided by the potential points available per measure determines the percentage of the shared savings pool to be incentivized to the provider. For example, of the eight measures, Provider X had an adequate sample size for seven of them, and performed among the other providers in the program within the above-illustrated percentile rankings to earn 15 of a total potential of 21 points. Earned points divided by potential points equals 71%, and that percentage times the previously established $5,000 shared savings pool via the Total Cost of Care component of the program would result in a $3,571 incentive earned.

### Reporting Period and Payment Schedule

| Reporting period | Claims paid through | Payment date |
|---|---|---|
| January 1, 2024, to December 31, 2024 | March 31, 2025 | June 2025 |

# Sample scorecard

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## Open Arms for Nursing Facilities

**Measurement Period:** January 1, 2024 - December 31, 2024

**Tax ID:** 123456789
**Tax Name:** NURSING FACILITY INC
**Room and Board Days:** 40,000

### Quality Performance Summary

| Quality Measure Detail | Numerator | | Denominator | Rate | Percent Rank | TCOC Points |
|---|---|---|---|---|---|---|
| Percentage of short-stay residents who were re-hospitalized | *40* | / | *65* | *61.53%* | *75.00%* | 3 |
| Percentage of high risk long-stay residents with pressure ulcers | *7* | / | *112* | *6.25%* | *32.00%* | 0 |
| Percentage of long-stay stay residents with one or more falls | *17* | / | *112* | *15.18%* | *48.00%* | 0 |
| Percentage of long-stay residents given the influenza vaccine | *109* | / | *112* | *97.32%* | *93.00%* | 3 |
| Percentage of long-stay residents given the pneumococcal vaccine | *105* | / | *112* | *93.75%* | *94.00%* | 3 |
| Percentage of long-stay residents who received an Antipsychotic Med | *32* | / | *112* | *28.57%* | *50.00%* | 1 |
| Percentage of long-stay residents with a urinary tract infection | *9* | / | *112* | *8.03%* | *90.00%* | 3 |
| Staffing Rating based on Centers for Medicare & Medicaid Standards | | | | *4 Stars* | *80.00%* | 3 |
| | | | | **Avg Percent Rank:** | *70.00%* | |



### Total Cost of Care Component

**TCOC Points Legend**
>60% = 3 Points
55% - 59% = 2 Points
50% - 54% = 1 Point
<50% = 0 Points

| Actual Cost | Expected Cost | Efficiency | Claims Spend | Potential Pool |
|---|---|---|---|---|
| $950,000 | $1,000,000 | 95% | $100,000 | $5,000 |

| Total Points Earned / Total Potential Points | Total Points Percentage | TCOC Payout |
|---|---|---|
| 16 / 32 | 50% | $2,500 |

### Incentive Summary

| Quality Performance Per Unit Incentive | | Total Cost of Care Incentive | | Program Payout: |
|---|---|---|---|---|
| *$37,200.00* | + | *$2,500.00* | = | *$39,700.00* |

## Facility appeal of ranking determination

- If a provider wishes to appeal their percentile ranking on any or all incentive components, this appeal must be in writing.
- The written appeal must be addressed to the Keystone First CHC Market Chief Medical Officer and specify the basis for the appeal.
- The appeal must be submitted within 60 days of receiving the overall ranking from Keystone First CHC.
- The appeal will be forwarded to the Keystone First CHC Open Arms for Nursing Facilities Review Committee for review and determination.
- If the Open Arms for Nursing Facilities Review Committee determines that a ranking correction is warranted, an adjustment will appear on the next payment cycle following committee approval.

## Important notes and conditions

- The sum of the incentive payments for the performance components of the program will not exceed 33% of the total compensation for medical and administrative services. Only capitation and fee-for-service payments are considered part of the total compensation for medical and administrative services.
- The performance measures are subject to change at any time upon written notification. We will continuously improve and enhance our quality management and quality assessment systems. As a result, new quality variables will periodically be added, and criteria for existing quality variables will be modified.
- A provider's participation in the program is voluntary or opt-out in nature, and a provider may terminate program participation at any time by providing 60 days written notice to the Plan, without affecting the provider's participation in the Plan's network of participating providers in any other respect. The provider is not entitled to receive any payments or retain any amounts paid in advance nor is the Plan under any obligation to pay any amount of incentive compensation for any partial year of participation by the provider in the program.
- For computational and administrative ease, no retroactive adjustments will be made to incentive payments.

**Keystone** First

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## Our Mission

We help people get care, stay well, and build healthy communities.

**www.keystonefirstchc.com**



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