FHCA 2019 Annual Conference & Trade Show

CE Session #53 – How Do You Measure Up? Strategies for Success with VBP, QRP and PDPM

Wednesday, August 7 – 5:45 to 6:45 p.m.

Celebration 7-8 – Operations/Quality Improvement

Upon completion of this presentation, the learner will be able to:

- Identify three strategies that can be used for successful implementation of PDPM
- Identify three approaches to improve facility rehospitalization measures
- Identify three methods for improving facility IMPACT Act measures

Seminar Description:

Did you know that the only profession more regulated than long term care is nuclear power plant centers? As crazy as that may sound, this is the world in which we live. Centers are expected to not only meet the regulatory standards of Value Based Purchasing (VBP), Quality Reporting Program (QRP) and the Improving Medicare Post-Acute Care (IMPACT) Act, but to exceed them. Last October, centers were given a joggle when the 2% reduction in payment occurred under VBP. An additional 40% of the centers across the country received no incentive payment. If that wasn't enough, many centers also received a QRP penalty as well. October 1, 2019, ushers in the new Medicare Part A Patient-Driven Payment Model (PDPM). This session will offer strategies for successfully implementing PDPM, approaches to improving your rehospitalizations and methods for improving IMPACT Act quality measures in your center.

Presenter Bio(s):

Maureen Hedrick has over 25 years of experience in revenue cycle management in the health care environment with a specialty expertise in long term post-acute care and hospital reimbursement. In her role as Vice President, Maureen is a member of the Richter Consulting team which provides training and consultation regarding the various federal billing compliance audit programs. Maureen manages the Richter team responsible for services provided to clients and users of the PointClickCare platform. Maureen is also the lead member of the Richter Audit team which provides training and consultation regarding the various federal billing compliance audit programs.

Jennifer Leatherbarrow, RN, BSN, RAC-CT, IPCO, QCP, CIC, is a graduate of Kent State University's School of Nursing. She has over 20 years of health care experience including Corporate Reimbursement Specialist, Director of Nursing, MDS Coordinator and Staff Development Coordinator. Jennifer is currently the Manager of Clinical Consulting for Richter Healthcare Consultants where she has been a State and National level speaker and author with a focus on the LTPAC communities. Jennifer's focus areas include regulatory compliance, process review and redesign, and education and training.

How Do You Measure Up?
CE Session #53

FHCA 2019 ANNUAL CONFERENCE & TRADE SHOW

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Objectives

- Participants will be able identify and define key Quality Measures required by federal QRP, IMPACT, PAMA/VBP, IPERA and other healthcare reform legislation.
- Participants will learn techniques to refine strategies for operations based on publically reported measures such as the CMS Five-Star Rating.
- Participants will discuss exceeding public demand under the patient-driven payment model for post-acute care.

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Payment Reform

- Goal is improving value for patients. CMS focus on value over volume.
  - QRP
  - PAMA/VBP
  - IPERA
  - Five Star Quality Measures
    - IMPACT QMs
  - PDPM
  - MSPB: Medicare Spending Per Beneficiary

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SNF Quality Reporting Measures (QRP)

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SNF Quality Reporting Measures (QRP)

- What are the SNF quality reporting measures?
  - Measures currently adopted and finalized for the SNF QRP are listed below. Data for the SNF QRP measures are collected and submitted through two methods:
    - Minimum Data Set (MDS) 3.0
    - Medicare Fee-For-Service Claims

QUALITY REPORTING

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SNF Quality Reporting Measures (QRP)

- **SNF QRP Measure 1:** Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
- **SNF QRP Measure 3:** Medicare Spending Per Beneficiary - PAC SNF QRP
- **SNF QRP Measure 3:** Discharge to Community - PAC SNF QRP
- **SNF QRP Measure 4:** Potentially Preventable 30-Day Post-Discharge Readmission Measure – SNF QRP
- **SNF QRP Measure 5:** Drug Regimen Review Conducted with Follow-Up for Identified Issues—PAC SNF QRP
- **SNF QRP Measure 6:** Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury

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SNF Quality Reporting Measures (QRP)

- Measures Removed from SNF
  - Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678)
    - This measure was finalized in the FY 2016 SNF PPS Final Rule which was published in the Federal Register on August 4, 2015 (80 FR 46433). Data collection for this measure began 10/1/2016. As finalized in the FY 2018 SNF PPS Final Rule which was published in the Federal Register on 08/04/2017 (82 FR 36572), this measure was replaced by a modified version of the measure entitled Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury beginning with the FY2020 SNF QRP.

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How to Measure Up for SNF QRP

- Falls management in the facility – Falls program. PIP if needed
- Medicare Spending Per Beneficiary – Lower cost and better outcomes
- Discharge to Community – Follow up within 3 days of discharge
- Potentially Preventable 30-Day Post-Discharge Readmission Measure – Follow
- Drug Regimen Review – Medication reconciliation
- Changes in Skin Integrity – Pressure ulcer management

SNF Value Based Purchasing Program (VBP)

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SNF VBP History

- Protecting Access to Medicare Act (PAMA) 2014 Section 215
  - Encourage coordination of care across continuum
  - Focus on measures of readmissions
  - Performance standards for achievement and improvement
  - SNF Performance Scores publicly ranked from low to high
- SNF VBP essentially a rate cut to offset "doc fix" – 2% of Medicare payments withheld to fund incentive payments
  - Incentive payments totaling 60% of the amount withheld from SNF payments
  - Bottom 40% of SNFs will receive up to 2% less in payments

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SNF VBP – FY2018 Final Rule

- $2 billion in savings over 10 years
- Payment impact began 10/1/18
- FY 2018 SNF PPS Final Rule
  - Performance and baseline periods for FY 2020 Program Year – October 1, 2018
  - Revision to rounding policy for SNF performance scores
  - Formula for translating performance scores to incentive multipliers
  - 60% of total amount withheld from SNFs Medicare payments for that FY will be paid out – based on performance
  - Phase 2 of the Review & Correction process
  - Public reporting and performance ranking

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SNF VBP

- One quality measure: hospital readmission
  - Skilled Nursing Facility 30 Day All-Cause Readmission Measure (SNFRM) – SNF PPS Final Rule FY2016
  - Estimates the risk standardized rate of unplanned readmissions within 30 days for people with FFS Medicare for any cause or condition
- Baseline period effecting payment determination FY 2019 was CY 2015
- Performance period effecting payment determination FY 2019 was CY 2017
- We are in performance period now for FY2021 payment

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SNF VBP

- SNF 30 Day All Cause Readmission Measure (SNFRM)
  - Hospital readmissions are identified through Medicare claims
  - Readmissions within 30 day window are counted even if resident had discharged home from the SNF
    - Excludes planned readmissions (based on reason for readmission)
  - Risk-adjusted based on resident demographics, principal diagnosis in prior hospitalization, comorbidities and other health variables that affect readmission

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SNF VBP – Next Level

- SNFRM replacement by All-Condition Risk-Adjusted Potentially Preventable Hospital Readmission Measure (SNFPPR) FY 2020
  - Claims based – no additional data required
  - Two categories
    - Within Stay
    - Post SNF Discharge to the end of the 30 day post hospital discharge
  - Risk-adjusted for patient demographics, comorbidities, number of prior hospitalizations in the past year (CBSA rate)
  - Scoring is on 0-100 point scale for achievement, 0-90 point scale for improvement
  - Measure is calculated using one full calendar year of data

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How to Measure Up for SNF VBP

- Readmissions, readmissions, readmissions
  - INTERACT program or equivalent in place
  - Educate nurses, residents, families, and physicians on process
  - Ensure physicians know what you can do in your facility
  - Start a nurse mentoring program for new nurses
  - Review CASPER reports, respond if reconsideration warranted

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How to Measure Up for VBP

- Case Management
  - Interventions at the facility level
  - Practitioner engagement
  - 30 day post discharge tracking
- Care Coordination
  - Holistic approach
  - Transparency
  - Patient engagement
  - Integration
  - Interoperability

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Improper Payment Elimination and Recovery Act (IPERA)

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Improper Payment Elimination and Recovery Act (IPERA)

- Purpose; boost transparency, hold agencies accountable, create incentives for eliminating improper payments
- 2015 OMB issued root cause classifications to better link improper payments to root causes
  - Failure to verify data
  - Medical necessity
  - Insufficient documentation

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Improper Payment Elimination and Recovery Act (IPERA)

Robust procedure to assure claims billed and payments received follow all the rules

- Valid provider certifications; perform audit of current certs and build in process for ongoing audit (incorporate into QAPI for identified deficiencies)
- Pre-submission Triple / Quadruple check documentation supporting claims
- Perform regular internal audits, full charge to chart of 10% of submitted claims

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How to Measure Up Under IPERA

What to focus on with your audit:

- Diagnosis
- Skilled Nursing Assessment and treatment documentation
- Daily skilled nursing documentation of medical necessity and skilled criteria
- Therapy assessment and treatment documentation
- Therapy orders
- Compliance with orders, minutes, modality and diagnosis
- Physician Certification

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Five-Star Quality Measures

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Five-Star Quality Measures

- On March 5, 2019, the Centers for Medicare & Medicaid Services (CMS) issued a press release, "CMS Improving Nursing Home Compare in April 2019" and alongside that, issued a new QSO memo that details all the changes to Nursing Home Compare and the Five Star Rating System that will be occurring.
- Due to the updates "many nursing homes will see a decline in their rating" in the Staffing and QM domains until they make improvements, including their overall star rating.

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Five-Star Quality Measures

- Health Inspection Ratings
- CMS found through its analysis there are slightly more deficiencies being given than under the prior survey process. This rating was unfrozen in April 2019, but that's not all:
  - Health inspection ratings will be based on 3 cycles of inspections again (Most recent 3 standard surveys and any complaints within the past 3 years)

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Five-Star Quality Measures

- Health Inspection Ratings
  - Pre-freeze weights for survey cycles will become effective
    - Cycle 1 will be weighted as ½
    - Cycle 2 will receiving a weighting of 1/3
    - Cycle 3 will have a weighting of 1/6
  - Special Focus Facilities (SFF) – Facilities designated as Special Focus Facilities will have their star ratings suppressed on Nursing Home Compare

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Five-Star Quality Measures

- Staffing Rating Domain.
  - The staffing rating grid has been adjusted to increase the weight of RN staffing on the staffing rating.
  - The threshold number of days without an RN on site has been reduced from 7 to 4
  - Facilities reporting 4+ days with no RN on-site (within the quarterly reporting period) will be automatically assigned a 1-star staffing rating.

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Five-Star Quality Measures

- Ratings for short-stay and long-stay ratings are going to be split into two groups with separate QM ratings.
- Facilities will continue to have an overall QM rating that will be used for the overall star rating based equally on short-stay and long-stay ratings.

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Five-Star Quality Measures

- Two weighting levels for QMs are being put into place – high and medium – which will reflect clinical significance and room for improvement.
- High weighted QMs can get a total of 150 points each and medium weighted QMs can get 100 points each.

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Five-Star Quality Measures

- QMs being added to Five-Star rating system.
  - Long-stay hospitalizations QM
  - Long-stay emergency department transfers
- QMs being replaced with measures from the SNF QRP Program.
  - Short-stay pressure ulcers
  - Short-stay successful discharge to the community QMs are being replaced

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Five-Star Quality Measures

- Long-stay residents who were physically restrained is being removed as a QM from the rating system but will still be reported on Nursing Home Compare.

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Five-Star Quality Measures

- QM thresholds to see continuous increases
- CMS is adjusting the ratings thresholds for QMs, and will be raising QM thresholds every 6 months to encourage and incentivize continuous quality improvement.
- The thresholds will be increased by 50% of the average rate of improvement in QM scores.

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Improving Medicare Post-Acute Care Transformation Act (IMPACT)

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Improving Medicare Post-Acute Care Transformation Act (IMPACT) QMs

- Functional status, cognitive function and changes in function and cognitive function
- Skin integrity and changes in skin integrity
- Medication reconciliation
- Incidence of major falls
- Transfer of health information and care preferences when an individual transitions
- Resource use measures including estimated Medicare spending per beneficiary
- Discharge to community
- All condition risk-adjusted potentially preventable hospital readmission rates

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Measuring up for IMPACT

- Use what we are given to set priorities and allocate resources; internalize and refine strategies for operations based on facility-wide assessment F838
- Value is defined as the health outcomes achieved that matter to patients relative to the cost of achieving those outcomes
- Improving value requires either improving one or more outcomes without raising costs or lowering costs without compromising outcomes, or both

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Patient Driven Payment Model (PDPM)

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Patient Driven Payment Model - PDPM

- A fundamental change in SNF reimbursement for Medicare A services
- Precursor of Unified Payment System
  - Unified payment system is required by the Impact Act for all post-acute care (initial reports are expected 2022 and 2023)
- Program for Evaluating Payment Patterns Electronic Report (PEPPER)
- Office of the Inspector General (OIG) Work Plan

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PDPM and ICD-10-CM Codes

- Skilled nursing facility patients will be classified into a clinical category based on the Primary/Principal diagnosis for the skilled stay
- Primary diagnosis for skilled nursing facility stay may be different from the primary diagnosis for the hospital stay
- ICD-10-CM codes documented in the MDS will be mapped to a PDPM clinical category
  - ICD-10-CM mapping is available from the CMS Patient Driven Payment Model webpage

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NTA Component and ICD-10-CM Codes

- NTA (Non-Therapy Ancillary) classification is determined by the presence of certain conditions or the use of certain extensive services that were found to be correlated with increases in NTA costs for SNF patients.
- There are 6 NTA CMGs
- CMS identified a list of 50 conditions and extensive services that were associated with increases in NTA costs.
- The presence of these conditions and extensive services is reported by providers on the MDS 3.0, with some of these conditions being identified by ICD-10-CM codes that are coded in Item I8000 of the MDS

CMS

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NTA Component and ICD-10-CM Codes

- HIV/AIDS
  - A diagnosis of HIV/AIDS will increase the NTA component by adding 8 points to the total comorbidity score
  - A diagnosis of HIV/AIDS will increase the Nursing component by adding 18% to the CMG per diem
  - Diagnosis is **not captured on the MDS**
  - Diagnosis is reported on the SNF UB-04 claim – use code B20

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Therapy Changes for PDPM (PT & OT)

- Sixteen (16) Case-mix Groupers (CMG) for Physical and Occupational Therapy included in PDPM are based on three (3) components:
  - PT & OT Clinical Categories
    - Major Joint Replacement
    - Non-Orthopedic Surgury/ Acute Nuerologic
    - Other Orthopedic
    - Medical Management
  - Section GG Functional Score
  - Section J Surgical Conditions

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Therapy Changes for PDPM (PT & OT)

- Variable per diem (VPD) begins on day 21 of resident stay with a 2% reduction of the PT/OT components only
  - ST component does not decrease
- VPD continues to decrease by an additional 2% every 7days and continues through discharge

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Therapy Changes for PDPM (PT & OT)

Medicare Payment Days	Adjustment Factor
1-20	1.00
21-27	0.98
28-34	0.96
35-41	0.94
42-48	0.92
49-55	0.90
56-62	0.88
63-69	0.86
70-76	0.84
77-83	0.82
84-90	0.80
91-97	0.78
98-100	0.76

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Therapy Changes for PDPM (SLP)

- Presence of Acute Neurologic Condition
- Presence of Speech Related Comorbidities
- Mild to severe cognitive impairment
- Section C of MDS – BIMS Score of 12 or under
- Swallowing Disorder
- Mechanical Diet

Aphasia	Laryngeal Cancer
CVA, TIA, or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy Care (While a Resident)	Oral Cancers
Ventilator or Respirator (While a Resident)	Speech and Language Deficits

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Therapy Changes for PDPM - SLP

Presence of acute neuro condition, SLP-related comorbidity, or Cognitive impairment	Mechanically altered diet or Swallowing disorder	SLP CMG	SLP CMI
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.66
Any one	Neither	SD	1.46
Any one	Either	SE	2.33
Any one	Both	SF	2.97
Any two	Neither	SG	2.04
Any two	Either	SH	2.85
Any two	Both	SI	3.51
All three	Neither	SJ	2.98
All three	Either	SK	3.69
All three	Both	SL	4.19

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PDPM Nursing Component

- The 25 CMGs for nursing in PDPM are based on the following components:
  - RUGS system (minus the therapy RUGs)
  - Depression
  - Restorative
  - Modified functional score (7 questions)
    - No oral hygiene
    - No toilet hygiene
  - Total possible score of 16

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Transition to PDPM MDS Assessments

All Medicare A and Medicare C (Medicare Advantage) residents must have an IPA assessment at the time of transition

- The ARD must be set for Oct 1, 2019 – Oct 7, 2019
- You still have 14 days to complete assessments from the ARD and 14 days to submit after completion

Interrupted Stay Policy

- Effective concurrent with PDPM - October 1, 2019
- Interruption "window" – three (3) consecutive days starting with the calendar day of discharge and including the two (2) immediately following calendar days, ending at midnight
  - Resident must return to the same SNF by 12:00am at the end of the third calendar day

Interrupted Stay Policy

- Scenario 1: Patient admitted to SNF 10/07/19, is admitted to the hospital on 10/18/19 and returns to the same SNF 10/28/19
  - New stay
  - Restarts the assessment schedule (new 5 Day Assessment)
  - Resets the Variable Per Diem (VPD) schedule

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Interrupted Stay Policy

- Scenario 2: Patient admitted to SNF 10/07/19, is admitted to the hospital on 10/18/19 and admitted to a different SNF 10/21/19
  - New stay
  - Restarts the assessment schedule (new 5 Day Assessment)
  - Resets the Variable Per Diem (VPD) schedule

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Interrupted Stay Policy

- Scenario 3: Patient admitted to SNF 10/07/19, is admitted to the hospital on 10/18/19 and returns to the same SNF 10/20/19
  - Continuation of previous stay
  - No new assessment required, IPA optional
  - Variable Per Diem (VPD) schedule continues from day of discharge

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Interrupted Stay Policy

- Days are not counted against benefit period/ utilization
- No change to spell of illness
- Reported on UB-04 per NUBC Guidelines
  - Value Code 81 – Non-Covered Days
  - Occurrence Span Code 74 with dates of LOA
  - Revenue Code 018x with 0.00 charges

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Claim Specifications for PDPM Assessments

- Case-Mix Grouper (CMG) replaces RUG
  - PT 16 CMG
  - OT 16 CMG (PT/OT CMG are always the same)
  - SLP 12 CMG
  - Nursing 25 CMG (Non Rehab RUGs, displayed as HIPPS character A-Y)
  - NTA 6 CMG
  - Modifier (0 = IPA, 1 = 5 Day, 6 = OBRA/ Combined with 5 day)

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PDPM Payment Groups

- RUG-IV algorithm revised for PDPM:
  - Character 1: PT/OT Payment Group
  - Character 2: SLP Payment Group
  - Character 3: Nursing Payment Group
  - Character 4: NTA Payment Group
  - Character 5: Assessment Indicator (0, 1, 6)

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PDPM Payment Groups

- Example 1 – 5 Day:
  - PT/OT Payment Group: TB
  - SLP Payment Group: SA
  - Nursing Payment Group: CBC1 = P
  - NTA Payment Group: NC
  - Assessment Type: 5 Day PPS Assessment
  - HIPPS Code: BAPC1

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PDPM Payment Groups

- Example 2 - IPA:
  - PT/OT Payment Group: TH
  - SLP Payment Group: SG
  - Nursing Payment Group: HDE2 = D
  - NTA Payment Group: NE
  - Assessment Type: IPA
  - HIPPS Code: HGDE0

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PDPM Payment Groups

- Example 3 – 5 Day combined with admission/discharge:
  - PT/OT Payment Group: TL
  - SLP Payment Group: SJ
  - Nursing Payment Group: LBC2 = J
  - NTA Payment Group: NA
  - Assessment Type: OBRA
  - HIPPS Code: LJJA6

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PDPM Payment Groups

- Default rate refers to lowest possible per diem rate
- PDPM CMG = ZZZZZ (as compared to RUG-IV default AAA00) equivalent to PDPM groups:
  - PT/OT TP
  - SLP SA
  - Nursing PA1 = Y
  - NTA NF

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How do you Measure up for PDPM?

- Provide PDPM training to all staff
  - Nursing – PDPM processes, skilled documentation, physician certs and recerts, restorative nursing, diagnosis management, Triple Check
  - MDS – PDPM, MDS changes, diagnosis management, Triple Check
  - Admissions – PDPM, pre-admission changes
  - Social Services PDPM, BIMS, PHQ-9
  - Therapy – PDPM, Triple Check
  - Business Office – PDPM, billing changes, Triple Check

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How do you Measure up for PDPM?

- Review frequently used primary/principle ICD-10-CM codes in your organization to determine clinical category
- Download the ICD-10 Crosswalk from the CMS PDPM webpage
  - Clinical Category Crosswalk
  - Non-Therapy Ancillary (NTA) Crosswalk
  - Speech Language Therapy (SLP) Crosswalk
  - Return to Provider (RTP) Crosswalk

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Best Outcomes at the Lowest Price

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Best Outcomes at the Lowest Price

- Move away from supply driven care organized around provider needs to patient-centered system organized around what each patient needs
- Shift focus to patient outcome profits from volume driven profits
- We do this by concentrating healthcare delivery on specific problem sets (specialized services)
- Greater value clearly requires greater coordination among providers

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Best Outcomes at the Lowest Price

- To improve value, foster clinically integrated environments,
  - Providers share clinical data
  - Optimize workflow for best practice (clinical pathways)
  - Agree on patient specific plans of care in each setting of the care continuum
- Foster care coordination – who are your care/case managers, care coordinators, discharge planners, etc.?
  - Each setting tracks patients after discharge and coordinates to improve outcomes

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Navigating Change

- Balance in growth and value produces ability to move forward
- Race for Value
- Follow Wayne Gretzky: “A good hockey player plays where the puck is. A great hockey player plays where the puck is going to be.”

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Thank You!

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