What I Hope You Leave With

- What is the need that accomplishes the deed
- An anticipation of what is to come with Five-Star
- Very specific “Ah-Ha” moments around PDPM
- An appreciation for the bowtie
Two Needs with One Deed

What Are the Needs?
• PDPM Excellence
• Five-Star

What is the Deed?
• Excellent Care and Accurate Reimbursement...
  ....and both begin with accurate assessment

And the Root of it All.....The MDS

- MDS DATA: Standardized Assessment in place since OBRA ’87
- Quality Measures: NQF endorsed (mostly) outcome measures, incorporated into...pretty much everything
- Reimbursement: All RUG systems, and now PDPM
The Quality of MDS Data

- 23,722 MDS assessments
- Jan – July 2018
- An "issue" in MDS data quality produces
  - “false negatives”
  - “false positives”
  - Inaccurate case-mix adjustment
  - Inaccurate reimbursement
  - Inaccurate careplans
  - Negative survey outcomes

Avedis Donabedian

Avedis Donabedian was a physician and founder of the study of quality in health care and medical outcomes research, most famously as a creator of The Donabedian Model of care.
A Framework Gets You Out of the “Blame Game”

**Structure**
- Staff Ratios
- Policies & Procedures
- Equipment Available
- Contracts

**Process**
- Medication administration & errors
- Accuracy of assessments
- Hours to nurse evaluation

**Outcome**
- 30 Day Rehospitalization
- Five Star domains
- PDPM outcomes

Take the first step
“Sunny Vista” has a strong reputation for complex orthopedic rehabilitation and referring hospitals seek them out as a preferred provider for their referral network.

The publication of new QMs have called Sunny Vista’s performance into question by consumers, hospitals and orthopedic surgeons in their area. Dismayed by this, the administrator (Kate) organizes an interdisciplinary team to better understand their data, and create an improvement plan.

| % | 60% discharge to community (29.9% N Average) | 38% QM Successful Discharge to community (55% N Average) | 30% of discharged residents go to Home Health Most go to one of three HHAs | 14% PointRight® Pro30™ Rehospitalization rate 6% for ortho, 20% for CHF/COPD | 22% QM Rehospitalization 21.06% (N Average) |

What jumps off the page?

Let’s identify additional questions/data requests

Then let’s talk about S.P.O. Measures that we’ll use in our QAPI program
How did we get here?

Brief history of current PPS/RUG system
• Origins
• Revisions
Always based upon Minimum Data Set (MDS)
Value = Volume
Always under scrutiny and criticized

Ongoing concern around reimbursement abuse

• By GAO/to OIG/MedPAC
• Scope creep with pretty much every RUG iteration
• PEPPER Reports
  – Ultra high rehab
  – Therapy w/high ADL
  – COT MDS
  – “Payment Patterns”
• Others
ACA transition from Volume to Value

- Formalization of these values, clearly influenced payment reform including PDPM
- CMMI examples – ACOs, Bundles, VBP in every sector
- PDPM Is NOT VBP, but movement away from volume

Patient Driven Payment Model (PDPM)

How did we land on PDPM
- The Contractors: Acumen
- RCS-1
- Tsunami of responses
Three Goals of Payment Reform

Three goals identified

• more accurately compensate SNFs;
• reduce incentives for SNFs to deliver therapy based on financial considerations, rather than resident need;
• maintain simplicity

Three goals remain
The Journey Continues

Open Door Forum in March 8, 2018, CMS indicated that it was not ready for RCS-1

Implied that requirement to shift to a unified post-acute payment (U-PAC) slowing the rulemaking process

Final Rule FY '19 codified PDPM effective FY '20

PDPM – From Volume to Value(ish)

• Payment is based upon verifiable patient characteristics and diagnoses, not the amount of therapy delivered
• More consideration of ancillary costs
• Fewer assessments required to establish rates
• Reimbursement adjusts automatically (downward) over time
• More Case Mix components included in determining payment
The Case-Mix Components

PDPM Case Mix Adjusted Payment

- **PT**: BASE RATE X PT CMI X ADJUSTMENT FACTOR
- **OT**: BASE RATE X OT CMI X ADJUSTMENT FACTOR
- **SLP**: BASE RATE X SLP CMI
- **Nursing**: BASE RATE X NURSING CMI
- **NTA**: BASE RATE X NTA CMI ADJUSTMENT FACTOR
- **Non-Case Mix**: BASE RATE
Let’s deal with the crazy

- “Cut MDS staff”
- “No longer give therapy”
- “Get ready for the new patient coming into SNF”
- “Less sophisticated providers exiting”
- “Need to hire ICD-10 coder”

Cut into some apple pie instead of your MDS staffing budget

It was about an hour after the release of the Center for Medicare & Medicaid Services’ proposed rule for FY19, which contained the big Patient-Driven Payment Model reveal, that a wave of bold and somewhat uninformed statements surfaced.

It was equal only to the saturation of “PDPM experts” who have seized upon this opportunity. The volume of misinformation is notable. Is this our own version of “false” news?

Here are some of my favorites:

- “The MDS is irrelevant in PDPM.” (Excuse me? I think I count only one non-MDS field)
- “We have to make way for and prepare for the ‘new resident’ coming in our buildings.” (…because up until PDPM they have been hiding precisely where?)
- “I’m going to fire my MDS staff!” (Ouch!)

It’s the last I want to discuss.

Others and I have tackled many of these myths in various McKnight’s blogs, but I’ve yet to see a compelling version of the MDS rebudgeting, with the ICD-10 coder transition in cross-65 – CPT (Semi-humorous)
How can you anticipate failure?

- PDPM = “Please Don’t Pester Me”
- Therapy relationships not reconsidered
- Over reliance of CMS PDPM conversion calculator
- Several vendors/accounting groups providing same
- Crunching MDS data to calculate PDPM

The case of Mrs. Jane Q

Jane Q.
Hispanic Female
77 years old

Admitted to SNF for PT/OT for strengthening following a fall. During acute stay, a pathological fracture was found on x-ray. COPD w/ acute exacerbation. No surgical procedure.

PT/OT Function Score:
Nursing Function Score:
Low BMI (dx of malnutrition)
Mechanically altered diet
BIMS score:
PHQ-9 score:
Impact of not properly identifying and coding comorbidities

Jane Q.
Hispanic Female
77 years old

If Primary dx code: M8008XG Age-related osteoporosis with current pathological fracture, vertebra(e), subsequent encounter for fracture with delayed healing

Clinical Category: Other Orthopedic
PT/OT: TG
SLP: SE (cog impairment and mech altered diet)
NTA: ND (COPD, Malnutrition)
Nursing: HBC2 (COPD w/ SOB, Depression)

PDPM Payment: $668.85
If no dx of Malnutrition: NTA drops to NE PDPM Payment: $639.62
If no cognitive impairment: SLP drops to SB PDPM Payment: $628.28
If no depression: Nursing drops to HBC1 PDPM payment: $589.19

Impact of not properly coding the right ICD-10 code and comorbidities

Jane Q.
Hispanic Female
77 years old

If Primary dx code: J114 Chronic obstructive pulmonary disease with (acute) exacerbation

Clinical Category: Medical Management
PT/OT: TK
SLP: SE (cog impairment and mech altered diet)
NTA: ND (COPD, Malnutrition)
Nursing: HBC2 (COPD w/ SOB, Depression)

PDPM Payment: $654.77
If no dx of Malnutrition: NTA drops to NE PDPM Payment: $625.54
If no cognitive impairment: SLP drops to SB PDPM Payment: $614.19
If no depression: Nursing drops to HBC1 PDPM payment: $575.10
How to anticipate success?

- PDPM “Patience-Driven Payment Model”
- Thoughtful renewal of therapy
- MDS coordinator role transitions (not cut)
- ICD-10 champion
- Qualified education (rinse and repeat)
- Key financial drivers periodically evaluated and benchmarked
- PDPM “practice assessments” to highlight differences
- Required compliance plan adjusted to PDPM drivers

Practices that will ultimately create compliance concerns…

- Changes in coding practices
- Outliers of key payment drivers
- Absence/significant cut in therapy
- Overuse of IPA

…and their consequences
Slippery Slopes: PDPM Financial Drivers

Facility Rates
- Depression 6%
- Swallowing Disorders: 9.1%
- Mechanically altered diet: 17.4%
- Cognitive Impairment: 4%

The ‘big picture drivers’ haven’t changed

- Hospital utilization
- Length of Stay
- Five-Star outcomes
- Creativity with up/down stream partner providers
- Staffing

The ‘big picture drivers’ haven’t changed

- Hospital utilization
- Length of Stay
- Five-Star outcomes
- Creativity with up/down stream partner providers
- Staffing
What’s on the Horizon That’s Got Me So Optimistic?

Unified (U) – Post Acute Care (PAC)

Required by IMPACT ACT of 2014 – (draft due ’22/’23)
MED-PAC recommends Implementing by 2021
SNFs are likely winners!
...and the Headlines Continue

July 18, 2018

Congress investigating alleged poor care at VA nursing homes

The House of Representatives is launching an investigation into alleged poor care at Veterans Affairs nursing homes, after a newspaper exposé pulled the curtain back on the issue.

USA Today and the Boston Globe revealed last month that the federal government has hidden poor quality rankings at its nursing homes from the public, despite tracking that information for years. About half of the agency’s homes received its lowest ranking — one star out of five — last year.

Now, after officials recently demanded action on the matter, the House Veterans Affairs Committee has initiated an investigation, the Globe reported Tuesday. A spokeswoman for Committee Chairman Phil Roe (TN-R) told the newspaper that the group hopes to hold a hearing this fall, and may release further details to the public as the investigation rolls...
Five-Star Does Nothing to Match The Right Person to The Right SNF

All SNFs are not the same
- De facto specialty care centers
- Acute Medical/Rehab
- Alzheimer's/Cognitive Impairment
- Mental Health
- End of Life/Frail Elders

All consumers coming into a SNF are not the same
- Some are patients and will be going home
- Some are residents and will not
- All have unique needs

Poorly rated nursing homes got HUD-guaranteed mortgages anyway

Hundreds of homes with lowest possible ratings from the federal government received HUD assistance worth billions

By Jeff Kelly Lowenstein 5:00 am, November 13, 2014 Updated: 2:50 pm, February 13, 2015
## Five-Star Uses (and Abuses) are Far Ranging

### Intended Uses
- Consumer placement
- Consumer monitoring of care

### Unintended Uses
- APM (ACOs, Bundles)
- HUD
- Commercial payers
- Plaintiff Attorney
- REITs

## APM: What is a Three-Day Requirement & Waiver?

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<td>Qualifying inpatient hospital stay of 3 consecutive days (midnights) or more (plus additional criteria)</td>
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<table>
<thead>
<tr>
<th>Waiver:</th>
</tr>
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<tbody>
<tr>
<td>For eligible programs, CMS will waive the requirement for a 3-day inpatient hospital stay prior to a Medicare-covered, post-hospital extended care service for eligible beneficiaries</td>
</tr>
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</table>
A Waiver is a good thing

For the ACO/Bundle it means the possibility of transitioning patient to lower cost center (the SNF)

For the SNF, it means a potentially better referral stream of higher acuity residents

The “spill over effect” – a hospital discharge planner knows what she knows… other FFS patients may turn up in same hospital to SNF stream

So how do you get one?

Who Gets a Three Day Waiver?

- SNF must have a 3 or better Overall Star Rating
- ACO: Track +1, Track 3 and Next Gen – July 2019 “Pathways to Success ACO”
- Bundles: For Model 2/Model 3 participants

…but there is always a catch!
### Five-Star Ratings & Rehospitalization Rates

#### Overall Rating

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#### Staffing Rating

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Overall Five-Star

Staffing Overall
Five-Star Updates: Health Inspection Domain

- The “freeze” of Health Inspection (HI) rating ends effective April 2019
  - Includes HIs conducted on or after November 28, 2017
- Three survey cycle calculation and 36 months of complaint inspections returns with the previous weighting
  - Cycle 1 weighting factor: 1/2
  - Cycle 2 weighting factor: 1/3
  - Cycle 3 weighting factor: 1/6
- Special Focus Facilities (SFFs) will have no star ratings (Overall and in the three domains)
  - Previously, SFFs were given a star rating, but Overall rating was capped at three stars
## What's in the Freezer?

**Five-Star is anything but frozen**

December 18, 2017

Somewhere between balking in the joy of a meaningful Thanksgiving Day celebration and contemplating the merits of an electrified turkeyhand for the holidays, you read the Centers for Medicare & Medicaid Services memo (Ref STC 58-04-385) regarding changes to the survey process: Nursing Home Compare and Five-Star.

The day after Thanksgiving, CMS further defined its intentions with the Five-Star Quality Rating System: more specifically how the new survey process and derivative data will be used in its calculation of the Health Inspection domain.

Over the past several months, words like "frosters" and "bald constant" have been used to describe the Five-Star Health Inspection domain. In response to the new survey process, which began less than a month ago (Nov. 28, 2017). However, prior to this memo, we hadn’t heard much about what appears to be a separate concept—a change in methodology.

### Blog

- Initial spike, then leveling off of average number of deficiencies
- Increase in G-level or greater
- More IJs
- Increase in total health inspection score

---

### Table: Weighting

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<th>CYCLE</th>
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<th>Weighting Current</th>
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<tr>
<td>3</td>
<td>16.66%</td>
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</table>
Five-Star Updates: Staffing Domain

- Updated Staffing rating thresholds for hours per resident per day (HPRD)
- Registered Nurse (RN) staffing HPRD given increased weight in the overall Staffing star calculation
- Lowered the threshold for number of days with reported RN staffing from seven days in the quarter to four days
  - Facilities reporting four or more days without RN 8+ hours onsite will receive a 1-star Staffing rating
  - A Staffing rating of 1 star also deducts one star from the Overall rating
- Staffing ratings no longer suppressed for facilities with 5+ days of no reported staffing
Five-Star Updates: Quality Measures Domain

• Two new claims-based Quality Measures (QMs) added:
  • Long-Stay Hospitalizations
  • Long-Stay Emergency Department Visits
• Long-Stay Physical Restraints QM removed
• Separate star ratings for Short-Stay and Long-Stay QMs in addition to the overall QM rating
  • Intended to allow consumers to see how facilities perform with each resident population
• Overall QM rating will still be used to calculate Overall Five-Star rating

Five-Star Updates: Quality Measures Domain (cont.)

• Two separate QM weightings (high and medium), with more points towards QMs with “greatest opportunity for improvement”
• Increased thresholds for QM ratings, with updates every six months
  • Increase will be 50% of the average rate of improvement for that measure
Health Inspection and Staffing Domains

1. Remember that HI has most significant impact on Five-Star
2. Staffing domain has the second impact score
3. Anytime these domains are “touched”, facility-level five-star changes occur

Identifying EoL: MDS

It's not morbid to talk about death ... a lot

A few weeks back, I attended my high school reunion. I found myself on the dance floor shaking a tail feather with Linda, a friend from 35 years ago who always made me laugh. Time didn’t diminish her sense of humor, but our conversation took a surprising turn when she segued from a quick reminiscence to an impassioned statement about dignity at end of life.

Linda decided, at age 53, to go back to school to become a nurse. She’s passionate about elder care and described the profound honor of aiding at the bedside during one’s passing. Linda didn’t know that in high school I made the decision to become a nurse, nor did she know that I’ve dedicated my entire career to the betterment of our elders, especially at end of life.
Power of Prediction: Mortality

End of Life “Mortality” prediction

- Hospitalization rate of long-stay elders is 16%
- 14% of those were at end of life
- Greatest risk of litigation is “unexpected death”
- Data Driven/Person centered Advance Directives discussion

LS ADL Decline

LS Worsening in Independent Movement

End-stage prognosis (J1400) and/or Hospice (O0100K2)

LS Antianxiety Hypnotic

SS Improvement in Function
Weight Loss QM recently switched to NQF version
EoL is now an exclusion!

Hospice (00100K2) is an exclusion
J1400: Prognosis

End Stage Prognosis (J1400)

Definition: Life Expectancy <6 Months

In the physician’s judgment, the resident has a diagnosis or combination of clinical conditions that have advanced (or will continue to deteriorate) to a point that the average resident with that level of illness would not be expected to survive more than 6 months. This judgment should be substantiated by a physician note. It can be difficult to pinpoint the exact life expectancy for a single resident. Physician judgment should be based on typical or average life expectancy of residents with similar level of disease burden as this resident.
A program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider. Under the hospice program benefit regulations, a physician is required to document in the medical record a life expectancy of less than 6 months, so if a resident is on hospice the expectation is that the documentation is in the medical record.

**Definition:**

**Hospice Services**

Hospice (00100K2)

---

The Power of Predicting Mortality: A Five-Star Story

- 17 Quality Measures are used in Five-Star*
  - 12 MDS-based QMs
  - 5 claims-based QMs
- Each QM is weighted and points are assigned based on facility performance relative to the national distribution of each measure (maximum 2500 points*)
  - 5-star threshold: 1606 points*

*Effective April 24, 2019
The Power of Predicting Mortality: A Five-Star Story

- Facility A has a Five-Star Overall rating of 4 stars
  - Quality Measure domain rating: 4 stars
    - Improving the QM rating to 5 stars would add one point to the Overall rating
- How can they improve?
- Overall QM points = 1546 (60 points away from the 5-star threshold)
- QMs to focus on:
  - Short-Stay Improvement in Function
  - Long-Stay ADL Decline
  - Long-Stay Worsening Mobility
- MDS-based QMs reflect resident conditions/services provided in the facility
  - Screen for high Mortality risk and evaluate residents for end-stage condition and/or potential Hospice referral

Applecore Acres: Overall Rating of 4 Stars

Applecore Acres
Overall 4
Quality Rating is also 4

Improving the QM rating to 5 stars would add one point to the Overall rating

How can they improve?
Overall QM points = 1546
(60 points away from the 5-star threshold)

QMs to focus on:
- Short-Stay Improvement in Function
- Long-Stay ADL Decline
- Long-Stay Worsening Mobility

Screen for high mortality risk and evaluate residents for end-stage condition and/or potential Hospice referral
Power of Prediction: Mortality

<table>
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<th>Descriptive Scales</th>
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### Power of Prediction: Mortality – the items

#### Model score Rank

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</table>

**60-day Assessment**: 69.35%
Thank you!

Steven Littlehale
Executive Vice President &
Chief Clinical Officer
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