What I Hope You Leave With

2

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Two Needs with One Deed

What Are the Needs?	What is the Deed?
• PDPM Excellence • Five-Star	• Excellent Care and Accurate Reimbursement… ….and both begin with accurate assessment

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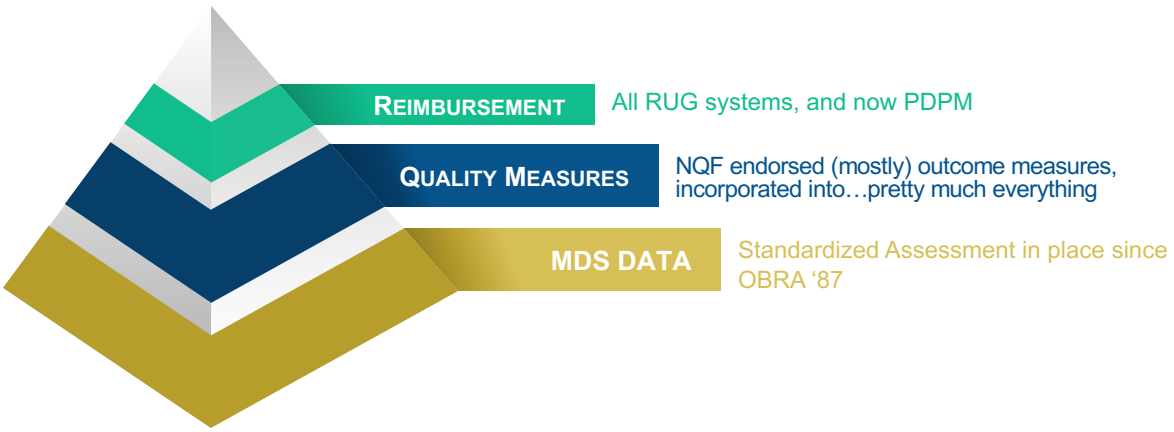
And the Root of it All…..The MDS



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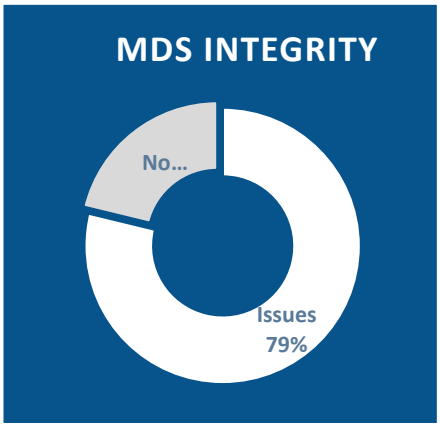
The Quality of MDS Data



- 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

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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.

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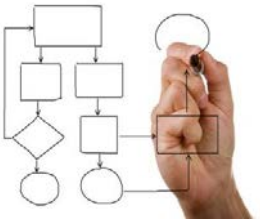
A Framework Gets You Out of the "Blame Game"

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

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Case Study

"**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)

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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

10

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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

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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

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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

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Patient Driven Payment Model (PDPM)

How did we land on PDPM

- The Contractors: Acumen
- RCS-1
- Tsunami of responses

Three Goals of Payment Reform

3

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

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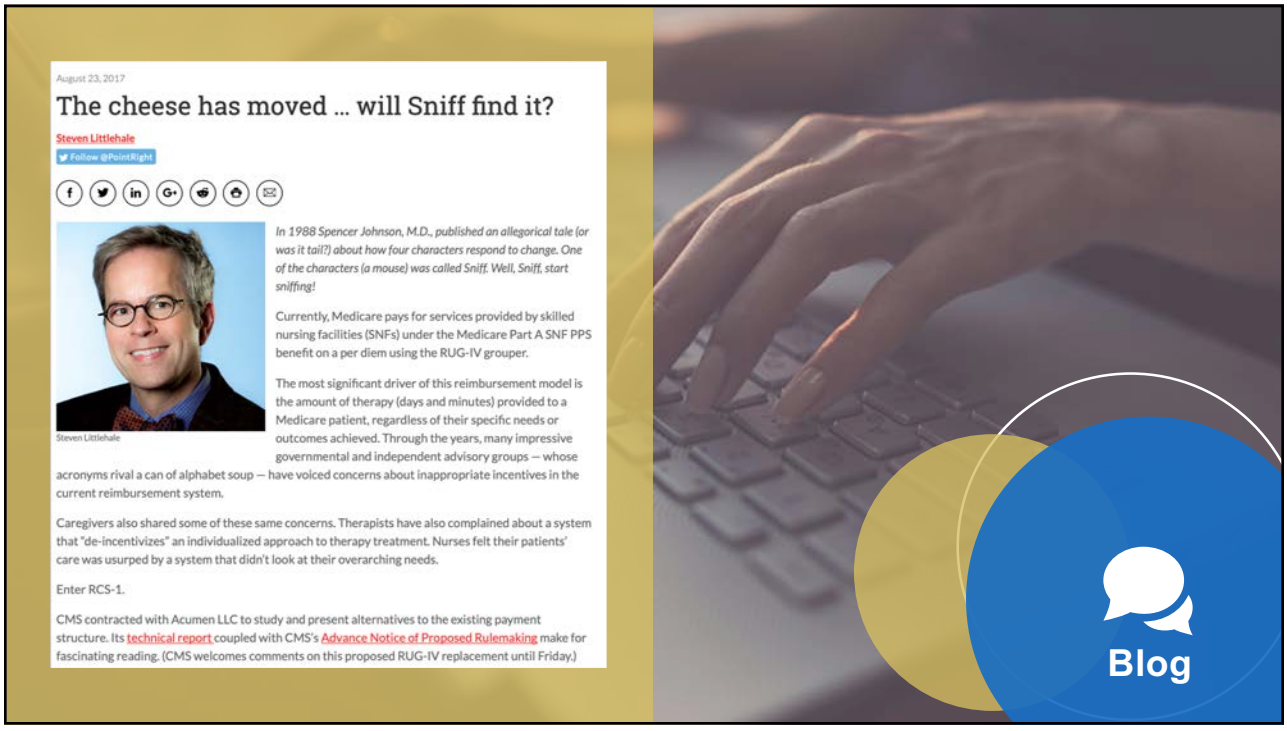


The Journey Continues

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

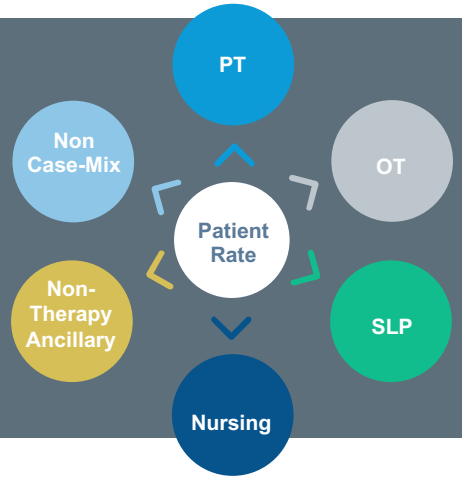
Implied that requirement to shift to a unified post-acute payment (U-PAC) slowing the rulemaking process

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



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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 +

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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"

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November 5, 2018

Cut into some apple pie instead of your MDS staffing budget

Steven Littlehale

Follow @PointRight

Steven Littlehale

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.

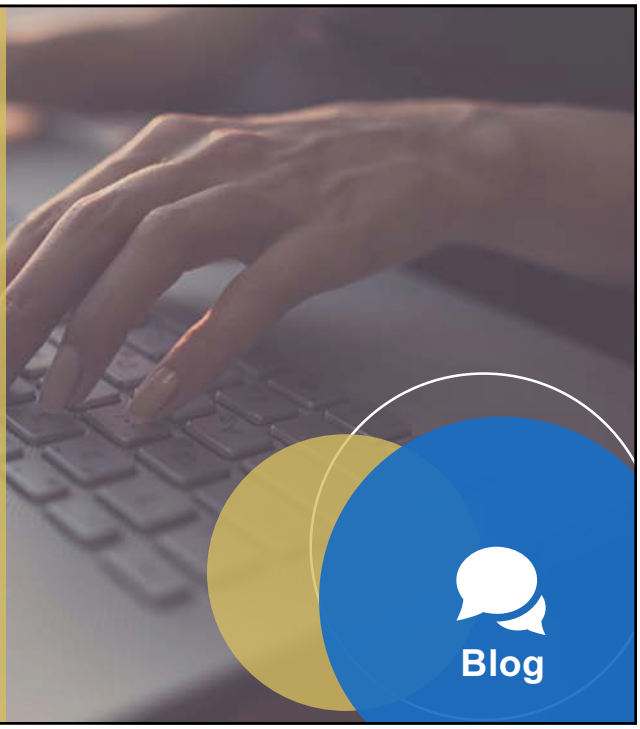
It was equal only to the saturation of "PDPM experts" who have seized upon this opportunity. The volume of misinformation is notable. Is this our own version of "fake" news?

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?); and
- *"I'm going to cut 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 analysis of the MDS volume issue, other than what was presented on page 287 of CMS'



How can you anticipate failure?

- PDPM = **"P**lease **D**on't **P**ester **M**e**"**
- Therapy relationships not reconsidered
- Over reliance of CMS PDPM conversion calculator
- Several vendors/accounting groups providing same
- Crunching MDS data to calculate PDPM

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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:

If no dx of Malnutrition: NTA drops to NE PDPM Payment:

If no cognitive impairment: SLP drops to SB PDPM Payment:

If no depression: Nursing drops to HBC1 PDPM payment:

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:

If no dx of Malnutrition: NTA drops to NE PDPM Payment:

If no cognitive impairment: SLP drops to SB PDPM Payment:

If no depression: Nursing drops to HBC1 PDPM payment:

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

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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

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Slippery Slopes: PDPM Financial Drivers

Slippery Slopes

Facility Rates

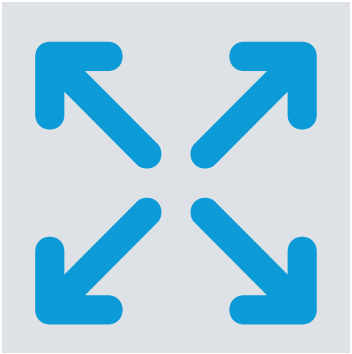
Depression 6%

Swallowing Disorders: 9.1%

Mechanically altered diet: 17.4%

Cognitive Impairment: 4%

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

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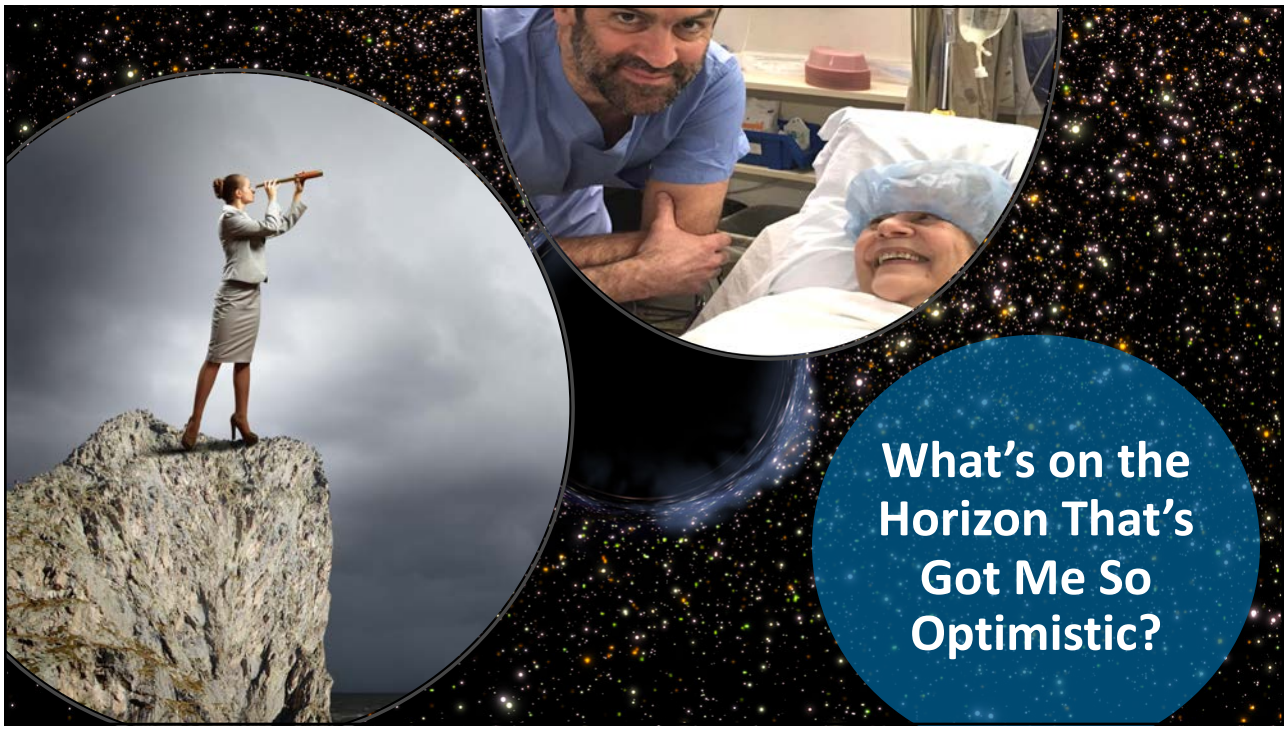

…and the Headlines Continue

McKnight's LONG-TERM CARE NEWS HOME NEWS COLUMNS RESOURCES REPORTS DIRECTORY MARKETPLACE EVENT

July 18, 2018

Congress investigating alleged poor care at VA nursing homes

Share this content:

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 start 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

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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

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The Center for Public Integrity
Winner of the 2014 Pulitzer Prize

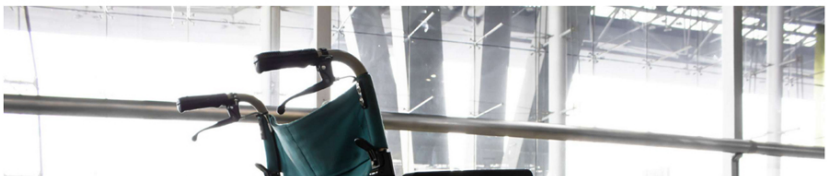
Politics National Security Business Environment Juvenile Justice Health

Health

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



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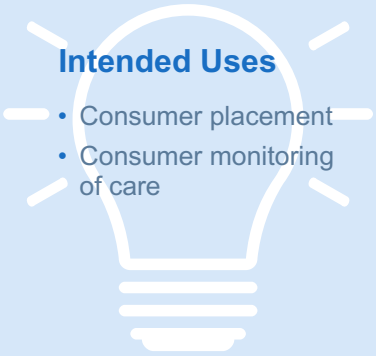
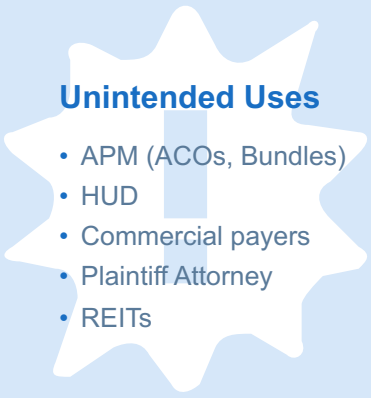
Five-Star Uses (and Abuses) are Far Ranging



Intended Uses

- Consumer placement
- Consumer monitoring of care



Unintended Uses

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

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

Requirement:	Waiver:
Qualifying inpatient hospital stay of 3 consecutive days (midnights) or more (plus additional criteria)	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

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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 July-18	Median Observed Rehospitalization Rate	Median Adjusted Rehospitalization Rate
5	14.1	15.0
4	16.2	16.4
3	17.3	16.9
2	17.8	17.5
1	19.5	18.3

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Five-Star Ratings & Rehospitalization Rates

Staffing Rating July-18	Median Observed Rehospitalization Rate	Median Adjusted Rehospitalization Rate
5	12.5	14.1
4	15.8	16.2
3	17.4	16.9
2	18.4	17.4
1	17.9	17.6

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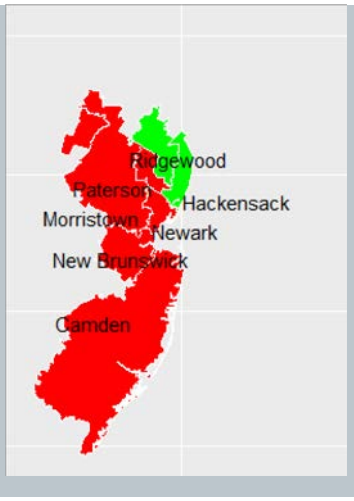
Overall Five-Star



Stars
5.00
4.75
4.50
4.25
4.00

HRR City	Median
Hackensack	5
Ridgewood	5
Camden	4
Morristown	4
New Brunswick	4
Newark	4
Paterson	4

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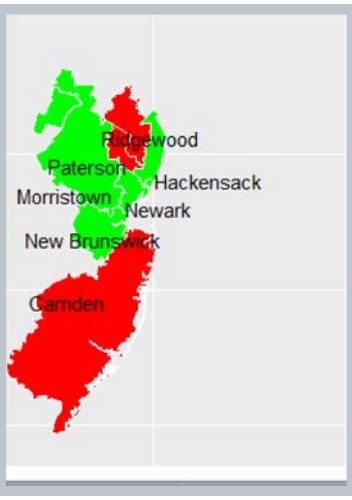
Staffing Overall



Stars
4.00
3.75
3.50
3.25
3.00

HRR City	Median
Hackensack	4
Morristown	4
New Brunswick	4
Newark	4
Camden	3
Paterson	3
Ridgewood	3

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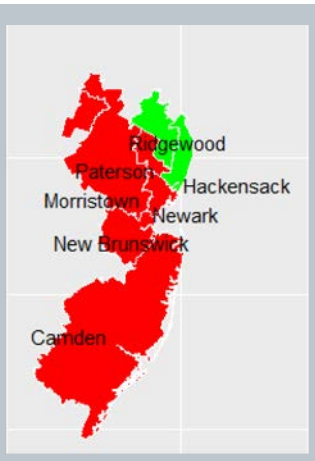
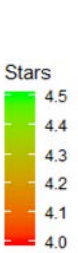
Staffing RN





HRR City	Median
Hackensack	4.5
Ridgewood	4.5
Camden	4.0
Morristown	4.0
New Brunswick	4.0
Newark	4.0
Paterson	4.0

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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

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CYCLE		Weighting: April 2019	Weighting: Current
1	Most recent standard survey + All complaint surveys in prior (1-12 months)	50%	60%
2	Prior standard survey + All complaint surveys in prior (13 - 24 months)	33.33%	40%
3	Prior to cycle 2 standard survey + All complaint surveys in prior (25 - 36 months)	16.66%	0%

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What's in the Freezer?

December 13, 2017

Five-Star is anything but frozen

Share this content:

Somewhere between basking in the joy of a meaningful Thanksgiving Day celebration and contemplating the merits of an elasticized waistband for the holidays, you read the Centers for Medicare & Medicaid Services memo (Ref: S&C 18-04-NH) regarding changes to the survey process, Nursing Home Compare and Five-Star.

Steven Littlehale

The day after Thanksgiving, CMS further defined its intensions 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 "frozen" and "held 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.

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

Blog

What's In the Freezer? More Survey Points

Region	States in Region	Health Inspection Score							
		Health Inspection Score - Scope & Severity							
		Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018
All		60	61	61	61	64	64	64	64
1	CT, MA, ME, NH, RI, VT	34	35	35	36	38	38	38	37
2	NJ, NY, PR, VI	39	37	35	34	32	32	32	32
3	DC, DE, MD, PA, VA, WV	60	62	62	63	67	67	67	67
4	AL, FL, GA, KY, MS, NC, SC, TN	43	44	45	44	46	46	46	46
5	IL, IN, MI, MN, OH, WI	53	54	55	56	59	59	59	59
6	AR, LA, NM, OK, TX	97	97	97	97	100	101	101	100
7	IA, KS, MO, NE	59	61	61	60	62	62	62	61
8	CO, MT, ND, SD, UT, WY	67	69	69	68	68	68	68	68
9	AZ, CA, GU, NV, HI	72	74	73	73	76	77	77	77
10	ID, OR, WA, AK	82	84	90	96	105	108	108	108

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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

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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

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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

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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

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Identifying EoL: MDS

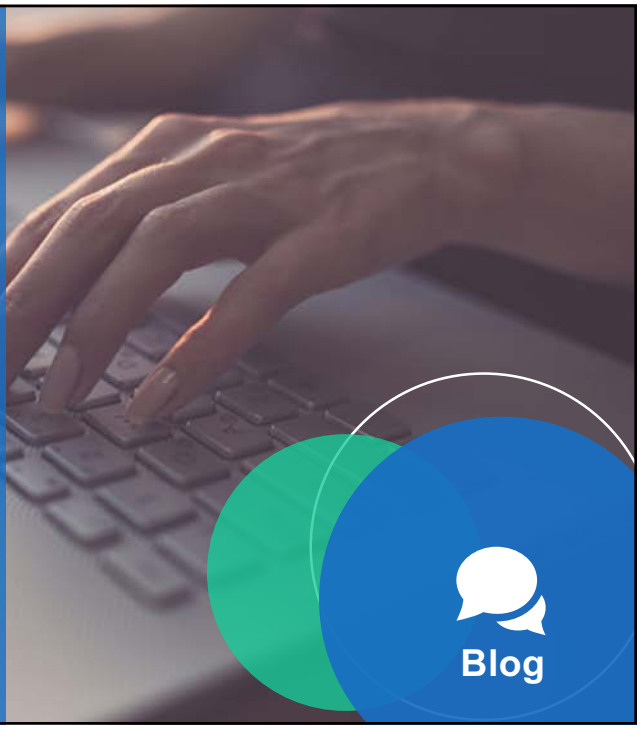
It's not morbid to talk about death ... a lot

Steven Littlehale

Follow @PointRight

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 devoted 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

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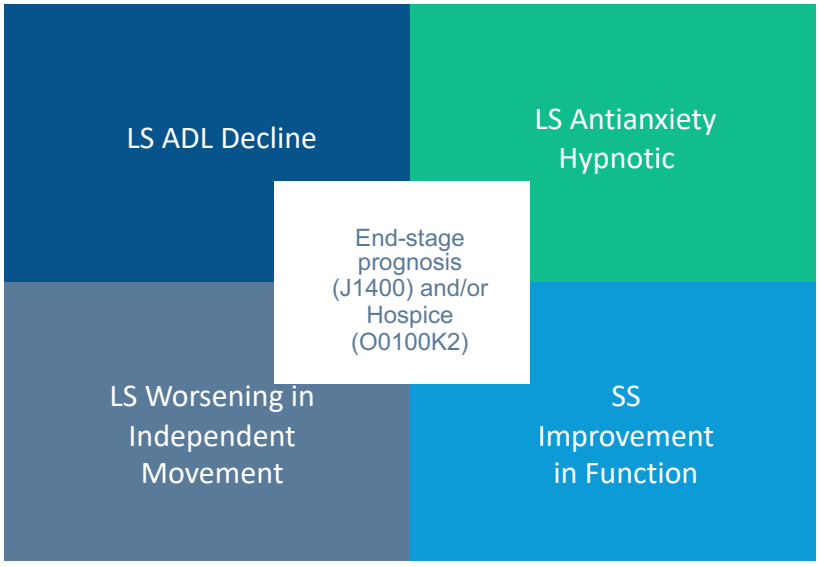

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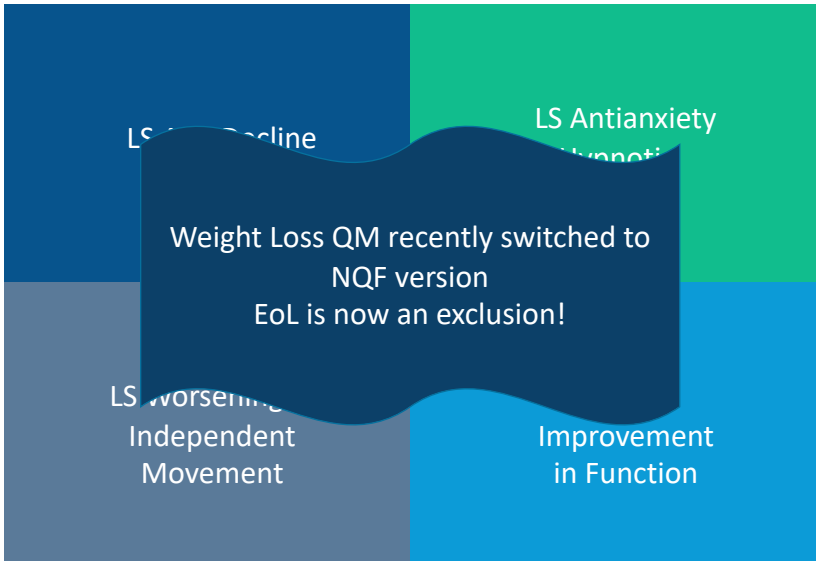

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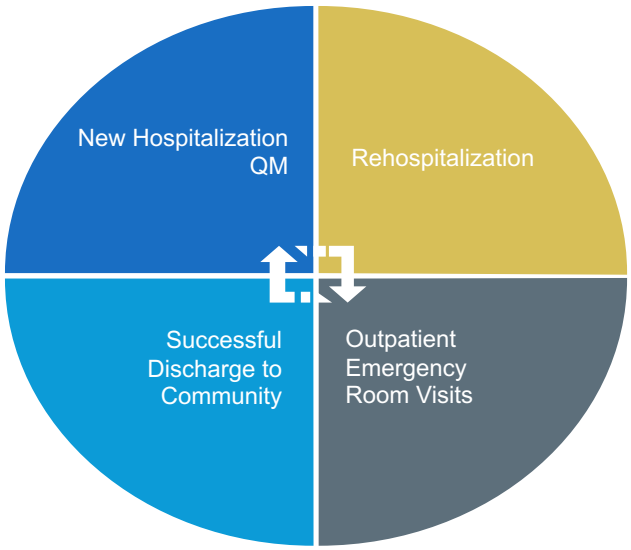
Hospice (00100K2) is an exclusion



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J1400: Prognosis

End Stage Prognosis (J1400)

J1400. Prognosis

Enter Code ☐ Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation)
0. No
1. Yes

Item Rationale

Health-related Quality of Life

- Residents with conditions or diseases that may result in a life expectancy of less than 6 months have special needs and may benefit from palliative or hospice services in the nursing home.

Planning for Care

- If life expectancy is less than 6 months, interdisciplinary team care planning should be based on the resident's preferences for goals and interventions of care whenever possible.

Steps for Assessment

1. Review the medical record for documentation by the physician that the resident's condition or chronic disease may result in a life expectancy of less than 6 months, or that they have a terminal illness.
2. If the physician states that the resident's life expectancy may be less than 6 months, request that he or she document this in the medical record. Do not code until there is documentation in the medical record.
3. Review the medical record to determine whether the resident is receiving hospice services.

DEFINITION

CONDITION OR CHRONIC DISEASE THAT MAY RESULT IN A LIFE EXPECTANCY OF LESS THAN 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.

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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.

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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.

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Definition: Hospice Services

Hospice (O0100K2)

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**

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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

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Applecore Acres: Overall Rating of 4 Stars

Applecore Acres

Overall 4

Quality Rating is also 4

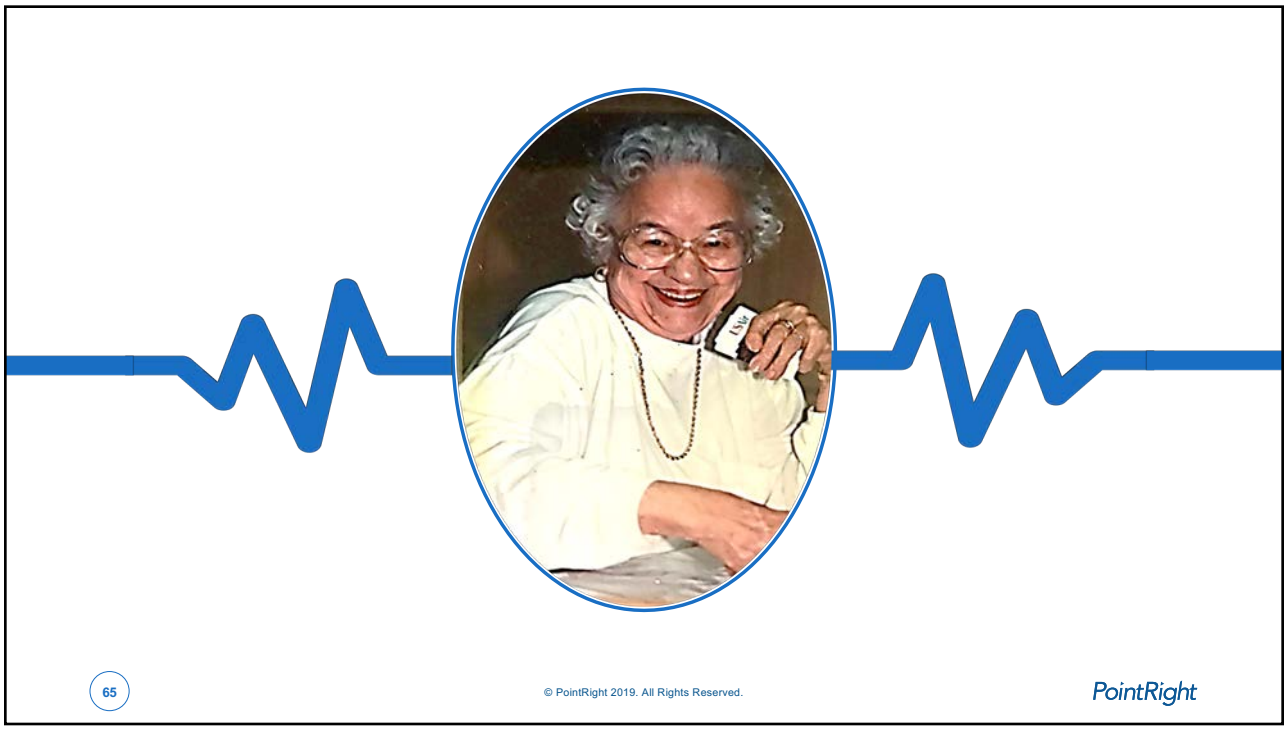
Improving the QM rating to 5 stars would add one point to the Overall rating

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



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Power of Prediction: Mortality

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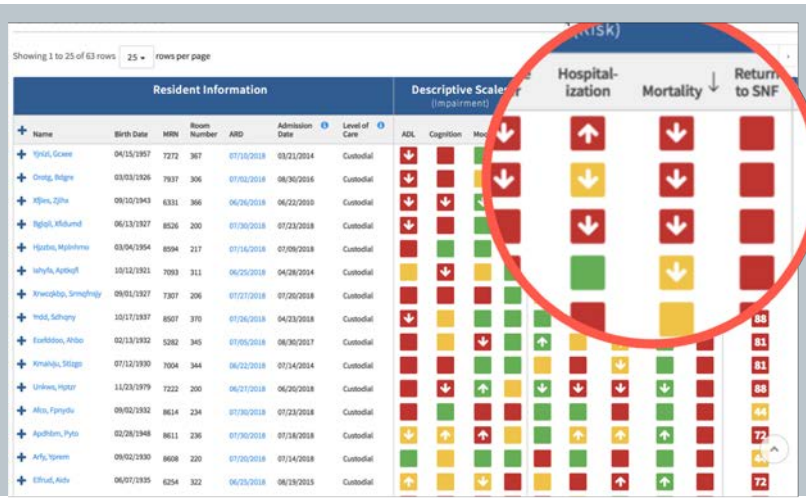

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Resident Information							Descriptive Scales (Impairment)				Predictive Scales (Risk)					Complexity
Name	Birth Date	MRN	Room Number	ARD	Admission Date	Level of Care	ADL	Cognition	Mood	Pain	Falls	Pressure Ulcer	Hospital-ization	Mortality	Return to SNF	Discharge Planning
Pkrwsa, Lpcqou Hospice	04/20/1946	-	1808-B	06/22/2018	02/13/2017	Custodial										96
Lxmvs, Bbxs	11/04/1959	-	-	07/24/2018	10/02/2013	Custodial										85
Dlexfvtk, Xkpv	10/16/1953	-	1809-B	07/21/2018	01/31/2005	Custodial										91
Nqjrfn, Zjrsh	11/12/1948	-	2817-A	07/17/2018	04/08/2010	Custodial										93
Avqvwo, Ccjcic	05/10/1946	-	1709-B	07/23/2018	01/25/2018	Custodial										88
Hzeqpdkyd, Wnmug	05/11/1963	-	2210-B	07/20/2018	07/13/2018	Custodial										98

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Power of Prediction: Mortality – the items

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Power of Prediction: Mortality – the items

Model score Rank	5- day Assessment		14 - day Assessment		30 - day Assessment		60 - day Assessment	
	Predicted Prob	Actual Rate	Predicted Prob	Actual Rate	Predicted Prob	Actual Rate	Predicted Prob	Actual Rate
10	68.71%	70.14%	62.58%	68.18%	58.07%	68.33%	69.54%	69.35%
9	51.71%	54.35%	49.79%	54.10%	48.86%	54.04%	50.00%	54.15%
8	42.29%	44.33%	40.97%	44.20%	39.35%	44.11%	40.18%	44.11%
7	33.80%	34.35%	33.66%	34.25%	30.76%	34.12%	31.36%	34.08%
6	27.91%	27.32%	27.82%	27.30%	26.47%	27.26%	25.02%	27.26%
5	23.18%	22.31%	23.54%	22.27%	22.30%	22.24%	20.42%	22.24%
4	17.95%	17.30%	18.76%	17.24%	16.95%	17.22%	16.13%	17.26%
3	12.43%	12.26%	12.97%	12.20%	12.09%	12.18%	10.70%	12.18%
2	6.72%	7.65%	7.06%	7.27%	6.61%	7.21%	6.01%	7.21%
1	3.82%	4.73%	3.31%	4.30%	3.02%	4.24%	3.12%	4.22%

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Thank you!

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