Value Based Care in LTC: The Quality Connection - Phase 2

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Objectives

• At the conclusion of this presentation, participants will be able to:
  – Outline and describe the recent changes in conditions of participation for skilled nursing facilities with a focus on phase 2 (2017) implementation
  – Describe the quality component to value based care and how these changes support this component
  – Explain the components of the Facility Assessment and how it can be used to strategically improve the planning for services
  – Outline the elements of the staffing component of the facility assessment
  – Discuss the elements of staff competency and how to link to the facility assessment
  – Explain the steps to implement an effective QAPI program
Progression to Value Based Payment

- Fee for Service (FFS)
- FFS with incentives or penalties
- Managed Care (No risk)
- Managed Care and Bundled Payment (Partial risk)
- ACO / DSRIP PPS (Full Risk)
SNF VBP Program

- SNF VBP aligns HHS and CMS efforts to improve coordination of care
  - Better Care: patient centered, reliable, accessible, safe
  - Healthy People and Communities: support proven interventions and provide higher quality care
  - Affordable Care: Reduce cost for patients and payers
- Patient Protection and Affordable Care Act of 2010 requires the Secretary of HHS to develop a value based payment program for Medicare
Where we are going...

As is
• Silo care delivery model
• Component based reimbursement
• Success for provider is based on maximizing utilization and reimbursement as much as possible

To be
• Integrated care delivery model
• Shared savings and risk
• Success for provider is based on achieving quality outcome with least reasonable resource utilization
Quality of Care

• CMS finds that there is extreme variability and lack of consistency of quality in SNFs across the country

• Facilities cycle in and out of compliance and do not maintain their standards of care consistently
Roadmap to Implementation

• **Continuous Quality Improvement Framework** to coordinate with other Medicare programs to improve quality of care
  – Expand quality measures
  – Structural measures for use of electronic health records
• **Defining the Focus Population** – most SNF residents are not in Medicare stays
• **Enhance Data Infrastructure and Validation**– validate quality care instead of rewarding those who report data well
• **Performance Scoring and Evaluation** based on goal attainment
Roadmap to Implementation

• **Funding Source/Performance Incentive Funds** linking payment to performance

• **Transparency and Public Reporting** by posting data on Nursing Home Compare

• **Coordination across Medicare Payment System** so that program coordinates and aligns with existing VBP, pay-for-reporting, and quality monitoring systems
# CMS Quality Initiatives

<table>
<thead>
<tr>
<th>Why?</th>
<th>CMS Five Star Ratings</th>
<th>Value Based Purchasing Program</th>
<th>Impact Act of 2014</th>
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<tr>
<td>Developed to help consumers select nursing homes based on performance</td>
<td>Protecting Access to Medicare Act of 2014 (PAMA) added sections to Social Security Act to begin SNF VBP in FY 2019</td>
<td>Creates standardized, interoperable patient assessment data across PAC settings and establishes SNF Quality Reporting Program (SNF QRP)</td>
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<td>When?</td>
<td>Implemented 2008 and modified each year for additional measures and revisions to existing ones</td>
<td>Facilities will receive confidential quality feedback reports on measure performance beginning in FY 2019</td>
<td>FY 2018 is affected with initial measurement period 10/1/2016 through 12/31/2016</td>
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<td>Data?</td>
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# Quality Payment Initiatives

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| **Federal** | Five Star Quality Rating System  
• Nursing Home Compare  
  • Five new measures July 2016  
• Staffing Data Submission (PBJ)  
  • Electronic file submissions Effective 7/1/2016  
• SNF Quality Reporting Program (SNF QRP)  
  • Effective 10/1/2016 through 12/31/2016 for Fiscal Year 2018 |
| Medicare Advantage Bundled Payment  
• Bundled Payments for Care Improvement (BCPI)  
• Comprehensive Care for Joint Replacement (CJR)  
• CHF and MI Proposed Bundles (2018)  
SNF Value Based Purchasing  
• 30 day all cause readmission measure (SNFRM) (data collection 10/1/16 for FY 2018) | |
| **State** | Nursing Home Quality Incentive (NHQI)  
• Effective 2013 with ongoing methodology changes |
| Mandatory Medicaid Managed Care for new LTC patients (since 2015)  
Delivery System Reform Incentive Payment (DSRIP)  
• Roadmap to VBP for subpopulations of LTC patients | |
2016 New Quality Measures

- Percentage of short stay (less than 100 days) residents with ER visit (Medicare claims based)
- Percentage of short stay residents who were successfully discharged to the community and did not die or readmitted to hospital or SNF within 30 days (Medicare claims based)
- Percentage of short stay residents who were re-hospitalized after SNF admission including observation stays (Medicare claims based)
- Percentage of short stay residents who made improvements in physical function and locomotion (MDS data based)
2016 New Quality Measures

• Percentage of Long Stay residents (greater than 100 days) whose ability to move independently worsened (MDS based)
• Percentage of Long Stay residents who received an anti-anxiety or hypnotic medication (MDS based)
Impact Act

• IMPACT: Improving Medicare Post Acute Transformation Act of 2014
• Purpose is to compare outcomes across PAC settings: SNF, HHA, Inpatient Rehab, Long Term Care Hospitals
• Standardizes data collection that currently differs by type of provider (e.g. MDS, OASIS, etc.)
• Will result in cross-setting standardized quality measures
• Data being collected NOW will impact FY 2018 rates, which will vary by facility based on performance!!!
Impact Act Quality Measures

• Minimum Data Set (MDS) Based Measures
  – Percent of residents with pressure ulcers that are new or worsened (short stay) – no change to MDS
  – Percent of residents experiencing one or more falls with a major injury (long stay) – no change to MDS
  – Percent of residents with an admission or discharge functional assessment and a care plan that addresses function
    • New section GG of MDS
    • Additional MDS submission: SNF Part A PPS Discharge Assessment
    • These are only for traditional Medicare fee-for-service – not for Medicare Advantage
Impact Act Quality Measures

• Claims Based Measures (Resource Use and Other Measures)
  – Total estimated Medicare spending per beneficiary (MSPB)
  – Discharge to the Community
  – Potentially preventable 30-day post-discharge readmission measure for SNF Quality Reporting Program
    • All cause, all condition
    • Risk adjusted
• Section GG: observing usual performance for three days
  – Establishes admission performance, discharge goal and discharge performance
  – Completed on admission and for planned discharges only (includes end of PPS stay due to benefit exhaustion or end of skilled need)
  – Coding is different than ADL language
    • GG—higher score represents more independence; opposite of Sect. G
  – Sixteen new items with focus on late loss ADLs
  – 2% payment penalty if 20% or more of MDSs missing required data
  – Which MDS counts in SNF QRP?
    • Depends on measure and risk adjustment
Use of Sect. GG Data

• CMS is researching future payment methods based on resident characteristics, such as payment for episodes of care similar to DRGs or HHRGs, or for care bundles
• We won’t know yet what our report card will look like for data we are sending now
Impact Act

• Medicare costs need to be controlled
• CMS wants value for dollars spent and consumer groups to be satisfied = QUALITY
• Your SNF QRP data will position your facility either favorably or unfavorably
• Providers will be chosen for partnering who have best quality and value
New 2017 Changes

• New F-tags, interpretive guidance, and survey changes (Phase 2)
  – Facility Assessment
  – Competencies
  – QAPI
  – Infection Control
  – New Survey Process
Facility Assessment

• Effective November 28, 2017
• Requires a well researched and documented initial assessment and annual update
  – Description of patient population
  – Facility capacity and services
  – Care required by population and acuity
Facility Assessment

• Review of Potential Capacity Options
  – Access referral source needs
  – Admission criteria
  – Skill level gap analysis for admission needs
  – Development of enhanced service offerings based on the above analysis
Facility Assessment

- Components of the Assessment
  - Staff competencies
  - Environment of care (facilities, equipment, services)
  - Analysis of ethnic, cultural, or religious make up of population
Facility Assessment

• Components of the Assessment
  – Facility resources
  – Provided services
  – Personnel
  – Contracts and MOUs
  – Health IT resources
Staff Competencies

• Physical and cognitive systems assessments
• Evidence based technical procedures
• Use of medical equipment/supplies for treatments
Staff Capacity

• Capacity of the organization to ensure sufficient staff and appropriate levels to carry out its processes and deliver health care services to patients
  – Include capacity to meet seasonal demands
  – Include capacity to deal with varying needs
Sufficient Staffing

- Based on Five-Star Staffing Calculation
  - Actual hours per patient day
  - Expected staffing hours
  - Adjusted staffing hours
Quality Assurance and Performance Improvement

• Quality Assurance
  – Establish standards of care
  – Measure and monitor meeting standards

• Performance Improvement
  – Continuous review of processes
Quality Assurance and Performance Improvement

• Performance Improvement Projects
For More Information

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