2019 SNF PPS Final Rule – "Ready or Not"

Arnett Carbis Toothman LLP

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OBJECTIVES:

- *Provide an overview of individual components contained within the final rule.*
- *Provide examples of how this rule may impact an organization financially.*
- *Provide recommendations and solutions on how an organization can prepare to achieve optimal reimbursement under the new methodology.*

COMPONENTS:

- *Industry Updates*
- *Patient-Driven Payment Model (PDPM)*
- *Quality Reporting Program (QRP)*
- *Value-Based Payment (VBP) Program*

Current Post Acute Trends

- Post-Acute Care (PAC) Environment
  - Reimbursement System Changes
  - Value-Based Purchasing
  - Subjective Quality Measures (QMs)
  - Increasing Compliance
  - Pressures on Census
  - Staffing Shortages
  - Decreasing Margins
  - Litigious Environment
  - Challenging Self-Pay Collections
  - Mergers, Acquisitions, Joint Ventures

Current Post Acute Trends

- Challenges Driving the Evolution of the Industry
  - Aging population requiring increasing care
    - Baby boomers and increasing life expectancy
  - Society's ability to pay for that care
    - Will there be additional funding for home and community based services?
- Efforts to Address these Challenges
  - Long-Term Changes to Delivery Model
    - Focus on broad picture of overall population health
      - Integrated system…not fragmented
      - Payment based on quality not quantity
      - Better outcomes at a lower cost
    - Accountable Care Organizations (ACOs)
      - There are some ACOs incorporating post-acute care providers
      - What measures will they be looking for in a provider:
        - Length of stay variance
        - Overall star ratings
        - Quality ratings
        - Readmission rates

Current Post Acute Trends

- Efforts to Address these Challenges
  - Long-Term Changes to Delivery Model
    - Managed Care Organizations (MCOs)
      - Focus on Integration of Services
      - Intense Case Management
      - Negotiate Contracts with MCOs
    - Third-Party Payors Focus on Case Management
      - Dashboards and Scorecards
      - Decrease Volumes
    - Narrow Networks
      - Insurers/Hospitals selecting Post-Acute Care Providers
    - Increased Relationships Among Providers
      - Hospitals/SNFs/HHAs, etc.

Current Post Acute Trends

- Efforts to Address these Challenges
  - Long-Term Changes to Delivery Model
    - Continued Push Toward Home and Community Based Services
    - Patient-Driven Payment Model
      - Based on Nursing…Not Therapy
    - Valued-Based Purchasing
      - Based on Value…Not Volume
    - Quality Reporting Program
      - Based on Quality…Not Quantity

Current Post Acute Trends

- Industry Trends and Challenges
  - Compliance Trends in Nursing Facilities
    - Recovery Audit Contractors (RACs)
    - Program for Evaluating Payment Patterns Electronic Report (PEPPER)
      - Report Released Annually in April
      - Provides a 3 Year History
      - Target Areas
        - Therapy Resource Utilization Groups (RUGs) with High ADL
        - Non-therapy RUGs with High ADL
        - Change of Therapy Assessment
        - Ultra high Therapy RUGs
        - 20-day Episodes of Care
        - 90+ Day Episodes of Care

Current Post Acute Trends

- Industry Trends and Challenges
  - Compliance Trends in Nursing Facilities
    - PEPPER report compares statistics with:
      - National Percentile
      - Jurisdiction Percentile
      - State Percentile
    - Percentiles at or above the 80th percentile for any target areas are at risk for overcoding, or at or below the 20th percentile for areas at risk for undercoding, indicate that the SNF may be at a higher risk for improper Medicare payment
    - Greater than 80th percentile will be "RED"
    - Less than 20th percentile will be "GREEN"

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Current Post Acute Trends

- Industry Trends and Challenges
  - Compliance Trends in Nursing Facilities
    - PEPPER report provides:
      - Suggested interventions for high outliers
      - Suggested interventions for low outliers
    - If you have an Outlier:
      - Understand and Analyze
    - PEPPER report should be utilized as a compliance tool for an organization
    - Continuous monitoring of compliance is key
      - Coding reviews
      - Utilization reviews
      - Billing reviews

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Current Post Acute Trends

- Industry Trends and Challenges
  - Compliance Trends in Nursing Facilities
    - Targeted Probe and Educate (TPE) Program
      - Designed to help providers and suppliers reduce claim denials and appeals
      - Intended to increase accuracy in very specific areas
      - Medicare Administrative Contractors (MACs) use data analysis to identify:
        - Providers and suppliers who have high claim errors or unusual billing practices
        - Items and services that have high national error rates and are a financial risk to Medicare
      - Providers whose claims are compliant with Medicare policy will not be chosen for a TPE

Current Post Acute Trends

- Industry Trends and Challenges
  - Compliance Trends in Nursing Facilities
    - Targeted Probe and Educate (TPE) Program
      - How does it work?
        - If chosen for the program, you will receive a letter from your MAC
        - The MAC will review 20-40 of your claims and supporting medical records
        - If compliant, you will not be reviewed again for at least one year on the selected topic
        - If some claims are denied, you will be invited to one-on-one education session
        - You will be given at least a 45-day period to make changes and improve

Current Post Acute Trends

- Industry Trends and Challenges
  - Compliance Trends in Nursing Facilities
    - Targeted Probe and Educate (TPE) Program
      - What are some common claim errors?
        - The signature of the certifying physician was not included
        - Encounter notes did not support all elements of eligibility
        - Documentation does not meet medical necessity
        - Missing or incomplete initial certifications or recertification

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Current Post Acute Trends

- Industry Trends and Challenges
  - Compliance Trends in Nursing Facilities
    - Targeted Probe and Educate (TPE) Program
      - What if my accuracy still does not improve?
        - This should not be a concern for most providers and suppliers
        - The majority of those that have participated in the TPE process increased the accuracy of their claims
        - However, any who fail to improve after three rounds of TPE will be referred to the Centers for Medicare and Medicaid Services (CMS) for next steps

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Current Post Acute Trends

- Industry Trends and Challenges
  - Census Trends in Nursing Facilities
    - Declining Volumes
    - Higher Acuity Residents
    - Lower Average Length of Stay
    - Reimbursement Impact

Current Post Acute Trends

- Industry Trends and Challenges
  - Staffing Trends in Nursing Facilities
    - Items for consideration
      - Total Nursing Cost Per Day
      - Hands on Nursing
      - Ratio of Registered Nurses to Licensed Practical Nurses to Certified Nursing Assistants
      - Optimal Staffing Level
      - Payroll Based Journal (PBJ) Submission Coding Accuracy
        - Started requests for audits
      - CMS Five Star Rating Staffing Component
        - Impact on Overall Five Star Rating

Current Post Acute Trends

- Industry Trends and Challenges
  - Staffing Trends in Nursing Facilities
    - Challenges to consider
      - Labor Cost and Potential Future Shortage of Staff
      - Competition in Market
      - Wage Alignment within Market
      - Access to Nurse Agency
      - Scheduling and Overtime
      - Training Programs and Retention

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Patient-Driven Payment Model (PDPM)

- History of Resource Utilization Groups (RUGs)
- Reasons behind changing payment system
- Payment components
- Changes to methodology
- Preparation strategies
- Rollout readiness

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Patient-Driven Payment Model (PDPM)

- History of RUGs
  - Established by the Balanced Budget Act of 1997
  - Effective July 1, 1998
  - Eliminated SNF cost-based reimbursement
  - Number of RUG categories have grown to 66 currently
  - Based on Minimum Data Set (MDS)
  - Four categories of the rate: Therapy Case Mix, Therapy Non-Case Mix, Nursing, and Non-Case Mix
  - Several assessments required (and optional) throughout a Part A stay
  - Multiple assessments result in multiple rate changes

Patient-Driven Payment Model (PDPM)

- CMS reasons for new payment system
  - "From 2006 to 2008, SNFs increasingly billed for higher paying RUGs, even though beneficiary characteristics remained largely unchanged." – OIG
  - "The Congress should . . . direct the Secretary to revise the Prospective Payment System (PPS) for skilled nursing facilities" and ". . . make any additional adjustments to payments needed to more closely align payment with costs." – MEDPAC
  - "The two most notable trends discussed in that memo were that the percentage of residents classifying into the Ultra-High therapy category has increased steadily and, of greater concern, that the percentage of residents receiving just enough therapy to surpass the Ultra-High and Very-High therapy thresholds has also increased." – CMS
  - "…is a strong indication of service provision predicated on financial considerations rather than resident need." – CMS
  - "To better ensure that resident care decisions appropriately reflect each resident's actual care needs, we believe it is important to remove, to the extent possible, service-based metrics from the SNF PPS and derive payment from verifiable resident characteristics." – CMS

Above are excerpts from the FYE 2019 SNF Proposed Rule.

Patient-Driven Payment Model (PDPM)

- Payment Components
  - Physical Therapy
  - Occupational Therapy
  - Speech Language Pathology (SLP) (Speech Therapy)
  - Nursing
  - Non-Therapy Ancillary (NTA) services (comorbidities and resources)

Patient-Driven Payment Model (PDPM)

- Changes to Methodology
  - New level of care presumption for skilled services
  - Admission 5-day and Discharge PPS required
  - Interim Payment Assessment (IPA) optional
  - Focus on functional abilities and goals (Section GG)
  - Reverse methodology in scoring Activities of Daily Living (ADL)
  - Heightened focus on diagnosis codes

Patient-Driven Payment Model (PDPM)

- Presumption of Skilled Services
  - Extensive Services, Special Care High, Special Care Low, Clinically Complex (No Change)
  - PT/OT = TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, TO
  - SLP = SC, SE, SF, SH, SI, SJ, SK, SL
  - NTA = upper 12 components

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Patient-Driven Payment Model (PDPM)

TABLE 32: Current PPS Assessment Schedule

Scheduled PPS assessments			
Medicare MDS assessment schedule type	**Assessment reference date**	**Assessment reference date grace days**	**Applicable standard Medicare payment days**
5-day	Days 1-5	6-8	1 through 14
14-day	Days 13-14	15-18	15 through 30
30-day	Days 27-29	30-33	31 through 60
60-day	Days 57-59	60-63	61 through 90
90-day	Days 87-89	90-93	91 through 100
Unscheduled PPS assessments			
Start of Therapy OMRA	5-7 days after the start of therapy		Date of the first day of therapy through the end of the standard payment period.
End of Therapy OMRA	1-3 days after all therapy has ended		First non-therapy day through the end of the standard payment period.
Change of Therapy OMRA	Day 7 (last day) of the COT observation period		The first day of the COT observation period until end of standard payment period, or until interrupted by the next COT-OMRA assessment or scheduled or unscheduled PPS Assessment.
Significant Change in Status Assessment	No later than 14 days after significant change identified		ARD of Assessment through the end of the standard payment period.

TABLE 33: PPS Assessment Schedule under PDPM

Medicare MDS assessment schedule type	Assessment reference date	Applicable standard Medicare payment days
5-day Scheduled PPS Assessment	Days 1-8	All covered Part A days until Part A discharge (unless an IPA is completed).
Interim Payment Assessment (IPA)	No later than 14 days after change in resident's first tier classification criteria is identified	ARD of the assessment through Part A discharge (unless another IPA assessment is completed).
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date	N/A.

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Patient-Driven Payment Model (PDPM)

- Section G = increasing score means increasing dependence
- Section GG = increasing score means increasing independence
- RUG-IV = increasing dependence = higher payment
- PDPM = no direct relationship between increasing dependence and higher payment

Patient-Driven Payment Model (PDPM)

SNF PDPM Technical Report:

https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/SNFPPS/therapyresearch.html

Patient-Driven Payment Model (PDPM)

- Capturing Comorbidities & Diagnosis Coding:
  - Comorbidity Mapping Tool
  - Primary Diagnosis Clinical Category
  - International Statistical Classification of Diseases (ICD)-10 Clinical Category Crosswalk
  - "High Impact" MDS Item Fields

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html#resources

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Patient-Driven Payment Model (PDPM)

- Preparation Strategies
  - Develop and monitor an implementation plan
  - Educate staff
  - Communicate with referral sources about documentation and record access needs
  - Review MDS roles and duties
  - Review nursing care and documentation systems
  - Develop coding expertise (ICD-10-CM)
  - Update therapy contracts
  - Monitor and understand software updates

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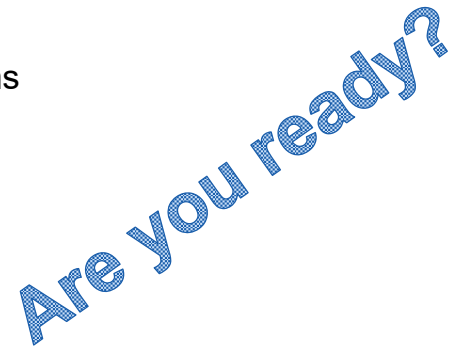
Patient-Driven Payment Model (PDPM)

- Rollout Readiness
  - Knowledge
  - Communication systems
  - Tools
  - Resources



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SNF Value-Based Purchasing (VBP)

- VBP focuses on better outcomes and rewards skilled nursing facilities (SNF) with incentive payments for the quality of care they give to Medicare residents.
- Financial Impact Started October 1, 2018
  - First “Incentive” Payment was on October 1, 2018
- Lose 2% Then Opportunity to Earn it Back Plus Incentive
  - 60% Will Be Paid Back in Incentive Payment
  - Performance score is placed in the logistic exchange function to determine the corresponding incentive multiplier

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SNF Value-Based Purchasing (VBP)

- Currently Based on Hospital Readmission
  - Discharged from SNF and has a Hospital Admission within 30 days – 30 Day Readmission Measure
- Measured Based on Performance Periods and Baseline Periods
- For October 1, 2018
  - Performance Period is 1/1/17 – 12/31/17
  - Baseline Period is 1/1/15 – 12/31/15

SNF Value-Based Purchasing (VBP)

- SNFs will be evaluated on a hospital readmission measure after a patient is discharged and has a hospital readmission within 30 days
- SNFs will receive a performance score based on their individual performance and a performance score based on their comparison to other SNFs in the country
- SNFs will receive confidential quarterly and annual reports about their performance on the program's measure
- SNFs will receive payment incentives based on their performance

SNF Value-Based Purchasing (VBP)

- SNFs will earn a Performance Score (0 to 100)
- Based on the Higher of:
  - Achievement Score
    - How a SNF Compares to National Benchmarks
    - 0 – 100 point scale
  - Improvement Score
    - How a SNF has Shown Improvement
    - 0 – 90 point scale

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SNF Value-Based Purchasing (VBP)

- Fiscal Year (FY) 2019 will be the performance period for the FY 2021 SNF VBP program year. In an effort to link performance as closely to the program year as possible, beginning with the FY 2022 program year, the performance period will be the one-year period following the performance period for the previous program year, and the baseline period will be one-year period following the baseline period for the previous year.
  - Performance period for FY 2022 program year will be FY 2020

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SNF Value-Based Purchasing (VBP)

- SNFs Have Received Quarterly Confidential Feedback Reports Since October 2016
  - Quarterly supplemental workbooks containing patient-level data are provided for quality improvement purposes
- Extraordinary Circumstances Exceptions (ECE) Policy
  - Provide relief to SNFs affected by natural disasters or other circumstances beyond the facility's control that affect the care provided to the facility's residents
  - If the SNF can demonstrate that an extraordinary circumstance affected the care that it provided and its measure performance, CMS will exclude from the calculation of the measure rate for the applicable baseline and performance periods the calendar months during which the SNF was affected by the extraordinary circumstance

SNF Value-Based Purchasing (VBP)

- SNFs have until March 31 following delivery of the confidential report containing facility-level information to submit a Phase One Review and Corrections request to SNFVBPinquiries@cms.hhs.gov
  - Do not send protected health information (PHI) in the email as it is not secured to receive this information
- SNFs can submit correction requests to their performance scores and ranks only found on the annual performance score report through Phase Two of the Review and Correction Process
  - Must submit within 30 calendar days following the annual performance score reports being made available
  - Submit request to SNFVBPinquiries@cms.hhs.gov

SNF Value-Based Purchasing (VBP)

- SNFs will receive two annual reports
  - One report contains a full performance period and their measure score
  - One report contains the SNF performance score, rank, and payment incentive to be applied to Medicare claims in the upcoming fiscal year
  - Reports can be accessed through Quality Improvement Evaluation System (QIES) Certification And Survey Provider Enhanced Reporting (CASPER) system
- Measures for SNF VBP are not the same measures used for SNF Quality Reporting Program (QRP)
- Important that SNFs Understand the Measure and Adopt Strategies to Make Sure They Are Maximizing Reimbursement
  - SNFs Need to Have a Process in Place to Track Performance

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SNF Value-Based Purchasing (VBP)

Your SNF's FY 2019 SNF VBP Program Performance

Annual Performance Score Report

Performance Information	
Baseline Period (CY 2015) RSRR	0.18824
Improvement Threshold (Baseline Period Inverted RSRR)	0.81176
Performance Period (CY 2017) RSRR	0.18455
Performance Period Inverted RSRR	0.81545
FY 2019 Achievement Threshold	0.79590
FY 2019 Benchmark	0.83601
SNF VBP Achievement Score	48.86687
SNF VBP Improvement Score	10.21649
SNF VBP Performance Score	48.86687
SNF VBP Program Rank	4,855
Incentive Payment Multiplier	0.9973178073

Note: There were 5,249 unique (non-tied) performance scores in the FY 2019 SNF VBP Program and 15,421 SNFs eligible for the Program nationally. RSRR = Risk-Standardized Readmission Rate; CY = Calendar Year; FY = Fiscal Year; N/A = Not Applicable

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SNF Value-Based Purchasing (VBP)

- Who pulls the VBP report?
- Who reviews the VBP report?
- How and to whom are the results communicated?

COMMUNICATION IS KEY

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SNF Value-Based Purchasing (VBP)

- Authorized by Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT)
- The Act requires CMS to develop and implement quality measures from five quality measure domains using standardized assessment data.
- The reporting measures pertain to resource use, hospitalization, and discharge to the community.
- The intent of the Act is to enable providers to facilitate coordinated care, improved outcomes, and overall quality comparisons.

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SNF Value-Based Purchasing (VBP)

- Beginning in FY 2019 (FYE 9/30/19) Payment Decreased by 2 Percentage Points for any SNF that does not comply with the Data Submission Requirements
  - Must Achieve 80% Compliance
- Data Submitted through MDS 3.0 through the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing System (ASAP)
  - Starting in March 2019, the QIES, Certification And Survey Provider Enhanced Reports (CASPER) and Automated Survey Processing Environment (ASPEN) will undergo enhancements. The new system will be called the Internet Quality Improvement and Evaluation System (iQIES). The new system will not change how providers currently submit data to CMS.

SNF Value-Based Purchasing (VBP)

- Measures – MDS and Medicare Fee-for-Service (FFS) Claims
  - Percent of Residents Experiencing One or More Falls with Major Injury
  - Functional Assessment
  - Discharge to Community
  - Potentially Preventable 30 Days Post Discharge Readmission
  - Medicare Spending Per Beneficiary (MSPB)
  - Drug Regimen Review Conducted with Follow-Up for Identified Issues
  - Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
    - Replaced Percent of Residents with Pressure Ulcers that are New or Worsened

SNF Value-Based Purchasing (VBP)

- CMS provided notifications only to facilities that were determined to be out of compliance with SNF QRP requirements for Calendar Year (CY) 2017, which effected their FY 2019 Annual Payment Update.
  - Non-compliance letters were mailed and also placed in CASPER on July 9, 2018
- SNFs have the opportunity to review their quality measure results during a 30-day preview period which is released quarterly by CMS before it is available for public display on Nursing Home Compare.
  - Reports are available on CASPER

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SNF Value-Based Purchasing (VBP)

- SNFs cannot correct the date; however they are allowed to request CMS to review the data if they believe it is inaccurate as long as they request the review during the 30-day preview period.
  - Must submit request to CMS via email with the subject line: "[Provider Name] SNF Public Reporting Request for Review of Data" and include their CMS Certification Number (CCN).

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SNF Value-Based Purchasing (VBP)

- Nursing Home Compare was updated in April 2019.
  - Data was based on quality data submitted by SNFs during:
    - Quarter 3 – 2017 to Quarter 2 – 2018 data for:
      - Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)
      - Percent of Residents with Pressure Ulcers that are New or Worsened (Short-Stay)
      - Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function
    - Quarter 4 – 2016 to Quarter 3 – 2017 data for:
      - Medicare Spending Per Beneficiary
      - Discharge to Community
- As VBP, Need to Have a Process in Place to Track Performance

SNF Value-Based Purchasing (VBP)

- Who pulls the VBP report?
- Who reviews the VBP report?
- How and to whom are the results communicated?

COMMUNICATION IS KEY

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QUESTIONS?

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