

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

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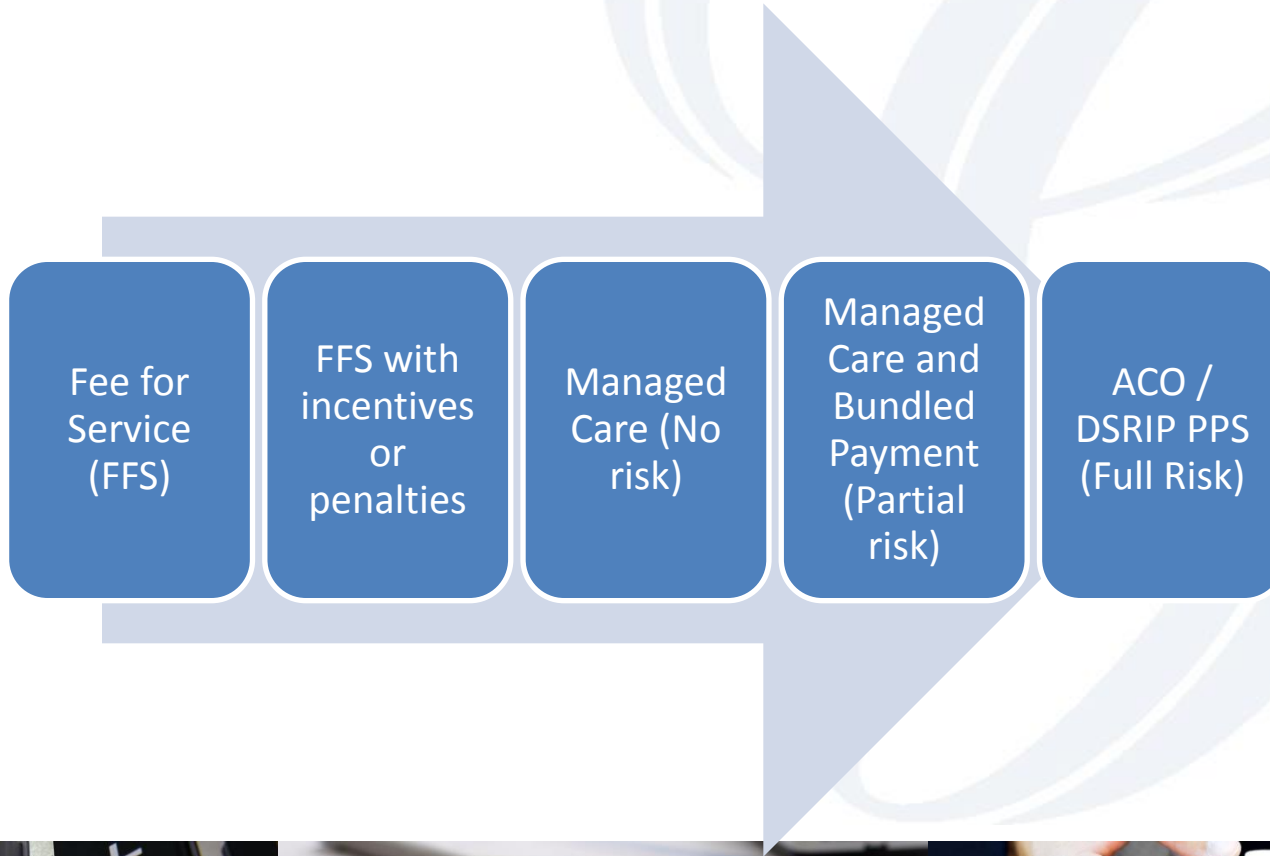


# Objectives

- 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



# 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

	CMS Five Star Ratings	Value Based Purchasing Program	Impact Act of 2014
Why?	Developed to help consumers select nursing homes based on performance	Protecting Access to Medicare Act of 2014 (PAMA) added sections to Social Security Act to begin SNF VBP in FY 2019	Creates standardized, interoperable patient assessment data across PAC settings and establishes SNF Quality Reporting Program (SNF QRP)
When?	Implemented 2008 and modified each year for additional measures and revisions to existing ones	Facilities will receive confidential quality feedback reports on measure performance beginning in FY 2019	FY 2018 is affected with initial measurement period 10/1/2016 through 12/31/2016
Data?	MDS 3.0 and Medicare Claims Data	Medicare Claims Data	MDS 3.0 and Medicare Claims Data



# Quality Payment Initiatives

	Payment	Quality
Federal	<p>Medicare Advantage Bundled Payment</p> <ul style="list-style-type: none"> <li>Bundled Payments for Care Improvement (BCPI)</li> <li>Comprehensive Care for Joint Replacement (CJR)</li> <li>CHF and MI Proposed Bundles (2018)</li> </ul> <p>SNF Value Based Purchasing</p> <ul style="list-style-type: none"> <li>30 day all cause readmission measure (SNFRM) (data collection 10/1/16 for FY 2018)</li> </ul>	<p>Five Star Quality Rating System</p> <ul style="list-style-type: none"> <li>Nursing Home Compare               <ul style="list-style-type: none"> <li>Five new measures July 2016</li> </ul> </li> <li>Staffing Data Submission (PBJ)               <ul style="list-style-type: none"> <li>Electronic file submissions Effective 7/1/2016</li> </ul> </li> <li>SNF Quality Reporting Program (SNF QRP)               <ul style="list-style-type: none"> <li>Effective 10/1/2016 through 12/31/2016 for Fiscal Year 2018</li> </ul> </li> </ul>
State	<p>Mandatory Medicaid Managed Care for new LTC patients (since 2015)</p> <p>Delivery System Reform Incentive Payment (DSRIP)</p> <ul style="list-style-type: none"> <li>Roadmap to VBP for subpopulations of LTC patients</li> </ul>	<p>Nursing Home Quality Incentive (NHQI)</p> <ul style="list-style-type: none"> <li>Effective 2013 with ongoing methodology changes</li> </ul>



# 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



# MDS Changes 10/1/2016

- 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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