VALUE BASED PURCHASING, IMPACT ACT, AND THE FUTURE OF REIMBURSEMENT METHODOLOGY
AGENDA

- SNF Value Based Purchasing
- IMPACT Act
  - Purpose
  - Measures
  - MDS Changes
- What Does the Future Hold?
VALUE BASED PURCHASING
Protecting Access to Medicare Act of 2014 (PAMA)

- Implements a Value Based Purchasing Program (SNF VBP)
- 2% withhold to Part A payments that can be partially earned back based on rehospitalization rate and level of improvement
- Passed in 2014, rates not impacted until FY 2019 (October 1, 2018); details to be developed by CMS rulemaking
CMS selected the Skilled Nursing Facility 30-Day All-Cause Readmission Measure risk adjusted rehospitalization measure (SNFRM NQF #2510)

Requested comments regarding how to develop the “rehospitalization score,” how to calculate “improvement,” how to redistribute the withhold, how to present rehospitalization rate and score to SNFs for preview, and how to present same for public reporting
- FY 2016 – measure development, data collection
- FY 2017 – SNF preview of data
- FY 2018 – public reporting of data
- FY 2019 – withhold implemented
Hospital readmissions of Medicare beneficiaries discharged from a SNF are common, studies suggest a large proportion are preventable.

Hospital readmissions also put beneficiaries at risk for complications.

The intent of the SNFRM is to encourage SNF providers to monitor and reduce hospital readmissions, thereby reducing costs and improving the quality of care Medicare beneficiaries receive during their SNF stay.
SNFRM estimated the risk-standardized rate of all-cause, unplanned hospital readmissions for SNF beneficiaries within 30 days of discharge from their prior proximal short-stay acute hospital discharge.

- SNF admission must have occurred within 1 day after discharge from the proximal hospital stay.

- Measure based on data for 12 months of SNF admissions.

- Beneficiaries with more than one eligible admission may be included in the measure multiple times within a given year.
SNFRM excludes certain stays:

- Stays for which patient had intervening PAC admission between hospital stay and SNF or after SNF discharge
- Patients who did not have FFS Part A enrollment before proximal hospital discharge
- Patients who did not have FFS Part A enrollment for entire 30 day risk window
- Patients whose hospitalization was for the medical (nonsurgical) treatment of cancer or receiving rehabilitation care or prosthesis fitting
SNF RM produces a risk-adjusted readmission rate for each facility, excluding planned readmission from the SNF.

Measure is computed by calculating the standardized risk ratio (SRR): the predicted number of readmissions at the facility divided by the expected number of readmissions for the same patients if these same patients had been treated by the average SNF.

SRR is then multiplied by the mean rate of readmission in the population to generate the facility-level standardized readmission rate, referred to as the Risk-Standardized Readmission Rate or RSRR.
Measure is designed to capture the outcome of unplanned all-cause hospital readmissions occurring within 30 days of discharge from the patients prior proximal acute hospitalization.

Hospital observation stays do not count as a readmission.

Readmissions identified as being planned using the CMS Planned Readmission Algorithm are excluded.

SNFRM is evaluated on a 1-year cycle.
Planned readmission is defined as any non-acute readmission in which one of a set of typically planned procedures or diagnoses occurred.

If any of the procedures denoted as planned occur in conjunction with a diagnosis that disqualifies a readmission from being considered planned, the readmission will be considered to be unplanned.
Planned readmission procedures:
   - One of a pre-specified list of procedures took place, or
   - Readmission for bone marrow, kidney or other transplant

Planned readmission diagnoses:
   - Maintenance chemotherapy and rehabilitation
   - Readmissions to psychiatric hospitals or units

Admissions for acute illness or for complications of care are not classified as "planned," even if a typically planned procedure is performed during the stay

Principal diagnosis and all procedure codes from the readmission are utilized to identify planned readmissions

SNFRM – PLANNED READMISSION
SNFRM RISK ADJUSTMENT

Covariates used in the measure:
- Age, gender
- Proximal hospitalization LOS
- Time in ICU?
- ESRD
- # Acute care hospitalizations in 365 days before proximal hospitalization
- Principal diagnosis

System-specific surgical indicators
- Kidney, cardiac, vascular patients with surgical indicators are higher risk
- Ortho with surgical indicator are lower risk

Individual comorbidities
- ESRD, diabetes, heart failure, pressure ulcers

Multiple comorbidities
- Charlson Comorbidity Index is calculated using both the number and seriousness of comorbidities
IMPACT ACT
IMPACT Act requires CMS to specify standard assessment tools across PAC providers (HH, SNF, IRF, LTCH) along with cross-setting quality measures.

Reporting of measures must occur no later than October 2017.

Proposed measures require 12 months of data, so data submission is required October 2016.

2% penalty (reduction in Medicare rates) for failure to submit required data.

Program is called Skilled Nursing Facility Quality Reporting Program (SNFQRP).
Percent of Residents or Patients with Pressure Ulcers That are New or Worsened
  - For SNFs, this is exactly the same as our current short stay measure, but will include only FFS Part A beneficiaries

Percent of Residents Experiencing One or More Falls With Major Injury
  - For SNFs, this is calculated like our current long stay measure, but will be calculated for FFS Part A beneficiaries at the end of the stay

Percent of ...Patients with an Admission and discharge Functional Assessment and a Care Plan to Address Function
This is a process measure (not an outcome measure) that reports the percent of patients/residents with an admission and a discharge functional assessment and a treatment goal that addresses function.

Requires the collection of admission and discharge functional status data by clinicians using standard assessment items that address specific functional activities – self care and mobility.
Although functional assessment data are currently collected in all PAC settings, it is not standardized across settings.

Further, different functional assessment items are coupled with different rating scales, making communication about patient functioning challenging when they transition from one type of provider to another.

Collection of standardized functional status data may also help improve patient functioning during episode of care by ensuring that basic daily activities are assessed at the start and end of each episode of care with the aim of determining if at least one functional goal is established.
The functional assessment items included in this measure are part of the Continuity Assessment Record and Evaluation (CARE) Item Set.

Items are daily activities typically assessed at the time of admission and/or discharge to determine the patient’s needs, evaluate progress, and plan for transition home or to another provider.

Requires new section (Section GG) be added to the MDS.

ADMISSION AND DISCHARGE FUNCTIONAL ASSESSMENT AND CARE PLAN MEASURE
Eating – the ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table or tray. Includes modified food consistency.

Oral hygiene – the ability to use suitable items to clean teeth. [Dentures (if applicable) – the ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them]

Toileting hygiene – the ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.
Sit to Lying – the ability to move from sitting on side of bed to lying on bed

Lying to sitting on side of bed – the ability to safely move from lying on back to sitting on the side of the bed with feet flat on the floor, and with no back support

Sit to stand – the ability to safely come to a standing position from sitting in a chair or on the side of the bed

Chair/bed-to-chair transfer – the ability to safely transfer to and from a bed to a chair (or wheelchair)

Toilet transfer – the ability to safely get on and off a toilet or commode
MOBILITY ITEMS

- For patients who are walking:
  - Walk 50 feet with two turns – once standing, the ability to walk at least 50 feet and make two turns
  - Walk 150 feet – once standing, the ability to walk 150 feet in a corridor or similar place

- For patients who use a wheelchair:
  - Wheel 50 feet with two turns – once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns
  - Wheel 150 feet – once seated in a wheelchair/scooter, the ability to wheel 150 feet in a corridor or similar place
    - For both, indicate type of wheelchair/scooter used (manual or motorized)
RATING SCALE: CODES AND DEFINITIONS

- 6. Independent – Patient completes the activity by him/herself with no assistance from a helper
- 5. Setup or clean-up assistance – helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity
- 4. Supervision or touching assistance – helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently
3. Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort

2. Substantial/maximal assistance – helper does MORE THAN HALF the effort. Helper lifts, holds or supports trunk or limbs and provides more than half the effort

1. Dependent – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the patient to complete the activity

RATING SCALE: CODES AND DEFINITIONS (CONTINUED)
If activity was not attempted, code reason

- 07. Patient refused
- 09. Not applicable
- 88. Not attempted due to medical condition or safety concerns
Will become part of the MDS item set effective with ARD on or after October 1, 2016

Watch for MDS manual updates

I recommend training staff during the summer – therapy will probably complete GG, but staff should think about how GG and G should relate

Could help improve ADL coding and Medicare reimbursement rates if there is proper understanding of the relationship

SECTION GG – MY THOUGHTS
The measures specified for SNFQR requires an assessment be completed at the end of each Part A stay to capture quality measure items. Discharge assessments are completed for Part A beneficiaries who go home at the end of the episode of care, but there is currently not an end of care assessment required for those who will remain in the facility at the end of Part A coverage.

Effective October 1, 2016 a new “SNF Part A PPS Discharge assessment” will be required in these circumstances.
WHAT DOES THE FUTURE HOLD?
In FY 2016 PPS Update Rule, CMS suggests that the measures specified for SNFQR may be used for “subsequent payment determinations in FY 2018

December 2015 notice of proposed rulemaking, CMS submits 12 additional measure to NQF for approval, under authority granted in IMPACT Act

Current draft legislation co-sponsored by Ways and Means Chair

EXPANSION OF VBP
CMS MEASURES UNDER CONSIDERATION

- Improvement in Self-care
- 90 Day cost per beneficiary
- Discharge to Community
- Potentially Preventable Readmissions after SNF discharge
- Improvement in Mobility
- Self-care at discharge
- Mobility at discharge
- Drug Regimen Review
- Pain managed
- Influenza vaccine
- Antipsychotic started
- 30 day potentially Preventable Readmission for SNF VBP
Add in 2016

Short Stay
- Rehospitalizations
- Discharge back to community
- Emergency room visits
- Change in ADL from admission to discharge

Long Stay QMs
- Mobility in room

Add in 2017

- Staffing turnover and retention from PBJ
- Other IMPACT act measures
Questions?

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