Data Analysis in Today's Skilled Nursing Facilities: How Data is Driving Reimbursement and 5-Star Ratings

Presented by:
Reinsel Kuntz Lesher
Senior Living Services Consulting

www.RKLcpa.com

REINSEL KUNTZ LESHER LLP
certified public accountants & consultants
Focused. On You.

Disclaimer

"The information contained herein is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavor to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act upon such information without appropriate professional advice after a thorough examination of the particular situation."

1

Learning Objectives

1. Gain an understanding of how data is changing the health care industry and, more specifically, its impact on SNFs.
2. Understand Medicare's alternative payment models and how data collection and analysis will drive reimbursement.
3. Learn the components of the 5 Star Quality Rating system and understand that data behind each component in an effort to drive rating enhancement at each community.

2

Data in Healthcare

Data in Healthcare

- Healthcare is shifting from fee-for-service to value-based care.
- Multiple new payment models emerging
- A flurry of various Acts and Rules have created a challenging environment as measures and metrics begin to drive healthcare payments

Data in Healthcare

- Two main programs established by the passage of the Patient Protection and Affordable Care Act (PPACA, also known as the ACA and “Obamacare”) in 2010:
  - Medicare Shared Savings Program
  - CMS Innovation

Data in Healthcare

- Medicare Shared Savings Program:
  - New approach to delivery of health care
  - Facilitate coordination and cooperation among providers to improve quality
  - Reduce unnecessary costs
  - Delivered through an Accountable Care Organization (ACO)

Data in Healthcare

- CMS Innovation
  - Supports the development and testing of innovative healthcare payment and service delivery models
  - There is a growing portfolio of models that aim to achieve better care and lower costs

Data in Healthcare

- CMS established a goal of tying Medicare payments to outcomes-based or patient management models:
  - 30% by 2016
  - 50% by 2018
- CMS announced in March, 2016 that it had already achieved its goal of 30% alternative payments with the addition of 121 ACOs and greater participation in other models

Data in Healthcare

- Many of the new models are data driven
- Also, much of the collaboration and partnering of various providers is based on key measures and metrics that rely on data
- The proper collection and reliability of data is critical in this new environment

Data in Healthcare

- To remain competitive, post-acute providers will need to collect and analyze their data
- This will help them understand their business and make more informed decisions
- Potential partners, such as hospitals as part of a ACOs, will be looking to partner with post-acute providers who deliver:
  - Highest quality care
  - Most favorable outcomes
  - Lowest cost

Data in Healthcare

- Providers will need to focus on their Five-Star rating as those with 3 stars or less may not qualify for partnership opportunities

Data in Healthcare

- Community HealthChoices (CHC) is changing the landscape in Pennsylvania as well
- Providers accepting Medicaid will need to partner with one or several Managed Care Organizations (MCO)
  - All providers will receive contracts for the first six months following implementation
  - Following that six-month period, MCOs will not be required to contract with all providers
  - This means that providers will have to be attractive to the MCOs in order to gain a contract

Data in Healthcare

- On August 30, 2016 the PA Department of Human Services (DHS) announced the three MCOs for CHC:
  - AmeriHealth Caritas
  - Pennsylvania Health and Wellness (Centene)
  - UPMC for You
- Providers will now wait for the details on contracting

Data in Healthcare

- Data analysis through measures and metrics will be the tool that will prove value to the MCOs
- Five-Star ratings will play an important role
- As the payment models and care delivery models continue to evolve in healthcare, the reliance on data will become increasingly important

Payment Models and the Data That Drives Them

Payment Models and Data

- There are a variety of new payment models and programs
- These are designed to increase quality of care and reduce the cost of providing that care
- The next several slides give an overview of the models

Payment Models and Data

- Medicare Shared Savings Program
  - Several ACO models where providers are incentivized to lower costs and increase quality and patient outcomes
  - Requires significant collaboration among various providers
  - DATA: need to improve various quality measures data points and demonstrate lower costs

Payment Models and Data

- Nursing Home Value-Based Purchasing
  - CMS assesses a SNF's quality performance based on four domains:
    - Staffing
    - Appropriate Hospitalizations
    - Minimum Data Set (MDS) Outcomes
    - Survey Deficiencies
  - DATA: Need to track various metrics, particularly Appropriate Hospitalizations.

Payment Models and Data

- Episode-based Payment Initiatives
  - Bundled Payment for Care Improvement (BPCI)
    - Evaluates four models of bundled payments for a defined episode of care to incentivize care redesign
  - Comprehensive Care for Joint Replacement (CCJR)
    - Pilot program that began April 2016 for knee and hip replacements
  - Proposal for Cardiac Rehabilitation Incentive Payment Model from July 2016
  - DATA: A complicated variety of metrics including rehospitalization, complication rates, and satisfaction surveys, among others

Five-Star Quality Rating System

Five-Star Quality Rating System

- Created by The Centers for Medicare & Medicaid Services (CMS) in December 2008 to enhance the Nursing Home Compare public reporting site.
- Effective July 2016, five of six newly introduced quality measures are being used in the Five-Star Quality Rating
- The goal of the rating system is to provide residents and families an easy way to compare between a high and low performing nursing homes.
- The system features a five-star rating based on three types of performance measures, each of which has its own five-star rating.

21

Five-Star Quality Rating System

- Three performance ratings:
  - Health Inspections – Measures based on outcomes from State Health inspections;
  - Staffing – Measures based on nursing home staffing levels; and
  - QM's – Measures based on certain MDS Quality Measures.

22

State Health Inspections

23

State Health Inspections

- Points are assigned to deficiencies found during the three most annual inspection surveys; and
- Substantiated findings from the most recent 36 months of complaint investigations.
- Each deficiency is weighted by scope and severity.
  - More points are assigned for more serious and widespread deficiencies.

24

State Health Inspections

- Health Inspection Score: Weights for Different Types of Deficiencies

Severity	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	**J** **50 points** **(75 points)**	**K** **100 points** **(125 points)**	**L** **150 points** **(175 points)**
Actual harm that is not immediate jeopardy	**G** 20 points	**H** **35 points** **(40 points)**	**I** **45 points** **(50 points)**
No actual harm with potential for more than minimal harm that is not immediate jeopardy	**D** 4 points	**E** 8 points	**F** **16 points** **(20 points)**
No actual Harm with potential for minimal harm	**A** 0 point	**B** 0 point	**C** 0 point

25

Scoring Rules

- Based on relative performance of facilities within the state;
- The top 10% (lowest 10 percent in terms of heath inspection deficiency score) in each state receive a 5-star rating;
- The middle 70% of facilities receive a rating of 2, 3, or 4 Stars, with an equal number (approximately 23.33%) in each rating category; and
- The bottom 20% receive a 1-Star rating.

26

Scoring Rules

- A higher score indicates worse performance on health inspections. The cut points are based on facility health inspection scores and are set separately for each state to achieve this distribution:
  - 5 stars: ≤10th percentile
  - 4 stars: >10th percentile and ≤ 33.33rd percentile
  - 3 stars: >33.33rd percentile and ≤ 56.667th percentile
  - 2 stars: >56.667th percentile and ≤ 80th percentile
  - 1 star: >80th percentile

Staffing Domain

Staffing Domain

- Based on two case-mix adjusted measures:
  - RN hours per resident day
  - Total nursing hours per resident day (RN + LPN + nurse aide hours)
- Payroll-Based Journal (PBJ) is required beginning July 1, 2016
  - First submission is due November 14, 2016
  - Is based on payroll data rather than self-reported Form 671
  - May have significant impact on the Staffing Domain

Staffing Domain

- Currently, the source data for the staffing measures is the CMS-671 form (Medicare and Medicaid application) from CASPER.
  - Includes:
    - Full time and Part-time employees
    - Contracted Staff
  - Does not include:
    - Family-funded private duty staff
    - Hospice staff
    - Feeding Assistants

30

Staffing Domain

- RN hours per resident day include:
  - RNs
  - RN Director of Nursing
  - Nurses (RNs and LPNs) with administrative duties
    - Those who perform RAI function and do not perform direct care functions; and
    - Those whose principal duties are spent conducting administrative functions.

31

Staffing Domain

- Total staffing per resident day includes:
  - RN hours (as described on previous slide)
  - LPNs
  - Nurse aide hours

32

Staffing Domain

- Resident census is based on the total count of residents from CMS form CMS-672 (Resident Census and Conditions of Residents)
  - Census includes total residents in the facility + bed holds on the day the survey began

33

Staffing Domain

- Ratings are based on *expected* staffing levels calculated based on resident acuity using RUGs
- Staffing is case-mix adjusted based on RUG-III (53 group version) categories
  - RUG-III groups are calculated on the last business day of each quarter for each active resident; uses quarter in which the staffing data was collected
  - Most recent MDS assessment (comprehensive, quarterly, or PPS) for each resident
- Calculations for “expected”, “reported” and “national average” hours are performed separately for RNs and total staff

34

Quality Measures

35

Quality Measures

- Developed from MDS-based indicators to describe the quality of care provided in nursing homes
- The measures address the resident's functioning and health status in multiple areas
- The Quality Measure domain for the five-star rating is based on a subset of 13 (out of 24) MDS –based QMs and three MDS and Medicare claims based measures.

Quality Measures

The Quality Measures include:

- 9 Long-Stay resident measures; and
  - Cumulative days in the facility greater than or equal to 101 days as of the end of the target period
- 7 Short-Stay resident measures.
  - Cumulative days in the facility less than or equal to 100 days as of the end of the target period
  - 3 of which are derived from claims data and MDS assessments

Quality Measures

Quality Measures derived from MDS assessments:

- Long-Stay Residents:
  - Percent of residents whose need for help with activities of daily living (ADL) has increased
  - Percent of residents whose ability to move independently worsened (added July 2016)
  - Percent of high risk residents with pressure ulcers (sores)
  - Percent of residents who have/had a catheter inserted and left in bladder
  - Percent of residents who are physically restrained

Quality Measures

Quality Measures derived from MDS assessments (cont'd)

- Long-Stay Residents:
  - Percent of residents with a urinary tract infection
  - Percent of residents who self-report moderate to severe pain
  - Percent of residents experiencing one or more falls with major injury
  - Percent of residents who received an antipsychotic medication

Quality Measures

Quality Measures derived from MDS assessments:

- Short-Stay Residents:
  - Percent of residents whose physical function improved from admission to discharge (added July 2016)
  - Percent of residents with pressure ulcers (sores) that are new or worsened
  - Percent of residents who self-report moderate to severe pain
  - Percent of residents who newly received an antipsychotic medication

Quality Measures

Quality Measures derived from claims data and MDS assessments:

- Short-Stay Residents: (added July 2016)
  - Percent of residents who were re-hospitalized after a nursing home admission;
  - Percent of residents who have had an outpatient emergency department visit; and
  - Percent of residents who were successfully discharged to the community.

Quality Measures

- Implementation of new 2016 QMs:
  - July 1, 2016 through December 31, 2016: the new measures will have 50% the weight of the 11 measures used prior to July 2016
  - January 1, 2017: the new measures will have the same weight as the 11 measures used prior to July 2016

42

Quality Measure 5-Star Scoring Rules

43

Scoring Rules

- Long-stay measures must have at least 30 resident assessments summed across three quarters to be included in the measure
- Short-stay measures will be included if data is available for at least 20 resident assessments
- 20 to 100 points are assigned to each measure based on facility performance
  - 10 to 50 points are assigned for the new QMs from July 1, 2016 through December 31, 2016
- The total score can range from 275 – 1,350
  - The total score range will increase to 325 – 1,600 on January 1, 2017
- The stars are assigned based on the Star cut points for the Quality Measure Summary Score

44

Scoring Rules

- Rating
  - The QM domain is calculated using the **four** most recent quarters of data available
  - The values for three QMs are risk adjusted (catheter, long-stay pain measure, and the short-stay pressure ulcers)
    - See the Quality Measure Users Manual
  - The Quality Measure (QM) corresponds to the QM value for the three most recent quarters and the denominator (D) is the number of eligible residents for the particular QM

45

Scoring Rules

- Rating (cont'd)
  - All facilities are scored on the same 1,350 point scale, points are rescaled for long and short-stay facilities
  - After the summary QM score is computed, the five-star QM rating is assigned
  - The thresholds were set so that the overall proportion of nursing homes would be approximately 25 percent 5-star; 20 percent for each of 2, 3, and 4-stars; and 15 percent 1 star.
  - The cut points will hold constant for a period of one year, allowing the QM rating distribution to change over time

46

Scoring Rules

- Star Cut Points:

QM Rating	Point Range for MDS Quality Measure Summary Score
1 Star	275 - 669
2 Star	670 - 759
3 Star	760 - 829
4 Star	830 – 904
5 Star	905 - 1350

47

Overall Nursing Home Rating

48

Overall Rating

- Five Steps:
  - *Step 1:* Start with the health inspection 5-star rating
  - *Step 2:* Add one star to the Step 1 result if the staffing ratio is 4 or 5-stars *and greater than* the health inspection rating; subtract 1-star if staffing is 1-star
  - *Step 3:* Add 1-star to Step 2 result if QM rating is 5-stars; subtract 1-star if QM rating is 1-star

49

Overall Rating

- Five Steps: (cont'd)
  - *Step 4:* If the health inspection rating is one star, than the overall quality rating cannot be upgraded by more than 1-star based on the staffing and QM ratings
  - *Step 5:* If the nursing home is a Special Focus Facility (SFF) that has not graduated, the maximum overall quality rating is 3-stars

50

Case Studies

51

Case Studies

- Understanding your surveys
  - *Three years of data*
- *Nurse staffing*
  - *Who is included?*
  - *Adjustments*
  - *Census or acuity adjusted*
- *Quality Measures*
  - *Proactive approach*
  - *CQI*

52

Strategies for Success

53

Strategies

- Data analytics
  - It is not about the data, but what you do with it
  - Analyze and Implement
- Quality Assurance Performance Improvement (QAPI)/Continuous Quality Improvement (CQI)
- Provide accurate information (i.e., claims, CMS-671 and CMS-672 form/PBJ data)
- Focus efforts on bottom-line issues:
  - Quality of care
  - Quality outcomes
  - Staffing levels consistent with acuity
  - Accurate MDS Coding and claims submission

Contact Information

Stephanie Kessler
Partner
Reinsel Kuntz Lesher
SKessler@RKLcpa.com
717.885.5724

Tracy Montag
Manager
Reinsel Kuntz Lesher
TMontag@RKLcpa.com
717.885.5727