Nursing Facility Payment Review and Redesign

Building Block #1: Staffing

10.1.2020

Today's Agenda

- New meeting format
- Steps in the review and redesign process
- Recap of purpose, principles and objectives
- Building Block #1: Staffing

New Meeting Format

- Principles and objectives
- Summary of previous decisions, discussion and considerations
- Each meeting's focus
  - Introduction, framing, terminology
  - Applicable data or analysis
  - Considerations, key issue, and potential choices
- Questions, next steps and request for input on future topics
- [feedback in written form]

Steps in the Review and Redesign Process

Suggested building blocks in a comprehensive NF payment, with a potential order of focus:

- Staffing (2-3 meetings)
- Quality (2 meetings)
- Infrastructure
- Rebalancing
- Capacity

Note: COVID has had a profound impact on long term care. Infection control is assumed to be an integral component of each building block.

Modeling to follow consideration of these building blocks for payment

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Purpose Statement

HFS proposes a structured and transparent approach to develop, deliberate, adopt and implement nursing home payments to achieve improved outcomes and increased accountability with an emphasis on patient-centered care. HFS believes the rate mechanism, funding model, assessment, quality metrics, and staffing requirements can and should be updated in conjunction with any new or additional appropriated funding. Further, additional federal funding should be captured to improve these areas through an increase in the current nursing home bed tax.

Original Objectives and Principles

- Transparent, outcome driven, patient-centered model with increased accountability
- Transition away from RUGS to federal PDPM case-mix nursing component
- Modify the support and capital rate into a set base rate similar to Medicare non-case-mix rate
- End the $1.50 bed fee and increase the occupied bed assessment to create a single assessment program which maximizes federal revenue
- Directly tie funding/rates/incentives to demonstrable and sustained performance on key quality reporting metrics
- Documentation to support, review and validation of level of care coding and appropriateness, outliers, actual patient experiences, etc.
- Align regulation and payment incentives to the same goals
- Ensure appropriate incentives for community placement, including both uniform and MCO-specific incentives
- Recalibrate/rethink payment for nursing home infrastructure to support emerging vision for the industry in the wake of the COVID-19 crisis, including single-occupancy rooms, certified facilities
- Integrate emerging lessons and federal reforms related to the COVID pandemic
- Improved cooperation, support and follow up, data sharing and cross-agency training from other agencies (OIG, IDPH, DoA)
- Build in flexibility to evolve as the industry evolves and establish ongoing channels of communication for new, proposed, or upcoming changes

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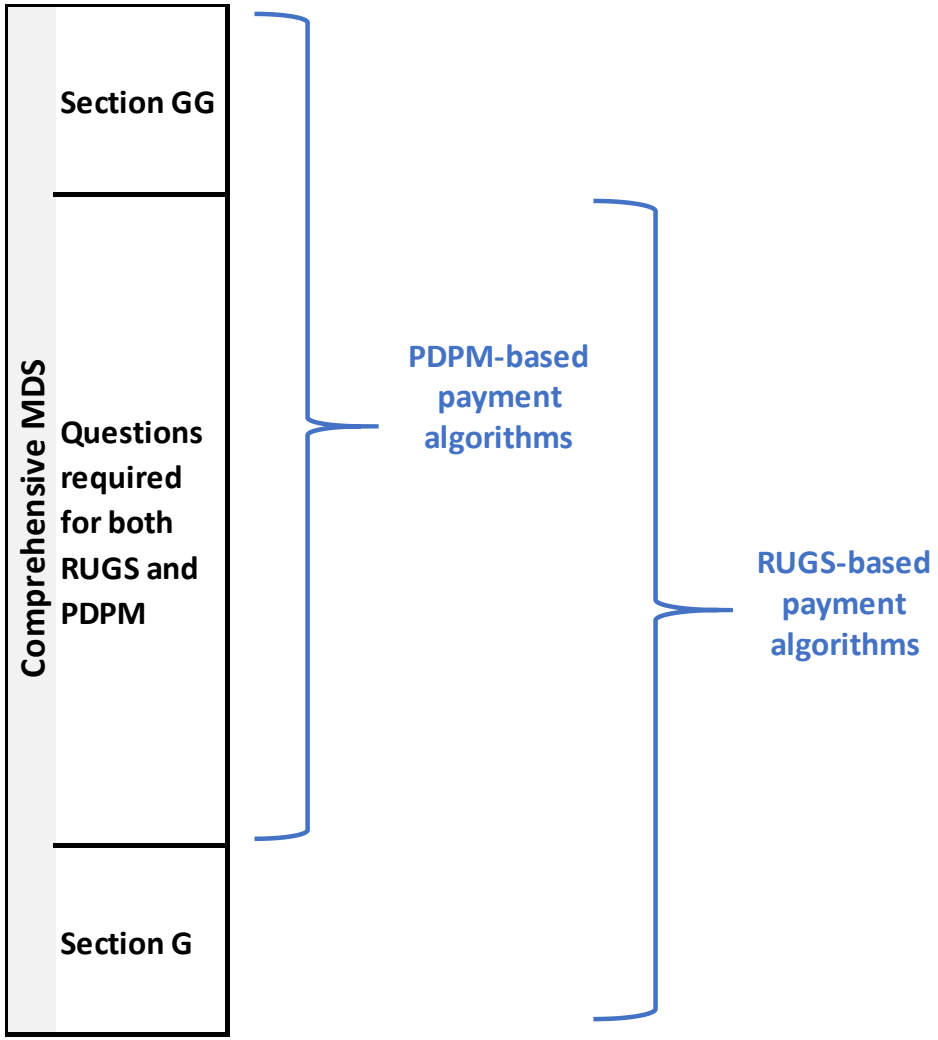
Building Block #1: Staffing

- Composition of PDPM v. RUGS
- Use of RUGS v. PDPM in staffing regulations and payment
- Considerations and choices in transitioning from RUGS to PDPM

Composition of PDPM v. RUGS

CMS' original plan was to eliminate Section G and add Section GG effective today (10/1/20200, but allowed states to retain Section G, which Illinois did.



Key Differences

Timeframe

- Section G has retrospective 7-day window
- Section GG has a 3-day window at the beginning of a PPS stay

Content

- Section G assesses ADLs (10), Bathing, Balance, Range of Motion, Device use, and Rehab Potential
- Section GG assesses Prior Device Use, Everyday Activities (4), Self Care (7), and Mobility (10)

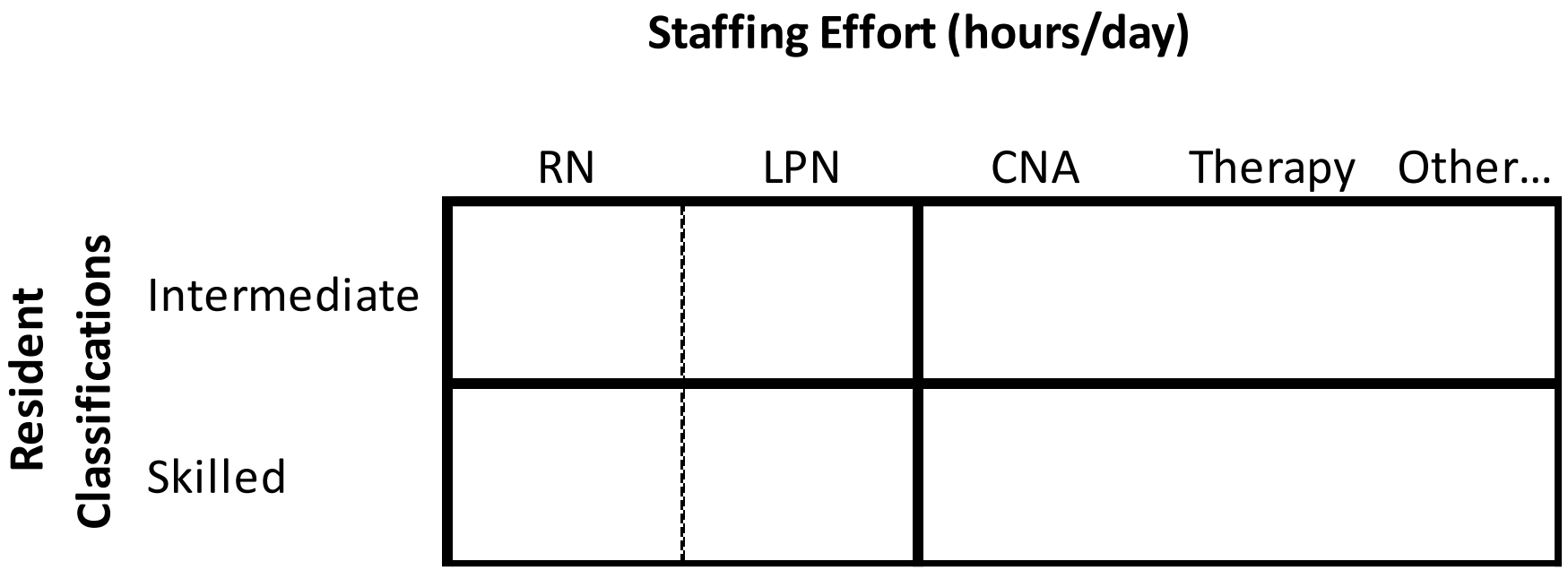
Classification algorithm

- RUGS incorporates 4 ADLs from Section G
  - Bed Mobility, Transfer, Eating, Toilet Use (both columns)
- PDPM incorporates these from Section GG
  - 11 ADLs from Self-Care and Mobility sections, including Eating, Toilet Hygiene, Sit to Lying, Lying to Sitting, Sit to Stand, Chair/Bed Transfer, Toilet Transfer

State Staffing Regulations

How to read this diagram…

Each solid-line box represents a unique patient-type + staff-type combination that contributes to rate development or compliance



Skilled v. Unskilled Staffing in Illinois Regulations

JCAR §77(I)(c)300.1230

"***Skilled care*** is skilled nursing care, continuous skilled nursing observations, restorative nursing, and other services under professional direction with frequent medical supervision."

"***Intermediate care*** is basic nursing care and other restorative services under periodic medical direction."

"***Care Determinations***. When differences of opinion occur between facility staff and Department surveyors regarding the care an individual resident may require, the surveyor shall determine whether the resident is receiving appropriate care. If the resident is receiving appropriate care, the surveyor will accept the facility's determination of the number of direct care hours the facility shall provide."

Skilled v. Unskilled Staffing in Medicare PPS

- Beneficiaries must meet the established SNF PPS eligibility requirements for Part A
  - Technical eligibility (i.e. Part A days available, 3 day stay, etc)
  - Clinical Eligibility (Need for and receives medically necessary skilled care on daily basis, services can only be provided in SNF, etc); and
  - Physician Certification – See Below

- The MDS manual establishes the criteria for determination of SNF level of care (LOC), i.e., physician certification:
  - The attending MD must certify that a resident meets the need for extended care services in a skilled nursing facility as defined in 42 CFR 424.20, or
  - The certification validates via written statement the resident's assignment to one of the upper PDPM groups (Defined below):
    - Nursing groups encompassed by Extensive Services, Special Care High, Special Care Low, and Clinically complex nursing categories.
    - PT and OT groups: TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN and TO
    - SLP groups SC, SE, SF, SH, SI, SJ, SK and SL
    - NTA component's uppermost (12+) comorbidity group.

State payment for SNF staffing
(per diem for each resident)

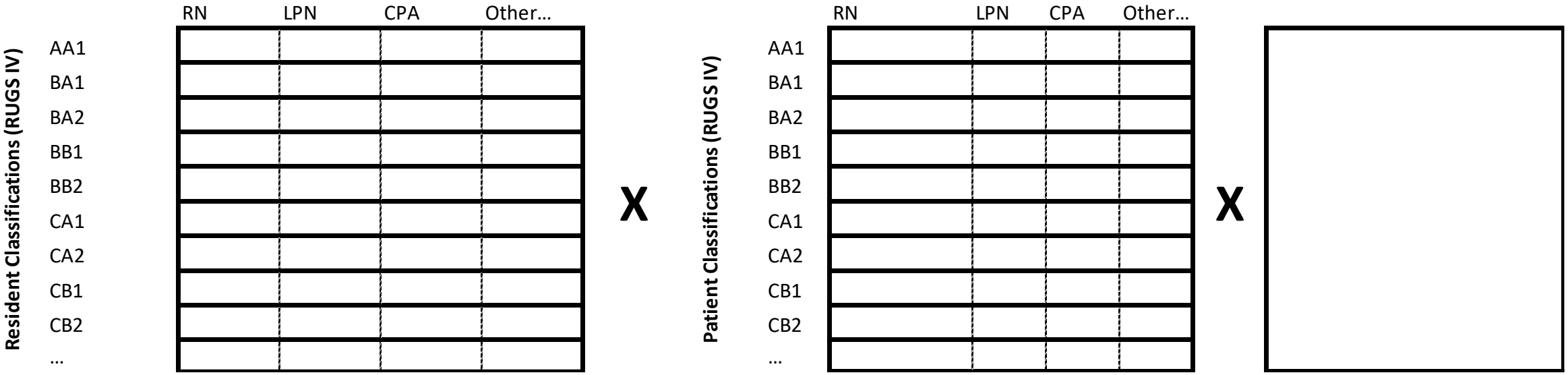
How to read this diagram…

Each solid-line box represents a unique patient-type + staff-type combination that contributes to rate development or compliance

Deriving a CMI weight for each RUG

Staffing Skill (implied relative wage ratio) | **Staffing Effort (implied hours/day)**

State Base Wage for Staffing (implied $/hour)



Important Note: Separation of skill and effort and associated dotted line detail reflects only the *initial, historical calculation of CMIs by Medicare.*

New Medicare PDPM Staffing Payment Methodology
(per diem for each resident)

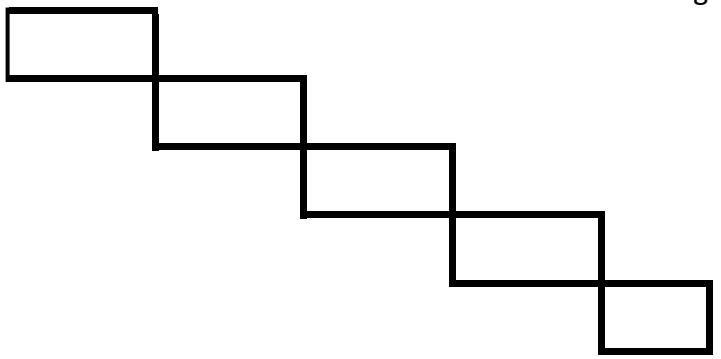
How to read this diagram…

Each solid-line box represents a unique patient-type + staff-type combination that contributes to rate development or compliance

CMI-adjusted rate formula for each Patient for each component ($ per day)

Staffing Skill ($wages)

PT OT SLP NTA Nursing



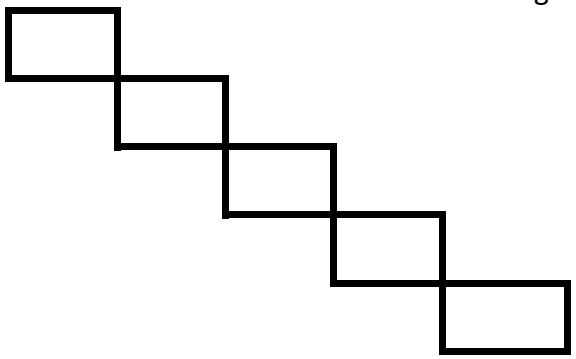
X

Resident-Specific CMI formulas*

PT CMI
OT CMI
SLP CMI
NTA CMI
Nursing CMI

Staffing Effort (hours/day)

PT OT SLP NTA Nursing



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VPD Adjustment (stage w/in limited stay)

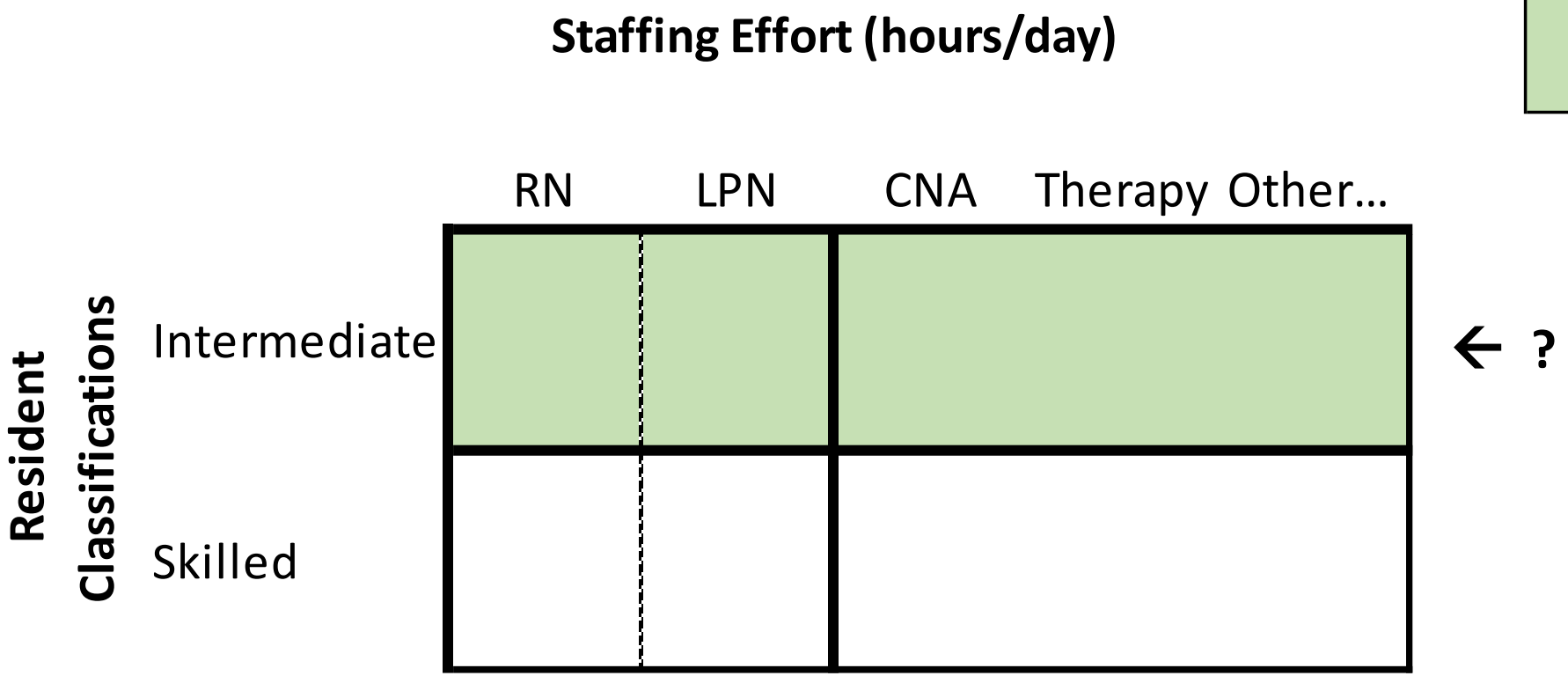
(does not vary by PDPM patient classification)

***CMIs are continuously-scaled component-specific combinations of clinical category, functional score, neurologic conditions, RUGS-IV scoring and/or comorbidities**

State Staffing Regulations

How to read this diagram…

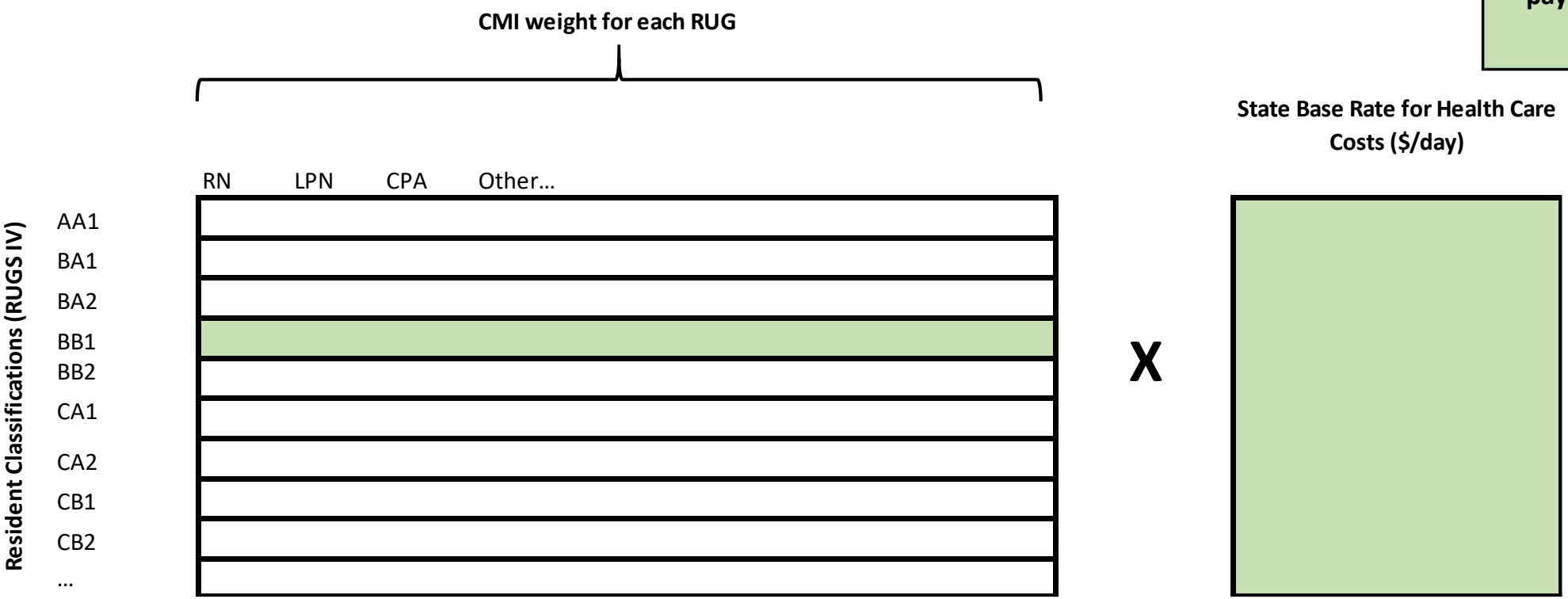
Shaded boxes represent factors contributing to compliance or payment for Resident A in 2020 (RUGS IV = BB1)



State payment for SNF staffing
(per diem for each resident)

How to read this diagram…

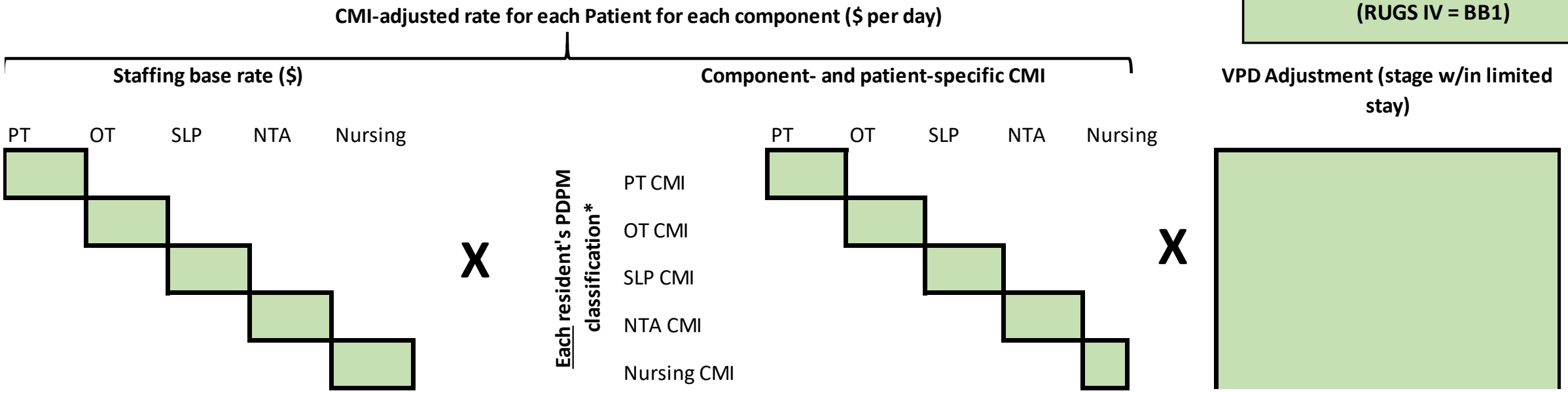
Shaded boxes represent factors contributing to compliance or payment for Resident A in 2020 (RUGS IV = BB1)



New Medicare PDPM Staffing Payment Methodology (per diem for each resident)

How to read this diagram…

Shaded boxes represent factors contributing to compliance or payment for Resident A in 2020 (RUGS IV = BB1)



***CMIs are based on component-specific combinations of clinical category, functional score, neurologic conditions, RUGS-IV scoring and/or comorbidities**

(does not vary by PDPM patient classification)

Issues and Consideration for Staffing

- Should changes to the current regulatory standard incorporate additional types of direct care staff?
- Should the regulatory and payment standards be aligned?
- Should staffing be separately reimbursed/incented?
- How detailed should staffing be tracked and reimbursed/funded? How precisely should skilled v. unskilled staffing be regulated and compensated? Is there a current mismatch between measured case mix and necessary skill mix?
- How would PDPM need to be (re-)calibrated to match Medicaid's case mix, i.e., are there case-types that are missing or mis-calibrated? What was the patient base for the studies and models now underlying Medicare PDPM CMIs?
- How should the VPD duration/stage adjustment be addressed in a state payment methodology?
- Should the state mimic Medicare by building rates from individuals up into an aggregate for facilities?
  - How "prospective" would state payment be, i.e., v. also reconciling to observed case mix over time?
  - What are the implications for data collection?
    - Operational/procedural and cash flow implications?
    - Relationship between case mix profiles used in payment and regulation of staffing ratios?

Questions & Next Steps

- Questions?
- Potential focus for next meeting(s)
  - NF Staffing in Illinois: available data and analysis
  - Staffing retention and continuity
  - Target ratios
  - Other staffing quality measures
- Request for content