Nursing Facility Payment Review and Redesign

Building Block #1: Staffing (Week 2)

10.8.2020

Today's Agenda

- Recap and Overview
- Questions and brief comment from Staffing Week 1
- New Content: Staffing Week 2
  - NF Staffing in Illinois: available data and analysis
  - Potential policy objectives
- Questions and brief comment on today's content
- Next Steps and Request for content (e.g., on Quality)

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
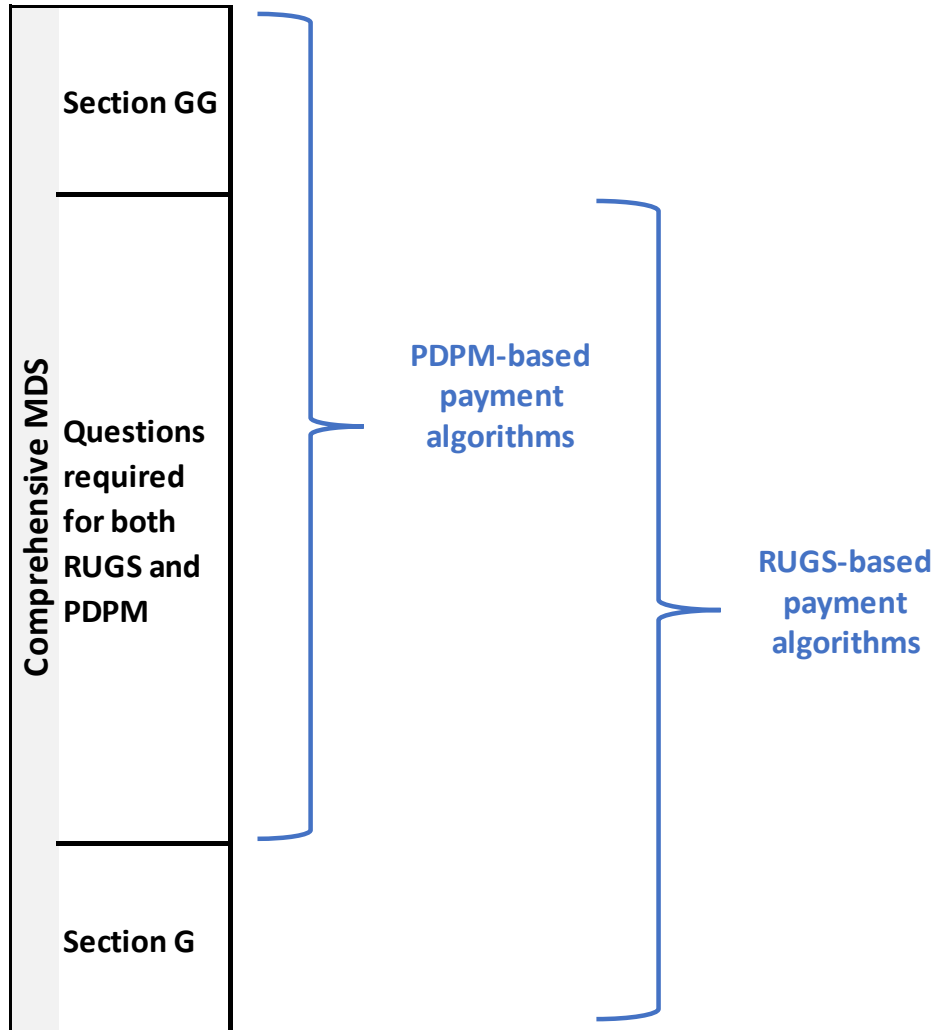
Original Objectives and Principles

Relevant to Today's Discussion:

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Composition of PDPM v. RUGS

CMS' original plan was to eliminate Section G and add Section GG effective 10/1/2020, but allowed states to retain Section G, which Illinois did.

Comprehensive MDS

Section GG

Questions required for both RUGS and PDPM

Section G

PDPM-based payment algorithms

RUGS-based payment algorithms

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

Staffing Effort (hours/day)

Contribution to case mix-adjusted direct care staffing minimum for facility:

	RN	LPN	CNA	Therapy	Other…
Intermediate					
Skilled					

Resident Classifications

2.5 hours per resident day

3.8 hours per resident day

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
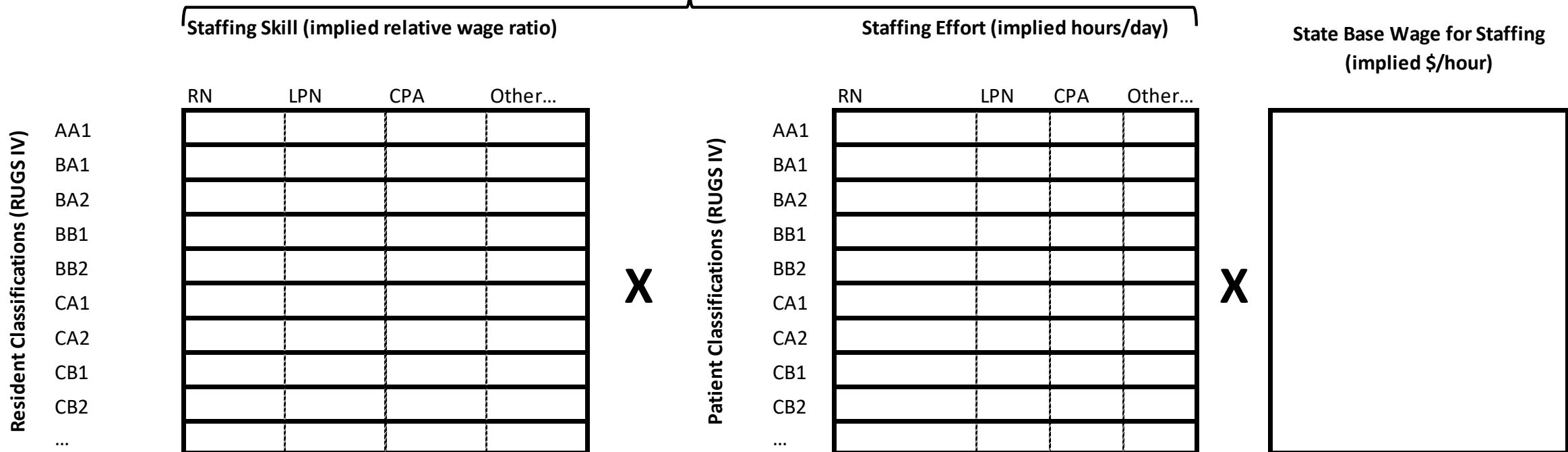
Staffing Skill (implied relative wage ratio)

Staffing Effort (implied hours/day)

State Base Wage for Staffing (implied $/hour)

Resident Classifications (RUGS IV)

	RN	LPN	CPA	Other…
AA1				
BA1				
BA2				
BB1				
BB2				
CA1				
CA2				
CB1				
CB2				
…				

X

Patient Classifications (RUGS IV)

	RN	LPN	CPA	Other…
AA1				
BA1				
BA2				
BB1				
BB2				
CA1				
CA2				
CB1				
CB2				
…				

X

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

8

STRIVE Time Study
Background for Potential Application to Payment or Regulation

STRIVE Nursing Staff Time Package
11/28/2011 V1.00

Source:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/TimeStudy

Table 1.
Staff Categories, Roles and Wage Weights

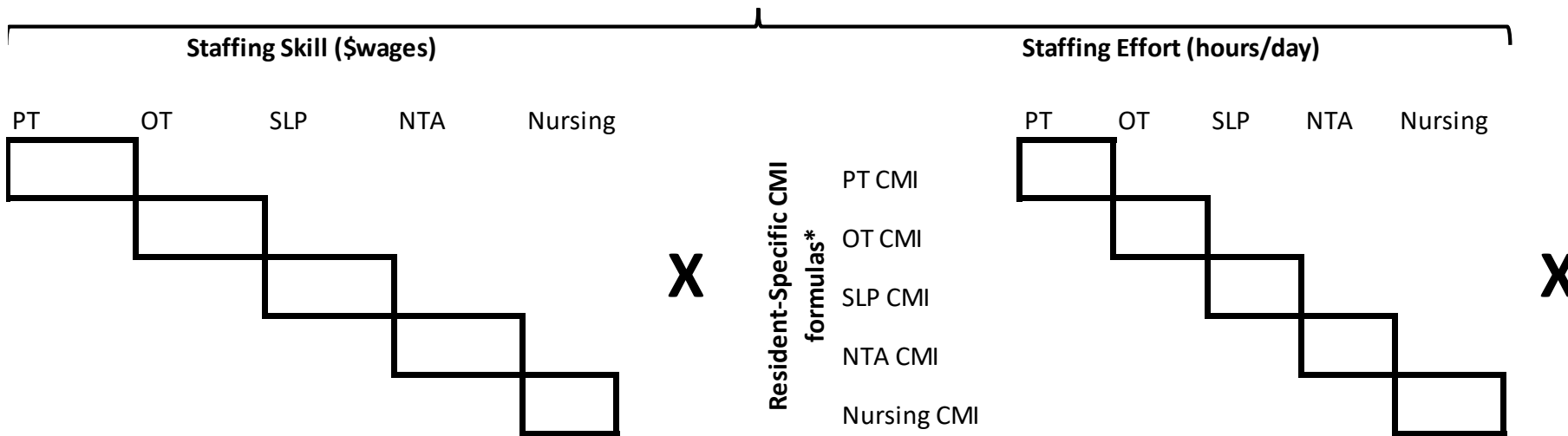| Staff Category	Staff Role Label (in CSV Files)	Staff Role Description	Wage Weight
RN	RN	Registered Nurse	2.58
	Resp. Ther.	Respiratory Therapist	2.14
LPN	LPN	Licensed Practical Nurse or Licensed Vocational Nurse	1.65
Aide	CNA, GNA, RCT	Certified Nursing Assistant or Geriatric Nurse Assistant or Resident Care Technician	1.00
	Cert. Med. Aide	Certified Medicaion Aide	1.00
	Restor. Aide	Restorative Aide	1.20
	Bath Aide	Bath Aide	0.85
	Feeding Aide	Feeding Aide	0.85
	Psych Aide	Psychiatric Aide	1.08
	Non Cert. Care Tech	Non Certified Care Technician	0.85
	Clin. Assoc.	Clinical Associate	1.00
	Transportation	Transportation Aide	0.85
	Resp. Ther. Asst.	Respiratory Therapist Assistant	1.76

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) | | | | | | Staffing Effort (hours/day) | | | | | VPD Adjustment (stage w/in limited stay) |

| PT | OT | SLP | NTA | Nursing | | PT | OT | SLP | NTA | Nursing | |

Resident-Specific CMI formulas*

PT CMI

OT CMI

X   SLP CMI   **X**

NTA CMI

Nursing CMI

(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

Therapy in RUGS v. PDPM

Assessment of need for therapy

Impact on payment

RUGS-based payment

<u>Uses initial 5-day and quarterly MDS</u>
Based on the number of days & minutes coded and ADL function there are two ways to meet RUGs Rehab Category:
- ≥ 5 days AND ≥150 minutes in any therapy; or
- 3 days AND ≥45 minutes in any therapy AND ≥ 2 restorative interventions

- Raises facility's CMI with 2Q lag
- Facility's *provision* of therapy factors directly into future payment

PDPM-based payment

<u>Uses initial 5-day MDS</u>
1. Determine the resident's primary diagnosis clinical category using ICD-10 codes AND whether to use default diagnosis instead. Determine whether the resident received a major joint replacement, spinal surgery, orthopedic surgery, or significant non-orthopedic surgical during prior inpatient stay (Several options)
2. Determine the resident's PT Clinical category (11 options)
3. Calculate the function score using items in GG
4. Determine the resident's PT group using case mix table

- *Need* for therapy affects the CMI-based *prospective* payment
- Facility's provision of care does not factor directly into payment

Issues and Considerations for Staffing

- What staffing policy objectives might be reflected in a Medicaid payment formula?
  - Pushing the statewide average up?
  - Raising the lowest facility averages up to a minimum?
  - Tightening resident-to-staffing assignments?
  - Increasing staff continuity and within-facility tenure?

Key topic for today

- 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?

- 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?

- 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 might 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?
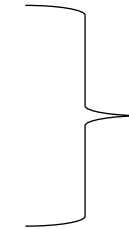
12

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Staffing Levels in Illinois SNFs

- **Illinois is very close to the national staffing average**
  - For RNs only, US = IL =.38 hours per resident per day
  - For RNs+LPNs+CNAs, US=3.21 hours per resident per day and IL=3.29
  - Source: *currently-posted* PBJ data (case mix adjusted)

> **NOTE: This slide contains incorrect analysis and interpretation. Please see October 22, 2020 supplemental presentation for corrected analysis and interpretations.**

- **Total staffing falls slightly below the STRIVE study target**
  - ~270,000 hours of *direct* staffing in Illinois SNFs each day
  - Statewide staffing is about 3% below a statewide STRIVE target for total hours
  - Sources: 4Q2019 MDS scores (n=720), Q42019 PBJs (n=625), and applying RUGS-IV 48 STRIVE targets (as in Round 1 CARES/CURE funding)

- **Staffing varies widely across Illinois SNFs**
  - SNFs that are below the STRIVE target miss the target by a combined 12%
  - SNFs that are above the STRIVE target exceed the target by a combined 9%
  - In total*, each group* departs from the STRIVE target by 10s of thousands of hours per day
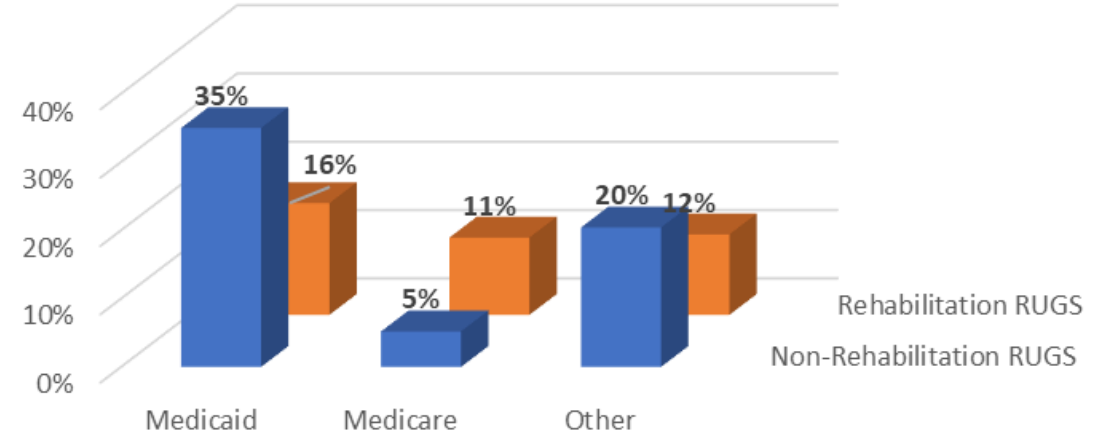 - Source: 4Q 2019 PBJs (n=625)

15

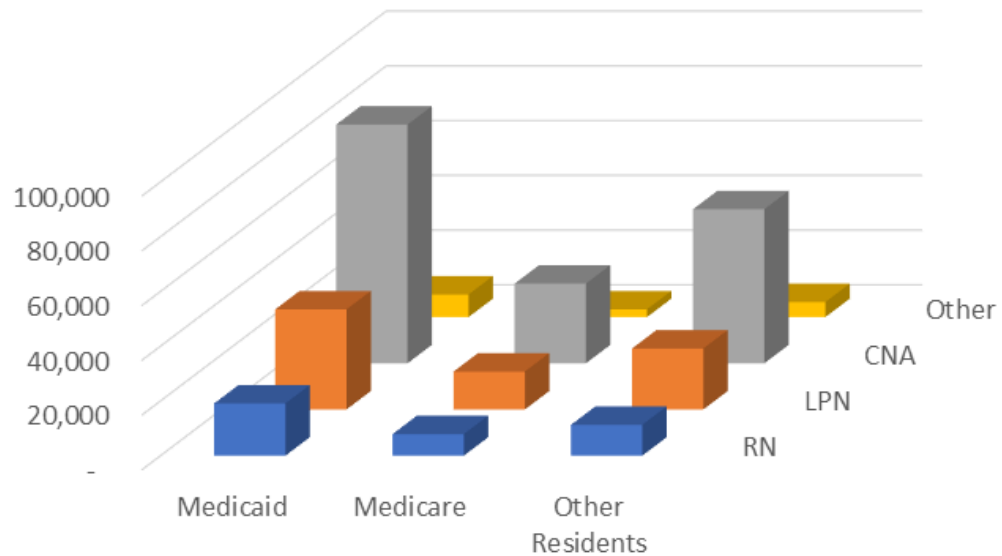# Payer and Resident Case Mix in Illinois SNFs
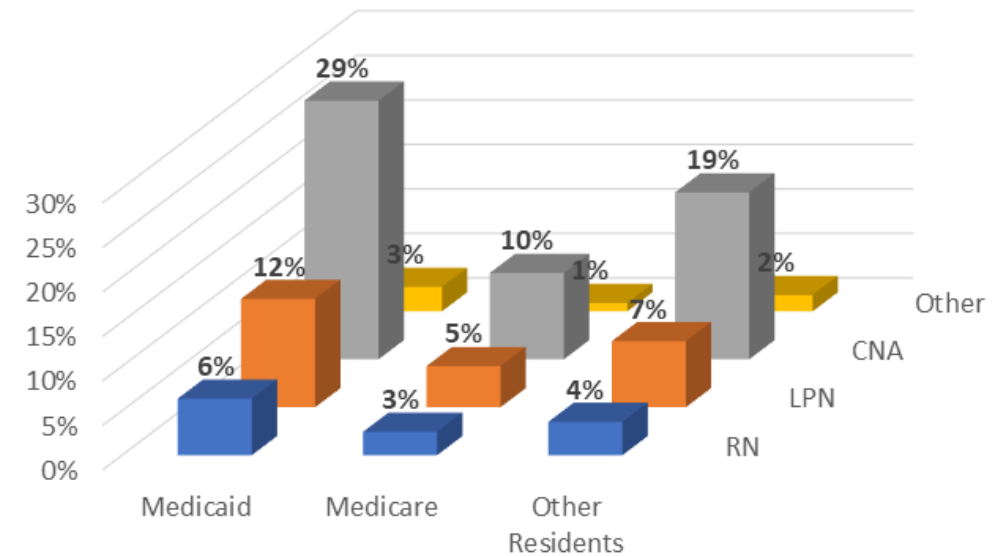## MDS 4Q 2019; 48 RUGS-IV Categories
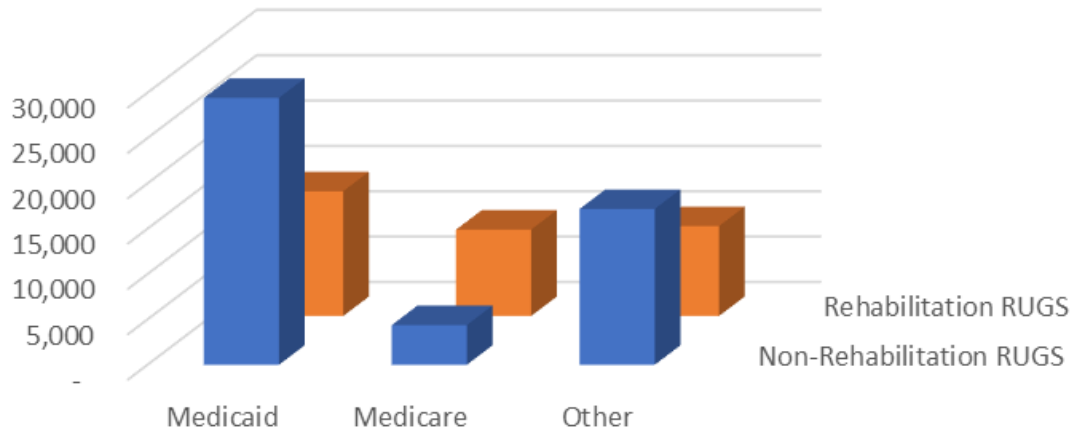
Hypothetical STRIVE-Based Staffing Hours by Payer
MDS 4Q 2019; All Direct Care Staff Time
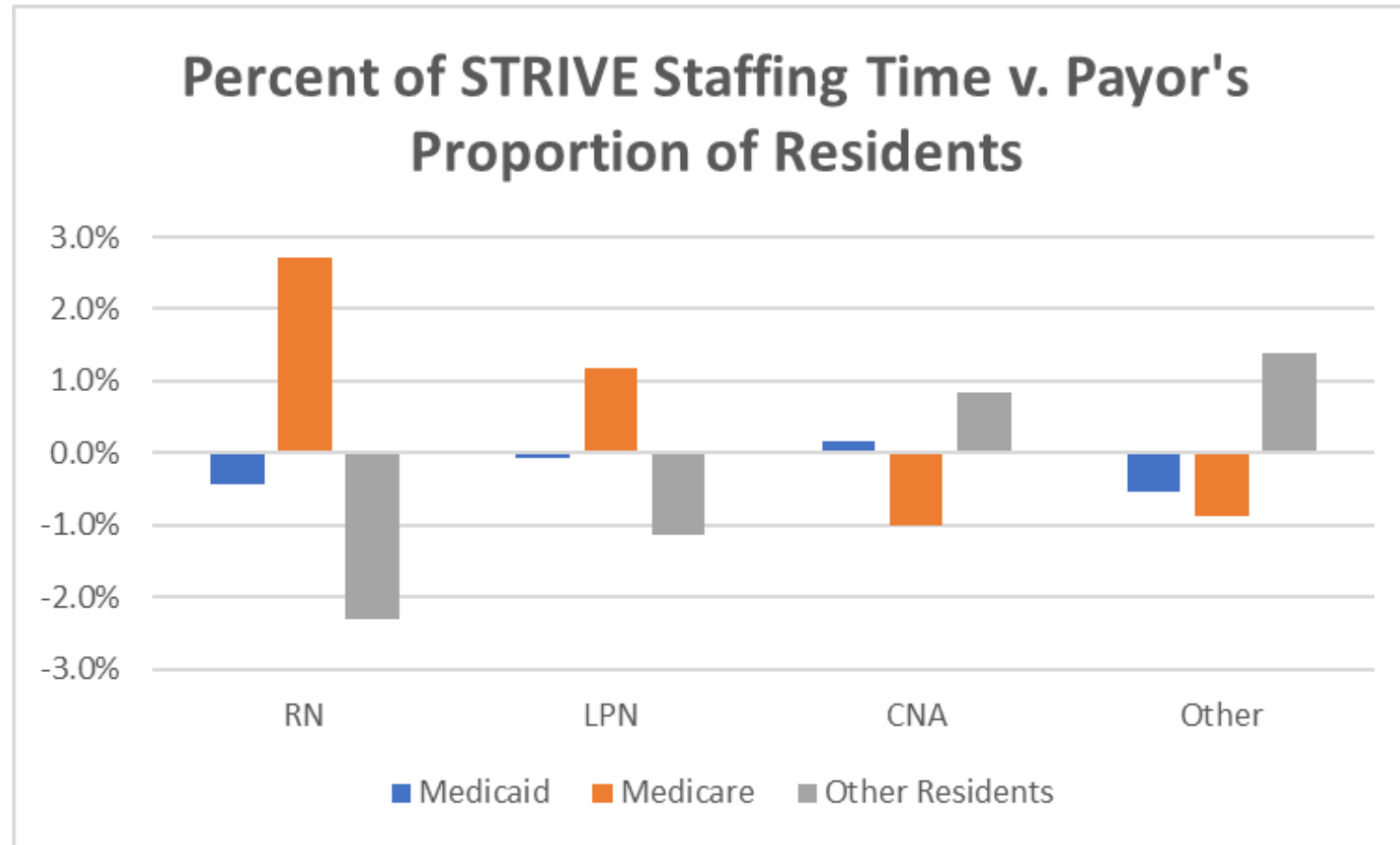

STRIVE Staffing Hours per Day

Expected Percent of STRIVE Staffing Hours

Note: Staff time by payer and resident is not tracked and recorded. These allocations are a hypothetical characterization for illustrative purposes only.

STRIVE Hours v. Resident Payer Mix
MDS 4Q 2019; All Direct Care Staff Time

Percent of STRIVE Staffing Time v. Payor's Proportion of Residents

Note: Staff time by payer and resident is not tracked and recorded. These allocations are a hypothetical characterization for illustrative purposes only.

Additional Questions about Staffing

- **Permanent v. contract staffing**
  - Attempted to use 2018 and 2019 CR data
  - SNF Staffing (RN, LPN, and CNAs) appears to be +/- ~2% "consultant"
  - Therapists only show .1% "consultant"
  - Does p. 20 of the CR reflect all contract work, or is there some classification of non-employee or shared employee reported elsewhere?
  - Is the remaining 98% employed and facility-specific, or do some reported in that category serve multiple facilities, i.e., within a system?

- **How has staffing changed in 2020?**
  - Will the decline in census in 2020 be reversed?
  - What is happening in the nursing and CNA labor markets since March?

- **Continuity**
  - Can this be measured with data that is currently reported?

- **STAR Ratings** [Next week]

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Potential Policy Objectives, Considerations and Remaining Questions

	Considerations	**Key Questions**

Potential Objective

Potential Objective	Considerations	Key Questions
Eliminate understaffing	• Poor management reduces job satisfaction, increases turnover and is difficult to fully compensate • Infection control would improve at or above minimum staffing levels	• Are low-staff NHs generally low-performing? • How to improve low-performing facilities? • What other facility characteristics affect job satisfaction (e.g., location, age, size, case mix)?
Increase staffing (broadly)	• Increasing overall staffing levels would also reduce resident assignment ratios	• How might the nursing market respond to increased demand?
Increase staffing continuity	• Continuity can be measured with turnover, retention, tenure, patient assignment durations, and resident-staff-assignment ratios	• How important is CNA turnover and can it be reduced? • Would assignment ratios inevitably improve with increased overall staffing ratios? • How tightly are staffing assignments managed?

Questions & Next Steps

- Questions and brief comment on today's content
- Potential focus for next meeting(s)
  - Non-nursing components of Medicare PDPM payments
  - STAR ratings for staffing
  - Target ratios & other staffing quality measures
- Request for content