Nursing Facility Payment Review and Redesign

Building Block #1: Staffing (Week 3)

10.15.2020

Today's Agenda

- Overview and Recap of Week 2
  - New building block
  - Non-Nursing PDPM components
  - VPD adjustment
  - STRIVE's "other" staffing category
- Questions and brief comment
- Staffing Week 3
  - Level and composition of staffing in Illinois SNFs
  - Defining continuity and assignment
- Questions and brief comment on today's content
- Next Steps and Request for content

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

Steps in the Review and Redesign Process

Building blocks in a comprehensive NF payment:

- Staffing (3 meetings)

- Quality (2 meetings)

- Physical Infrastructure

- Rebalancing

- Capacity (facilities and staffing)

- *Case Mix, Equity and Demographics (**NEW**)*

- Modeling (multiple meetings)

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

Original Objectives and Principles for Reform

Relevant to Today's Discussion on Staffing:

- **Transparent, outcome driven, patient-centered model with increased accountability**

- **Transition away from RUGS to federal PDPM case-mix nursing component**

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- **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**

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- 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
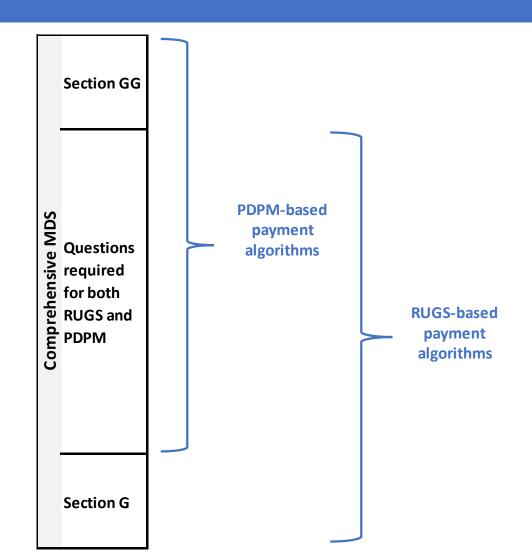
Issues and Considerations for Staffing

Today's Focus

- 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?

- **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?**

- **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?**

- 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 v. also reconciling to observed case mix over time?

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

8

State Staffing Regulations

Staffing Effort (hours/day)

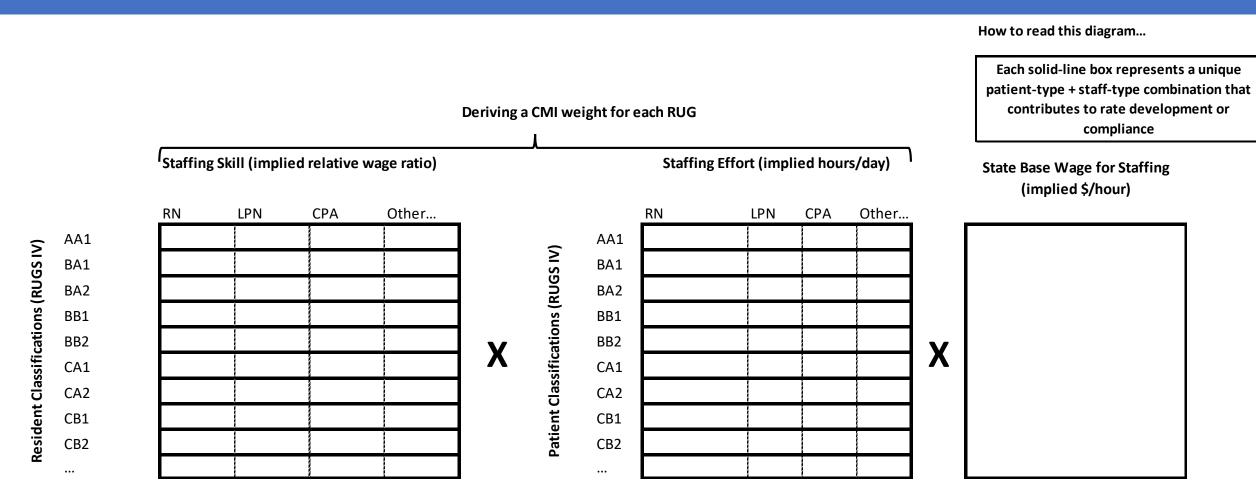|	RN	LPN	CNA	Therapy	Other...
Intermediate					
Skilled					

Resident Classifications

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

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

State Base Wage for Staffing (implied $/hour)

Staffing Skill (implied relative wage ratio)

Resident Classifications (RUGS IV)	RN	LPN	CPA	Other…
AA1				
BA1				
BA2				
BB1				
BB2				
CA1				
CA2				
CB1				
CB2				
…				

X

Staffing Effort (implied hours/day)

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.*

10

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

11

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
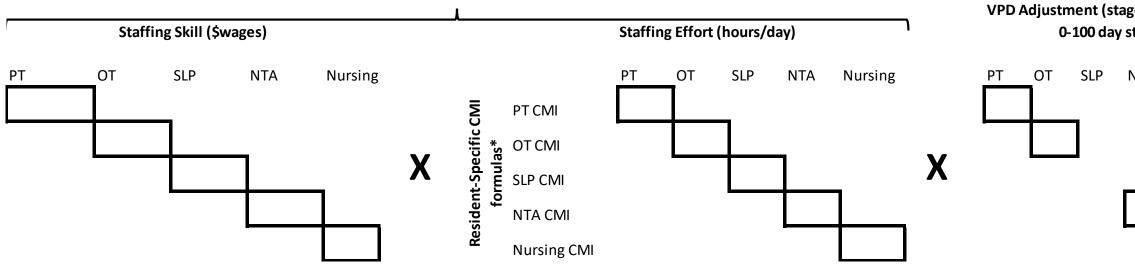- Facility's provision of care does not factor directly into payment

12

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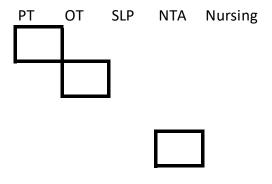## (per diem for each resident)

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

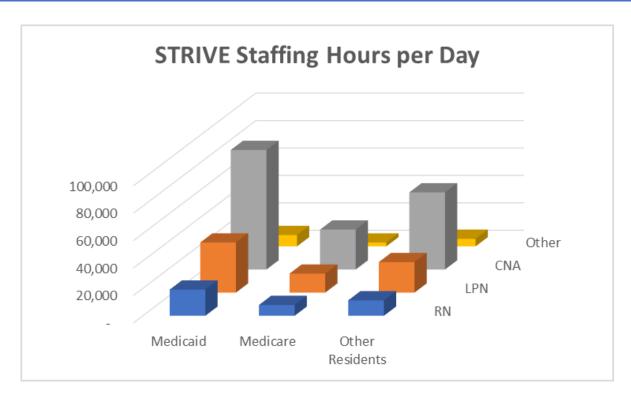CMI-adjusted rate formula for each Patient for each component ($ per day)
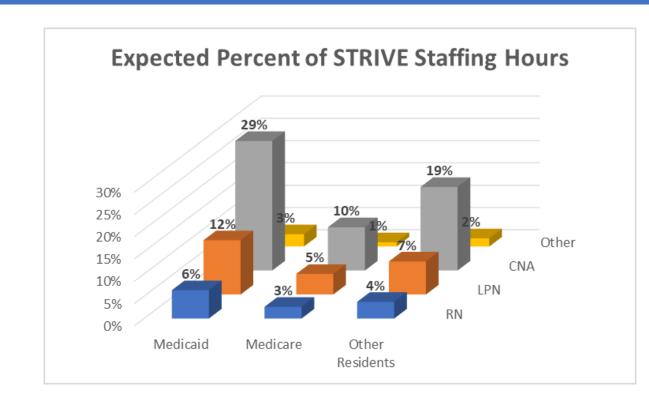
VPD Adjustment (stage w/in limited 0-100 day stay)

Staffing Skill ($wages)

Staffing Effort (hours/day)

PT   OT   SLP   NTA   Nursing

Resident-Specific CMI formulas*

PT CMI
OT CMI
SLP CMI
NTA CMI
Nursing CMI

PT   OT   SLP   NTA   Nursing

PT   OT   SLP   NTA   Nursing

X

X

Data Sources for Each PDPM Case Mix Index

	Clinical Category (ICD-10 mapped to 4 PT&OT Categories)	Functional Score (sum of ten GG item scores)	Acute Neurologic Condition	SLP-Related Comorbidity or Cognitive Impairment	Mechanically-altered Diet	Swallowing Disorder	RUGS-IV Category	NTA Comorbidity Score
PT CMI	X	X						
OT CMI	X	X						
SLP CMI			X	X	X	X		
NTA CMI								X
Nursing CMI		X					X	

We plan to revisit CMIs later in the process

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

Notes:
- Staff time by payer and resident is not tracked and recorded. These allocations are a hypothetical characterization for illustrative purposes only.
- ****NEW**** Other Staff include Cert. Med. Aide, Restor. Aide, Bath Aide, Feeding Aide, Psych Aide, Non Cert. Care Tech, Clin. Assoc., & Transportation Resp. Ther. Asst.

15

Staffing Levels in Illinois SNFs

- **Illinois is very close to the national staffing average**
  - For RNs only, both the US and IL average .38 hours per resident per day
  - For RNs+LPNs+CNAs, US averages 3.21 hours per resident per day and IL
  - 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)

16

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Staffing Composition in Cost Reports and the PBJ

- **Employee v. contract staffing in Cost Reports**
  - Attempted to use 2018 and 2019 CR data
  - SNF Staffing (RN, LPN, and CNAs) appears to be +/- ~2% "consultant"
  - Therapists only show .1% "consultant"

- **Employee v. Contract staffing in the PBJ**
  - Contract v. employee: no real difference with CR measure of nursing "consultants"
  - PBJ counts of "contracted" therapy are much higher than CR count of "consultants"
    - 78% of all therapy time (.36 hours per resident day on average) was contracted
    - There is a -.13 correlation with County NF Census and % therapy time contracted
      - Cook County's consultant therapist percentage is 69% DuPage's 70%, Lake 64%
      - Kane is at 100% and Will 91%

STAR Rating System for Staffing
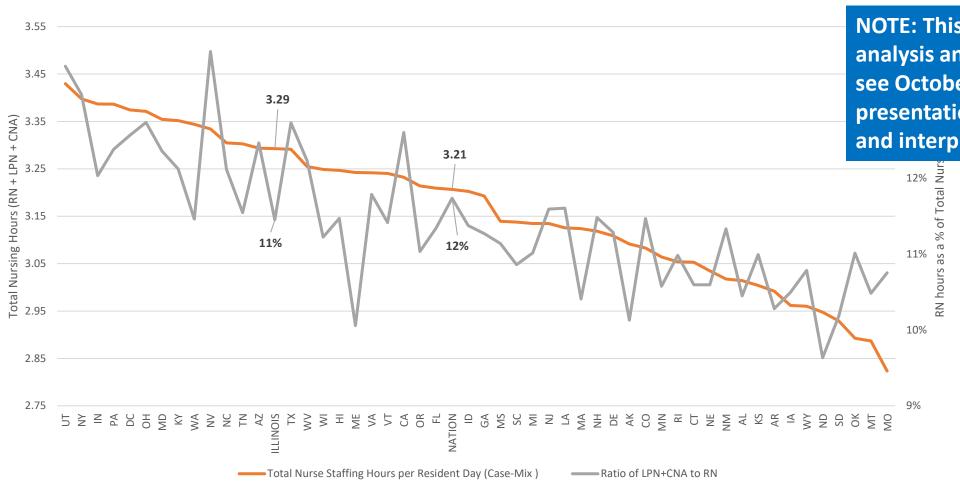## (using normalized or CM-adjusted hours/resident day)

Staffing and Rating (updated April 2019)

RN rating and hours		Total nurse staffing rating and hours (RN, LPN and nurse aide)				
		1	2	3	4	5
		< 3.108	3.108–3.579	3.580 - 4.037	4.038–4.407	≥4.408
1	< 0.317	★	★	★★	★★	★★★
2	0.317 - 0.507	★★	★★	★★	★★★	★★★
3	0.508–0.730	★★	★★★	★★★	★★★	★★★★
4	0.731–1.048	★★★	★★★	★★★★	★★★★	★★★★
5	≥1.049	★★★	★★★★	★★★★	★★★★★	★★★★★

Staffing thresholds are absolute and based on staffing-quality relationship. For inspection-based Star ratings the target distribution is:
Top 10 percentile Five Star; 10-33.33rd Four Stars; 33.34-56.66th Three Stars; 56.67-90th Two Stars; Bottom 10 percentile 1 Star)

State Rankings for Nurse Staffing Ratios
(All case-mix adjusted; source Medicare COMPARE 10.12.2020)

NOTE: This slide contains incorrect analysis and interpretation. Please see October 22, 2020 supplemental presentation for corrected analysis and interpretations.
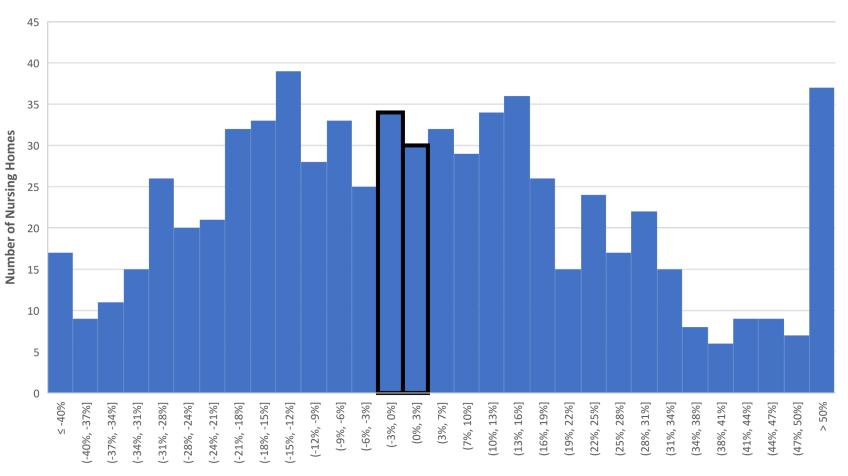
Overall staffing ratios *also* tend to have
- fewer RNs
- fewer RNs per non-RN

Illinois is very close to the national average in both

Distribution of State SNFs by % of STRIVE Staffing Target
(MDS case-mix adjusted; source 4Q2019 PBJ)

SNF staffing levels vary widely in Illinois and are not concentrated around STRIVE targets.

Raising all below-target SNFs would raise Illinois' average to #1 nationally (by far)

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Potential Payments for Retention

"The Department shall allocate an amount for staff retention. To receive the quality incentive payment for this measure, the facility's staff retention rate shall meet or exceed the threshold established and published by the Department based upon statewide averages and must be at least 80 percent.

1) Retention relates to the extent to which an employer retains its employees and may be measured as the proportion of employees with a specified length of service expressed as a percentage of overall workforce numbers.
2) The staff retentions shall reflect the percentage of individuals employed by the facility on the last day of the previous calculation period who are still employed by the facility on the last day of the following calculation period.
3) Staff retention shall be calculated on a semiannual basis.
   A. The June 30 calculation will be based on the percentage of full-time (defined as 30 or more hours per week) direct care staff employed by the nursing facility on January 1 and still employed by the nursing facility on June 30. The deadline for reporting this information shall be July 31. Direct care staff is defined as certified nursing assistants.
   B. The December 31 calculation shall be based on the percentage of full-time direct care staff employed by the nursing facility on July 1 and still employed by the nursing facility on December 31. The deadline for reporting this information shall be January 31.
4) The staff retention rate is calculated using full-time direct care staff employed in a facility.
5) Documentation in the employee's record shall support the retention rate submitted.
6) Facilities shall submit the required information to the Department in a format designated by the Department."

Source: JCAR 89(I)(d)147.345

Potential Payments for Continuity

"The Department shall allocate an amount for consistent assignments. To receive the quality incentive payment for this measure, the facility shall meet the threshold established and published by the Department based upon statewide averages.

1) Consistent assignments shall be calculated on a semiannual basis. The deadline for reporting this information shall be July 31 and January 31, respectively.
2) The facility shall have a written policy that requires consistent assignment of certified nursing assistants and it shall specify a goal of limiting the number of certified nursing assistants that provide care to a resident to no more than 8 certified nursing assistants per resident during a 30-day period.
3) Documentation shall support that no less than 85 percent of Long Term Care residents received their care from no more than 8 different certified nursing assistants during a 30-day period.
4) There shall be evidence the policy has been communicated, and understood, to the staff, residents and family of residents.
5) Facilities shall submit the required information to the Department in a format designated by the Department."

Source: JCAR 89(I)(d)147.345

Potential Policy Objectives, Considerations and Remaining Questions

What Other Potential Objectives are There?

Potential Objective	Considerations	Key Questions
Reduce 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 (or consistency), 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?

Evaluating the Potential to Improve Patient Care through Staffing Regulation and Payment

What Other Potential Roles are there?

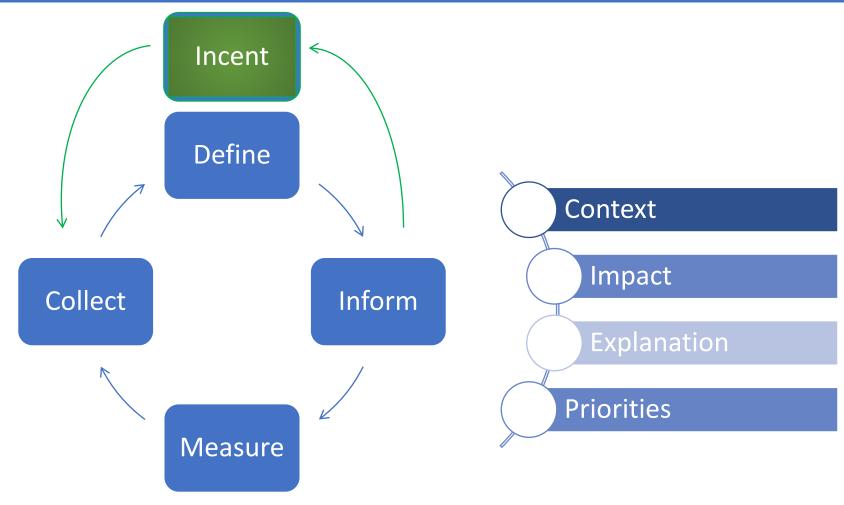| **Potential Objective**	Theoretical Roles for Regulation	Theoretical Roles for Payment
***Reduce* understaffing**	• Define regulatory minimum(s) • Penalize under-staffing	• Link payment to staffing minimums • Penalties • Link payment to employment conditions that contribute to under-staffing
Increase staffing (broadly)	• Define scopes of practice or health professions to support career pathways • Incorporate staffing levels into facility licensure reviews	• Link payment to staffing levels • Reward increases and/or higher levels
Increase staffing continuity	• Establish regulatory targets for assignment and retention • Require the adoption of staffing policies, management practices, and reporting • Penalize low continuity or retention	• Link payment to the composition, tenure and/or resident assignments of facility staff • Tie payment or incentive programs to staffing policies, management practices, work conditions, reporting, etc.

27

Developing and Using Staffing Outcomes

At what stage is Illinois for:

- **Reducing understaffing?**
- **Increasing overall staffing?**
- **Increasing continuity?**

Questions & Next Steps

- Questions and brief comment on today's content
- Next Meeting: Quality Week 1
- Request for content