Nursing Facility Payment Review and Redesign

Building Block #4: Rebalancing

12.3.2020

Today's Agenda

- Overview
- Recap
- Questions and brief comment
- Rebalancing
  - Overview of LTC rebalancing
  - Data: characterizing balance in recipient choice
  - Isolating the role of NF payment in rebalancing
- 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.

Steps in the Review and Redesign Process

Building blocks in a comprehensive NF payment:

- Staffing (3 meetings)
- Quality (2 meetings)
- Physical Infrastructure (2 meetings)
- Rebalancing
- Capacity (facilities and staffing)
- Case Mix, Equity and Demographics
- 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

Potentially Relevant to Today's Discussion on Quality:

- **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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CMS' Overall STAR Rating

Inspections   **Staffing**   **Quality**

+1 Star if:
- Staffing is 4 or 5 Stars; AND
- Staffing stars > Inspection Stars

+1 Star if:
- Quality is 5 Stars; AND
- A Staffing Star wasn't already added to a 1-Star Inspection Rating

0 Stars if:
- Staffing is 2 or 3 Stars; OR
- Staffing Stars <= Inspection Stars

Health Inspection Stars

0 Stars if:
- Quality is 2 - 4 Stars;

Overall STAR Rating (1-5)

-1 Star if:
- Staffing is 1 Star

-1 Star if:
- Quality is 1 Star

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Developing and Using Outcomes

Implications for new metrics:

- We have **less information** about them, including validation of their impact, an explanation of that impact, and the mechanisms for moving the needle
- NFs also know less, and face **risk** when spending money to move the needle
- In addition, NFs face the economic **incentive to wait** for others to solve the puzzle
- Risk and this '**tragedy of the commons**' predictably lead to collective under-investment
- So what approach should the state take with new metrics?

Incent

Define

Collect

Inform

Measure

Context

Impact

Explanation

Mechanisms

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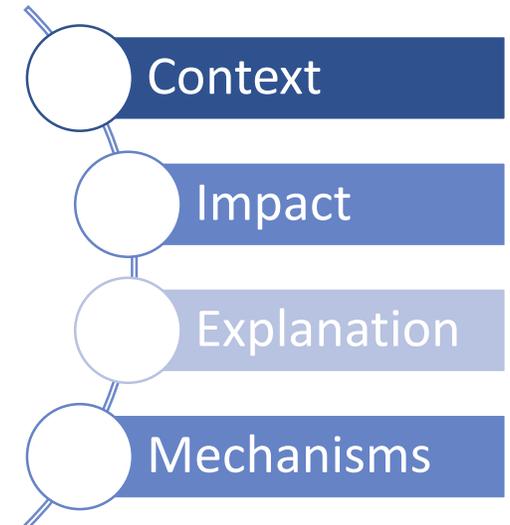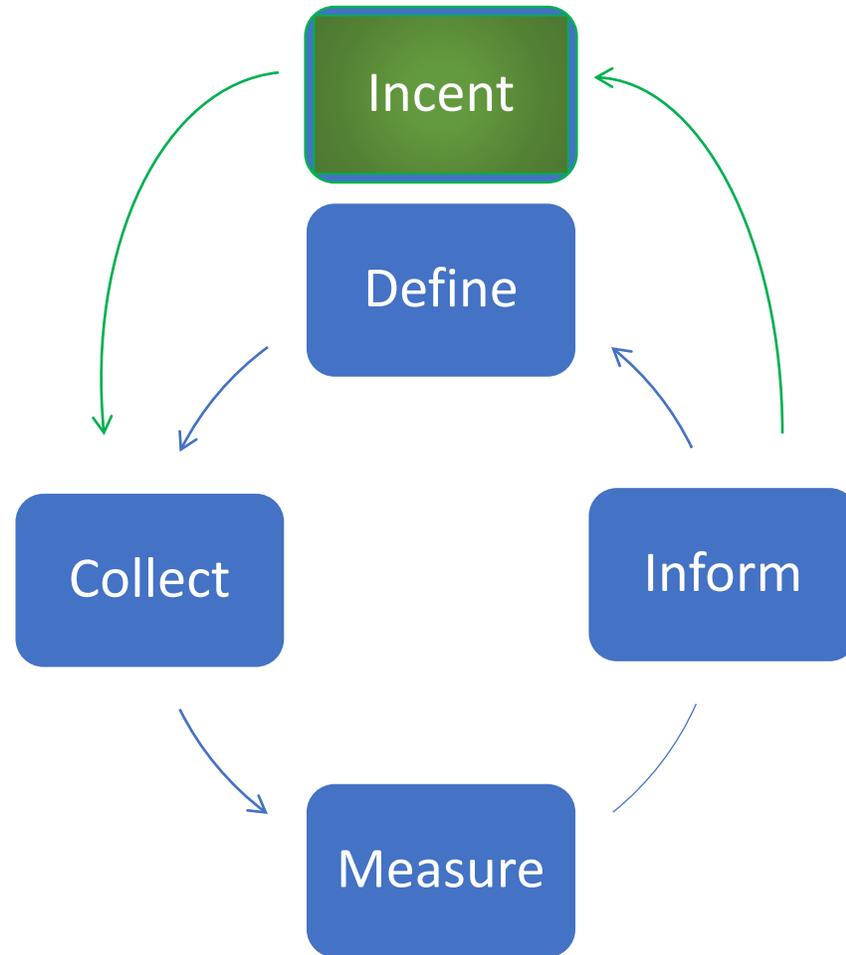
Evaluating an Outcome Measure
Examples of Policy Objectives

| Outcome Maturity	Example policy goals in incentive design
New	Coordinate/motivate broad initial investments by NFs
	Learn from investments and varying NF initiatives
Mixed	Improve overall (and top) performance
	Motivate rapid improvement & investment by low-performers
Mature	Maintain target performance; prevent degradation across many outcomes
	Bring all performance up at margin?
	Eliminate remaining under-performance

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Matching Available Levers to Outcomes
Key Questions

NF Lever*	Description	New Outcomes	Mixed Outcomes	Mature Outcomes
Payment Incentive	Dollar or percentage adjustments to (part of) the per diem	Are payment incentives flexible enough to support NF experimentation?		What is the remaining potential for improvement?
MCO LTC placement	Influence or incent community v. NF 'A' v. NF 'B' placement		What is the MCOs' role in managing NF/LTC outcomes?	
CON	Requirements for new investment		Which types of outcomes might fit this lever?	
Regulatory minimums	$ Penalties		Which outcomes work best here? Would regulations compliment payment incentives?	
Medicaid participation	Transition of all current Medicaid residents		Would any such outcome rise to this level of importance?	Which outcome(s) might rise to this level of importance?
Licensure	Transition of all current residents		Would any such outcome rise to this level of importance?	Which outcome(s) might rise to this level of importance?

*Not a characterization of current Illinois policy. Some options would require policy changes to be deployed.

How Does CMS Make SNF Quality STAR Ratings?
Metric Selection

- *Note: STAR ratings are the pre-eminent and most sophisticated example found for aggregating NF quality metrics into performance indices. Although Medicare does not use STAR ratings in payment, the final step from index to payment would be computationally straightforward.*

- CMS adds or subtracts quality metrics periodically and currently maintains a list of 34 MDS-based and 5 claims-based metrics
- STAR measures were selected from this list "based on their validity and reliability, the extent to which nursing home practice may affect the measures, statistical performance, and the importance of the measures." *– Technical User's Guide October 2019*
  - 15 of the MDS-based metrics are available only to facilities on CMS' QIES website
  - 24 remaining metrics are included in CMS' Nursing Home Compare public reporting system
  - Of these, 15 were selected for the Quality STAR Rating

How Does CMS Make SNF Quality STAR Ratings?
From Raw Data to a STAR rating

Collect Data	**Make NFs Comparable****	**Make Metrics Comparable**	**Create an Index**	**Convert to a STAR Rating***

Raw MDS Scores

&

Raw Claims Score

Exclude Residents and/or Risk Adjust, i.e., "case mix adjust"

Assign points to each metric using a linear conversion of percentile scores to either a 100 or 150 point scale

Aggregate metrics into separate point totals for Short Stay and Long Stay residents

Separately, increase the SS point total to account for the unequal number of LS and SS measures

⇨ Assign SS and LS Quality STAR ratings

⇨ Assign Overall Quality STAR rating

consistent, complete scoring

expert judgement, statistical benchmarking

policy / value judgements

policy / value judgements

policy / value judgements, transparent interpretation

*See next page
** Example to follow

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COMPARE/STAR Quality Results
Long Stay Measures

COMPARE Quality Measure	Nation	IL	IL Ranking
Percentage of LS residents whose need for help with daily activities has increased	14.5	13.7	14
Percent of LS Residents Who Lose Too Much Weight	5.5	6.2	33
Percent of Low Risk LS Residents Who Lose Control of Their Bowel or Bladder	48.4	46.1	15
Percent of LS Residents with a Catheter Inserted and Left in Their Bladder	1.8	2.1	26
Percent of LS Residents With a Urinary Tract Infection	2.6	2.9	25
Percent of LS Residents Who Have Depressive Symptoms	5.1	21.9	40
Percent of LS Residents Who Were Physically Restrained	0.23	0.19	18
Percentage of LS residents experiencing one or more falls with major injury	3.4	3.2	16
Percentage of LS residents assessed and appropriately given the pneumococcal vaccine	93.9	89.2	40
Percentage of LS residents who received an antipsychotic medication	14.2	18.3	38
Percentage of LS residents whose ability to move independently worsened	17.1	15.8	10
Percentage of LS residents who received an antianxiety or hypnotic medication	19.7	19.4	25
Percentage of high risk LS residents with pressure ulcers	7.3	7.6	23
Percentage of LS residents assessed and appropriately given the seasonal influenza vaccine	96	93.7	37
Number of Hospitalizations per 1,000 long-stay resident days	1.7	1.8	29
Number of outpatient emergency department visit per 1,000 long- stay resident days	0.96	1.02	25

Source: COMPARE "State US Averages" as of 9/1/2020 (based on 2019 data)

COMPARE/STAR Quality Results
Short Stay Measures

COMPARE Quality Measure	Nation	IL	IL Ranking
Percentage of SS residents assessed and appropriately given the pneumococcal vaccine	83.9	74.6	38
Percentage of SS residents who newly received an antipsychotic medication	1.8	2.1	31
Percentage of SS residents who made improvements in function	68	63	36
Percentage of SS residents who were assessed and appropriately given the seasonal influenza vaccine	82.9	74.1	39
Percentage of SNF residents with pressure ulcers that are new or worsened	1.4	1.5	22
Percentage of SS residents who were re-hospitalized after a nursing home admission	20.8	22.1	31
Percentage of SS residents who had an outpatient emergency department visit	10.3	10.1	15
Rate of successful return to home and community from a SNF	N/A	N/A	N/A

Source: COMPARE "State US Averages" as of 9/1/2020 (based on 2019 data)

2013 Measure Recommendations for Incentive Program
HFS nursing advisory group's prioritized metrics

Very Important
- Staff retention / stability
- Consistent assignments
- Pressure ulcers (long stay residents)
- Re-hospitalizations

Important
- Attendance by Direct Care Staff at Resident Care Plan meetings
- Falls
- *Moderate / Severe Pain (QM)*
- Restraints
- Unintended weight loss
- Pressure ulcers (short stay residents)
- Psychoactive medication use
- Resident / family satisfaction
- Staff satisfaction
- Participation in Advancing Excellence

Somewhat Important
- Catheter use
- Person centered approaches (Care, Environment and Community)

The nurse advisory group's emphasis in 2013:
- They chose not to focus on inspections
  - Because Medicare already did?
  - Because IDPH oversight mechanisms already did?
- Thought long-stay metrics were more relevant to Medicaid
- Staffing was top of mind by this group of expert practitioners

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Nursing Facility Infrastructure

Change in LTC Facility Licensure over Time
Source: IDPH records 1999-2015
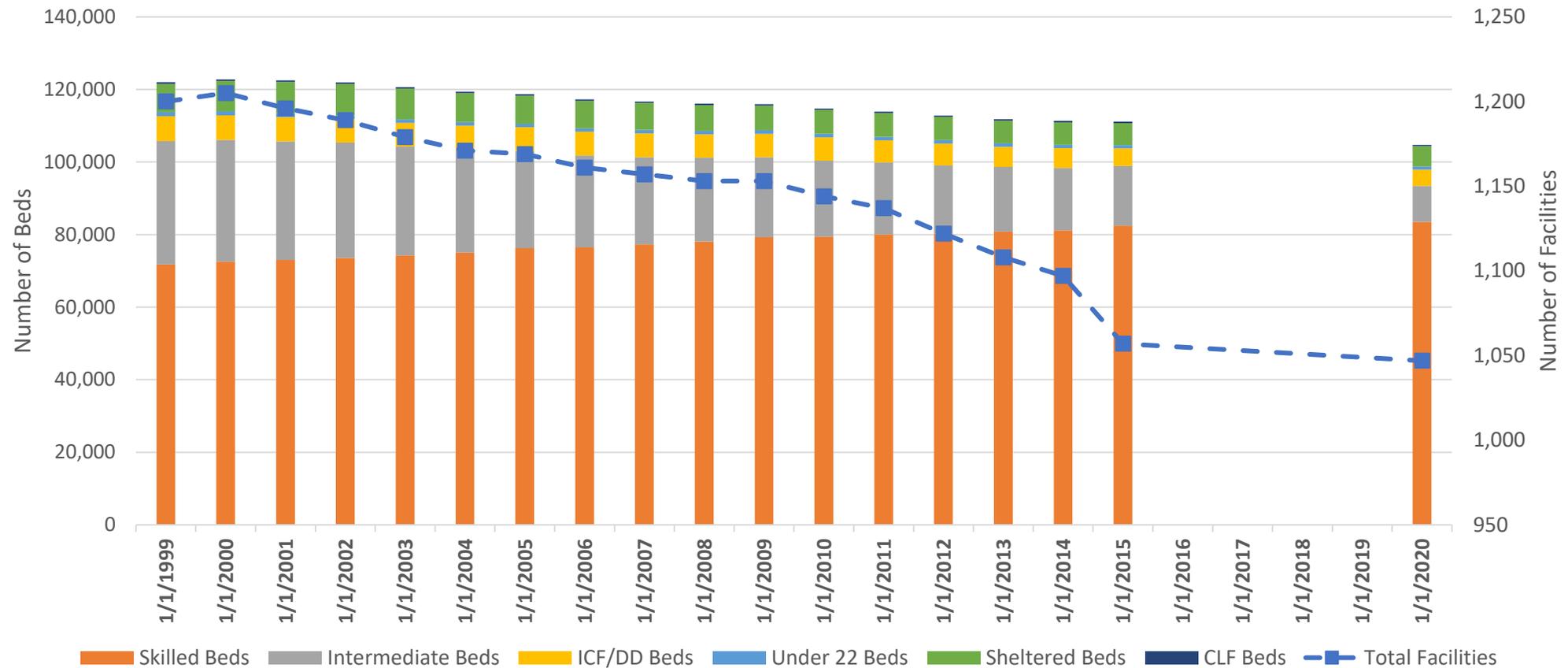
Nursing Facility Census


LTC Facility Census Decline
Data Pulled 11.10.2020
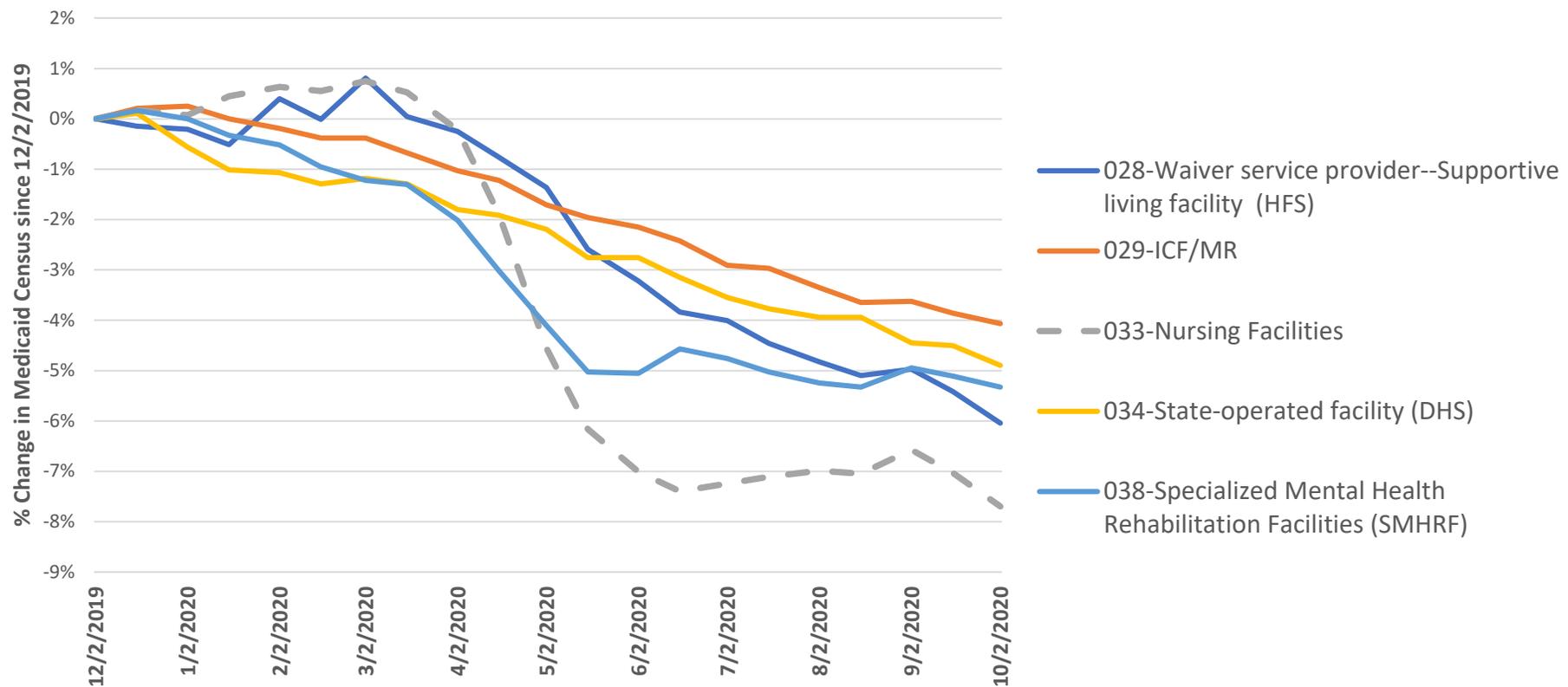
The Medicaid NF census fell with the initial spread and fatal impact of COVID and did not recover during COVID's lull

The drop of ~7-7.5% represents about 3,500 daily Medicaid residents since the beginning of March

Nursing Facility Infrastructure Age

## Cost Report Bed Counts by First (not earliest) Year of Construction Listed
Only facilities with matching p. 2 and p. 12 Bed Counts Included
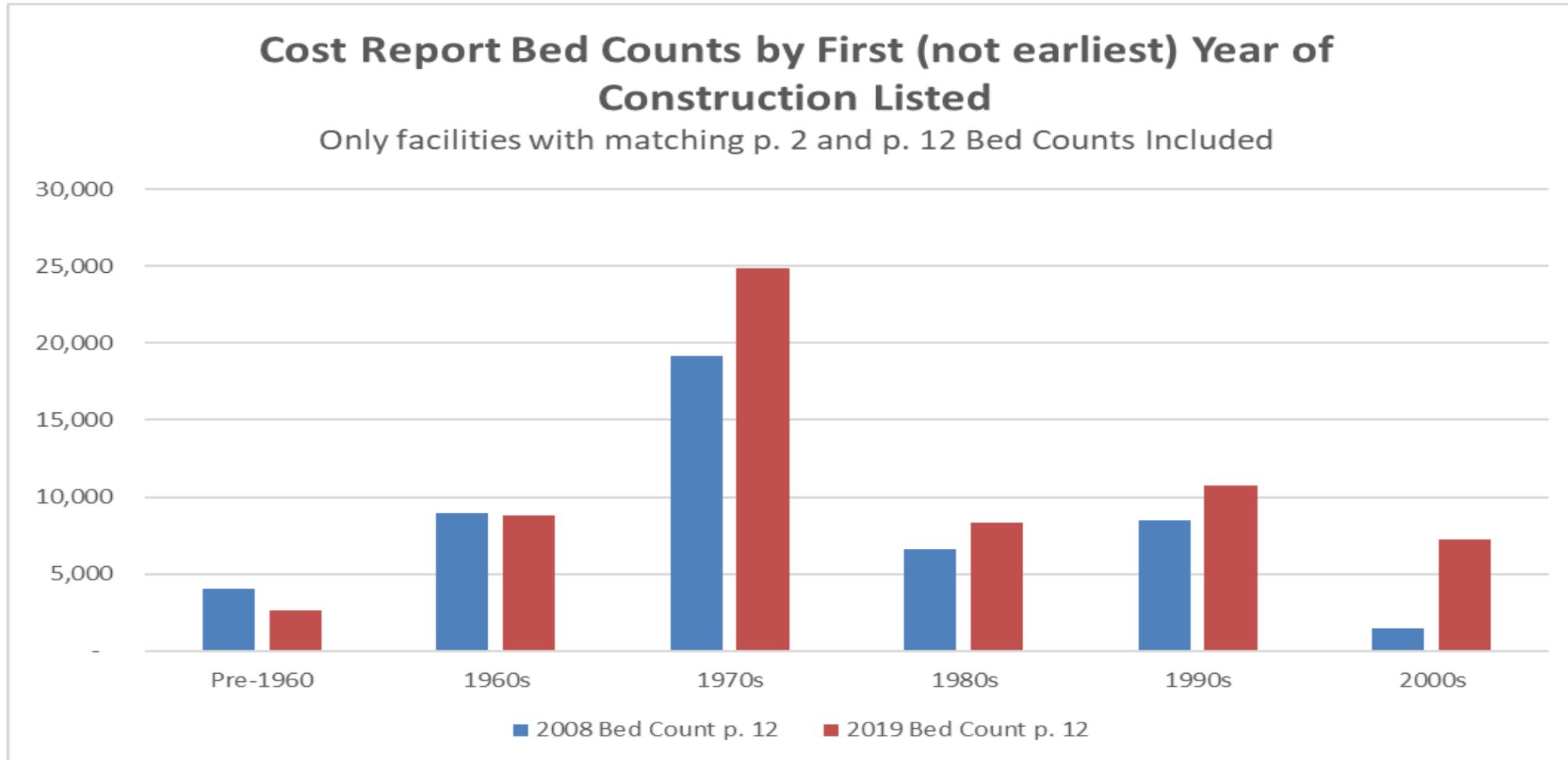
For 2019 622 facilities with 68,210 beds including 2010s and 62,565 without the 2010s.

For 2008 512 facilities and 48,675 beds.

Sources: Completed HFS 2019 Cost Reports

Concentration of Residents within Nursing Facilities
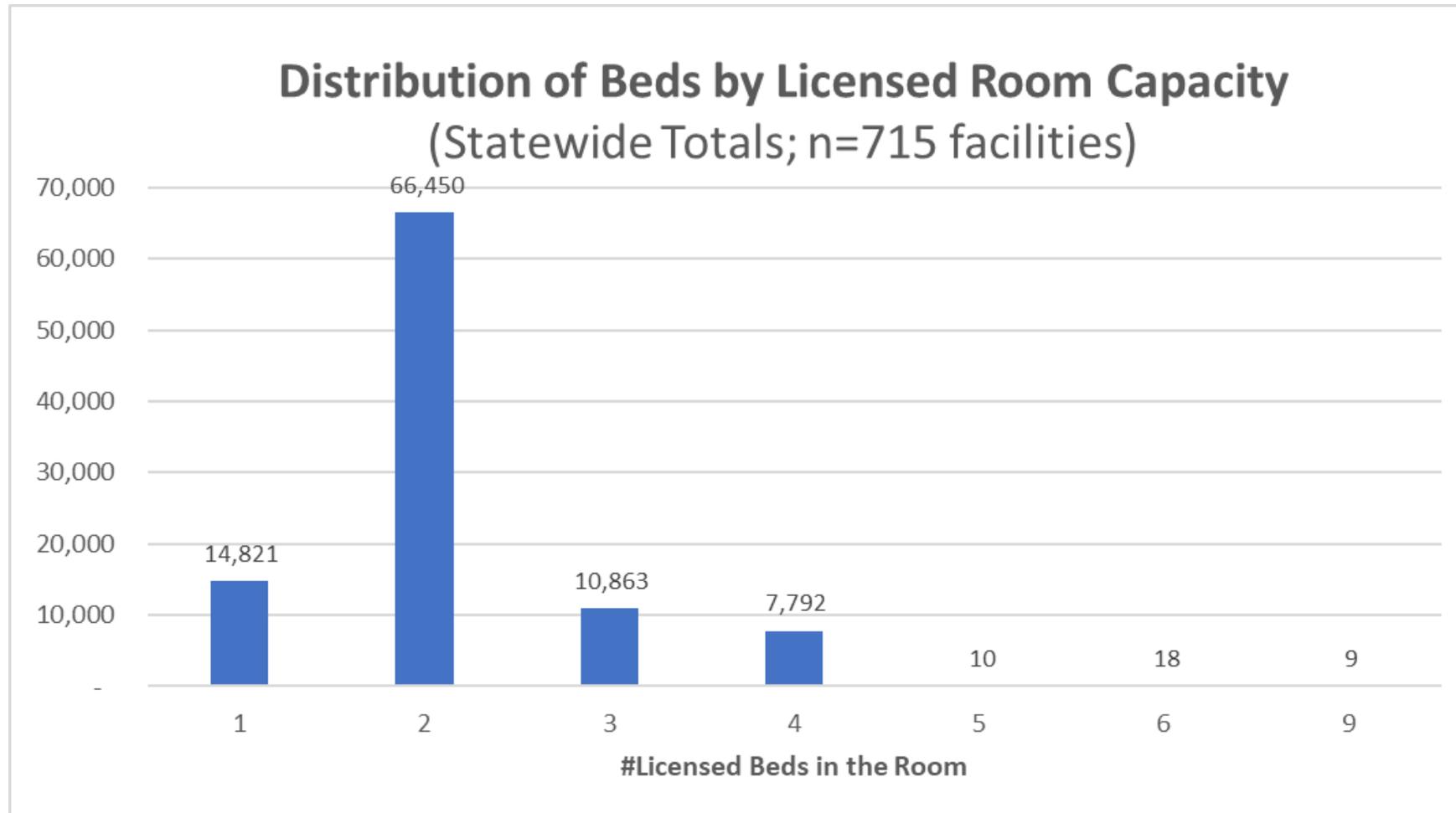
Source: IDPH licensure room count 9/2020

COVID's Impact on Illinois Nursing Facility Residents in Wave 1

Likelihood of contracting Covid varied by type of residence (e.g., SNF v. other) and concentration of Covid cases in the area
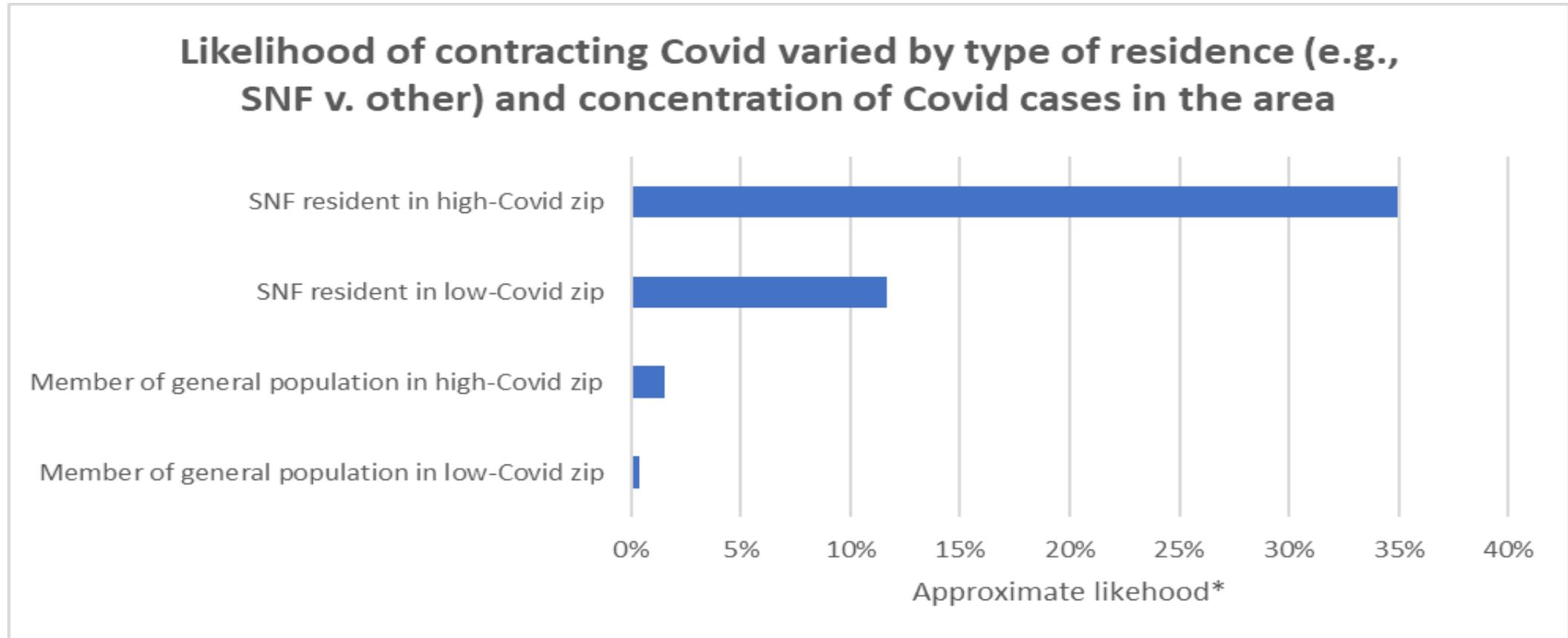
*"High" is above-average, "Low" is below. Aggregated IDPH Covid data from 6.26 for facilities and 5.29 for general population. Missing Covid data treated as zeros. Numerator is cumulative cases, not point in time. This chart (only) was prepared before the availability of 2019 resident counts and uses SNF bed counts as a denominator instead.

COVID Infections in Illinois Nursing Homes: All Skilled Nursing Facilities
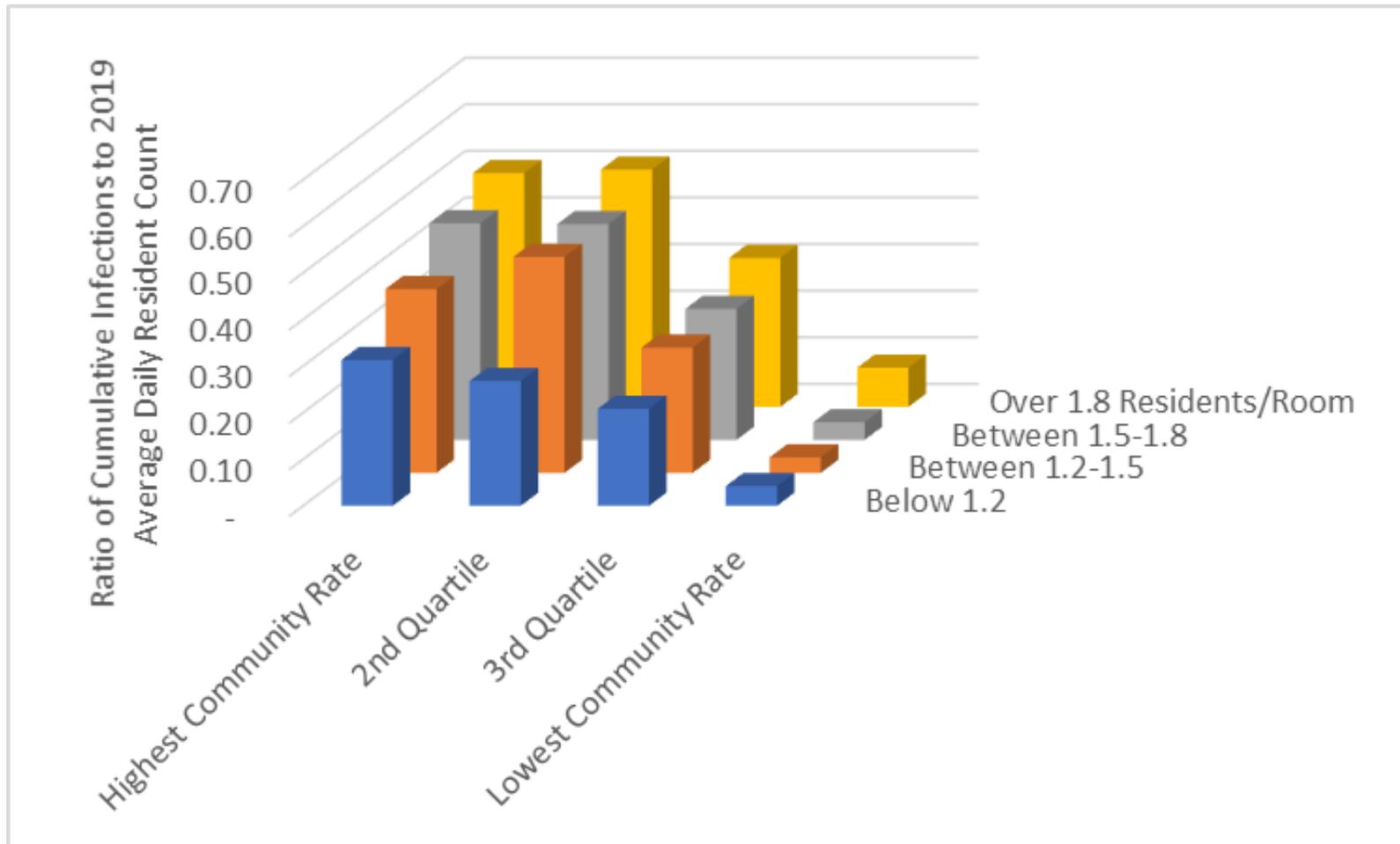
The average number of residents per room appears to explain Covid's Wave 1 spread somewhat better than total square footage.

In additional analysis (not shown), it appears that above an average of ~2.1 residents per room, COVID infection ratios may *go back down, e.g.,* to about the level observed for facilities with 1.5-1.8 per room. **In other words, infections may have peaked at 1.8-2.1 residents/room.**

Sources: IDPH Aggregated COVID Records 5/2020; IDPH Room Count 9/2020; Preliminary HFS 2019 Cost Reports

Summary of Nursing Home Infrastructure and the Spread of Coronavirus

Based on existing, though incomplete evidence:

- Community rates of infection appear to have had the greatest impact on resident infections (and presumably deaths)

- Physical characteristics of NFs appear to have had significant impact on COVID's spread
  - Resident density *within* nursing homes, especially in the form of residents/room, also appears to have had a very large impact on resident infections
  - Facility size, multi-floor facilities and Chicago-area location are all also (individually) related to Wave 1 COVID infections
  - All of these facility characteristics are correlated with each other, leaving causation uncertain
  - Resident density is strongly correlated with NF infections after controlling for *each* of the rest

- Little is known about airflow, replacement, and filtering in Illinois nursing homes – three presumptive keys to infection control for the airborne Coronavirus

- Recent guidance form the CDC/OSHA/EPA and IDPH may provide additional mitigation controls, e.g., prior to effective vaccinations

Summary of Feedback on Infrastructure

- Ideas for reprogramming funding for capital improvements
    - some states use bed buybacks
    - some states enable selling or banking of beds
    - Consider potential dilution of targeted funding (for physical infrastructure) due to independent MCO contracting process
- Illinois has one of the highest occupancy penalties in the country in its Medicaid rate, so this could be lowered
- Consider tying (formulaic components for) profit and support to infrastructure quality, e.g., different tiers for different levels of density or room occupancy
- Consider the potential complementarity (or substitutability) of
    - airflow improvements v.
    - physical redesign (occupancy) v.
    - staffing assignments (limiting internal spread)
    - …and therefore the potential to fund the three (if it's three) together, e.g., giving the choice to NFs about which path to take -- at least for purposes of infection control
- Other infrastructure considerations could include specialized beds, outdoor space and other "homelike" improvements in the physical environment such as eliminating nursing stations, room-based medication (carts?), and moving towards suite- or "neighborhood-" type pods or areas with *shared* homelike infrastructure
- Allow for the preference some may have for double-occupancy

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National Trends in Rebalancing

- Rebalancing is "achieving a more equitable balance between the share of spending and use of services and supports delivered in home and community-based settings relative to institutional care" (CMS)
- Since the 1980s, the proportion of total Medicaid LTSS spending on institutional care has decreased, and the proportion spent on home and community-based services has increased
- States vary in legal pathways to and extent of HCBS adoption.
    - In FY 2016, the proportion of HCBS expenditures within LTSS ranged from 81.2% in Oregon to 27% in Mississippi with an average of 56.6%
    - In this national tally, Illinois spent 49.4% of total expenditures on HCBS in 2016 (see HFS Annual Reports for state-level tally)
- Remaining barriers to HCBS services include lack of capacity that include shortages for specific geographic areas and populations, low public information, lack of resources dedicated to community transitions and diversions, and burdensome HCBS eligibility policies and processes
- Published research has identified rebalancing as a function of *both* increases in access to HCBS services *and* policies/programs designed to reduce NF placement

Medicaid's Journey Toward Balance and Choice
Federal Policy Changes

1959

Congress creates the Kerr-Mills program providing Federal matching funds to help states with the costs of nursing home care

1965

Congress creates Medicaid as an expansion of the Kerr-Mills program

Figure I.2: Timeline of Selected LTSS Rebalancing Legislative and Program Actions

1975 — Personal care services became a Medicaid state plan option

1981 — Social Security Act section 1915(c) (OBRA 81, Pub. L. 97-35) allows states to provide HCBS to people who would otherwise be served in an institution

1987 — Omnibus Budget Reconciliation Act (Pub. L. 100-203) requires Preadmission Screening and Resident Review process

1990 — Americans with Disabilities Act (ADA) (Pub. L. 101-336) requires states to serve people with disabilities "in the most integrated setting appropriate"

1999 — Olmstead v. L.C. prohibits the unjustified segregation of people with disabilities

2005 — Deficit Reduction Act (Pub. L. 109-171) creates section 1915(i) and 1915(j) options, and the Money Follows the Person (MFP) demonstration

2010 — Patient Protection and Affordable Care Act (PPACA) (Pub. L. 111-148) creates section 1915(k) option, extends MFP, and creates the Balancing Incentive Program (BIP)

2014 — HCBS Final Rule defines the criteria of a home and community-based setting

2017 — CMS's Meaningful Measures Initiative further guides HCBS quality improvement efforts

Source: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf

Medicaid's Journey Toward Balance and Choice
HCBS's Increasing Share of LTC Spending Nationally

(CMS, 2020)

Figure I.3. Medicaid HCBS and institutional LTSS expenditures as a percentage of total Medicaid LTSS expenditures, FY 1988 to 2018

Source: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf
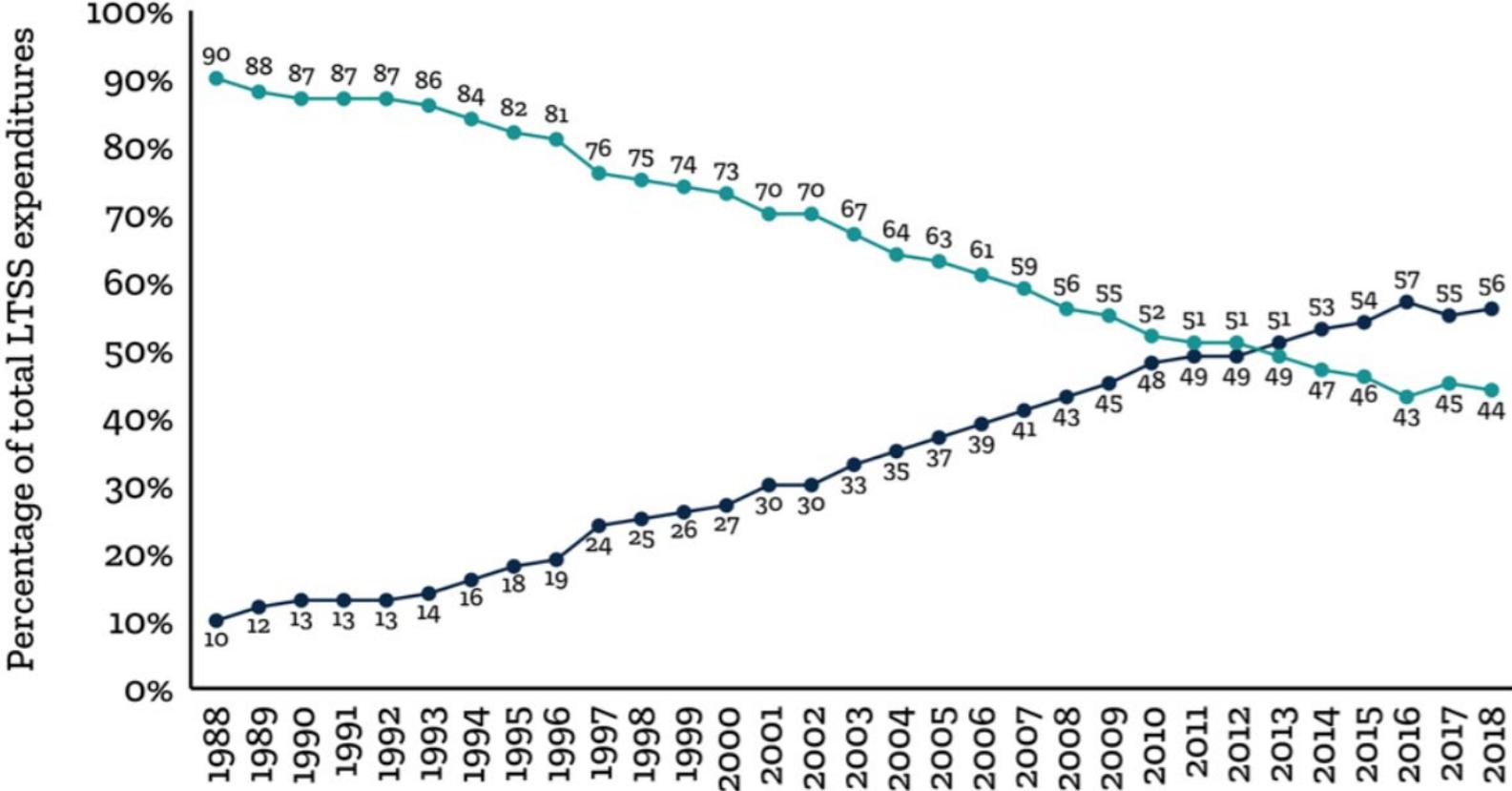
Rebalancing in Illinois
HCBS's Increasing Share of LTC Spending

LTC and Home and Community-Based Services (HCBS) Expenditures

State Fiscal Year	Total LTC Expenditures	Total HCBS Expenditures	% of Expenditures for HCBS Services
2010	$3,914,893,414	$1,464,254,044	37.40%
2011	$4,795,106,902	$1,863,593,405	38.86%
2012	$4,047,496,360	$1,870,323,894	46.21%
2013	$4,697,974,907	$1,937,032,337	41.23%
2014	$4,753,731,217	$2,047,212,673	43.07%
2015	$4,285,410,655	$1,904,597,533	44.44%
2016	$4,033,112,614	$1,844,756,004	45.74%
2017	$3,575,144,457	$1,650,610,488	46.17%
2018	$3,621,178,629	$1,719,559,617	47%
2019	$3,071,946,212	$1,585,848,577	51.62%

Table does not reflect services received in a given year. Expenditures are reported for all agencies as reflected in the CMS-64 quarterly claim totals as submitted to Federal CMS. Fiscal year totals include adjustments made for services received in previous years.

Rebalancing in Illinois

- Illinois was recognized as one of the top 10 states in making progress on rebalancing in terms of HCBS as a percentage of total LTSS expenditures between 2012-2016
  - During this period, Illinois leveraged federal incentives to expand access to HCBS.
  - As of 2019, roughly half of LTSS expenditures were dedicated to HCBS

- In the last two decades, Illinois has been subject to several lawsuits resulting in consent decrees which require the state to provide the opportunity for care in the most community-integrated setting possible

- The Choices for Care program and Coordinated Care Unit (CCU), as well as PASRR, are also designed to screen and 'deflect' institutionally-qualifying individuals to the community

- Illinois requires managed care plans to cover nursing facility services, home health services and some HCBS waiver services

- MCO enrollment tends to follow LTC placement since pre-LTSS coverage is more likely through Medicare via Shared Savings Program health plans for duals

- Like many other states, Illinois MCO capitation rates for members receiving LTSS incorporate an escalating risk-adjusted target ratio of HCBS v. NF recipients

MCOs' Role in Rebalancing
Programs and approaches from Illinois and Elsewhere

- Clear assignment of responsibility to MCOs with the lead role in diversion and transitions

- Assessment of need, member counseling and modified plans of care for NF residents
  - Use of tools such as the RAI
  - Deference to inherited POCs
  - Initial assessment and in-person screenings by care coordinators for new enrollees already in NFs
  - Periodic (e.g., annual) assessment of candidates for transition to the community
    - Often non-specific language/guidance for MCO identification of potentially transition-able residents
    - Sometimes specific commitments to regular and more frequent reviews/screens of resident needs
  - Opportunistic outreach and queries of member interest in community care
  - Some POCs could include services for residents in addition to the care NFs provide
  - Once initiated, transitions are subject to relatively stringent guidelines and prescribed steps to ensure continuity of care to a community setting

- Diversion to community care for at-risk members
  - Classification of potential candidates (e.g., experiencing declines in care or acute events)
  - Regular, automated monitoring/surveillance and systematic follow-up
  - Interventions to possibly include pro-active increases in community-based care, home modifications, and community integration support (employment, social activity, housing, etc.)

- Internal MCO scorecards and performance monitoring of screenings, diversions, transitions, overall rebalancing, etc.

- NF provider performance incentive programs, e.g., $PMPM, local news & provider directory distinction

MCOs' Role in Rebalancing
Illinois Contract Language on Institutional Transitions

- **5.18 TRANSITION OF CARE**
  - 5.18.1 Transition-of-Care process. Contractor will manage Transition of Care and Continuity of Care for new Enrollees and for Enrollees moving from an institutional setting to a community setting. Contractor's process for facilitating Continuity of Care will include:
    - identification of Enrollees deemed critical for Continuity of Care;
    - communication with entities involved in Enrollees' transition;
    - Stabilization and provision of uninterrupted access to Covered Services;
    - assessment of Enrollees' ongoing care needs;
    - monitoring of continuity and quality of care, and services provided; and
    - medication reconciliation.
  - 5.18.4 Transition of Care for new Enrollees. Contractor will identify new Enrollees who require transition services by using a variety of sources, including:
    - prior claim history as provided by the Department;
    - IPoC provided by the previous Contractor;
    - health-risk screenings completed by new Enrollees;
    - Providers requesting information and service authorizations for Enrollees (existing prior authorizations for new Enrollees shall be honored by Contractor);
    - communications from Enrollees; and
    - communication with existing agencies or service Providers that are supporting Enrollees at the time of transition.

7.23 Community Transitions Initiative Incentive Arrangement

The Department shall make incentive payments to Contractor, in accordance with 42 CFR 438.6, for achieving performance targets established for the Community Transitions Initiative discussed in section 5.18.6.

- 7.23.1 For Enrollees identified to transition from an institutional setting to the community, Contractor shall complete a comprehensive transition plan that includes evidence of appropriate permanent housing and submit to the Department for Prior Approval before transitioning an Enrollee to the community. To be considered a successful community transition Contractor must document in a format determined by the Department: (1) that the Enrollee continuously resides in the community setting for a minimum of six (6) months, and (2) the activities Contractor directly undertook to be primarily responsible for the Enrollee's community transition.

- 7.23.2 For Enrollees residing in an institution identified by Contractor as having an impairment, cognitive and/or medical, so significant that community transition is not a safe and viable option, Contractor shall document the basis for that determination in a completed comprehensive community transition evaluation and submit to the Department for Prior Approval.

- 7.23.3 The Department will determine minimum performance targets for: (1) successful community transitions, and, (2) Department-approved comprehensive community transition evaluations documenting impairments that preclude transition. Contractor must achieve the performance target(s) to qualify for an incentive payment. For each calendar year, incentive payment performance targets will be specified in a counter-signed letter between the Department and Contractor.

- 7.23.4 When Contractor achieves the specified performance target for successful community transitions, the Department will make an incentive payment of $4,000.00 for each transition. When Contractor achieves the specified performance target for Department-approved comprehensive community transition evaluations documenting impairments that preclude transition, the Department will make an incentive payment of $500.00 for each approved evaluation. For subsequent successful transitions and approved evaluations, incentive payments will be paid as they are achieved.

- 7.23.4.1 The Department will pay Contractor an additional incentive payment of $500.00 upon an Enrollee's community transition date anniversary when the Enrollee has continued to reside in the community. Contractor may earn this incentive payment, for each transitioned Enrollee, up to a maximum of three such annual payments.

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Medicaid's % of General Nursing Residents Varies
(n=691 Multi-Level Facilities with >= 10 General Nursing Residents; From Health Facilities and Services Review Board 2018 Survey)
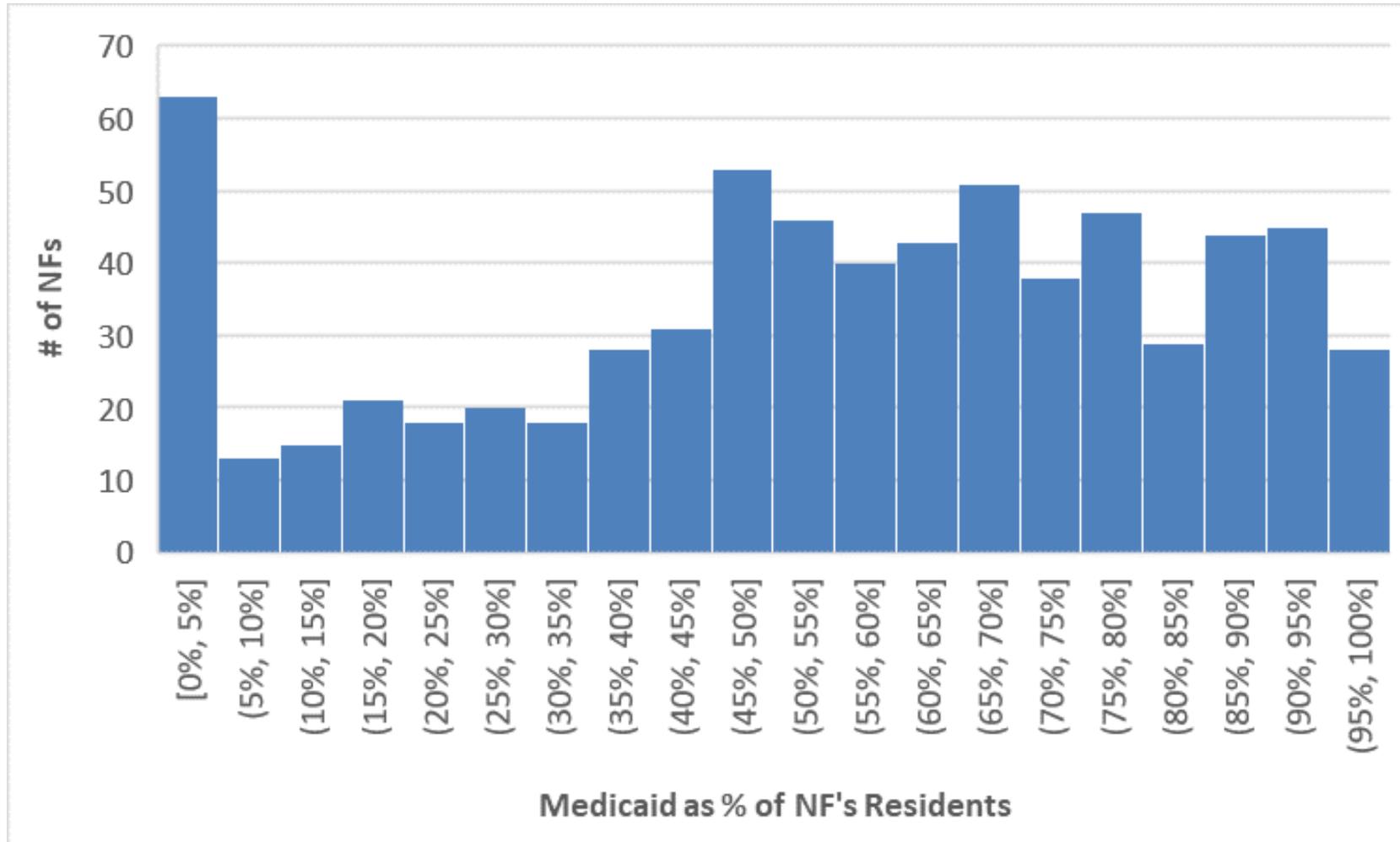
Racial Balance in Illinois NFs
(n=695 Multi-Level Facilities with >= 10 General Nursing Residents; From Health Facilities and Services Review Board 2018 Survey)
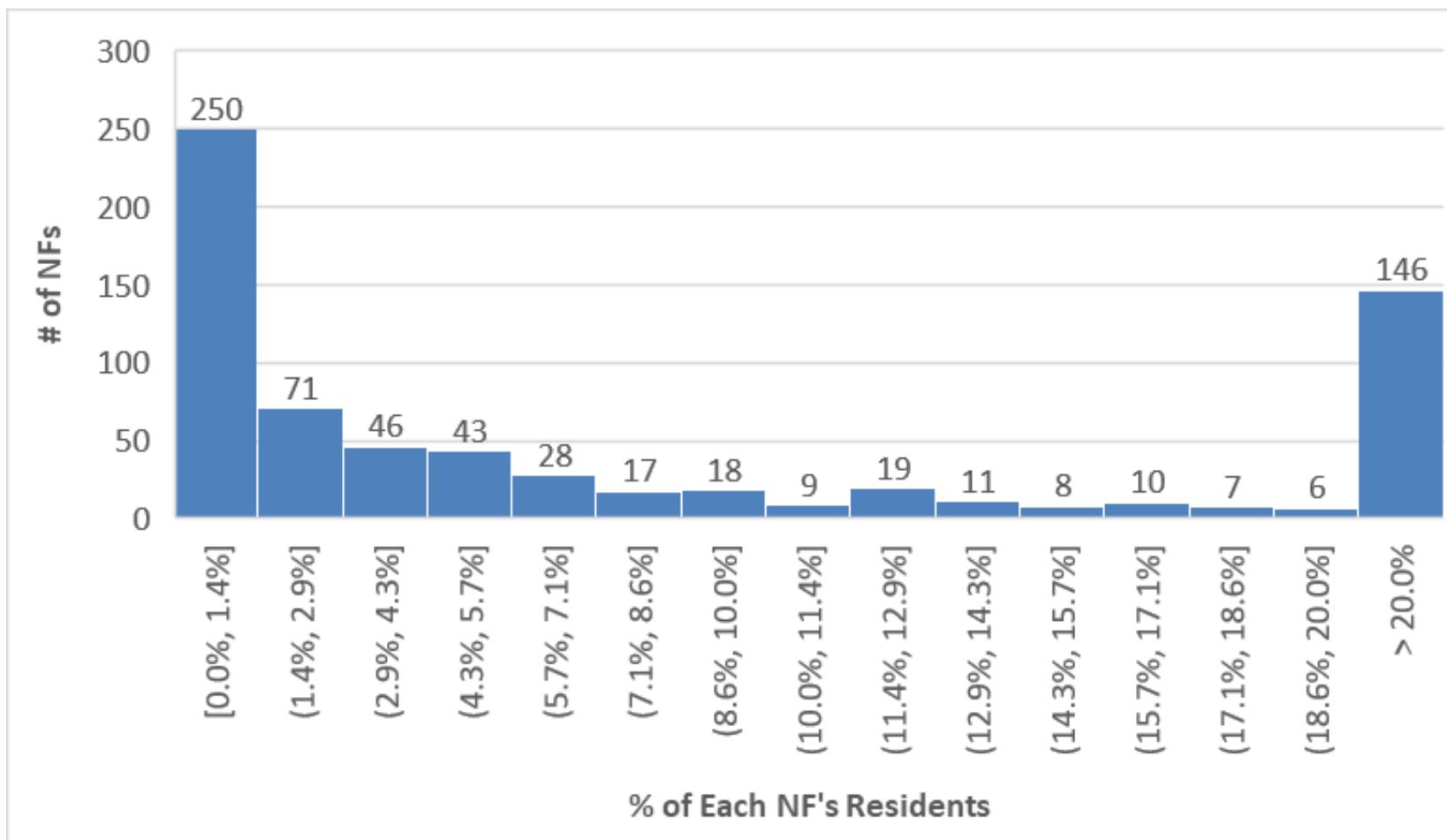
Payer and Racial Balance in Illinois NFs
(n=681 Multi-Level Facilities with >= 10 General Nursing Residents; From Health Facilities and Services Review Board 2018 Survey)
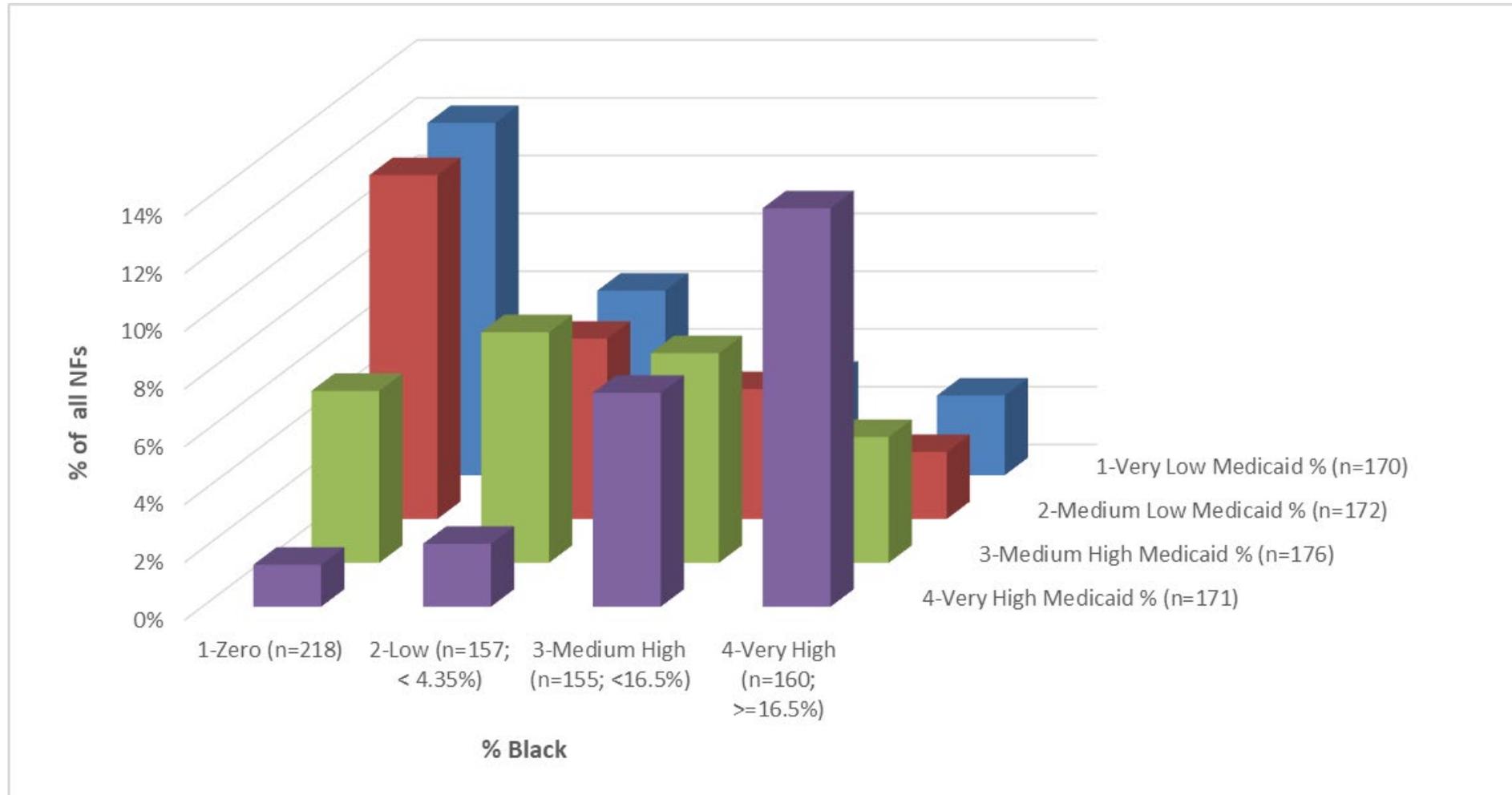
NF Admissions Restrictions
(n=691 Multi-Level Facilities with >= 10 General Nursing Residents; From Health Facilities and Services Review Board 2018 Survey)

Percentage of NFs with Various Admissions Restrictions in 2018, by Level of Medicaid Service

0-Medicaid Restricted (n=34)
1-Very Low Medicaid % (n=138)
2-Medium Low Medicaid % (n=172)
3-Medium High Medicaid % (n=175)
4-Very High Medicaid % (n=172)
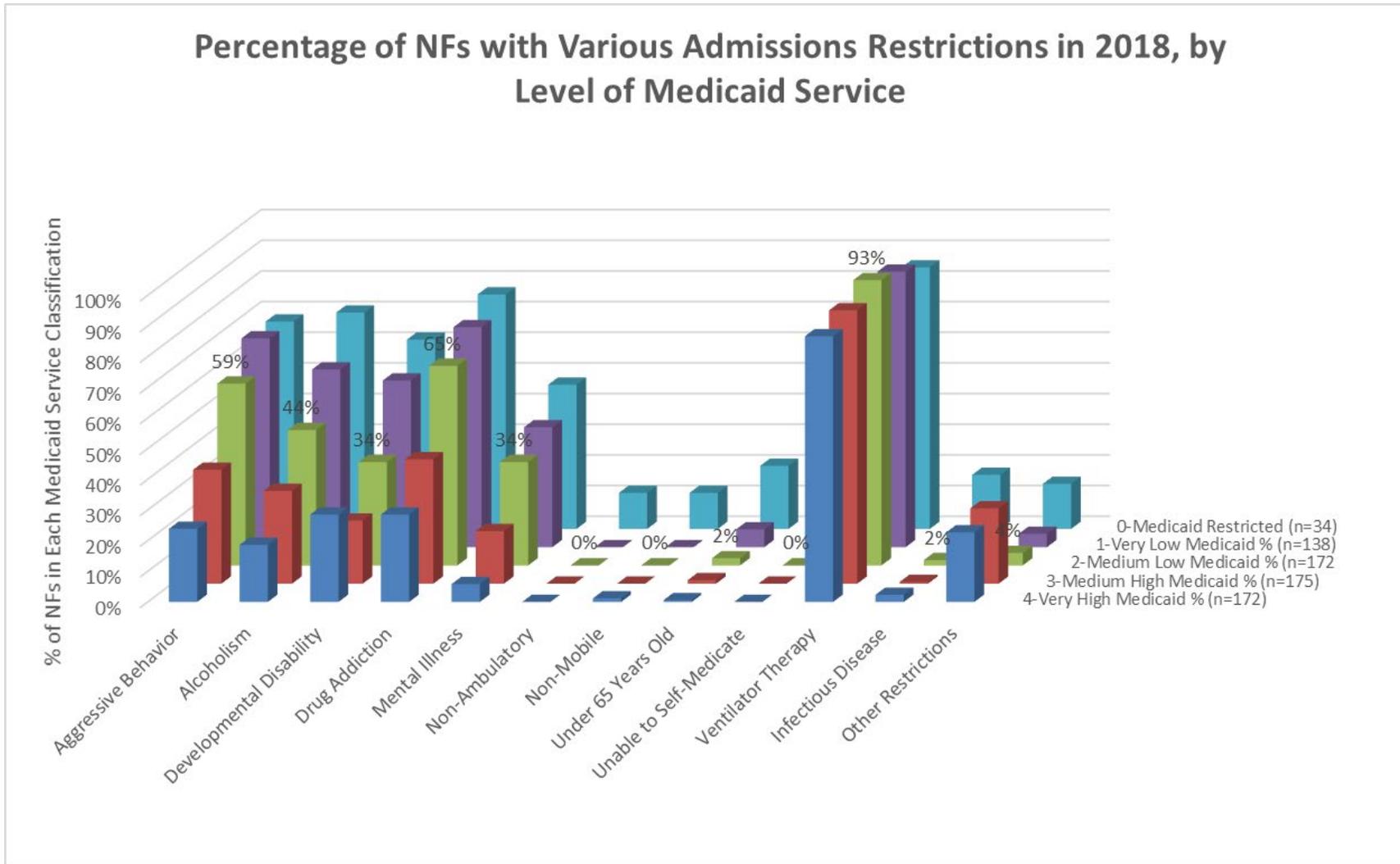
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Programmatic Role in LTC Choice and Placement

Choices For Care & PASRR Screening Process
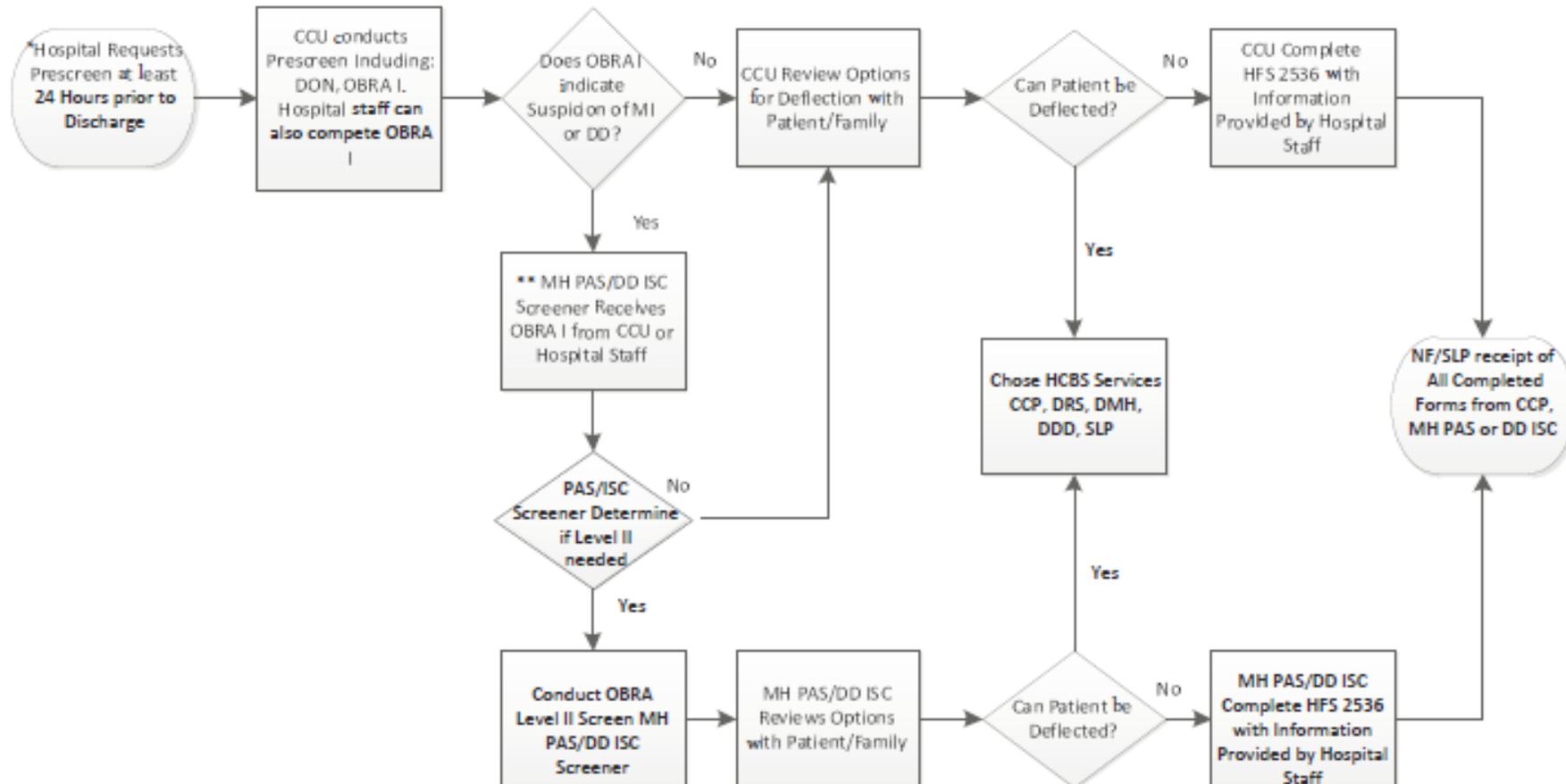
Hypothetical Profile of Institutional Qualifiers Over Time
For a Cohort of New Qualifiers

The size of each shaded area represents the proportion of this cohort of institutional qualifiers *as measured at each stage*

Community Place-*able or* Transition-*able*

Needs NF Services

Pre-Placement

Rehab Need
High | Low

5 days?

Post-Admission

Rehab Need
High | Low

Community Placed

~90 Days?

Post-Medicare

Rehab Need
High | Low

Hypothetical Profile of Institutional Qualifiers Over Time
For a Cohort of New Qualifiers

Pre-Placement

Rehab Need	
High	Low

Community Place-*able* or Transition-*able*

Needs NF Services

Hashed areas represent suggested target populations for CCU diversion/deflection effort in Lewin's 2016 evaluation of the Choices for Care program

5 days?

Post-Admission

Rehab Need	
High	Low

Community Placed

~90 Days?

Post-Medicare

Rehab Need	
High	Low

Influences on LTC Choice & Placement

Pre-Placement

- Hospital Discharge Planners
- CCU Counsel
- DON and PASRR Screens
- LTC Providers
- Anything else?

Post-Admission

- MDS
- LTC Providers
- MCOs
- Anything else?

Post-Medicare

- LTC Providers
- MCOs
- Anything else?

Hypothetical Profile of Institutional Qualifiers Over Time
For a Cohort of New Qualifiers

Pre-Placement

Rehab Need	
High	Low

Post-Admission

Rehab Need	
High	Low

Post-Medicare

Rehab Need	
High	Low

Community Place-*able or* Transition-*able*

Community Placed

How might NF payment affect recipient placement and care?

For which types of recipients?

5 days?

~90 Days?

Needs NF Services
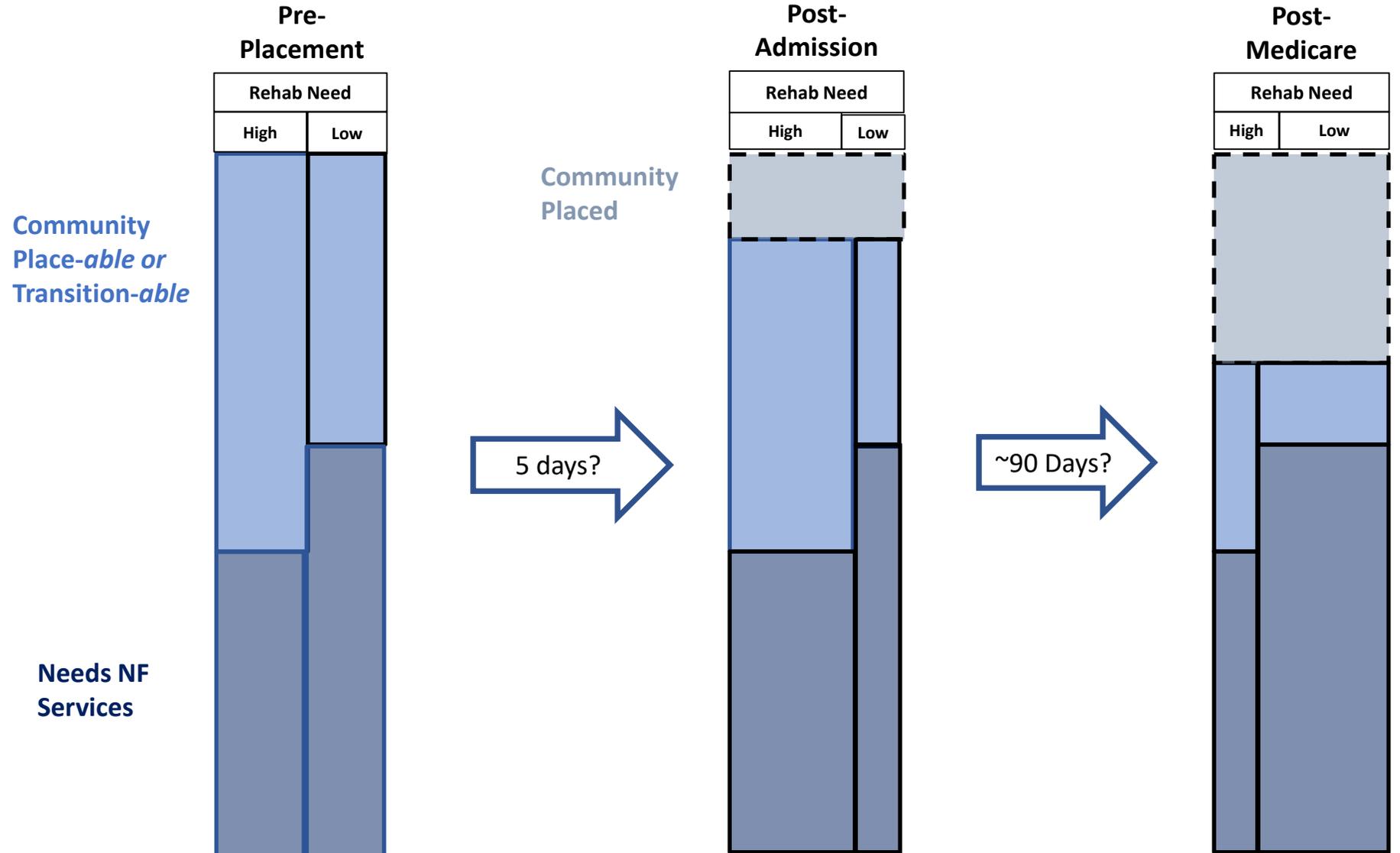
Therapy in RUGS v. PDPM

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

45

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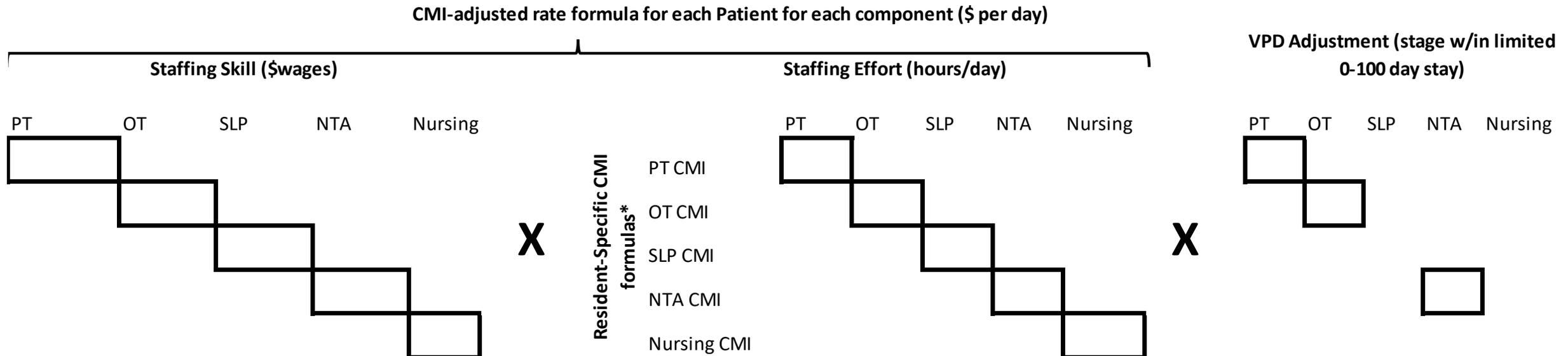
CMI-adjusted rate formula for each Patient for each component ($ per day)

Staffing Skill ($wages)

Staffing Effort (hours/day)

VPD Adjustment (stage w/in limited 0-100 day stay)

PT   OT   SLP   NTA   Nursing

Resident-Specific CMI formulas*

PT CMI

OT CMI

SLP CMI

NTA CMI

Nursing CMI

X

PT   OT   SLP   NTA   Nursing

X

PT   OT   SLP   NTA   Nursing

Today's Agenda

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Questions for Discussion
NF Payment's Role in Rebalancing

- Does the current approach to payment incent or dis-incent Medicaid admissions?
  - Of lower-needs institutional qualifiers?
  - Of higher-needs institutional qualifiers?
  - Of those expected to need only short-term rehab-focused NF care?
  - Of other types of Medicaid recipients? Which, and why?

- What changes would be necessary to render Medicaid NF payments incentive-neutral with respect to Medicaid recipients with…
  - challenging conditions?
  - little or no need for rehab?

- What is the ideal role NFs and their staffs would play in rebalancing, i.e., in achieving optimal/appropriate community placement?
  - In diversion?
  - In NF length of stay and community transition?

- Would transition incentive payments to NFs accelerate rebalancing?
  - Would transition payments (for out-placement)
  - What considerations should be given in designing and including incentives of this type?
  - Incentives or performance/quality metrics related to CCU and/or MCO referrals for transition candidates?

- Should hospitals be incented in similar fashion for diversion/deflection? Why or why not?

- What additional data analysis or collection do we need to address these questions?

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