A GUIDE TO PREPARING FOR THE CHANGING REGULATORY LANDSCAPE

Overcome regulatory hurdles and stay ahead of the pack

Analytics to Answers
PointRight®

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About the Author

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Since 2005, Paola DiNatale has been with the PointRight Inc., a healthcare data analytics company based in Cambridge, Mass. Paola provides expertise in quality improvement services and clinical program development, continuing care retirement community and single SNF facility operations analysis, due diligence, long term care survey and certification process, assisted living operations improvement, and Medicare and Medicaid reimbursement. Her master's degree is in nursing as a clinical nurse specialist in gerontology.

Introduction

The introduction of the Patient Protection and Affordable Care Act (PPACA) in 2010, more commonly referred to as the Affordable Care Act (ACA), represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. Recent regulations have put the spotlight on accelerating value-based care initiatives and they are proving to be both complex and challenging for today's long-term care and post-acute providers. This guide provides an in-depth look at some of the more pressing regulatory requirements and identifies what providers can anticipate in the coming months, while also providing steps providers can take to prepare their facility for upcoming changes.

Comprehensive Care for Joint Replacement (CJR)

CJR implementation began April 1, 2016

The CJR model holds hospitals accountable for the quality of care delivered to Medicare fee-for-service beneficiaries for hip and knee replacements and/or other major leg procedures from surgery through recovery.

The CJR model is a retrospective bundled payment model that supports the efforts of the Department of Health & Human Services to transform the healthcare system to focus on better quality of care, smarter spending, and healthier populations.

The CJR Model is implemented in 67 metropolitan statistical areas (MSAs).

A CJR episode is defined by the admission of an eligible Medicare fee-for-service beneficiary to a hospital paid under the Inpatient Prospective Payment System (IPPS), which eventually results in a discharge paid under MS-DRG 469 (major joint replacement or reattachment of lower extremity with major complications or comorbidities) or 470 (major joint replacement or reattachment of lower extremity without major complications or comorbidities). The episode of care continues for 90 days following discharge.

Beneficiaries are eligible for the 3-day qualifying hospital stay waiver and still receive Medicare covered Skilled Nursing Facility (SNF) services related to the two MS-DRGs *if* the beneficiary is discharged to a SNF that has an overall 3-star rating in the Center for Medicare & Medicaid Services (CMS) Five-Star Quality Rating Program, as reported on Nursing Home Compare (NHC).

The waiver provision begins in performance year 2: January 1, 2017.

Eligible SNFs need to have maintained a 3-Star or better in seven of the twelve months before they can admit a patient under the waiver program.

In summary, if a SNF wants to admit patients under the waiver program on January 1, 2017, it must already be a 3-Star and this rating must be maintained.

New Quality Measures

New QMs were introduced effective July 2016

Beginning July 2016, CMS will incorporate all new Quality Measures, *with the exception of the antianxiety/hypnotic medication measure*, into the calculation of the Nursing Home Five-Star Quality Ratings System.

As of April 26, 2016, Nursing Home Compare had already posted the new short stay and new long stay QMs.

- Three of these six new short stay QMs are based on Medicare-claims data submitted by hospitals and they measure rehospitalization rate, emergency room use, and community discharge among nursing home residents.
- The remaining three measures (1 short stay and 2 long stay) are MDS-based and measure improvement in function, ability to move independently worsened and *antianxiety/hypnotic medications use*.

Five of the new QMs will be introduced between July 2016 and January 2017 (*the antianxiety/hypnotic medication measure will be excluded)*.

In July 2016, they will have 50% of the weight of the current measures, and in January 2017, they will have the same weight as the current measures. These measures greatly expand the number of short-stay measures used on Nursing Home Compare from three to seven, in addition to adding important domains that are not currently covered by other measures.

The five new measures being added to the Five-Star QM domain include:

1. Percentage of short-stay residents who were successfully discharged to the community (claims-based)
2. Percentage of short-stay residents who have had an outpatient emergency department visit (claims-based)
3. Percentage of short-stay residents who were re-hospitalized after a nursing home admission (claims-based)
4. Percentage of short-stay residents who made improvements in function (MDS-based)
5. Percentage of long-stay residents whose ability to move independently worsened (MDS-based)

The introduction of the new QMs has resulted in changes to the methodology and calculations behind the Five-Star Rating System.

The methodological changes that will be introduced in July include:

- ✓ Using four quarters of data rather than three for determining QM ratings.
- ✓ Reducing the minimum denominator for all measures (short-stay, long-stay, and claims-based) to 20 summed across four quarters.
- ✓ Revising the imputation methodology for QMs with low denominators meeting specific criteria. A facility's own available data will be used and the state average will be used to reach the minimum denominator.
- ✓ Using national cut points for assigning points for the ADL QM rather than state-specific thresholds.

Reference Links

Press Release: CMS Adds New Quality Measures to Nursing Home Compare
Issue Date: April 27, 2016
Click to Download

MDS 3.0 QM User's Manual V10.0
Issue Date: April 28, 2016
Click to Download

CMS Five-Star Technical Users' Guide
Issue Date: August 1, 2016
Click to Download

Payroll Based Journal (PBJ)

Mandatory collection of staffing data begin July 1, 2016

Section 6106 of the Affordable Care Act (ACA) requires nursing homes to electronically submit staffing data to the Centers for Medicare & Medicaid Services (CMS) in a standard format, including agency and contract staff data.

The data, when combined with census information, can then be used to not only report on the level of staff in each nursing home, but also to report on employee turnover and tenure, which can impact the quality of care delivered. This system will allow staffing and census information to be collected on a regular and more frequent basis.

Voluntary reporting began October 1, 2015 and mandatory collection of staffing data began July 1, 2016.

An updated errata V2.1 has been posted on the CMS website for the PBJ Data Submission Specifications, which went into effect on June 27, 2016.

Available materials can be found on the CMS.gov website, listed under the following section: Staffing Data Submission PBJ.

While July 1, 2016 marked the start of mandatory data collection, the first mandatory reporting deadline is November 14, 2016 (for the quarter running from July 1 – September 30, 2016)

Note: CMS may use its enforcement authority for non-compliance with the requirement to submit data; imposition of civil money penalties (CMPs).

Medicare Prospective Payment System (PPS) Consolidated Billing for Skilled Nursing Facilities

Final Rule Fiscal Year 2017 published in Federal Register August 5, 2016

The final rule updates the PPS payment rates for FY 2017, as required under section 1888(e)(4)(E) and section 1888(e)(4)(H) of the Social Security Act.

In addition, it proposes to specify a potentially preventable readmission measure for the Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) Program, and makes other proposals related to that Program's implementation for FY 2019.

CMS is also proposing to adopt and implement four new quality and resource use measures for the *SNF Quality Reporting Program (SNF QRP)* and are proposing new SNF review and correction procedures for performance data that is to be publicly reported to meet the requirements of the IMPACT Act.

Posted SNF VBP measure updates as of August 5, 2016:

1. SNF-30 Day all-cause readmission measure (SNFRM-NQF#2510) final rule specifies that this measure with an all-condition, risk-adjusted potentially preventable hospital readmission rate to be replaced by the SNF-30 day potentially preventable readmission measure (SNFPPR), as the all-cause, all-condition risk-adjusted potentially preventable hospital readmission measure.
    a. The goal of this measure is not for SNFs to reach zero readmission but to identify potentially preventable readmissions that could have been avoided.
    b. This is an all claims-based measure and appropriately risk adjusts for patient case mix even among patients that may be at end-of-life.
    c. The 30-day readmission window used in both SNFRM and SNFPPR was developed to 'harmonize' with measures used in the hospital setting.

Proposed FY 2017 SNF PPS payment rate update would be an estimated increase of $800 million in aggregate payments to SNFs during FY 2017; however, final rule updates that estimated payments for SNFs are projected to increase to $920 million in aggregate payments to SNFs during FY 2017

FY 2017 proposed rule-based SNF market basket growth rate was estimated to be 2.6 percent, which is based on the IHS Global Insight, Inc. first quarter 2016 forecast with historical data through fourth quarter 2015. However Final rule denotes the revised market basket growth rate is 2.7 percent.

Click here for more information on the Final Rule.

MDS 3.0 RAI Manual

MDS Updates, including Section GG

On May 11, 2016, CMS posted a new ***DRAFT*** RAI Manual (v1.14) to allow users to preview significant changes before they become effective October 1, 2016. (Download Manual)

Following that posting, updates were made on May 26, 2016 to Appendix B of the RAI Manual which contains changes to the list of State RAI Coordinators, MDS Automation Coordinators, RAI Panel members, and Regional Office contacts. (Download Appendix B)

The following items are set to change:

Chapter 3, Section GG: Functional Abilities and Goals:

- Functional Abilities and Goals assesses the need for assistance with self-care and mobility activities; it is collected at the start of a Medicare Part A stay on the 5-Day PPS assessment and is also collected at the end of the stay on the Part A PPS Discharge assessment.
- Data collection for Section GG does not substitute for the data collected in Section G because of the difference in rating scales, item definitions, and type of data collected. Providers are required to collect data for both Section GG and Section G.

Chapter 2 and Chapter 3, Section A: Information on the new Part A PPS Discharge Assessment:

- A *Part A PPS Discharge Assessment* is required under the Skilled Nursing Facility Quality Reporting Program (SNF QRP) on planned discharges when the resident's Medicare Part A stay ends (End Date of Most Recent Medicare Stay) but the resident remains in the facility.

Suggested Tips & Advice

Critical Steps for Positioning Your Facility for Success

Comprehensive Care for Joint Replacement (CJR)

Be aware of your center's Five-Star Rating – your ranking amongst the players is not enough – knowing the areas that impact your Overall rating score is critical.

- ✓ Use the PointRight® Five-Star FastTrack™ solution to perform 'What if' scenario testing and identify survey, staffing and QM measures that can be improved upon.
- ✓ Use the PointRight® RADAR™ report to identify residents at risk for rehospitalization
- ✓ Use the PointRight® Pro30™ rehospitalization report to identify trends and rehospitalization rates relative to joint replacements
- ✓ Analyze trends, conduct root cause analysis and incorporate reporting and monitoring through QAPI process

New Quality Measures (QMs)

Enhance your understanding of these new QMs and their potential impact. Increase your awareness of your facility's QM measures and ranking when compared to both the state and the nation.

- ✓ Use the PointRight® RADAR™ report to identify residents with ADL decline, and residents at risk for rehospitalization
- ✓ Use the PointRight® Pro30™ rehospitalization report to identify trends in length of stay relative to all payer and diagnosis/cohort group
- ✓ Analyze trends and incorporate reporting and monitoring through QAPI program and communication throughout the IDT

Payroll Based Journal (PBJ)

Ensure that your data complies with the technical specifications required for submission and ensure accuracy of submission details.

- ✓ Download the PBJ policy manual (V2.1) reflecting changes to the submission guidelines and have available as reference guide

MDS 3.0 RAI

Download, read and become familiar with the changes noted to the MDS 3.0 RAI Manual draft version 1.14 and MDS coding recommended approach.

- ✓ Ensure that MDS Coordinator(s) and assessment teams are prepared and well-informed to address section GG-Functional Abilities and Goals relative to Self-care and Mobility
- ✓ Ensure MDS Coordinator and IDT is conversant regarding section A-Type of Assessment coding to identify SNF Part A-Discharge (end of Stay) assessment

Final Rule Update

Take the time to read sections of the Medicare PPS Consolidated Billing FY 2017 become familiarized with the quality reporting measures which can potentially impact operational perspectives.

Conclusion

There's no denying the complexity of these new and forthcoming regulations. Whether they focus on quality, staffing or reimbursement, it's become increasingly difficult for long-term care and post-acute providers to stay ahead of the frequent updates and specific requirements. Despite this daunting task, there's never been a more important time in our industry for providers to stay informed and "in the know". The industry's shift towards value-based care has made coordination of care across the continuum a priority and payers, hospitals, Accountable Care Organizations (ACOs) and physician groups are requiring more information (and data) on post-acute care than ever before. Providers who stay ahead of these regulations will be better equipped to successfully navigate today's new value-based world.

About PointRight Inc.

PointRight Analytics to Answers

PointRight brings visibility to post-acute and long-term care populations through predictive data analytics. Using the largest database of Minimum Data Sets (MDS) in the industry, and nationally endorsed data models, we enable our clients to manage risk, reduce rehospitalization and achieve superior outcomes. Our data-driven solution aligns both payers and providers across the continuum, accelerating the delivering of outcomes-based care. Visit www.PointRight.com for more information or contact info@pointright.com to find out what predictive analytics can do for your facility.