Understanding SNF Value Based Purchasing Programs

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Objectives

- Describe the SNF Value-Based Purchasing Program
- Understand which SNF are included in the SNF VBP program
- State the measure used in the program
- Explain how the performance scores will be calculated
- Note the time period of the program
- Know the process for reviewing and correcting data used in calculating the incentive
- Develop strategies for improving readmissions
- Discuss how telehealth can improve readmissions

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SNF PPS Final Rule Key Points

- **Effective 10/1/18**
  - Value Based Purchasing Program
  - Quality Reporting Program Penalties
  - Medicare payment rates increase by 2.4%

- **The revised case-mix methodology is called:**
  - Patient-Driven Payment Model (PDPM)
  - Effective October 1, 2019

SNF VBP Program

- Builds on previous quality measures
- Rewards SNF with incentive payment for quality care
- Pays providers based on the quality, rather than the quantity, of care they give patients.
- Started Oct 1, 2018

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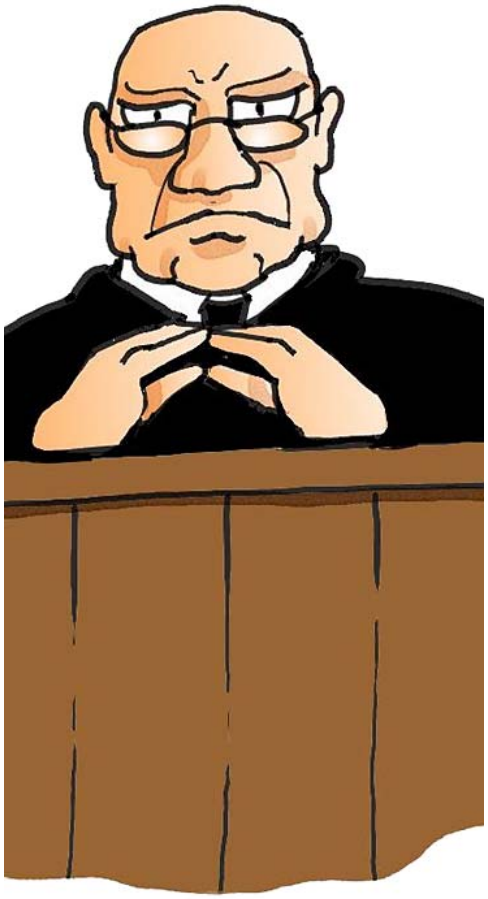
Protecting Access to Medicare Act of 2014

- **Program requirements include:**
  - Readmission quality measure
  - Performance standards
  - Scores publicly ranked from low to high
  - 2% of SNFs' Medicare payments withheld
  - Incentive payments
  - No volume exclusions
  - Confidential reporting



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SNFs Included in VBP

- All SNFs paid under the Prospective Payment System
- Include freestanding SNFs, SNFs associated with acute care facilities, and all non-critical access hospital (CAH) swing bed rural facilities.

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SNFRM Readmission Measure

- Medicare Fee-For-Service Part A Claims for inpatients at PPS, critical access, or psychiatric hospitals
- Readmissions within 30-day window from hospital discharge any cause or condition During and after SNF stay
- Hospital readmissions not SNF readmissions
- Risk-adjusted
- Excludes planned readmissions and observation stays
- The SNFRM will be in use for the FY 2019, 20 & 21

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SNFPPR

- 30 day potentially preventable inpatient readmission measure
- In the FY 2017 SNF PPS final rule, the second measure
- The SNFPPR assesses the risk-standardized rate of unplanned, potentially preventable readmissions (PPRs) from a prior hospitalization
- Propose to replace the SNFRM with the SNFPPR in future rulemaking

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SNFRM Risk Adjusted

- Patient demographics
- Principal diagnosis in the prior hospitalization
- Comorbid conditions
- Disability as the original reason for Medicare coverage
- Health service factors

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment- Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html.

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Planned vs Unplanned

- Readmission Algorithm to ID planned readmissions
- Specific list of procedures or admitting DX
- If planned procedure occurs in combination with DX that disqualifies from being planned then will be considered unplanned
- Claims based measure no additional data to be submitted

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Exclusions

- An intervening post-acute care admission within the 30-day measure window
- More than 1 day between the prior proximal hospital discharge and the SNF admission
- Discharged from the SNF against medical advice
- The principal diagnosis from the prior hospitalization was medical nonsurgical treatment of cancer, rehabilitations services or prothesis fittings

Special Exceptions

- **Low volume SNFs**

  <25 eligible stays neutral incentive multiplier

- **New SNFs**

  Zero eligible stays during baseline and performance periods neutral incentive multiplier

- **Missing Baseline Period**

  Zero eligible stays during baseline but > 25 during performance period score based only on achievement

- **Extraordinary Circumstances**

  Natural or manmade disasters if approved period of time excluded form counting RM rate

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SNF VBP Program

- 60% of the 2% held will be redistributed
- Baseline year 2015
- Performance year 2017
- Improvement score
- Achievement score
- Higher will equal performance score

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Scoring

- Achievement score compares to SNFs nationally
- Improvement score how SNFs compare to own baseline

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2015 Performance Standards

- 25th percentile = 20.41%
- Achievement Threshold 79.59%
- Mean of best decile = 16.40%
- Benchmark = 84.60%

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Achievement Score

- Performance period (CY 2017) with the performance of all facilities nationally during the baseline period (CY 2015)
- Rate ≥ benchmark (84.6%) RM Rate <16.4%:
  100 points
- Rate < achievement threshold (79.59%) RM rate >20.4%:
  0 points
- Rate between the two: 1 – 99 points
- 40% SNF rate lower under VBP then before VBP

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Improvement Score

- Comparing the facility's rate during the performance period (CY 2017) with its previous performance during the baseline period (CY 2015)
- Rate better than or equal 16.4%: 90 points
- If readmission rate for CY 2017 > CY 2015: 0 points
- Rate between the two: 1 – 89 points

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Performance Scores

- Scored based on performance during the applicable baseline period and performance period
- Higher of the Achievement or Improvements score
- Performance Period CY 2017
- Baseline Period CY 2015

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Payment

- Score = payment
- Simultaneously all SNF reduced by 2%
- Increased up to 3.65 based on your performance score – national ranking
- Net impact -2% - +1.65%
- Assigned an incentive payment multiplier
- Applies to all claims Oct 1 2018 - Sept 2019
- New multiplier each year

Incentive Payment Multiplier

- **The IPM is applied directly to your facility's adjusted federal per diem rate on each claim at step three from above.**

- **It is NOT applied after a 2% cut as it already contains the cut.**

- **An IPM of 1.00000 means you will NOT see a cut, an IPM >1 means you will see a payment increase, and an IPM of <1 means you will see a cut.**

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Nursing Home Compare

- SNF performance data for the baseline year CY 2015 is now publicly available via Nursing Home Compare

- Provide provider number, name of facility, address and 2015 CY, baseline year, readmission percent

- Aggregate = 19.002

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Nursing Home Compare

CARILION TAZEWELL COMMUNITY HOSPITAL	18.995
SOUTH ROANOKE NURSING HOME INC	17.087
MANORCARE HEALTH SERVICES-ALEXANDRIA	18.065
RICHFIELD RECOVERY & CARE CENT	18.678
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	22.219
WOODBINE REHABILITATION & HEALTHCARE CENTER	20.704
KENDAL AT LEXINGTON	18.719
MANASSAS HEALTH AND REHAB CENTER	18.399
MANORCARE HEALTH SERVICES-RICHMOND	20.711
OAKWOOD MANOR BEDFORD MEM	15.586
GOODWIN HOUSE ALEXANDRIA	18.128
SIGNATURE HEALTHCARE OF NORFOLK	18.061
THE GARDENS AT WARWICK FOREST	18.683
HEARTLAND HEALTH CARE CENTER - LYNCHBURG	18.228
HEALTH CARE CENTER LUCY CORR	17.576
RIVER VIEW ON THE APPOMATTOX HEALTH & REHAB CENTER	19.311
KINDRED TCC AND REHABILITATION-BAY POINTE	19.313
SALEM HEALTH & REHABILITATION	16.499
FRIENDSHIP HEALTH AND REHAB CENTER	18.571

Nursing Home Compare

- List of SNFs included in FY 2019 SNF VBP Program
- Incentive payment multipliers
- Rankings
- 15,306 SNFs
- 5,230 unique rankings
- SNFs with the best performance appear at the top of the list and SNFs with tied rankings are ordered by CMS Certification Number (CCN)
- Range of multipliers 0.9802457176 to 1.0164677296

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Ranking of SNF

675935	1.0164677296	1
676167	1.0164677296	1
676201	1.0164677296	1
335644	1.0163064825	441
495168	1.0163046723	442
495346	1.0163037642	443
365775	1.0163028542	444
145434	1.0162973520	445
185178	1.0162964283	446
146129	1.0162955021	447
255168	1.0162936437	448
215193	1.0162917770	449
055208	1.0162889621	450
676256	1.0162823210	451

Quarterly Confidential Feedback Reports

- Quarterly confidential reports
- Quality Improvement Evaluation System (QIES) and CASPER
- help@qtso.com.

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Performance Score Report Contents

- Cover Sheet
- Eligible Stays
- Facility Level
- Data Dictionary

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Tab 1 Cover Sheet

- **Performance period: CY 2017**
- **Baseline Period: CY 2015**
- **Provider name and number**

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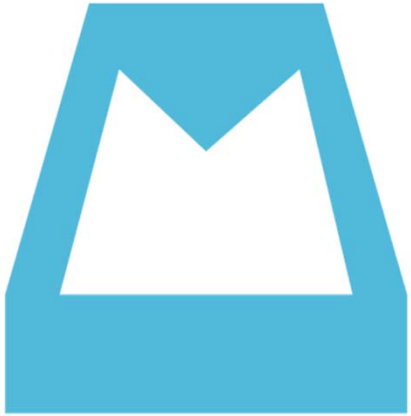
Tab 2 Eligible Stays

- **Complete list of stays**
- **Patients admitted**
  - 1/17 – 12/17
- **Submit corrections**
  - 3/31/2019
- **SNFVBPinquiries@cms.hhs.govmailbox**
- **Don't email PHI**



MAILBOX

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Tab 2 Eligible Stays

- Hospital data (claims)
- DC date
- Readmitted in 30 days
- Planned vs unplanned
- Patient characteristics used to risk adjust

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Tab 3 Facility Performance

- Achievement score
- Improvement score
- Performance score
- VBP Program rank
- Incentive payment multiplier

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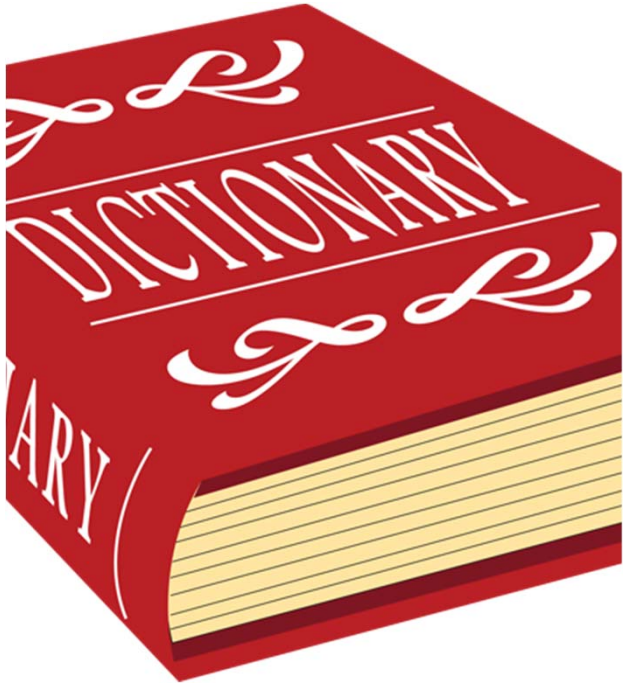
Tab 4 Data Dictionary

- Descriptions
- Definitions
- Help understand report



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Payment Adjustments

- Payment adjustments are made in the order of:

- 1) Market basket adjustment
- 2) QRP adjustment (if any)
- 3) VBP adjustment
- 4) Sequestration

Strategies

- Know and understand your data
- Who, when, diagnosis, why, MD, day of the week, post d/c SNF
- Ask patient, family, ACF case managers, ED staff, SNF staff floor nurse, aide, therapist, management
- Review chart

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Nursing Home Study

47 Nursing Home in New York

26,746 Residents

Three strongest predictors

1. Nursing communication with physicians
2. MD treat residents in nursing home, hospitalization last resort
3. Improved training for nurses and NA related to end of life care

Young Y et al. Clinical and nonclinical Factors associated with potential avoidable hospitalizations among nursing home residents in NYS. JAMDA 2011; 12:364 - 371

American Health Care Association
Lower Rehospitalization Rates

1. Use all components of Interact program
2. Understand resident's wishes and goals have discussions related to end of life care
3. Track hospitalization rates
4. Conduct root cause analysis
5. Perform risk assessment related to rehospitalization
6. Coordinate care post SNF
7. Improve nurse to MD communication

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Strategies

- Depending on what data tells
- Better handoffs
- Disease specific programs
- Provider availability

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Telehealth

Establish Telehealth goals

- **Provider availability**
- **Readmission rate**
- **Referrals readmission rate**
- **Losing referrals to competitors**
- **Quality publicly reported outcomes**
- **Transportation costs**
- **Staffing**
- **Resident/family satisfaction**

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Staff

- Senior level engagement and support
- Engage Medical Directors and front line staff
- Educate
- Champion
- Reach out to colleagues use their experiences

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Residents Served

- Demographic
- Population
- Payer

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Research

- Reimbursement
- Licensure options
- Different TH equipment
  - iPad
  - Kiosk
  - BP cuffs
  - Camera
  - EKG

Budget

- Establish budget
- Develop long term financial plan
- Equipment
- Maintenance
- Staff/Providers

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Vendors

- Prior to on-site evaluation develop tool to use in selection process
- Evaluate and select vendor by team including nurses, physicians and leadership
- Work with vendors on implementation table

Develop

- Compliant policies and procedures
- Define operational steps
- Billing process if able
- Marketing messages

Timeline

- Develop project plan
- Realistic timeframes
- Determine tasks
- Assign responsible parties
- Revisit on regular basis

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Scorecard

Based on goals

Determine what to measure and why

When to measure

Who and how to measure

Key metrics number of TH visits, MDs, patient types, reimbursable, readmissions, transportation costs, new admissions

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ROI

Based on goals

- Reduced readmissions
- Transportation costs
- Admissions new revenue

ROI

- Resident satisfaction/retention
- Access to specialists
- Rural coverage
- Provider satisfaction

Telehealth Information

MGMA Stat poll 40% of medical groups stated they are planning to offer TH this year

American Well/Harris Poll Survey nearly 2/3 patients would like PCP to offer TH

Reach Health 2017 U.S. Telemedicine Industry Benchmark Survey reimbursement and EMR systems pose two impediments

2017 Telemedicine and Digital Health Survey ¾ offer or plan to offer TH

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Successes

University of Pittsburg Medical Center since Nov 2015 avoided 140 transfer from SNF to ACF with a cost savings of $400,000

Curavi + Raven (CMS funded grant)

- 25.9% reduction in all cause hospitalization
- 27.8% potentially avoidable hospitalizations
- 40% potentially avoidable ED visits

RTI Year 3 Report - https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NFPAH2015AnnualReport.pdf

https://www.healthcarefinancenews.com/news/how-upmc-commercialized-its-curavi-health-telemedicine-technology

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Success

- **American Journal of Managed Care (AJMC) 365-bed Cobble Hill Health Center in Brooklyn, N.Y. 91 avoided hospitalizations total Medicare savings based on the 91 patients with avoided hospitalizations was estimated at more than $1.55 million**
  - **https://www.ajmc.com/press-release/afterhours-telemedicine-helps-skilled-nursing-facilities-avoid-unnecessary-hospitalizations-ajmc-study-findS**

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Summary

- Funding has changed
- Opportunity to be creative with care based on residents characteristics and not services provided
- Do you know your readmission rates?
- Why are residents being readmitted?
- What strategies have you implemented?
- Will Telehealth help?

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- Provide education
- Review SNF VBP reports
- Analyze date
- Interview residents, staff, administration, referral sources, MD
- Complete chart audits
- Determine reasons for readmissions
- Recommend strategies to reduce rehospitalizations
- Develop a plan

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Questions?

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