POST-ACUTE HOT TOPICS

Pamela Duncan, JD, CHC, CHIAP

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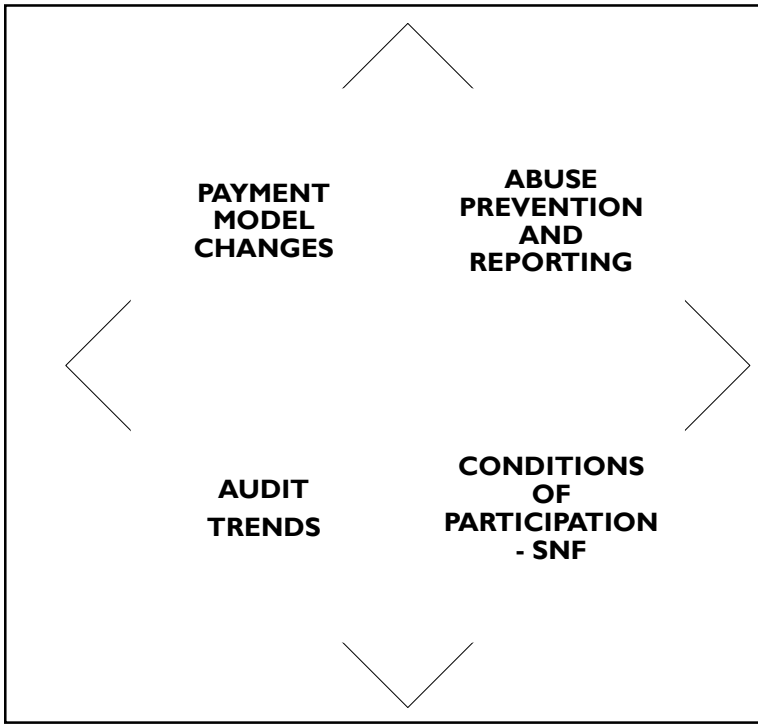

TODAY'S POST-ACUTE HOT TOPICS

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PAYMENT MODEL CHANGES

- Looking at:
  - Home Health
  - Hospice
  - Skilled Nursing Facilities
  - Inpatient Rehab Hospitals

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Patient-Driven Groupings Model (PDGM) Effective 1/1/20

"Episode" changes from 60 days to 30

Assigns 30-day periods of care into one of 432 case-mix groups

PAYMENT – HOME HEALTH

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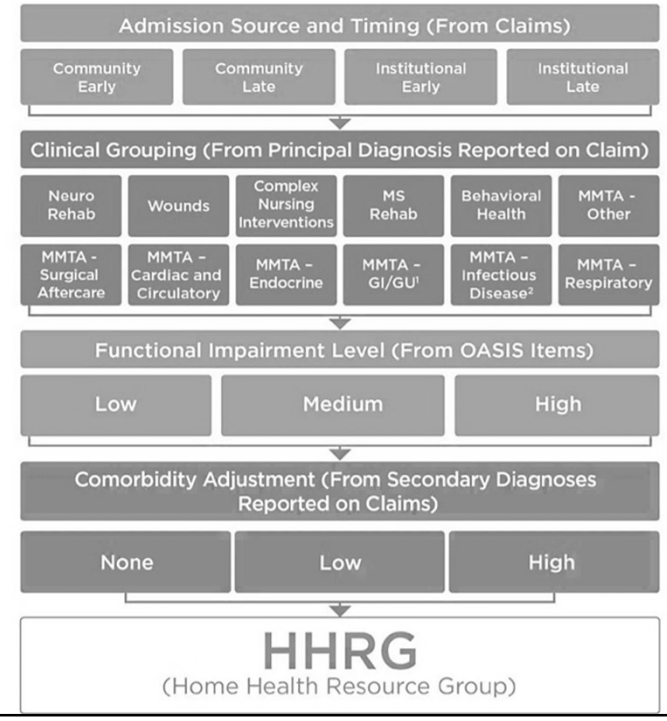

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- Low-Utilization Payment Adjustment (LUPA) changes
  - Old model: four or fewer visits per 60-day episode of care
  - New model: LUPA thresholds will vary based on the 10th percentile of visits in a 30-day period of care for each case-mix group in the PDGM

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PAYMENT - HOSPICE

- Traditionally, there were 4 levels of care/payment rates
  - Routine Home Care
  - Respite
  - Continuous Care
  - General Inpatient
- In 2016, routine home care rate was split into 2 categories:
  - Days 1-60, higher reimbursement
  - Days 61+, lower reimbursement rate
- Also in 2016, the Service Intensity Add-On (SIA) was implemented
  - Additional reimbursement during the last 7 days of a patient's life if there are sufficient staff visits

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PAYMENT - HOSPICE

- FY 2020, the reimbursement rates were rebased
  - Routine Home Care – virtually unchanged
  - Respite – significant increase
  - Continuous Care – slight increase
  - General Inpatient – significant increase
- Reasons and Results:
  - SNFs and other inpatient settings
  - Impact on Cap

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PAYMENT – SKILLED NURSING FACILITIES

- Patient-Driven Payment Model (PDPM) Effective 10/1/19
- Rate classification based on objective clinical information rather than service provision
- Established case-mix-adjustment to adequately reimburse for clinically complex patients
- Eliminates therapy 'minutes' as the basis for the therapy payment

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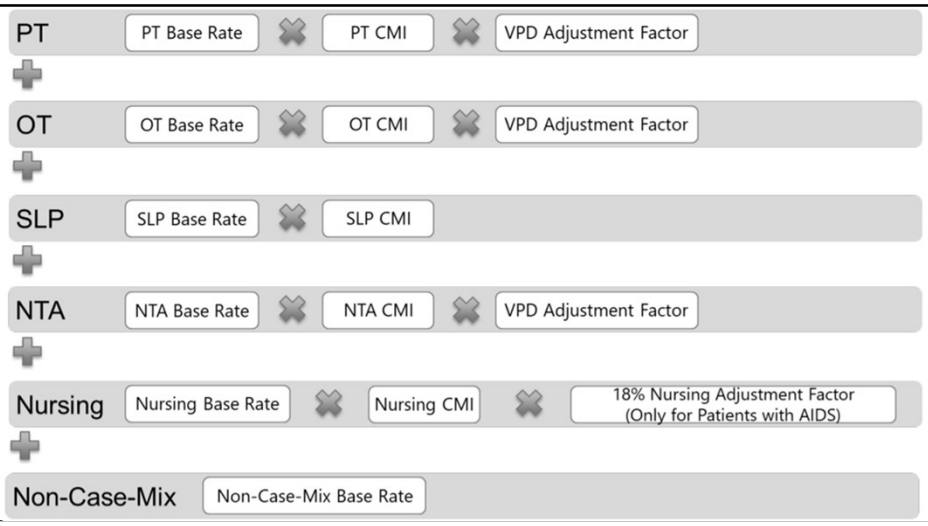

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- All but the base rate component are adjusted by a Case Mix Index (CMI)
- The CMI attempts to capture and reimburse for higher complexity residents
- The CMI is calculated differently for each component because the clinical and functional factors that impact each component are different

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PT & OT Components: Payment Groups

Clinical Category	PT & OT Function Score	PT & OT Case Mix Group	PT CMI	OT CMI
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53	1.49
Major Joint Replacement or Spinal Surgery	6-9	TB	1.69	1.63
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88	1.68
Major Joint Replacement or Spinal Surgery	24	TD	1.92	1.53
Other Orthopedic	0-5	TE	1.42	1.41
Other Orthopedic	6-9	TF	1.61	1.59
Other Orthopedic	10-23	TG	1.67	1.64
Other Orthopedic	24	TH	1.16	1.15
Medical Management	0-5	TI	1.13	1.17
Medical Management	6-9	TJ	1.42	1.44
Medical Management	10-23	TK	1.52	1.54
Medical Management	24	TL	1.09	1.11
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27	1.30
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48	1.49
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08	1.09

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- **As examples:**
  - **PT, OT (above) CMI adjustments**
  - **SLP (right) CMI adjustments**

SLP Component: Payment Groups

Presence of Acute Neurologic Condition, SLP Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case Mix Group	SLP Case Mix Index
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.66
Any one	Neither	SD	1.46
Any one	Either	SE	2.33
Any one	Both	SF	2.97
Any two	Neither	SG	2.04
Any two	Either	SH	2.85
Any two	Both	SI	3.51
All three	Neither	SJ	2.98
All three	Either	SK	3.69
All three	Both	SL	4.19

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- For the PT, OT, and NTA components, the rate is further adjusted by a Variable Per Diem (VPD) factor
- VPD recognizes that the highest utilization of resources in caring for a resident is right after admission
- VPD establishes diminishing schedule of reimbursement for each day of the patient's stay

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Variable Per Diem Adjustment Schedules

- PT & OT Components

Day in Stay	Adjustment Factor	Day in Stay	Adjustment Factor
1-20	1.00	63-69	0.86
21-27	0.98	70-76	0.84
28-34	0.96	77-83	0.82
35-41	0.94	84-90	0.80
42-48	0.92	91-97	0.78
49-55	0.90	98-100	0.76
56-62	0.88		

- NTA Component

Day in Stay	Adjustment Factor
1-3	3.00
4-100	1.00

- **PT, OT and SLP reimbursement reduces incrementally throughout the stay**
- **NTA increases reimbursement at the start of the stay and then adjusts itself on day 4, remaining constant throughout the remainder of the stay**

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RUG-IV Assessment Schedule

Old Way

Scheduled Assessment			
Medicare MDS Assessment Schedule Type	Assessment Reference Date	Assessment Reference Date Grace Days	Applicable Standard Medicare Payment Days
5-day	Days 1-5	6-8	1 through 14
14-day	Days 13-14	15-18	15 through 30
30-day	Days 27-29	30-33	31 through 60
60-day	Days 57-59	60-63	61 through 90
90-day	Days 87-89	90-93	91 through 100
Unscheduled Assessment			
Start of Therapy Other Medicare-Required Assessment (OMRA)	5-7 days after	start of therapy	Date of the first day of therapy through the end of the standard payment period
End of Therapy OMRA	1-3 days after	end of therapy	First non-therapy day through the end of the standard payment period
Change of Therapy OMRA	Day 7 (last day) of	Change of Therapy (COT) observation period	The first day of the COT observation period until end of standard payment period, or until interrupted by the next COT-OMRA assessment or scheduled or unscheduled PPS Assessment
Significant Change in Status Assessment	No later than 14 days after	significant change identified	Assessment Reference Date (ARD) of Assessment through the end of the standard payment period

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PDPM Assessment Schedule

New Way

Medicare MDS Assessment Type	Assessment Reference Date	Applicable Standard Medicare Payment Days
Five-day Scheduled PPS Assessment	Days 1-8	All covered Part A days until Part A discharge (unless an IPA is completed)
Interim Payment Assessment (IPA)	Optional Assessment	ARD of the assessment through Part A discharge (unless another IPA assessment is completed)
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date	N/A

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- IRFs historically measured functional *independence* (FIMS)
- CMS implemented functional *impairment* scoring 10/1/2019
- Aligns functional scoring data across HHA, SNF and IRF
- The IMPACT Act mandates alignment of patient assessment measures in order to establish a unified post-acute payment model

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Elder Justice Act

OIG Focus on Abuse

CMS Focus on Abuse

[redacted]

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ABUSE PREVENTION AND REPORTING

Elder Justice Act

- Section 1150B of the Social Security Act
- Established by section 6703(b)(3) of the Patient Protection and Affordable Care Act
- The statute requires that:
  - **Covered individuals timely report any reasonable suspicion of a crime against a resident/person receiving care from a LTC facility**

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Covered Individuals:

- "Covered individual" means each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility

Timely:

- If the events result in serious bodily injury, the report must be made immediately after forming the suspicion (not later than two hours after forming the suspicion)
- Otherwise, the report must be made not later than 24 hours after forming the suspicion

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OIG FOCUS ON ABUSE

RECENT REPORTS

"Incidents of Potential Abuse and Neglect at SNFs Were Not Always Reported and Investigated"

"CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect"

"A Resource Guide for Using Diagnosis Codes …To Help Identify Unreported Abuse or Neglect"

"Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm"

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- Studied acute care claims for patients received from SNFs
- Targeted 'suspicious' diagnoses that were NOT also coded as potential abuse or neglect
- Reviewed acute care and SNF records to determine likelihood abuse occurred
- Determined if potential abuse was reported

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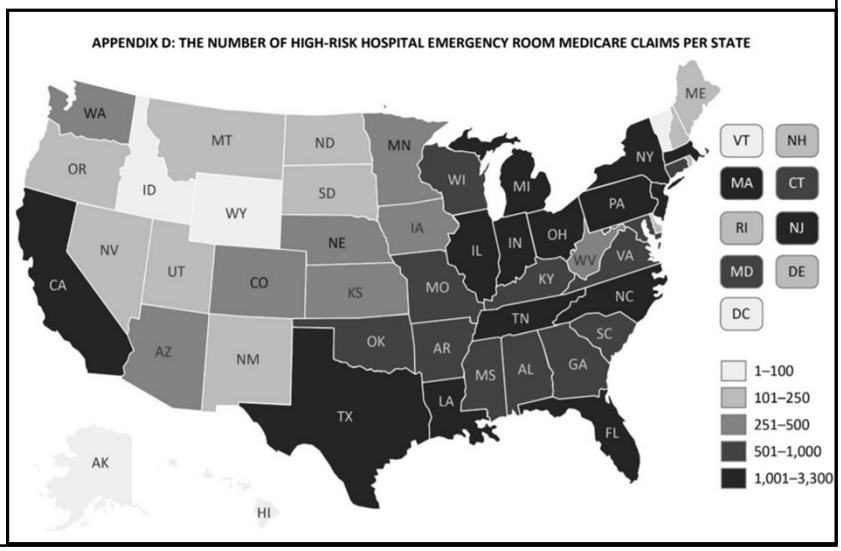
Report in Brief
Date: June 2019
Report No. A-01-16-00509

U.S. Department of Health & Human Services
Office of Inspector General



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- The OIG:
  - Estimated 1:5 high-risk hospital ER claims were the result of potential abuse or neglect of beneficiaries residing in a SNF
  - Found that the SNFs failed to report many of these incidents to the Survey Agencies as required
  - Also found that, in many instances, substantiated findings of abuse were never reported to local law enforcement
  - Recommended CMS take action to ensure that potential abuse or neglect of Medicare beneficiaries in SNFs is identified and reported
  - CMS concurred with the OIG recommendations

"Incidents of Potential Abuse and Neglect at SNFs Were Not Always Reported and Investigated." A-01-16-000509

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OIG FOCUS ON ABUSE:

REPORT II

"CMS Could Use Medicare Data to Identify Instances of Potential Abuse or Neglect"

A-01-17-00513

- Here, the OIG studied the claims that *were* coded as potential abuse to determine:
  - The prevalence of incidents of potential abuse or neglect
  - Who may have perpetrated those incidents
  - Where they occurred
  - Whether the incidents were reported to law enforcement officials, and
  - Whether CMS also identified similar incidents of potential abuse or neglect during the audit period and took action to address them

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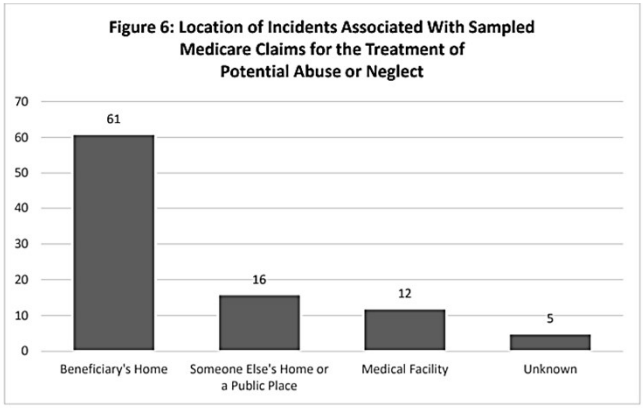

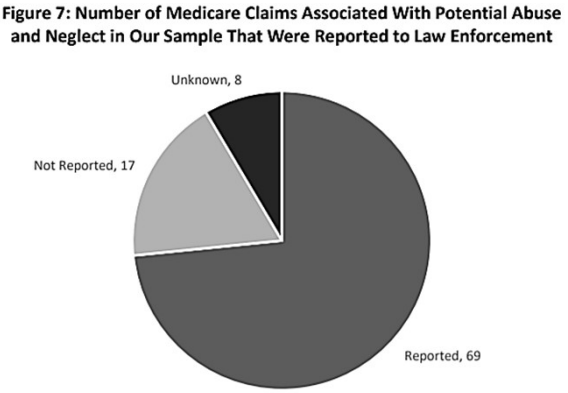

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"CMS Could Use Medicare Data to Identify Instances of Potential Abuse or Neglect"

A-01-17-00513

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"A Resource Guide for Using Diagnosis Codes …To Help Identify Unreported Abuse or Neglect"

1) Identify Risk Areas
2) Determine Reporting Requirements for Risk Areas
3) Determine Diagnosis or Procedure Codes that Correspond to Risk Areas
4) Determine Data Available for Use During Data Analysis
5) Identify Claims Using Analytic Techniques Data that Contains Identifying Markers Such as Specific Diagnosis Codes
6) Investigate, Audit, or Review Resulting Data

A-01-19-00502

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[redacted]

In this report, the OIG urged CMS to:

1) Strengthen requirements for hospices to report abuse, neglect, and other harm;
2) Ensure hospices educate their staff to recognize signs of abuse, neglect, and other harm;
3) Strengthen guidance for surveyors to report crimes to local law enforcement;
4) Monitor surveyors' use of immediate jeopardy citations; and
5) Improve and make user-friendly the process for beneficiaries and caregivers to make complaints

- CMS concurred with 1-4 and partially concurred with 5

Key Takeaway

Some beneficiaries have been seriously harmed when hospices provided poor care or failed to take action in cases of abuse.

These cases reveal vulnerabilities in beneficiary protections that CMS must address, including strengthening reporting requirements, to better ensure that beneficiary harm is identified, reported, addressed, and, ultimately, prevented. OEI-02-17-00021

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- Updated PACE program abuse prevention and reporting regulations to mirror those of SNF

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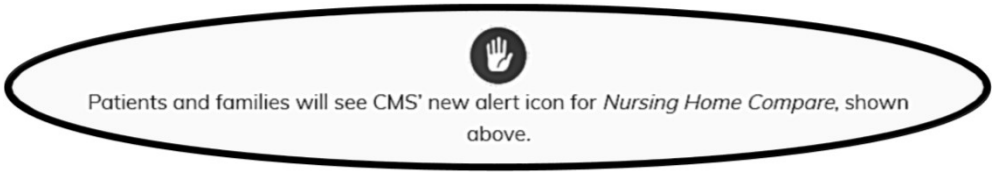
- 10/2019, CMS updated the Nursing Home Compare site with a public alert for SNFs who have been cited for abuse or neglect



Patients and families will see CMS' new alert icon for *Nursing Home Compare*, shown above.

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- Massive overhaul of the SNF Conditions of Participation published 10/2016
- Staggered effective dates (Phases I, II and III)
- Phase III, the heaviest lift, was originally to be effective 11/2019
- A proposed rule potential to delay implementation of some components of Phase III
- May 2019 expiration of SNF CMP moratorium

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Quality Assurance & Performance Improvement (QAPI) Program

- SNFs must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program focused on indicators, outcomes of care, and quality of life
- The QAPI program must review allegations and incidences of abuse, neglect, and exploitation
- The governing body is accountable for the QAPI program

Trauma-Informed Care/Behavioral Health

- SNFs must ensure residents who are trauma survivors receive culturally competent, trauma-informed care per professional standards of practice and plan of care
- SNFs must account for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization
- SNFs must have sufficient staff with the appropriate competencies to care for residents with mental and psychosocial disorders and those with a history of trauma and/or PTSD
- Facilities must implement non-pharmacological interventions

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Infection Preventionist (§ 483.80)

- The facility must designate an infection preventionist (IP) responsible for its infection prevention and control program
- The IP must:
  - Have primary professional training in nursing, medical technology, microbiology, epidemiology, or a related field
  - Be qualified by education, training, experience, or certification
  - Have completed specialized infection prevention and control training
  - Serve as a member of the QAPI program

Staff Training and Competencies (§ 483.95)

- The facility must develop, implement, and maintain an effective training program for all new and existing staff, contract service staff, and volunteers
- Training topics must include, but are not limited to, communication, residents' rights and facility responsibilities, QAPI, infection control, compliance and ethics, dementia management, resident abuse prevention, care of the cognitively impaired, and behavioral health

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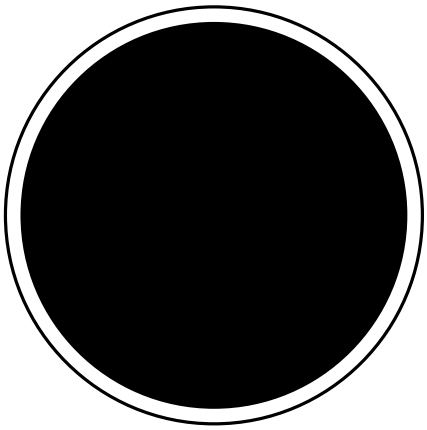

- **Compliance & Ethics Program (§ 483.85)**
  - The facility must develop, implement, and maintain a written compliance and ethics program that:
    - Is appropriate for the complexity of the organization
    - Designates an individual within the high-level personnel with overall responsibility to oversee compliance
    - Is periodically assessed to identify necessary changes
    - Contains written standards, policies, and procedures reasonably capable of reducing violations
    - Includes mandatory training, methods for reporting potential violations, auditing and monitoring to identify potential violations
    - Identifies steps to be taken to respond appropriately to a violation and to prevent further similar violations
    - Is consistently enforced

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SPOTLIGHT ON TWO EXTERNAL AUDIT TYPES

Target, Probe and Educate

Pre-Claim Review/Review Choice Demonstration

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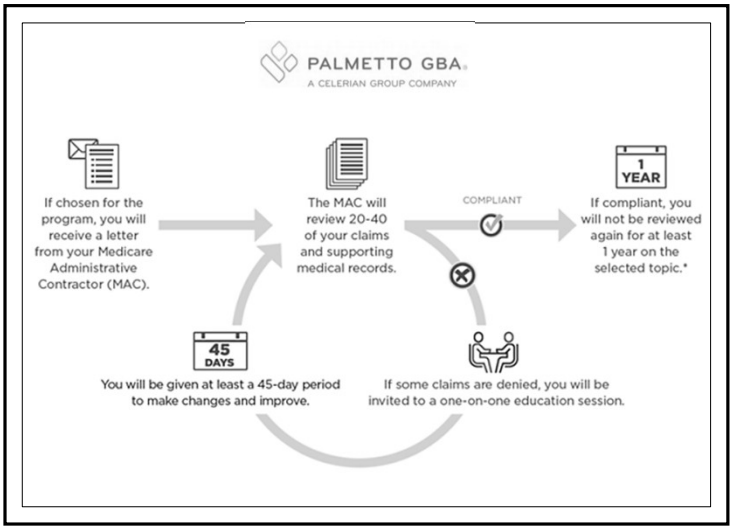
- Target, Probe and Educate (TPE)
  - MAC audit
  - "Designed to reduce and prevent improper payments by preventing payment of claims that do not comply with Medicare's coverage, coding, payment and billing policies."



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TRIGGERING A TPE

Data is analyzed to identify services that have a high payment error probability and/or present the greatest risk

These services may be identified via previous review activity conducted by the MAC, the CERT contractor, the OIG and other CMS contractors

Once the services are identified, additional data analysis includes (but is not limited to) establishing a baseline to identify unusual trends such as provider's rank against peers and changes in utilization over time

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Part A Outpatient Therapy: Missing certification, progress notes, initial evaluation, plan of care, total therapy minutes

Part A DRG 885 Psychoses: Missing valid certification, initial psychiatric evaluation, valid recertification

Part B Ambulance (emergent): Missing signature from beneficiary and receiving facility

Ambulance (non-emergent): Missing clinical documentation, Physician certification statement, signature from beneficiary and receiving facility

Evaluation and Management: Missing documentation, incorrect DOS or type of documentation

Hospice: Election statement, F2F, POC, certification/Physician's narrative, documentation to support the level of care, rendering provider is not the same as the billing provider

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HOME HEALTH PRE-CLAIM REVIEW

- Pre-Claim Review
  - Affects Home Health
  - Coming to NC in May 2020
  - Changed names to **Review Choice Demonstration**
  - Providers choose 1 of 3 options for how the review process will be conducted

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The initial review choices are:

- Choice 1: Pre-claim Review
  - All episodes of care are subject to pre-claim review
  - Unlimited resubmissions allowed for non-affirmed decision prior to submission of final claim for payment
- Choice 2: Post-payment Review (Default)
  - 100% of claims are reviewed
  - After claim submission, MAC will issue an ADR
  - After each 6 month period a claim approval rate will be calculated and communicated to the HHA
- Choice 3: Minimal review
  - 100% of claims have a 25% payment reduction
  - Excludes MAC TPEs, but not RAC audits
  - *HHAs remain in this option for the duration*

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The subsequent review choices are:

- If the approval rate is ≥90%, the subsequent review choices are:
  - Choice 1: Pre-claim Review
  - Choice 4: Selective Post-payment Review (default)
    - A random sample of claims will be chosen for review every 6 months
    - *HHAs remain in this option for the duration*
  - Choice 5: Spot Check Review
    - Every 6 months, 5% of claims are randomly chosen for review
    - May remain in this option as long as they continue to show compliance with Medicare coverage rules and guidelines

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QUESTIONS?

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