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"NEWS AND VIEWS YOU CAN REALLY USE"

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SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE ADELMAN ADVANTAGE by Rebecca Adelman

Patient-Driven Payment Model – The Keys

On April 27, 2018, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule outlining Fiscal Year (FY) 2019 Medicare payment updates and proposed quality program changes for skilled nursing facilities (SNFs).

There are three key provisions of the proposed rule:

Key 1 - The proposed changes to the case-mix classification system used under the SNF Prospective Payment System (PPS);
Key 2 - The SNF Value-Based Purchasing Program (VBP); and
Key 3 – The SNF Quality Reporting Program (QRP). T

In addition to payment and policy updates for FY 2019, the skilled nursing facility (SNF) proposed rule includes a proposal to revise the payment model from the current Resource Utilization Groups (RUG-IV) case-mix classification to the Patient-Driven Payment Model (PDPM) beginning on October 1, 2019 for FY 2020.

The three key FY 2019 proposals and other issues discussed in the proposed rule are summarized below. By way of a brief history, in May 2017, CMS released an Advanced Notice of Proposed Rulemaking (ANPRM), outlining the Resident Classification System, Version I (RCS-I), which was a new case-mix model. It was proposed to replace the existing Resource Utilization Group, Version IV (RUG-IV) case-mix model. The RUG-IV model was used to classify residents into payment groups in a Part A stay under the SNF Prospective Payment System (PPS). Since the ANPRM was released over a year ago, stakeholders and commenters raised concerns and questions. Consequently, CMS made significant changes to the RCS-I model, resulting in renaming the model to the SNF PDPM.

Key 1 - Modernizing the SNF PPS Case-Mix Classification System
The proposed new model is designed to improve the incentives to treat the needs of the whole patient, instead of focusing on the volume of services the patient receives, which requires substantial paperwork to track over time. CMS also significantly reduced the overall complexity of the proposed PDPM, as compared to RUG-IV or RCS-I, based on stakeholder feedback. The proposed new case-mix classification system (the PDPM) would be effective October 1, 2019. The improved structure of this proposed model would move Medicare towards a more value-based, unified post-acute care payment system that puts the unique care needs of the patient first while also reducing significantly the administrative burden associated with the SNF PPS. PDPM would focus on clinically relevant factors, rather than volume-based service for determining Medicare payment. PDPM would adjust Medicare payments based on each aspect of a resident's care, most notably for Non-Therapy Ancillaries (NTAs), which are items and services not related to the provision of therapy such as drugs and medical supplies, thereby more accurately addressing costs associated with medically complex patients. It would further adjust the SNF per diem payments to reflect varying costs throughout the stay and incorporate safeguards against potential financial incentives to ensure that beneficiaries receive care consistent with their unique needs and goals.

RUG–IV classifies each resident into a single RUG, with a single payment for all services. **By contrast, the proposed PDPM would classify each resident into five components (physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), non-therapy ancillary (NTA), and nursing) and provide a single payment based on the sum of these individual classifications.** The payment for each component would be calculated by multiplying the case-mix index (CMI) for the resident's group first by the component federal base payment rate, then by the specific day in the variable per diem adjustment schedule. The proposed PDPM is designed to separately identify and adjust for the varied needs and characteristics of a resident's care and combine this information together to determine payment. CMS believes that the proposed PDPM would improve the SNF PPS by basing payments predominantly on clinical characteristics rather than service provision, thereby enhancing payment accuracy and strengthening incentives for appropriate care.

Responding to stakeholder comments encouraging a more simple payment model, the proposed SNF PDPM would **reflect an approximately 80 percent reduction in the number of payment group combinations** compared to the RCS-I. Additionally, it would reflect **updates to the data used as the basis for CMS'analyses, to ensure that the results reflect the current resident population**. PDPM, as compared to RCS-I, would also **make greater use of certain standardized items for payment calculations**, such as in using function items also used for the SNF QRP. Finally, PDPM would **simplify complicated paperwork requirements** for performing patient assessments by significantly reducing reporting burden (approximately $2.0 billion over 10 years), helping to create greater contact between health care professionals and their patients.

PDPM would be effective October 1, 2019.

As noted by *LeadingAge*, not-for-profit organizations representing the field of aging services, CMS offers estimates of the differences between the current RUG-IV payment model and the proposed PDPM system, however, considerations should be made to:

- The impacts presented assume consistent provider behavior in terms of how care is provided under RUG–IV and how care might be provided under the proposed PDPM.
- Changes in state Medicaid programs resulting from PDPM implementation would not have a notable impact on payments for Medicare-covered SNF stays.
- Impacts are assumed in a budget neutral manner through application of a parity adjustment to the case-mix weights under the proposed PDPM.
- Estimates are a comparison between RUG-IV and the proposed PDPM using claims data from FY 2017.

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Key 2 - SNF Quality Reporting Program (QRP)
The SNF QRP is authorized by section 1888(e)(6) of the Social Security Act and applies to freestanding SNFs, SNFs affiliated with acute care facilities, and swing-bed rural hospitals except for critical access hospitals. **Under the SNF QRP, SNFs that fail to submit the required quality data to CMS will be subject to a 2 percentage point reduction to the otherwise applicable annual market basket percentage update with respect to that fiscal year.**

CMS reviewed the SNF QRP's measure set in accordance with the Meaningful Measures Initiative, and is working to identify how to move the SNF QRP forward in the least burdensome manner possible while continuing to incentivize improvement in the quality of care provided to patients. Specifically, the goals of the SNF QRP and the measures used in the program cover most of the Meaningful Measures Initiative priorities, including making care safer, strengthening person and family engagement, promoting coordination of care, promoting effective prevention and treatment, and making care affordable.

In this proposed rule, **CMS is proposing to adopt an additional factor to consider when evaluating measures for removal from the SNF QRP measure set**. This factor takes into account costs that are associated with a measure and weighs them against the benefit of its continued use in the program. CMS is also proposing to publicly display the four SNF QRP assessment-based quality measures, and increase the number of years of data used to display two claims-based SNF QRP measures, Discharge to the Community and Medicare Spending per Beneficiary, from 1 year to 2 years. CMS is also proposing to codify policies that have been finalized under the SNF QRP.

Key 3 - SNF Value-Based Purchasing Program (VBP)
Beginning **October 1, 2018** services, the SNF VBP Program will apply either positive or negative incentive payments to skilled nursing facilities based on their performance on the program's readmissions measure. The single claims-based all cause 30-day hospital readmissions measure aims to improve individual outcomes through rewarding providers that take steps to limit the readmission of their patients to a hospital. This single measure does not require SNFs to report information in addition to the information they already submit as part of their claims because CMS uses existing Medicare claims information to calculate the measure.

Other Keys - The FY 2019 proposed rule proposes updates to policies, including the performance and baseline periods for the FY 2021 SNF VBP Program year, an adjustment to the SNF VBP scoring methodology, and an Extraordinary Circumstances Exception (ECE) policy.

AHCA's Comments – During the comment period on the proposed PDPM, the American Health Care Association commented as follows on June 25, 2018:

We understand the challenges CMS is attempting to solve with PDPM. However, we believe PDPM could create new challenges without additional simulation and notable refinements. Regarding our concerns, we believe PDPM still would not mitigate access barriers for patients with high non-therapy ancillary service costs. Additionally, as we have shared with CMS and CMS' contractor, Acumen, we do not believe the data and related analytics are sufficient to support the model. We believe further simulation is needed, study on the components, and a thorough retooling of the assessment proposals, particularly the proposed new use of multiple ICD-10 codes on the MDS, and the interrupted stay proposal. Furthermore, reductions in payment to Medicare low-volume providers would perpetuate, if not exacerbate, existing access issues.
Mark Parkinson, CEO/President

AHCA's top comments and recommendations are as follows and we'll await further proposed changes from SMC now that the comment period concluded.

Section 1 – SNF Wage Index. AHCA proposes both an interim step towards a SNF wage index as well as a phased longer-term plan. In the short term, AHCA proposes "trimming" hospital data to eliminate labor categories which are not found in SNFs as well as to account for the differences between hospital employee and SNF employee benefit costs. In the longer term, AHCA has recommended a phased approach of gradually shifting away from the current hospital based system to SNF wage data. AHCA proposes shifting from 25% hospital based wage data and 75% SNF wage data in year one with year-over-year increases in SNF wage data use by 25% per year. Once the transition begins, a four-year phase-in would begin with protections for increases or decreases of more than 5% until the transition is complete.

Section 2 – Consolidated Billing. AHCA has long believed that CMS takes too narrow an interpretation of its flexibility in the four exclusion areas as well as in its interpretation of the definition of a "resident of skilled nursing facility" which has implications for site of service challenges. CMS policy has not kept pace with the entry of new, very high cost medications to the health care market, including over 100 drugs which fall within CMS' exclusion criteria. CMS should add at least these medications to its exclusion list immediately. Second, the definition of a "resident of a skilled nursing facility" has limited exclusion of high-cost services that now are often delivered in specialized imaging centers, ambulatory surgical centers, and other outpatient settings. CMS should modernize its policies and avail itself of the flexibility available in the definition noted above.

Section 3 – Patient-Driven Payment Mode (PDPM). For a number of years, AHCA has participated in an array of SNF payment reform technical expert panels and submitted extensive comments on CMS' SNF payment reform work. AHCA appreciates many changes made to the 2017 Resident Classification System Version 1 (RCS-1) concept. The PDPM concept is simpler than RCS-1 and CMS incorporated a number of AHCA requests for clarification and modifications. AHCA urges CMS to return to the RCS-1 group and concurrent therapy proposal of 25% for group and 25% for concurrent rather than the PDPM proposal.

Section 4 – SNF Quality Reporting Program (QRP). AHCA is a strong supporter of the SNF QRP initiative and offers support for several of the proposed future improvements to the SNF QRP program. AHCA also offered comments related to concerns with the content and timing of public display of the MSPB and mobility and self-care outcomes measures.

Section 5 – SNF Value-Based Purchasing Program (VBP). AHCA appreciates the careful consideration CMS has put towards ensuring the SNF VBP program is administered fairly for all centers, even those with special considerations such as small SNFRM denominator sizes, newly opened facilities without baseline SNFRM data, those with a high proportion of patients with social risk factor and those affected by extraordinary circumstances outside of their control. AHCA believes that the proposed additions to the program made in the NPRM will ensure that no centers are unfairly harmed by the VBP scoring methodology.

Section 6 – Interoperability Request for Information. AHCA appreciates the value and importance of interoperable health information data elements. However, the SNF profession is struggling financially and does not receive financial assistance for information technology under the HITECH Act or from other sources. AHCA offered creative financing options for CMS consideration, suggestions for a LTPAC IT Technical Expert Panel, and plans to reach out to the Office of the National Coordinator to share our ideas.

At this point, we are awaiting a revised draft of the PDPM model. We recommend that providers familiarize themselves with the proposed system and look at CMS estimates of the impact on their communities at CMS.gov.

Rebecca Adelman is an entrepreneur, influencer, thought leader and founder of Adelman Law Firm, established in 2001. For nearly 30 years, Rebecca has concentrated her practice in insurance defense and business litigation. The firm's practice extends through the Tri-States of Arkansas, Mississippi and Tennessee. Rebecca's insurance defense practice includes representation of insurance companies and long-term care providers and their insurers, both regionally and nationally. She also provides consulting services and educational programming to healthcare professionals and business associates. She has active practices in the areas of general liability, professional liability, premises, and employment law. She is a listed mediator serving all areas of business and healthcare litigation. Visit Rebecca at www.adelmanfirm.com and www.rebeccaadelman.com.

Getting on the Same Page by Paige Hector, LMSW

Addressing Psychosocial Aspects of Pain to Improve Well-Being

This July, I attended an outstanding conference titled "Behavioral Treatment of Chronic Pain: Evidence-Based Techniques to Move People from Hurt to Hope" by Robert Rosenbaum, PhD. It was a magical day of learning and I ended up with four pages of single-spaced typed notes. Seminars abound on the topic of pain management, especially opioids and deprescribing. What I appreciated about this seminar was that Dr. Rosenbuam focused on the behavioral and psychosocial components of pain.

Pharmacological management of pain is vital. But, there is so much more we can offer people. Better understanding of the nature of pain (both ours and the people we serve) provides valuable insight into a successful pain management regimen. Some of the techniques Dr. Rosenbaum suggested require training and it would be irresponsible to attempt any intervention outside one's skill level or scope of practice.

Consider the bigger picture of the treatment of pain in your facility. No one would disagree with including non-pharmacologic interventions in a pain management program. But, are those just words in your facility, words written on a care plan but not operationalized? What does pain management mean in your facility and how does staff assess, intervene, communicate and care plan this sometimes elusive reality for most residents and patients?

Below are a few great points by Dr. Rosenbaum. In parenthesis starting with my initials, I inserted comments to help ground the teachings in settings that serve older adults. As you read, do two things: 1) Consider your *personal* experience with pain (everyone has pain - and we're not just considering physical pain), and 2) Reflect on how pain is managed in your work setting. Are there things you can do differently in your life and at work?

- We've come to accept pain and sleep deprivation as "normal" in this society. Although they may be common, <u>they are not normal</u>. We live in a "push through it" society where we are expected to not show weakness or admit to having pain which is detrimental to our well-being. (PH: Improving sleep hygiene and pain management are critical to well-being.)
- Pain is pain whether it's psychological, physical, spiritual, mental, emotional, or financial. The pain is whatever the patient says it is and there are many definitions.
- Too often chronic pain is treated as acute pain which is wrong. (PH: Staff and providers must know the difference, assess and treat accordingly.)
- People must feel listened to, heard, and validated. Validation and acknowledgement are crucial to developing a trusting, working relationship. Say, "You shouldn't be in this much pain. It's awful." "You are hurting terribly. I hear you." (PH: Let's be honest, sometimes it's tough to validate another person's experience of pain if they are behaving in a way we perceive as unpleasant. This, however, does not give us a "pass" on listening, hearing and validating their personal experience with pain.)
- Pain assessment is not separate from treatment; they intertwine. Consider this assessment question, "When you've gotten a better handle on your pain, what will you be doing?" (Notice the use of the term 'when' and not 'if.') Then ask, "What would be the first step on your way to doing [*activity*]?" (PH: Help the individual see beyond the pain to identify what brings their life joy and meaning. Perhaps it's something as simple as sitting comfortably in a wheelchair and visiting with family, sleeping through the night, going on an outing, walking, returning to a job – no matter what the person shares, incorporate elements of that activity into the plan of care.)
- Pain can be intensified when a person feels they do not have a choice, that they are being controlled by their pain. As clinicians, we can help cultivate the ability to see pain as just pain, that is, *a sensation*. Do not misunderstand this as minimizing one's pain or denying its existence. The purpose is to simply *take the pressure away from the pain* and help the individual develop a gateway to ease and enjoyment. (PH: A simple question like, "Do you feel that the pain is in control of your life?" could invite deeper dialogue to help frame pain as a sensation and to begin the process of putting the individual back in charge of their experience with pain.)
- The question "How can I enjoy myself (for the next 5 minutes, hour, day)?" can help the person feel more in charge of their life, their day, their moment. Sometimes just appreciating the difficulty of finding something enjoyable can be appreciated! Mindfulness and enjoyment, even in the presence of pain, are strategies in our pain management armamentarium that we can help patients learn and utilize. (PH: I've begun experimenting with this concept in my personal life when my experience with my mom, who is living with frontotemporal dementia, is challenging. It's validating to allow myself permission to acknowledge that sometimes there is very little in the present moment to appreciate except the difficulty of the situation.)

I encourage readers to consider processes in their own setting. There is always room for improvement! Convene a focus group and invite staff, the consultant pharmacist, providers and the medical director to engage in dialogue about the facility pain program. What's going well? What can be improved? Dr. Rosenbaum recommended a great resource, the book titled *You Are Bigger Than the Pain: Six Comfort Strategies for People in Chronic Pain* by Daniel Lev. I now have this book in my library and am delighted at the practical, insightful strategies to develop comfort skills around pain.

Next month, I'll delve more deeply into one area of pain assessment and non-pharma interventions.

Contact Paige at 520-955-3387 or at paige@paigeahead.com
Discover more about her at www.paigeahead.com

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News Release

Adelman Law Firm resumes practice in Downtown Memphis

MEMPHIS, TENN., August 2018 — Rebecca Adelman, a former founder of Hagwood Adelman Tipton, today announced she resumed full operation of her firm, Adelman Law Firm, which was originally founded in 2001.

Adelman Law Firm's team of legal professionals will serve the public in the areas of medical malpractice, long-term care and aging services, professional liability, general litigation, insurance defense, government tort liability, public entity defense and risk reduction and loss avoidance. As a woman-owned business, Adelman Law Firm seeks to lead and mentor women in the business, insurance and health care sectors.

"Today is exciting for me, as well as the legal teams and strategic partners who have joined me in this venture that I started nearly 20 years ago," Adelman said. "At Adelman Law Firm, our culture nurtures and strives to achieve innovation, creativity, legal expertise and is client-focused."

Adelman is a mother, entrepreneur, influencer, thought leader and founder of Adelman Law Firm. With more than 30 years of experience, she has established herself as an expert in the legal field, as well as entrepreneurship, and has received numerous awards, including the inaugural American Assisted Living Nursing Association *Ethel Mitty Heart Award* and was a finalist for the Claims and Litigation Management Alliance *Professional of the Year - Outside Counsel award.* Locally, Adelman was named to *Super Women in Business, Women to Watch, Top 10 Women in Business* and *Top 40 Under 40* by the Memphis Business Journal. She was also named a *Memphis Power Player* in Defense Litigation by Inside Memphis Business.

Adelman and her colleagues at Adelman Law Firm are servant leaders and supporters of various nonprofit organizations dedicated to the health and well-being of children through sports and education. Sixteen years ago, Adelman founded a nonprofit Montessori school to provide alternative education to children in rural Colorado.

About Adelman Law Firm:
Founded in 2001, Adelman Law Firm has expertise in multiple areas of insurance defense litigation, professional malpractice, business and employment and healthcare law. Located in Downtown Memphis in the South Main Historic Arts District, Adelman Law Firm provides legal services in Arkansas, Mississippi and Tennessee. For more information about Adelman Law Firm, visit www.adelmanlawfirm.com.