PDPM, Quality and Value: How to Succeed in 2019 and Beyond

Presented by
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Maureen is the President/CEO of Celtic Consulting, LLC. She has been a registered nurse for 30 years with experience as an MDS Coordinator, Director of Nursing, Rehab Director and a Medicare biller.

McCarthy is a recognized leader and expert in clinical reimbursement in the skilled nursing facility environment. She is certified in the resident assessment process, QAPI and Director of Nursing Services, by nationally recognized organizations and holds Master Teacher status in all three certifications. She sits on the Board of Directors for the American Association of Post-Acute Care Nurses (AAPACN) and serves as an Expert Advisory Panel member for American Association of Nurse Assessment Coordination (AANAC). McCarthy was recently presented the ACHCA 2018 Education Award.

• Maureen and her associates at Celtic Consulting regularly provide the following services for SNFs, state affiliates and provider organizations:
  • 5 Star Quality Improvement Program
  • Quality Auditing
  • Clinical Care Management
  • PDPM/MDS/CMI Services
  • Compliance Solutions
  • Medicare Compliance Auditing
  • Customized Education / In-Services
Objectives

• Explain the April 2019 changes to the 5-star Rating System
• Review the SNF Quality Reporting Program
• Discuss SNF Value-Based Purchasing Program
• Identify the overlaps between the programs and their differences and how PDPM will effect
• Reviewing your ‘next steps’ towards improvement

Current CMS Measurement Reporting

• Reporting structure
  o Quality measures
  o CASPER reporting
  o 5-star rating system
  o PEPPER reports
  o SNF Value Based Purchasing
  o SNF Quality Reporting Program
• Medical record reviews (ADR) through the MAC/RAC or others
5 Star Survey

Survey Weights-REVISED

• 3 most recent annual inspections
  • Includes substantiated complaint surveys
  • Each deficiency is weighted by scope & severity
  • More recent surveys weigh more heavily
    • Most recent= ½ of survey score total
    • 1st prior survey= 1/3 of survey score
    • 2nd prior survey= 1/6 of survey score
Complaint Surveys

- Substantiated findings from last 36 months
- Within the last calendar year = ½ weight
- 13-24 months ago = 1/3 weight
- 25-36 months ago = 1/6 weight

Re-survey for Compliance

Table 2
Weights for Repeat Revisits

<table>
<thead>
<tr>
<th>Revisit Number</th>
<th>Noncompliance Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>0</td>
</tr>
<tr>
<td>Second</td>
<td>50 percent of health inspection score</td>
</tr>
<tr>
<td>Third</td>
<td>70 percent of health inspection score</td>
</tr>
<tr>
<td>Fourth</td>
<td>85 percent of health inspection score</td>
</tr>
</tbody>
</table>

Note: The health inspection score includes points from deficiencies cited on the standard health inspection and complaint inspections during a given survey cycle.
### Table 1
Health Inspection Score: Weights for Different Types of Deficiencies

<table>
<thead>
<tr>
<th>Severity</th>
<th>Scope</th>
<th>Isolated</th>
<th>Pattern</th>
<th>Widespread</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate jeopardy to resident health or safety</td>
<td>J</td>
<td>G</td>
<td>H</td>
<td>L</td>
</tr>
<tr>
<td></td>
<td>50 points*</td>
<td>20 points</td>
<td>35 points</td>
<td>150 points*</td>
</tr>
<tr>
<td></td>
<td>(75 points)</td>
<td></td>
<td>(40 points)</td>
<td>(175 points)</td>
</tr>
<tr>
<td>Actual harm that is not immediate jeopardy</td>
<td>K</td>
<td>G</td>
<td>H</td>
<td>I</td>
</tr>
<tr>
<td></td>
<td>100 points*</td>
<td>20 points</td>
<td>35 points</td>
<td>45 points</td>
</tr>
<tr>
<td></td>
<td>(125 points)</td>
<td></td>
<td>(40 points)</td>
<td>(50 points)</td>
</tr>
<tr>
<td>No actual harm with potential for more than minimal harm that is not immediate jeopardy</td>
<td>D</td>
<td>G</td>
<td>H</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>4 points</td>
<td>20 points</td>
<td>35 points</td>
<td>16 points</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(40 points)</td>
<td>(20 points)</td>
</tr>
<tr>
<td>No actual harm with potential for minimal harm</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0 point</td>
<td>0 points</td>
<td>0 points</td>
<td></td>
</tr>
</tbody>
</table>

Note: Figures in parentheses indicate points for deficiencies that are for substandard quality of care.
Shaded cells denote deficiency scope/severity levels that constitute substandard quality of care if the requirement which is not met is one that falls under the following federal regulations: 42 CFR 483.13 resident behavior and nursing home practices, 42 CFR 483.15 quality of life, 42 CFR 483.25 quality of care.

* If the status of the deficiency is “past non-compliance” and the severity is Immediate Jeopardy, then points associated with a “G-level” deficiency (i.e., 20 points) are assigned.

Source: Centers for Medicare & Medicaid Services

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**5 Star Staffing**
Where Does CMS Get Staffing Data Now?

- Staffing numbers used to come from the CMS-671 form completed during survey
  - Full time employees
  - Part time employees
  - Contracted staff
  - Now uses facility PBJ data submitted quarterly
- Census from the 672 (total residents)
  - Resident census & conditions report
  - Was replaced by MDS census 2018

Expected Staffing Weights

- Staffing is a case-mix adjusted based on RUG-IV categories
  - RUGs for each resident are calculated for the previous quarter using the most recent assessment for each resident at the facility during the quarter
  - Facilities with higher acuity are expected to have higher staffing levels
PBJ Job Codes Used in the RN, LPN, and Nurse Aide Hours Calculations:

- RN hours: Includes RN director of nursing (job code 5), registered nurses with administrative duties (job code 6), and registered nurses (job code 7).
- LPN hours: Includes licensed practical/licensed vocational nurses with administrative duties (job code 8) and licensed practical/vocational nurses (job code 9)
- Nurse aide hours: Includes certified nurse aides (job code 10), aides in training (job code 11), and medication aides/technicians (job code 12)

The Daily Resident Census, is Derived From MDS Census and is Calculated as Follows:

1. Identify the reporting period (quarter) for which the census will be calculated (e.g., CY 2018 Q2: April 1 – June 30, 2018).
2. Extract MDS assessment data for all residents of a facility beginning one year prior to the reporting period to identify all residents that may reside in the facility (i.e., any resident with an MDS assessment may still reside in the facility). For example, for the CY 2018 Q2 reporting period, extract MDS data from April 1, 2017 through June 30, 2018.
Identify Discharged Residents Using the Following Criteria:

• If a resident has an MDS Discharge assessment, use the discharge date on that assessment and assume that the resident no longer resides in the facility as of the date of discharge on the last assessment. If there is a subsequent admission assessment, then assume that the resident re-entered the nursing home on the entry date indicated on the entry assessment.

• For any resident with an interval of 150 days or more with no assessments, assume the resident no longer resides in the facility as of the 150th day from the last assessment. If no assessment is present, assume the resident was discharged, but the facility did not transmit a Discharge assessment.

Staffing ‘Data Not Available’

Results reported for those facilities with improbable PBJ data

• Total nurse staffing (job codes 5-12) < 1.5 HRD
• Total nurse staffing (job codes 5-12) > 12 HRD
• Nurse aide staffing (job codes 10-12) > 5.25 HRD
# Staffing Cut Points

Table 3
National Star Cut Points for Staffing Measures, Based on Adjusted Hours per Resident Day (updated April 2019)

<table>
<thead>
<tr>
<th>Staff type</th>
<th>1 star</th>
<th>2 stars</th>
<th>3 stars</th>
<th>4 stars</th>
<th>5 stars</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>&lt; 0.316</td>
<td>0.316 - 0.500</td>
<td>0.501 – 0.723</td>
<td>0.724 – 1.041</td>
<td>≥1.042</td>
</tr>
</tbody>
</table>

Note: Adjusted staffing values are rounded to three decimal places before the cut points are applied.

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Table 4
Staffing and Rating (updated April 2019)

<table>
<thead>
<tr>
<th>RN rating and hours</th>
<th>Total nurse staffing rating and hours (RN, LPN and nurse aide)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Note: Adjusted staffing values are rounded to three decimal places before the cut points are applied.
Scoring Exceptions

• Providers that fail to submit any staffing data by the required deadline will receive a one-star rating for overall staffing and RN staffing for the quarter.

• Providers that submit staffing data indicating that there were four or more days in the quarter with no RN staffing hours (job codes 5-7) will receive a one-star rating for overall staffing and RN staffing for the quarter.

Scoring Exceptions

• CMS conducts audits of nursing homes to verify the data submitted and to ensure accuracy.

• Facilities that fail to respond to these audits and those for which the audit identifies significant discrepancies between the hours reported and the hours verified will receive a one-star rating for overall staffing and RN staffing for three months from the time at which the deadline to respond to audit requests passes or discrepancies are identified.
Measures for Long-Stay Residents

- Percent of residents whose need for help with ADLs has increased
- Percent of residents whose ability to move independently worsened
- Percent of high-risk residents with pressure ulcers
- Percent of residents who have/had a catheter
- Percent of residents with a urinary tract infection
- Cut points have been recalculated- Deciles and Quintiles (15 or 20 point per level)
- Restraints removed
Measures for Long-Stay Residents

- Percent of residents experiencing one or more falls with major injury
- Percent of residents who self-report moderate to severe pain
- Percent of residents who received an antipsychotic medication
- Number of hospitalizations per 1,000 long-stay resident days*
- Number of outpatient emergency department (ED) visits per 1,000 long-stay resident days*

*claims based measures

Measures for Short-Stay Residents

- Percent of residents who made improvement in function
- Percent of SNF residents with pressure ulcers that are new or worsened
- Percent of residents who self-report moderate to severe pain
- Percent of residents who newly received an antipsychotic medication
Measures for Short-Stay Residents-Claims

• Percent of short-stay residents who were re-hospitalized after a nursing home admission
• Percent of short-stay residents who have had an outpatient emergency department (ED) visit
• Rate of successful return to home and community from a SNF
• All of the claims-based measures are risk adjusted

Cut Point Tables for QM Ratings

<table>
<thead>
<tr>
<th>QM Rating</th>
<th>Long-Stay QM Rating Thresholds</th>
<th>Short-Stay QM Rating Thresholds</th>
<th>Overall QM Rating Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>★</td>
<td>175 – 524</td>
<td>167 – 541</td>
<td>342 - 1066</td>
</tr>
<tr>
<td>★★</td>
<td>525 – 619</td>
<td>542 – 638</td>
<td>1067 – 1258</td>
</tr>
<tr>
<td>★★★</td>
<td>620 – 704</td>
<td>639 – 714</td>
<td>1259 – 1419</td>
</tr>
<tr>
<td>★★★★</td>
<td>705 – 799</td>
<td>715 – 805</td>
<td>1420 – 1605</td>
</tr>
<tr>
<td>★★★★★</td>
<td>800 - 1250</td>
<td>806 – 1250</td>
<td>1606 - 2500</td>
</tr>
</tbody>
</table>

Note: the short-stay QM rating thresholds are based on the adjusted scores (after applying the factor of 1250/900 to the unadjusted scores)
### Quality Measures that are Included in the QM Rating

<table>
<thead>
<tr>
<th>MDS 3.0 Long-Stay Measures</th>
<th>Provider</th>
<th>State</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016Q2</td>
<td>2016Q3</td>
<td>2016Q4</td>
</tr>
<tr>
<td>Percentage of residents experiencing one or more falls with major injury</td>
<td>2.4%</td>
<td>2.4%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Percentage of residents who self-report moderate to severe pain&lt;sup&gt;2&lt;/sup&gt;</td>
<td>7.6%</td>
<td>9.2%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Percentage of high-risk residents with pressure ulcers</td>
<td>2.5%</td>
<td>1.4%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Percentage of residents with a urinary tract infection</td>
<td>2.5%</td>
<td>1.3%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Percentage of residents with a catheter inserted and left in their bladder&lt;sup&gt;2&lt;/sup&gt;</td>
<td>2.5%</td>
<td>0.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Percentage of residents who were physically restrained</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Percentage of residents whose need for help with daily activities has increased</td>
<td>9.5%</td>
<td>12.1%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Percentage of residents who received an antipsychotic medication</td>
<td>15.0%</td>
<td>16.0%</td>
<td>17.2%</td>
</tr>
<tr>
<td>Percentage of residents whose ability to move independently worsened&lt;sup&gt;2&lt;/sup&gt;</td>
<td>30.5%</td>
<td>29.2%</td>
<td>22.0%</td>
</tr>
</tbody>
</table>

### MDS 3.0 Short-Stay Measures

**Higher percentages are better:**

| Percentage of residents who made improvements in function<sup>2</sup><sup>3</sup> | 80.8% | 74.0% | 67.4% | 69.0% | 72.4% | 40.00 | 85.0% | 63.0% |

**Lower percentages are better:**

| Percentage of residents who self-report moderate to severe pain | 28.9% | 21.2% | 17.0% | 23.4% | 22.5% | 40.00 | 16.0% | 16.7% |
| Percentage of residents with pressure ulcers that are New or worsened<sup>2</sup> | 0.9% | 0.9% | 0.0% | 0.0% | 0.4% | 75.00 | 1.0% | 1.2% |
| Percentage of residents who newly received an antipsychotic medication | 0.7% | 1.4% | 3.2% | 2.4% | 2.0% | 40.00 | 1.7% | 2.2% |

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### Time period for data used in reporting is 7/1/2014 through 6/30/2015

<table>
<thead>
<tr>
<th>Claims-Based Measures</th>
<th>Provider 075333</th>
<th>State</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Observed Rate&lt;sup&gt;4&lt;/sup&gt;</td>
<td>Expected Rate&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Risk-Adjusted Rate&lt;sup&gt;6&lt;/sup&gt;</td>
</tr>
<tr>
<td>Percentage of residents who were successfully discharged to the community&lt;sup&gt;2&lt;/sup&gt;&lt;sup&gt;3&lt;/sup&gt;</td>
<td>58.5%</td>
<td>58.8%</td>
<td>55.3%</td>
</tr>
<tr>
<td>Percentage of residents who were re-hospitalized after a nursing home admission&lt;sup&gt;2&lt;/sup&gt;&lt;sup&gt;3&lt;/sup&gt;</td>
<td>21.8%</td>
<td>21.9%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Percentage of residents who had an outpatient emergency department visit&lt;sup&gt;2&lt;/sup&gt;&lt;sup&gt;3&lt;/sup&gt;</td>
<td>13.9%</td>
<td>10.6%</td>
<td>14.5%</td>
</tr>
</tbody>
</table>

**Total Quality Measure Points**

Total QM points with new quality measures weighted 50% for Provider: 905.00
SNF Quality Reporting Program

QMs for SNFQRP Under IMPACT

- **2016 MDS-Based Measures:**
  - Functional status and cognition changes from admit to d/c (10-1-16)
  - Skin integrity and changes: new or worsening pressure ulcers (10-1-16) *adding unstageable pressure ulcers 10-1-18*
  - Falls with major injury (10-1-16)

- **2017 Claims-Based Measures**
  - MSPB—Medicare Spending per Beneficiary
  - Discharge to Community
  - Potentially Preventable Re-hospitalizations

- **2018 Additions**
  - Medication reconciliation/Drug Regimen Review
  - Change in Self-Care Score for Medical Rehab Patients
    - Change in Mobility Score for Medical Rehab Patients
    - Discharge Self-Care Score for Medical Rehab Patients
    - Discharge Mobility Score for Medical Rehab Patients

- Care Plan—communication of health info (10-1-20?)
Reporting Data

• Collected through MDS submissions
  o Claims data is not covered under this requirement
• At least 80% of all MDSs submitted must report this data (no dashes)
• DO NOT submit managed care MDSs unless they satisfy an OBRA (survey) MDS requirement, i.e. significant change, annual, admission, quarterly
• 2% penalty for not reporting per requirements
  o Penalty is enforced for the entire fiscal year, annual payment update

Exclusions to PPR

• Discharge to another SNF/IRF/LTCH
• Residents who expire during their Medicare covered episode
• Discharges AMA (against medical advice)
• Acute care stay for cancer treatment or pregnancy
• Residents who exhaust their Medicare benefits
• Residents who were not Medicare beneficiaries for 12 months prior or 3 months after the stay
• Transfers to federal hospitals
• ESRD
**Most Common Reasons for Readmissions**

1. Inadequate management of chronic conditions
2. Inadequate management of infections
3. Inadequate management of other unplanned events
4. Inadequate injury prevention

*multiple SNF admissions during a 12 month period will all count*

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**What’s Potentially Preventable?**

- Respiratory: COPD, asthma, aspiration PNA, bacterial PNA, flu
- Cardiac: CHF, hypo/hypertension, some arrhythmias
- Some diabetic complications
- Skin/Subcutaneous: pressure ulcers, infections
- Septicemia
- GI/GU: UTI, Cdiff, dehydration, gastroenteritis, acute kidney failure, electrolyte imbalances, intestinal impaction
SNFQRP Exclusions for Discharge to Community

- Discharge to a psych hospital
- Discharge to Hospice facility, or community hospice
- Discharge to law enforcement
- Discharge AMA (against medical advice)
- Discharge to another SNF
- Acute care stays for cancer treatment
- Planned discharges
- Benefits exhaust

MSPB Example

<table>
<thead>
<tr>
<th>Episode 1</th>
<th>Episode 2</th>
<th>Episode 3</th>
<th>Episode 4</th>
<th>Episode 5</th>
<th>Episode 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,300</td>
<td>$4,890</td>
<td>$4,020</td>
<td>$5,270</td>
<td>$6,850</td>
<td>$5,460</td>
</tr>
</tbody>
</table>

Expected Spending

- $4,000
- $4,100
- $3,700
- $6,200
- $5,900
- $5,000

Ratio of Obs/Exp

- 0.825
- 1.193
- 1.086
- 0.850
- 1.161
- 1.092

Provider's Average Obs/Exp Ratio

\[= 6.207\]

MSPB PAC Amount

\[= 6.207 / 6 \text{ episodes} = 1.035\]

National Average Observed Episode Spending = $5,325

\[1.035 \times 5,325 = 5,509\]

National Median MSPB PAC Amount = $5,700

\[5,509 / 5,700 = 0.966\]
### Table Legend
- **[a]**: The treatment period is the time during which the patient receives care services from the attributed LTCH and includes Part A, Part B, and Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims.
- **[b]**: The associated services period is the time during which any Medicare Part A and Part B services other than those in the treatment period are counted towards the episode spending.
- **N/A** = Not Available
- **Note**: Claims-based measures do not have CASPER™ Hospital Level Quality Measure reports.

### Average Spending Per Episode

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>CMS Measure ID</th>
<th>Number of Eligible Episodes</th>
<th>Average Spending Per Episode</th>
<th>MSPB Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Spending Per Beneficiary (MSPB)</td>
<td>LO19.C1</td>
<td>21</td>
<td>$11,206</td>
<td>$16,216</td>
</tr>
<tr>
<td>Post Acute Case Long Term Care Hospital Quality Reporting Program</td>
<td>LO19.C1</td>
<td>6,000,000</td>
<td>$15,865</td>
<td>$18,473</td>
</tr>
</tbody>
</table>

**EXAMPLE DATA**

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### SNF Value Based Purchasing

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37

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38
SNF VBP

Result of PAMA of 2014 enacted 4-1-14 under Social Security Act

• Focus of the program:
  o Performance standards including ‘achievement’ and ‘improvement’ ratings
  o Rank SNFs for from low to high based on performance
  o 2% of PPS/Medicare payment withheld to fund program
  o Incentive payments to providers must total 50-70% of amount withheld
  o Incentive payments=buying your money back

• Both measures are based on hospital readmissions
  o SNF RM- all-cause/condition, original measure (began 1-1-17)
    • Payments affected 10/1/18
  o SNF PPR- potentially preventable, risk adjusted (10/1/20?)

SNF VBP Re-hospitalization Measure RM

_________________________ 2018 your SNF

↑ ‘Improvement’ Rating up to 90 points

_________________________ 2016 your SNF

Better of the two, Improvement Rating or Achievement Rating
SNF VBP Re-hospitalization measure RM

**Benchmark:** Average top 10% performing SNFs in 2015 (83.721)

- If your SNF meets the BENCHMARK, then your rating is 100.
- If your SNF doesn’t meet at least the 25th percentile, then your rating is 0.
- Remainder will be disbursed, 0-99.

**Achievement Rating:** SNF reaches 25% threshold (19.782)

### SNF VBP Measure

- Results in achievement rating score based on percentage of residents that were **not** readmitted during the window
- Compares value rating scores between providers
- How did you do in 2018 compared to all SNFs nationwide in 2016?
  - If you did better than benchmarks (100 points)
  - If you did worse than achievement threshold (0 points)
  - All facilities in between points assigned based on “Achievement Score”
- Second score “Improvement Score” based on how well your facility did in 2018 compared to your 2016 data
  - Above benchmark (90 points)
  - If worse than 2016 (0 points)
Performance Scores for FY20

The lower the readmission rate, the better.
Since a lower readmission rate is better, CMS has inverted every SNF’s readmission rate using (1 – readmission rate) for the purposes of the performance standards (i.e., benchmark and achievement threshold) and performance scoring.

- Standard 2016
- 25th Percentile 19.782%
- Achievement Threshold 80.218%
- Mean of the Best Decile 16.279%
- Benchmark 83.721%

Supplemental Workbook - Eligible Stays tab

<table>
<thead>
<tr>
<th>PATIENT CHARACTERISTICS</th>
<th>INDEX SNF INFORMATION</th>
<th>PRIOR PROXIMAL HOSPITAL INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID Number</td>
<td>HICN</td>
<td>Sex</td>
</tr>
</tbody>
</table>
Facility Level Data

Your SNF’s FY 2019 SNF VBP Program Performance

Annual Performance Score Report

<table>
<thead>
<tr>
<th>Performance Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Period (CY 2015) RSRR</td>
<td>0.18998</td>
</tr>
<tr>
<td>Improvement Threshold (Baseline Period Inverted RSRR)</td>
<td>0.81002</td>
</tr>
<tr>
<td>Performance Period (CY 2017) RSRRA</td>
<td>0.19753</td>
</tr>
<tr>
<td>Performance Period Inverted RSRR</td>
<td>0.80247</td>
</tr>
<tr>
<td>FY 2019 Achievement Threshold</td>
<td>0.79590</td>
</tr>
<tr>
<td>FY 2019 Benchmark</td>
<td>0.83601</td>
</tr>
<tr>
<td>SNF VBP Achievement Score</td>
<td>19.74196</td>
</tr>
<tr>
<td>SNF VBP Improvement Score</td>
<td>0.00000</td>
</tr>
<tr>
<td>SNF VBP Performance Score</td>
<td>19.74196</td>
</tr>
<tr>
<td>SNF VBP Program Rank</td>
<td>10,049</td>
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<tr>
<td>Incentive Payment Multiplier</td>
<td>0.9816988654</td>
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</table>

Note: There were 3,249 unique (non-tied) performance scores in the FY 2019 SNF VBP Program and 15,421 SNFs eligible for the Program nationally. RSRR = Risk-Standardized Readmission Rate; CY = Calendar Year; FY = Fiscal Year; N/A = Not Applicable.

Provider Reports

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<tbody>
<tr>
<td>3 out of 6,700</td>
<td>012345</td>
<td>YOUR SNF</td>
<td>I WELLNESS      DR</td>
<td>BANGOR</td>
<td>MAINE</td>
<td>04401</td>
<td>PENOBSCOT</td>
<td>12.364 %</td>
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Next Steps

- Monitor readmissions monthly- resident level
- Look for trends, patterns, specifics
- Identify opportunities to apply strategies to apply to residents with similar conditions
- Be aware of facility rankings in the SNFVBP program
- Keep an eye on readmission rates on a monthly basis to identify increases timely

PDPM Sweet Spot for SNFs

- The ‘carrot’ for SNF providers is to provide enough care and services to keep resident out of the hospital for 30 days
- Keep rehab costs down, but still achieve good outcomes
  - Restorative nursing
  - Utilize concurrent and group therapy
    - Practice with managed care or other Non-RUG payers now
    - Prepare for PDPM cost containment
Questions??

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