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Billing Alert for Long-Term Care

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How PBJ staffing data is affecting your bottom line

Payroll-Based Journal (PBJ) data submitted to the Centers for Medicare & Medicaid Services (CMS) in accordance with the agency's requirement that went into effect July 1, 2017, is now live on Nursing Home Compare and is being used to calculate the staffing rating in the Nursing Home Five-Star Quality Rating System. Beginning June 1, 2018, CMS will no longer collect facility staffing data through the CMS-671 form, meaning that providers will no longer have to fill out page 2 of this form.

In a memo sent to surveyors on April 6, 2018, CMS emphasized the importance of adhering to the RN staffing requirement in particular, which mandates that facilities have an RN on-site for eight hours per day, seven days a week.

"For facilities with less than 50 beds, this may be the director of nursing (DON), but for larger facilities with 50 beds or more, an RN must be present for eight hours per day in addition to the DON," says **Reginald Hislop III, PhD**, owner of H2 Healthcare Consulting. This requirement will have the biggest impact on facilities' star ratings, he says. "If the PBJ data shows seven shifts or more in a month with no RN, the corresponding star rating drops to one."

Facilities could be presumed to have low levels of staffing if the following occurs:

- Audits identify significant inaccuracies between the hours reported and the hours verified, or if the facility fails to submit any data by the required deadline
- Failure to respond to an audit request pertaining to the data
- The inability of CMS to audit the data and confirm the staffing numbers alleged

Any of the above listed events could result in a one-star rating in the staffing domain, dropping the facility's overall star rating by one star for that quarter.

PBJ reporting periods

Fiscal Quarter	Reporting Period	Due Date
1	Oct 1 to Dec 31	Feb 14
2	Jan 1 to March 31	May 15
3	April 1 to June 30	Aug 14
4	July 1 to Sept 30	Nov 14

PBJ: Helpful or harmful?

Does PBJ data paint an accurate picture of how many staff members are on the floor at any given time? Providers have argued that the system doesn't account for the creative staffing measures that long-term care facilities have to take depending on resident needs. For example, the PBJ system won't accept hours exceeding 40 worked by salaried employees unless a bonus is paid for the excess hours.

Steven Calderbank, MS, senior analyst at PointRight sees two sides to PBJ: One side allows beneficial auditing capabilities, and the other side, he says, could use improvement. "PBJ offers little flexibility in how data is captured and doesn't align with the realities of staffing at most SNFs. It doesn't seem quite fair that salaried staff who work a few extra hours not have that time reflected in the PBJ system," he says. "Additionally, many SNFs cross-train their staff, yet PBJ creates barriers to capturing these creative approaches to meeting resident needs. It's not to say that it's impossible to capture the hours in both these cases [using the PBJ system], it's just administratively burdensome to do so, especially in comparison to the prior system."

Calderbank is referring to the CMS 671 form, which used to measure staffing rates over a two-week stretch, once a year, as part of SNFs' annual survey. "Understanding that a two-week stretch may not accurately reflect a facility's true staffing, CMS pushed forward the PBJ," he says, noting that this "allows staffing and census information to be collected on a daily basis that is both comprehensive and auditable. The transition from 671 to PBJ has increased the sample size, improved accuracy, and aligned SNFs' measurement window to ensure that seasonal trends or holidays do not unfairly impact individual nursing homes. This process will undoubtedly help providers systematically track staffing rates and properly position themselves amongst their peers."

And although PBJ data does not currently account for the case-mix adjustment factor (or the idea of adjusting payments based on residents' varying care needs), "it is sensitized by Resource Utilization Group (RUG) data and the number of residents in a facility," says Hislop.

His advice for effectively using this data? "Know your case-mix and acuity levels plus resident needs and staff

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accordingly. Every facility should be capable of acuity-based staffing, and now, with Phase II requirements as part of the survey tasks and the facility assessment requirement front and center, facilities should have adequate data to create proper staffing plans."

Tying PBJ data to revenue cycle management

Revenue cycle management is a financial process that begins at pre-admission and considers how administrative and clinical functions will impact claims processing, payment, and revenue generation at multiple points throughout the resident's stay. With this philosophy in mind, facilities should be using the available data provided by PBJ (delivered to long-term care facilities through the Public Use File [PUF] and containing the facility's census for each day within the quarter as calculated using the MDS submission) to identify areas for improvement in the revenue cycle.

The facility assessment, for example, identifies what resources will be necessary for a facility to care for residents during daily operations. "A facility may conduct a facility assessment and find that there is a large cohort of residents with some level of cognitive impairment," says **Paola M. DiNatale, MSN, RN, NHA**, senior healthcare specialist at PointRight. "They then have to consider how current staffing patterns and staff expertise fit in with this finding. For example, does the facility need to reallocate the current staffing resources by shift or unit? In addition, there might be changes in activities or diet that need to be taken into consideration when evaluating staffing levels." How well facilities determine these staffing levels is subject to public scrutiny on Nursing Home Compare.

In addition to conducting a thorough facility assessment, DiNatale notes the importance of another key role in effective revenue cycle management: the MDS coordinator. "The MDS assessment is foundational to the care planning process, but also directly relates to billing, as the individual resident acuity reflected in the MDS drives reimbursement on both the state and federal levels. Inaccurate assessments can lead to inaccurate care plans and billing errors. Care plans that do not address individual resident needs can lead to negative care outcomes and poor surveys, which can lead to poor star ratings. Poor star ratings can impact census. As you can see, it is a circular relationship in which accurate MDS assessments are key," she says.

Hislop warns that facilities sometimes focus too much on the case-mix aspects of revenue cycle management and therefore miscode the MDS, leading to inaccurate quality measures and star ratings. Facilities can get into major trouble if this is the case, he explains, as surveyors and Recovery Auditors have become wise to the disconnect between MDS scores and the documentation included in residents' charts. He encourages facilities to focus less on "achieving a star rating" and more on "what the stars mean." Facilities that concentrate on quality, resident care, and outcomes, he says, will have zero issues with PBJ and the resultant star rating.

A reminder to support billing claims under new proposed payment system

DiNatale notes that with the proposed prospective payment system reform unveiled in a proposed rule published in April, which introduced the Patient-Driven Payment Model (PDPM) as a replacement for RUG-IV, "MDS coordinators or another team member will need to be well versed in ICD-10 coding and sequencing." Although the proposed rule would not implement PDPM until October 2019, DiNatale recommends that providers prepare now by validating resource utilization categories, non-therapy ancillaries, and ICD-10 sequencing on bills prior to submission to ensure prompt payment after the bill is submitted, as well as have a process for auditing MDS accuracy on a regular basis as part of a robust compliance plan. "These basic steps can ensure that MDS assessments are accurate, and therefore the facility's billing claims will be accurate," she says.

Hislop points out that while CMS doesn't specifically say so, PDPM (and the shift away from RUGs, minutes, and therapy payments, etc., to a whole-resident approach) will fundamentally change the industry, the role of revenue cycle, and the job of the MDS coordinator.

But "CMS has long identified staffing as a key component of a facility's ability to provide quality care to residents," says Calderbank, noting at least one consistency that providers can rely on amidst the waves of a rapidly shifting industry.