PACAH Spring Conference

April 27, 2018

Data Impact to Upcoming SNF Reimbursement Methodologies

- PBJ
- Hospital Referral Data
- Medicare Advantage
- Reimbursement Methodologies

PBJ – 5 Star Rating

Q4 2017 – April 2018

Q1 2018 – July 2018

Measures Posted to Nursing Home Compare

- RN Hours per resident day
- Total Nursing Hours per resident day
- Physical Therapist Hours per resident day
- Census
  - MDS discharge assessment

Percentage of Resident Stays with Missing MDS Discharge Assessment	Number of Centers in Nation	Average Total Staffing HPRD
0%	758	4.29
>0% to 2%	3,632	4.09
>2% to 5%	5,495	3.80
>5% to 10%	3,962	3.68
> 10%	1,798	3.55

Reduced to 1 star staffing rating

- Reported no RN hours for 7 or more days in period
  - 1,004 facilities based on Quarter 3 2017 data (15,647 total)
- Audit finds inconsistencies in data submitted
- PBJ data submitted after deadline

State	Hours PPD
Pennsylvania	3.82
Ohio	3.66
Illinois	3.44
Michigan	4.06
Florida	4.24

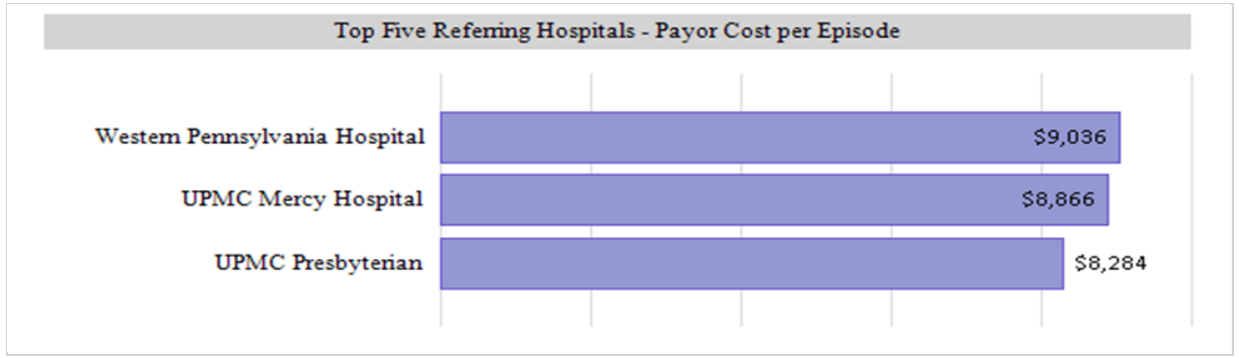
Hospital Referrals

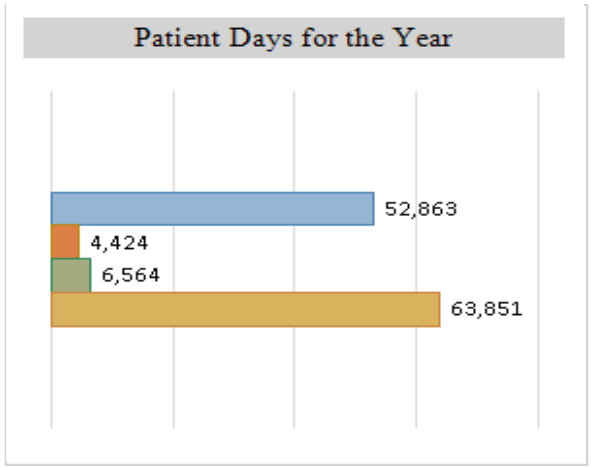
Medicare Market Integration

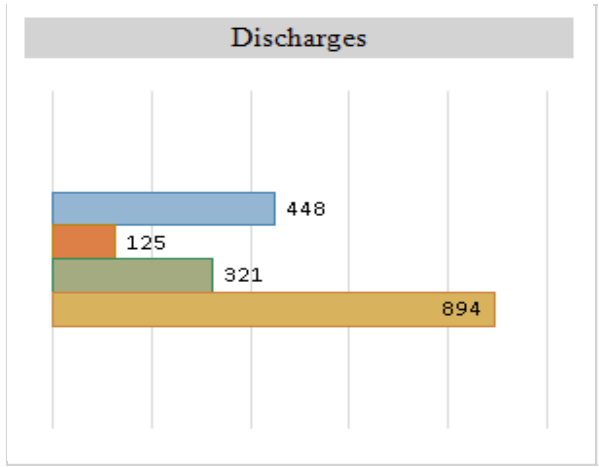
General Facility Information

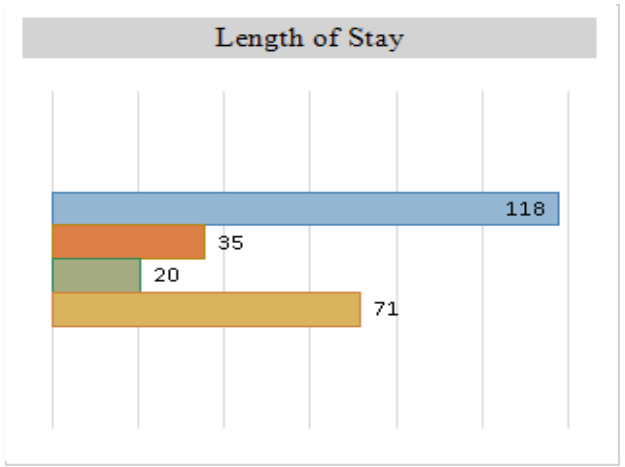
Sample SNF — Pittsburgh, PA 15232

Total Admissions	# of Staffed Beds
894	197
Financial Data as of	**Occupancy %**
06/30/2016	88.80 %



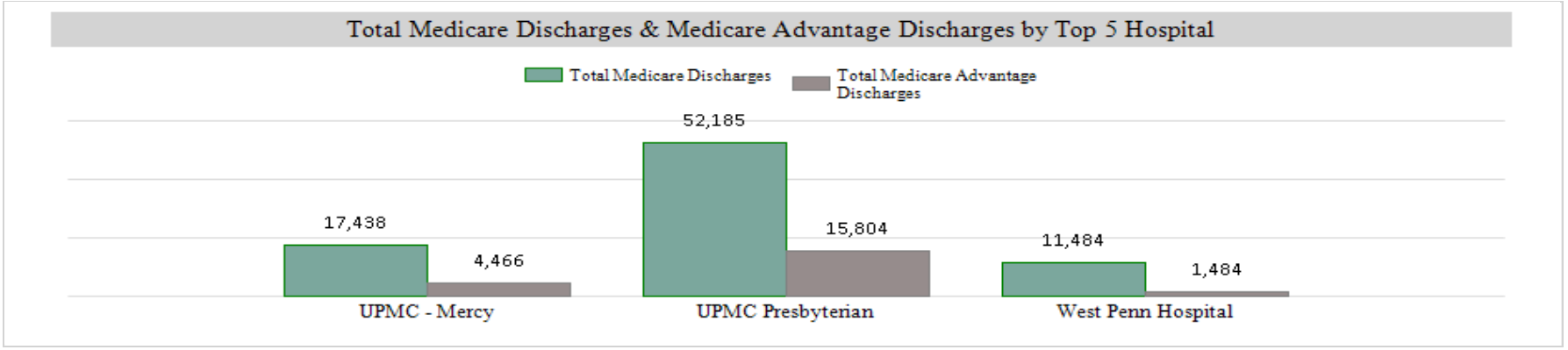


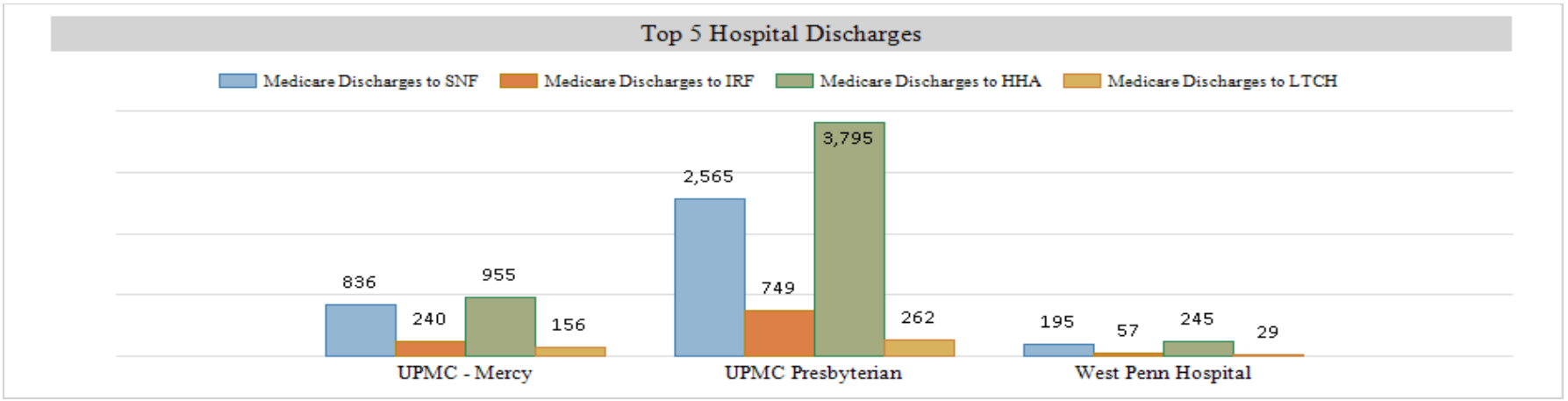




Medicaid | Medicare | Private/Self/Other | Total

Market Area Hospital Discharges





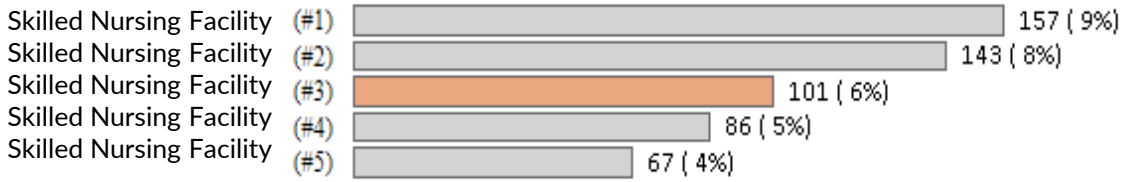
Market Area Hospital Referrals to SNFs

Referral Hospital Analysis

Referral Year: 2016

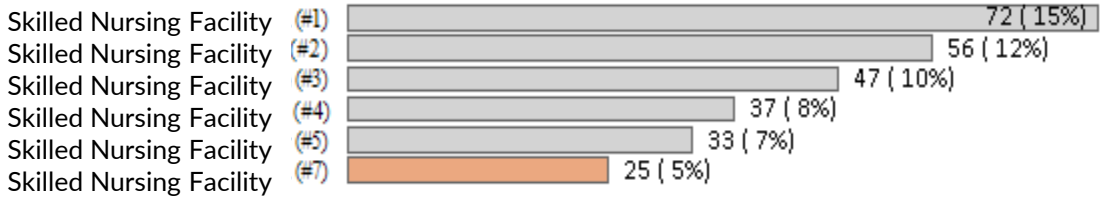
UPMC Presbyterian

SNF Count (>10 Referrals) : 62
SNF Count (<=10 Referrals) : 225



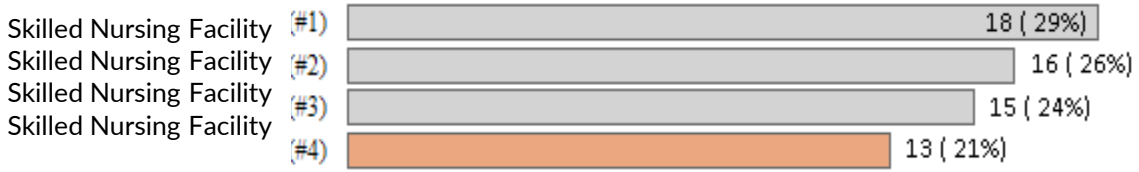
UPMC Mercy Hospital

SNF Count (>10 Referrals) : 17
SNF Count (<=10 Referrals) : 149



Western Pennsylvania Hospital

SNF Count (>10 Referrals) : 4
SNF Count (<=10 Referrals) : 77

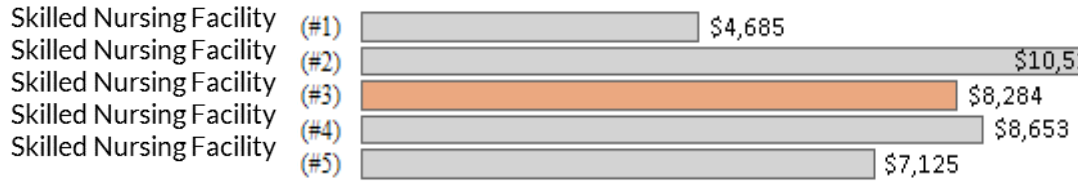


Market Area Cost Analysis

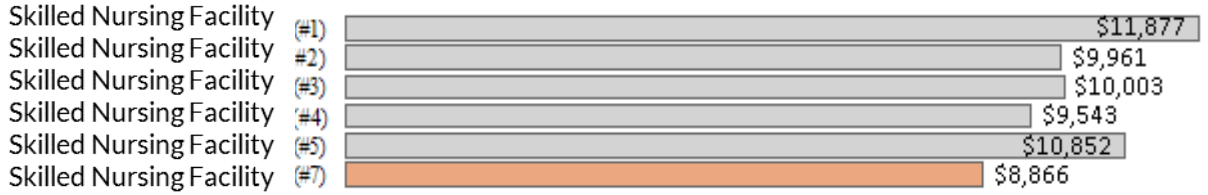
Competitive Cost Analysis

Payor Cost per Episode for 2016 Referral Year

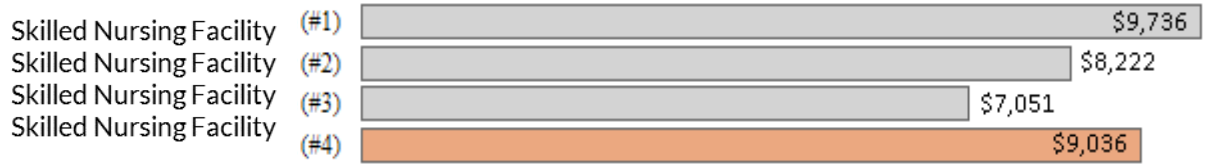
UPMC Presbyterian



UPMC Mercy Hospital



Western Pennsylvania Hospital



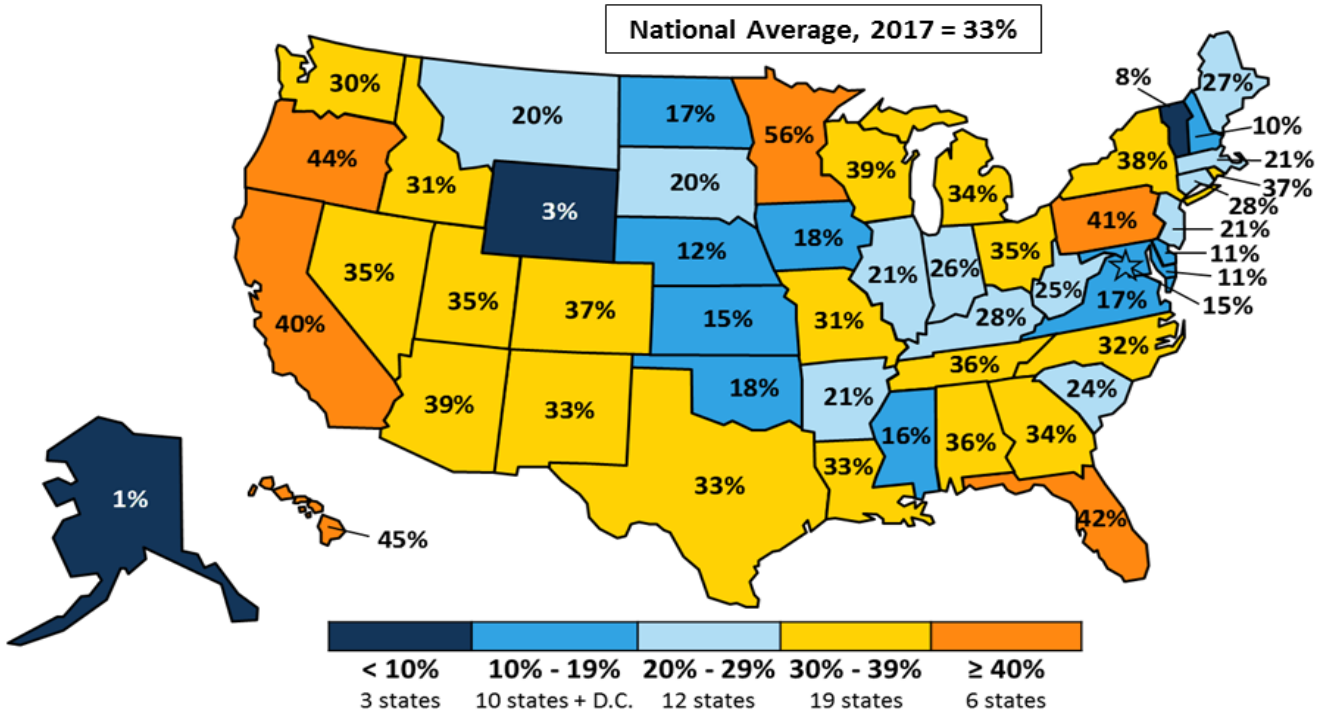
Medicare Advantage

Medicare Advantage Enrollment

Figure 4

Enrollment in Medicare Advantage plans varies across states

Share of Medicare Beneficiaries Enrolled in Medicare Private Health Plans, by State, 2017



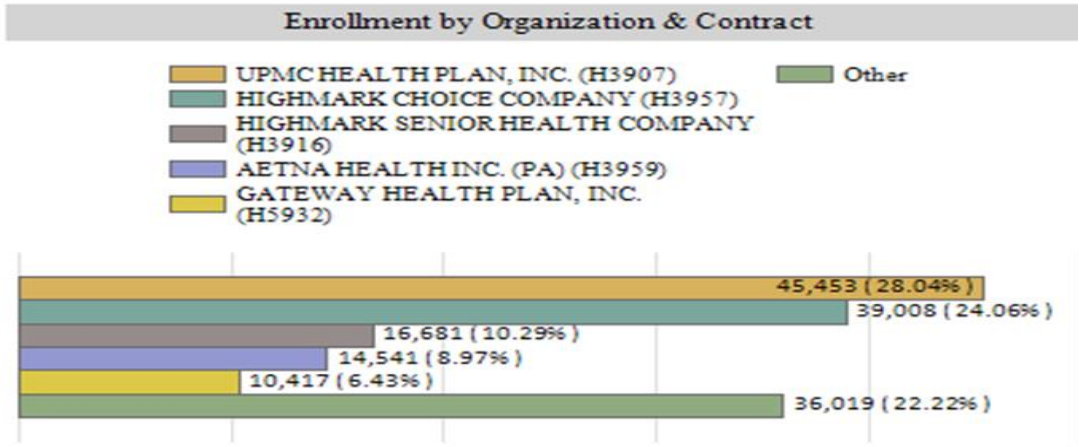
NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses and beneficiaries in territories other than Puerto Rico.
SOURCE: Authors' analysis of CMS State/County Market Penetration Files, 2017.

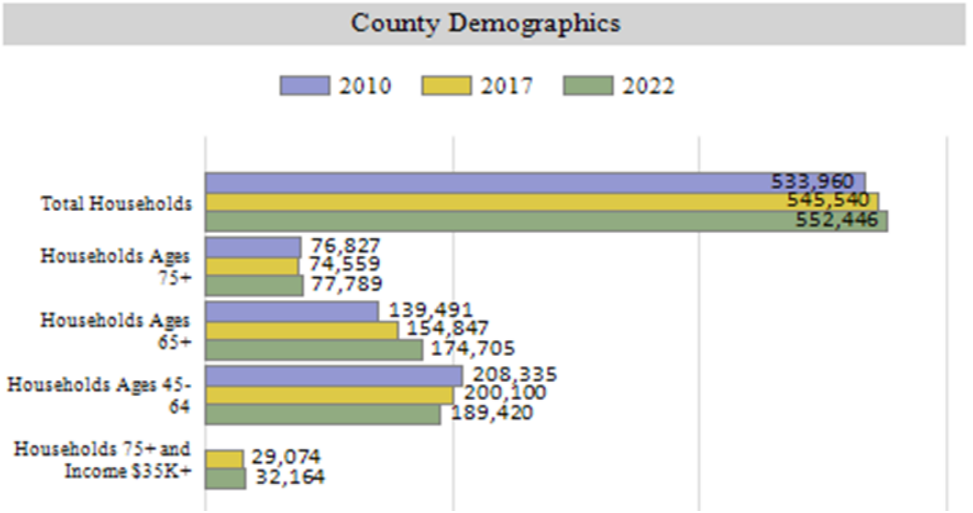
THE HENRY J. KAISER FAMILY FOUNDATION

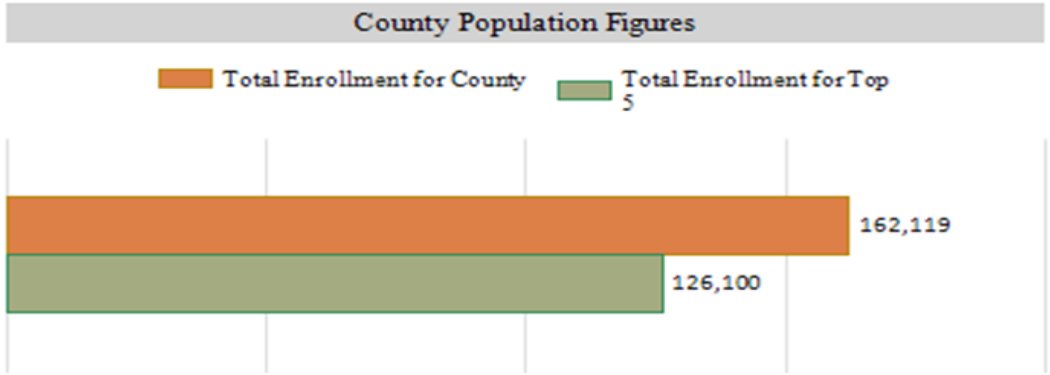
Regional State Medicare Advantage Enrollment

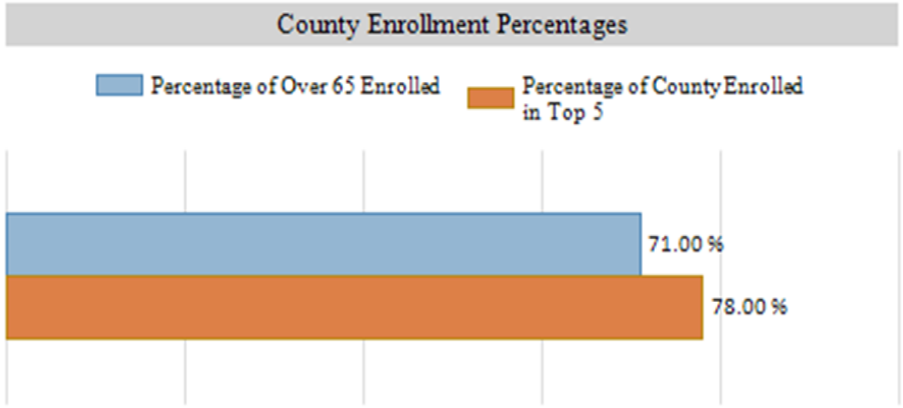
Medicare Advantage Enrollment By State						
State	2016 Enrollment	2017 Enrollment	Change in Total Enrollment, 2016-2017	Percent Change in Enrollment, 2016-2017	2016 Penetration Rate	2017 Penetration Rate
Ohio	748125	787209	39084	5.00%	34.00%	35.00%
Illinois	405756	454965	49209	12.00%	19.00%	21.00%
Indiana	279338	311612	32274	12.00%	24.00%	26.00%
Michigan	621118	673166	52048	8.00%	32.00%	34.00%
Pennsylvania	1022462	1065053	42591	4.00%	40.00%	41.00%

Health Plans









Pittsburgh Medicare Benchmarks

Pittsburgh CBSA

MEDICARE

Medicare Vitals

Description	Measured	State (655)	CBSA (117)	For-Profit (383)	Not-For-Profit (248)	Gov't (24)	National (14313)
Medicare Profitability (ppd)							
Revenue		$490.96	$469.28	$497.35	$484.33	$457.63	$495.74
Routine Expense		$216.44	$212.17	$199.14	$240.21	$246.94	$193.44
Capital Expense		$22.72	$21.55	$27.03	$17.55	$7.42	$22.45
Therapy Expense		$125.92	$124.34	$124.22	$126.44	$147.95	$132.75
Other Ancillary Expense		$56.43	$60.18	$56.82	$55.40	$60.67	$53.08
Total Expense		$421.52	$418.24	$407.22	$439.60	$462.98	$401.72
Profit (Loss)		$69.44	$51.04	$90.13	$44.73	($5.35)	$94.02
Medicare Profitability (Per Episode)							
Revenue		$24,553.46	$17,973.35	$26,841.23	$20,735.80	$27,493.57	$22,830.63
Total Expense		$22,855.42	$16,196.80	$25,171.85	$18,376.17	$32,174.81	$18,533.83
Profit (Loss)		$1,698.04	$1,776.55	$1,669.39	$2,359.63	($4,681.24)	$4,296.80
Medicare RUG Concentration							
Rehab Residents		92.43%	92.99%	91.47%	94.57%	85.76%	92.04%
Clinical/Other Residents		7.57%	7.01%	8.53%	5.43%	14.24%	7.88%
Weighted Nursing Index		1.40	1.38	1.42	1.36	1.36	1.36
% of Rehab Residents in Extensive		1.45%	1.11%	1.94%	0.78%	0.62%	1.77%
Medicare Utilization							
Utilization - Medicare - SNF & NF		10.61%	8.14%	11.17%	10.35%	4.21%	14.10%
ALOS - Medicare - SNF		42.00	35.74	43.46	39.09	49.68	41.21
Medicare Therapy							
Therapy Revenue (ppd)		$193.91	$184.69	$198.51	$188.18	$179.33	$197.01
Therapy Expense (ppd)		$125.92	$124.34	$124.22	$126.44	$147.95	$132.75
Therapy Net Profit (Loss) (ppd)		$67.99	$60.35	$74.29	$61.74	$31.38	$64.26
Weighted Therapy Case-Mix Index		1.54	1.59	1.57	1.49	1.44	1.52
Therapy Cost per Case-Mix		$82.85	$78.31	$79.26	$85.99	$108.71	$88.55

Pittsburgh Medicare Benchmarks

Pittsburgh - Based on filed CMS Cost Reports

MEDICARE

RUG Concentrations

Description	Measured	State (655)	CBSA (117)	For-Profit (383)	Not-For-Profit (248)	Gov't (24)	National (14313)
Reporting Period							
Concentration of RUG Categories							
Rehab		**92.43%**	**92.99%**	**91.47%**	**94.57%**	**85.76%**	**92.04%**
Extensive Care		**1.00%**	**0.59%**	**1.39%**	**0.44%**	**0.64%**	**0.56%**
Special Care		**3.64%**	**3.75%**	**4.03%**	**2.63%**	**7.77%**	**3.93%**
Clinically Complex		**1.63%**	**1.50%**	**1.67%**	**1.41%**	**3.18%**	**1.75%**
Behavior Problems		**0.08%**	**0.05%**	**0.09%**	**0.06%**	**0.14%**	**0.22%**
Reduced Physical Function		**0.93%**	**0.78%**	**1.02%**	**0.73%**	**1.51%**	**1.02%**
Default		**0.29%**	**0.35%**	**0.33%**	**0.16%**	**1.00%**	**0.41%**
Rehab Therapy Utilization							
Ultra High		**56.91%**	**61.56%**	**62.16%**	**49.69%**	**47.66%**	**55.26%**
Very High		**28.76%**	**28.03%**	**24.52%**	**35.07%**	**31.07%**	**29.30%**
High		**9.01%**	**6.99%**	**7.75%**	**10.62%**	**12.44%**	**10.59%**
Medium		**5.25%**	**3.38%**	**5.53%**	**4.51%**	**8.75%**	**4.76%**
Low		**0.08%**	**0.03%**	**0.05%**	**0.12%**	**0.08%**	**0.06%**
Rehab ADL Concentration							
X - Extensive Assistance		**1.09%**	**0.69%**	**1.52%**	**0.49%**	**0.30%**	**1.02%**
L - Moderate Assistance		**0.37%**	**0.41%**	**0.42%**	**0.29%**	**0.33%**	**0.75%**
C - Extensive Assistance		**44.41%**	**40.75%**	**45.92%**	**42.00%**	**45.29%**	**34.41%**
B - Moderate Assistance		**32.68%**	**33.84%**	**31.52%**	**34.89%**	**28.07%**	**37.10%**
A - Low Assistance		**21.46%**	**24.31%**	**20.62%**	**22.33%**	**26.02%**	**26.68%**

Managed Care Profitability Analysis

Medicare Managed Care Charges Per Trial Balance										
Department	PT	OT	ST	Pharmacy	IV	Lab	Med Sup	Oxygen	X-Ray /EKG	Total
MCR Managed Care Charges	343,895	368,822	84,862	154,119	0	11,215	116,367	0	4,678	1,083,958
Estimated Managed Care Ancillary Costs with Overhead										
MCR Managed Care Cost	203,157	229,184	64,269	145,016	0	11,215	23,952	0	4,678	681,471
PY Total Managed Care Cost	*176,891*	*174,619*	*42,115*	*130,760*	*0*	*9,827*	*24,802*	*0*	*6,042*	*565,056*
% Change	*15%*	*31%*	*53%*	*11%*	*0%*	*14%*	*-3%*	*0%*	*-23%*	*21%*

Medicare Managed Care Profit / (Loss)										
			FY 2017			FY 2016				
			MC Revenue Per Diem	MC Expense Per Diem	MC P/(L) Per Diem	MC Revenue Per Diem	MC Expense Per Diem	MC P/(L) Per Diem		
Estimated Routine Cost Portion			$ 156.42	218.47	$ (62.05)	$ 169.88	$ 204.63	$ (34.75)		
Therapy Portion			131.12	118.07	13.05	142.39	106.41	35.98		
Pharmacy			25.54	34.48	(8.94)	27.74	35.35	(7.61)		
Other Ancillary Portion			6.15	9.47	(3.32)	6.68	11.00	(4.31)		
Total Estimated PPS			$ 319.23	$ 380.49	$ (61.26)	$ 346.69	$ 357.39	$ (10.70)		
Benchmark (based on PM sample)			$ 390.51	381.34	$ 9.17					
Average Part A Medicare Rate			$ 576.65	$ 404.41	$ 172.24	$ 574.39	$ 394.06	$ 180.33		

Reimbursement Methodologies

Proposed Reimbursement Models

- **Bundled Payment**
  - Move from mandatory to voluntary on CJR
  - Eliminated proposed cardiac bundle
- **MedPac proposal**
  - Unified post-acute payment methodology (LTAC, IRF, SNF,HHA)
- **Proposed RCS-1 as new SNF RUGs reimbursement**
  - CMS feels designed to better align payment with need
  - Reduction in payment rate as length of stay increases
  - Change in MDS schedule
  - Potential October 2019 Implementation

BPCI Advanced

- Bundled Payments for Care Improvement Advanced (BPCI Advanced) by CMS
- Defined by the following characteristics:
  - Voluntary Model
  - A single retrospective bundled payment and one risk track, with a 90-day Clinical Episode duration
  - 29 Inpatient Clinical Episodes
  - 3 Outpatient Clinical Episodes
  - Qualifies as an Advanced APM
  - Payment is tied to performance on quality measures
  - Preliminary Target Prices provided in advance of the first Performance Period of each Model Year
- Aims to encourage clinicians to adopt best practices, reduce variation from standards of care, and provide a clinically appropriate level of services for patients throughout a Clinical Episode
- BPCI Advanced will operate under a total-cost-of-care concept
- Starts on 10/1/18 and runs through 12/31/2023

MedPac

Medicare Payment Advisory Commission, MedPAC, continues to urge Congress to issue a revamped prospective payment system in 2018 report to Congress. Below are some of the highlighted recommendations and statistics.

- Eliminate the market basket update and implement a redesigned PPS that more closely aligns payments with costs.
- SNF margin for all payers (managed care, Medicare, Medicaid and private) and all lines of business (hospice, ancillary services, home health and investment income) in 2016 was 0.7%, this is down from 1.6% in 2015.
- MedPac supports Resident Classification System (RCS-1) and urges quick implementation, as this design and its impact is consistent with a 2008 design recommendation

MedPac

- In 2016, the combination of decreased SNF admissions (-6.5%) and sharper declines in days resulted in shorter stays averaging 25.7 days in length per 1,000 FFS beneficiaries.
- Trends in admissions and LOS reflect growing presence of alternative payment models, i.e. ACO's and bundled payments
- "There is some evidence that providers participating in alternative payment models refer fewer patients to PAC (post acute care) and that their SNF use includes shorter and less therapy intensive stays."

Resident Classification System (RCS-1)

- "Better account for resident characteristics and care needs, thus better aligning SNF PPS payments with resource use and eliminating therapy provision-related financial incentives inherent in the current payment model used in the SNF PPS"
- Four rate components: PT/OT, SLP, nursing, and non-therapy ancillary. A resident would be classified into each of the four components, a case-mix adjustment would be applied, and a single per diem payment derived.
- RCS-1 payment rates would include a "variable per diem adjustment," which reduces the per diem payment rate as the length of stay increases. This would align payment with costs, which are shown to decrease over the course of a stay.

SNF Quality Reporting Program (QRP)

- IMPACT Act imposed data reporting for Post-acute providers
- 80% of MDS assessments submitted must be in compliance with SNF QRP requirements
- 2% reduction to annual market basket update factor starting in FY2018
- Appeals delayed implementation due to technical coding issues. 1st thru 3rd quarters to coincide with 4th quarter of 2017 (May 15, 2018)
- Public reporting on measures – October 2018 will be FY data
- Check CMS website under SNF Quality Reporting Program – frequent updates (December 6th webinar). Check CASPER for reports.

Quality Measures from MDS

- Percent of (short stay) Residents with Pressure Ulcers that are New or Worsened (NF 0678);
- Percent of (long stay) Residents Experiencing One or More Falls with Major Injury (NF#0674); and
- Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NF #2631)
- Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care Skilled Nursing Facility Quality Reporting Program (October 2018 implementation)

Quality measures that are derived from *claims*

- Total estimated Medicare spending per beneficiary (MSPB); Begins on SNF admission and ends 30 days post discharge from SNF based on fee for service claims. CY2016 data in October 2017 report.
- Discharges to the community (DTC) post-acute. SNF to community without unplanned readmission to hospital within 31 days of discharge. CY2016 data.
- Potentially preventable 30-day post-discharge readmissions (PPR). Readmissions that could be prevented by proper care discharge planning and care coordination. CY2015 & 2016 data.

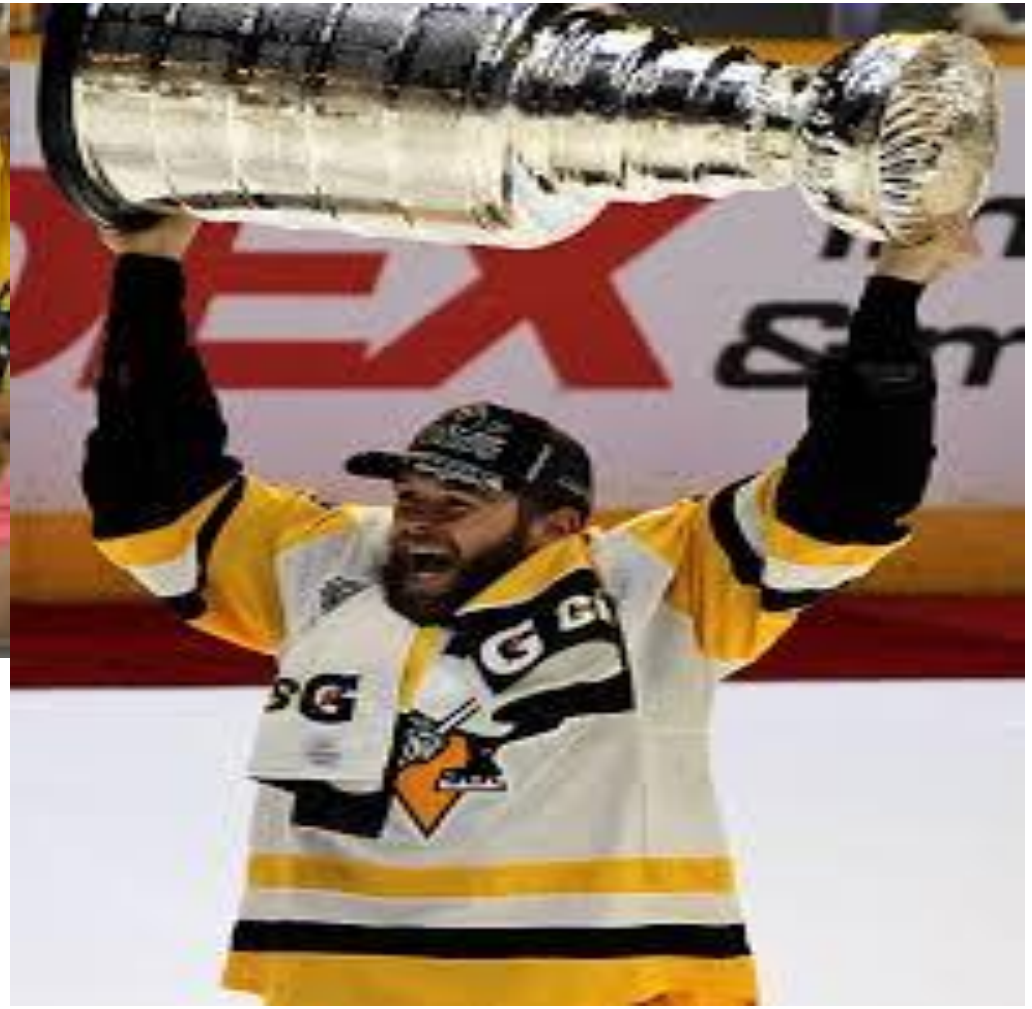
Value Based Purchasing

- CY2017 will be used for rates starting October 1, 2018 (FY19)
- FY20 based on 10/1/17 to 9/30/18 data
- Provider payments reduced by 2% starting FY19 and 60% of the funds will be paid back to providers who earn incentive.
- SNF 30-Day Potentially Preventable Readmission Measure, (SNFPPR), as the all-cause, all-condition risk-adjusted potentially preventable hospital readmission measure
- SNFPPR assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for SNF patients within 30 days of discharge from a prior admission to a hospital paid under the Inpatient Prospective Payment System, a critical access hospital, or a psychiatric hospital.

Value Based Purchasing

- Provider will receive higher of achievement score or improvement score to determine if incentive is earned. Higher ranking providers will receive larger share of incentive payment.
- 60 days prior to 10/1/18 providers will be notified of their incentive amount
- Providers will have a 30 day period to challenge the determination

Do you know this guy?



Betsy Rust, Partner | Plante Moran
Healthcare Strategy & Operations Leader
betsy.rust@plantemoran.com
(248) 223-3437

Contact Information

Denise Gadomski, CPA
Partner
Senior Care & Living Services
216.274.6514
Denise.Gadomski@plantemoran.com