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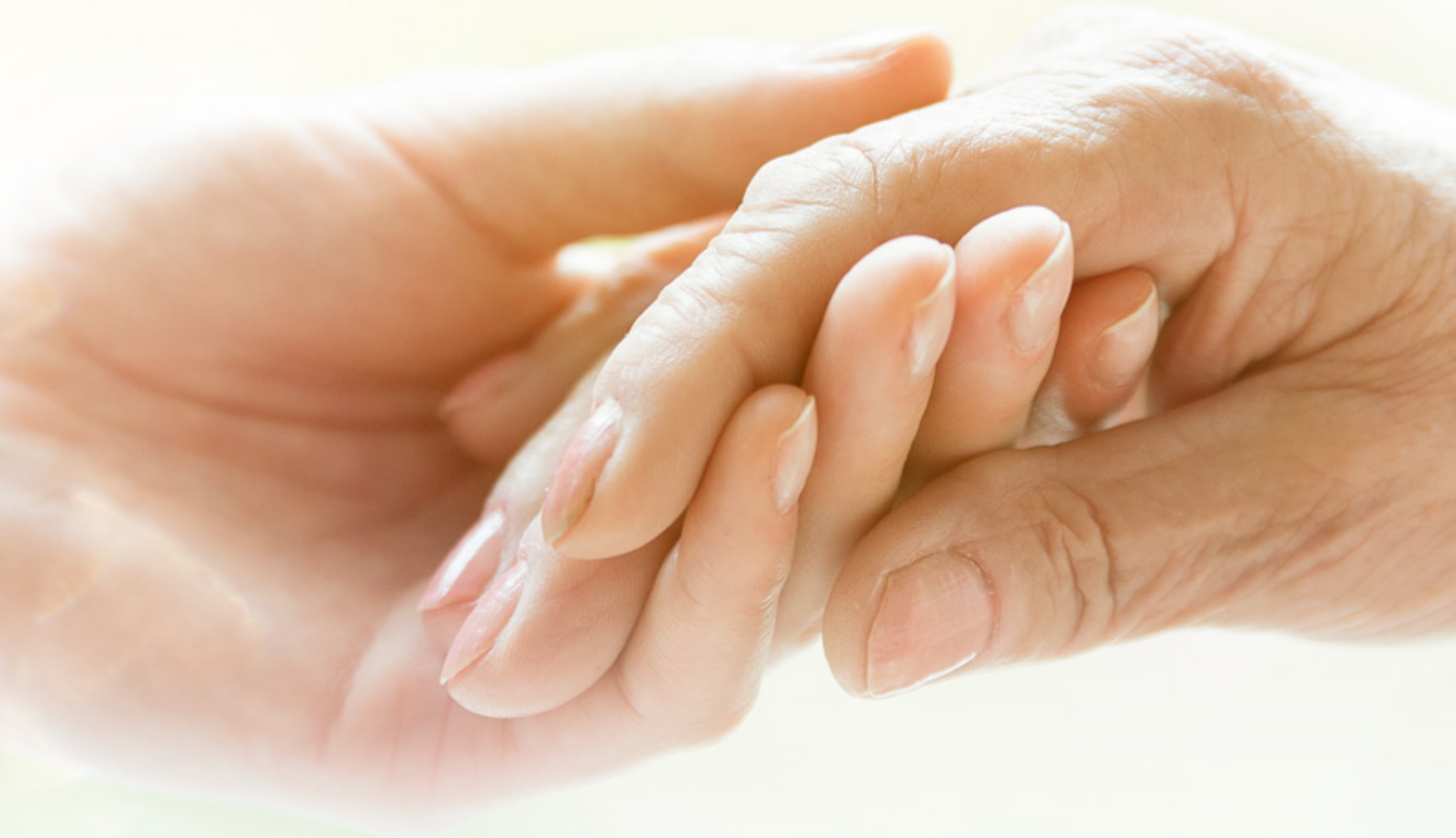

Addressing Changes in Post-Acute Care

Is your organization prepared?

Post-Acute Care (PAC) organizations provide critical services to an aging population whose numbers and health demands continues to increase. In fact, according to the U.S. Census Bureau, by the year 2030, one in every five residents will be retirement age, with all baby boomers older than age sixty-five.[1]

PAC providers deliver the necessary care for our loved ones who required short-term skilled nursing and/or rehabilitation services, as well as long-term care for persons who cannot safely reside within a setting of greater independence. Facilities provide a high level of clinical excellence, compassion, and adaptability critical to our healthcare system. However, despite their importance, they face many challenges within their market environment.

Common obstacles for PAC facilities can include:

- Finding & retaining qualified staff
- Better leveraging both up- and down-stream provider relationships
- Accuracy and adequacy in reimbursement
- Adjusting to new minimum wage requirements (in certain states)
- Addressing rising costs from suppliers

In this whitepaper, our experts will explore the most recent changes facing Post-Acute Care facilities, the implications involved, and how organizations can prepare for these changes. We'll also review where the industry has been to better understand why and how change is a constant part of PAC services.

About Our Authors:

Lou Ann Brubaker
President and Founder of Brubaker Consulting

Lou Ann Brubaker is a highly accomplished Senior Healthcare Consultant, Entrepreneur, and Educator with more than 30 years of success in the post-acute care marketplace. She is the President and Founder of Brubaker Consulting.

Leveraging extensive experience working with senior care professionals, ranging from C-suite to the front-line, Lou Ann is a valuable asset for healthcare organizations across the provider continuum in achieving their financial, occupancy, and staff recruitment/retention goals. She also works extensively with ancillary services and products providers, helping them increase their sales to post-acute care organizations.

Before founding her own company, Lou Ann directed the North American marketing for a technology division of the American Chemical Society. In three years, this division grew to become the world's largest provider of online medical, scientific, and technical information.

Lou Ann holds a B.S., Public Policy & Political Science from Kent State University. She is Past Chair and Past Director of the Board of Trustees for The Beacon Institute (the educational affiliate of Mid-Atlantic Lifespan, the largest senior care association in Maryland). She also served as a nationally elected Director of the Business & Professional Women's Foundation.

John Hall, Principal Consultant
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John hall has over 30 years of management experience in the Consumer Package Good (CPG) industry including 15 years as Senior Vice President and officer at a $240 million privately held company. His responsibilities included strategic planning, mergers & acquisitions, sales, marketing and operations.

His experience has served him well over his 10+ years at ERA. John is particularly interested in Senior Care based on his personal family experiences with Assisted Living, Skilled Nursing and Hospice Care providers. As such, he has devoted a significant amount of his effort to this area.

Fall 2019: A Major Change to the Payment Model

If there is any constant within PAC facilities, it is change: within residents' physical and cognitive needs, lengths of stay, and reimbursement. All three will come even more to the forefront in a significant way beginning in October 2019. As a helpful distinction, we will differentiate acute care from post-acute care (PAC), inclusive of skilled nursing facilities/SNFs, assisted living facilities/ALFs, Home Health Agencies/HHAs, and Hospice.

Beginning October 1, 2019, SNFs will be paid for Medicare A services under the Patient Driven Payment Model (PDPM). The impetus for this came from several sources, including an Office of the Inspector General (OIG) analysis with input from the Medicare Payment Advisory Council (MEDPAC) targeting greater accuracy in payments based upon individual resident needs.

Why this change matters now:

PDPM is only a few short months away. The near-term and long-term implications on PAC facilities include, but are not limited to:

- Steep PDPM learning curve
- Accuracy in Minimum Data Set (MDS) following resident admission
- Potential resources required in increasing skilled nursing capabilities

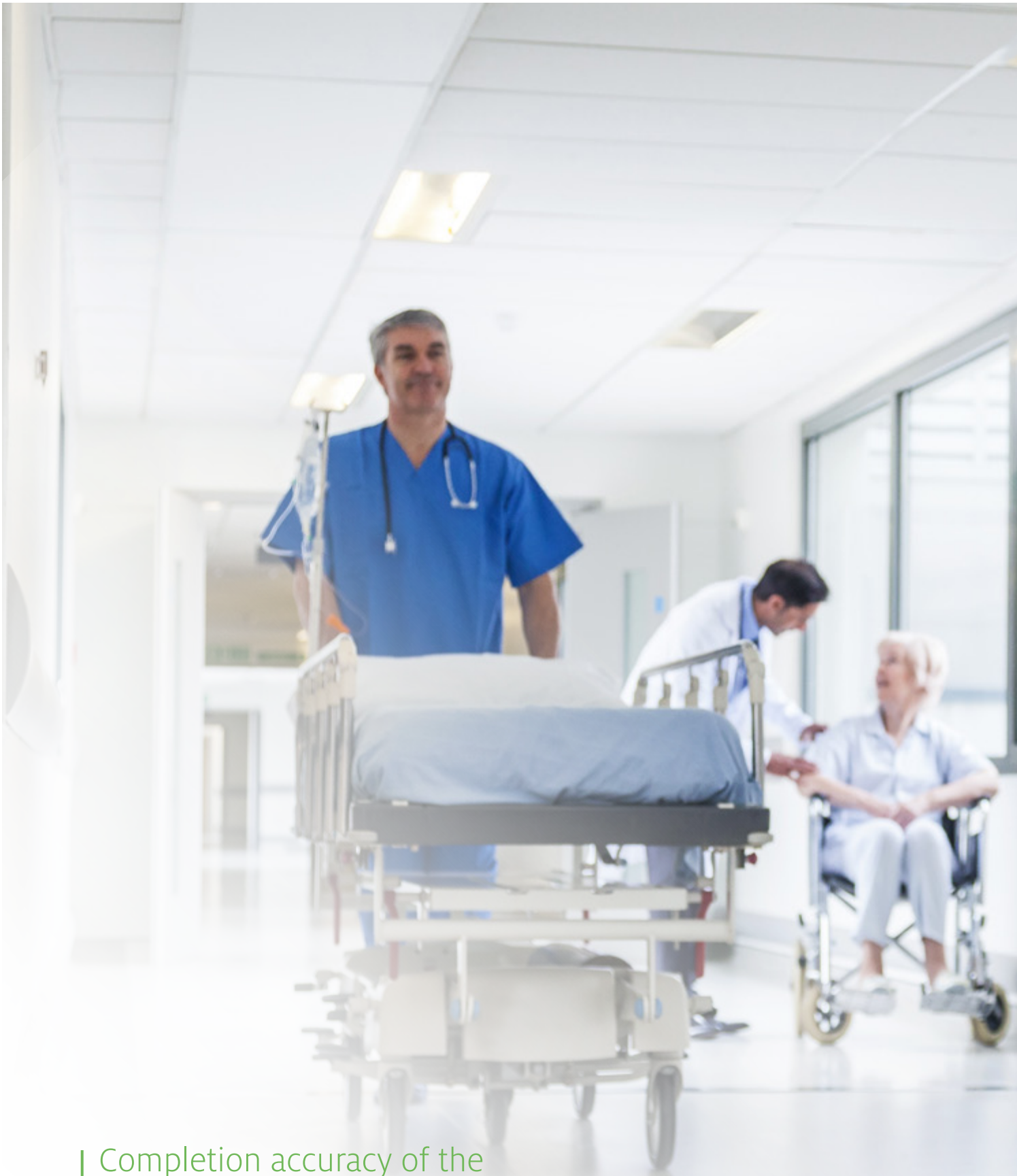
The ongoing challenges of staffing, wages, and supplier price increases will continue putting further pressure on profits. Utilization management is more important than ever to protect against the implications and risks outlined above.

Why the Payment Model is Changing

PDPM seeks to increase alignment of provided services more closely with individual resident need. It also targets more accurate payments within specific areas of care by separating components formerly combined under the Prospective Payment System (PPS). Within PDPM separate calculations will be used for each of the reimbursement components.

PDPM is part of a larger Value-Based Purchasing and Quality Reporting Program. Providers should expect further increases in Medicare A Quality Measures and higher scrutiny of costs of care. Data on Medicare Spending Per Beneficiary (MSPB) for residents is already included in SNFs' short-stay Quality Measures (www.Medicare.gov). Expressed as a ratio, it shows whether Medicare spends more, less, or about the same on an episode of care for a Medicare resident treated in a specific SNF compared to how much Medicare spends on an episode of care across all SNFs nationally. From the perspective of both Medicare and third-party payers, a ratio lower than 1.0 is more desirable and positions the SNF as a more attractive referral recipient.

If there is any constant within PAC organizations, it is change: in patient type and need, lengths of stay, and reimbursement.



Completion accuracy of the 5-day post-admission MDS will be more critical than ever. There will be only one opportunity to get it right.

What is the Significance of this Change?

Within PDPM six defined Groupers (versus RUGs) will be used (and combined to determine the Medicare A per diem): Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), medications (NTA), Nursing, and non-case mix (room & board, capital costs). Grouper assignments will be made upon admission/first MDS and remain constant over the length of stay (unless a significant change in resident status occurs).

The previously used five scheduled MDS assessments will be reduced to one scheduled (upon admission). Completion accuracy of this 5-day post-admission MDS will be more critical than ever. In most instances, there will be only one opportunity to get it right.

Three factors require attention by SNFs under PDPM: Condition (documented as a reason for admission), Cognition, and Co-Morbidities. The assessment must carefully identify resident cognitive challenge as this will impact payment more directly. The use of ICD-10 codes will be required. While MDS Coordinators will not have to have extensive experience in working with ICD-10 Codes, they WILL need to be able to identify the most common ones associated with typical resident admissions to assure optimal reimbursement.

A variable per diem will be implemented within PDPM. Payments will be highest during the first three days of a resident's stay. Within the NTA Grouper, base rate X case mix X3 (the adjustment factor) will drop back to a 1X multiplier between days 4 - 100. This will have a significant impact.

PT and OT also will be subject to an adjustment factor that reduces base rate X case mix by 2% every seven days beginning on day 21 and again every seven days going forward. Given payers' continued pressure upon SNFs to reduce Medicare lengths of stay, these 2% reductions should have a low financial impact.

Under PDPM, the financial incentive to provide higher minutes of therapy as a reimbursement driver will cease. SNFs will need to judiciously align therapy minutes with resident needs/goals. Greater payor scrutiny of both positive outcomes (based upon dollars paid) and lengths of stay will occur.

Pressure also will continue to maintain a four or five-star rating to encourage a steady stream of the acute care and managed care referrals.

Review: Where the Industry has Been

The current payment methodology for Medicare covering skilled nursing care is the Prospective Payment System (PPS), implemented in 1998, replacing the previous cost-reimbursed one. It requires the use of a comprehensive assessment tool, the Minimum Data Set (MDS), completed at specific intervals over a SNF resident's length of stay. Through these assessments, residents are assigned to one of 66 Resource Utilization Groups (RUGs), which are associated with specific per diem payments for care. In the third quarter of 2018, the average Medicare SNF per diem was $515. (Medicaid per diem was $209; private pay $261 and managed Medicare per diem was $427.)[4]

Each RUG category is comprised of 3 components: rehabilitation therapy, nursing/medications/social services, and room/board/capital expense. Only the first two components are case mixed (subject to change based upon initial and subsequent RUG assignment). Fairly quickly, SNFs discovered that utilization of RUGs within the rehab component increased reimbursement via the provision of higher weekly therapy minutes. Secondarily, SNFs found margins improved within these rehab RUG components over the length of stay, especially within lower extremity joint SNF admissions.

Dual-eligible programs for individuals covered by both Medicare and Medicaid now have been implemented within each state. Primarily managed by insurers, these programs seek to reduce overall costs of long-stay Medicaid SNF residents who require Medicare-covered support for a short episode of care. Through a 'one card, one phone number' approach, utilization of the long-stay SNF resident's Medicare benefit is more tightly managed, especially concerning emergency department visits and re-hospitalizations. The impact from this is the reduction in SNFs' financial opportunity from a Medicaid A resident admitted to the hospital following the Medicare A qualifying three nights and returning to the facility with a higher level of reimbursement.

The rise of managed Medicare 'Advantage Plan' enrollment continues to tick upward. Potential reasons could include greater

affordability, clearer billing, and easier access to health services. As of 2017 one-third of all Medicare recipients were enrolled in a managed Medicare plan. While many SNFs are cautious in participating in managed Medicare agreements (since average rates are 13% lower than traditional fee-for-service rates), Medicare has set clear goals to substantially reduce payments made within a fee-for-service model. Moreover, pressure by Medicare and managed Medicare plans has reduced average length of stay to below 20 days versus 23 days for traditional Medicare.[5]

Lastly, under Phase One of the Mega Rule in 2016, substantial regulatory compliance changes were implemented within SNFs, including a new standard survey process that increased both scrutiny and deficiency risk. Phase 2 renumbered F-tags, adding new ones for Behavioral Health Services, Baseline Care Plan (within 48 hours following admission), Facility Assessment, and Antibiotic Stewardship, and trauma-informed care.

While ALFs continue to be primarily a privately paid type of care, some senior care insurance policies include some ALF coverage. In recognition that ALF-provide care is less expensive, all states and the District of Columbia have implemented programs to pay for some medically necessary services through Medicaid programs. This payment does not include room and board.

Far from the 'social model' ALF care was initially thought to provide the clinical complexity of ALF residents has substantially increased. The 2012 Performance Measures Report by the National Center for Assisted Living (NCAL) revealed that 94% of ALF residents had access to a registered nurse. [3, 2]

Preparing for the Changes Ahead

Begin reducing indirect overhead expenses ASAP. The cash flow this generates serves two purposes. First, it will help you weather the financial pressures that will inevitably come as your organization adapts and recalibrates to PDPM. Second, other services with increased care costs (combined with shorter lengths of stays) will likely occur due to PDPM's impact. The cash retrieved by reducing expenses can help to cover this cost.

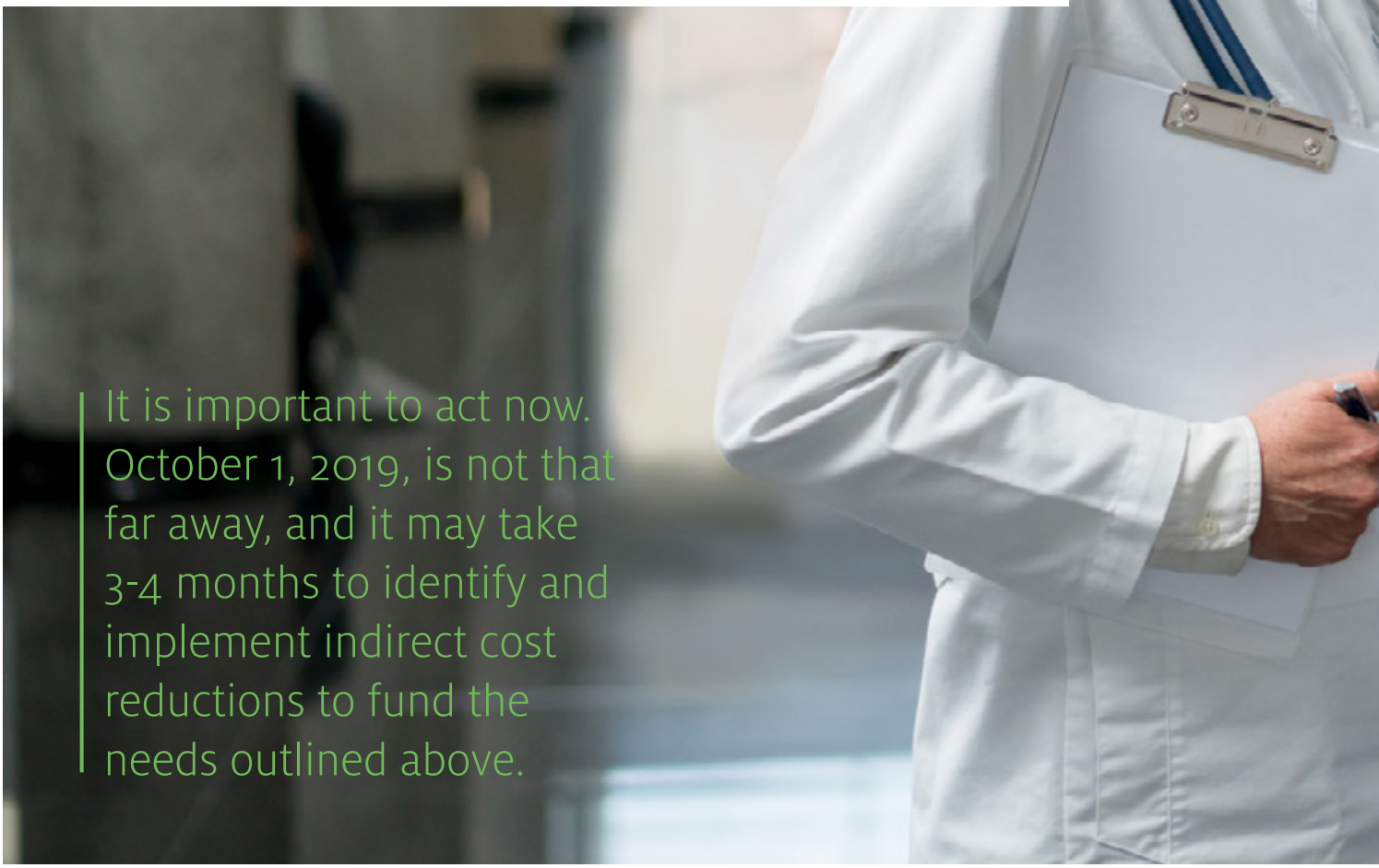
It is important to act now. October 1, 2019 is not that far away, and it may take 3-4 months to identify and implement indirect cost reductions to offset the challenges outlined above.

PDPM has both the potential to increase or erode your revenue and margin, driven especially by accuracy of ICD-10 coding and MDS completion. As a reimbursement example, within the PDPM notification document, a comparison of two residents' care (one neurological and one orthopedic with different co-morbidities) was provided. Under PPS both residents would have been classified into the same RUG category. Calculating reimbursement for each under PDPM highlighted an increase for both.[6]

Consider a 'competency and scalability' deep dive into your current clinical capabilities. You'll need to know your team's acumen to support increased skilled nursing capabilities and potentially higher volume of non-orthopedic admissions.

Examine unmet needs within your marketplace through acute care and managed care outreach. If the addition of new care programs is advantageous to you, an objective consultant can provide insight into your return-on-investment and cash flow impact.

Target your Medicare A Spend Per Beneficiary to assure you are below 1.0 in your ratio. This will be a critical element in positioning your facility for participation in a managed Medicare agreement. Third-party payers need to know that you can support their margin goals through cost and length of stay vigilance.



Sources:

(1) U.S. Census Bureau's 2017 National Population Projections

(2) Elderlawanswers.com "Medicaid's Benefits for Assisted Living Residents"

(3) 3National Center for Assisted Living

(4) National Investment Center for Seniors Housing & Care (NIC), Skilled Nursing News, March 4, 2019.

(5) Skilled Nursing News, March 27, 2018, Maggie Flynn.

(6) Medicare Program; Prospective Pay System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for FY 2019, SNF Value-Based Purchasing Program and SNF Quality Reporting Program. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

Value Through **Insight** ™

Changes are coming to Post-Acute Care, so it's more important than ever to understand the value of the possibilities available.

Our consultants will look into every aspect of your business, both present and future to deliver Value through Insight™.

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