ZIMMET HEALTHCARE SERVICES GROUP, LLC

CORE analytics

PDPM REIMBURSEMENT ANALYSIS

November Claims:

Projected v. Realized Performance in the Context of Healthcare Reform

Z-CORE Analytics, LLC and Zimmet Healthcare Services Group, LLC are pleased to present our latest observations based on November 2019 Medicare Part A claim data.

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I. INTRODUCTION

Zimmet Healthcare Services Group, LLC (ZHSG) established Z-CORE Analytics, LLC (CORE) in 2017 as a platform for innovative claim-based applications that provide insight into healthcare utilization trends and provider-specific reimbursement performance, using current skilled nursing facility (SNF) UB-04 data as primary source material. While CORE remains a distinct, independent corporate entity, ZHSG fully manages all operations. This document is therefore released under the auspices of both companies: CORE provided the data, while ZHSG ascribed commentary within the context of a rapidly changing healthcare continuum.

Prior to Thanksgiving, we released a report entitled *"PDPM REIMBURSEMENT ANALYSIS: Financial Impact, Observations, Rate Measures & Comparative Integrity."* That analysis distilled October 2019 billing activity from the first month of claims processed under the new system based on contributions from CORE's initial client base (the "October Release").

This submission is not an "update" to the October Release in the traditional sense. Instead, we examined provider performance from a different perspective and offer nuanced observations on PDPM Component issues we feel, if adjusted, may improve the revenue allocation integrity of a fundamentally sound payment model. That said, we recommend reading our October Release prior to considering the commentary within this document, as the former explains why fundamental differences between the Patient Driven Payment Model and RUG-IV essentially obviate performance comparisons predicated on traditional, unadjusted measures. To address this incongruity, the October Release was clear and explicit in its primary intent to "begin the discussion about how provider performance should be measured in context with the unfamiliar structural mechanics of the Patient Driven Payment Model."

CORE's database has since expanded significantly in both scale and scope. To avoid sample bias, this analysis compared CORE's November 2019 claims against CMS' SNF PDPM Provider-Specific Impact File to assess the accuracy of original projections.

Summary of Findings

Note: Our results do not qualify as a statistically valid sample of national PDPM outcomes

- Performance is measured based on "average per diem rate," as opposed to aggregate Medicare revenue. This approach was required to account for changes in market conditions between November 2019 and the 2017 base year on which CMS' analysis was based.
- After adjusting for market basket updates but not potential sample bias, CORE's facilities' average November 2019 PDPM per diem rate was estimated to be 5.27% above CMS' forecast, but in many cases overall (prorated) provider revenue is below base-year projections due to atrophy of the Medicare Fee-For-Service population as explained within.
- We expect PDPM per diem rates to increase modestly to appropriate levels, primarily as resource-needs associated with services/conditions that existed but were not captured pre-PDPM become properly represented on patient assessments. However, we identified six specific reimbursement-sensitive variables with high probability to disproportionately distort revenue allocation due to significant "mispricing."
- PDPM is structurally sound but may be highly sensitive to poorly targeted funding adjustments.
- Component refinement would likely correct potential rate distortion, increase equitable allocation and encourage further coding accuracy.
- The PT/OT component is most in need of case-mix reallocation, irrespective of other issues noted within.

The PDPM-Effect

PDPM is a highly complex system relative to the decades-old RUG methodology it replaced, irrespective of the performance distortions associated with technical aspects of the October 1 transition. The exponential rise in complexity is worth the price of admission. PDPM is unquestionably a monumental improvement over every iteration of RUGs in terms of rate setting integrity.

We now have nearly three months of claim data and four months of extensive observational & practical experience with the new system. We find most providers acclimating reasonably well (some much better than others), while a small but significant few are struggling due to lack of preparation and/or resources. The system appears to be working generally as advertised. However, as expected with any change of this magnitude, PDPM requires refinement to address specific "mispriced" payment-drivers and procedural concerns, several of which are addressed within this submission.

In deference to how easily a specific dataset can be misinterpreted, such endeavors must have clarity of purpose and defined observational impacts. As explained and reiterated throughout, PDPM and RUG-IV are non-comparable when expressed as a per diem rate within homogeneous market conditions. In other words, the phrase "all other things being equal" should serve as a warning to the reader – we are discussing a benefit that in many markets is being aggressively reshaped (and reduced) by Medicare Advantage, Alternative Payment Models and hospital inpatient "observation" classification incentives – factors that hardly register in other locales. Averaging these two extremes to draw conclusions and set national policy specific to Fee-For-Service spending is problematic on many levels.

II. A DIFFERENT PERSPECTIVE

To produce a meaningful comparison of RUG-IV and PDPM provider performance requires a consistent adjustment factor that differs based on the target-metric. The October Release compared our clients' October 2019 PDPM performance to a theoretical, but reasonably constructed, 2020 RUG-IV baseline to assess changes in per diem rates by converting PDPM scores to a CORE Standard Rate (CORE-$). This was necessary to calculate facility-specific PDPM rates against the same measure had RUG-IV continued unabated into 2020. The results showed that 91.5% of our facilities realized a higher PDPM rate than would have been achieved under RUG-IV. For this installment, we analyzed PDPM performance against an alternate, more familiar benchmark.

CORE's November 2019 PDPM performance is measured against CMS' SNF PDPM Provider-Specific Impact File ("CMS Projection"), the official analysis based on 2017 facility-specific data that unofficially launched "PDPM-mania" across the nation. CMS posted the document to "assist stakeholders in understanding the potential impacts of the proposed PDPM… which details the estimated impact of the PDPM model… on Medicare Part A payments to each SNF in the country..."

The October Release did not consider the CMS Projection; this report evaluates its accuracy. In other words, this is not an "update" to our first analysis, it is a different comparative measure altogether

Rate v. Revenue

For this discussion, mind the distinction between the terms Medicare **RATE** and Medicare **REVENUE/SPENDING**. We are evaluating the impact of PDPM on per diem rates detailed within the CMS Projection, not aggregate Medicare revenue. Specific to average **rate**, we found a far greater share of CORE's providers benefiting from PDPM rather than suffering losses as originally predicted.

The SNFs with higher rates are relieved, but higher rates do little to ease the burden of systemic local market reform. Total Medicare days (and revenue) are below the CMS Projection for many providers, presumably cannibalized by Medicare Advantage, tempered by Alternative Payment Models or disqualified by changing hospital "inpatient" classification patterns. That is why, as expounded upon within, our focus is specific to the average per diem RATE, as opposed to total Medicare reimbursement/spending which is beyond the confines of this discussion.

The CMS Projection included approximately 50.6 million covered days across 13,769 SNFs. Total Medicare revenue was divided by total covered days, resulting in an average 2017 RUG-IV per diem rate equaling $527. This figure does not represent the average provider's rate; the compilation is "weighted" among SNFs with wide ranging Medicare utilization and wage adjustment factors. For perspective consistency, we applied two adjustments required to compare different systems and base years, without which the exercise would offer little value.

Next, we updated the $527 "baseline rate" to reflect the accretive effect of three subsequent annual Market Basket adjustments (2018, 2019 and 2020), which increased the 2017 aggregate baseline rate by 7%. Based on these adjustments/updates to the CMS Projection, the average 2017 baseline rate equaled $564.

III. THE CORE DATABASE

CORE's user base has become considerably larger and more diverse over the past two months. The number of contributing SNFs increased from **623 to over 1,000**, spread across 38 states plus Washington DC. Most of these new providers are not located in the Northeastern part of the United States and maintain fewer licensed beds. In fact, only one in five of the facilities analyzed within are located in our largest markets of New Jersey and New York. Nevertheless, the "sample" remains non-random and therefore lacks formal statistical significance. **Accordingly, we reiterate that our findings cannot be used in any manner to reflect national performance.**

Not all of CORE's facilities are included in this analysis for several reasons; more than 100 uploads were incomplete or included non-Part A claims that had not been corrected in time for this study. We also excluded 43 facilities with three or fewer Medicare patients billed in November, as we felt inclusion would inappropriately skew outcomes. We were left 859 SNFs classified as follows:

Facilities included:	**859**
Freestanding:	98.2%
Hospital-Based:	1.8%
For-Profit:	86.5%
Non-Profit:	12.9%
Government:	0.6%

Our analysis is far from perfect. For example, Area Wage Indices change every year. We assumed they remained constant for all providers; we also ignored sequestration and co-payment adjustments. Finally, we recognized but did not account for vestiges of the October transition distortion in November's claims. The 3-day NTA allowance for transitioned residents is gone, but some patients admitted prior to October 1 remained covered in November. A portion of these carryover beneficiaries were likely admitted with reimbursement-sensitive conditions that resolved by the time the PDPM assessment was completed and therefore may have diluted average rates. However, these distortions are largely negligible for purposes of our analysis.

IV. CORE-RESULTS: NOVEMBER CLAIMS

As noted, the adjusted/updated average 2017 RUG-IV rate from the CMS Projection was $564 per patient day (PPD). Isolating the 859 CORE facilities from the CMS Projection and repeating the adjustment/update process produced a higher baseline of $591 PPD. The difference between baselines of CMS' 13,769 and a subset of 859 is irrelevant as a nominal figure for purposes of this analysis; it simply reflects the reality that CORE's clients include a disproportionate number of urban facilities in above average wage areas with slightly above average 2017 Ultra High RUG capture ratios. What matters is each facility's November rate relative to the CMS Projections.

The average November rate of the CORE facilities, using respective AWIs (what we call the "Realized" rate) was nearly identical to October at $614. That said, it would increase/decrease inversely to changes in ALOS.

The **CMS Projection** specific to CORE's 859 facilities anticipated the following redistributive effect on average per diem **RATES** (as opposed to total reimbursement). These percentages do not represent the dollar value of rate changes; they reflect the ratio of SNFs that were expected to gain or lose any amount of $PPD:

CMS Projection on CORE SNFs' $PPD

CORE SNFs expected to LOSE $PPD:	68.6%
CORE SNFs expected to GAIN $PPD:	31.4%

CORE's Realized November 2019 $PPD

CORE SNFs that LOST $PPD:	32.6%
CORE SNFs that GAINED $PPD:	67.4%

CMS' Projection underestimated the percentage of facilities that would realize a $PPD gain (POSITIVE RATE) impact from the transition to PDPM.

The CMS Projection (fully updated to reflect annual market basket increases) anticipated CORE's clients' average Medicare RATE to decline by 1.37% per patient day; the aggregate average increase was actually 3.90%. Accordingly, PDPM average RATES were 5.27% above CMS' impact projections for our population.

The primary flaw in this analysis is the exclusion of ALOS distortion; changes in ALOS from the 2017 baseline to November 2019 would undoubtedly alter these ratios. That said, ***covered days continue to trend down nationally as supported by the MedPAC data below. But as mentioned, such data lacks local context – many of CORE's providers reported significantly more distressing declines. Specific to CORE contributors with RATES above CMS Projections, covered days are below baseline at over half of the facilities. Thus, despite the positive RATE effect, aggregate revenue would continue to dissipate as the FFS population atrophies.***

TABLE 8-2 — SNF admissions and days continued to decline in 2017

Volume measure	2010	2013	2016	2017	Percent change 2016-2017	Percent change 2010-2017
Covered admissions per 1,000 FFS beneficiaries	73.0	69.3	65.9	64.6	-2.0%	-11.5%
Covered days per 1,000 FFS beneficiaries	1,972	1,872	1,693	1,623	-4.1	-17.7
Covered days per admission	27.1	27.0	25.7	25,1	-2.3	-7.4

Note: SNF (skilled nursing facility), FFS (fee-for-service), "FFS beneficiaries" includes users and non-users of SNF services. Data include 50 states and the District of Columbia.

Source: Centers for Medicare & Medicaid Services 2018c.

Component Distributions

By CORE's measure, most SNFs are better served financially under PDPM from a RATE perspective, but not by as much as October suggested from a different baseline. Furthermore, capture trends are evolving quickly. We identified six specific variables driving most of the variation due to case-mix distortions.

We conclude that, irrespective of total SPENDING, targeted refinement to Component rate variability would improve the integrity of a fundamentally sound PDPM construct. However, if a budget-neutral reduction was triggered, an "across the board" rate cut would unfairly perpetuate and accelerate our concern of inappropriate revenue allocations.

The following brief observations prove consistent with each new contributor (detailed distributions and benchmarks are available within the CORE application).

PT/OT:

As expected, there was little change in PT/OT rate performance – and don't expect any in the near future. RUG-IV treatment protocols that focused on the 720-minute mark did not discriminate by diagnosis. The CMS Projection reflects the resulting lack of variability in this PDPM component. As I wrote nearly 18 months ago, I believe this Component is most in need of adjustment. For context, the average PT/OT payment (irrespective of Function Score) was about $177 per day in October. Our November average was $176. Ironically, this is PDPM's greatest flaw; paying similar rates irrespective of patient-specific condition strangely perpetuates a practice the system was intended to eliminate. Again, refer to my 2018 paper for further explanation. Allocation among Clinical Categories can be adjusted without impacting aggregate Medicare funding.

SLP:

While this Component represents the smallest nominal reimbursement allocation, average rates are expected to disproportionally increase. Medicare patients without a reported Swallowing Disorder or Mechanically Altered Diet dropped from 67% in October to 62% in November. These two conditions raise the Component rate, but many patients scored with "Neither" had speech therapy charges reported on the UB-04. This gets technical, but implies PDPM SLP drivers are present and treated, but not captured for payment.

Nursing:

This Component was responsible for the most significant average rate variability. Physical scores dropped from 23.5% to 18.0%. See CORE's peer group data distribution to identify factors driving the migration of Nursing groups and End Splits to levels more commensurate with SNF-level of care needs. Then review your documentation to protect the reimbursement integrity of services provided and captured.

Non-Therapy Ancillaries:

NTA measures are simple to quantify yet difficult to draw conclusions from due to the October distortion. We therefore opted to delay reporting on this component until our next release. That said, the share of assessments reporting zero NTA qualifiers is dropping (detailed measures are available within the CORE application).

V. THOUGHTS ON RATE ESCALATION

There is nothing in this discussion to suggest changing care patterns, but that's not the whole story. Under RUG-IV, therapy and ADLs represented the near entirety of "reimbursement-sensitive" services. The burden of meticulously documenting every activity to meet aggressive reimbursement-auditor standards for complex conditions that did not impact reimbursement is impossible.

The pejorative term "Case-Mix Creep" implies that non-existent (or at least non-qualifying) medical services and conditions manifest when they become "reimbursement-sensitive." Like Schrödinger's Cat, a patient has the condition when it's observed (documented) but gone when no one is looking. In reality, when reimbursement-sensitivity is introduced, providers invest time and resources into complex systems and adopt compliant strategies to ensure they are credited for the care provided.

For example, a patient received physical therapy under RUG-IV also required medically necessary daily nebulizer treatments. After a 20 day stay, outcomes and beneficiary satisfaction were outstanding. An internal audit identifies a minor clerical error on the respiratory therapy logs during one treatment. Post-payment review would have no negative financial impact because payment was dependent on the physical therapy only. Respiratory therapy "Care" was delivered but not "Captured." The respiratory documentation mishap on RUG-IV payment can be classified as "no harm, no foul."

Absent physical therapy, the patient would have scored PB1. So why did the RUG-IV assessment omit nebulizers? More burden, no funding. Meanwhile, that patient enters PDPM at PBC1, priced at $120/day for the Nursing Component. PDPM changed this – facilities that ensure the integrity of daily respiratory documentation may now be reimbursed for doing so.

There is no impact on patient care or outcomes in these scenarios, but average reported patient acuity "creeps" up as documentation incentives are introduced. That PBC1 modeled in the 2017 analysis becomes HBC1; a deeper understanding of homesick-induced depression may change the score to HBC2, which pays $237/day under the PDPM Nursing Component. That's not "Creep," that's survival. It's not "gaming the system," it is honoring the system.

The politically correct term for the scenario just described is "changing provider behavior," and it's universally used by payers when reimbursement increases subsequent to payment model reform. This was a valid point when RUG-IV replaced RUG-III, but I question that logic today.

The most profitable RUG-IV patient profile was a non-medically complex RUB with minimal medication costs. Co-morbidities can be expensive – and many providers simply could not afford the resources to address non-reimbursable underlying conditions. PDPM is far more reimbursement-sensitive, making complex care financially viable. This is theoretical so early into the system, but I would not be surprised if the data ultimately reflects shorter hospital stays made possible by earlier admission to the SNF. This comes on top of the reality that non-medically complex RUB patients were few and far between in 2019 – they may have been relatively common in 2017, but now often bypass the SNF altogether. Despite the "mispricing" of therapy at the Ultra-High level, beneficiaries requiring SNF care are in fact more medically complex (and expensive to care for) today. My point is, increased Medicare spending under PDPM may not be caused by "changing provider behavior" as much as it is by Medicare's recognizing "changing patient profiles."

And herein lies the problem with measuring PDPM budget neutrality. This is unlike 2011, when only a simple change in the mode of therapy delivery unintentionally generated an untenable increase in Medicare SNF spending. Direct, patient-specific care needs are easily identifiable under PDPM. A viable argument could be made that providers lacking resources required to pay for expensive ancillary services or manage documentation in a manner sufficient to defend against aggressive, third-party auditors are underpaid.

VI. THE BUDGET NEUTRAL EQUATION

The fact that PDPM was intended as a "Budget Neutral" initiative has been well-covered, but not adequately defined. Without clarity, there is simply no way to draw conclusions about total program spending, only relative provider performance. Case in point:

I recently presented to a group of hospitals and SNFs at an ACO event. A specific exchange between an ACO case manager and a SNF operator exemplified the difficulty in measuring the Medicare budgetary impact between RUG-IV and PDPM. The ACO and SNF had collectively invested considerable clinical and technological resources to improving outcomes, shorten stays and facilitate care transition compliance. Mission accomplished.

Meanwhile, over the course of a year, the SNF's ALOS for associated ACO beneficiaries dropped from 27 days to 18. Additionally, the ACO explained its intention to superimpose specialized care management software on the SNF's EMR so that patients could be monitored remotely 24/7 with the stated objective to reduce target ALOS to 14 days.

The SNF pleaded for network priority to "backfill" the associated loss of covered days; the ACO countered that the SNF's per diem rate increased from $672 under RUGs to $861 in November. Care is improving, outcomes are generally positive and program savings are realized. But where does this leave our SNF? The bottom line is that this high-quality provider faces growing financial pressure on multiple fronts.

As explained in CORE's initial release, average per diem RUG v. PDPM revenue cannot be compared without a neutralizing factor, given PDPM's variable payment adjustment. In the previous scenario, the SNF's rate increased by 28% on a per diem basis. But its total Medicare revenue per admission decreased by nearly 15%. How does this difference factor into accounting for Budget Neutrality? I have no idea. Again, all we can do is analyze relative provider outcomes and changing capture patterns in the "revenue delivery system," not the "big picture" of aggregate Medicare SNF funding in an environment so dissimilar due to factors that hardly registered in the base year.

We are discussing a benefit that is being aggressively reshaped (and reduced) by Medicare Advantage, Alternative Payment Models and hospital discharge patterns, but drawing conclusions from Fee-For-Service spending only. How does CMS account for Medicare Advantage's enrollment increase from 11 million to 20 million beneficiaries between 2011 – 2018. Surely many of these Medicare Advantage enrollees were admitted to SNFs, but technically that does not qualify as Medicare FFS spending (which is highly tempered by ACOs and BPCI). Then consider the burgeoning ISNP movement – a program predicated on avoiding long-term care patients from being hospitalized and returning to the SNF under a Part A benefit. If ISNPs successfully eliminate 5% of FFS Part A episodes this year, do these FFS "savings" raise CMS' tolerance for higher aggregate PDPM FFS rates without deference to the Budget Neutral equation?

The debate is endless because the market impact of Federal initiatives is so unevenly distributed throughout the nation, down to the county level. The argument could be made that there is no "National Nursing Home Industry." The fact that Federal SNF policies are superimposed on dramatically diverse state guidelines in unique local healthcare markets is enough to invalidate or mitigate every conclusion about SNFs that includes the qualifier "National." Yet here we are.

There are only two immutable truths as SNFs care for sicker patients under increasing funding and coverage pressure: Too many providers are struggling financially and can ill-afford continued instability, and the differences among markets are so severe that the entire Revenue Delivery System requires remodeling. If left unchecked, that ACO-associated SNF that so admirably improved post-acute efficiency is subject to the same Federal funding changes as a provider operating in an area devoid of Alternative Payment Models or Medicare Advantage. The totality of the fragmented SNF revenue allocation system is worse than broken, it's essentially arbitrary, yet national performance will dictate the fate of each and every SNF's FFS Medicare revenue – without which few nursing facilities could survive.

Further complicating matters is simple timing – this generational RUG-IV – PDPM transition is embedded within Healthcare Reform's rapid but uneven evolution. Healthcare's pace of change is rivaled only by the technology sector. For context, PDPM is rooted in a CMS contract for alternative SNF payment development that began exactly eight days after Apple's press event unveiling the iPhone 5 in 2012. Anyone reading this on an iPhone 5? Forgive the hyperbole, but CMS must ensure appropriate payment defined by a sustainable model, and that is mathematically impossible under inconsistent budget constraints.

Given so many important influencing variables, what can we conclude about the future of PDPM funding? That only time (and the Federal Government) will tell.

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ABOUT ZIMMET HEALTHCARE SERVICES GROUP & CORE ANALYTICS

Zimmet Healthcare Services Group, LLC is a full-service consulting firm dedicated to enhancing the post-acute provider experience since 1993. The 60-person team supports ~3,000 SNFs and industry stakeholders nationwide on matters relating to reimbursement, regulatory-compliance, litigation support, transaction advisory, performance analytics and market strategy.

The UB-04 (formerly UB-92) has been our primary "tool of choice" for two decades. The claim's diverse item-set is distinct from the MDS or medical record, and as such offers unique insight into provider and market dynamics – CORE Analytics was created to unlock this potential.

CORE delivers a superior alternative to Medicare public claims data used to measure provider-value. Public claims data is aggregated, lacks the finer-points of secondary UB-04 fields and is often a year old by the time it's presented. CORE's claims-based insight offers far greater detail, relevance and timeliness. Aggregated data based on thousands of claims can define a market, but a single SNF UB-04 holds far greater promise as a patient-specific PDPM and value-based management tool.

CORE is a stand-alone system that requires no technology integration. SNFs simply upload 837i files to CORE as they would to Medicare. There are no on-boarding costs, no cancellation fees, no contract lock-in burden… and no more than 30 minutes needed to realize results!

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