The CORE *Reporter*

October 2021

"With data collection, 'the sooner the better' is always the best answer."

Marissa Mayer, former Yahoo! CEO

New perspective.
Better data.

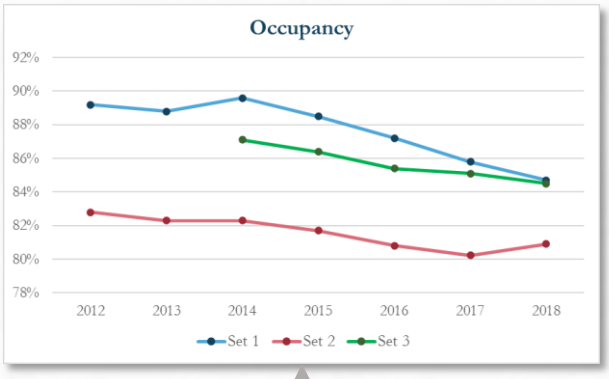
CORE analytics

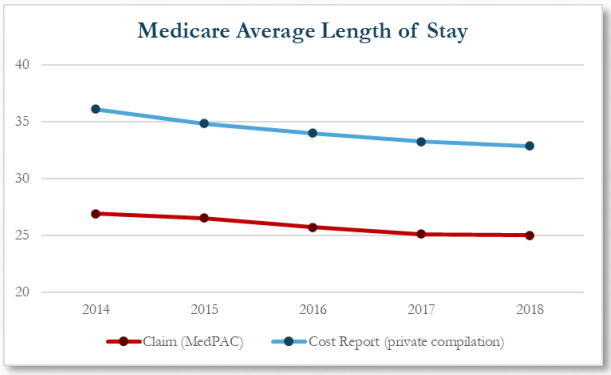
www.zcoreanalytics.com

Data Analytics is among the fastest growing business intelligence applications across all industries, and healthcare is no exception. SNF stakeholders now have access to an array of diverse resources to inform decision-making. There is only one problem; reporting from distinct sources on the same metrics are often inconsistent – sometimes significantly so.

Providers submit data to fragmented agencies in different formats, at dissimilar intervals, using alternative standards. The three primary reporting instruments within the SNF revenue-cycle (Medicare cost report, Minimum Data Set & UB-04 claim) are prime examples. All were originally designed for independent purposes long before the term "Data Analytics" existed; despite their connection to the same process, they remain largely disjointed. The MDS is a clinical assessment tool retrofitted for reimbursement assignment. The cost report's payer mix statistics are a frustrating vestige from the program's inception. Days are classified as Medicare, Medicaid & Other, the last includes Managed Medicare & Medicaid, Private pay, Hospice, VA and… well, "Other" (secondary coverage is also absent). The UB-04 is most perplexing, as utilization is not reported until an episode is closed.

Today's data wasteland is the result. We must reconcile inconstant answers to the same questions, as exemplified by divergent reporting of the following SNF performance metrics:

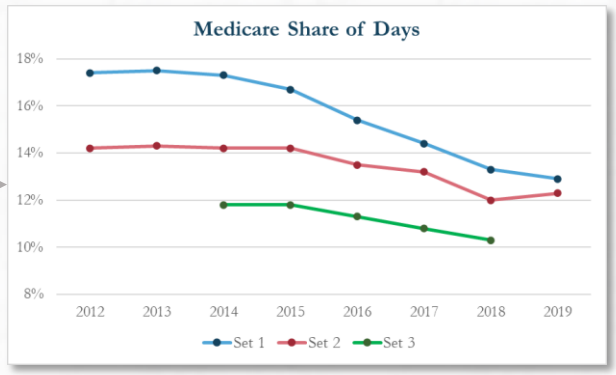




Set 1:
Industry group compilation using a small, clustered, homogeneous sample

Set 2:
KFF State Health Facts from CMS source data

Set 3:
Professional services firm compilation citing CMS as source data



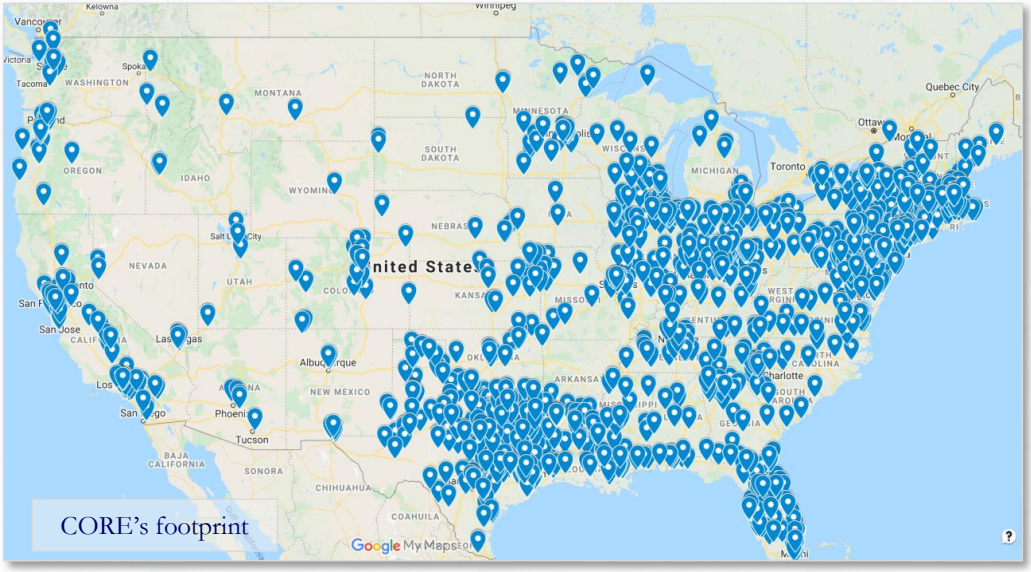
Which dataset is most accurate? Each of these metrics can be calculated using two of the three instruments referenced above as source data. They may all be fully accurate in their own way. The problem with reporting is source data consistency. The problem with the end user is lack of context.

Medicare claims (UB-04s) are an invaluable source of SNF data. CMS releases quarterly "LDS" claim files which allow for Medicare utilization & market analysis. Third-party vendors offer useful tools that quantify referral patterns and performance metrics, but the data falls short in two critical ways. The first is timeliness; healthcare evolves rapidly but we must wait up to a year for a complete record of utilization activity. Do not be fooled by marketing; this data has been commoditized – no one has "early access" to the file, and "most up to date" refers to the LDS release date – not the data it contains. The other shortcoming is that only FFS Medicare claims are included, a population that no longer represents the plurality of coverage in many markets.

Relying on such outdated information has always been subject to qualification, but to do so now is strongly ill-advised. The pandemic (and 1135 Waiver) distorts outcomes to the point of damaging a provider's data profile. Worse, because claims are up to a year old when released, the public data may suffer from pandemic bias until 2023. The LDS is useful but can be dangerous as well.

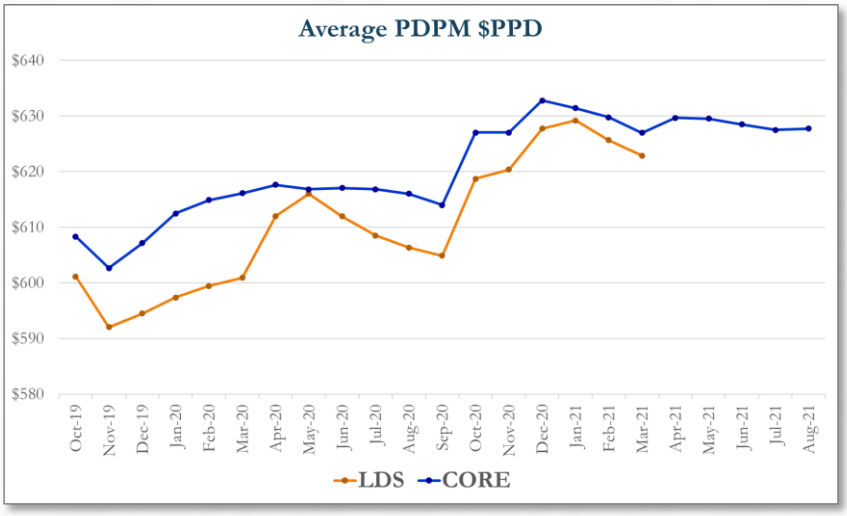
CORE analyzes **current** Medicare and Medicare Advantage claims to identify reimbursement opportunities and measure a facility's value-proposition against its peer group. As of October 1, CORE tracks Medicare performance through August 2021, while the LDS does not extend past March. CORE also delivers the same standard LDS tools, but we believe providers should not be forced to pay for access to public data; we simply include the functionality as a handy value-added service.

CORE data is based on claims submitted by an average of 2,089 SNFs per month (3,128 unique facilities from 49 states that collectively submit ~ 35% of all Medicare Part A SNF claims nationally). We are confident that our analysis serves as a reasonable proxy for industry performance.



Medicare Part A: Average PDPM Per Diem Rate

As expected, both LDS and CORE data confirm a steady increase in PDPM per diem rates. CORE's benchmark is about 1.8% higher than the LDS figure, a spread explained by differences in the provider-set and applied base-rate.



Insights & Observations

Many of CORE's initial contributors were well-prepared for the PDPM transition. As months passed and new clients were added, we found the learning curve began later for the industry overall. Also, our early adopters were disproportionately located in areas impacted earliest by the pandemic, specifically the Northeast. The largest monthly difference between trend lines was recorded in February 2020, when New York City was under siege, then fully corrected by May as our user base diversified and COVID spread to other regions.

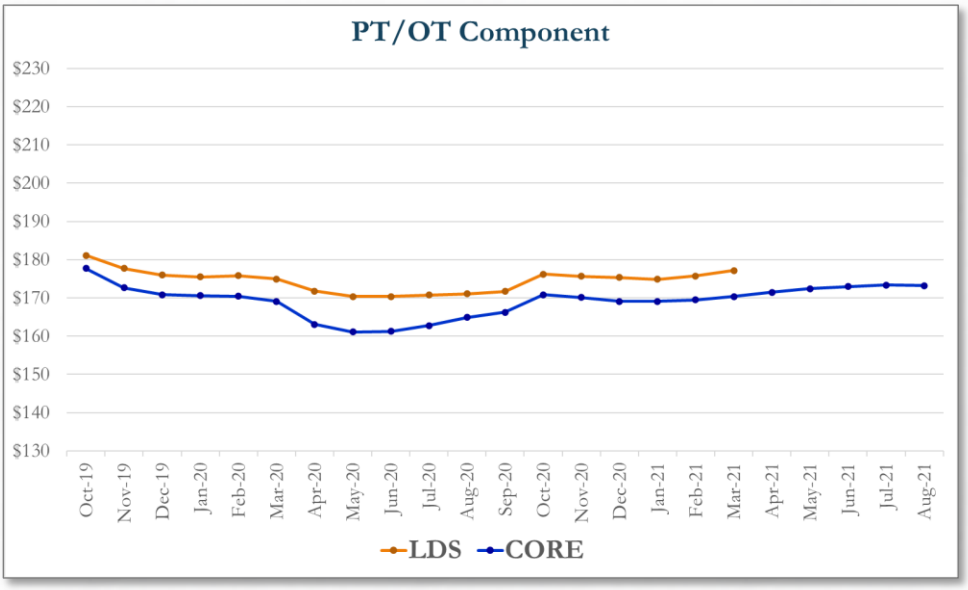
In addition, CORE's database contains a smaller share of rural providers than the national distribution. To ensure comparative integrity, we standardize all PDPM scores by applying the unweighted Urban rate set, while the LDS more appropriately reflects the Rural rate differential.

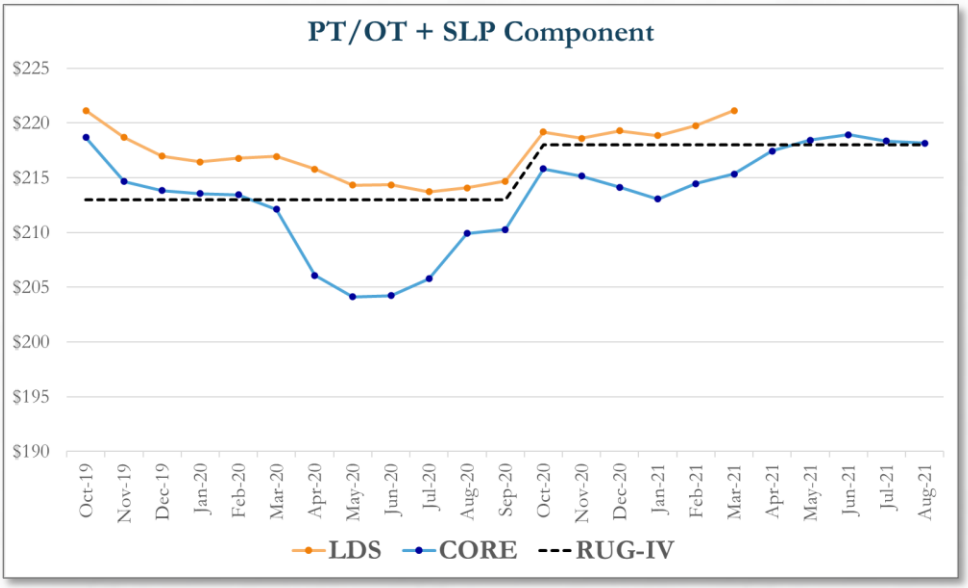
That all said, the most statistically affirming characteristic of the trend lines is that they follow the same month-to-month pattern – the normal progression of a maturing acuity-based system, in this case distorted by a once-in-a-century pandemic.

Note: The decrease from October – November 2019 was caused by the transition methodology.

Therapy Reimbursement Trends

The graphs below reflect therapy reimbursement trends for the PT/OT Component and compares total daily rehab payments under PDPM to RUG-IV (calculated using the 2019 distribution trended for 2020). Note that the 2.2% Market Basket increase was applied effective October 1, 2020.





Insights & Observations on Therapy Reimbursement

- Despite all the early attention to diagnosis coding, there is virtually no rate variability among the four PT/OT groups. In fact, there is only a $1.47 difference between facilities reporting total PDPM rates in the top and bottom quartiles (through July 2021). PDPM was modeled on RUG-IV utilization patterns; most patients were scored in Ultra-High or Very-High Rehab RUGs irrespective of diagnosis. This PDPM PT/OT reimbursement oddity is the result.
- When including speech, PDPM per diem rehab rate averages are slightly higher than the therapy component realized under RUG-IV (this has nothing to do with pandemic distortion). At the same time, Medicare Part A therapy expenses are lower, as evidenced by 2020 cost report filings.
- Concurrent & Group Therapy limitations are misunderstood. The mode & minutes of therapy are irrelevant when a beneficiary is skilled for nursing services ("clinical eligibility").

Impact on SNF Management

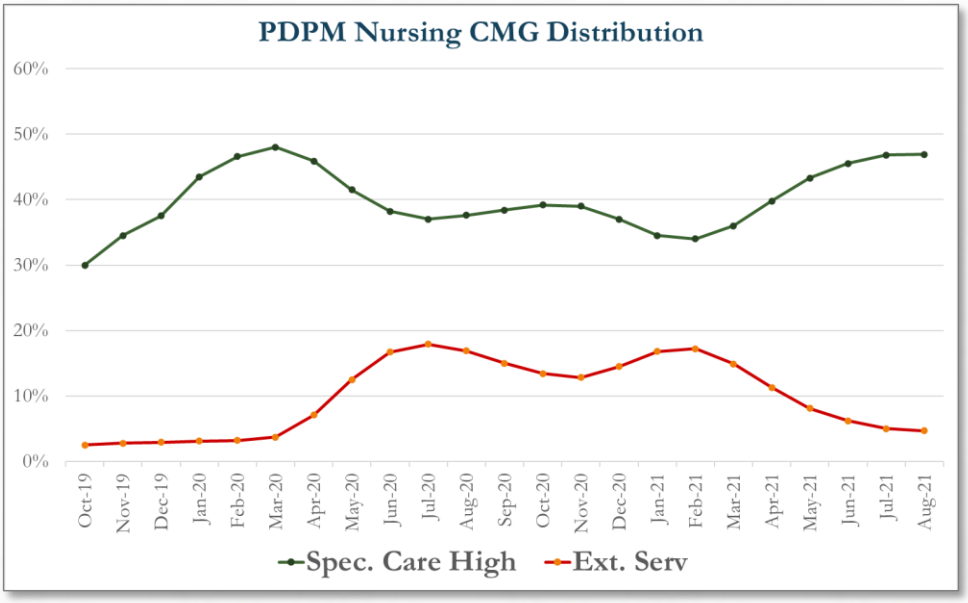
- Contract therapy has proven to be an important resource through unprecedented challenges. However, financial incentives between rehab companies and SNFs are no longer aligned for the short-term care population. Anecdotally, we have noticed an increase in Part B utilization where volume still drives the equation. However, ISNP growth has tempered that strategy as well. The bottom line is that SNFs are pressing for more competitive contract pricing but learning that "you get what you pay for." The relationship must work for both parties, or it works for neither.
- The reduction in one-on-one therapy treatment and slight reduction in overall utilization has another unintended consequence: every minute a patient is not in the gym is another minute on the nursing floor, adding to an already precarious direct care dynamic.

What to Expect?

- CORE analyzes the correlation between therapy charges reported on the UB-04 to PT/OT category. Our findings suggest that PT/OT weights will eventually be recalibrated, resulting in greater variability among condition categories.
- PDPM was designed to eliminate the financial incentive to deliver unnecessary therapy, but instead opened SNFs to scrutiny for rationing treatment. COVID notwithstanding, less therapy may add another layer to negligence arguments. Plaintiff attorneys love data discrepancies, and "rationing" makes a great soundbite.

PDPM: Nursing Component Distribution

The graph below tracks capture ratios within PDPM's Nursing Component in the Special Care High and Extensive Services case-mix groups.



Insights & Observations

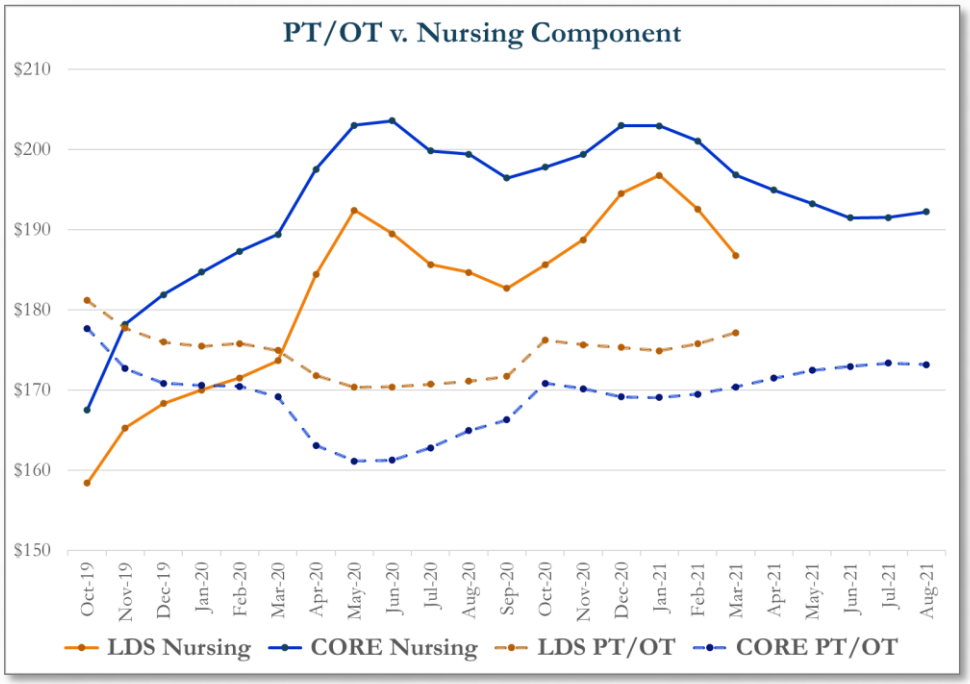
The nursing component is responsible for the greatest percentage of PDPM rate escalation; it also reveals the fundamental flaw in CMS' original recalibration methodology.

CMS proposed using the 2020 average PDPM per diem rate as the target against which to assess budget neutrality compliance. To mitigate reimbursement distortion caused by the Coronavirus, claims containing the COVID diagnosis code and benefit periods qualified by the 1135 Waiver were removed from the benchmark. The problem with this approach is that the COVID diagnosis code was not recognized for service dates prior to April 2020, yet the pandemic had already changed SNF clinical profiles in the preceding months.

As noted in the chart above, Isolation capture (ES1) began rising in the first quarter of 2020, then ebbed and flowed in correlation to infection waves. Omitting pandemic related claims does not explain this pattern. As a result, the CMS PDPM benchmark rate did not fully neutralize COVID distortion and overstated the 2020 spending increase.

PDPM: PT/OT – Nursing Component Rate Inversion

The graph below tracks SNF average component rates under the Patient Driven Payment Model.



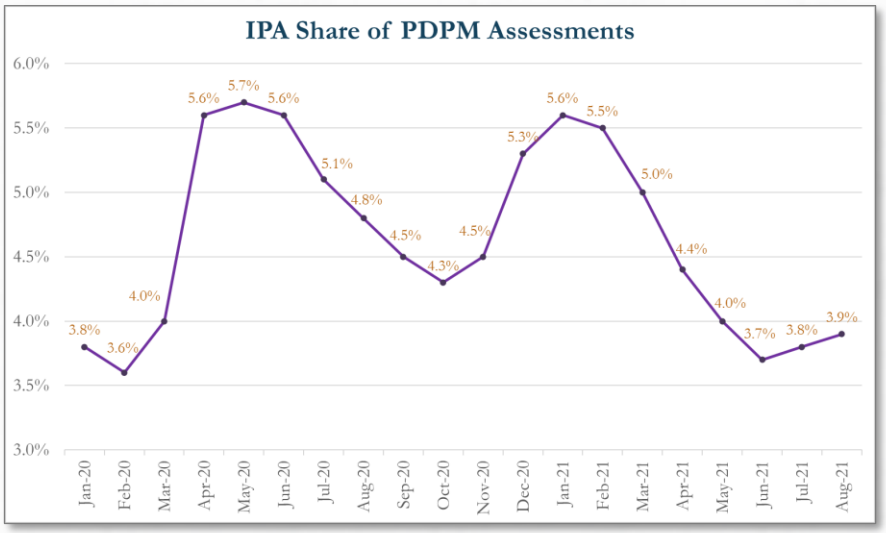
Insights & Observations

- Diagnosis grouping has little impact on PT/OT Component reimbursement, and while Section GG drives payment within clinical categories, Function Score has an inverse (and greater) effect on the Nursing case-mix rate. As a result, SNFs with the highest overall PDPM reimbursement have lower PT/OT rates than the average facility.

- As previously stated, contract therapy companies are an important resource to overburdened providers, but the most common pricing model has an unintended consequence that negatively impact the SNF's bottom line. Specifically, when therapy fees are based on a percentage of the overall PT/OT component rate *and* therapists complete Section GG – SNF expenses were found to increase while overall PDPM reimbursement declines.

PDPM: Interim Payment Assessments

The graph below tracks the ratio of IPAs to total PDPM assessments.



Insights & Observations

IPAs comprise 4.4% of PDPM assessments within CORE's database, but 25% of SNFs account for 70% of IPAs. CORE applies Logic Tests to Medicare claims that identify potential IPA oversights, and as suggested by IPA statistics, SNFs are missing opportunities to capture condition changes that would appropriately increase reimbursement.

IPA trends are highly correlated to pandemic waves and Isolation capture, suggesting COVID also impacted post-admission clinical management. IPA statistics are as follows:

- Average IPA was completed 25.4 days into the benefit period
- ALOS for benefit periods with an IPA was 49.5 days (~ 21 days longer than overall ALOS)
- Average IPA rate increase = $93 x 24 days = $2,232
- **5% OF IPAs resulted in a LOWER rate (they were unnecessary)**
- Most common PDPM Component changes by IPA:
    - Any nursing score to ES1 (Isolation)
    - Physical Function nursing score to Special Care High
    - SLP "Neither" to "Both" (Swallowing Disorder & Mechanically Altered Diet)
    - NTA increase from E/D to C

Medicare Part A: PDPM Recalibration Watch

The 2022 SNF PPS Proposed Rule introduced a highly flawed reimbursement recalibration methodology to correct for unintended program spending. While unlikely to be effectuated, rates would have been reduced by about 5% (~ $30 PPD) starting October 1, 2021. Based on CORE's claim data through August 2021, the accretive adjustment to achieve budget neutrality would be 7% - 9%. This is less than our original projection of 10% - 12%, as the previously discussed issue of Isolation capture (for claims without the COVID diagnosis code or unrelated to the 1135 Waiver) artificially inflated the benchmark rate. Recent capture patterns suggest that "ES1" has returned to its likely baseline. Irrespective of Isolation, our analysis indicates that the PDPM learning curve is not yet complete.

CORE applies over 1,000 proprietary "Logic Tests" to Medicare claims which identify potential lost reimbursement opportunities. Condition codes, ancillary charges, tertiary ICD-10 codes and utilization data not included in the MDS/EMR are cross-referenced to PDPM scores. For fiscal year 2020, CORE identified (and validated) an average of $21 per patient day in lost reimbursement. Claims through August indicate that figure has been reduced to $12 and continues to decline. Accordingly, we expect rate escalation to continue, although at a slower pace than 2020.

CMS justifies recalibration by tying rate escalation to changes in provider behavior, but that logic dismisses the reality of 2020. Consider – there are three possible explanations for the increased SNF spend:

1. Behavior has not changed, but SNFs are caring for higher acuity patients than in years past.
2. Acuity has not changed, but services/conditions are now being captured appropriately, or
3. Providers are inappropriately capturing services/conditions and overbilling Medicare.

There is absolutely no evidence to suggest the third sentiment is at play. Higher reimbursement is required to meet the needs of more complex admissions. Even casual observation supports the first two explanations and validates the following hypothesis: Recalibration is a punishment for more accurate assessment, therefore SNFs have been underpaid all along.

There is one more issue to consider: CMS projected hospital-based SNFs would realize the greatest percentage increase in Medicare reimbursement, and as such any recalibration is effectively a redistribution of funds from freestanding facilities to hospital systems. Based on the unique pressures on post-acute care, SNFs should not be subsidizing the acute-care side of the healthcare continuum.

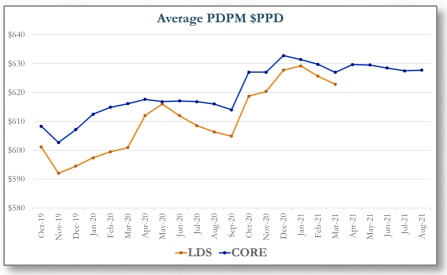


TABLE 17: Impact to the SNF PPS for FY 2020

From 2020 rule	Number of Facilities FY 2020	PDPM Impact	Update Wage Data	Total Change
Group				
Total	15,078	0.0%	0.0%	2.5%
Urban	10,951	-0.7%	0.0%	1.8%
Rural	4,127	3.7%	0.2%	6.4%
Hospital-based urban	380	10.0%	0.1%	12.6%
Freestanding urban	10,571	-1.0%	-0.1%	1.5%
Hospital-based rural	245	20.4%	0.4%	23.3%
Freestanding rural	3,882	3.1%	0.2%	5.8%

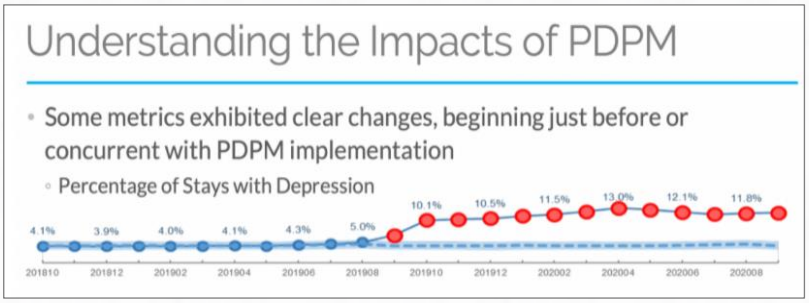
PDPM: Depression Disconnect

CORE is far more than a data aggregator. Our mission is to add perspective to quantitative measures and best inform stakeholder decision-making. We do not question the accuracy or veracity of any comparative metrics we aim to replace, but the term "analytics" demands more than just a computation. Interpretation is as important as the data; as Mark Twain said, "Data is like garbage. You'd better know what you are going to do with it before you collect it."

There is a dark side to Mr. Clemens' maxim. Data should validate or disprove a hypothesis, but far more often, a biased assumption is reached first, then data is shaped to support the forgone conclusion. We understand there is more than a fine line separating context from opinion, but the discussion surrounding PDPM Depression capture is in serious need of a reality check.

CMS uses the PHQ scale as PDPM's Depression reimbursement qualifier. As an "end split," the payment mechanism functions as a $20 – $40 daily add-on to Nursing's Clinically Complex & Special Care groups. Depression statistics have long confounded us; the figures referenced by CMS and MDS technology applications seemed to defy logic. Upon review, their conventional wisdom proved mathematically accurate, but the narrative still defies our logic.

The following infographics are as presented by, and linked to, their respective source:



From CMS presentation at MDS analytics company symposium

From another MDS analytics company study

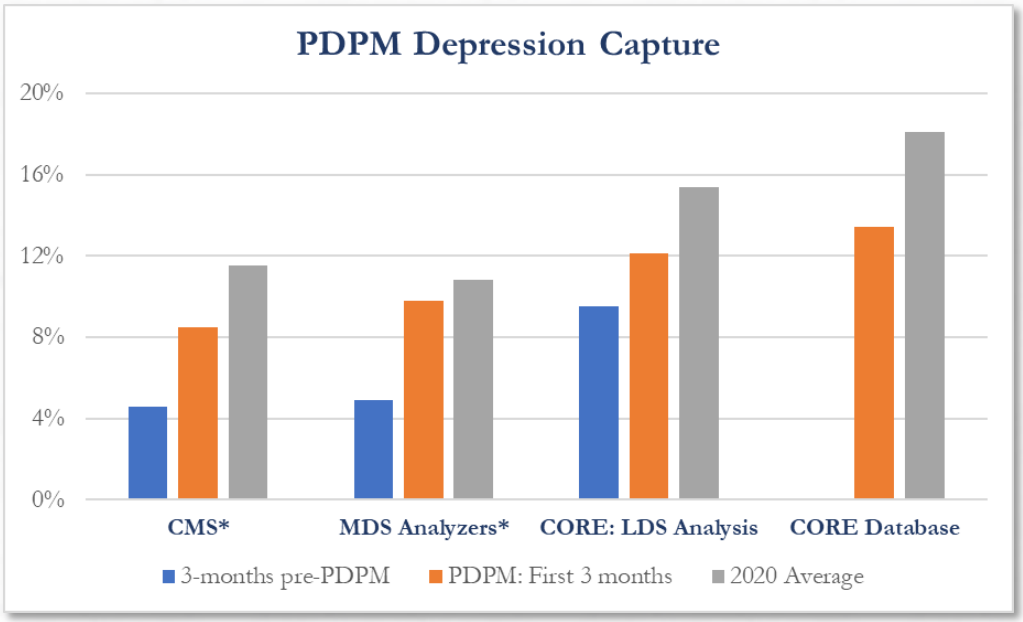
	Pre PDPM (July, Aug, Sept)	Post PDPM (Oct, Nov, Dec)	(Jan, Feb, Mar) (COVID)	(Apr, May, Jun)	(Jul, Aug, Sept)
	CYQ3(2019) FYQ4 (2019)	CYQ4 (2019) FYQ1 (2020)	CYQ1 (2020) FYQ2 (2020)	CYQ2 (2020) FYQ3 (2020)	CYQ3 (2020) FYQ4 (2020)
Depression	4.9%	9.8% ↑	11.4% ↗	11% →	11.3% →

PDPM: Depression Disconnect (continued)

The preceding data was compiled from Medicare MDS assessments, dividing PHQ-qualifying submissions by total assessments. The narrative is that Depression capture tripled in 2020, driven by "changes in provider behavior" to increase PDPM payment. Context is critical here for two reasons.

First, CMS intimates this capture pattern is indicative of "Case-Mix Creep," a pejorative term suggestive of "gaming the system." PDPM reimbursement trends make recalibration a near certainty, and we are concerned CMS will use this approach to justify future rate reductions unless the industry can discredit its misguided data-driven logic. Next, we find the discussion unnerves the provider community. Operators reporting outlier distributions fear the specter of subsequent audits.

CORE's Depression statistics are significantly higher than those reported by the MDS analytics community, and our interpretation of the data differs significantly from CMS' perspective.



** Estimate based on respective infographics*

To reiterate, we do not question the accuracy of others' calculations, but we feel strongly that metrics derived from the standard methodology are misleading.

PDPM: Depression Disconnect (continued)

CORE uses claim data to calculate Depression statistics. MDS Section D alone cannot quantify the Medicare reimbursement impact any more than claim data can be used to calculate the percentage of assessments with a qualifying PHQ score. This is because only Clinically Complex & Special Care (CC-SC) nursing scores are sensitive to Depression capture. Accordingly, we express Depression capture using total CC-SC scores as the universe, not total Medicare assessments. The importance of this distinction should not be dismissed; it speaks to both perceived SNF audit exposure and recalibration. For perspective, neutralizing for the following distortions would have reduced CMS' recalibration factor by approximately 50%.

1. The percentage increase in total PHQ-qualifying assessments has a negligible effect on Medicare spend relative to the exponential expansion of Depression-sensitive case-mix groups. Per CMS' Provider Use File, only 4.5% of 2019 Medicare days were billed at CC-SC, and only 10% of that universe captured the Depression end-split. Absent rehab RUGs, the CC-SC universe jumped to 63% during the first year of PDPM, with about 16% of these assessments indicating Depression capture (a 60% increase).

2. CORE's Depression statistic is a fraction of CMS' near tripling representation, but any "provider behavior changes" are still overstated. Per CHE Behavioral Health, the largest provider of psychology services to SNFs, Depression is far more likely to be captured upon admission than later in the stay. A minimum of five assessments were required under RUG-IV; PDPM eliminated all but the initial MDS from the equation. In reimbursement-management terms, intentionally overrepresenting high case-mix scores is known as "Stacking," a strategy strongly discouraged. Specific to this discussion, CMS has essentially mandated Stacking and may end up using the outcomes against us.

3. CMS' proposed recalibration formula neutralized COVID distortion by removing claims containing the COVID diagnosis code and benefit periods allowed under the 1135 Waiver. While imperfect, this process eliminated patient-specific high-spend outliers from the equation. However, unlike Isolation, Depression became a heightened risk-factor across all SNF patients. CMS reports the highest monthly Depression ratio was 13%, an impossibly low figure. Logic dictates SNFs failed to capture the condition and as such, we submit that Medicare reimbursement was inadequate during the pandemic.

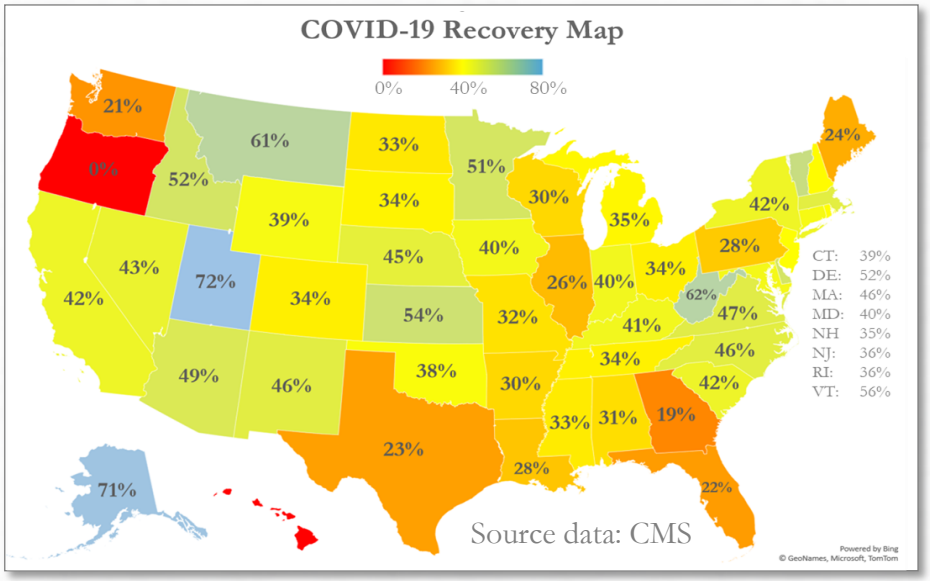
Depression is only one example of how data requires context before application. Such observational logic offers an important lesson in recalibration, no matter how CMS calculates "unintended spending" under PDPM. We hope this improves everyone's mood.

ZHSG & ECAP are pleased to introduce EcapINTEL.

A first look at this ground-breaking, comprehensive resource for SNF analytics/information.

CMS provides easy access to every facility's occupancy data (with minimal reporting lag). Instead of simply reformatting public data, **EcapINTEL's Occupancy Recovery Index** (ORI) compares a market's current census to its pandemic-era nadir, relative to 2019 levels.

Occupancy is calculated by dividing total patient days by capacity, but using "licensed beds" as the denominator is cause for concern. There are fewer licensed beds today than pre-pandemic, and beds lost were disproportionately located in regions with the most excess capacity. More relevant, many SNFs are unable to operate at full licensed capacity, irrespective of demand. High-occupancy rooms are largely untenable in today's market, while operators have converted many semi-private rooms to singles to remain competitive. The net effect is reduced practical supply, which in any market drives up the cost of an asset… exactly what investors have realized. Furthermore, the intractable staffing shortage is driving more operators to limit admissions to avoid overburdening remaining caregivers – such is the reality of Post-Pandemic Capacity.



Nationally, the average SNF occupancy in 2019 was 80.8%, dropped to a low of 68.0% in January 2021, then increased to 72.4% in August 2021. In other words, the industry recovered 4.2 of 12.8 percentage points for an ORI = 34.7%. The map above details August 2021's ORI on a state-by-state basis. **EcapINTEL's occupancy recovery projection tool arrives next month. For immediate county-level information, contact info@zhealthcare.com**

About CORE Analytics

CORE is the leading claims-based intelligence solution for market analytics and reimbursement-compliance management. CORE leverages the Medicare UB-04's diverse item set to develop insight into patient-specific revenue opportunities and value-based performance. Unlike other claims-based applications, CORE provides insight into current utilization activity. Data is available immediately after a facility bills – this applies to both Fee-for-Service and Medicare Advantage claims. Our MAPAX application is the first and only source for comparative MA benchmarks.

The CORE Reporter brings insight and perspective to SNF performance data. We invite you to contact us at support@zcoreanalytics.com.

About EcapINTEL

EcapINTEL is a comprehensive data & information resource for SNF stakeholders. A new era in post-acute information & analytics launches November 2021.