What's New with Medicaid, Medicare and Managed Care

Presented by

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President & CEO

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Objectives

- Explain the FY24 CMS changes to revenue calibration
- Discuss the Medicaid rate freeze and the preparation for the PDPM transition
- Identify coming changes for Managed Care coverage

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Reimbursement Changes for FY24

Rate Calibration

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Parity Adjustment Delay FY22

- Increase in aggregate spending of 5.3%
- Delayed for FY22, similar outcome to the 2012 reduction of 12.5%
- Due to an increase in CMIs from 2017 estimates to 2020 actual
- Estimated an increase of 1.46 (46%) actual increase higher, CMS proposing a reduction of CMIs to 37%
- Parity adjustment of $1.7 billion proposed resulting in a 5% reduction to PPS rates over 2 years

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Table 13: Average Case-Mix Index, Expected and Actual, by PDPM Component

Component	Expected Average CMI (FY 2019 Estimate, Subject Population)	Actual CMI per Stay (Control, Period, Subset, Population)	Percentage Difference
PT	1.51	1.52	0.4%
OT	1.51	1.52	0.4%
SLP	1.40	1.66	18.6%
Nursing	1.45	1.60	10.8%
NTA	1.16	1.20	3.0%

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Base Rates FY 24

TABLE 3: FY 2024 Unadjusted Federal Rate Per Diem—URBAN

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$70.27	$65.41	$26.23	$122.48	$92.41	$109.69

TABLE 4: FY 2024 Unadjusted Federal Rate Per Diem—RURAL

Rate Component	PT	OT	SLP	Nursing	NTA	Non-Case-Mix
Per Diem Amount	$80.10	$73.56	$33.05	$117.03	$88.29	$111.72

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2024 Final Rule p.32

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FY23 Parity Adjustment Impact (Nursing Case Mix Group)

URBAN

	NSG-2023 Base Rate	Nursing CMI-2022	Nursing CMI-2023	CMI Difference	% CMI decline	$ difference	% $ difference
A	$115.15	4.06	3.95	0.11	2.70%	-$3.11	2.70%
B	$115.15	3.07	2.99	0.08	2.61%	-$3.01	2.61%
C	$115.15	2.93	2.85	0.08	2.73%	-$3.14	2.73%
D	$115.15	2.40	2.33	0.07	2.92%	-$3.36	2.92%
E	$115.15	1.99	1.94	0.05	2.51%	-$2.89	2.51%
F	$115.15	2.24	2.18	0.06	2.68%	-$3.09	2.68%
G	$115.15	1.86	1.81	0.05	2.68%	-$3.09	2.68%
H	$115.15	2.08	2.02	0.06	2.88%	-$3.32	2.88%
I	$115.15	1.73	1.68	0.05	2.89%	-$3.33	2.89%
J	$115.15	1.72	1.67	0.05	2.91%	-$3.35	2.91%
K	$115.15	1.43	1.39	0.04	2.78%	-$3.20	2.78%
L	$115.15	1.87	1.82	0.05	2.67%	-$3.07	2.67%
M	$115.15	1.62	1.58	0.04	2.47%	-$2.84	2.47%
N	$115.15	1.55	1.51	0.04	2.58%	-$2.97	2.58%
O	$115.15	1.09	1.06	0.03	2.75%	-$3.17	2.75%
P	$115.15	1.34	1.30	0.04	2.99%	-$3.44	2.99%
Q	$115.15	0.94	0.91	0.03	3.19%	-$3.67	3.19%
R	$115.15	1.04	1.01	0.03	2.88%	-$3.32	2.88%
S	$115.15	0.99	0.96	0.03	3.03%	-$3.49	3.03%
T	$115.15	1.57	1.53	0.04	2.55%	-$2.94	2.55%
U	$115.15	1.47	1.43	0.04	2.72%	-$3.13	2.72%
V	$115.15	1.22	1.19	0.03	2.46%	-$2.83	2.46%
W	$115.15	0.71	0.69	0.02	2.82%	-$3.25	2.82%
X	$115.15	1.13	1.10	0.03	2.65%	-$3.05	2.65%
Y	$115.15	0.66	0.64	0.02	3.03%	-$3.49	3.03%
AVERAGES	$115.15	1.71	1.66	0.04	2.76%	-$1.98	2.76%

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FY24 Urban CMI

PDPM Group	PT CMI	PT Rate	OT CMI	OT Rate	SLP CMI	SLP Rate	Nursing CMG	Nursing CMI	Nursing Rate	NTA CMI	NTA Rate
A	1.45	$101.62	1.41	$91.97	0.64	$16.74	ES3	3.84	$469.06	3.06	$282.01
B	1.61	$112.83	1.54	$100.45	1.72	$45.00	ES2	2.90	$354.24	2.39	$220.26
C	1.78	$124.74	1.60	$104.37	2.52	$65.92	ES1	2.77	$338.36	1.74	$160.36
D	1.81	$126.84	1.45	$94.58	1.38	$36.10	HDE2	2.27	$277.28	1.26	$116.12
E	1.34	$93.91	1.33	$86.76	2.21	$57.81	HDE1	1.88	$229.64	0.91	$83.87
F	1.52	$106.52	1.51	$98.50	2.82	$73.77	HBC2	2.12	$258.96	0.68	$62.67
G	1.58	$110.73	1.55	$101.11	1.93	$50.49	HBC1	1.76	$214.98	-	-
H	1.10	$77.09	1.09	$71.10	2.7	$70.63	LDE2	1.97	$240.64	-	-
I	1.07	$74.99	1.12	$73.06	3.34	$87.37	LDE1	1.64	$200.33	-	-
J	1.34	$93.91	1.37	$89.37	2.83	$74.03	LBC2	1.63	$199.10	-	-
K	1.44	$100.92	1.46	$95.24	3.5	$91.56	LBC1	1.35	$164.90	-	-
L	1.03	$72.18	1.05	$68.49	3.98	$104.12	CDE2	1.77	$216.21	-	-
M	1.20	$84.10	1.23	$80.23	-	-	CDE1	1.53	$186.89	-	-
N	1.40	$98.11	1.42	$92.63	-	-	CBC2	1.47	$179.56	-	-
O	1.47	$103.02	1.47	$95.89	-	-	CA2	1.03	$125.81	-	-
P	1.02	$71.48	1.03	$67.19	-	-	CBC1	1.27	$155.13	-	-
Q	-	-	-	-	-	-	CA1	0.89	$108.71	-	-
R	-	-	-	-	-	-	BAB2	0.98	$119.71	-	-
S	-	-	-	-	-	-	BAB1	0.94	$114.82	-	-
T	-	-	-	-	-	-	PDE2	1.48	$180.78	-	-
U	-	-	-	-	-	-	PDE1	1.39	$169.79	-	-
V	-	-	-	-	-	-	PBC2	1.15	$140.47	-	-
W	-	-	-	-	-	-	PA2	0.67	$81.84	-	-
X	-	-	-	-	-	-	PBC1	1.07	$130.70	-	-
Y	-	-	-	-	-	-	PA1	0.62	$75.73	-	-

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FY 24 Proposed Rule

Market Basket and Adjustments	Figures
Unadjusted	2.7%
Forecast Error Remains Helpful	3.6%
MFP Decrease of 0.2%	-0.2%
Year 2 of 2-Year Parity Adjustment Phase-in Decrease of 2.3%	-2.3%
Net Final Market Basket	**3.7%**

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High Risk Areas for Revenue Recoupment

- Diagnostic Assignment
  - Primary and other
- Supportive documentation- Skilled services, no hospital stay
- Signatures and dates
- Coding
  - MDS
  - Claims

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MDS and Regulatory Changes for 10/1/2023

The Mess

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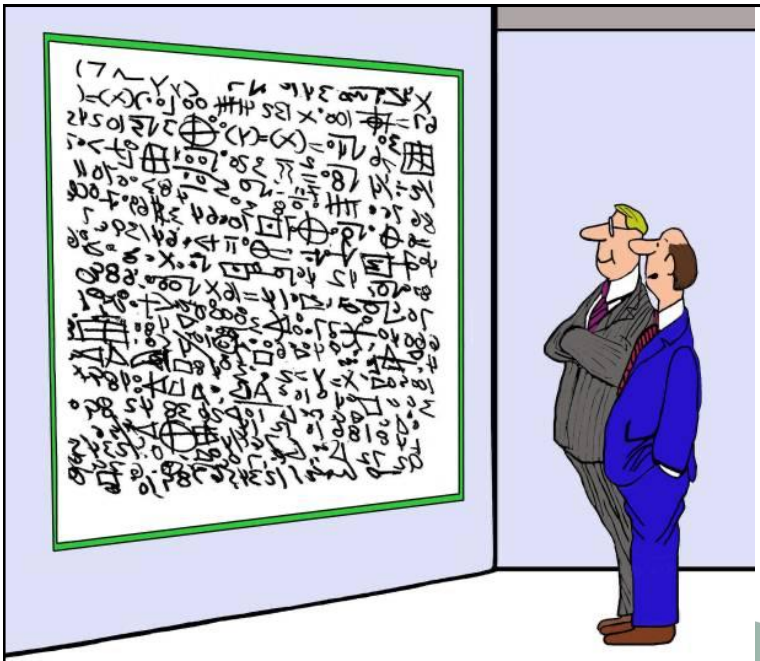

October 1, 2023

- Significant MDS Changes Effective ARD 10/1/23
- Software updates (issues)
- DRAFT RAI Manual (August final released, multi updates)
- Finalized MDS item sets released (again 10/20/23)
- QM Manual updated 10/1/2023
- QRP manual released 9/6/23

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Standardized Patient Assessment Data Elements (SPADES)

- Effective Oct. 1, 2023, seven social determinants of health (SDOH) standardized patient assessment data elements (SPADEs) was added to the MDS v1.18.11 item sets as follows:
  - Utilizes: Race and Ethnicity-Sections A1005, A1010
  - Language-Sections A1110A and A1110B
  - Health Literacy-Section B1300
  - Transportation-Section A1250
  - Social Isolation- Section D0700
- ***Data collection will start 10/1/23 on selected SPADES with new MDS Item Set Questions***
- 2% Part A rate ***penalty for not reporting***

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REMINDER:

80% of MDS assessments need to contain 100% of the SNF QRP required data from the MDS, and SNFs also need to submit 100% of data for the COVID-19 and Influenza Vaccination for Healthcare Personnel to the CDC NHSN system. If information is missing either way, the penalty will apply.

In the Proposed Rule, CMS would like to increase the required MDS data ***threshold from 80% to 90% beginning with data collected 1/1/2024***, for a payment impact on 10/1/25.

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Top Considerations for MDS Transition

- New data collection items
- New processes
- Staff workload
- OSA/Rate Freeze/PDPM transition for Medicaid CMI states
  - Last minute memos having significant impact on providers
- Understanding the future impact to quality programs

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10/1/2023 MDS Transition Issues

- Not calculating HIPPS scores (OBRA)
- Not correctly calculating HIPPS scores (Medicare)
- Incorrect skip patterns
  - CMS Technical errors
  - Software technical errors
- Unable to submit MDS assessments
- Software Patches too late, and not consistently updated

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Errata V3.01.4 for MDS 3.0-V3.01.1 (FINAL) Data Submission Specifications

- This change will be made in the next version of the MDS 3.0 Data Submission Specs. It will be included in a production release of IQIES scheduled for 12/12/2023 but will be RETROACTIVE for assessments with a target date of 10/1/23 and later.
- Cognition Section C, Mood Section D, Function Section GG, Rehab Section O, Discharge Planning Section Q, Transfer of Health Information Section A
- Survey issue, but could have financial impact too

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Triple Check Recommendations

- Wait until software is fully updated to send MDS assessments
- Refresh once software is updated
- Do not rely on system generated reports
- Pull prior period reports to verify PDPM scores before 10/1/23
- Verify each CMG for those MDSs completed on or after 10/1/23
  - Use your cheat sheets to verify what the CMG should be
- Review CMI scores for 3rd quarter 2023 to optimize Medicaid

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MDS Transition Impact to QMs

- Section G (ADLs) now utilizing Section GG (functional Status)
- Section D (Mood State) impacting depression capture
- New Social Determinants of Health (SDOH) items on the MDS creating new QMs

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TABLE 11: Quality Measures Currently Adopted for the FY 2024 SNF QRP

Short Name	Measure Name & Data Source
Resident Assessment Instrument Minimum Data Set (Assessment-Based)	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
Application of Functional Assessment/Care Plan	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
Change in Mobility Score	Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients
Change in Self-Care Score	Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
TOH-Provider*	Transfer of Health (TOH) Information to the Provider Post-Acute Care (PAC)
TOH-Patient*	Transfer of Health (TOH) Information to the Patient Post-Acute Care (PAC)
Claims-Based	
MSPB SNF	Medicare Spending Per Beneficiary (MSPB)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
DTC	Discharge to Community (DTC)–Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
SNF HAI	SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization
NHSN	
HCP COVID-19 Vaccine	COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel (HCP)

*In response to the public health emergency (PHE) for the Coronavirus Disease 2019 (COVID-19), we released an Interim Final Rule (85 FR 27595 through 27597) which delayed the compliance date for collection and reporting of the Transfer of Health (TOH) Information measures for at least 2 full fiscal years after the end of the PHE. The compliance date for the collection and reporting of the Transfer of Health Information measures was revised to October 1, 2023 in the FY 2023 SNF PPS final rule (87 FR 47547 through 47551).

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Future SNF VBP Measures

Measure Name	Measure Short Name	Measure Status	First Program Year	First Performance Period*
SNF 30-Day All-Cause Readmission Measure	SNFRM	Adopted, implemented	FY 2017**	FY 2015
SNF Healthcare-Associated Infections Requiring Hospitalization Measure	SNF HAI Measure	Adopted, not implemented	FY 2026	FY 2024
Total Nurse Staffing Hours per Resident Day Measure	Total Nurse Staffing Measure	Adopted, not implemented	FY 2026	FY 2024
Total Nursing Staff Turnover Measure	Nursing Staff Turnover Measure	Proposed	FY 2026+	FY 2024
Discharge to Community – Post-Acute Care Measure for SNFs	DTC PAC SNF Measure	Adopted, not implemented	FY 2027	FY 2024 and FY 2025
Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) Measure	Falls with Major Injury (Long-Stay) Measure	Proposed	FY 2027+	FY 2025
Discharge Function Score for SNFs Measure	DC Function Measure	Proposed	FY 2027+	FY 2025
Number of Hospitalizations per 1,000 Long Stay Resident Days Measure	Long Stay Hospitalization Measure	Proposed	FY 2027+	FY 2025
SNF Within-Stay Potentially Preventable Readmissions Measure	SNF WS PPR Measure	Proposed	FY 2028+	FY 2025 and FY 2026

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Measure and Link to Technical Report	Adopted in SNF PPS Final Rule	FY 2023 Program Year	FY 2024 Program Year	FY 2025 Program Year	FY 2026 Program Year	FY 2027 Program Year	FY 2028 Program Year
Skilled Nursing Facility Healthcare-Associated Infections (SNF HAI) Requiring Hospitalization	FY 2023	–	–	–	✓	✓	✓
Total Nurse Staffing Hours per Resident Day (including Registered Nurse [RN], Licensed Practical Nurse [LPN], and Nurse Aide hours)	FY 2023	–	–	–	✓	✓	✓
Total Nursing Staff Turnover	FY 2024	–	–	–	✓	✓	✓
Discharge to Community—Post-Acute Care (DTC-PAC) Measure for SNFs	FY 2023	–	–	–	–	✓	✓
Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)	FY 2024	–	–	–	–	✓	✓
Discharge Function Score for SNFs	FY 2024	–	–	–	–	✓	✓
Number of Hospitalizations per 1,000 Long Stay Resident Days	FY 2024	–	–	–	–	✓	✓
Skilled Nursing Facility Within-Stay Potentially Preventable Readmission (SNF WS PPR) Measure	FY 2024	–	–	–	–	–	✓

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Managed Care/Medicare Advantage

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Medicare Advantage Is On the Rise

- CMS is encouraging beneficiaries to enroll in managed care plans
  - Marketing efforts increased for seniors, or those approaching
  - More and more beneficiaries are choosing MA plans

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MAO Denials on the Rise

- Light needs to be shed on provider issues involving MA plan denials
  - Case managers 'choosing' PDPM scores and requiring MDSC to falsify MDS coding to match their PDPM scores
  - Misinterpretation of RAI guidelines to deny coding, assessment types, ARDs, completion dates, and submission dates
- **Managed Care Final Rule published 4/12/23 addresses these issues!**

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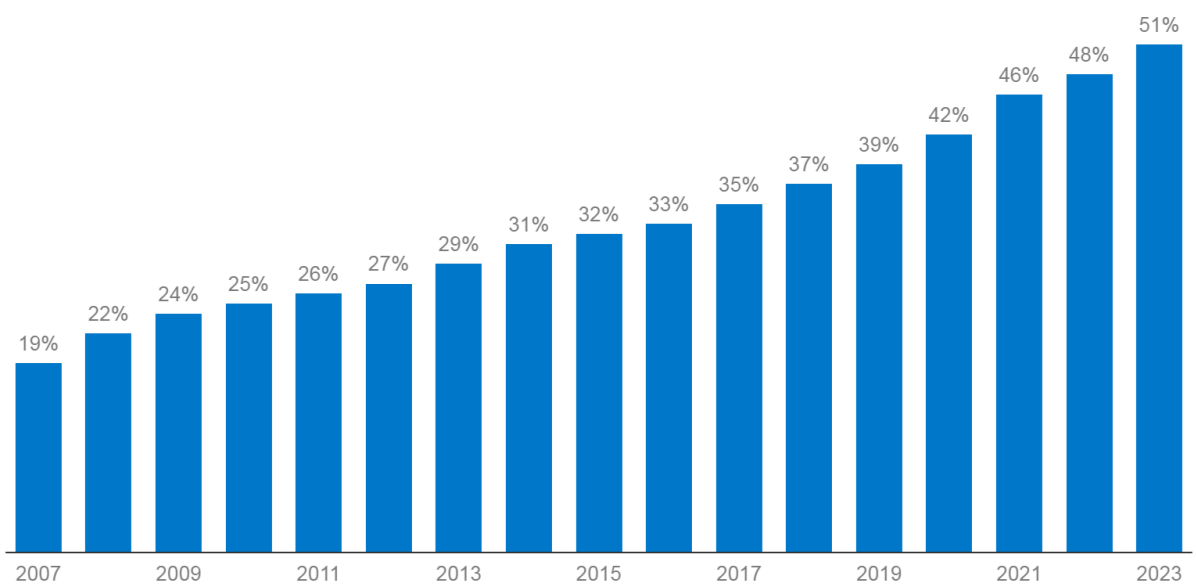
Total Medicare Advantage Enrollment, 2007-2023



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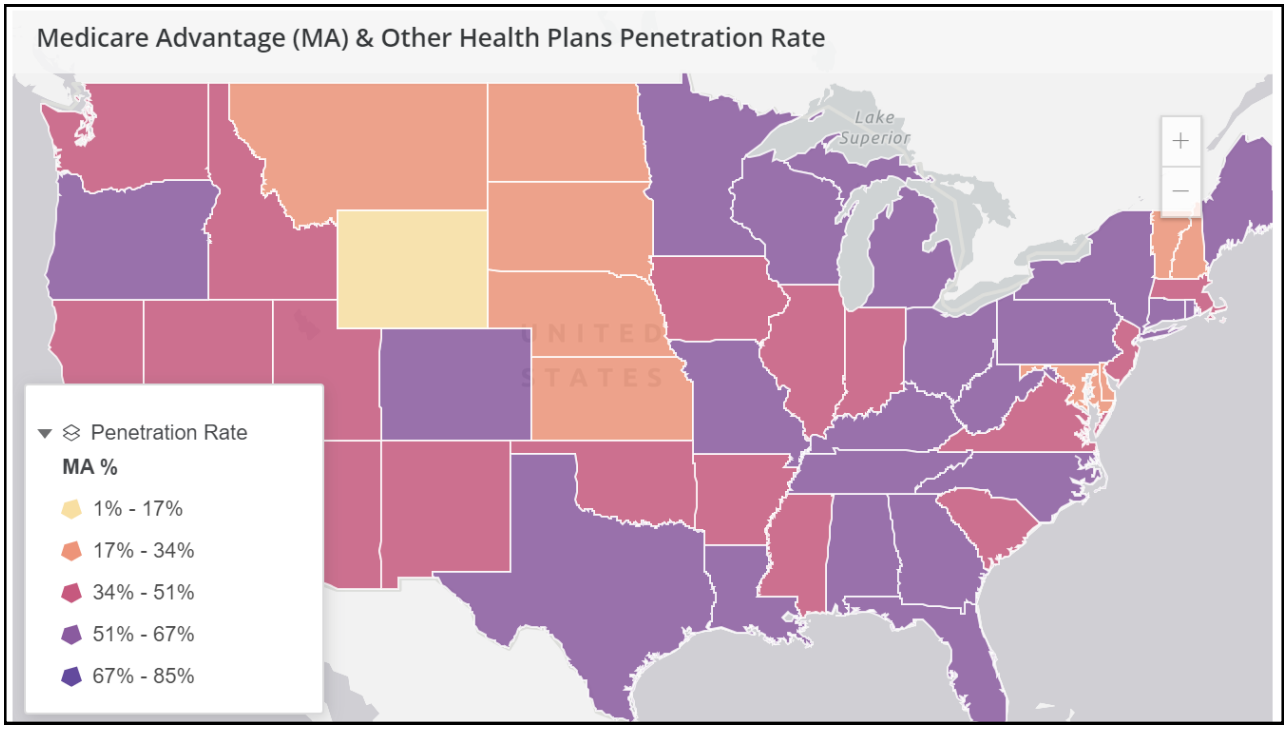
Medicare Advantage (MA) & Other Health Plans Penetration Rate
Lake Superior
Penetration Rate
MA %
1% - 17%
17% - 34%
34% - 51%
51% - 67%
67% - 85%

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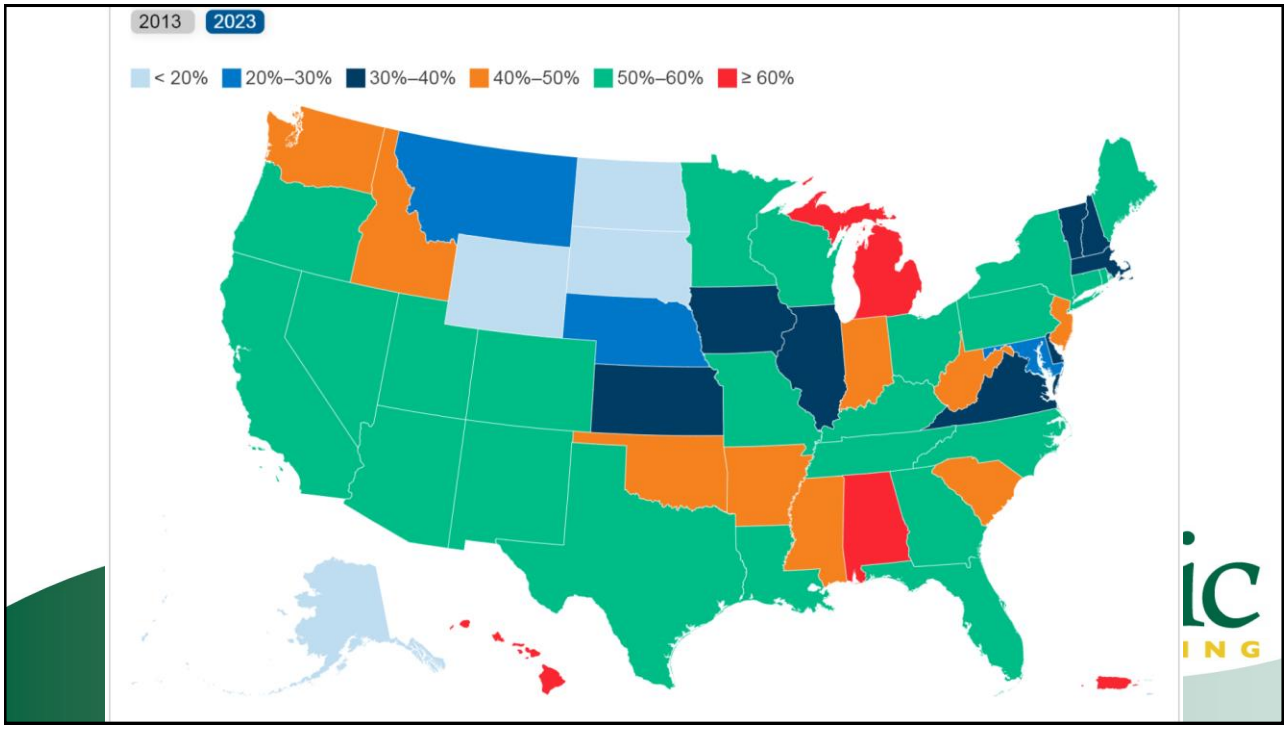
2013
2023
< 20%
20%–30%
30%–40%
40%–50%
50%–60%
≥ 60%

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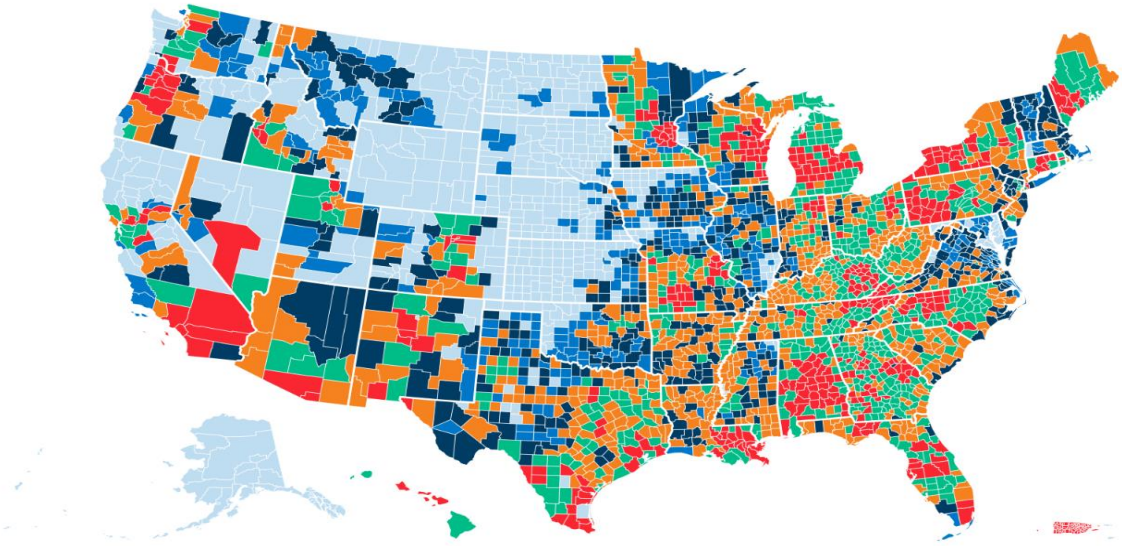
Medicare Advantage Penetration, by County, 2023

< 20% | 20%–30% | 30%–40% | 40%–50% | 50%–60% | ≥ 60%



NOTE: Includes only Medicare beneficiaries with Part A and B coverage.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2023 and March Medicare Enrollment Dashboard, 2023. • PNG

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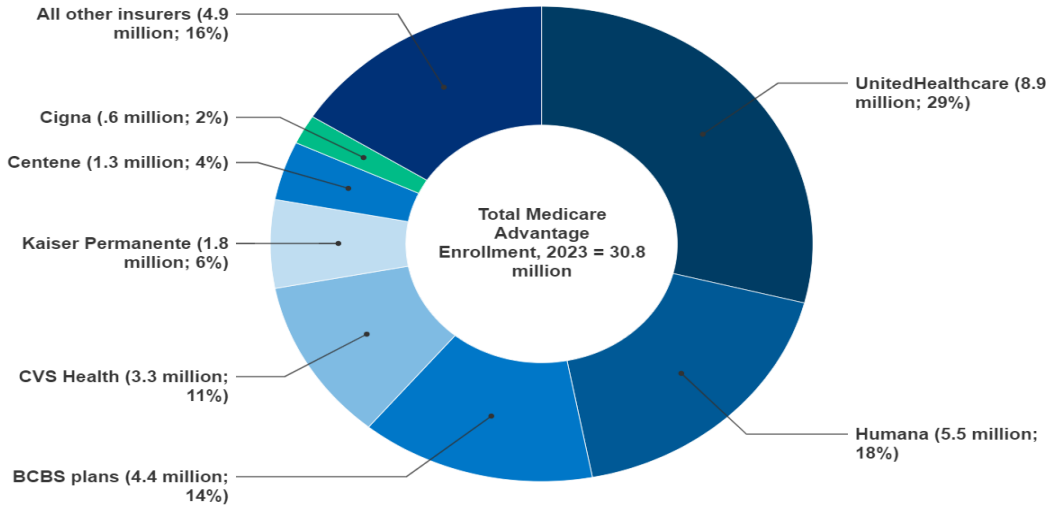
Medicare Advantage Enrollment by Firm or Affiliate, 2023



NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and includes Anthem BCBS plans (Elevance). Non-BCBS Elevance plans are 2% of total enrollment.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2023. • PNG

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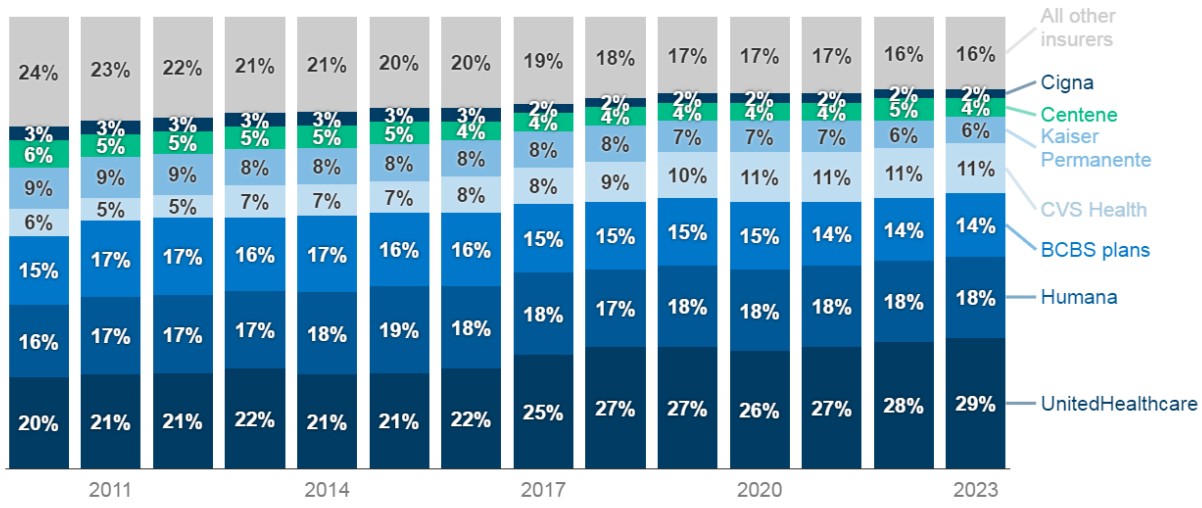
Medicare Advantage Enrollment by Firm or Affiliate, 2010-2023



NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and includes Anthem BCBS plans (Elevance). Non-BCBS Elevance plans are 2% of total enrollment. Percentages may not sum to 100% due to rounding.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2023. • PNG

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Average Reimbursement per Payer
(through January 2023) $124/$119 (22)/$101 (21)

Revenue Per Patient Day						
Medicaid	$269	0.5%	$256	0.2%	$271	0.0%	$270	0.7%
Medicare	$592	-0.4%	$589	0.0%	$590	-0.1%	$593	-0.5%
Managed Medicare	$468	0.3%	$431	0.3%	$469	0.6%	$472	0.3%
Private	$321	1.3%	$291	1.1%	$303	1.8%	$334	1.1%

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Office of Evaluations and Inspections (OEI) 4/27/22 Report Finds Delays and Denials of Medicare Covered Services

- Medicare Advantage Organizations (MAO) are incentivized to deny beneficiaries access to care and deny payments to providers to increase profit margins
- CMS audits have revealed widespread and persistent problems related to inappropriate denials of service and payment

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What the Study Showed

- 250 cases of denied care and 250 payment denials by 15 of the largest MAOs were audited
- Claims review period (6/1/19- 6/7/19)
  - Claims for services that meet Medicare coverage and regulatory guidelines were denied
  - Claims that met both Medicare and MAO billing regulations were denied
  - Additional administrative burden was created by the MAO that required the provider to perform ‘extra steps’

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What the Study Showed

- 13% of denied prior authorization requests met coverage guidelines and would have been paid for under FFS Medicare
- 18% of denied payments met Medicare coverage regulations
  - MAOs payment systems were not updated causing system processing errors
  - Manual claims reviews “missing documents” included for review by the provider

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Common Causes Identified for Denials

- MAOs using clinical criteria not contained in Medicare coverage rules
  - ‘Making up their own rules’
- Denying based on ‘lack of supportive documentation’, which was included as part of the medical record
  - Medical necessity was clearly present, yet payment denied
  - Not accepting the documentation provided

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OEI Recommendations to CMS

- CMS to issue guidance to MA plans on appropriate use of clinical criteria to meet medical necessity
- MAOs to update protocols on auditing claims particularly for post acute facility stays, which had been one of the two top providers for denied care (MRI and SNF)
- MAO to take additional step to identify and address the issues found in the report

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MAO Changes effective 1/1/2024

- Prior Authorization will be used only to confirm a diagnosis or other medical condition and once granted, will remain valid as long as medically necessary based on:
  - Past medical history of resident
  - Recommendations of the **treating physician**

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MAO Changes effective 6/5/2023

- Coverage must be based on LCDs, NCDs and benefits included in traditional Medicare
  - If no LCD or NCD, may create internal coverage guidelines, which must be posted and publicly accessible
  - If coverage criteria is unspecified, the internal guidelines must be based on current evidence-based criteria
    - Must be widely used treatment guidelines or clinical literature
  - Must provide evidence that was considered during the development of the internal criteria to make medical decisions

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MAO Changes effective 6/5/2023

- Must establish a Utilization Review Committee to review all criteria annually to ensure the criteria remains consistent with coverage requirements
  - Utilization management
  - Coverage criteria
  - Prior Authorization process
  - Policies
- Marketing to seniors will also be limited and waiting periods enforced

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Proposed Appeal Process- MAO

- Currently appeals are handled by the MAO
- CMS issues a proposed rule to address moving to the 5 levels of appeal utilized by traditional Medicare.

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Medicare Fee-For-Service (FFS) Appeals Process Overview

- **Level 1:** Redetermination by a Medicare Administrative Contractor (MAC)
- **Level 2:** Reconsideration by a Qualified Independent Contractor (QIC)
- **Level 3:** Decision by the Office of Medicare Hearings and Appeals (OMHA) (**ALJ)**
- **Level 4:** Review by the Medicare Appeals Council
- **Level 5:** Judicial Review in Federal District Court

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Questions?

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