The Only Thing For Certain Is Change
PACAH FALL 2017

Brandon Harlan, CPA
Partner – Health Care Services

Denise A. Park, RN
Manager – Clinical Nurse Consultant

Michael J. Kessler, CPA, CGMA
Senior Manager – Health Care Services
Agenda

• Introduction
• Industry Update
• Changes in Reimbursement
• Compliance / Operational
• Strategic Planning
Introduction

- Factors Driving the Evolution of the Industry
  - Aging population requiring increasing care
  - Society’s ability to pay for that care
  - Advances in technology and medical procedures
- Shift from Short-Term Reductions in Payment to Initiatives with Much Broader Impact on Volumes
- Focus on Broad Picture of Overall Population Health
  - Integrated system...not fragmented
  - Payment based on quality not quantity
  - Better outcomes at a lower cost
Industry Update

- Long-Term Changes to Payor Models
  - Bundled Payment Initiatives
    - Bundled Payments for Care Improvements (BPCI) – Began in April 2013
    - Comprehensive Care for Joint Replacement (CJR) – April 1, 2016
    - CMS finalized new initiatives on December 20, 2016
      - Two new cardiac care payment models
      - One new orthopedic care payment model
  - Community HealthChoices
    - Effective for Southwest PA on January 1, 2018, Southeast PA on July 1, 2018, remainder of state on January 1, 2019
    - Focus on Integration of Services
    - Intense Case Management
    - Negotiate Contracts with MCOs
    - After eighteen months, every current provider may not get a contract
Industry Update

— Narrow Networks
  • Insurers/Hospitals Choosing Which Post-Acute Care Providers to Refer to

— Value-Based Purchasing
  • Based on Value... Not Volume
  • Beginning October 1, 2018, Skilled Nursing Facilities (SNFs) subject to 2% reduction in payments
  • SNFs will have the opportunity to earn back more than the 2%
  • Key metrics: 30-Day All-Cause Readmission Measure, Quality Measure Ratings, etc.

— Federal Oversight Surveys
  • Industry Observations
    — Increased Relationships Among Providers
      • Hospitals/SNFs/HHAs, etc.
    — Declining Census
      • Shorter average lengths of stay
Industry Update

- Push to diversification
- Better utilization of technology
  - Electronic Health Records
  - Data analytics
- Tighter margins
- Alternative care models
  - Care Cottages
  - CCRC at Home
- Institutional Special Needs Plans (ISNP)
- Aggressive marketing and admissions
Changes in Reimbursement

- Bundled Payments
- SNF PPS Payment Reform
- Community HealthChoices
# Bundled Payment Overview - BPCI

*Developed by CMS Innovation Center which was established by the Affordable Care Act*

## Comparing the Four Models

<table>
<thead>
<tr>
<th></th>
<th>Model 1: Hospital Inpatient Services for All DRGs</th>
<th>Model 2: Hospital and Physician Inpatient and Post-Discharge Services</th>
<th>Model 3: Post-Discharge Services Only</th>
<th>Model 4: Hospital and Physician Inpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible Participants</strong></td>
<td>Physician groups, acute care hospitals reimbursed under IPPS¹, health systems, PHOs, conveners of participating providers</td>
<td>Model 1 participants plus post-acute care providers</td>
<td>Model 1 participants plus post-acute care providers, long-term care hospitals, inpatient rehab facilities, home health agencies</td>
<td>Model 1 participants</td>
</tr>
<tr>
<td><strong>Clinical Conditions</strong></td>
<td>All Medicare DRGs</td>
<td>Select inpatient DRGs, proposed by applicants</td>
<td>Inpatient hospital and physician services; related readmissions</td>
<td>Inpatient hospital and physician services; related readmissions</td>
</tr>
<tr>
<td><strong>Included Services</strong></td>
<td>Inpatient hospital services</td>
<td>Inpatient hospital and physician services; related post-acute care and readmissions</td>
<td>Post-acute care; related readmissions</td>
<td>Inpatient hospital and physician services; related readmissions</td>
</tr>
<tr>
<td><strong>Expected Discount</strong></td>
<td>Minimum increases from 0% for first six months to 2% in year 3</td>
<td>Minimum of 3% for 30-89 days post-discharge services; minimum 2% for 90+ days post-discharge</td>
<td>Proposed by applicant (no set minimum)</td>
<td>Minimum 3% discount (larger for DRGs in ACE² Demonstration)</td>
</tr>
<tr>
<td><strong>Provider Payments</strong></td>
<td>IPPS payment less discount for Part A services; physicians reimbursed on traditional fee schedule</td>
<td>Retrospective bundling method: providers receive traditional fee-for-service payments, subject to post-episode reconciliation against target price</td>
<td></td>
<td>Prospective bundling method: hospital collects and distributes payments to clinicians</td>
</tr>
<tr>
<td><strong>Quality Measures</strong></td>
<td>All Hospital IQR³ measures, plus additional measures proposed by applicants</td>
<td>Proposed by applicants, with CMS ultimately establishing a standardized set of metrics aligned with measures in other CMS programs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

¹ Inpatient Payment System.  
² Acute Care Episode.  
³ Inpatient Quality Reporting.

Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board interviews and analysis.
Bundled Payment Overview - CJR

- Established under Section 1115A of the Social Security Act (SSA)
- Certain modifications to CJR made with December 20, 2016, rulemaking
- Beneficiaries retain their freedom of choice
- Bundled payments for lower extremity joint replacement (LEJR) – DRGs 469 and 470
- Based on 90 day episodes starting with the hospital admission
- First performance period began on April 1, 2016, and ended on December 31, 2016. Continues for the following 4 years
- Mandatory in 67 MSAs including Pittsburgh, Harrisburg-Carlisle, Reading, and Akron
Bundled Payment Overview - CJR

- **Flexibilities afforded by CJR**
  - Waiver of 3-day hospital stay prior to admission to a covered SNF stay (under certain conditions) – effective 1/1/17
    - Creates complications when patients discharged to SNF with less than 3 stars
    - Beneficiary notice required
  - Allowing payment for certain physician visits via telehealth
  - Allows clinical staff to furnish certain post-discharge home visits under the general, rather than direct, supervision of a physician or nonphysician practitioner
  - Allowed to enter into certain financial arrangements with collaborating providers
    - Tightly regulated
    - See “New Models” section for further discussion
Bundled Payment Overview - New Models

- Finalized additional/revised models on December 20, 2016
- Implemented under Section 1115A of the SSA
- Proposed rule published on 8/2/16 and final rule published on 1/3/17 (472 pages)
- Referred to as:
  - Acute Myocardial Infarction Model (AMI)
    - MS-DRGs 280 - 282 (possibly additional DRGs depending on diagnosis code)
  - Coronary Artery Bypass Graft Model (CABG)
    - MS-DRGs 231 - 236
  - Surgical Hip and Femur Fracture Treatment Model (SHFFT)
    - MS-DRGs 480 - 482
  - Cardiac Rehabilitation Incentive Payment Model (CR)
Bundled Payment Overview - New Models

- CMS believes can improve quality and reduce cost through care redesign
  - Increase post-hospitalization follow-up
  - Coordination of care across post-acute spectrum
  - Conducting appropriate discharge planning
  - Improving adherence to treatment and drug regimens
  - Reduce readmissions and post-discharge complications
  - Improve management of chronic diseases
  - Better choice of post-acute setting
  - Coordination of care among all providers
  - New models uncertainty – reduction in MSAs, push back of timelines?
Bundled Payment Overview - New Models

- **Episode begins with hospitalization and extends 90 days following discharge**
- **The first performance period will begin on January 1, 2018, and end on December 31, 2018 (further delays possible)**
- **Program will last until December 31, 2022**
- **AMI and CABG implemented in 98 MSAs**
  - Akron, Canton, Erie, Lima, Reading, Youngstown
- **SHFFT – Implemented in same 67 MSAs as CJR**
SNF PPS Payment Reform Overview

RCS-1 - What is it?

What is it?

• Resident Classification System – Version 1
• Suggested new payment model by CMS
• Assigns every resident to a classification driving reimbursement
• Replacement (not a revision) to the current RUG system
• Budget Neutral
Why Replace RUGs?

- Index maximizing leads to 90% of residents having payments primarily driven by therapy services provided
- CMS view of therapy in SNFs being predicated on “financial considerations” as opposed to resident needs
  - Thresholding
  - Ultra High domination
- Multiple reports and studies published by OIG and MedPAC expressing concerns with incentives in current RUG model
## SNF PPS Payment Reform Overview

### RUGs vs. RCS-1

<table>
<thead>
<tr>
<th>RUGs</th>
<th>RCS-1</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 2 case-mix components</td>
<td>• 4 case-mix components</td>
</tr>
<tr>
<td>• Index maximizing</td>
<td>• Index combining</td>
</tr>
<tr>
<td>• Group/Concurrent deterrent</td>
<td>• Group/Concurrent benefits</td>
</tr>
<tr>
<td>• 5 scheduled PPS assessments</td>
<td>• 1 scheduled PPS assessment</td>
</tr>
<tr>
<td>• Constant rates for LOS</td>
<td>• Declining rates over LOS</td>
</tr>
<tr>
<td>• Maximum therapy incentivized</td>
<td>• Minimum therapy incentivized</td>
</tr>
</tbody>
</table>

Source: Optima Healthcare Solutions, Understanding SNF PPS Proposed Payment Reform
Elimination of Index Maximizing

RUGs
Grouper identifies all classifications (Therapy & RUG) that a patient fits into. The one with the highest case-mix index is used for payment.
- 66 possible classifications (RUG scores)
- 23 are rehabilitation classifications

RCS-1
Grouper identifies classification for each of the 4 components. The corresponding rates for each of the component indexes are summed to determine per-diem payment rate.

Source: Optima Healthcare Solutions, Understanding SNF PPS Proposed Payment Reform
SNF PPS Payment Reform Overview

Unanswered Questions

- Where is pay-for-performance?
- If an outcomes component is introduced, what model will be used?
- When will the transition actually occur?
SNF PPS Payment Reform Overview

Anticipated Impact

- **Therapy Services**
  - Significant reduction in minutes provided
  - More concurrent & group
  - Less demand for therapists in SNF
  - Easier staffing

- **Financial**
  - SNF: Positive
  - Therapy Service Providers: Mixed
    - Revenue: Negative
    - Margin: Neutral to Positive

Source: Optima Healthcare Solutions, Understanding SNF PPS Proposed Payment Reform
Community HealthChoices

• DHS will pay the three Managed Care Organizations (MCOs) directly.
• MCOs will negotiate contracts with providers.
• For the first 36 months after the implementation of CHC, providers will be paid a rate no lower than the rate floor.
• Rate Floor – Determined by the average Medicaid rate of the previous 4 quarters of rates prior to the implementation of the Rate Floor.
Community HealthChoices

• The rate floor will not preclude providers from negotiating a higher rate based on resident acuity and the availability of nursing facility care.

• MCOs must remit separate payments for exceptional durable medical equipment, in addition to the rate floor per diem.
Community HealthChoices

???
Compliance / Operational

- HIPAA HITECH
- Nursing Home Final Rule
- Five Star
HIPAA HITECH

Data Breaches by Industry

- Healthcare: 27% (263 incidents)
- Other: 16% (159 incidents)
- Government: 14% (137 incidents)
- Financial: 12% (118 incidents)
- Education: 11% (102 incidents)
- Retail: 11% (102 incidents)
- Technology: 9% (90 incidents)
HIPAA HITECH

Data Records Lost/Stolen by Industry

- **43%** Government
  - 307,122,342 RECORDS
- **19%** Healthcare
  - 134,385,415 RECORDS
- **17%** Other
  - 121,129,222 RECORDS
- **12%** Technology
  - 84,394,833 RECORDS
- **6%** Retail
  - 40,075,707 RECORDS
- **3%** Education
  - 19,328,253 RECORDS
- **<1%** Financial
  - 1,074,043 RECORDS

Arnett Carbis Toothman LLP
CPAs & Advisors
HIPAA HITECH

5 Ways to Reduce Risk Related to Personal Health Information

1. **Conduct a risk assessment to determine vulnerabilities.**
2. **Identify the ePHI within the organization.**
3. **Develop action plans around the external sources of ePHI (e.g., vendors, consultants, and IT suppliers).**
4. **Review the “Security Rule” to determine whether the implementation specifications for protecting ePHI are “addressable” or “required.”**
5. **Make sure the required business associate agreements are comprehensive and address liability in the event of noncompliance or a breach.**

Source: [www.hfma.org](http://www.hfma.org) by Rachel V. Rose – Attorney
HIPAA Breach Notification Rule

The HIPAA Breach Notification Rule requires covered entities to notify affected individuals, HHS and, in some cases, the media of a breach of unsecured PHI. Most notifications must be provided without unreasonable delay and no later than 60 days following the discovery of a breach. Notifications of smaller breaches affecting fewer than 500 individuals may be submitted to HHS annually. The Breach Notification Rule also requires business associates of covered entities to notify the covered entity of breaches at or by the business associate. Visit the HHS HIPAA Breach Notification Rule webpage for more information and guidance on the reporting requirements.
**HIPAA HITECH**

Resolution Agreements and Civil Money Penalties

- Careless handling of HIV information jeopardizes patient’s privacy, costs entity $387k - May 23, 2017

- Texas health system settles potential HIPAA violations for disclosing patient information - May 10, 2017

- $2.5 million settlement shows that not understanding HIPAA requirements creates risk – April 24, 2017

- No Business Associate Agreement? $31K Mistake - April 20, 2017

- Overlooking risks leads to breach, $400,000 settlement - April 12, 2017

- $5.5 million HIPAA settlement shines light on the importance of audit controls - February 16, 2017

- Lack of timely action risks security and costs money - February 1, 2017
## Cases Currently Under Investigation

This page lists all breaches reported within the last 24 months that are currently under investigation by the Office for Civil Rights.

### Breach Report Results

<table>
<thead>
<tr>
<th>Name of Covered Entity</th>
<th>State</th>
<th>Covered Entity Type</th>
<th>Individuals Affected</th>
<th>Submission Date</th>
<th>Type of Breach</th>
<th>Location of Breached Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD everywhere, Inc.</td>
<td>TX</td>
<td>Business Associate</td>
<td>1396</td>
<td>08/10/2017</td>
<td>Unauthorized Access/Disclosure</td>
<td>Other</td>
</tr>
<tr>
<td>City of Hope</td>
<td>CA</td>
<td>Healthcare Provider</td>
<td>3400</td>
<td>08/03/2017</td>
<td>Hacking/IT Incident</td>
<td>Email</td>
</tr>
<tr>
<td>Braun Dermatology &amp; Skin Cancer Center</td>
<td>DC</td>
<td>Healthcare Provider</td>
<td>1200</td>
<td>07/28/2017</td>
<td>Unauthorized Access/Disclosure</td>
<td>Email</td>
</tr>
<tr>
<td>Plastic Surgery Associates of South Dakota</td>
<td>SD</td>
<td>Healthcare Provider</td>
<td>10229</td>
<td>07/27/2017</td>
<td>Hacking/IT Incident</td>
<td>Network Server</td>
</tr>
<tr>
<td>Christine D. Collins, APC &amp; Ann Hofstadter, MD Inc.</td>
<td>CA</td>
<td>Healthcare Provider</td>
<td>1500</td>
<td>07/27/2017</td>
<td>Hacking/IT Incident</td>
<td>Email</td>
</tr>
<tr>
<td>Anthem, Inc.</td>
<td>IN</td>
<td>Health Plan</td>
<td>18580</td>
<td>07/24/2017</td>
<td>Unauthorized Access/Disclosure</td>
<td>Email</td>
</tr>
<tr>
<td>BlueCross Blue Shield of TN, Inc.</td>
<td>TN</td>
<td>Health Plan</td>
<td>2117</td>
<td>07/21/2017</td>
<td>Unauthorized Access/Disclosure</td>
<td>Paper/Films</td>
</tr>
<tr>
<td>The University of Vermont Medical Center</td>
<td>VT</td>
<td>Healthcare Provider</td>
<td>2300</td>
<td>07/21/2017</td>
<td>Hacking/IT Incident</td>
<td>Email</td>
</tr>
<tr>
<td>Performance Physical Therapy and Wellness</td>
<td>CT</td>
<td>Healthcare Provider</td>
<td>571</td>
<td>07/21/2017</td>
<td>Hacking/IT Incident</td>
<td>Email</td>
</tr>
<tr>
<td>Massachusetts Department of Public Health - Tewksbury Hospital</td>
<td>MA</td>
<td>Healthcare Provider</td>
<td>1176</td>
<td>07/21/2017</td>
<td>Unauthorized Access/Disclosure</td>
<td>Electronic Medical Record</td>
</tr>
<tr>
<td>Kaleida Health</td>
<td>NY</td>
<td>Healthcare Provider</td>
<td>2789</td>
<td>07/21/2017</td>
<td>Hacking/IT Incident</td>
<td>Email</td>
</tr>
<tr>
<td>Vision Care Specialists, Inc.</td>
<td>CO</td>
<td>Healthcare Provider</td>
<td>703</td>
<td>07/20/2017</td>
<td>Theft</td>
<td>Paper/Films</td>
</tr>
<tr>
<td>Metropolitan Life Insurance Company</td>
<td>NY</td>
<td>Health Plan</td>
<td>4220</td>
<td>07/19/2017</td>
<td>Hacking/IT Incident</td>
<td>Other</td>
</tr>
<tr>
<td>SAGE DENTAL MANAGEMENT, LLC</td>
<td>FL</td>
<td>Business Associate</td>
<td>5000</td>
<td>07/19/2017</td>
<td>Theft</td>
<td>Other</td>
</tr>
<tr>
<td>Women’s Health Care Group of PA, LLC</td>
<td>PA</td>
<td>Healthcare Provider</td>
<td>300000</td>
<td>07/15/2017</td>
<td>Hacking/IT Incident</td>
<td>Desktop Computer, Network Server</td>
</tr>
</tbody>
</table>
HIPAA HITECH

When my health IT developer installs its software for my practice, does its implementation process address the security features listed below for my practice environment?

- ePHI encryption
- Auditing functions
- Backup and recovery routines
- Unique user IDs and strong passwords
- Role- or user-based access controls
- Auto time-out
- Emergency access
- Amendments and accounting of disclosures
Why is Health Care Being Attacked?

• Medical identity theft affected an estimated 1.5 million people in the U.S. at a cost of $41.3 billion last year
• Health care organizations are a newly favored target among cybercriminals
• Information contained in medical records has much broader utility, can be used to commit multiple types of fraud or identity theft, and does not change, even if compromised
• Medical fraud takes more than twice as long to identify as regular identity theft
• $50 for stolen medical information vs. $1 for a stolen SSN
Nursing Home Final Rule

The final rule will revise the requirements that Long-Term Care facilities must meet to participate in the Medicare and Medicaid programs. These changes are necessary to reflect the substantial advances that have been made over the past several years in the theory and practice of service delivery and safety. These revisions are also an integral part of the efforts to achieve broad-based improvements both in the quality of health care furnished through federal programs, and in patient safety, while at the same time reducing procedural burdens on providers.

Source: Centers for Medicare and Medicaid Services, Publication date: 10/4/16
# Nursing Home Final Rule

<table>
<thead>
<tr>
<th>Implementation Date</th>
<th>Type of Change</th>
<th>Details of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>November 28, 2016</td>
<td>Nursing Home Requirements for Participation</td>
<td>New Regulatory Language was uploaded to the Automated Survey Processing Environment (ASPEN) under current F Tags</td>
</tr>
<tr>
<td>(Implemented)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase 2:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>November 28, 2017</td>
<td>F Tag numbering</td>
<td>New F Tags</td>
</tr>
<tr>
<td></td>
<td>Interpretive Guidance (IG)</td>
<td>Updated IG</td>
</tr>
<tr>
<td></td>
<td>Implement new survey process</td>
<td>Begin surveying with the new survey process</td>
</tr>
<tr>
<td>Phase 3:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>November 28, 2019</td>
<td>Requirements that need more time to implement</td>
<td>Requirements that need more time to implement</td>
</tr>
</tbody>
</table>
Nursing Home Final Rule

• Implement by November 28, 2017
• Providers must be in compliance with Phase 2 regulations
• All States will use new computer–based survey process for LTC surveys
• All training on new survey process needs to be completed before go live date
Nursing Home Final Rule

• The new survey process builds on the best of both survey processes
• Process is computer software-based
• Input from various stakeholders
• Survey process and software are in testing and development and validation

Source: Centers for Medicare and Medicaid Services
## Nursing Home Final Rule

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Quality Indicator Survey (QIS)</th>
<th>New Survey Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Survey team collects data and records the findings on paper</td>
<td>Each survey team member uses a tablet PC throughout the survey process to record findings that are synthesized and organized by the QIS software</td>
<td>Each survey team member uses a tablet or laptop PC throughout the survey process to record findings that are synthesized and organized by new software</td>
</tr>
</tbody>
</table>
## Nursing Home Final Rule

<table>
<thead>
<tr>
<th>Traditional</th>
<th>QIS</th>
<th>New Survey Process</th>
</tr>
</thead>
</table>
| - Sample size determined by facility census  
- Residents are pre-selected based on QM/QI percentiles (total sample)  
- Sample may be adjusted based on issues identified on tour  
- Maximum sample size is 30 residents  
- Includes complaints | The ASE-Q provides a randomly selected sample of residents for the following:  
- Admission sample is a review of up to 30 current or discharged resident records  
- Census sample includes up to 40 current residents for observation, interview, and record review  
- With QIS 4.04, complaints can be included in census sample | - Sample size is determined by the facility census  
- 70% of the total sample is MDS pre-selected residents and 30% of the total sample is surveyor-selected residents. Surveyors finalize the sample based on observations, interviews, and a limited record review.  
- Maximum sample size is 35 residents |
# Nursing Home Final Rule

<table>
<thead>
<tr>
<th>Traditional</th>
<th>QIS</th>
<th>New Survey Process</th>
</tr>
</thead>
</table>
| • Review Casper 3 and 4 reports  
• Survey team uses QM/QIs report offsite to identify preliminary sample of residents areas of concern | • Review the Casper 3 report and current complaints  
• Download the MDS data to PCs  
• ASE-Q selects a random sample of residents for Stage 1 from residents with MDS assessments in past 180 days | • Each team member independently reviews the Casper 3 report and other facility history information  
• Review offsite selected residents and their indicators and the facility rates. |

Source: Centers for Medicare and Medicaid Services
# Nursing Home Final Rule

<table>
<thead>
<tr>
<th>Traditional</th>
<th>QIS</th>
<th>New Survey Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Roster Sample Matrix Form (CMS-802)</td>
<td>• Obtain census number and alphabetical resident census with room numbers and units</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• List of new admissions over last 30 days</td>
<td>• Completed matrix for new admissions over the last 30 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Facility census number</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Alphabetical list of residents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• List of residents who smoke and designated smoking times</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare and Medicaid Services
## Nursing Home Final Rule

<table>
<thead>
<tr>
<th>Traditional</th>
<th>QIS</th>
<th>New Survey Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Gather information about pre-</td>
<td>• No sample selection</td>
<td>• No formal tour process</td>
</tr>
<tr>
<td>selected residents and new concerns</td>
<td>• Initial overview of facility,</td>
<td>• Surveyors complete a full observation, interview all interviewable residents, and</td>
</tr>
<tr>
<td>• Determine whether pre-selected</td>
<td>resident population and staff/resident</td>
<td>complete a limited record review for initial pool residents:</td>
</tr>
<tr>
<td>residents are still appropriate</td>
<td>interactions.</td>
<td>• Offsite selected residents</td>
</tr>
<tr>
<td>• 1 – 3 hours on average</td>
<td>• 30 – 45 minutes on average for initial</td>
<td>• New admissions</td>
</tr>
<tr>
<td></td>
<td>overview</td>
<td>• Vulnerable residents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identified Concern that doesn’t fall into one of the above subgroups</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 8 hours on average for interviews, observations, and screening.</td>
</tr>
</tbody>
</table>
# Nursing Home Final Rule

<table>
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<tr>
<th>Traditional</th>
<th>QIS</th>
<th>New Survey Process</th>
</tr>
</thead>
</table>
| • Resident sample is about 20% of facility census for resident observations, interviews, and record reviews | • Stage 1: Preliminary investigation of regulatory areas in the admission and census samples and mandatory facility tasks started  
• Stage 2: Completion of in-depth investigation of triggered care areas and/or facility tasks based on concerns identified during Stage 1 | • Resident sample size is about 20% of facility census  
• Interview, observation and limited record review care areas are provided for the initial pool process; surveyors can ask the questions as they would like  
• Surveyors meet to discuss and select sample, may have more concerns than can be added to the sample; may need to prioritize concerns |
| • Phase I: Focused and comprehensive reviews based on QM/QI report and issues identified from offsite information and facility tour |                                                                      |                                                                                  |
| • Phase II: Focused record reviews                                           |                                                                      |                                                                                  |
| • Facility and environmental tasks completed during the survey               |                                                                      |                                                                                  |
Five Star

• Three Components of Five Star
  – Health Inspections
  – Staffing
  – Quality
Five Star

• Health Inspections
  – Based on most recent health inspection + prior 2 cycles
  – Includes complaint surveys with deficiency findings
  – Additional points are assigned if deficiency findings are not cleared when re-visits occur
**Five Star**

- **Health Inspections**

* If the status of the deficiency is “past non-compliance” and the severity is Immediate Jeopardy, then points associated with a ‘G-level” deficiency (i.e. 20 points) are assigned.

<table>
<thead>
<tr>
<th>Health Inspection Score: Weights for Different Types of Deficiencies Scope</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Severity</strong></td>
</tr>
<tr>
<td>Immediate jeopardy to resident health or safety</td>
</tr>
<tr>
<td>Actual harm that is not immediate jeopardy</td>
</tr>
<tr>
<td>No actual harm with potential for more than minimal harm that is not immediate jeopardy</td>
</tr>
<tr>
<td>No actual harm with potential for minimal harm</td>
</tr>
</tbody>
</table>
Five Star

• Health Inspections

**Revisit**: Points reassigned if not cleared

- 50% of total points added if not cleared on 2nd visit
- 70% by the 3rd visit
- 85% by the 4th visit

Points then totaled for each survey cycle based on time in which the deficiencies were identified

- Current cycle weight is ½ (50%)
- prior cycle 1/3 (33%)
- and second prior cycle is 1/6 (16.66%)
Five Star

• Healthy Inspections
  – CMS posts cut-points tables monthly establishing cut-points for each star level by state.

<table>
<thead>
<tr>
<th>STARS</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>10.00</td>
</tr>
<tr>
<td>4</td>
<td>23.33</td>
</tr>
<tr>
<td>3</td>
<td>23.33</td>
</tr>
<tr>
<td>2</td>
<td>23.33</td>
</tr>
<tr>
<td>1</td>
<td>20.00</td>
</tr>
</tbody>
</table>
Five Star

- **Staffing**
  - Hours of care provided on average to each resident each day by nursing staff.
  - Form-671 (staff hours)
  - Form-672 (resident census)
  - Includes full and part time staff and individuals under an organization or agency contract.
Five Star

- **Staffing**

Case-Mix Adjustment Applied to RN & Total Nursing Hours

\[
\text{Hours Adjusted} = \left( \frac{\text{Hours Reported}}{\text{Hours Expected}} \right) \times \text{National Average}
\]
## Five Star

### Staffing

- **Star Cut Points - Case-Mix Adjusted Hours**

<table>
<thead>
<tr>
<th>RN Rating &amp; Hours</th>
<th>Total Nurse Staffing Rating &amp; Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stars</strong></td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>&lt;.283</td>
</tr>
<tr>
<td>2</td>
<td>0.283 - .378</td>
</tr>
<tr>
<td>3</td>
<td>.379 - .512</td>
</tr>
<tr>
<td>4</td>
<td>.513 - .709</td>
</tr>
<tr>
<td>5</td>
<td>≥ .710</td>
</tr>
</tbody>
</table>
Five Star

• Quality Measures
  – 16 different measurers impact rating.
  – All measures are given equal weight and point values are summed.
  – Information collected for all residents via Minimum Data Set (MDS) and Medicare Claims data.
Strategic Planning

WE HAVE A
STRATEGIC PLAN
IT'S CALLED
DOING THINGS.

Herb Keller
Strategic Planning

Who Will Succeed in the Evolving Environment?

• Strong balance sheet and statement of operations
• Good access to capital
• Well diversified in various aspects of service delivery
• Poised to form formal relationships with other health care providers
• Good reputation and appeal to consumers
• Low cost provider
• Ability to adapt to change quickly
• Strong leverage with insurers
• High CMS Five Star Rating
• Formation of Strategic Alliances
• Evaluation of Mergers and Acquisitions
Strategic Planning

In Summary – What Does All of This Mean to a Provider?

• Lower overall volumes
  • Less Medicare Part B services
  • Lower census
  • Aggressive care planning

• Lower payment and reimbursement levels
  • Lower Resource Utilization Groups (RUGs)

• Higher focus on quality measures and ratings
  • CMS Five Star Rating system
Contact Information

• Brandon Harlan – Phone: 724-658-1565 – ext. 217
  
  Email: Brandon.Harlan@actcpas.com

• Denise Park – Phone: 724-658-1565 ext. 163
  
  Email: Denise.Park@actcpas.com

• Michael Kessler – Phone: 724-658-1565 ext. 236
  
  Email: Mike.Kessler@actcpas.com