Medicare and Medicaid benefit is managed. Total savings will not materialize unless the following:

- Medicaid Managed Care

  "You can’t manage a Medicaid Day" (Jay Gormley)

- Service reductions
- Reduced provider $ = access problems
- How? To where?
- Get them out / keep them out?
- Where will savings come from?
- Provider protections
- Insurer risk administratively pass-through?
- Get them out etc.

• Moved aggressively into LTC

Outlook: Negative to Neutral

Trend 1:

Understanding the Changes

SNF Market Trends
Expenditure/Beneficiary Year by Type of LTC

Source: Effect of Long-term Care Use on Medicare and Medicaid Expenditures for Dual Eligible and Non-dual Eligible Elderly Beneficiaries. Robert L. Kane, Andrea Wysocki, Shriram Parashuram, Tetyana Shippee, Terry Lum

Trend 2: Traditional Medicare

- **Outlook: Positive**
  - Part A FFS remains our strongest payer
  - Margins down but remain robust
  - Aging population will result in many more short-term stays (10,000 new beneficiaries per day)
  - Payment reform fragmenting the population and reducing SNF utilization
  - Acceleration toward Medicare Advantage
Medicare Program’s Health

- $613B in 2014 to grow to $1T by 2026
  - Total income = $599B
- Trust Fund solvent through 2030
- Rate of growth has slowed
  - Historical annual increase:
    - 11% (1973 – 2013) to 4% (2010 – 2014)
  - Total annual spending growth projection:
    - 5% - 7% over next decade
  - Per bene growth of 1% per year since 2010
- Expected beneficiary growth from 54M (2014) to 81M (2030)

Medicare Growth Projection

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2020*</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Enrollment</td>
<td>52</td>
<td>64</td>
<td>23%</td>
</tr>
<tr>
<td>SNF Days</td>
<td>84</td>
<td>98</td>
<td>23%</td>
</tr>
</tbody>
</table>

All figures in Millions

* Enrollment projection provided by CBO; SNF Days projection based on 5% reduction in utilization
**MedPAC Report**

- **Same Story:**
  - SNF Medicare rates remain high, should not subsidize inadequate Medicaid rates
  - **Need for immediate reform**
  - Large SNF cost variation with limited alignment to quality

- From 2011 – 2013:
  - Community discharges: 33.2% to 37.5%
  - 30-day potentially avoidable readmission rates during/after SNF: 16.5% to 15.1%

---

**SNF Medicare Trends**

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2013</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admits/1,000 FFS benes</td>
<td>72</td>
<td>67</td>
<td>-7.5%</td>
</tr>
<tr>
<td>Covered Day (in thousands)</td>
<td>1,892</td>
<td>1,835</td>
<td>-3.1%</td>
</tr>
<tr>
<td>ALOS</td>
<td>26.3</td>
<td>27.6</td>
<td>4.7%</td>
</tr>
<tr>
<td>RV/RU %</td>
<td>42%</td>
<td>79%</td>
<td>46.8%</td>
</tr>
</tbody>
</table>

Source: MedPAC
SNF Medicare Part A Margins

For-Profit margins = 15.3%
Not-for-Profit margins = 5.0%

Source: MedPAC

Trend 3: Medicare Advantage

- **Outlook:** Strong Negative
- **ZHSG data:**
  - LOS: MA up to 50% lower than FFS
  - Rates: MA is 25% lower
  - Revenue Cycle: MA is 19 days longer
  - Administration: MA is 45 minutes/day more
  - Arbitrary denials
  - “Murky” appeals process
2015 Medicare Advantage Penetration %

http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population/
### FFS v. MA Rate Analysis

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Diversicare</td>
<td>-</td>
<td>$61</td>
<td>-</td>
<td>1.16</td>
</tr>
<tr>
<td>Ensign</td>
<td>$172</td>
<td>$149</td>
<td>1.44</td>
<td>1.36</td>
</tr>
<tr>
<td>Extendicare</td>
<td>$37</td>
<td>$20</td>
<td>1.08</td>
<td>1.04</td>
</tr>
<tr>
<td>Kindred</td>
<td>$86</td>
<td>$115</td>
<td>1.21</td>
<td>1.26</td>
</tr>
<tr>
<td>Skilled HC</td>
<td>$130</td>
<td>$112</td>
<td>1.33</td>
<td>1.27</td>
</tr>
</tbody>
</table>

Source: MedPAC
### ZHSG Managed Care Audits

- Old rate structures
- No follow up on incorrectly paid claims (contract/billed/paid rate mismatch)
- Individual therapy minutes (often in excess of rate level)
- Failure to receive timely prior authorization
- No case management on Rate Exclusions
- Poor management of acuity change between authorizations
- Denials “gone wild” and not appealed

---

### ZHSG Managed Care Audits

- Non-“Umbrella” contracts for multi-platform insurance plans
- No follow up on Part B payments
- Not submitting “Utilization Claims”
- Failure to manage non-reimbursable co-pay/bad debt

- New observations since last year:
  - NP onsite to manage short-term populations
  - Denials based on failure to submit assessments (all v. OBRA)
  - Move to “blended” rates
Is There Value in MA?

Do extra payments translate to improved care?

http://www.nytimes.com/2014/08/19/upshot/medicare-advantage-is-more-expensive-but-it-may-be-worth-it.html?_r=0&abt=0002&abg=0

Trend 4:
Innovation & New Payment Models

• **Outlook: Mixed, skewed Negative**
  – Accountable Care Organizations
  – Bundling
  – Value-Based Purchasing

• Provider payment still FFS
• In first 2 years of ACOs, SNF spending decreased by > 20% for ACO population
• Bundling expected to have same trend
• New ACOs: 3-day stay waiver
• Narrowed Networks
**Bundling Reality:**

Proposed Rule: July 2015

- **Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacements**
- Mandatory hospital participation (in 75 regions)
- All related care within 90 days of H discharge for the procedures included in the episode of care
- Hospital that is the site of surgery would be held accountable for spending during episode
- 5-year “performance period” test (start 1/1/16)
- FFS payments used to calculate an “episode” payment
Shifting Medicare FFS Distribution

- **2009**: 45.5M covered
  - Traditional FFS: 77%
  - Medicare Advantage: 23%

- **2014**: 54M covered
  - Traditional FFS: 53%
  - Medicare Advantage: 30%
  - Accountable Care Organization: 14%
  - Dual Demonstration: 4%

- **2019 (estimate)**: 60M covered
  - Traditional FFS: 24%
  - Medicare Advantage: 38%
  - Accountable Care Organization: 26%
  - Dual Demonstration: 12%

FFS Impacted by Payment Reform

- **2014**
  - VBP: 34%
  - Unaffected Spending: 65%

- **2019**
  - Bundled: 23%
  - Unaffected Spending: 31%

* "Moderate" estimate produced by Avalere
CMMI

- The Center for Medicare & Medicaid Innovation supports the development and testing of innovative health care payment and service delivery models
- http://innovation.cms.gov/

SNF Payment Reform Initiatives

- SNF Therapy Research Project (Part A)
  - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html
  - Looking for best possible “implementable” model to replace current Tx payment
  - Phase II (10/13 – 10/15): Evaluate two approaches to Patient Characteristics Model
  - Objective to replace current system
  - New OIG report (July 2015)

- Part B likely to move to Episodic

- SNF Non-Therapy Ancillary (NTA) Payment
**Possible PPS Future??**

- Patient with Hip Fracture & Parkinson’s, ADL = 10; NTAs = $100 per day

  - **RUG:** LD1
  - **Nursing rate:** $350
  - **NTA add-on:** $45
  - **Total per diem:** $395 per day
  - **Therapy:** $3,000 lump sum
  - **LOS threshold:** 14 days (downward adjustment for short-stays)

  +/ - for overall SNF quality (e.g. readmissions)

---

**The LTAC Model**

- Typical Medicare discharge pattern by day for all diagnosis categories, relative to the threshold day (2008 - 2013)
**Trend 5:**

**Data Analytics & New Metrics**

- **Outlook: Positive**
  - New technology enables SNFs to provide measurable performance metrics to partners
  - New payers and programs require SNFs to rethink measures of performance
  - Presentation and risk-adjustment of data is critical
  - Need for accurate and timely input data
    - MDS and UB-04

---

**What are the New Financial Metrics?**

- **Old:**
  - Census, Average Rate, RU%, ADLs

- **New:**
  - Hospitalization rates (short- and long-term)
  - Episodic Rate Average (ERA)
    - by Payer and Diagnosis
  - Functional status upon admission and discharge
  - Cost of care post-SNF discharge
  - Quality measures impacting reimbursement
The ZHSG “Backfill” Equation

- As “quality” improves, LOS will go down and admissions should increase

<table>
<thead>
<tr>
<th></th>
<th>Old</th>
<th>New</th>
<th>Diff.</th>
<th>Rate</th>
<th>Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALOS</td>
<td>27</td>
<td>22</td>
<td>5</td>
<td></td>
<td>$500</td>
</tr>
<tr>
<td>x Admits/Year</td>
<td>240</td>
<td>240</td>
<td></td>
<td></td>
<td>$600,000</td>
</tr>
<tr>
<td>= Days/Year</td>
<td>6,480</td>
<td>5,280</td>
<td>1,200</td>
<td>$500</td>
<td>$600,000</td>
</tr>
</tbody>
</table>

**BACKFILL**

<table>
<thead>
<tr>
<th></th>
<th>FFS</th>
<th>or</th>
<th>Episodic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difference</td>
<td>1,200</td>
<td>Loss</td>
<td>$600,000</td>
</tr>
<tr>
<td>/ ALOS</td>
<td>22</td>
<td>/ ERA</td>
<td>$9,000</td>
</tr>
<tr>
<td>= New Admits Need</td>
<td>55</td>
<td>= New Admits Need</td>
<td>67</td>
</tr>
</tbody>
</table>

**Trend 6:** Post-Acute “Rationalization”

- **Outlook: Positive**
  - Medicare paid $59B to 29,000 PA providers in 2013 (double 2001)
  - Tremendous variance in cost (billing) but not in quality/outcomes across venues (especially between IRF & SNF)
    - Spending for patients using IRFs is 60% higher than SNFs for comparable patients during initial PAC stay
    - IRF use is far lower in MA than FFS
      - FFS: 10.1 cases/1,000 enrollees
      - MA: 3.8 cases/1,000 enrollees
**PAC Spending Growth ($B)**

![Chart showing PAC spending growth over years](chart)

**Post-Acute “Rationalization”**

- **MedPAC:**
  - “Need for PAC is not well-defined”
  - Recommends site-neutral payments for SNF & IRF for select conditions
  - Uniform payment system achievable in 2023
- SNF/IRF site neutral payments would lower spending by 7% for 22 select conditions
  - IRF rates would come down, SNF rates would remain constant
- **ACOs and BCPI should facilitate Rationalization**
IMPACT Act

- **Improving Medicare Post-Acute Care Transformation Act** signed into law in 2014
- PAC providers will begin collecting uniform assessment data in 2018
- After 2 years of data, HHS will submit report to Congress recommending a uniform payment system for PAC
- Requires development of a prototype PPS spanning PAC venues
- Report due in 2016 presenting an approach for a cross-setting PAC payment system

**Trend 7:**

**Duals Management**

- **Outlook:** Negative
- The only way to significantly reduce Dual spending is by management of both Medicare & Medicaid benefits
- 12 states now have Duals programs
  - “Passive” enrollment
  - “Active” disenrollment
- Welfare Benefit v. Entitlement
- Need for Provider Engagement
  - Financial (dis)incentive
### Dual Demo (FIDA) v. ISNP

<table>
<thead>
<tr>
<th><strong>Dual Demo</strong></th>
<th><strong>ISNP</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Passive enrollment</td>
<td>Active enrollment</td>
</tr>
<tr>
<td>Large opt-out %</td>
<td>Low opt-out</td>
</tr>
<tr>
<td>Multiple MCOs managing M&amp;M</td>
<td>Single payer for enrolled</td>
</tr>
<tr>
<td>for individual residents</td>
<td>residents</td>
</tr>
<tr>
<td>Limited Shared Savings</td>
<td>Shared Savings potential</td>
</tr>
<tr>
<td>Low provider engagement</td>
<td>Enhanced clinical resources</td>
</tr>
<tr>
<td></td>
<td>Greater provider engagement</td>
</tr>
</tbody>
</table>

### Trend 8: Provider Risk

**Outlook: Mixed**
- What we call managed care is still FFS when compared to:
  - Episodic / Capitation / Shared Savings
- New incentives to improve quality and reduce utilization
- Law of Large numbers
- Outlier Management
- IPA movement ("move up the value chain")
- Establish financial Risk tolerance
- Reinsurance
Risk Management Team

- **Risk Management is the new Compliance**
- **Meet the Risk Management team:**
  - Case Manager
  - Finance Manager
  - Director of Rehab
  - Director of Nursing
  - Actuary
  - “SNFist”
  - Care Transition Coordinator

**Trend 9:** They Paid HOW MUCH for that Facility?!?

- **Outlook: Positive (especially if selling)**
  - Number of transactions and price-per-bed set new records in 2014
    - Average price per bed = $76,500 (up 4%)
    - Nearly 300 M&A in Senior Housing (up 26%)
  - Partially driven by strategic positioning in specific markets
  - Value of provider-operated ancillaries
  - Access to Capital
  - Real Estate Investment Trusts
  - Not-for-Profit conversions
  - Future Demographics
**Trend 10:**
**The Audit Onslaught**

- **FFS Medicare MACs:**
  - Data driven across all areas of claims processing targeting providers with higher reimbursement compared to peers
  - Focus on therapy with low ADLs (RUA) and Part B services with poor diagnosis support & timing to CMI capture

- **Medicare Advantage:**
  - Internal audits to validate coverage policies and hiring independent contractors to find unsupported payments

- **RACs:**
  - On hiatus for new projects due to pending lawsuits
  - Resumed medical review of 2014 Part B therapy services over the $3,700 therapy cap (suspended in March 2014)
Trend 10: The Audit Onslaught

- **ZPICs:**
  - Continued audits investigating potential fraud/abuse & false claim submission

- **Medicaid Agencies:**
  - Focus on MDS accuracy for CMI

- **OIG:**
  - New report & continuing investigation into misuse of COTO assessments; SNFs manipulating MDS schedules (esp. for therapy)
  - Also checking readmission stats; employee background checks; survey violation corrections and excessive Part B services billing

Trend 11: “Boutique” Inpatient Care

- **Outlook: Major disruption to local markets**
  - Consumer-focused healthcare
  - New and refurbished facilities focused exclusively on short-term residents
  - Many do not accept Medicaid
  - Amenities and Aesthetics
  - Large investments justified by significant shift in payer mix
**Trend 12: Regulatory Changes**

- **Outlook:** Neutral to Positive

<table>
<thead>
<tr>
<th>2016 SNF PPS Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>• MBI = 2.4% less 0.6% forecasting error and 0.6% MFP = 1.2% ($430M in additional funding)</td>
</tr>
<tr>
<td>• Establishes new Quality Reporting Program effective FY 2018 across all 4 PAC settings</td>
</tr>
<tr>
<td>• SNF “all cause, all condition” H readmission measure for new SNF VPB program (ACA) to begin FY 2019</td>
</tr>
<tr>
<td>• SNF VBP incentive payments begin FY 2019</td>
</tr>
<tr>
<td>• <strong>MDS is primary source for reporting new quality measures data</strong></td>
</tr>
<tr>
<td>• Reporting requirements for SNFs to submit staffing info based on payroll data including contract/agency staff</td>
</tr>
</tbody>
</table>
Sustainable Growth Rate

- Medicare Access & CHIP Reauthorization Act
  signed into law in April 2015
- Repeals SGR formula (averts a 21% pay cut to Part B therapy)
  - Partially paid for by MBI reduction
- Extends therapy caps exceptions process until January 1, 2018
- Replaces the current process of manual medical review with a new process of targeted reviews
- Amendment to repeal spending caps on therapy failed to pass by 2 votes

Improving Access to Medicare Coverage Act of 2015

- To amend title XVIII of the Social Security Act to count a period of receipt of outpatient observation services in a hospital toward satisfying the 3-day inpatient hospital requirement for coverage of skilled nursing facility services under Medicare.
- www.govtrack.us prognosis: 1% chance of being enacted
The Bundling and Coordinating Post-Acute Care Act of 2015

- **BACPAC Act** (H.R. 4673)
- Provides for a Medicare post-acute, risk-based, bundled payment that would be made, per beneficiary, to a **PAC Coordinator**
- Using prior year’s costs as a baseline, savings shared between Coordinator (up to 70%), physician, hospital and PAC provider
- Specifies use of CARE tool

Distribution of Medicare Savings in President Obama’s FY2016 Budget

- Total Medicare Savings, 2016-2025 = $498 billion

Note: Excludes provisions that would increase Medicare spending and excludes interactions between provisions. IPAB is the Independent Payment Advisory Board. Numbers may not sum due to rounding.