HEDGEYE POTOMAC RESEARCH

POST-ACUTE PROVIDERS

OVERVIEW OF MAJOR REGULATORY TRENDS

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QA@HEDGEYE.COM

*ANSWERED AT THE END OF THE CALL

SECTION ONE

THE SEMANTIC CHALLENGES

1

DEFINITION: CARE DELIVERED AFTER HOSPITAL STAY

- No agreement on which patients are treated where (a SNF versus and IRF, for example)
- In Medicare practice is more expansive and include patient admitted from community

2

MEDICARE DEFINITION, CARE PROVIDED IN:

- Skilled Nursing Facilities (SNF)
- Long-term Care Hospitals (LTCHs)
- Inpatient Rehabilitation Facilities (IRFs)
- Home Health Agencies (HHA)

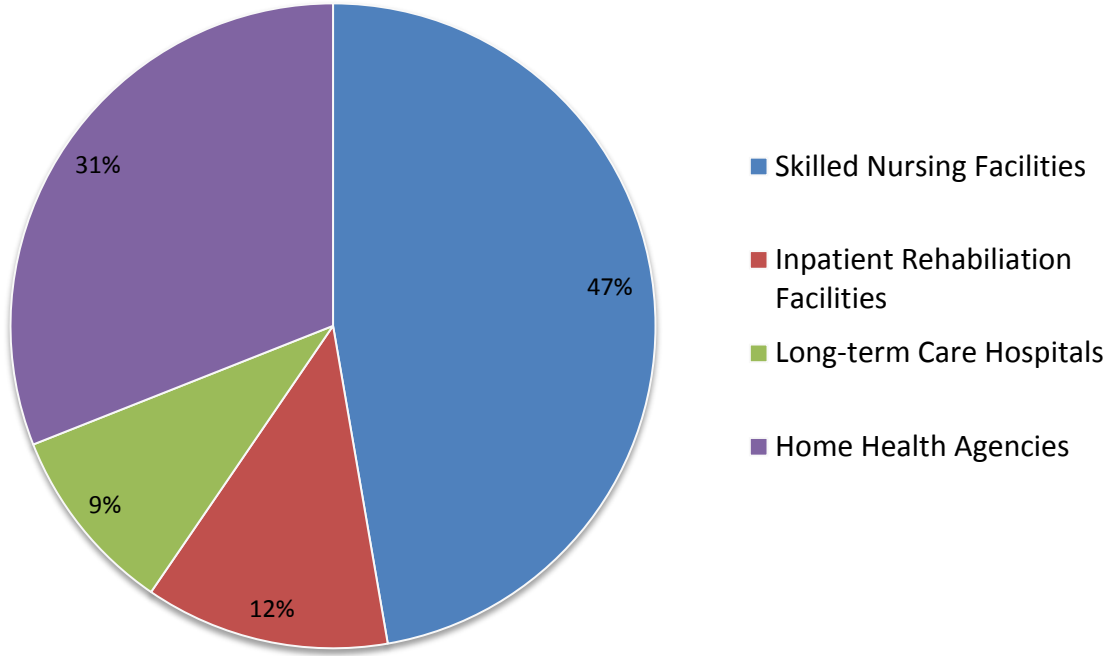
3

DEFINITION RELIES HEAVILY ON FACILITY TYPE

- Generally ignores the needs of the patient and emphasizes site of care

MEDICARE SPEND

$57.1B BY SILO - 2014



Source: MedPAC March 2014 Report to Congress

- SNFs represent biggest portion of Medicare spend at $57B
- Total Spend down 9% since 2010

POST-ACUTE PROVIDERS - SNF

1

THERE ARE 15,005 SNFS IN US

- 1.6 million beds certified by Medicare, Medicaid or both
- Only about 213,000 of those beds are owned/operated by one of the major for profit chains
- Providers paid on per diem basis adjusted for therapy visits

2

MAJOR SNF FOR-PROFIT OPERATORS

- GEN, Manor Care, Golden Living, Life Care Centers of America, Signature Healthcare, ENSG, KND, Formation Capital (EXE), NHC, DVCR

3

REQUIREMENTS FOR COVERAGE

- Must have spent at least thee days in the hospital
- Need post-acute care like skilled nursing or therapy services

POST-ACUTE PROVIDERS - IRFS

1

THERE ARE 1,177 FACILITIES

- 251 are freestanding facilities
- 926 are hospital-based Rehab Units
- Rehab Units represent 79% of IRFs but only 52% of discharges
- Providers paid on a per discharge basis adjusted for condition

2

MAJOR IRF FOR-PROFIT OPERATORS

- HLS owns/operates about 120 facilities representing almost half of all freestanding IRFs
- KND, SEM are the other major players in freestanding IRFs
- HCA, THC also own a few facilities

3

REQUIREMENTS FOR COVERAGE

- Need intensive therapy
- 60% of patient admitted must require treatment for a defined list of conditions

POST-ACUTE PROVIDERS - LTCHS

1

TINY SEGMENT – 391 FACILITIES

- Most are for-profit
- About 130,000 cases a year
- About 25,000 beds
- Providers paid on a per discharge basis with payments adjusted for condition

2

MAJOR LTCH FOR-PROFIT OPERATORS

- KND is dominant player with about 70 facilities classified as LTCHs and about 6,000 beds
- SEM has about 90 facilities with 4,000 beds
- Ownership data from CMS a bit of a mess

3

REQUIREMENTS FOR COVERAGE

- Need hospital level care for an extended (more than 25 days) period of time

POST-ACUTE PROVIDERS - HHAS

1

THERE ARE OVER 12,000 HHAS

- Virtually all are for-profit
- About 6.6 million 60 day episodes per year
- Provider paid on a per episode basis with adjustments for therapy use

2

MAJOR HHA FOR-PROFIT OPERATORS

- Dominant players are KND with 250 agencies; AMED with 170 agencies LHCG with about 127 agencies and HLS with 83 agencies

3

REQUIREMENTS FOR COVERAGE

- Patient must be homebound

RIPE FOR REFORM

1

NEED FOR POST-ACUTE CARE NOT WELL DEFINED

- Medicare gives providers a great deal of latitude in deciding which patients they admit
- Placement decisions often reflect variety of non-clinical factors
- Similar patients are treated in different settings with widely varying payments by Medicare

2

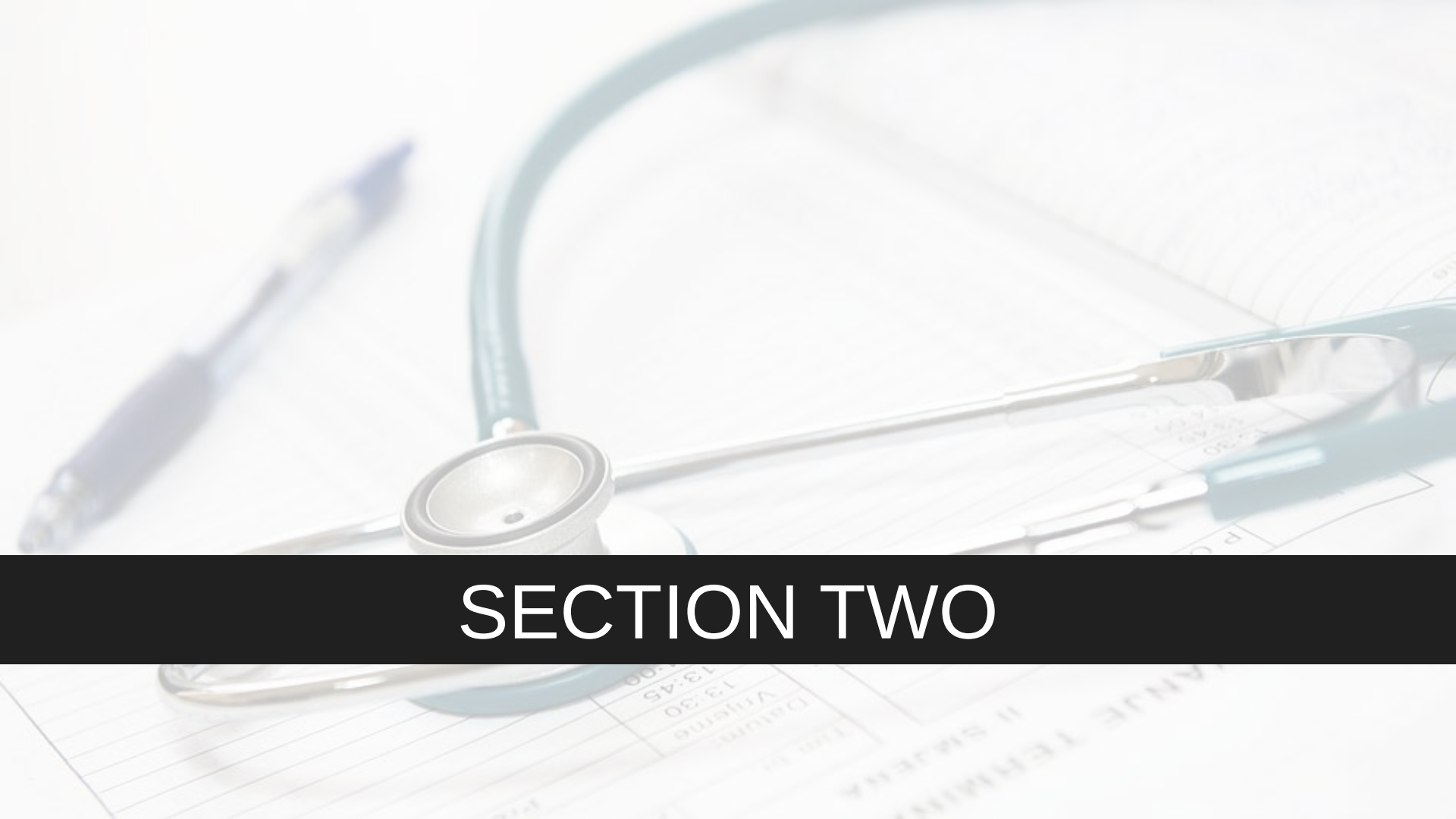
HIGH VARIABILITY IN PAYMENTS AND SPENDING

- Medicare per capita spending varies more than any other covered service
- Large differences in the availability of LTCHs and IRFs across markets
- Similar patients treated in different settings result in very different Medicare payments
- Consistently high Medicare “margins”

3

LACK OF UNIFORM PATIENT ASSESSMENT

- SNFs use MDS and HHAs use OASIS
- No crosswalk to normalize assessment data across post-acute settings



SECTION TWO

KEY DRIVERS OF REFORM

1

COST TO MEDICARE

- Spending flat to slightly negative since 2010 but up 36% since 2005
- Medicare “margins” can be high

2

OUTCOMES

- System of silos encourages cost shifting (and the corresponding care necessary) to next setting
- No significant improvement in quality

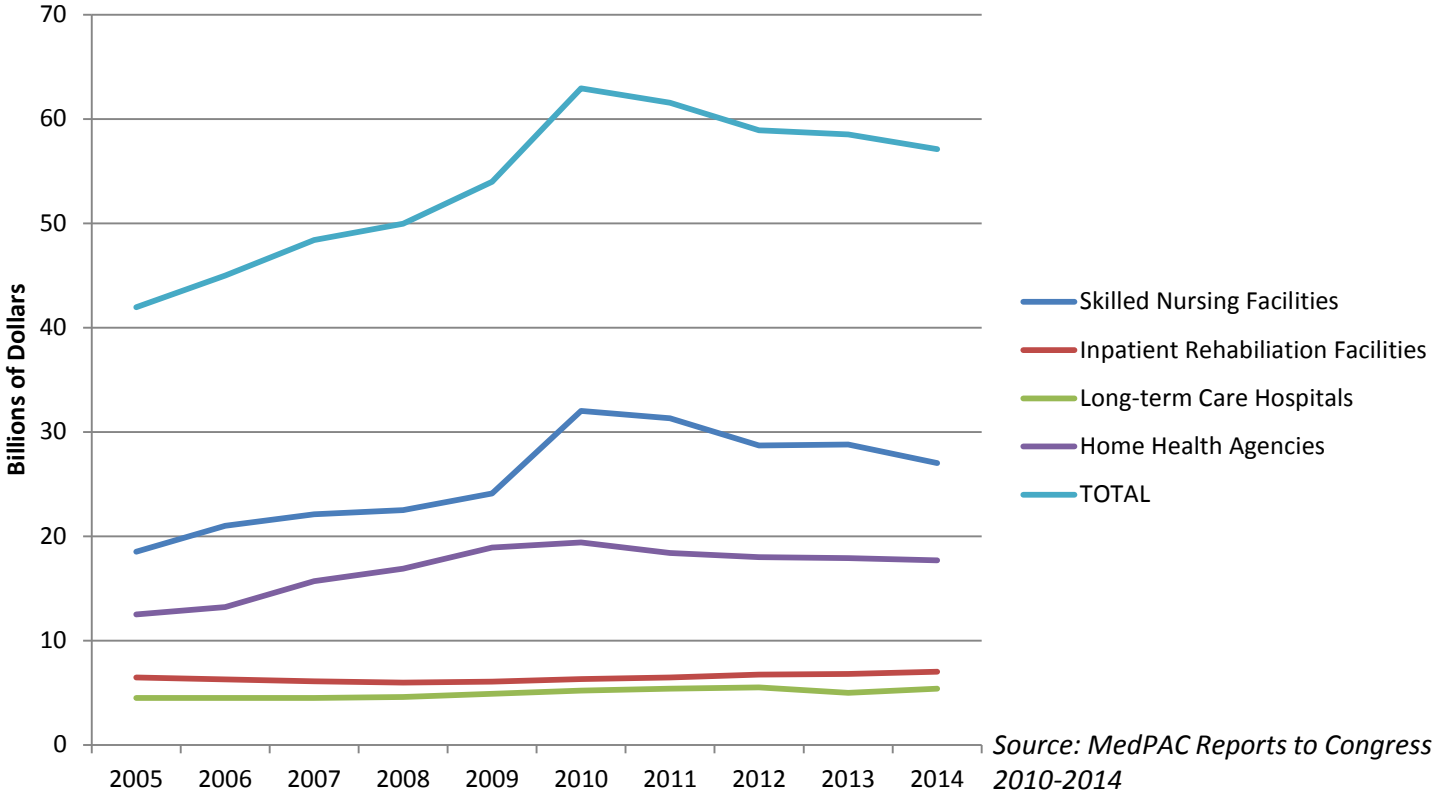
3

ILLOGICAL SYSTEM EMPHASIZES SITE OF CARE

- Payment system based on site of service not patient characteristics
- Varying payments systems (per episode versus per discharge, etc.)

KEY DRIVES OF REFORM

COST OF POST-ACUTE CARE 2005-2014

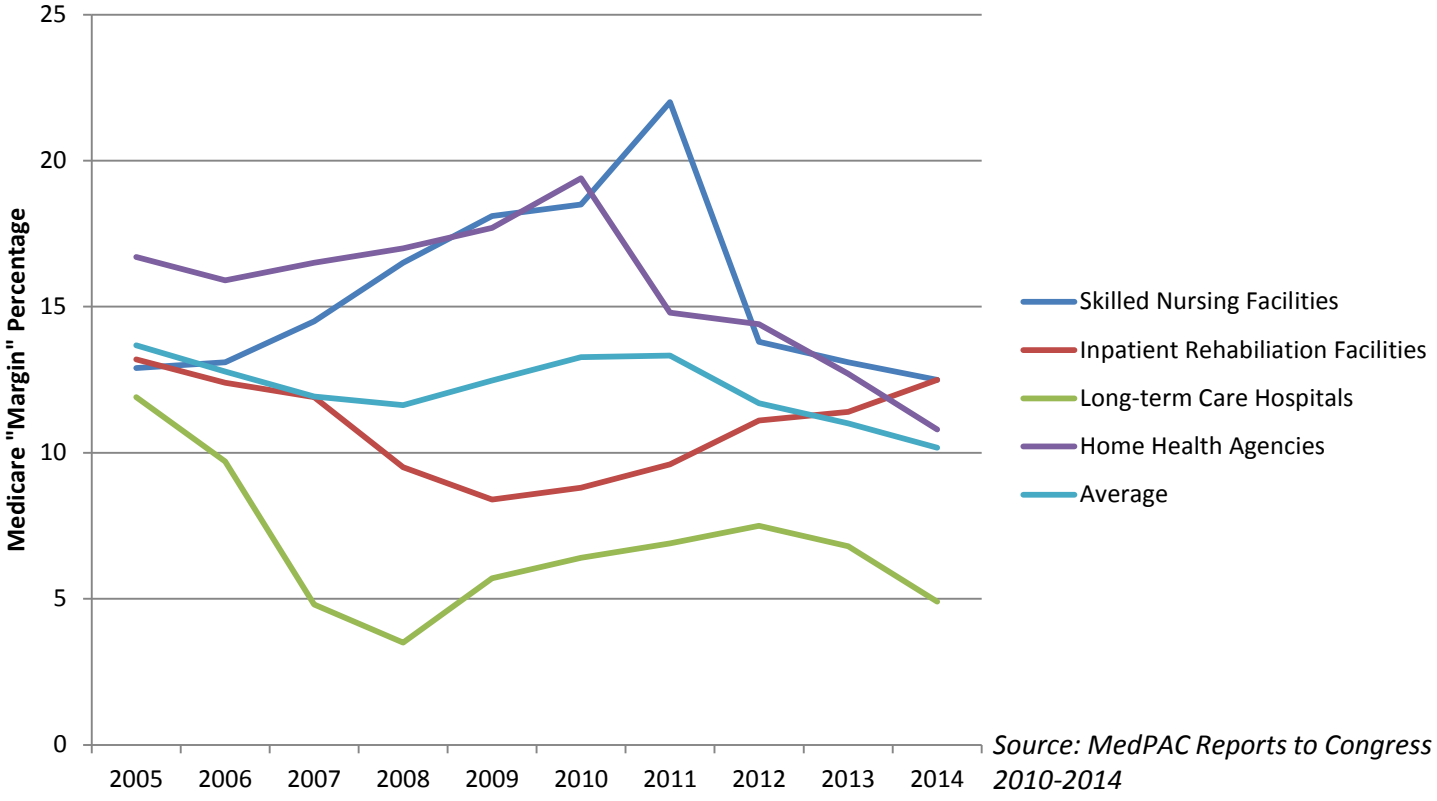


Source: MedPAC Reports to Congress 2010-2014

- Although all silos were affected by ACA some were more resilient
- Effect of ACA to wear off around 2018

KEY DRIVES OF REFORM

CHANGE IN MEDICARE "MARGINS" 2005-2014

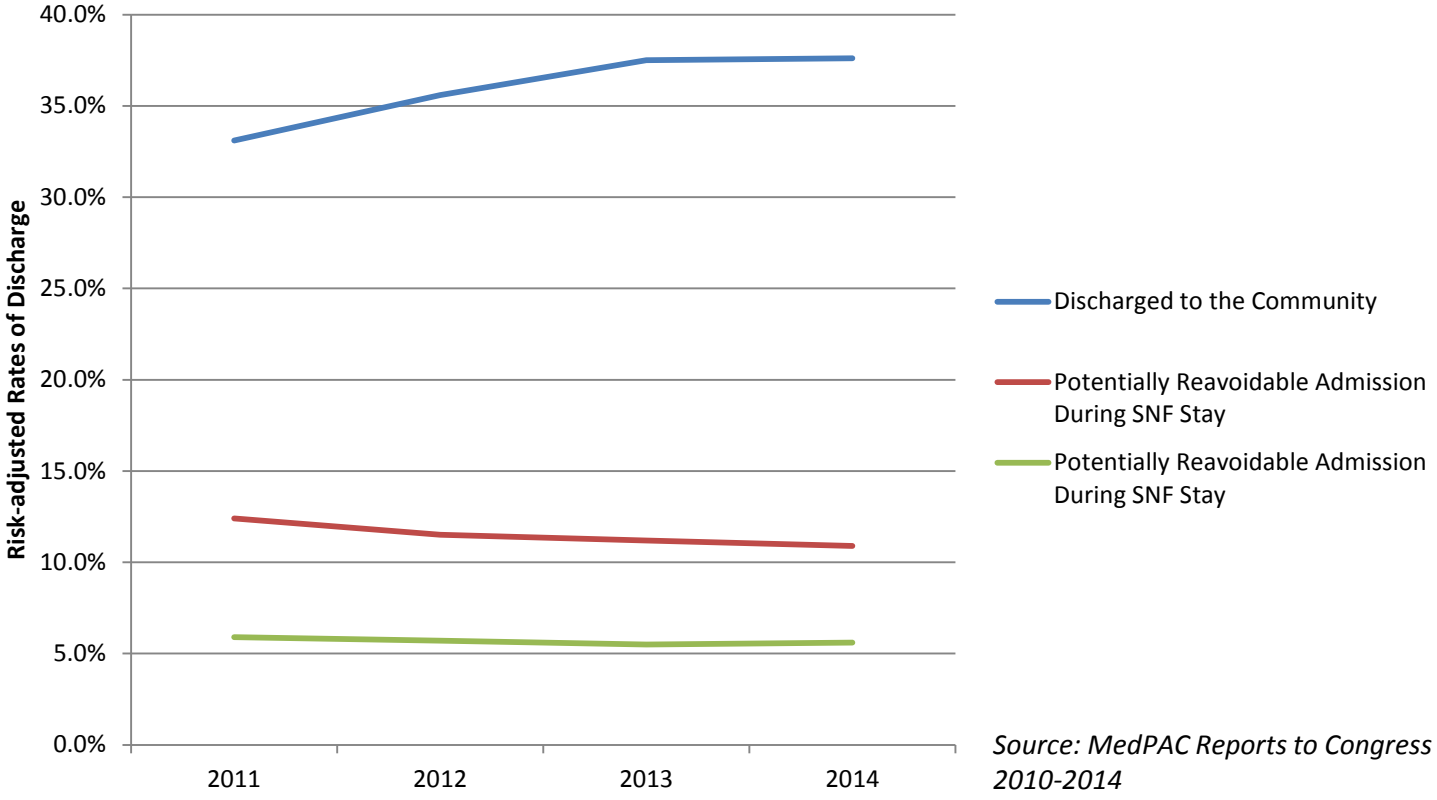


Source: MedPAC Reports to Congress 2010-2014

- Different trend from spending – all over the map but on average downward sloping
- Still to high for policy makers

KEY DRIVES OF REFORM

SNF QUALITY MEASURES



Source: MedPAC Reports to Congress 2010-2014

- Reliable quality data only recently collected
- Improvement nominal to non-existent

IRF QUALITY MEASURES

Measure	2011	2012	2013	2014
Motor Functional Independence Measure ™	22.3%	22.7%	23.1%	23.5%
Cognitive Functional Independence Measure ™	3.6%	3.7%	3.8%	3.9%
Potentially Avoidable Rehospitalization	2.8%	2.6%	2.5%	2.5%
Discharged to a SNF	6.9%	6.6%	6.7%	6.9%
Discharged to Community	74.1%	75.3%	75.9%	76.1%
Potentially Avoidable rehospitalizations during 30 days after Discharge	4.9%	4.6%	4.5%	4.5%

Source: MedPAC Reports to Congress 2010-2014

- Little growth but metrics good in absolute terms
- Coverage requirements skew patient population to healthier people

LTCH QUALITY MEASURES

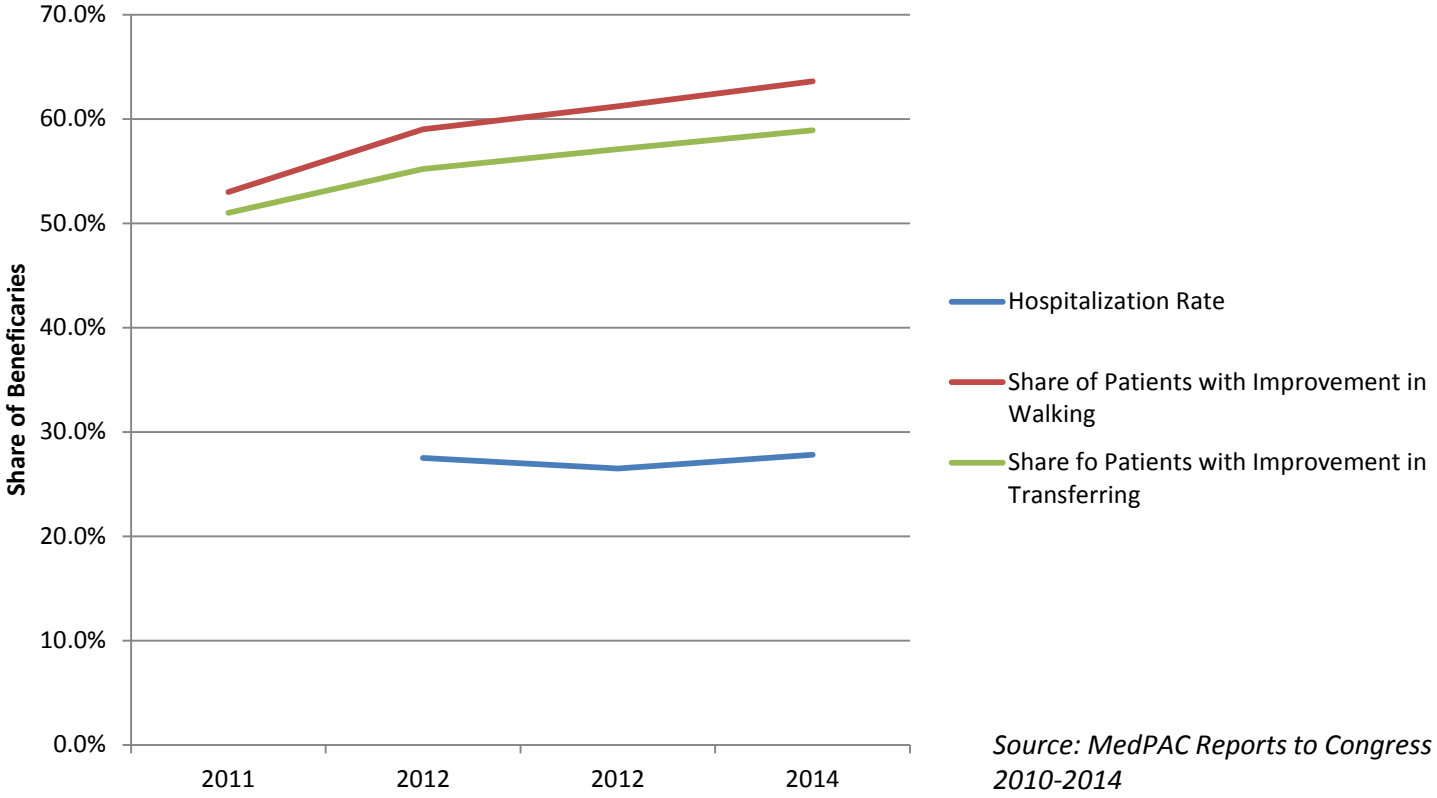
No Data Available

- CMS started collecting quality data in 2014

Source: MedPAC Reports to Congress 2010-2014

KEY DRIVES OF REFORM

HHA QUALITY MEASURES

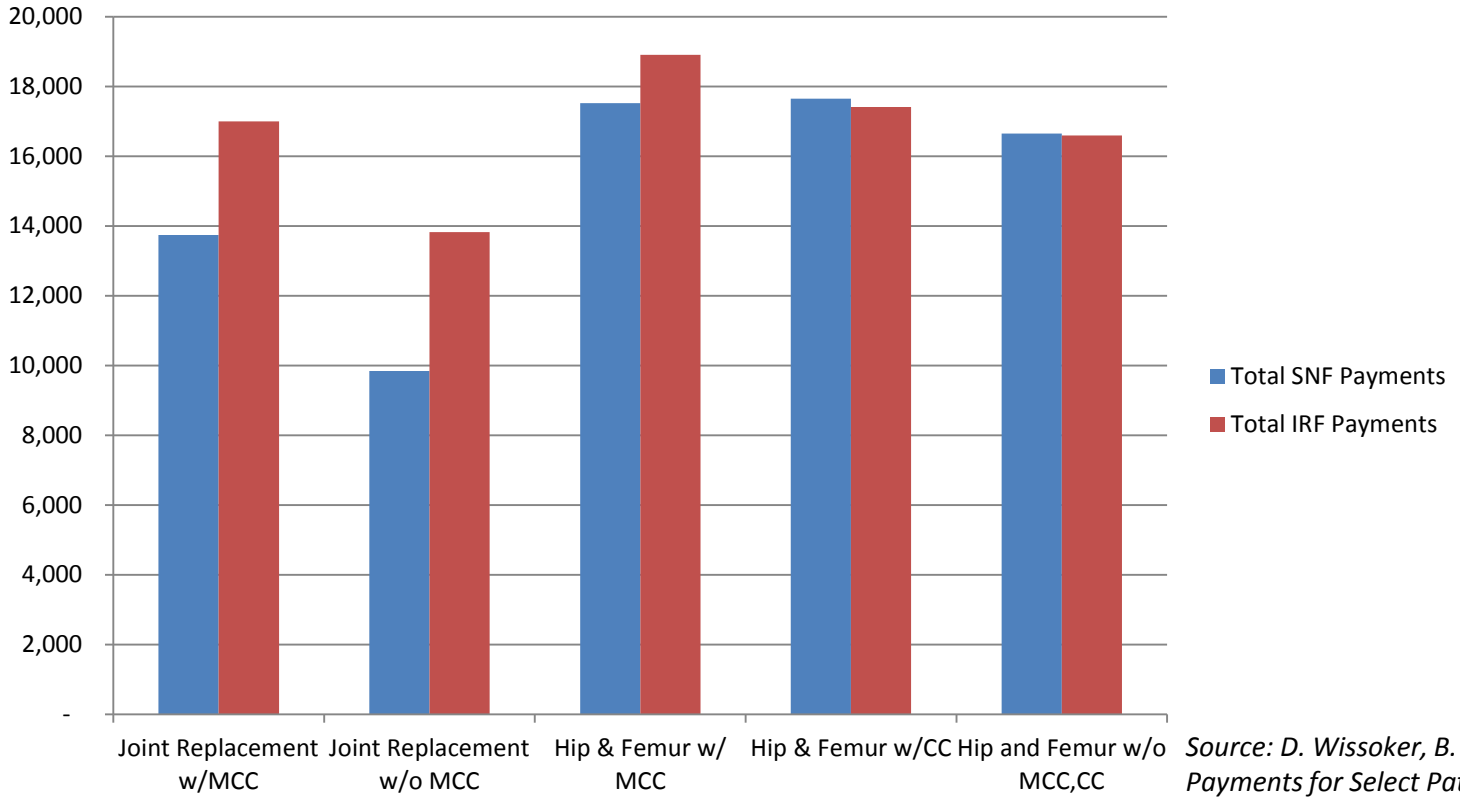


Source: MedPAC Reports to Congress 2010-2014

- Historical data includes only patients who did not return to hospital
- Data is skewed toward healthier patient

KEY DRIVES OF REFORM

ILLOGICAL SYSTEM EMPHASIZES SITE OF SERVICE



- Best data on conditions treated at IRFs and SNFs
- 2011 Claims and Cost Data

Source: D. Wissoker, B. Garrett., Equalizing Medicare Payments for Select Patients in IRFs and SNFs, June 2014

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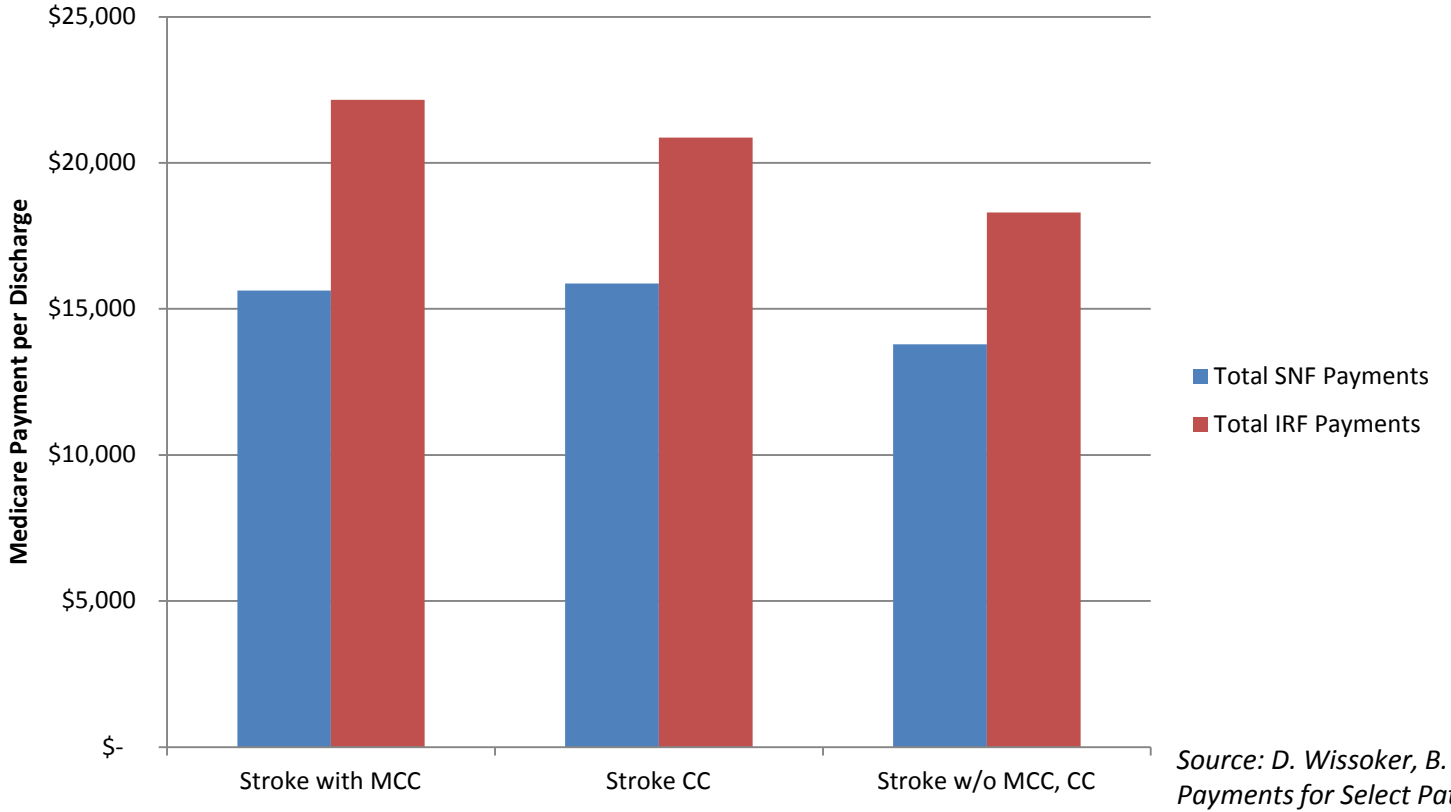

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HISTORICAL BARRIERS TO REFORM

1

THE DATA PROBLEM

- Lack of uniform patient assessment information across PAC settings.
- Lack of uniform quality data
- Limited data sharing among providers

2

LACK OF COMMERCIAL/PRIVATE PAYERS' INTEREST

- Medicare's dominance limits interest from non-Medicare payers
- Cost controls in commercial/private payers focused on premiums, deductibles

3

LACK OF BROAD LEGISLATIVE AUTHORITY

- For uniformity in assessment and data collection
- To prohibit data blocking

HISTORICAL BARRIERS TO REFORM

THE SNF PROBLEM

- **Medicare is NOT the dominant payer**
  - Medicare pays for about 23% of SNF services
  - Medicaid pays for about 33 % of NF services

- **Medicare subsidizes Medicaid patients**
  - Medicare “margins” are high – over 10 percent
  - Medicaid “margins” are low – below zero

- **Significant changes to Medicare reimbursement could hurt Medicaid patients**

SECTION THREE

HELLO, CHANGE

1

IMPACT ACT OF 2014 AND SGR REPEAL

- Requires uniform patient assessment
- Development of PAC PPS to span all settings
- Uniform quality measures
- Prohibited data blocking

2

PATHWAY TO SGR REFORM ACT OF 2013 AND BIPARTISAN BUDGET ACT OF 2015

- Site neutral payments for LTCHs
- New HOPDs reimbursed at ASC or PFS

3

AFFORDABLE CARE ACT

- Authorized CMMI
- Inspired Health Care Payments and Learning Action Network

HISTORICAL BARRIERS TO REFORM

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DEVELOPMENT OF POST-ACUTE PPS

Major Features

- Common unit of service
- Common risk adjustment using patient characteristics
- Adjust to align HHA Payments with costs
- Separate payment models for non-therapy ancillary services (like drugs) and routine plus therapy services
- Two outlier policies – one for high cost, one for short stay
- Give providers flexibility by limiting or eliminating site-specific criteria like 60% threshold for IRFs

DEVELOPMENT OF POST-ACUTE PPS

Timeline

- MedPAC report (pending)
- HHS Secretary's report using uniform patient assessment data – 2020
- MedPAC report on prototype design – 2023
- Could begin earlier with administrative data

CMMI IMPLEMENTATION OF BUNDLED PAYMENTS

Comprehensive Care for Joint Replacement

- Bundle for hip and knee replacement, one of the most thoroughly studied procedure
- Mandatory
- Rolling out in 67 MSAs
- Effective April 1, 2016
- Encourages shared data across PAC setting and with Inpatient Hospitals

PRIVATE SECTOR INITIATIVES

Bundled Payment Spillover

- Largely anecdotal evidence of commercial payers
- Catalyst for Payment Reform driving self insured funds

Site neutral payments

- Not as much as issue since Medicare represents most PAC volume

Other Efforts

- Health Care Payments and Learning Action Network

SECTION FOUR

NEXT UP?

1

SITE NEUTRAL POSSIBILITIES

- Stroke patients
- Additional research needed

2

BUNDLED PAYMENTS

- Cardiac Cath

3

PRESSURE FROM SELF INSURED FUNDS

- Bundled payments for non-Medicare-centric procedures like maternity
- Indications are that savings will not come from increasing cost-sharing

INDUSTRY RESPONSE

1

INTEGRATION

- Providers need to be able to direct patient to right setting
- Negotiation with episode initiator of bundles/vendors
- HLS and KND acquisition of HHAs, AMED and LHCG?
- Where are the hospitals?

2

CONSOLIDATION

- Rollups of highly decentralized HHA industry
- SNFs?

3

EMPHASIS ON QUALITY

- With payments more normalized, quality will become more of a differentiator.
- More likely positive outcome for highly capitalized, sophisticated operators.

CONCLUSION

1

POST-ACUTE PAYMENT REFORM IS HERE

- Barriers have been lifted
- Slow process
- Some in industry appear to be getting ahead of change but not by a lot

2

DISRUPTIVE BUT GREATER CONSISTENCY

- Some silos will have a rougher ride
- But what results will be a more predictable payment system which means less tendency for arbitrary payment reductions

3

EMPHASIS ON QUALITY

- Outcomes will matter and CMS will make it a central part of payment system

FOR MORE INFORMATION, CONTACT US AT:

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