Medicare Managed Care: An Advanced Look

LeadingAge NY: May 20, 2015

Agenda

- Medicare Trends
- Medicare Managed Care
- Variations in PAC
The Case for Managed Care

- US healthcare spending is highly disproportionate to other countries
- Outcomes and longevity are unfavorable despite cost difference
- Tremendous variation in regional cost, quality and utilization of care, especially in Post-Acute Care
- Managing the small % of high cost patients and reducing re-hospitalizations would generate large savings

Healthcare Spending as % of GDP (2011)

[Bar chart showing healthcare spending as a percentage of GDP for various countries, with the United States at 17.7% and the OECD average at 9.3% percent.]
90-Day Episodic Spending

<table>
<thead>
<tr>
<th>Condition</th>
<th>Readmission rate</th>
<th>Mean episode spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>16%</td>
<td>$38,078 $19,824</td>
</tr>
<tr>
<td>Simple pneumonia &amp; pleurisy</td>
<td>17</td>
<td>$24,974 $9,722</td>
</tr>
<tr>
<td>Coronary bypass w/cardiac catheterization</td>
<td>18</td>
<td>$55,591 $38,840</td>
</tr>
<tr>
<td>Heart failure &amp; shock</td>
<td>28</td>
<td>$24,900 $10,003</td>
</tr>
<tr>
<td>Major small &amp; large bowel procedures</td>
<td>14</td>
<td>$38,297 $21,095</td>
</tr>
<tr>
<td>Major joint replacement</td>
<td>8</td>
<td>$40,172 $21,313</td>
</tr>
<tr>
<td>Hip &amp; femur procedures except major joint</td>
<td>15</td>
<td>$49,517 $32,707</td>
</tr>
<tr>
<td>Fractures of hip &amp; pelvis</td>
<td>13</td>
<td>$34,550 $20,335</td>
</tr>
<tr>
<td>Kidney &amp; urinary tract infections</td>
<td>18</td>
<td>$25,511 $11,183</td>
</tr>
<tr>
<td>Septicemia without ventilator 96+ hours</td>
<td>20</td>
<td>$33,985 $15,447</td>
</tr>
<tr>
<td>Average for 10 conditions</td>
<td>17</td>
<td></td>
</tr>
</tbody>
</table>

Source: MedPAC

All Roads Lead to Managed Care

- Medicare Advantage
- Special Needs Plans
- FIDA
- Medicaid Managed LTC
- Medicare FFS
  - ACOs
  - Bundling
  - Payment Reform (therapy)
  - IMPACT
Managed Care Objectives

• Enhance coordination of care
• Improve outcomes
• Reduce expenditures

Medicaid Managed Care

• Moving aggressively into LTC
• Let’s define it
  – Provider protections
  – Insurer risk or pass-through?
• “You Can’t Manage a Medicaid Day”
• Reduced provider $ = Access problems
• Keep them out / Get them out?
  – How? To where?
  – HCBS = more H (Medicare $)
• Total savings will not materialize unless the Medicare AND Medicaid benefit is managed
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

Old World
- Care Silos
- Distinct provider payments
- Incentives for enhancing utilization
- Limited integration among providers
- No quality/financial link

New World
- "Quality Networks" & Preferred Providers
- Distinct Costing, Data, & Assumption of Risk
- ACOs, Bundling & Value-Based Purchasing
- Care Coordination & Transitions
- CARE tool, Re-H penalties
**Key Industry Trends**

- Fewer SNF admissions
- Shorter LOS
- Push to HCBS
- New Payment Models
- Ongoing Rate & Audit Pressure
- Managed Care

- Aging Population
- PAC Neutralization
- Decrease in Beds
- Rewards for Quality
- Managed Care

**Medicare FFS Hosp. Discharges**

- Cumulative % Change

- 2006: -15%
- 2007: -10%
- 2008: -5%
- 2009: 0%
- 2010: 5%
- 2011: 7%
- 2012: 8%
- 2013: 12.6%
- 2014: 17%
- 2015: 23%
- 2016: 28.5%

- Inpatient
- Outpatient
What Makes Up the SNF Rate?

- **Not a problem**
  - Nursing
  - Overhead
  - Capital

- **Big problems**
  - Therapy
  - Non-Therapy Ancillaries

CMS Initiatives

- SNF research projects designed to improve payment accuracy and monitor expense & utilization patterns
  - **SNF Non-Therapy Ancillary (NTA) Payment**
    - Current SNF nursing component does not track sufficiently with resident NTA costs
    - Research ongoing with process of adjusting model to reflect MDS 3.0 and RUG-IV elements
    - Analysis reveals that, in most cases, NTA costs are not driven by high volume of low-cost NTAs but by a few high cost NTAs
  - **Outlier v. Rate Adjustment**
CMS Initiatives

- **SNF Therapy Research Project**
  - Looking for best possible “implementable” model to replace current Tx payment
  - Phase I (10/12 - 10/13): Communication and review with stakeholders to identify possible alternatives to existing SNF therapy payment component
  - Phase II (10/13 – 10/15): Evaluate two approaches to **Patient Characteristics Model** with objective to replace current system; TEP involvement

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)

Shifting FFS Distribution

“Aggressive” estimate produced by Avalere

2009

Traditional Fee-for-Service 76%
Medicare Advantage 24%

N = 45.5 million

2014E

Traditional Fee-for-Service 55%
Medicare Advantage 26%
ACOs 14%
Deals/Demos 4%

N = 52.0 million

2019E

Traditional Fee-for-Service 29%
ACOs 26%
Medicare Advantage 33%
Deals/Demos 12%

N = 60.3 million
Shifting FFS Payment Model

“Moderate” estimate produced by Avalere

2014 PROJECTION

<table>
<thead>
<tr>
<th>Distribution of Medicare Enrollment</th>
<th>FFS Spending Impacted by Payment Reforms</th>
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<tbody>
<tr>
<td>Medicare Advantage 23%</td>
<td>Unaffected Spending 65%</td>
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<tr>
<td>ACOs 14%</td>
<td>Value-Based Purchasing 34%</td>
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<tr>
<td>Duals / d eens 4%</td>
<td>Bundled Payments 1%</td>
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</table>

2019 PROJECTION

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<th>Distribution of Medicare Enrollment</th>
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<tr>
<td>Duals / d eens 4%</td>
<td>Bundled Payments 26%</td>
</tr>
</tbody>
</table>

Managed Care Business Issues

- **Who is managing the process?**
  - Complex rate structures
  - Case management and MCO liaison
  - Cost of Care (per diem / episodic / PMPM)
  - Market power
  - Multi-platform acuity scoring
  - Clinical integration across venues
  - Risk tolerance
Total Medicare Private Health Plan Enrollment, 1999-2014

In millions:

<table>
<thead>
<tr>
<th>Year</th>
<th>Enrollment</th>
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<tr>
<td>1999</td>
<td>6.9</td>
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<tr>
<td>2000</td>
<td>6.8</td>
</tr>
<tr>
<td>2001</td>
<td>6.2</td>
</tr>
<tr>
<td>2002</td>
<td>5.6</td>
</tr>
<tr>
<td>2003</td>
<td>5.3</td>
</tr>
<tr>
<td>2004</td>
<td>5.3</td>
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<td>2005</td>
<td>5.6</td>
</tr>
<tr>
<td>2006</td>
<td>6.8</td>
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<tr>
<td>2007</td>
<td>8.4</td>
</tr>
<tr>
<td>2008</td>
<td>9.7</td>
</tr>
<tr>
<td>2009</td>
<td>10.5</td>
</tr>
<tr>
<td>2010</td>
<td>11.1</td>
</tr>
<tr>
<td>2011</td>
<td>11.9</td>
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<tr>
<td>2012</td>
<td>13.1</td>
</tr>
<tr>
<td>2013</td>
<td>14.4</td>
</tr>
<tr>
<td>2014</td>
<td>15.7</td>
</tr>
</tbody>
</table>

% of Medicare Beneficiaries:

- 18% in 1999
- 17% in 2000
- 15% in 2001
- 14% in 2002
- 13% in 2003
- 13% in 2004
- 13% in 2005
- 16% in 2006
- 19% in 2007
- 22% in 2008
- 23% in 2009
- 24% in 2010
- 25% in 2011
- 27% in 2012
- 28% in 2013
- 30% in 2014

NOTE: Includes MSA, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans.


Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2012

National Average, 2012 = 27%

NOTE: Includes cost and demonstration plans, enrollees in Special Needs Plans, as well as other Medicare Advantage plans.

Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2014

NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans.

MA % By County (2014)

<table>
<thead>
<tr>
<th>County</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Albany</td>
<td>41%</td>
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<tr>
<td>Allegany</td>
<td>34%</td>
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<tr>
<td>Bronx</td>
<td>51%</td>
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<tr>
<td>Broome</td>
<td>34%</td>
</tr>
<tr>
<td>Cattaraugus</td>
<td>44%</td>
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<tr>
<td>Cayuga</td>
<td>25%</td>
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<tr>
<td>Chautauqua</td>
<td>44%</td>
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<tr>
<td>Chemung</td>
<td>31%</td>
</tr>
<tr>
<td>Chenango</td>
<td>32%</td>
</tr>
<tr>
<td>Clinton</td>
<td>16%</td>
</tr>
<tr>
<td>Columbia</td>
<td>27%</td>
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<tr>
<td>Cortland</td>
<td>22%</td>
</tr>
<tr>
<td>Delaware</td>
<td>23%</td>
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<tr>
<td>Dutchess</td>
<td>18%</td>
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<tr>
<td>Erie</td>
<td>56%</td>
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<tr>
<td>Essex</td>
<td>16%</td>
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<tr>
<td>Franklin</td>
<td>20%</td>
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<tr>
<td>Fulton</td>
<td>41%</td>
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<tr>
<td>Genesee</td>
<td>55%</td>
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<tr>
<td>Greene</td>
<td>30%</td>
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<tr>
<td>Hamilton</td>
<td>19%</td>
</tr>
<tr>
<td>Herkimer</td>
<td>34%</td>
</tr>
<tr>
<td>Jefferson</td>
<td>23%</td>
</tr>
<tr>
<td>Kings</td>
<td>38%</td>
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<tr>
<td>Lewis</td>
<td>25%</td>
</tr>
<tr>
<td>Livingston</td>
<td>59%</td>
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<tr>
<td>Madison</td>
<td>31%</td>
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<tr>
<td>Monroe</td>
<td>63%</td>
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<tr>
<td>Montgomery</td>
<td>36%</td>
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<tr>
<td>Nassau</td>
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<tr>
<td>New York</td>
<td>32%</td>
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<tr>
<td>Niagara</td>
<td>52%</td>
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</table>
### MA % By County (2014)

<table>
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<th>County</th>
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<tr>
<td>Oneida</td>
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<td>Onondaga</td>
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<tr>
<td>Ontario</td>
<td>58%</td>
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<tr>
<td>Orange</td>
<td>15%</td>
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<tr>
<td>Orleans</td>
<td>52%</td>
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<tr>
<td>Oswego</td>
<td>32%</td>
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<tr>
<td>Otsego</td>
<td>18%</td>
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<tr>
<td>Putnam</td>
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<td>Queens</td>
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<td>Rensselaer</td>
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<tr>
<td>Richmond</td>
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<tr>
<td>Rockland</td>
<td>17%</td>
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<td>Saratoga</td>
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<td>Schenectady</td>
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<td>Schoharie</td>
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<td>Schuyler</td>
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<tr>
<td>Seneca</td>
<td>41%</td>
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<tr>
<td>St. Lawrence</td>
<td>19%</td>
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<tr>
<td>Steuben</td>
<td>30%</td>
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<tr>
<td>Suffolk</td>
<td>20%</td>
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<tr>
<td>Sullivan</td>
<td>9%</td>
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<tr>
<td>Tioga</td>
<td>34%</td>
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<tr>
<td>Tompkins</td>
<td>19%</td>
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<tr>
<td>Ulster</td>
<td>22%</td>
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<tr>
<td>Warren</td>
<td>37%</td>
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<tr>
<td>Washington</td>
<td>36%</td>
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<tr>
<td>Wayne</td>
<td>56%</td>
</tr>
<tr>
<td>Westchester</td>
<td>23%</td>
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<tr>
<td>Wyoming</td>
<td>52%</td>
</tr>
<tr>
<td>Yates</td>
<td>50%</td>
</tr>
</tbody>
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### Medicare Advantage Enrollment, by Firm or Affiliate, 2014

- United Healthcare: 20%
- Humana: 17%
- BCBS: 17%
- Kaiser Permanente: 8%
- Aetna: 7%
- Cigna: 3%
- Other national insurers: 5%
- All other insurers: 23%

**Total Medicare Advantage Enrollment, 2014 = 15.7 Million**

**NOTE:** Other includes firms with less than 3% of total enrollment. BCBS are BlueCross BlueShield affiliates and includes WellPoint BCBS plans that comprise 4% of all enrollment (approximately 600,000 enrollees) in Medicare Advantage plans. Other national insurers includes approximately 428,000 enrollees across the following firms: Wellcare, HealthNet, Universal American, Munich American Holding Corporation, and Wellpoint non-BCBS plans. Accounts for merger between Coventry and Aetna in 2013. Medicare Advantage plans offered by Coventry covered 306,000 beneficiaries and Aetna plans covered 615,000 in 2013. Percentages may not sum to 100% due to rounding.

**SOURCE:** NPP/Kaiser Family Foundation analysis of CMS Enrollment Files, 2014.
Medicare Margins Remain High

Above is for Freestanding SNFs
For profit 2012 margin = 16.1%; NFP = 5.4%
## FFS v. MA Rate Analysis

<table>
<thead>
<tr>
<th>Company</th>
<th>Ave. Diff</th>
<th>Ratio</th>
<th>Ave. Diff</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversicare</td>
<td>-</td>
<td>-</td>
<td>$61</td>
<td>1.16</td>
</tr>
<tr>
<td>Ensign</td>
<td>$172</td>
<td>1.44</td>
<td>$149</td>
<td>1.36</td>
</tr>
<tr>
<td>Extendicare</td>
<td>$37</td>
<td>1.08</td>
<td>$20</td>
<td>1.04</td>
</tr>
<tr>
<td>Kindred</td>
<td>$86</td>
<td>1.21</td>
<td>$115</td>
<td>1.26</td>
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<tr>
<td>Skilled HC</td>
<td>$130</td>
<td>1.33</td>
<td>$112</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 (often outsourced)
  - Denials based on failure to submit assessments (all v. OBRA)

Is There Value in MA?

- Extra payments have not translated to improved care
Special Needs Plans

- SNP is a Medicare Advantage program designed to reduce costs for the long-term care population
- Goal is to improve outcomes and reduce costs (esp. hospital admissions) through improved coordination of care management
- ISNPs enroll only Medicare (A & B) eligible LTC residents (regardless of primary payer)
- Intense use of NPs and clinical protocols to reduce hospitalizations

SNP $ Considerations

- Shared savings potential
  - Insurance company receives monthly payment from Medicare per enrollee (PMPM)
  - All Medicare payments, administration costs, NP, etc. must be paid by MCO
- Part A derived from LTC population
- Part B therapy (billing, therapy company use, cap issues)
- Medicaid rate (higher MA rates makes SNP more attractive)
### Poor Candidates
- Many LTC hospitalizations
- High % of Part A $ from LTC
- High Part B in-house therapy
- Low MA rate

### Marginal

### Excellent Candidates
- Few LTC hospitalizations
- Low % of Part A $ from LTC
- Low/outsourced therapy
- Higher MA rate

---

### SNP Sample Calculation

- CMS pays plan: $1,500 PMPM
- Plan pays SNF: $350 PMPM (Part A)
- Plan pays SNF: $50 PMPM (Part B)
- Plan pays other: $500 average PMPM
- Plan admin: $100 PMPM
- Remaining: $500 PMPM
- SNF share (40%): $200 PMPM
- Total SNF revenue: $600 PMPM
<table>
<thead>
<tr>
<th>Independent Provider Association</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Opportunity to become provider and payer</td>
</tr>
<tr>
<td>– More input on clinical care issues</td>
</tr>
<tr>
<td>– Assumption of risk</td>
</tr>
<tr>
<td>– More flexibility in operations</td>
</tr>
<tr>
<td>– Expansion of revenue stream</td>
</tr>
<tr>
<td>– Improved relations with insurance companies and hospitals</td>
</tr>
<tr>
<td>– Enhanced market power</td>
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<table>
<thead>
<tr>
<th>Variances in PAC</th>
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<tbody>
<tr>
<td>• PAC represents among the largest variances in any healthcare sector</td>
</tr>
<tr>
<td>– Fragmented market</td>
</tr>
<tr>
<td>– Diverse patient population</td>
</tr>
<tr>
<td>– Different treatment protocols across regions</td>
</tr>
<tr>
<td>• Payers are taking note</td>
</tr>
<tr>
<td>• Neutralizing variances to demonstrate value will create opportunity</td>
</tr>
</tbody>
</table>
RUG Days Billed per RUG

Source: CMS

SNF RU % by Region (2012)

Source: CMS
PAC Reform (MedPAC)

- Hospitals have had no incentive to discharge to most efficient PAC
- “PPSs encourage providers to furnish certain services to boost payments or admit certain kinds of patients based on profitability”
- “Clear need for reform”
- “Medicare margins exceptionally high”
- “Overlap in the types of patients treated in different settings”
- “Treating similar patients in different settings can unnecessarily increase spending”
PAC Reform (MedPAC)

- MedPAC continues to discuss equalizing $ for different PACs but has not issued formal recommendation
  - IMPACT Act (passed)
  - B-CARE assessment tool
- Who favors site neutral payment? AHCA
- Who disagrees with site neutral payment?
  - American Medical Rehabilitation Providers Association (IRF association)

IMPACT Act

- Require PAC providers to report standardized assessment data, data on quality measures, and data on resource use and other measures;
- Require the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes;
- Modify PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers.
PAC Variation

• PAC is the largest driver of overall variation (NEJM)

• PAC $ growing faster than H
  – 1994 – 2009 (for major PAC utilization Dx):
    • H $ grew by 1.7% per year
    • PAC $ grew 7.5% per year

PAC Spending by DRG (2008)

Source: NEJM
### Post-Acute Care Data

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<tbody>
<tr>
<td>SNF</td>
<td>14,938</td>
<td>$31.3 +</td>
<td>$10,849 +</td>
<td>27.2 +</td>
<td>66</td>
</tr>
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<td>IRF</td>
<td>1,166</td>
<td>$6.5B +</td>
<td>$17,398 -</td>
<td>13 -</td>
<td>92</td>
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<tr>
<td>HHA</td>
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<td>$18.6B -</td>
<td>$2,691 +</td>
<td>17.2:V -</td>
<td>153</td>
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<tr>
<td>LTAC</td>
<td>437</td>
<td>$5.4B +</td>
<td>$38,664</td>
<td>26.3 -</td>
<td>751</td>
</tr>
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</table>

+ trending up; - trending down; V: Visits

### PAC Spending Growth ($B)

![Graph showing PAC spending growth (2001-2012)]
Medicare Spending Variances

New England Journal of Medicine: Newhouse & Garber 2013
Medicare Spending Variances

If variations in PAC spending were eliminated, the overall total spending variation across the country would drop by 73% (as opposed to a 27% decline if hospital cost variation was eliminated).

New England Journal of Medicine: Newhouse & Garber 2013

CLUMPs

• Data v. Information
• When Clinical Quality is neutralized, Managing Risk in PAC involves the following:
  – Cost control
  – Large numbers
  – Understanding variables
  – Management data
  – Predictive power
LOS of Stay in SNF: Not Predictable

Explaining Variations in PAC

- Function
- Co-Morbidities
- Living Status
- Diagnosis
- Functional Recovery
- Burden of Care
- Length of Stay
- Readmission Probability
Functional Improvement in SNF: Predictable

80 yr old female with CHF, cellulitis, UTI and prior stroke

Regression Analysis: SNF LOS

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Coefficient</th>
<th>Patient’s Actual Value</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Random Error (constant)</td>
<td>24.45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission Function</td>
<td>-0.473</td>
<td>32</td>
<td>-15.21</td>
</tr>
<tr>
<td>Age</td>
<td>0.034</td>
<td>82</td>
<td>2.78</td>
</tr>
<tr>
<td>Days Post Onset</td>
<td>0.565</td>
<td>4</td>
<td>2.26</td>
</tr>
<tr>
<td>Condition (IV/Obese)</td>
<td>2.1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Predicted Episode LOS = 16.38
**Plans are Getting Smarter**

- In PAC, significant variation in cost is often accompanied by relatively little variation in patient outcome
- Using data analysis to compare providers based on adjusted expectations and reorganizing PAC
  - Severity adjusted performance measures
  - Alignment of expectations/risk sharing
  - "Narrowing" of networks***
  - High volume to select providers
  - Implementing structural payment model changes (P4P, case-rates, Capitation – especially for integrated PAC companies)

**The Results of PAC Management**

- Situation:
  - Regional MA Plan with HMO and PPO products (urban and rural presence)
  - Historically high SNF utilization (>1,700 days/k) and large fragmented SNF network
- Results:
  - Year 1 SNF utilization reduction resulted in ~$19 PMPM savings
  - Plan experienced only a $1 PMPM increase in HH and no material rise in readmissions
  - Based on positive clinical and financial results, plan expanded contract from SNF-only to a capitated model across all post-acute care (SNF, IRF, LTACH, HH and 60-day readmissions)
  - After year 1, SNF days / 1,000 expected ~1,050
The Results of PAC Management

### Average Medicare FFS
- LOS: 27 days
- Days/k: 1,938
- PMPM: $44.12

### Average MA Plan
- LOS: 22 days
- Days/k: 981
- PMPM: $22.06

### 1 Million Managed Lives
- LOS: <16 days
- Days/k: 634
- PMPM: $13.04

Impact of transition from Medicare SNF FFS to full “managed” model

SNF Days/1,000

Year 1 results:
Aggregate SNF/1,000 reduction of 38%+
Estimated run-rate of 1,050 SNF days/1,000:
~40% below pre-implementation

Pre-implementation

Qtr 1 Qtr 2 Qtr 3 Qtr 4 Qtr 5