Reforming Healthcare Reform

Regulatory and Market Issues Driving Change in Post-Acute Care

LeadingAge New York
Financial Professionals 2017

Agenda

• Market Issues
  • The Financial Backdrop
  • National Healthcare Reform
  • Demographics & SNF Utilization
  • Trends in Litigation
  • Transactions and (Re-)Fragmentation

• Reimbursement Issues
  • MedPAC Report
  • Alternative Payment Models
  • Medicare Advantage
  • Long-Term Care Population Issues
  • 2018 PPS Final Rule & Advanced Notice of Proposed Rulemaking
The Financial Backdrop

- **2016 National Debt = $19.9T**
- **US GDP = $18.6T**
- **Federal Budget = $3.9T**
- 2015 US healthcare spending rose at fastest rate in 8 years (DHHS)
  - Fueled primarily by ACA and prescription drugs
  - 5.8% growth compared 3.9% for the overall economy
  - $3.2T, about $9,990 per person
- **In 2015, Federal gov’t became largest payer for health care**
  - Federal Government: 29%
  - Households: 28%
  - Businesses: 20%
  - State/Local Gov’t: 17%

What is driving our debt?

- **70% of Federal spending is on:**
  - Social Sec.: 23.6%
  - Medicare: 15.3%
  - Defense: 15.2%
  - Medicaid: 9.6%
  - Interest: 6.3%

**The Pareto Principle:**
“Law of the Vital Few”
Problems with the US Healthcare System

- Normal economic principals do not apply
- Industry structure
- No consistency of product / Large variation in cost of care, quality and clinical outcomes
- Defensive medicine
- Cultural / resistance to “rationing”
- Insurance companies
- Pricing
- Cost shifting “subsidies”
- Lobbying

ACA v. AHCA/BCRA

- **Obama:**
  - “You can keep your doctor... keep your plan”
  - “Premiums will come down $2,500”
  - Extended Medicare solvency through higher taxes and provider payment cuts
  - Exchanges & subsidies, pre-existing condition protection, minimum coverage standards, Medicaid expansion
  - Higher taxes and provider payment reductions

- **Trump:**
  - “ObamaCare is imploding; I can do better... & reduce costs”
  - Roll back private insurance mandates and taxes
  - Extend Medicare solvency through economic growth
  - Reduce Medicaid spending **growth**
Patient Protection and Affordable Care Act Facts

• **Who Benefited?**
  - Only 9% of the population is uninsured (lowest on record)
  - 12M more on Medicaid (in 2017, up from 9.1M in 2015)
  - **Even without repeal, FMAP reduction pressures state budgets**
    - 10M on Exchanges (85% receive subsidies; Subsidy $ came in below forecast?)
  - **Extended Medicare program solvency**
    - Industry players (Hospitals, insurance companies)

• **Who Didn’t? SNFs!**
  - Young & healthy pay more to strengthen risk pool
  - Middle class Exchange customers: Single = $47,520; Family of 4 = $97,200

The Problem with Iowa

• Counties may be left with **zero** ACA Exchange insurers

• **“The Patient”**
  - Lesson in statistics / actuarial tables
    - 1 in 30,000 can destroy the model
    - *Especially when it is already stressed by too few young and healthy enrollees*
  - What happens to him/her without ACA?
  - What happens to him/her under Reform?

• Oh, and the Managed Medicaid program?
Employee Sponsored Coverage

- Average family plan 2016 = $18,142 [up 3.4% from 2015 compared to wages (up 2.5%) and inflation (up 1.1%)]
- Workers cover average of 30% ($5,277)
- Employers pay average of 70% ($12,865)
- The average family plan cost $11,480 in 2006 (workers paid $2,973)

Source: Kaiser

Heading Towards a Single Payer System?

- Full government financing? **We’re almost there already.**

California Health Care Expenditures (Billions of Dollars), 2016

<table>
<thead>
<tr>
<th>Health Care Expenditure Category</th>
<th>Expenditures, in Billions (% of Total Expenditure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health care expenditures</td>
<td></td>
</tr>
<tr>
<td>Direct government expenditures</td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>$74.7 (20.3%)</td>
</tr>
<tr>
<td>Medi-Cal/Healthy Families</td>
<td></td>
</tr>
<tr>
<td>Federal share</td>
<td>$52.8 (17.1%)</td>
</tr>
<tr>
<td>State share</td>
<td>$37.4 (12.2%)</td>
</tr>
<tr>
<td>Other government programs</td>
<td>$10.0 (2.7%)</td>
</tr>
<tr>
<td>County health expenditures</td>
<td>$10.0 (2.7%)</td>
</tr>
<tr>
<td>Government employer premium contributions</td>
<td></td>
</tr>
<tr>
<td>FEHB</td>
<td>$1.9 (0.5%)</td>
</tr>
<tr>
<td>GaPERS</td>
<td>$7.1 (1.9%)</td>
</tr>
<tr>
<td>TRICARE</td>
<td>$4.1 (1.1%)</td>
</tr>
<tr>
<td>Tax subsidies</td>
<td></td>
</tr>
<tr>
<td>Tax subsidies for ESI</td>
<td></td>
</tr>
<tr>
<td>Federal</td>
<td>$33.1 (9.0%)</td>
</tr>
<tr>
<td>State and local</td>
<td>$10.0 (3.0%)</td>
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<tr>
<td>ACA subsidies</td>
<td>$8.9 (2.4%)</td>
</tr>
<tr>
<td>Total public health care expenditures</td>
<td>$356.9 (100.0%)</td>
</tr>
</tbody>
</table>

| Private health care expenditures      |                                                   |
| Employer share of premiums            | $58.3 (15.9%)                                     |
| Employee share of premiums            |                                                   |
| FEHB premiums                         | $0.7 (0.2%)                                       |
| GaPERS premiums                       | $1.0 (0.3%)                                       |
| Private employee premiums             | $18.7 (5.1%)                                      |
| Premium contributions for individually purchased insurance | |
| Covered California                    | $3.8 (0.1%)                                       |
| Outside Exchange                      | $8.6 (0.3%)                                       |
| OOP expenses for covered benefits     | $15.5 (4.2%)                                      |
| Total private health care expenditure | $126.6 (35.0%)                                    |
| Total California health care expenditures | $356.9 (100.0%)                                   |

http://kff.org/other/state-indicator/total-population
Litigation & Liability

• Average 2017 SNF liability costs increased to $2,350 per bed*
  • Broad range from $7,500 in FL to $480 in MN
• Claims frequency ranges by county (e.g. Cook County, IL was 26% higher than the rest of the state)
• High % of claims result in recovery for Plaintiff (85% in Cook County)
• Quality of Care actions continue in absence of tort reform
  • Traditional plaintiff strategy: Prove inaction by clinical team
  • New plaintiff strategy: Nursing Home Compare, “Reported/Expected” hours to cost report
  • Defense: Cost report hours are inaccurate; PPD averages are not patient-specific; RUG nursing applications are flawed; CMI “snapshots” over-report daily-average acuity

* Aon/AHCA 2015 Long Term Care General Liability and Professional Liability Actuarial Analysis

Transactions 2016

• Average SNF price hit record $99,200 per bed (15% above 2015)
  • Driven by divestiture of large chains, smaller operators “getting out at the top” and not-for-profit conversions
• Average ALF price reached $193,650 per unit (2% above 2015)
• 337 long-term care deals (similar to 2015)
• Long-term care was the largest healthcare deal sub-sector by deal value at $14.4B (36% of all healthcare deals)
• HH/Hospice activity rose 12%; Rehab sector rose 21%; Managed care sector activity fell 53%
  • Cost of capital, lower PE (net seller for 2016)
  • Sources: PwC, Irving Levin Associates
Change in Market Dynamics

- Large chains divesting assets or exiting
- New operators continue to join the industry
- Debt service coverage ratios will be tested
- Technology / outsourcing solutions redefining economies of scale
- Impact of demographic and market factors will be geographically uneven
- Evolving nature of healthcare increasingly requires local / regional management and strategic positioning

ZHSG’s Outlook for SNF industry:
- High quality/efficient facilities will thrive
- Strong Regional chains have an advantage

Supply Side: SNF Beds

- **National SNF occupancy = 81.8% in Q4 2016 (source: NIC)**
  - 2007 occupancy = 89.0% (AHCA)
  - Lowest in 5 years and 3rd consecutive quarterly drop
  - Skilled mix was 24.3%
  - Medicaid up slightly at 66.2% of patient days
  - Decline in MA $/day slowed by more than 50%, year-over-year
    - $19 to $9 between 4Q 2014 – 4Q 2015

- We’ve lost 1,000 SNFs (many HB)
- **What will drive future SNF census?**
  - Aging population
  - Barriers to entry into SNF market
  - Alzheimer’s
Demographics Trends Will Drive Volume

Projected US Population Age Growth (Millions)

- Blue bars: 80 – 84 years
- Red bars: 80+ years

Source: US Census Bureau

Projected Post-Acute Care Spending, 2016-2024
Spending on home healthcare, nursing facilities, and other non-acute care is expected to see strong growth in the coming years, creating significant opportunity for healthcare IT companies that service these markets.

Source: CMS

Demographics Trends Will Drive FFS Volume

Outstripping reductions in SNF utilization

Discharges to PAC expected to increase 64% from 2015 - 2035

2015 Post-Acute Care Destination Distribution

- Medicare Acute Hospital Discharges
- SNFs: 48%
- HHAs: 39%
- IRFs: 9%
- LTACHs: 3%

Compiled by Omega Investors

MedPAC

ZIMMET HEALTHCARE SERVICES GROUP, LLC, 2017
The Coming Pandemic

• $43B: Medicaid Alzheimer’s spend for 65+ pop in 2016
• 5.3M: People in the US diagnosed in 2016
• 8.4M: US projected Dx in 2030 (Alzheimer’s Association)
• 50.4%: SNF residents had Alzheimer’s/Dem Dx in 2014 (CDC)
  • If these ratios persist, by 2030, 400,000 additional Alzheimer’s patients will require long-term SNF care
• There are currently 1.62M certified SNF beds
• At 81.8% occupancy, there are currently 295,000 empty beds
• There are virtually no new SNF beds being certified

Alzheimer’s by the Numbers

2016: 2M with Alzheimer’s are 85+ (37% of all sufferers)
2030: >3M people age 85+ will have Alzheimer’s
Source: Alzheimer’s Association
2017 Medicare Trustees Report

• Medicare Part A Trust Fund expected to reach “zero balance” in 2029 (2016 projection was 2028)
• IPAB NOT TRIGGERED!

MedPAC: March 2017 Medicare Payment Report

• 2015: SNFs furnished 2.4M Medicare-covered stays to 1.7M FFS beneficiaries at a cost of $29.8B
• Access to SNF services remains adequate for most beneficiaries
• Average total margin = 1.6% (down slightly from 2014)
• Average Medicare margin = 12.6%
• Average non-Medicare margin = (2.0%) from (1.5%) in 2014
• Continued RUG “creep”
• Reiterates comments about perverse incentives and high profit margins endemic to current PPS
• Recommends rebasing, reducing Medicare payments and continues to rebut argument that Medicare must subsidize Medicaid in SNFs

http://www.medpac.gov/
### 2017 MedPAC Report

#### Utilization

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2015</th>
<th>Change</th>
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</thead>
<tbody>
<tr>
<td>Adm / 1,000 FFS</td>
<td>71.5</td>
<td>67.7</td>
<td>-5.31%</td>
</tr>
<tr>
<td>Days / 1,000 FFS</td>
<td>1,938</td>
<td>1,792</td>
<td>-7.53%</td>
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<tr>
<td>ALOS</td>
<td>27.1</td>
<td>26.5</td>
<td>-2.21%</td>
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</tbody>
</table>

#### Quality

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>D/C to Community</td>
<td>33.2</td>
<td>38.8</td>
<td>16.87%</td>
</tr>
<tr>
<td>Potentially avoidable hospital readmissions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From SNF</td>
<td>12.4</td>
<td>10.4</td>
<td>-16.13%</td>
</tr>
<tr>
<td>Within 30 days SNF d/c</td>
<td>5.9</td>
<td>5.0</td>
<td>-15.25%</td>
</tr>
</tbody>
</table>

### Alternative Payment Models: Impact on SNFs

- There is a 27% difference between the most and least “efficient” markets with respect to SNF utilization (MedPAC)
- ACOs & Bundling are here to stay – first target is always PAC
- **Major utilization indicators are lower under APMs than FFS**
  (admits/1,000, ALOS, Episodic revenue; Hospital readmissions)
- Proliferation of “Narrowed networks”
- Birth of SNF Analytics, Care Management & Care Transitions tech.
- Driving “Direct to Consumer” marketing efforts
2014 Medicare FFS SNF Utilization Data

Admits/1,000 Beneficiaries

- High: CT (103)  NY: 66
- Low: AK (13)    NJ: 86

Covered Days/1,000 Beneficiaries

- High: IN (2,397) NY: 1,790
- Low: AK (320)   NJ: 2,156

Source: Kaiser

How is Bundling Impacting SNFs?

- Model 2: Medicare $ for H + 90-days post-discharge fell $864 for ortho episodes initiated at BPCI-participating hospitals – due to reduced use of institutional PAC.
  - Use of institutional PAC by BPCI ortho patients **dropped from 64% to 57%**: similar to PAC declines for cardiovascular surgery patients; non-BPCI “remained virtually unchanged.”
  - Beneficiaries under BPCI **indicated greater improvement in mobility measures than from comparison hospitals**.
- Model 3: No statistically significant efficiencies

*The Lewin Group: CMS Bundled Payments for Care Improvement Initiative (2016)*

ZIMMET HEALTHCARE SERVICES GROUP, LLC, 2017
Bundling Study:
Perelman School of Medicine at the UPenn

• 3,738 joint replacement surgery patients from 2008 – 2015 at Baptist Health System in Texas
• 20.8% spend decrease; **quality of care unchanged or improved**
• Average cost of joint replacement + 30 days’ PAC fell $5,577
  • From $26,785 to $21,208
• **The cost reductions came mainly from two sources:**
  • 29% ($1,921) drop in the average per case cost of an artificial joint, accomplished in part through use of evidence-based data
  • 27% ($2,443) drop in the average per case PAC spend

Accountable Care Organizations

• Program has grown from 220 ACOs in 2013 to 480 in 2017
• ACOs have achieved **2% per beneficiary spending reduction**, with up to 30% from reducing post-acute spend (Health Affairs)
• Harvard Medical School / Vanderbilt School of Medicine study:
  • ACOs that joined in 2012 achieved a 9% reduction in PAC spending by 2014
  • Savings driven by fewer patients being discharged into SNFs and shorter LOS for those who were admitted
  • **No “ostensible deterioration” of care quality, re-H rates or mortality**
• **“Next Gen” ACOs**
  • All-Inclusive Population-Based Payments (AIPBPs)
Medicare v. Medicare Advantage Outcomes

Length of Stay in SNF Following Total Joint Arthroplasty

• **Purpose:** To compare functional outcomes and SNF LOS among patients with Medicare FFS v. Medicare Advantage following total joint arthroplasty (114 patients)
  - ALOS: FFS = 24     MA = 12 days

  • **After adjusting for covariates, MA patients had significantly greater achievements in all functional outcomes measured.**
  - FFS patients achieved similar functional outcomes by day 14 as MA patients achieved by day 12, yet FFS group not discharged until several days later.
  - “FFS associated with poor outcomes, long LOS, and slow progress in the SNF.”
  - “Our results suggest that insurance may be primary factor in decision to discharge, rather than the achievement of functional milestones.”

Published August 10, 2016; http://www.arthroplastyjournal.org/article/S0883-5403(16)30465-X/pdf

SNF Part A Average Length of Stay

• Traditional FFS: 27 days

• Accountable Care Org.: 20 days

• Medicare Advantage: 14 days

**Source:** AHCA
Medicare Advantage

- **2017 major milestone**: 1/3 of beneficiaries enrolled
  - Projected to reach 41% in 2027 (CBO)
- SNF rate differential
- “Market Power” analysis

- SNF Trends:
  - Move towards blended rates
  - Episodic payment structures
  - Tie-in with different products (MLTC, ISNP) in certain markets
  - Operational / Capture / Collection problems remain
  - Hospital diversion

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![Graph showing Medicare Advantage plan enrollment share from 2004 to 2017.](image)

**2017 Plan Enrollment Share**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Enrollment Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>United</td>
<td>24%</td>
</tr>
<tr>
<td>Humana</td>
<td>17%</td>
</tr>
<tr>
<td>Blue Cross</td>
<td>16%</td>
</tr>
<tr>
<td>Kaiser</td>
<td>8%</td>
</tr>
<tr>
<td>Aetna</td>
<td>7%</td>
</tr>
<tr>
<td>Cigna</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>26%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100%</td>
</tr>
</tbody>
</table>

![Map showing Medicare Advantage plan enrollment by state in 2017.](image)

**Hi/Low: Counties with 100k Beneficiaries**

- Lake, IL: 11%
- Allegheny, PA: 62%
- Montgomery, MD: 11%
- Monroe, NY: 65%
- Baltimore, MD: 14%
- Miami, FL: 65%

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[http://www.kff.org](http://www.kff.org)
### Medicare Advantage Enrollment by State

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total U.S.</td>
<td>16,761,673</td>
<td>18,973,154</td>
<td>2,211,481</td>
<td>13%</td>
<td>31%</td>
<td>33%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>232,445</td>
<td>271,778</td>
<td>39,333</td>
<td>17%</td>
<td>30%</td>
<td>33%</td>
</tr>
<tr>
<td>Maryland</td>
<td>76,375</td>
<td>106,861</td>
<td>30,486</td>
<td>40%</td>
<td>8%</td>
<td>11%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>233,084</td>
<td>266,741</td>
<td>33,657</td>
<td>14%</td>
<td>19%</td>
<td>21%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>76,776</td>
<td>93,708</td>
<td>16,932</td>
<td>22%</td>
<td>14%</td>
<td>16%</td>
</tr>
<tr>
<td>Missouri</td>
<td>311,364</td>
<td>368,222</td>
<td>56,858</td>
<td>18%</td>
<td>28%</td>
<td>31%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>222,846</td>
<td>326,486</td>
<td>103,640</td>
<td>47%</td>
<td>15%</td>
<td>21%</td>
</tr>
<tr>
<td>New York</td>
<td>1,212,239</td>
<td>1,325,900</td>
<td>113,661</td>
<td>9%</td>
<td>37%</td>
<td>38%</td>
</tr>
<tr>
<td>Ohio</td>
<td>811,503</td>
<td>787,209</td>
<td>-24,294</td>
<td>-3%</td>
<td>38%</td>
<td>35%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>1,001,864</td>
<td>1,065,053</td>
<td>63,189</td>
<td>6%</td>
<td>40%</td>
<td>41%</td>
</tr>
</tbody>
</table>

Source: CMS, Kaiser

### Discharge Destination Following Major Joint Replacement

#### Medicare FFS
- **Post-Acute Care:** 81%
- **Home**: 19%

#### Medicare Advantage
- **Post-Acute Care:** 54%
- **Home**: 46%

*Home* without Home Health

Source: Avalere
Discharge Destination Following Inpatient Stay

Medicare FFS
- LTCH: 1%
- IRF: 4%
- SNF: 16%
- HHA: 16%
- Home*: 63%

Medicare Advantage
- LTCH: 0%
- IRF: 1%
- SNF: 11%
- HHA: 11%
- Home*: 77%

* Home without Home Health
Source: Avalere

LTC Population: Financial Issues

- **Trump future of Medicaid funding: Block Grants / Per Capita??**
- Continued state budgetary pressures impacting rate increases, bed hold policy and accelerating HCBS & managed care initiatives
- “Is this a good state...?”
  - Program stability, Deficit levels, Demographics, Market Saturation
- **Medicaid Managed Care**
  - Theory v. Practice
  - Systemic Change or Administrative Contract?
  - Funding Structure (“rate cells”)  
  - Provider Protections (Rate Setting, AWP, Prompt Payment)
- **ISNP and ECCP (Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents)**
ECCP / Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents (RAH)

- CMS: **45%** of hospital admissions for SNF duals (Medicare skilled or Medicaid LTC) were avoidable.
  - 314,000 admissions, $2.6B in 2005
  - 6 conditions linked to 80% of them
- RAH currently in Phase 2 (thru 2020);
- Increases payment to practitioners and SNFs to decrease hospitalizations.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>32.8%</td>
</tr>
<tr>
<td>Dehydration</td>
<td>10.3%</td>
</tr>
<tr>
<td>CHF</td>
<td>11.6%</td>
</tr>
<tr>
<td>UTI</td>
<td>14.2%</td>
</tr>
<tr>
<td>Skin ulcers, cellulitis</td>
<td>4.9%</td>
</tr>
<tr>
<td>COPD, asthma</td>
<td>6.5%</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>80.3%</strong></td>
</tr>
</tbody>
</table>

See MedPAC June 2017 Report to Congress, Chapter 9 discussion

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Institutional Special Needs Plans

- **Characteristics**
  - Medicare Advantage
  - Active in 30 states
  - Risk share
  - No FFS coverage
- **Goals**
  - Reduce hospitalization
  - Lower spending
  - Optimize HCC scores
- **SNF Payment Mechanism**
  - No impact on R&B/CMI
  - Capitation + shared savings
  - Compare to historical FFS $

RAH / Enhanced Care Coordination Providers

- **Characteristics**
  - Medicare FFS (CMMI)
  - 250 SNFs in 7 states
    - AL, IN, MO, NE, NV, NY, PA
  - No risk, No FFS impact
- **Goals**
  - Reduce hospitalization
  - Lower spending
  - Disease specific
- **SNF Payment Mechanism**
  - No impact on R&B/CMI
  - Supplemental per diem
  - Up to $218/day
Results:
Enhanced Care Coordination Providers

NY-Reducing Avoidable Hospitalizations

- NY-RAH: NYC pilot program with 29 participating SNFs
- ECCP’s education-based program to assist SNFs in identifying causes of potential avoidable Hs and enhancing procedures to prevent them
- 9% reduction in all-cause H in 2015 compared to 2012
- Outcomes suggest H reduction in 7 of 8 utilization estimates
- Total estimated Medicare and physician $ showed small increases during 4-year eval period, while all other expenditures decreased
- The mixed $ results suggest that the hospitalizations prevented by the ECCPs may be exclusive to lower-cost initiatives, while more expensive hospitalizations remain burdensome.

https://innovation.cms.gov/initiatives/rahnfr/
2018 SNF PPS Final Rule & ANPRM

- **1% payment update effective 10/1/17 ($370M)**
  - 2.6% less ACA productivity adjustment and “Doc Fix” limit
- Revise/rebased market basket index base year and enhance detail of cost/category weights for SNF MBI
- Details on SNF Value-Based Purchasing (VBP) and Quality Reporting Program (QRP) measures (Rate impact 10/1/18)
  - 2% MBI penalty for SNFs that do not satisfy QRP requirements
  - VBP withhold of 2% for FY 2019 based on CY 2017 re-H rate and level of improvement that can be “earned back” by qualifying SNFs (available funds = 60% of withhold)
- CBSA - AWI changes – some big winners & losers
- **Advanced Notice of Proposed Rulemaking: RCS-I**

### 2018 CBSA / AWI % Changes

<table>
<thead>
<tr>
<th>Area</th>
<th>2018</th>
<th>2017</th>
<th>Change</th>
<th>$/0.01</th>
<th>$/Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York Rural</td>
<td>0.8494</td>
<td>0.8408</td>
<td>0.0086</td>
<td>$2.95</td>
<td>$2.54</td>
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<tr>
<td>Albany-Schenectady-Troy</td>
<td>0.8160</td>
<td>0.8217</td>
<td>(0.0057)</td>
<td>$2.95</td>
<td>(1.68)</td>
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<tr>
<td>Binghamton</td>
<td>0.8441</td>
<td>0.8521</td>
<td>(0.0080)</td>
<td>$2.95</td>
<td>(2.36)</td>
</tr>
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<td>Buffalo-Cheektowaga-Niagra</td>
<td>1.0590</td>
<td>1.0506</td>
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<td>Dutchess-Putnam County</td>
<td>1.1199</td>
<td>1.1330</td>
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<td>(3.86)</td>
</tr>
<tr>
<td>Elmira</td>
<td>0.8497</td>
<td>0.8794</td>
<td>(0.0297)</td>
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<td>(8.76)</td>
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<td>Glens Falls</td>
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<td>0.8042</td>
<td>0.0309</td>
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<td>$9.12</td>
</tr>
<tr>
<td>Ithaca</td>
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<td>0.9455</td>
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<td>(1.21)</td>
</tr>
<tr>
<td>Kingston</td>
<td>0.8888</td>
<td>0.9106</td>
<td>(0.0218)</td>
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<td>(6.43)</td>
</tr>
<tr>
<td>Nassau-Suffolk County</td>
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<td>$2.15</td>
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<tr>
<td>NYC-White Plains</td>
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<td>(2.42)</td>
</tr>
<tr>
<td>Rochester</td>
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<tr>
<td>Syracuse</td>
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<td>0.9899</td>
<td>0.0116</td>
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</tr>
<tr>
<td>Utica-Rome</td>
<td>0.9316</td>
<td>0.9100</td>
<td>0.0216</td>
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<td>$6.37</td>
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<tr>
<td>Watertown-Fort Drum</td>
<td>0.9950</td>
<td>0.9224</td>
<td>(0.0726)</td>
<td>$2.95</td>
<td>(5.13)</td>
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</table>
SNF Reimbursement

• Significant changes to all components since 1999
  • Medicare Part A
    • Cost-based to PPS RUG-III, refinement, MDS 3.0/RUG-IV, recalibrations
  • Medicare Part B (therapy)
    • Cost-based to Fee Screen, Consolidated Billing, Annual Caps, MPPR
  • Medicare Part B (other ancillary)
    • Allowance limitations, Consolidated Billing, Competitive Bidding
  • Medicaid
    • Cost-based to CMI, Budget Adjustment Factors
• Managed Care and Value-Based Payment programs have been superimposed on our entire revenue stream

New Concepts in SNF Reimbursement Management

• “Value, Value, Value”
• Analytics – applied to everything!
  • Variable, Condition-Specific, Functional, Quality, Outcomes, Episodic…
• Scaled Risk and Statistics
• Shared Savings
• Care Management Technology
• Interoperability
• Diversion / Treat-in-Place / TeleHealth
• Care Transitions
• Conflicting Utilization Incentives
Analytics

- **Efficiency measures:**
  - Re-H rate 30/60/90 days; Average cost of an episode; ALOS; **Case-Mix Adjusted?**

- **Quality measures:**
  - 5-star; functional measures

- **Patient Satisfaction measures:**
  - Patient Reported Outcome (PRO) data, overall satisfaction, recommend to others?

- What are we measuring?
- Can it be measured?
- What are we using it for?
- Is it comparable?
- What is the source?
- Is the source accurate?
- MDS, UB-04, EMR

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2017 OIG Workplan

<table>
<thead>
<tr>
<th>MDS / Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare payment. Previous OIG work found that SNFs are billing for higher levels of therapy than were provided or were reasonable or necessary. We will review the documentation at selected SNFs to determine if it meets the requirements for each particular resource utilization group.</td>
</tr>
</tbody>
</table>

OAS: W-00-16-35784  •  Expected Issue Date: FY 2017

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SNF PPS Requirement

Medicare requires a beneficiary to be an inpatient of a hospital for at least 3 consecutive days before being discharged from the hospital to be eligible for SNF services (SSA § 1861(j)). If the beneficiary is subsequently admitted to an SNF, the beneficiary is required to be admitted either within 30 days after discharge from the hospital or within such time as it would be medically appropriate to begin an active course of treatment. Prior OIG reviews found that Medicare payments for SNF services were not compliant with the requirement of a 3-day inpatient hospital stay within 30 days of an SNF admission. We will review compliance with the SNF prospective payment system requirement related to a 3-day qualifying inpatient hospital stay.

OAS: W-00-16-30014  •  Expected Issue Date: FY 2017

Potentially Avoidable Hospitalizations of Medicare- and Medicaid-Eligible Nursing Facility Residents

High occurrences of patient transfers from nursing facilities to hospitals for potentially preventable conditions could indicate poor quality of care. Prior