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Reading the Tea Leaves:

Fortune-Telling an Uncertain Future for Senior Services

LSA Strength and Service Series

10 March 2021

Lutheran Services in America

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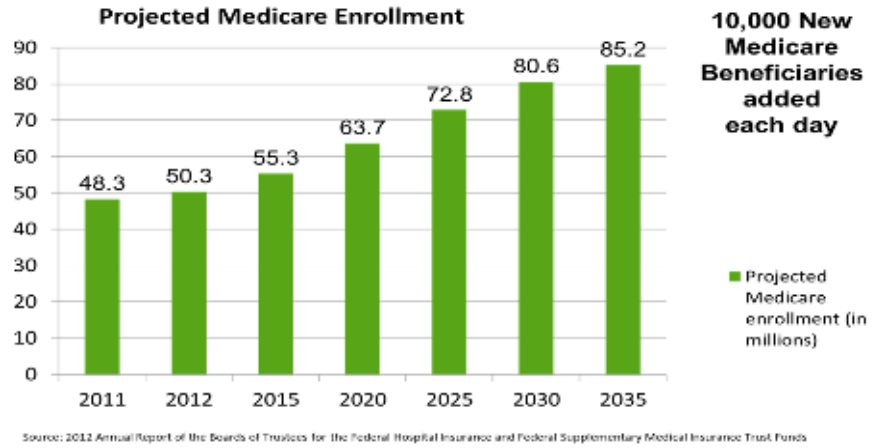
The Backdrop: Forces, Payers and Change

What's Keeping People Up At Night?

- COVID, COVID, COVID
- Shifting clinical needs and the regulatory merry-go-round
- Will volumes ever return to normal?
- How do we stay relevant or essential in our markets?
- What are hospitals and payers thinking?
- What's it all mean?

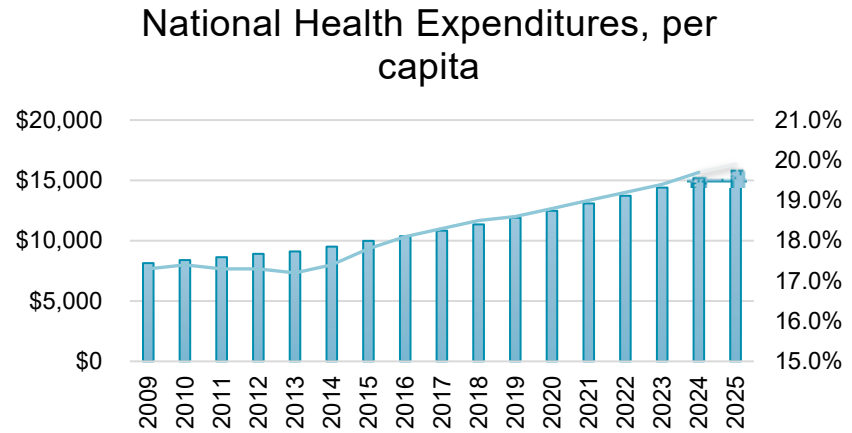
Drivers for a Burning Platform

1. Aging Population

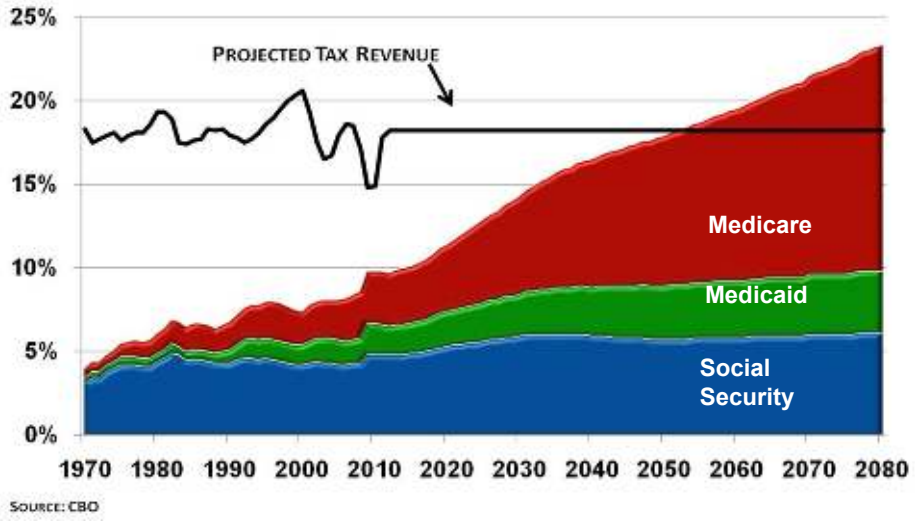


Source: 2012 Annual Report of the Boards of Trustees for the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds

2. Significant Spend Increase

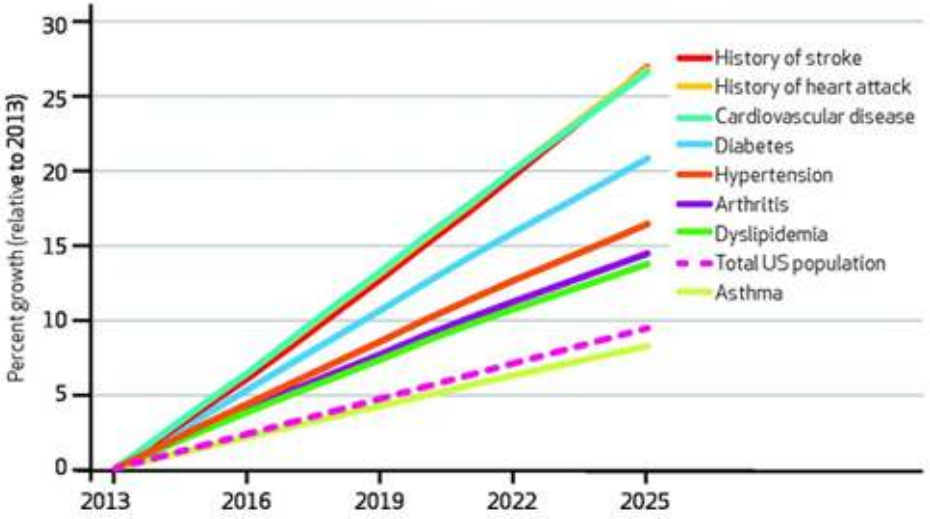


3. Not Fiscally Sustainable

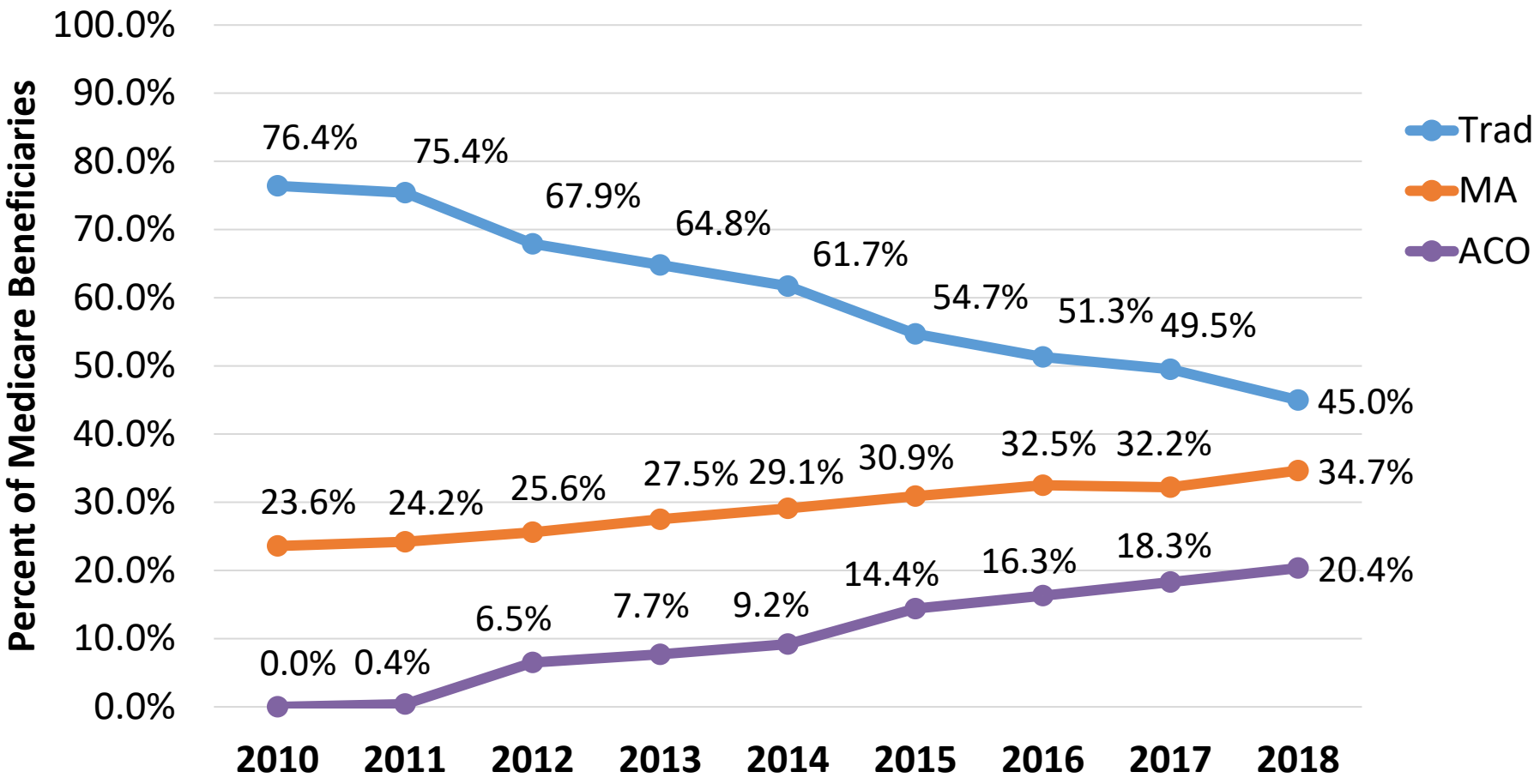


Source: CBO

4. Chronic Conditions



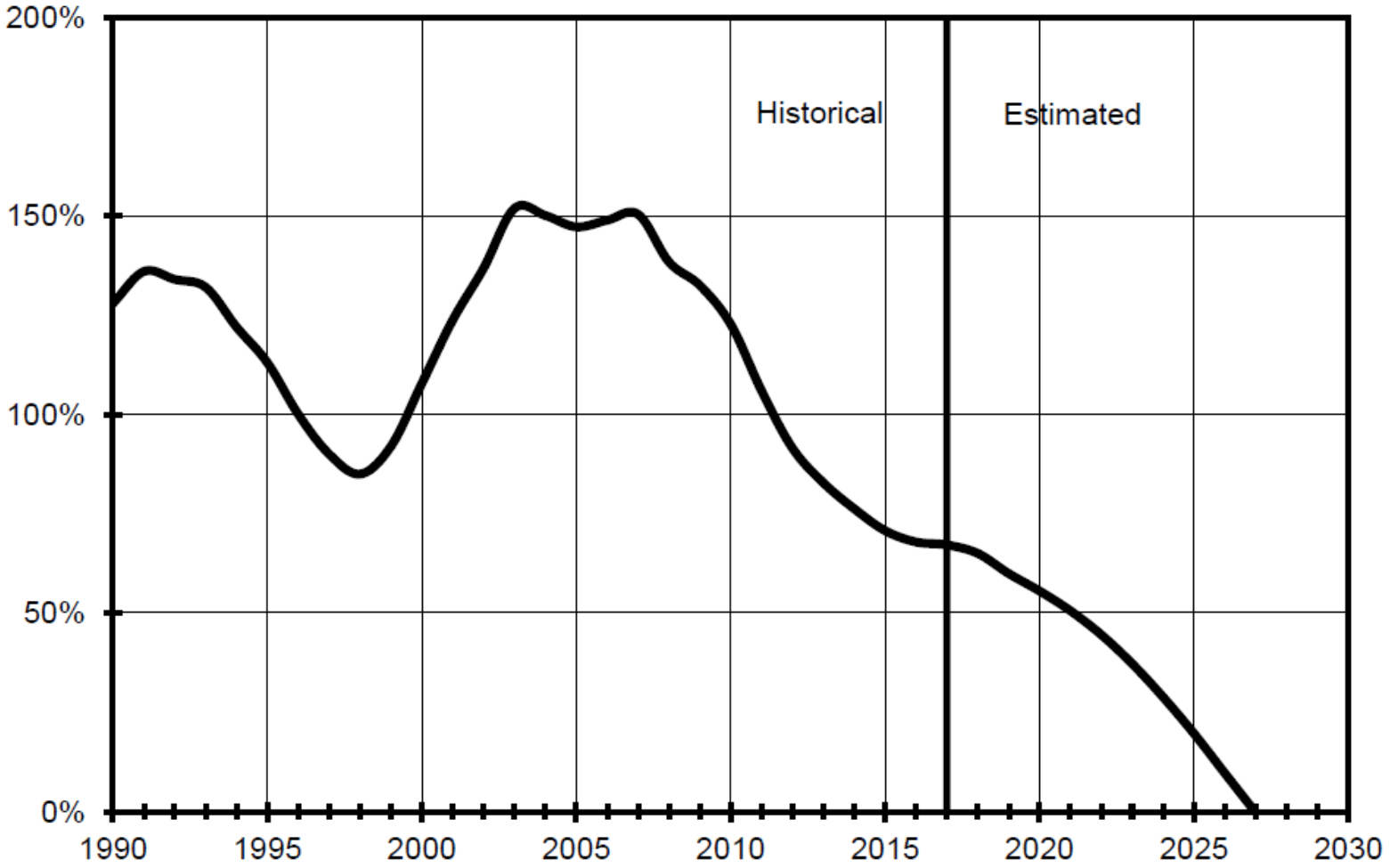
Medicare: FFS/MA/ACO Trends Speak for Themselves



Sources: FierceHealthcare: https://www.fiercehealthcare.com/healthcare/healthcare-outlook-for-2018-expect-more-m-as-and-unpaid-medical-bills-and-a-refocus
Medicare Enrollment Dashboard: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard.html
Medicare Shared Savings Program: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/SSP-2018-Fast-Facts.pdf
2017 Next Generation ACO Model: https://innovation.cms.gov/Files/fact-sheet/nextgenaco-fs.pdf

Medicare Part A Trust Fund Insolvent by 2027…or Sooner

Figure II.E1.—HI Trust Fund Balance at Beginning of Year as a Percentage of Annual Expenditures



Post-COVID-19 Drivers Impacting Thinking

Financial stability

- Capital partners, consolidations, & new arrangements among providers and plans
- Need for integration, efficiencies, how to rationalize and consolidate services

Federal / state deficits

- FFS payment cuts, Medicare Advantage, and managed Medicaid reductions
- Providers can position value-based payment and risk as a better way forward / more consistent payments

Health plans, disruptors (venture capital-backed PE, standalone entities)

- Positioning to own health care delivery assets given access to capital / clinicians' desire for stable income
- Increasing alignment and integration among physician, hospitals, systems and even payers to foster outcomes and savings

Patient fears of returning, preferences for new care delivery models (e.g., telehealth, home care, home dialysis, etc.)

- Major providers must reconsider strategy, delivery and asset allocation, likely away from bricks and mortar

Unemployment, uncompensated care, changing payer mix

- Intensifying social determinants of health and behavioral health needs
- Focus on cost management, utilization and containment

Fiscal Realities, Spending and the Part A Trust Fund

Realities

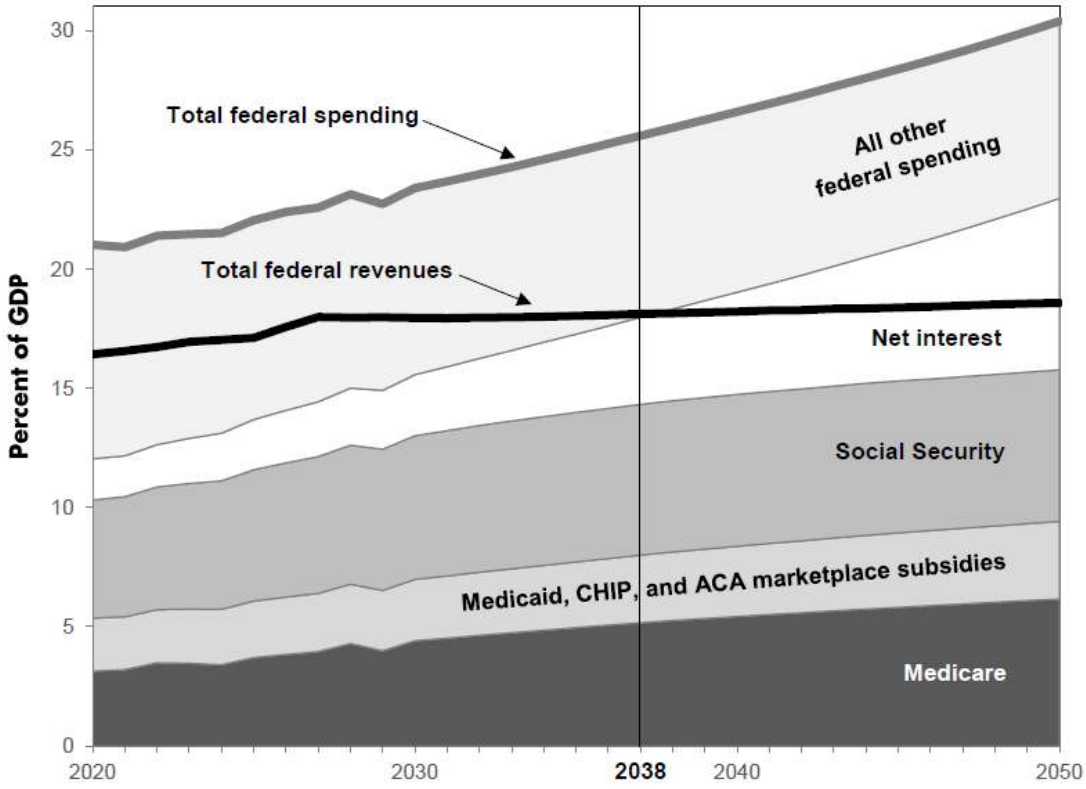
- Medicare Trust Fund depleted as early as 2023

Drivers

- Aging population
- Rising costs
- Lower tax revenue
- Growth of chronic disease

Figure 1-9. Spending on Medicare, other major health programs, Social Security, and net interest is projected to exceed total federal revenues by 2038

[Data updated since March 2020 report]



Note: GDP (gross domestic product), CHIP (Children's Health Insurance Program). The potential effects of the COVID 19 pandemic are not included in these projections.

Potential Approaches to Mitigating Crisis

Increase funding

- Raise Medicare taxes
- Tie Part A to General Revenue
- Means testing / increase Medicare premiums for higher-income beneficiaries (Part B and D)

Alter available benefits

- Reduce benefits
- Enhance attractiveness of Medicare Advantage plans through benefit enhancements
- Raise eligibility age
- Medicare shift to a premium support plan

Adjust payment model

- Significant FFS payment reduction / Site neutrality
- Shift risk to willing participants through APMs
- Create incentives for MA growth through payment updates

Adjusting the Payment Model

Total cost of care models

- Medicare Shared Savings Program – Basic or Enhanced Track
- Next Gen ACO
- Direct Contracting – Professional, Global, or Geographic

Primary-care Focused Models

- Comprehensive Primary Care Plus
- Primary Care First
- Primary Care First – High Needs populations

Episodic Payment Models

- Bundle Payment for Care Improvement – Advanced
- Comprehensive Joint Replacement
- Oncology Care Model

Bundled Payment About to Shift Hard and Fast

- Given the arc of Medicare funding and historic performance, CMMI is revising the Bundled Payment for Care Improvement Advanced initiative
- If current participants elect to continue, they must shift their participation into broader clinical categories by 2021 (eliminating past efforts to choose "select" options)
- All of this is **building up to a MANDATORY, nationwide bundled payment program** – likely in 2023

Clinical Episode Service Line Groups (CESLGs)

34 procedures or diagnoses across eight CESLGS, encompassing common high-volume hospital procedures:

1. Cardiac Care
2. Cardiac Procedures
3. Gastrointestinal Surgery
4. Gastrointestinal Care
5. Spinal Procedures
6. Neurological Care
7. Orthopedics
8. Medical and Critical Care

Many of these traditionally involve PAC, often in a SNF or HHA

Site Neutral Payment Marches Forward

- The IMPACT act required MedPAC to explore a site-neutral payment system by 2018 for deployment by 2023
- MedPAC's updated evaluation in June 2016 proposed an accelerated adoption timeframe to 2021.

Payment Model Features

- Common unit of service (i.e., a stay or episode) with a patient characteristic risk-adjustment system
- Payment adjustment to reflect lower costs in HHA settings.
- Separate payments for routine and therapy services and for non-therapy ancillary services such as drugs
- Outlier policies for unusually high-cost stays and unusually short stays.

Site-neutral is essentially DRGs for post-acute care – an episodic model that will demand service need evaluation upon admission, proactive LOS management, and aggressive quality/performance management

PAC Unified PPS Goals

- Payments would be based on patient acuity rather than the PAC setting.
- Providers would have fewer incentives to selectively admit some patients over others because payment would track patient resource needs better

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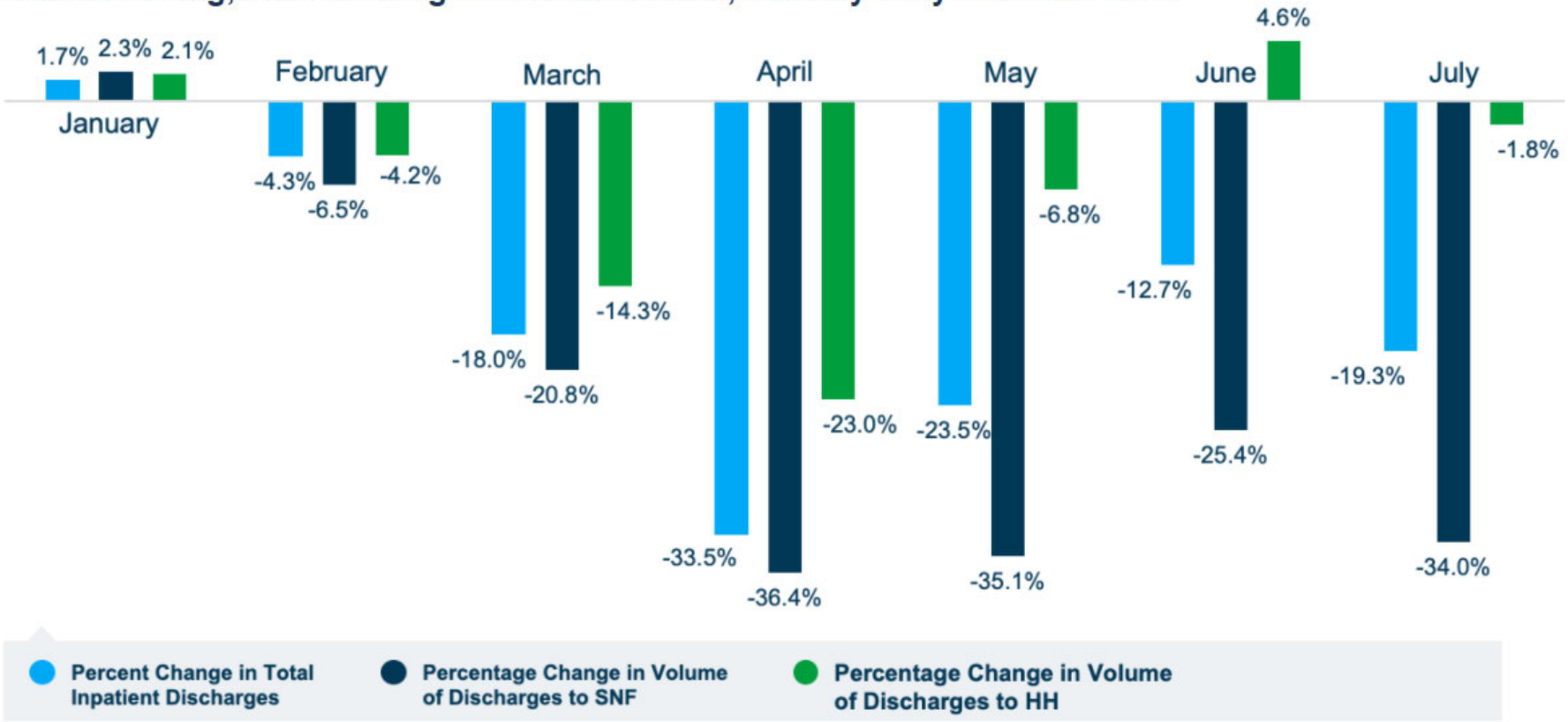
Post-COVID Realities and the Near-Term

Staggering Impacts Across the Board...

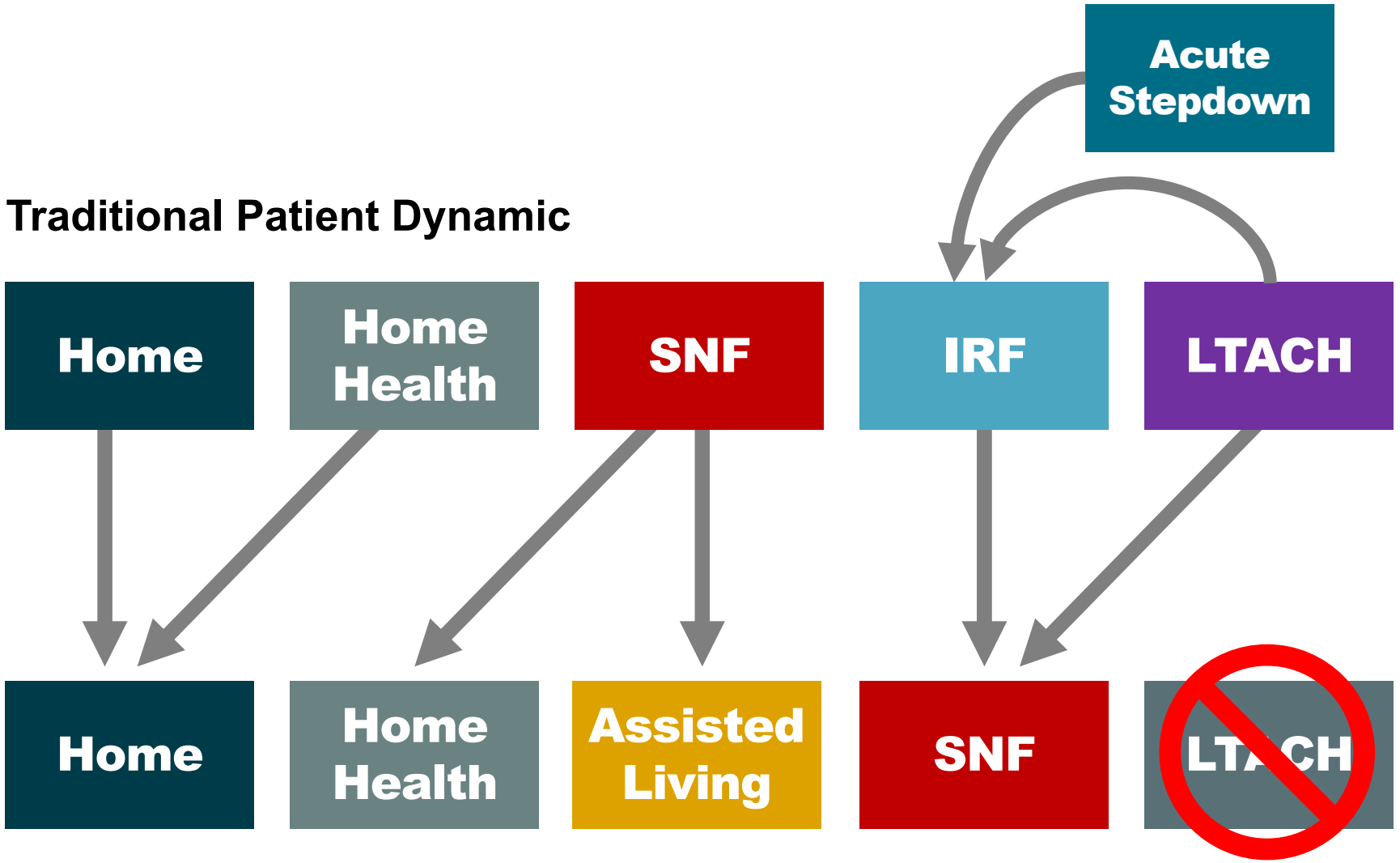
Figure 1. Year-Over-Year Percentage Change in Total Inpatient Hospital Discharges, Discharges to Skilled Nursing, and Discharges to Home Health, January–July 2019 and 2020



Source: Avalere analysis, 2020.


EXIT 12
SNF
Straight
Home

The Increasing Slide of Acuity Pushdown



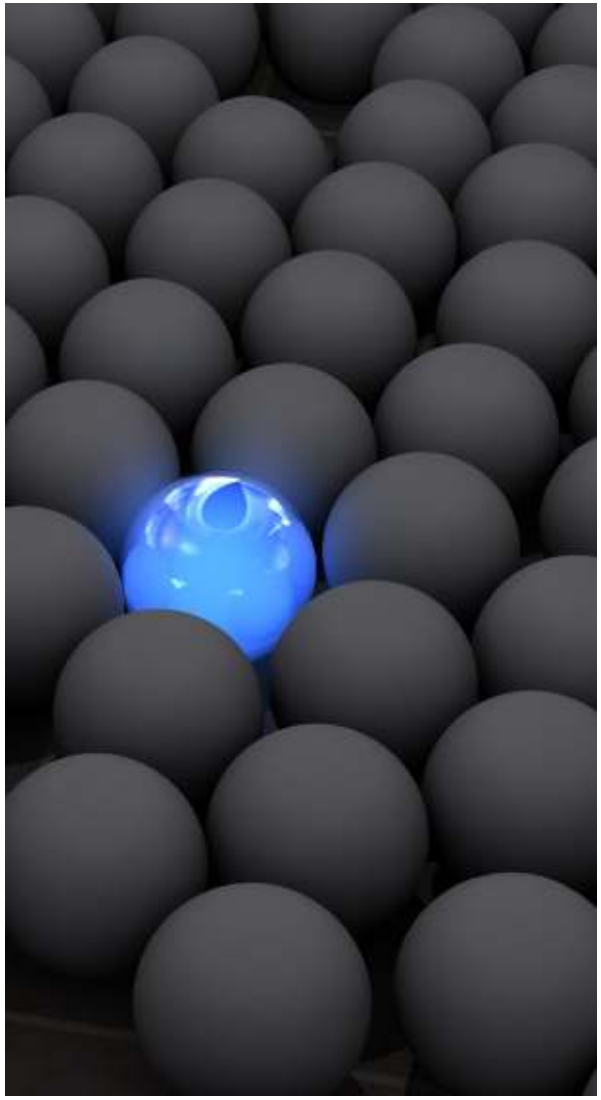
Fundamental Focus...

In the near to short-term, the focus should likely to be primarily around key revenue drivers (i.e., SNF) and focusing on the fundamentals:

- Reaffirming referral status
- Growing capabilities
- Outlining paths to partnership

#1: Reaffirming Preferred Provider Status

- Leading edge **clinical/programmatic alignment with hospitals and payers**
- Demonstrated **infection control management** and outcomes
- Optimized use and **capabilities around telemedicine**
- Low/near zero hospital readmissions and best-in-class approaches to **post-SNF transitions of care**
- High patient satisfaction (>90%)
- Robust **continuous quality improvement with documented results**
- **Cost of care is lowest** in comparison to peers with comparable or better quality



#2: Growing Clinical Capabilities

- **STANDARDIZATION!**
- Consistent use of evidence-based clinical pathways to support complex patients and decision support tools to manage high-acuity
- **Medical Management:** Increasing primary care resources to improved coverage and engage directly in clinical oversight and medical management
- Developing internal capacity for self-directed utilization management that tracks all “at-risk” populations
- Understand direct-care costs associated with particular patient types – CHF, TJR, UT, COPD
- Growing beyond EHR to informatics to predict and drive CQI, rather than retrospective QA

#3: Strength in Numbers: Partnering/Consolidation

- Sales, mergers, and consolidations of standalone SNFs and SNF organizations around the country offer a compelling vision of the future for many – **fewer providers overall is the future**
- Managed care contracting models, IPAs and clinical integration models offer a step-wise introduction to both risk and closer alignment
- **Joint venture relationships with health systems may emerge** as a renewed consideration in many markets around the country
- Understanding your collective "value" or partnership "capital" is an important consideration in defining a future partnering strategy

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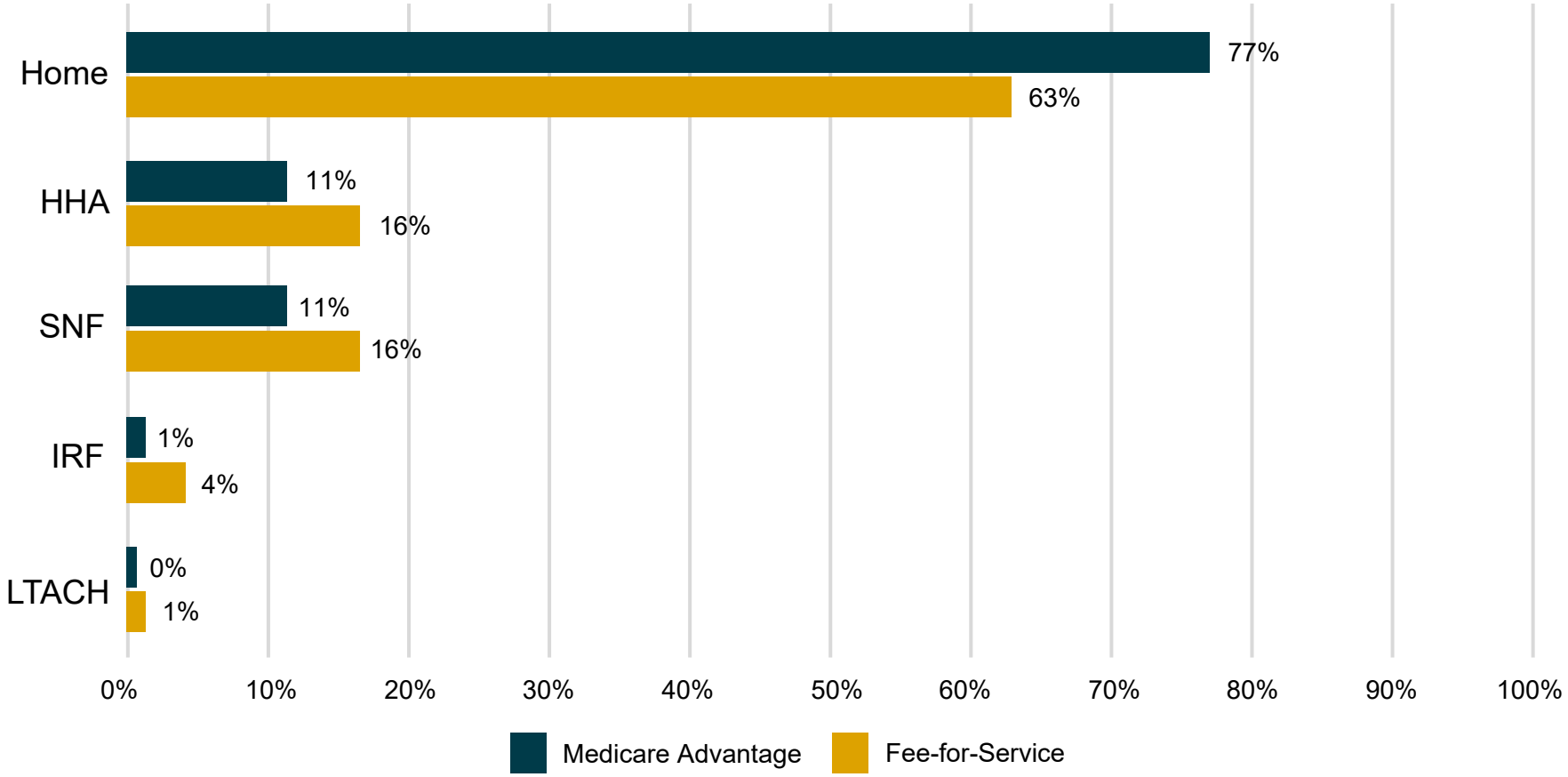
Looking Farther Down the Road…


HOUSTON
WE HAVE A
PROBLEM

Medicare Advantage Use Paints a Future Picture

Discharge Destination Following an Inpatient Stay by Payer Type (MA vs. FFS)



Source: Avalere analysis utilizing Medicare FFS and MORE Medicare Advantage claims data.

The CHRONIC Care Act of 2017

- The CHRONIC Care Act of 2017 (CCA) allows Medicare Advantage plans to cover many “non-traditional/non-medical” services – like transportation, nutritional supports, support for ADLs and so on.
- This shift is ideally and specifically aligned for many of the services that eldercare providers could provide in the home
- Expanded services under MA may further the acceleration of MA penetration in many markets – increasing opportunity and challenge for aging services organizations
- But management of these offerings represents a potential challenge for payers and competition in this space may be particularly profound

2020-2030: The Decade of Home Health

The next 10 years will see rapid and dramatic growth of home health services – given payment, capabilities and preference

HHA is THE Platform

- For ACOs, bundlers, payers and other risk entities, HHA is the best rock upon which everyone is building their community strategy
- Home Health – unlike hospice – operates under multiple payment scenarios and by multiple payer types
- Value-based organizations and payers seeking capable HHA to shorten LOS and avoid other PAC
- In-home tech use is already soaring in HHA and will be an essential adjunct to address the growing demand

Home Health Giants Look to Accelerate Diversions, Capitalize on 'Long Haul Back for the SNFs' Post-COVID

Skilled Nursing News

By Alex Spanko | July 7, 2020


Moving Upstream...
Follow the Money!
• Payers
• Value-Based Entities
• Government

Evolving Risk Considerations & Strategies…

Three Common Approaches

Physician Strategies

- Seeking strategic partnerships to advance primary care – either in-situ or in the home
- Positions for evolving models tied to physician scale and payment but volume is key

Institutional Special Needs Plan

- Taking direct Medicare risk for an institutional population and managing utilization of services
- Requires more infrastructure and likely a partner but garners greater control (and $) overall

Community-Based Care Management

- Building models to address special or high-risk populations (i.e., disease specific or income-qualified)
- Typically involves an alternative payment model (commonly at-risk) that requires scale over the long-term

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Thinking Strategically

Emerging Organizational Tiers & Value-Based Enterprises

Healthcare is permanently changed as a result of the economic stress of COVID-19, organizational tiers are emerging, based on fiscal strength and market position

- **Tier 1:** Lightly affected organizations will be in a strong position to build scale and invest in capabilities that build competitive strength in their markets.
- **Tier 2**: Moderately affected organizations may have an opportunity to rebuild with a well-executed recovery strategy and remain viable as an independent organization.
- **Tier 3:** Heavily affected organizations will have limited choices. Although damaged, they may still be attractive acquisition targets depending on attributes or rebuilt with investment.

Near term, organizations will be forced to configure services flexibly to manage the pandemic and ramp up revenue-generating volume

Emerging Tiers: Key Takeaways

- Regardless of how impacted, organizations will look to **develop scale through consolidation and delivering services remotely**
- Rising unemployment and COVID costs will drive **reimbursement further to capitation and two-sided risk**
- Providers will increasingly seek the financial certainty of payments offered by value-based care and risk
- **The end game is the Value Based Healthcare Enterprise**

Where do Aging Services organizations land in this space?

Tiers Tied to Financial Position and Market Presence Will Define Potential Recovery Options

Tier 1 Provider

TYPE OF PROVIDER

- **Large regional provider or organization with an expansive geographic footprint**
- Owns or has formal arrangements with providers across the entire continuum of care
- Healthy cash reserves on-hand
- Value-based/risk-sharing payment model(s)

RECOVERY PLANNING AREAS OF FOCUS:

- Pursue full-risk payment models at an expedited pace
- Partner with innovative technology companies (e.g., patient contact tracking)
- Expand telehealth capabilities
- **Acquire providers** across the continuum

Tier 2 Provider

- **Community-based provider organization with some scale**
- Modest to strong presence within local market
- Few or no formal arrangements across the continuum of care
- Financial position and ability to take on more debt has been compromised Modest cash reserves on-hand
- Fee-for-service business with limited value-based payment model(s)

- **Look for capital partners** through acquisitions (i.e. other providers of similar type, health system, or for-profit operator)
- If able to remain independent, shore up financial position through operational restructuring and well-executed strategic growth

Tier 3 Provider

- **Stand-alone entity**
- Limited presence within local market
- Limited service line offering
- No formal arrangements across the continuum of care
- No cash reserves on-hand → high-risk of closure
- Fee-for-service business with high Medicaid and self-pay payer mix

- **Look for capital partners** (i.e. private equity group)
- If capital investors are not interested, cease operations
- If capital investors are interested, look at feasibility to re-purpose operations (e.g., stand-alone ED, outpatient facility, post-acute facility, etc.)

Questions?

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Thank You!

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