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Health Care Market Intelligence 2016

Post-Acute Care Summary Report–Q2

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1. Key Findings

- **CMS** proposed an $800-million Medicare payment increase for **SNFs** in FY 2017, a 2.1% increase from this year, while **hospice** payments would rise by $330 million, or 2%. **Home healthcare** agencies may see a 1% drop in Medicare reimbursement in 2017 after the CMS proposed rates that pay agencies $180 million less next year than in 2016.
- The **U.S. Supreme Court**'s ruling in Universal Health Services v. United States held that the theory of implied false certification is "in certain circumstances" an acceptable basis of liability in **False Claims Act** cases. The unanimous decision instructs a lower court to re-examine a ruling allowing Universal to face an FCA lawsuit for allegedly employing unlicensed and unsupervised staff.
- **Cybersecurity** remains an ever-present priority for healthcare authorities. Providers must ensure ongoing compliance with the latest requirements, especially as the use of data to guide care decisions continues to grow.
- **Medicare Part D** spending received ample attention when a **MedPAC** report to Congress warned that rising drug costs and other factors helped drive Part D spending up nearly 60% from 2007 to 2014. A MedPAC advisory panel also voted to back a variety of changes to the prescription drug program that could save as much as $10 billion over five years.

2. Industry Trends

- **Skilled nursing facility** prices saw an average price of $85,900 per bed in 2015, representing a 12% increase in the average price per bed from 2014, which also saw record price increases. The **assisted living** market similarly saw average prices increase, reaching $189,200 per unit in 2015. The only senior care sector where prices declined was the **independent living** community market.
- Critics say **hospice care** has few set quality requirements and low barriers to entering the business, making the system vulnerable to **fraud and abuse**. Federal investigators prosecuted more than 60 cases of Medicare fraud involving hospice care in 2015, involving hundreds of millions of dollars across the U.S.
- The Centers for Disease Control and Prevention found **nursing home discharges** increased, while **occupancy rates**, the number of facilities and revenues all dropped. Some operators are expanding into other areas, such as hospice and home health, to diversify their products.
- The **skilled nursing facility** sector is expected to see demand increase in the long term due to the growing number of people with **chronic diseases**. However, SNF construction was projected to slow in 2016, while overall supply will continue to drop as older facilities close.
- While Medicare's hospice program is designed for patients who aren't expected to live more than six months, it is often used by patients **with long-term conditions**. Despite accounting for just 1.3% of Medicare hospice patients, this group received 14% of total **Medicare hospice spending** from 2005-2013, during which time spending approximately doubled to reach about $15 billion.
- **Nursing homes** are increasingly phasing out the use of personal alarms, fall mats and other long-used **fall prevention** measures in favor of more proactive, attentive care. There's growing evidence that alarms and other measures do little to prevent falls and can instead contribute to falls by surprising residents, creating an uneven floor surface and instilling complacency in staff.
- Researchers found that in the year after seniors reach **Medicare** eligibility, there is close to a 10% increase in those seeking **rehabilitation care** services.
- A **CMS** report found use of **antipsychotic medications** in nursing homes has declined 27% since the launch of the National Partnership to Improve Dementia Care in Nursing Homes. The prevalence of antipsychotic use in nursing homes fell to 17.4% in Q3 2015, with results varying by state.

3. Transactions

- **Genesis HealthCare** completed the divestiture of the majority of its home health and hospice operations. The operations were sold to community-based hospice and palliative care network **Compassus** for $72 million in cash and a $12-million short-term promissory note.
- **Kindred Healthcare** sold two and acquired four long-term acute care (LTAC) hospitals from **Select Medical Holdings**. The swap agreement saw Kindred acquire leased hospitals in four cities, while Select acquired one owned and one leased hospital, both in Cleveland.
- **Avalere**, **Inovalon** and **Kindred Healthcare** entered into a multi-year agreement to utilize data and analytics to engage payers in the post-acute care space. The partnership will give Kindred access to a data-driven platform to improve clinical outcomes, while hospitals and health plans will receive access to patient-level assessments of post-acute care value to inform site selection and contracting decisions.
- **Magellan Health** acquired **The Management Group**, a Wisconsin-based long-term services company that supports nearly 13,000 individuals with physical disabilities, adults with developmental disabilities and frail elders, with a special focus on self-directed long-term services.
- **TeamHealth** bought **IPC Healthcare** for $1.4 billion. The deal allows TeamHealth, which provides contract workers for emergency rooms and hospitals, to expand into IPC's specialist area of post-acute care, such as nursing homes and assisted-living facilities.
- **Humana** partnered with **Guthrie** to form an ACO initiative for Humana's 4K Medicare Advantage members in north central Pennsylvania and south central New York.
- Conn.-based **MedOptions**, a provider of outsourced behavioral health services to skilled nursing and assisted living facilities, acquired Calif.-based **Vericare**, a behavioral health clinical care provider. The combined business is expected to create the sole national provider of outsourced behavioral health services to long-term care facilities, serving more than 180,000 beds across more than 1,500 facilities.
- **Almost Family**, a home health nursing services provider in 14 states, acquired Natick, Mass.-based **Long Term Solutions**, one of the largest providers of in-home nursing assessments for the long-term care insurance industry for $20 million in cash, a $6-million note payable and $11 million in stock.

4. Reimbursement

- State officials in **Ohio** requested federal approval to charge a monthly **Medicaid** fee to covered Ohioans. The proposal would require certain adults in Medicaid to pay into an HSA to help cover their medical expenses. If approved, the new charges would be imposed in 2018.
- **CMS** proposed an $800-million Medicare payment increase for **SNF** in FY 2017, a 2.1% increase from this year, while **hospice** payments would rise by $330 million, or 2%. The proposal also includes the creation of an SNF purchasing program that would provide value- and performance-based financial incentives beginning in FY 2019.
- **Home healthcare** agencies may see a 1% drop in Medicare reimbursement in 2017 after the **CMS** proposed rates that pay home health agencies $180 million less next year than in 2016.
- The Michigan Health Endowment Fund's **Michigan Medigap Subsidy** includes $120 million in funding over four years to help low-income seniors and disabled individuals pay for Medigap insurance, used to supplement Medicare.
- The U.S. **Department of Housing and Urban Development** proposed in a draft handbook for the Section 232 Healthcare Mortgage Insurance Program, which includes changes that could make it easier for **senior housing**, **assisted living** and **residential care** companies to obtain financing.

5. Enforcement/Regulatory

- The **U.S. Supreme Court**'s ruling in Universal Health Services v. United States held that the theory of implied false certification is "in certain circumstances" an acceptable basis of liability in **False Claims Act** cases. The unanimous decision instructs a lower court to re-examine a ruling allowing Universal to face an FCA lawsuit for allegedly employing unlicensed and unsupervised staff.
- Medicaid's spending on **long-term care** is disproportionately high for the number of beneficiaries receiving it, according to the **Medicaid and CHIP Payment and Access Commission**'s June Report to Congress. Medicaid funds one-third of all nursing facilities in the U.S. and paid $169 billion on long-term care in 2012, which accounted for approximately 43% of Medicaid's total expenditures that year even though only 6.2% of Medicaid beneficiaries required such services.
- The **CMS**' FY 2016 to 2017 **Nursing Home Action Plan** outlined five strategies to guide efforts by the **Division of Nursing Homes** to improve safety and quality: Enhance consumer awareness and assistance; strengthen survey processes, standards and training; improve enforcement activities; promote quality improvement in specific areas; and create strategic approaches through partnerships between healthcare stakeholders.
- **CMS** released a final rule outlining updated **fire protection guidelines** for certain healthcare facilities. The provisions gave LTC facilities more flexibility in what they can place in corridors, allowing them to have home-like items, such as fixed seating in the corridor, and some decorations in patient rooms, such as decorative items.
- **HHS** reported **hospices** often bill **Medicare** for a higher level of care than patients need. Investigators found Medicare often pays twice for the prescription drugs provided to people who are terminally ill, at an extra cost of more than $260 million a year.
- Post-acute care providers were among 301 doctors, nurses and other medical professionals charged in the largest-ever healthcare fraud takedown. The sweep, led by **Medicare Fraud Strike Force** teams, uncovered schemes totaling $900 million and included violations of anti-kickback laws to aggravated identity theft. Many of the cases involve alleged false claims or kickback schemes made by **home healthcare** agencies.
- The **Department of Labor** issued the final version of its so-called persuader rule, which requires employers to report **anti-union** and **collective bargaining activity** to employees. It also requires employers to disclose any relationships with labor consultants hired to dissuade employees from unionizing.
- The U.S. Court of Appeals for the Seventh Circuit ruled against Wisconsin-based healthcare software provider **Epic Systems**, finding that companies can't require employees to sign arbitration clauses blocking them from banding together in legal actions.
- Eden Prairie, Minn.-based **Evercare Hospice and Palliative Care**, now **Optum Palliative and Hospice Care**, agreed to pay $18 million to resolve Department of Justice allegations that it knowingly claimed Medicare reimbursement for hospice care for patients who weren't terminally ill.

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5. Enforcement/Regulatory *(continued)*

- The U.S. Court of Appeals for the District of Columbia ruled **ManorCare of Kingston**, a SNF in Kingston, Penn., has the right to refuse to bargain with its union after it ruled employees made credible threats of violence during the 2013 union election.
- New York-based **CenterLight Healthcare** reached a $47-million settlement of claims it fraudulently enrolled more than 1,200 Medicaid beneficiaries. The skilled nursing, rehabilitation and home health company will pay approximately $28 million to New York's Medicaid program and $19 million to the federal government.
- In a federal whistleblower lawsuit filed on behalf of a former nurse, the U.S. is accusing Virginia hospice company **Caris Healthcare** of using its patients to take millions of dollars from the Medicare and Medicaid programs.