A Proskauer Webinar Series

State of Home Care: Tailwinds and Headwinds

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Overview: Tailwinds and Headwinds

- Fragmented Market Creates Opportunities to Grow Market Share
- COVID-19 and the End of the Public Health Emergency
- The “Care at Home” Movement
- Our Aging Population and the Growth of Medicare Advantage
- Labor
- Reimbursement Risks and Opportunities
- Recent Lawsuits and Regulatory Scrutiny

Fragmented Market Creates Opportunities to Grow Market Share

- Overview
  - $55 billion industry and growing annually 4-5%.
  - Thirty acquisitions closed in the first quarter of 2022, up 15% year-over-year.
  - Number of Medicare Certified Home Care Agencies declining.*
    - 2020 there were 9,378
    - 2019 there were 9,893
    - 2014 there were 10,852.
  - Number of Medicare episodes increasing.*
    - 2017 – 4.1 M Part B Home Health Episodes
    - 2021 – 7.4 M Part B Home Health Episodes
  - Many of the home health operators in this fragmented market are still small (employing less than 50 people).
    - However, due to their size, they may not be able to diversify their businesses to introduce other service lines (e.g., hospice care, etc.) in order to be able to continue to compete with other larger home health providers.

*Research Institute for Home Care's 2022 Home Care Chartbook

Mega Deals – Payors are Buying into Home Health

- United Healthcare's $5.4 billion acquisition of LHC Group, announced in March 2022 and closing February 2023.
- Humana's hallmark $5.7 billion acquisition of Kindred at Home in August 2021. (Now rebranded as CenterWell Home Health and Humana divested majority interest in 2022.)
  - Humana just announced closing SeniorBridge (focused on private duty nursing and infusion) located in 9 states.
- CVS Health to buy Signify Health for $8 billion.
- Amazon buying One Medical and Iora Health subsidiary for $3.9 billion.
- Walgreens acquires remaining 45% of CareCentrix for $392 million.
- Mega deals in 2023 not likely to continue with interest rates and buyer's borrowing ability limited.
- The largest home care companies only control single-digit market shares.

Primary Tailwinds

- In spite of the notable material acquisition of existing home health platforms, as noted previously, there are still numerous founder-owned smaller home health operations that are fragmented across all jurisdictions in the United States – and for the reasons below, could compel them to sell at this juncture.
  - By way of example, one of the stronger tailwinds that supports the "buy and build" investment thesis in home health is that most hospitals are narrowing their potential home health partners and funneling more opportunities to larger platforms; as such:
    - (1) there will be number of potential targets of smaller operators, who may suffer increasingly lower market share as compares to years past and may want to sell at its historical run rates;
    - (2) if able to successfully establish a significant scaled platform, such platform will be able to take advantage of being included in the pool of preferred partners to the hospital systems; and
    - (3) Extension of COVID-19 measures (i.e. waivers).
- A movement by hospital systems that view home health alternatives as a vital tool to defray costs of expensive hospital admissions and as a tool to support patient "activities of daily living." In short, home health is not going away due to hospital system's reliance on them as part of the care continuum.
- Founders who have been in the business for a long time and do not have the appetites to learn and adopt a new pricing model (e.g., Home Health Value Based Purchasing Model of CMS) may desire to sell.
- Increase % of baby boomers.
- Increase acceptance of palliative care services.
- Managed healthcare plans discharging patients sooner from hospitals to either a home based care or subacute services.
- Home health has constituted historically in the past two years a lower market share of healthcare transactions in the past two fiscal years, but have been increasing quarter over quarter during such period, and continue to increase.

Primary Headwinds

- The home health space is experiencing certain residual consequences of the COVID-19 pandemic, which contribute in part to the headwinds noted below.
  - Staffing matters: (1) shortage of qualified staffing; and (2) due to shortage of staffing, use of contractors and temporary staffing narrows margins.
  - Potential changes to CMS reimbursement policies/programs, including those that were imposed during COVID.
  - Uncertainty of valuation based on macro-economic factors.
  - Lack of Sizeable Targets: Due to the high fragmentation in this industry, it may be difficult to find the initial platform acquisition. As such, one may need build a platform through series of acquisitions.

Opportunity for Private Equity and Strategic Led Consolidations

- Pressures on operating margins make it imperative to search for economies of scale for long-term sustainability (e.g. synergy of back office operations and implementation of tech-enabled services).
- Wide breadth of smaller companies (with a material portion of such companies limited to 1-4 sites).
- Demand of home care high.
- Not a high-capital-intensive industry.
- 2023 likely to see divestitures of some business lines operated by larger health systems or payors that are not core to an organizations health care business.
- Increase demand for home care technologies – diagnostic and monitoring devices.

Tailwinds:
COVID-19 and the End of the Public Health Emergency

- The Public Health Emergency will end on May 11, 2023 and with it many of the § 1135 waivers that were issued in 2020.
- Face-to-Face Encounters
  - Telehealth visits will continue to suffice for F2F.
  - Other F2F encounter requirements from the CARES Act survive.
- If telehealth services are contemplated for a patient, they must be covered in the Plan of Care.
- Telehealth visits can be used to satisfy Aide supervision once every 60-day certification period but only in “rare” circumstances.
- Allowed practitioners will still be able to certify eligibility and sign the Plan of Care within applicable State rules.
- OTs will continue to be able to perform initial and comprehensive assessments.

Key § 1135 Waivers That Will Expire on May 11

- Discharge planning & information sharing for discharging patients.
- Delivery timeframe for patient requested medical record copies.
- Onsite supervisory visits – Aides except for telehealth expansion.
- 12-hour annual in-service – Aides.
- Modified QAPI requirements.
- OASIS submission elasticity.
- Comprehensive assessment rules related to therapist performance of the assessment at 42 CFR § 484.55.

Tailwinds: The “Care at Home” Movement

- COVID created a demand for in-home care and funding for in-home care.
- The aging and chronically ill are looking to stay at home and out of hospitals and skilled nursing facilities.
- Patients with chronic illnesses needing less intensive medical supervision are demanding care at home.
  - CMS has stated that “treatment for more than 60 different acute conditions, such as asthma, congestive heart failure, pneumonia, and chronic obstructive pulmonary disease (COPD) care, can be treated appropriately and safely in home settings with proper monitoring and treatment protocols.”
- Remote Patient Monitoring (RPMs)
  - 53 Million users in U.S. in 2023 – 8% of users before COVID and now 20%.
  - https://www.insiderintelligence.com/content/us-remote-patient-monitoring-forecast-2021
- Up to $265 billion worth of care services for Medicare FFS and MA beneficiaries (which accounts for up to 25% of the total cost of care) could shift from traditional facilities to home-based care by 2025 – McKinsey & Co Report.

Tailwinds: The "Care at Home" Movement (*cont'd*)

- On Thursday, December 29, 2022, President Biden signed into law H.R. 2716, the Consolidated Appropriations Act (CAA) for Fiscal Year 2023.
  - $1.7 trillion to fund various aspects of the federal government.
  - Extension of telehealth waivers.
    - According to HHS, the share of Medicare visits conducted through telehealth rose from 840,000 in 2019 to 52.7 million in 2020.
    - Open application process for Hospitals to extend or participate anew in the Acute Hospital Care at Home (AHCaH).

Headwinds: The “Care at Home” Movement

- CMS proposed rule looking at MA plans shifting too much care to the home.
  - The proposed rule would prohibit MA organizations from denying coverage for SNF care and redirecting the patient to home health care services unless the patient does not meet the coverage criteria required for SNF care.
- The challenge is how to deal with sicker patients at home; need better training and technology.
  - Remote diagnostic tools and monitoring devices.
  - Telehealth through the TV and not just the phone or iPad.
- Physician and acute care buy-in.
- Reimbursement policies and payment innovation – parity or value-based payment.

Tailwinds:
Our Aging Population and the Growth of Medicare Advantage

- Aging Population
  - By 2030, all baby boomers will be older than 65.
    - (1 in 5 Americans to be classified as “retirement age”).
  - Chronic Disease is the leading cause of death or disability (all require ongoing monitoring and oversight) and about 45% of the population has a chronic condition.
    - Diabetes
    - Congestive heart failure
    - Chronic obstructive pulmonary disease
- Family Support
  - The ratio of unpaid family members aged 45 to 64 caring for those over 80 is dropping.
    - 7 to 1 in 2016
    - 4 to 1 in 2030
- The number of adults in need of care is increasing and the number of family available to care for them is shrinking – this is going to drive a demand for home-based care services.

The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers by Donald Redfoot, Lynn Feinberg, Ari Houser, Public Policy Institute, August, 2013

Growth of Medicare Advantage

- Medicare Advantage enrollment comprises 46% of all eligible Medicare beneficiaries.
  - Modest growth for 2023
    - 1.5 million enrollees in 2023
    - 1.9 million enrollees in 2020
    - 2.2 million enrollees in 2021
    - 2.3 million enrollees in 2022
- 15 states exceeded a 50% penetration rate in MA.
- Enrollment declined in 2023 in: California, Illinois, Connecticut and DC.
- Special Needs Plans (SNPs) — MA tailored to people with specific diseases or characteristics.
  - Biggest enrollment increase in 2023 – added 1 million enrollees, comprising 18% of total Medicare Advantage enrollment.
- Supplemental benefits offered by MA Plans.
  - Pest control, meals, handyman, dental, vision, transportation and home care.
  - In-Home Support Services offered by MA Plans increased by 32%.

The Chartis Group, LLC, In a Shifting Market, Medicare Advantage Shows Continued – but Decelerating – Growth 2023 Medicare Advantage Competitive Enrollment Report

Medicare and Medicaid – Dual Products

- January 2023, CMS released guidance to state Medicaid programs on innovative ways to address health-related social needs of Medicaid beneficiaries through the use of “in lieu of services and settings” (e.g., transportation and housing).
- Addressing Social Determinants of Health (SDoH) (non-medical factors that influence health outcomes) is a public policy trend to reduce health care expenses.
- A wave of new public and private initiatives addressing SDoHs could improve the health of older adults and at-risk Americans nationwide.
- All of this aligns with the move to Value Based Payments by addressing SDOHs and reducing avoidable health care cost, particularly focused on the most vulnerable – the Medicare and Medicare populations.
- Medicare Advantage Proposed Rule – Health Equity Index (HEI) would reward for the 2027 Star Ratings to incent MA plans to focus on improving care for enrollees with social risk factors (SRFs).
  - Digital health education requirement

Headwinds: Labor

- Nursing
  - During 2020, significant exodus of nurses from the profession.
  - During 2020, most HH patients refused visits – many HH nurses became under-employed.
  - Home health agencies are generally unable to compete with sign-on bonuses, higher salaries and benefits offered by health systems and larger entities.
  - HH nursing salaries avg. $78,000 – hospitals $85,000 and O/P centers $93,000.
  - 2022 report from ECRI notes that patient safety is a leading concern arising from the nursing shortage.
  - Survey implications arising from reduced nursing visits are also a concern.
- Home Health Aides
  - With the pandemic, many Aides were lured by higher wages in less demanding environments.
  - 678,000 jobs for this sector by 2026 with predictions of 368,000 Aides and personal care workers moving on to jobs in other environments.
  - Aide demand is expected to increase 33% between now and 2030.

Headwinds: Other Factors

- Home health providers have been under close scrutiny for years.
- As FFS Medicare patient volume give way to Medicare Advantage scrutiny – and varying payment rules – are creating havoc.
- Contractors – especially those working for Medicare Advantage plans and state Medicaid agencies – are becoming much more aggressive in their findings especially in the area of "technical" errors.
  - Recent example – VA Medicaid MCO denying claims based on a narrow technicality related to signatures on Plans of Care that is contrary to both federal and state regulations.
  - These types of examples, while once rare, are now commonplace.

Headwinds: Reimbursement

- Government Funding
  - Home Health Care has a high concentration of federal government funding (Medicare and Medicaid).
  - Government reimbursement rate pressures and proposed cuts.
  - Reimbursement for home care is largely guided by Medicare fee-for-service reimbursement.
    - CMS and the Medicare Payment Advisory Commission (MedPAC) believe home health agencies rates are high.
    - Providers disagree given inflationary costs, staffing constraints and poor reimbursement.

Headwinds: Reimbursement (*cont'd*)

- Original Medicare
  - Home health final payment rule
    - 7.85% permanent adjustment to the 30-day payment rate when fully implemented in 2024.
    - Although CMS didn't implement its proposed cuts in its final rule for 2023, the agency is moving forward with plans to claw back billions in perceived Patient Driven Groupings Model (PDGM) overpayments.
  - CMS continues to refine the PDGM for reimbursement.
    - 2023 is the Home Health Value-Based Purchasing (HHVBP) model's first performance year.

Reimbursement Risks and Opportunities

- Managed Care Payment Models
- MA has generally paid far less for home health care services than traditional Medicare.
  - Medicare Advantage – moving to a per-visit model to incent efficiencies and quality.
    - In October 2022, Amediys announced a deal with Aetna based on case-rates tied to quality metrics (e.g., rehospitalizations).
  - Focus on narrower networks – fewer larger providers – to drive volume to higher-quality providers that are capitalized to drive efficiencies of scale.
  - Value based payment – total cost of care – to include home care and doing away with controlling utilization for Caregivers.

Tailwinds: Reimbursement

- Medicare Advantage Federal Proposed Regulations – Medicare Program; Contract Year 2024 Policy and Technical Changes
  - Would create guardrails for utilization management and coverage determinations.
    - Prior authorization approvals would be valid for the duration of the approved course of treatment with a minimum 90-day transition period if an enrollee undergoing a course of treatment switches to a new MA plan.
  - Coverage and benefit determinations must follow traditional Medicare.
    - Basic benefits coverage for MA enrollees would not be more restrictive than Traditional Medicare.
    - MA plans would not be able to deny coverage of a Medicare covered item or service based on internal, proprietary, or external clinical criteria not found in Traditional Medicare coverage policies.
    - Pre-authorized services could not later be denied by the MA plan for lack of medical necessity, except determinations for which the plan has the authority to reopen the decision for good cause or fraud.

Tailwinds: Reimbursement (*cont'd*)

- Medicare Advantage Federal Proposed Regulations – Medicare Program; Contract Year 2024 Policy and Technical Changes
  - CMS is soliciting comments regarding:
    - Gold Carding – If MA plans should allow relaxation or reduction of prior authorization requirements for compliant providers (Medicare FFS Review Choice Demonstration for Home Health Services).
    - Termination of Care in Post Acute Care Settings - When care can be delivered in more than one way or in more than one type of setting, and a contracted provider has ordered or requested Medicare covered items or services for an MA enrollee, the MA plan may not deny coverage.
    - How MA plans should preauthorize treatment in discrete increments.
    - Whether enrollees should have additional time to file appeals or be able to file late appeals regarding terminations of services.
    - Whether enrollees should receive information regarding the basis for termination of services (for example, the clinical rationale for termination of services) as part of the termination notice.

Comment period on proposed regulation has closed.

Reimbursement Risks and Opportunities

- Largest Medicare Advantage Payors
  - Humana, Cigna and Aetna
- Overpayments
  - A series of 90 government audits found CMS overpaid the plans approximately $12 million between 2011 and 2013.
  - Nine regional MA plans were underpaid by CMS.
- Final MA Rule related to Risk Adjustment Data Validation
  - Allows CMS to use extrapolation back to 2018 where medical records do not support the coding used to justify any risk adjusted premiums.
- https://khn.org/news/article/audits-hidden-until-now-reveal-millions-in-medicare-advantage-overcharges/

Reimbursement Risks and Opportunities (*cont'd*)

- Proposed Change to the "Overpayment Rule"
  - CMS is looking to eliminate the reasonable diligence standard prior to triggering the 60-day overpayment rule.
  - Currently, a Medicare enrollee must report and return an overpayment within 60 days of identification of an overpayment and there is a six month period from receiving "credible information" of a potential overpayment in which to investigate whether that enrollee did, in fact, receive such an overpayment.
  - CMS is looking to align the overpayment rule with the more rigid "knowledge" standard used in False Claims Act (FCA) cases.
    - "Identified" an overpayment would be triggered when the person knowingly receives or retains an overpayment.
    - Knowing standard means **actual knowledge** of the existence of an overpayment or **acting in reckless disregard** or with **deliberate ignorance** of the overpayment.

      See 87 Fed. Reg. 79452, 79559 (Dec. 27, 2022).

Recent Lawsuits and Regulatory Scrutiny

- Federal agency authority – being challenged.
  - American Hospital Association v. Becerra (CMS failed to follow proper procedures to reduce rates to Hospital Pharmacies for 340B Drugs).
- Home Care False Claims Act Allegations

FOR IMMEDIATE RELEASE – Tuesday, October 18, 2022

- Oklahoma City Home Health Company and Two Former Corporate Officers Agree to Pay $22.9 Million to Settle Federal False Claims Act and Kickback Allegations Arising From Improper Payments to Referring Physicians
- Carter Healthcare Affiliates and Two Senior Managers to Pay $7.175 Million to Resolve False Claims Act Allegations for False Florida Home Health Billings

- OIG Audit – Missouri overpaid $918 Million in Medicaid payments for consumer directed PCA.
  - Errors related to timesheets lacking documentation, units of services exceeded authorized services, lack of employee documentation and plans of care not signed.

Recent Lawsuits and Regulatory Scrutiny (*cont'd*)

- Federal Government Scrutiny over Private Equity in Health Care
  - False Claims Act awards treble damages as a penalty for fraud against the United States Government.
  - As the federal government is the largest payor of health care, the False Claims Act has been a tool used by DOJ to fight against health care fraud.
  - False Claims occur not just by "presenting" a false claim to the government, but also can be brought against an individual or entity that "causes" a false claim to be presented to the government. For example:
    - Private equity investor has a "bare requisite level of awareness" that a portfolio company is acting badly.
    - PE entity exercises of control over the portfolio company or actively participates in the health care investment company.
    - Actual Knowledge, Deliberate Ignorance and Reckless Disregard of the Truth.

PE Protections

- Protect the corporate veil and respect corporate formalities between the health care operating entity and the investors.
- Avoid communications (emails and texts) whereby the investor is exercising control and decision making authority over the operating company.
- PE participation in operating company governance meetings creates exposure if the PE advisor becomes aware of any compliance issues.
  - Investigate, address and remediated.
- Address compliance concerns to avoid reverse false claims.
  - Self-reporting
  - Return of overpayments

Data Breaches

- Aveanna Healthcare reached proposed settlement for data breach stemming from phishing attacks that also led to class action lawsuit.
  - Audit for compliance with federal and state requirements to adhere privacy and security standards and training of employees.

FTC and DOJ

- The Federal Trade Commission (FTC) enforces the antitrust laws in health care markets to prevent anticompetitive conduct that would deprive consumers of the benefits of competition.
  - The agency also gives guidance to participants in the health care market to help them comply with antitrust laws.
- The mission of the Department of Justice (DOJ) Antitrust Division is to promote economic competition through enforcing and providing guidance on antitrust laws and principles.
- Recent relevant activity
  - FTC Proposed Rule – Ban on Employer Non-competes.
  - FTC Proposed Rule – Lengthen 30-day review period for transactions subject to Hart-Scott-Rodino.
  - DOJ withdraws long-standing antitrust policy statements addressing healthcare markets in place since 1993.
    - “overly permissive on certain subjects, such as information sharing, and no longer serve their intended purposes of providing encompassing guidance to the public on relevant healthcare competition issues in today’s environment. Withdrawal therefore best serves the interest of transparency with respect to the Antitrust Division’s enforcement policy in healthcare markets.”

Questions?

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