



Reimbursement Analysis (1/2)

Case Studies



Engagement Type

Transaction Diligence

Transaction Diligence

Situation

A PE firm evaluating an investment in a large single-state multispecialty physician practice and management services organization sought to understand the government program and commercial reimbursement outlook for the practice.

A lender evaluating providing debt financing to a multi-state operator of skilled nursing facilities sought to understand the key federal and state reimbursement catalysts and policy trends impacting the target Company.

- Medicare fee-for-service reimbursement analysis at a code-specific and payment reform level
- Medicare Advantage penetration rate and premium analysis at a national and county level
- Outlook for Physician Accountable Care Organization ("ACO") migration to risk sharing models
- Commercial health plan reimbursement analysis at an E&M code-specific level

- Medicare SNF analysis including overview and assessments of Medicare coverage, reimbursement methodology, reimbursement outlook, SNF value-based purchasing and bundled payment initiatives, and Dual Eligible/Coordinated Care Demonstration programs
- Analysis of Medicaid and Medicaid Managed Care reimbursement for the Company in select key states, including insights from Medicaid Managed Care Plans on trends in utilization management, network management and reimbursement for SNF services

Description of Marwood's Work and Analysis

Medicare Payment Scenario Analysis

MA Enrollment in the State Will Likely See Steady Enrollment Growth, As There is Not Currently High Penetration

| Year | MA Enrollment (%) | FFS (%) | Medicare Growth (%) |
|------|-------------------|---------|---------------------|
| 2015 | 12.5 | 87.5 | 1.2 |
| 2016 | 13.1 | 86.9 | 1.1 |
| 2017 | 13.7 | 86.3 | 1.0 |
| 2018 | 14.3 | 85.7 | 0.9 |
| 2019 | 14.9 | 85.1 | 0.8 |
| 2020 | 15.5 | 84.5 | 0.7 |

ACA Expanded The Physician Quality Reporting System As A First Step To Physician Pay For Performance

ACA expanded the Physician Quality Reporting System (PQRS), which includes dermatologists, by establishing a penalty as a first step in developing a physician pay-for-performance program.

- The PQRS is a precursor to pay for performance
- CMS provides incentive payments to eligible professionals (EPs) who voluntarily report data through the PQRS on quality measures for selected specialties to Medicare beneficiaries
- The Medicare Incentives for Physicians and Providers Act of 2008 extended the PQRS through December 31, 2013, and extended the PQRS from then on to the end of 2015, respectively
- ACA extended this program through 2014 and added a penalty starting in 2015 for eligible professionals who do not report the required data
- In 2015, the program was successfully expanded to 2015 and received a 1% increase in 2015. Those who successfully report in 2015 through 2016 received a 3% bonus in the subsequent year
- An additional 1% bonus was available from 2011 through 2014 for those who used the requirements of a Merit-based Incentive Payment Program, which is defined as a certification assessment program that allows for quality incentives for cost containment practices by focusing on the improvement of patient care, and/or better care coordination
- Eligible professionals who do not satisfactorily report on quality measures for the January 1, 2014 to December 31, 2015 reporting period will be subject to a 1% adjustment on their fee schedule payments in 2016
- The same penalty will apply to subsequent periods
- CMS estimated that PQRS will contribute over the next several years, but only \$1 billion over the following 5 years, as average rates to score will decline
- The PQRS will end following the 2016 calendar year, as the newly passed permanent doc fix includes the Merit-based Incentive Payment System (MIPS), which combines 3 quality incentive payment programs, including PQRS, into one quality incentive payment program

CMS Will Continue To Support The ACO Program; The Long Term Goal Is To Move Providers To Two-Sided Models

Marwood believes that CMS will continue to significantly invest in ACO program over the next few years as motivated by continued efforts to "align", programmatic elements to improve participation, over time, the goal to move more ACOs to models with two-sided risk

- Expansion of alternative payment models, primarily ACOs and bundled payments, is a top priority for CMS
- In January 2013 announcement, CMS launched (under administrative approval) a goal of having 50 percent of total payment arrangements by the end of 2014, and having 50 percent of payment to risk models by the end of 2017
- Over the past few years, as the ACO program has continued to roll out, CMS has made notable adjustments to incentives to encourage participation and success, including:
 - Changes to how shared savings are calculated
 - Changes to how shared savings are shared
 - Changes to how shared savings are shared
- CMS has also been moving to "encourage" ACOs to two-sided risk models, although it is unlikely ACOs will be forced to do so in the short term
- For example, using the alternative Payment Model from Track 2 and MIPS ACOs will encourage ACOs to enter other models other than Track 1
- The CMS bonus incentive for ACOs will be a substantial incentive to move physicians to two-sided risk models
- CMS will support an ACO Track 1+ model that will be available in 2014 and currently and advanced ACOs to enter other models other than Track 1

The Outlook For Part A SNF Reimbursement Is Slightly Positive In The Near Term, Potential Pressure For Medium Term

Dual-Eligible Plans Receive Medicare And Medicaid Capitation Payments For Service Delivery

Under the demonstration program, in states utilizing a capitated payment model, duals plans receive Medicare and Medicaid capitation payments, which are then be used by the plans, as the single public payer to reimburse providers for the delivery of services.

- Medicare Related Capitation Payment:
 - For Medicare Part A, CMS develops an estimate of baseline costs for Medicare A and B services for each demonstration county - an estimation of what CMS would have paid absent the demonstration
 - Monthly net amount, which is derived each year from the composite Part D funding process
 - Each state utilizes an independent, objective source to estimate the Medicare A & B component
 - In 2014, the average net amount for 2014 was \$1.1 billion, which was 1.1% below the 2013 net amount
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 - In 2020, the average net amount for 2020 was \$1.1 billion, which was 1.1% below the 2019 net amount
- Medicaid-Related Capitation Payment:
 - States develop their own Medicaid capitation payment methodology, but generally payment is calculated using a base rate that is modified by risk adjustment, risk stratification, and other factors
 - Under the capitated model, the duals plans are responsible for reimbursing service providers - there are no set fee schedules that plans must use, so plans negotiate rates with providers

SNF Utilization Management Will Continue To Grow As A High Priority In Both State 1 And State 2

- With plans looking to reduce the LOS in high-acuity settings, SNF utilization remains a priority
- Plans in New Mexico have increased the priority of SNF services and believe this trend will continue
 - One plan notes the trend is not unique to SNF, but rather a company-wide effort to reduce LOS
 - "Length of stay is being more scrutinized to ensure patient safety, not just to save"
 - One State 1 plan expects length of stay (LOS) to increase as SNF use decreases, though this plan expects 20% to decrease
 - High LOS rates have been associated with "community migration"
 - LOS has been observed to be high in those states and has been a focus for community migration
- Note that State 2 only covered in SNFs since 2015, but SNF utilization management is currently and will continue to do so in high acuity for State 2 states
- Although SNF utilization management is a focus, a State 2 plan notes it is "becoming more of a focus"
 - 75% of State 1 plans and 65% of State 2 plans expect average LOS to decrease due to LOS focus
 - There should be a decrease of admissions per 1000 patients, which would lead to a reduction of average length of stay, instead of a "bunching" of only high acuity, there may be a "flattening"
 - Length of stay will dip and will not be as high. This reduction may reduce the amount of SNF LOS

Marwood Completed A Referral Source Analysis Within Three Key Markets

| Provider Type | MSA 1 | MSA 2 | MSA 3 |
|-----------------|-------|-------|-------|
| Rehab | 1 | 2 | 9 |
| Long Term Acute | 1 | 2 | 5 |
| Hospital | 5 | 14 | 6 |
| Home Health | 17 | 12 | 10 |
| TOTAL | 24 | 30 | 30 |

- Marwood was engaged to complete a referral source survey regarding subjects in three key markets, the survey was performed in a "secret shopper" style
 - Marwood focused on the Company's potential referral sources within three markets:
 - MSA 1: Facility 1, Facility 2, Facility 3 and Facility 4
 - MSA 2: Facility 5, Facility 6 and Facility 7
 - MSA 3: Facility 8
 - Marwood conducted referral sources in the three markets, where respondents were asked for a list of the providers they would recommend for a skilled nursing provider, if the Company was not listed, Marwood asked if they were "aware" of the Company
 - In 4 out of 5 cases, respondents were asked about their experiences with the Company and with other providers (if they were ranked)



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Situation

A private equity sponsor was evaluating a potential investment in a multi-state Dental Service Organization (“DSO”) with Commercial Health Plan and Medicaid/Medicare Managed Care exposure.

A leading private equity-backed physical therapy treatment provider was evaluating an add-on acquisition with operations in three key states and needed to understand the reimbursement outlook for Medicaid, Workers’ Compensation, Auto Insurance and Commercial Health Plan payors.

- Analysis and outlook of federal legislative and regulatory initiatives impacting DSOs and insurance coverage for dental care
- Commercial insurer analysis to identify and provide outlook on trends impacting network, reimbursement and utilization management for dental services
- Overview and outlook for Medicaid reimbursement in the Company’s five key states

- Provided outlook of Medicaid, workers’ compensation, auto insurance and commercial health plan payer environments in key states
- Conducted surveys and discussions with commercial health plans and Medicaid managed care plans to assess trends in coverage, utilization, network access, reimbursement methodology and reimbursement trends for outpatient physical therapy services

Description of Marwood’s Work and Analysis

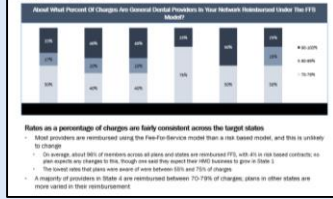
Members Of Congress May Continue To Express Concerns About DSOs, But Legislative Action Is Unlikely

- Marwood believes that members of Congress may continue to express concern about fraud and other abuses by DSOs, but no legislation will advance
- A June 2012 report from the Senate Finance and Judiciary Committees on the “corporate practice of dentistry in the Medicaid program” focused on one dental practice management company that effectively limited the dentists’ autonomy. HHS OIG eventually learned the company from Medicaid
- In February 2014 letter to Inspector General David L. Leonow, Rep. Michael Burgess (R-TX) and Rep. Dana Rohrabacher (R-CA) expressed concerns about alleged deceptive practices of dental practice management companies
- The letter called on HHS OIG to conduct an independent review of dental companies from participating in the Medicaid program
- Burgess also requested Congress take the right of first refusal to investigate and control how the practice management companies are managed and operated
- Representatives Burgess and Coughlin’s letter prompted responses from further consolidation and management of dental services
- The letter states that states have broad coverage over the corporation structure, citing the 22 states and the District of Columbia that have already passed or passed legislation
- In July 2013, Senator Cassidy sent letters to Attorney General Loretta Lynch and HHS OIG Director Levinson, asking them what their agencies are doing to prevent and punish Medicaid dental services in California, New York, Louisiana, and Idaho
- Despite these concerns, legislation related to corporate practice of dentistry is unlikely to move, as many members view such issues as a matter of state rather than federal law
- There have not been any hearings on the subject, and no bills have been introduced in the session

State Medicaid Key Takeaways: State 1 and State 2

| | State 1 Medicaid | State 2 Medicaid |
|-------------------------------|---|---|
| Network Structure | Contracted services for dentists | Network of dentists |
| Reimbursement | Reimbursement rates are based on a fee schedule | Reimbursement rates are based on a fee schedule |
| Utilization Management | Utilization management is required for all services | Utilization management is required for all services |
| Specialty Services | Specialty services are covered | Specialty services are covered |
| Preventive Services | Preventive services are covered | Preventive services are covered |
| Emergency Services | Emergency services are covered | Emergency services are covered |
| Out-of-Pocket | Out-of-pocket is not applicable | Out-of-pocket is not applicable |

Plans Generally Reimburse 70%-100% Of Charges For General Dentistry



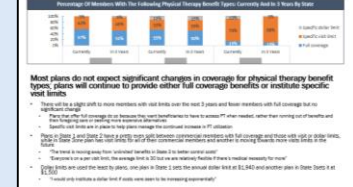
Nearly All State 1 Medicaid Children Will Continue To Receive Dental Services Through Managed Care

- Marwood believes that nearly all Medicaid-eligible children will continue to be required to enroll in a dental managed care plan
- Most Medicaid-eligible children currently receive dental services through two risk-based Dental MCOs
- The state’s dental managed care program for most Medicaid-eligible children was managed care in 2012 through an HHS request to the state’s dental managed care program
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State By State Health Plan View Comparison

| State | Commercial Health Plan View | Medicaid Health Plan View |
|---------|-----------------------------|---------------------------|
| State 1 | Network of dentists | Network of dentists |
| State 2 | Network of dentists | Network of dentists |
| State 3 | Network of dentists | Network of dentists |

Physical Therapy Commercial Benefit Coverage Is Stable



Most Medicaid Plans Will Continue To Base Reimbursement Off of Their State Medicaid Fee Schedule

- Most Medicaid managed care plans reimburse PT providers on a percent of the state Medicaid fee schedule; the plans do not expect to change their reimbursement methodology in the future
- Most plans used a percent of Medicaid benefit if inpatient, reimbursement methodologies did not differ by facility
- Three plans used a different reimbursement methodology
- Medicaid plans are likely to continue to base reimbursement off of their state Medicaid fee schedule
- One Medicaid plan in State 3 uses a % of charges methodology; Medicaid is not representative of services only
- One Medicaid plan in State 2 uses a time-based reimbursement methodology

Some PT Networks in State 1 And State 3 Are Narrowing; State 2 Networks Will Remain Open

