Managed Care Update

TRENDS, CHALLENGES, AND OPPORTUNITIES

Session Speaker

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Grant brings over 25 years of post-acute care knowledge across multiple service domains including skilled nursing, assisted living, home health, hospice, outpatient rehabilitation, and adult day care. His financial and operational contract development expertise is focused on building sustainability and ensuring that mandates are met and offers knowledge vital to the development of effective payor arrangements.

Session Summary

Managed care continues to evolve rapidly, creating both challenges and opportunities for aging services providers. This session will provide an update on the current managed care landscape, explore the key market and policy factors shaping the future, identify the issues organizational leaders should be monitoring, and highlight practical opportunities to strengthen partnerships and improve organizational performance. Participants will also gain a better understanding of the strategic value of Senior Care Resources and how membership can strengthen managed care contracting, advocacy, and collaborative initiatives that support long-term success. Attendees will leave with actionable insights to help their organizations navigate an increasingly complex managed care environment.

Key Topics

Managed Care Landscape

- How did we get here?
- Historical overview

Current Pressures & Influences

- What does this mean?
- Provider impact

Opportunities & Options

- What actions can we take?
- Response initiatives

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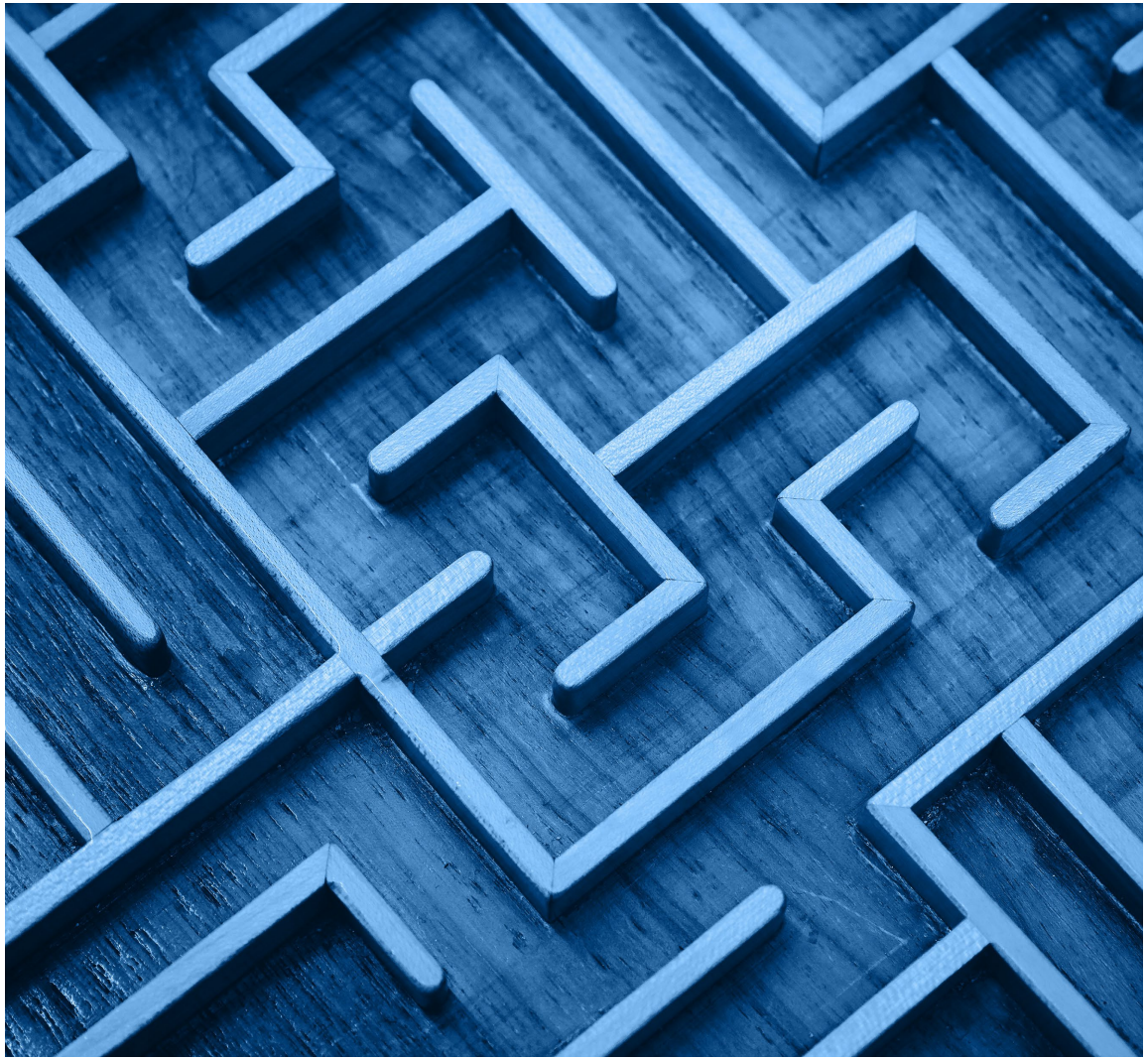
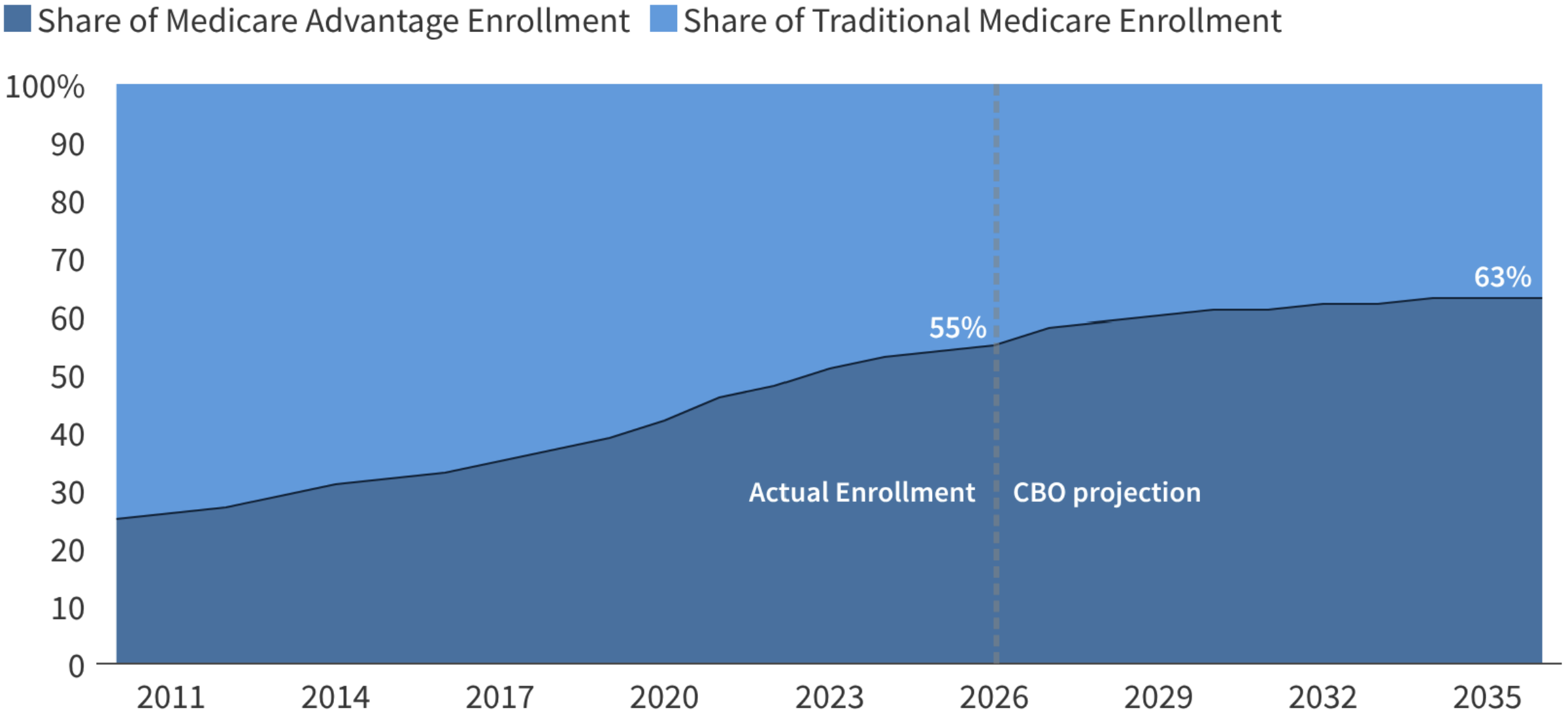


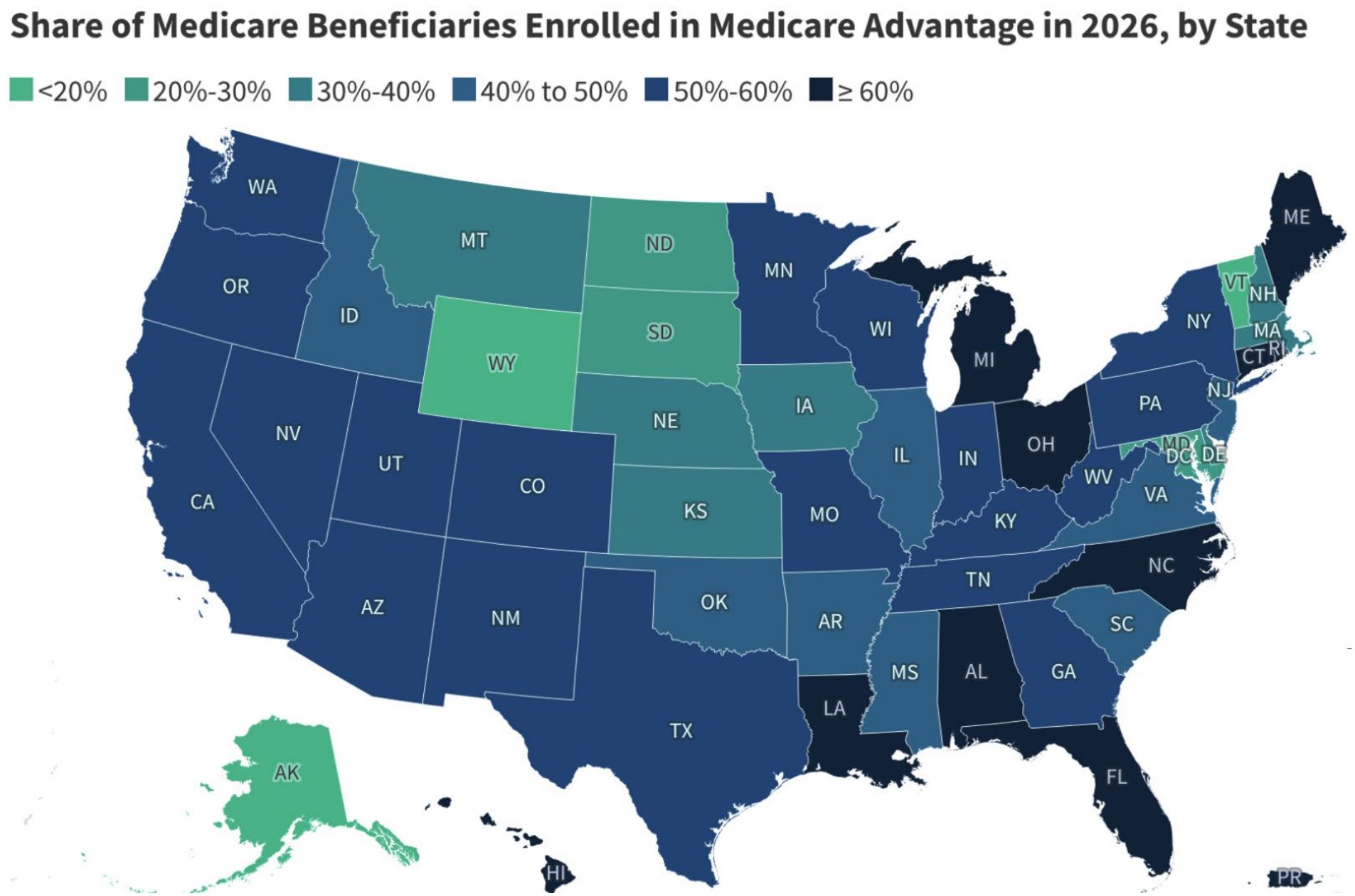
Managed Care Landscape

HOW DID WE GET HERE?

Medicare Advantage and Traditional Medicare Enrollment, Past and Projected



Source: Medicare Advantage in 2026: Enrollment Update and Key Trends, (KFF, June 5, 2026) https://www.kff.org/medicare/medicare-advantage-in-2026-enrollment-update-and-key-trends/ (August 4, 2026)



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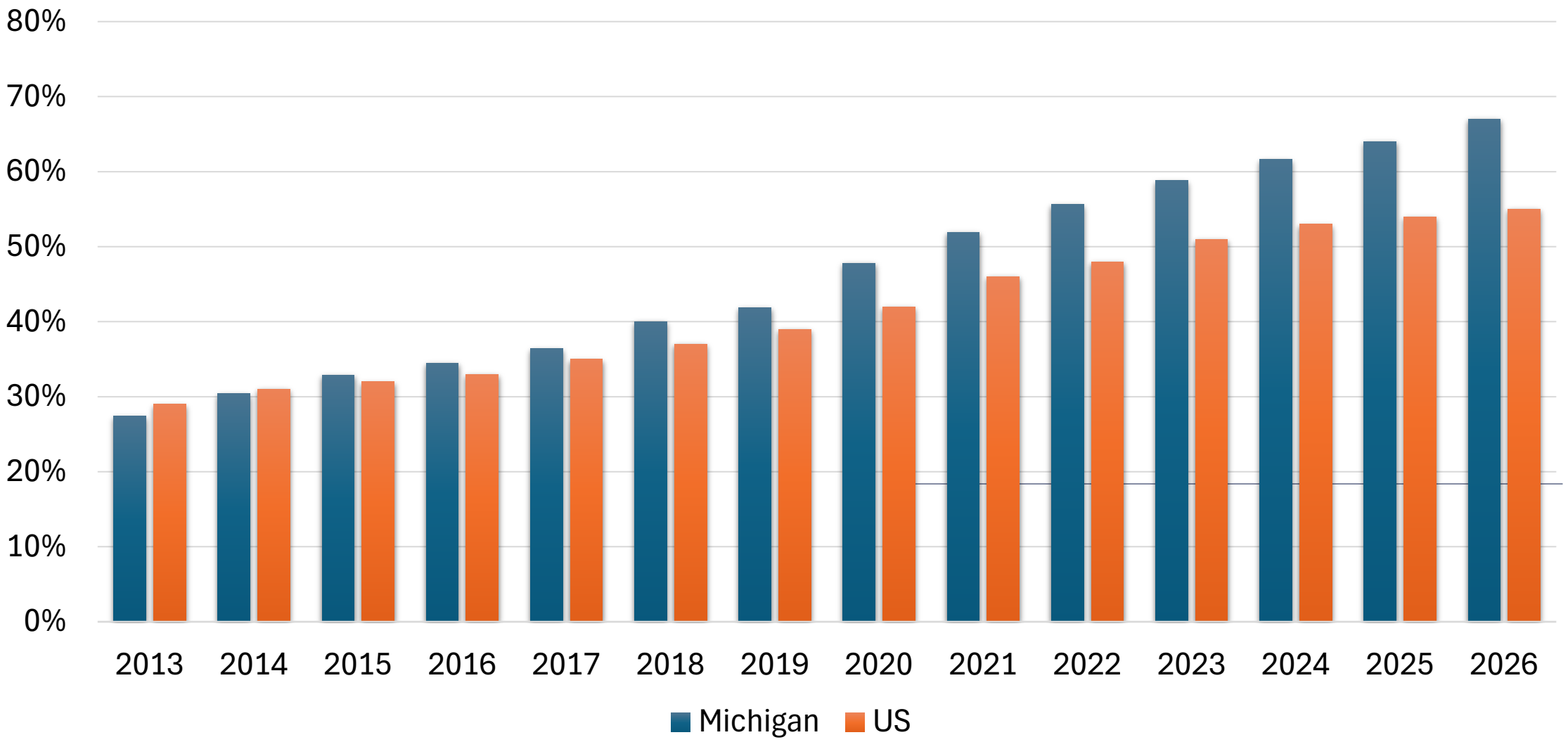
Medicare Advantage Enrollment Trend



Medicare Advantage Growth Factors

Cost Savings

Lower Premium

Lower Cost-Sharing

Expanded Benefits

Dental

Vision

Hearing

Wellness

Government Retirees

Medicare Supplement replaced by Medicare Advantage

Special Needs Plans

Institutional

Dual Eligible

Chronic Conditions

Medicare Advantage Enrollment by Parent Organization, 2025-2026

Parent Organization	March 2025 Enrollment	March 2026 Enrollment	Change in Number of Enrollees: 2025 to 2026
UnitedHealth Group Inc.	9,902,837	9,256,079	−646,758
Humana Inc.	5,721,711	7,023,428	1,301,717
CVS Health Corporation	4,078,959	4,050,030	−28,929
Kaiser Foundation Health Plan Inc.	1,951,484	2,038,285	86,801
Elevance Health Inc.	2,226,608	1,880,531	−346,077
All other parent organizations	10,256,897	10,960,374	703,477

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Headlines

Fact Sheets Jul 29, 2026

Fiscal Year 2027 Skilled Nursing Facility Prospective Payment System Final Rule

For FY 2027, CMS finalized updating SNF PPS rates by 2.4% based on the final SNF market basket of 3.3%, reduced by a 0.9% productivity adjustment, for an estimated increase of $882.74 million in aggregate payments to SNFs.

Fact Sheets Apr 06, 2026

2027 Medicare Advantage and Part D Rate Announcement

In the CY 2027 MA and Part D Advance Notice, CMS proposed updates to payment factors for CY 2027 and received a wide variety of comments on the proposals. CMS appreciates the submitted comments. We carefully considered all applicable comments as we finalized the policies contained in the CY 2027 Rate Announcement. The final policies in the CY 2027 Rate Announcement are projected to result in an increase of 2.48% or over $13 billion in payments to MA plans in CY 2027. When accounting for estimated risk score trend in MA due to factors such as population changes and coding practices, this amounts to a 4.98% increase.

Humana Profits Hit $694 Million As Medicare Costs Fall In Line

By Bruce Japsen, Senior Contributor. ⓘ Bruce Japsen writes about healthcare business and policy. Follow Author

Humana reported net income of $694 million, or $5.73 per share compared to $545 million, or $4.51 per share in the year ago period. Revenue jumped to $40.8 billion thanks largely to the influx of Medicare Advantage enrollees compared to nearly $32.4 billion in the year-ago quarter.

UnitedHealth blows past estimates, hikes earnings outlook as it reins in costs

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SHARE

The healthcare giant is working to stabilize margins by shrinking membership, exiting unprofitable contracts and pouring $1.5 billion into artificial intelligence to streamline operations.

FY 2027 Skilled Nursing Facility Final Rule

FY 2027 SNF PPS Payment Update

- 3.3% market-basket increase, reduced by a 0.9% productivity adjustment, producing a 2.4% net increase
- CMS estimates this will increase aggregate Part A payments by approximately $882.74 million before SNF VBP

SNF VBP

- The FY 2027 SNF VBP Program is expected to reduce aggregate SNF payments by approximately $203.60 million

Accelerated Quality-Data Deadlines

- FY 2029 SNF QRP, MDS and applicable data must generally be finalized by the 15th day of the second month following each quarter—roughly 45 days, rather than 4.5 months

All-payer MDS expansion

- Beginning with admissions on October 1, 2029, SNFs must submit MDS data for covered skilled care regardless of payer.

COVID-19 measure removal

- CMS is removing both COVID-19 vaccination measures from the SNF QRP beginning with FY 2028
- Public reporting ending after the October 2026 Care Compare refresh.

FY 2027 Skilled Nursing Facility Final Rule

Date	Required Action or Milestone
October 1, 2026	FY 2027 SNF PPS rates take effect; resident COVID-19 vaccination data become voluntary for discharges on or after this date.
October 2026	Last Care Compare refresh displaying the two COVID-19 vaccination measures.
January 1, 2027	CY 2027 data collection begins for the accelerated FY 2029 SNF QRP submission deadlines.
May 17, 2027	First accelerated MDS submission/correction deadline, covering CY 2027 Q1.
October 1, 2027	MDS item O0350 is scheduled for technical removal.
October 1, 2029	All-payer MDS submission begins for residents admitted or readmitted for covered skilled care.
FY 2031 SNF QRP	First payment year in which the all-payer MDS requirement applies.

The Changing Landscape

Medicare Advantage (MA) Enrollment

- MA enrollment continues to grow – but at a slower pace
- MA Special Needs Plan (SNP) enrollment – Dual; Chronic Condition; Institutional
- D-SNP is nearing 80% of the total SNP enrollment – growth under HIDE & FIDE programs
- MA option for employer/unions – 31% of MA enrollment in Michigan

Market Trends

- MA plans offered are changing annually
- MA plan ownership consolidation

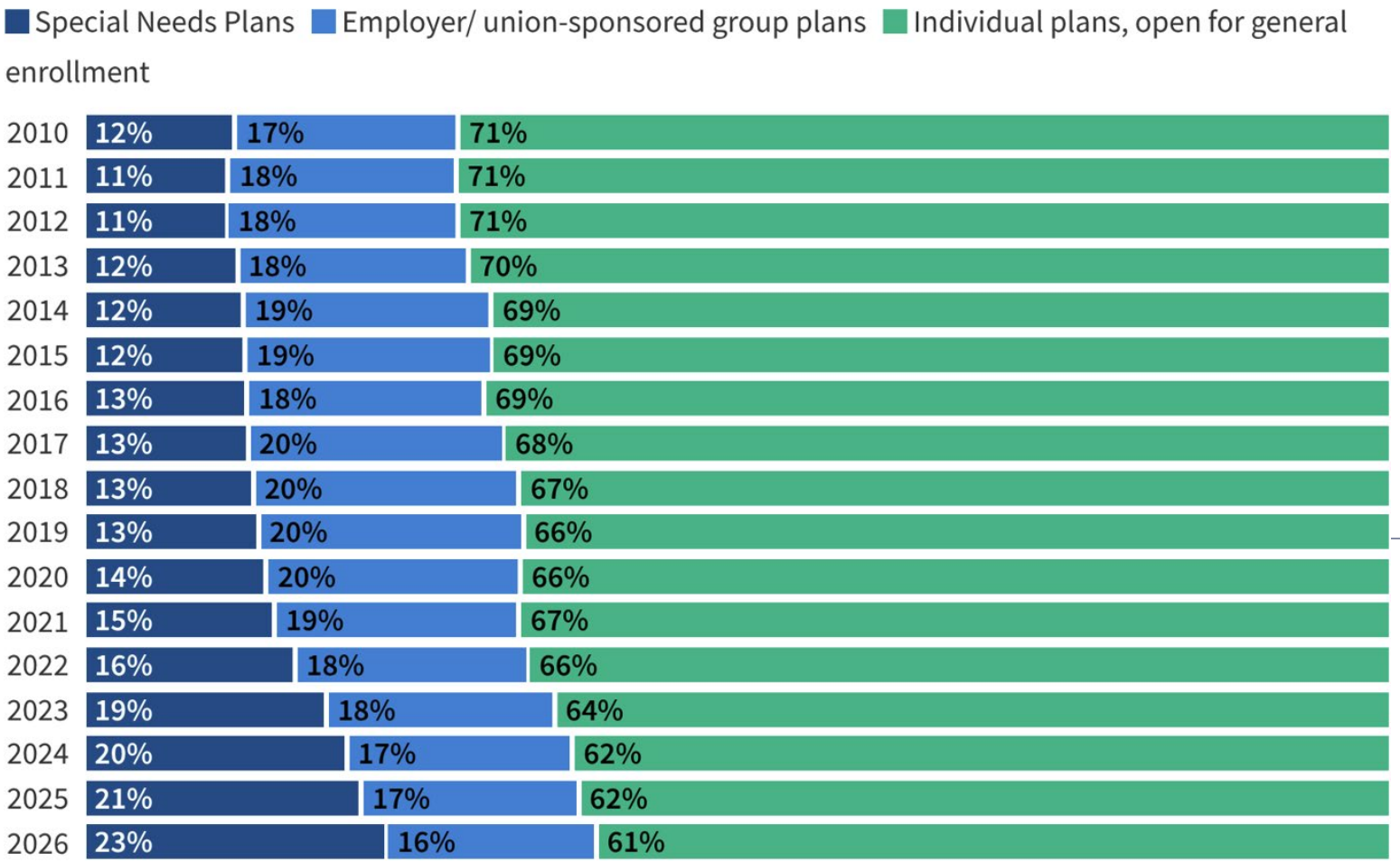
Impact

- More MA plan types to contract
- More complexity navigating unique terms and procedures

Distribution of Medicare Advantage Enrollment, 2010-2026

Click on the buttons below to see the share and number of Medicare Advantage enrollees across plan types:

Share of beneficiaries | *Number of beneficiaries*



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The Changing Landscape

ACA/Marketplace

- Declining enrollment as enhanced subsidies expired
- Reduced plan participation as risk pools and profitability concerns grow

Market Trends

- Aetna fully exited
- Molina partially exited
- Cigna is planning to exit in 2027

Impact

- Increase in underinsured and uninsured

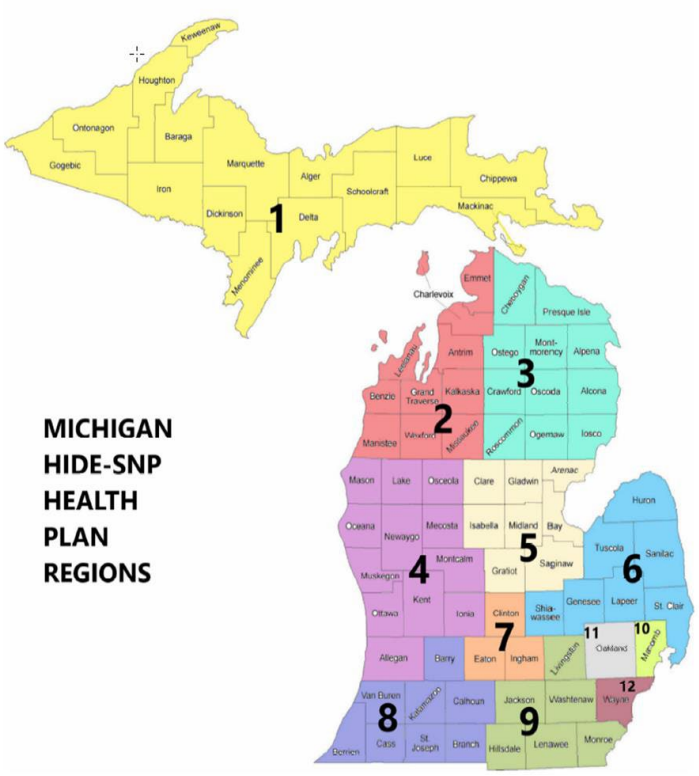
The Changing Landscape

Highly Integrated D-SNPs National Context

- Medicare-Medicaid Plan (MMP) demonstration ended in 2025
- Replacement program utilizes the D-SNP model (HIDE & FIDE)

Michigan Transition

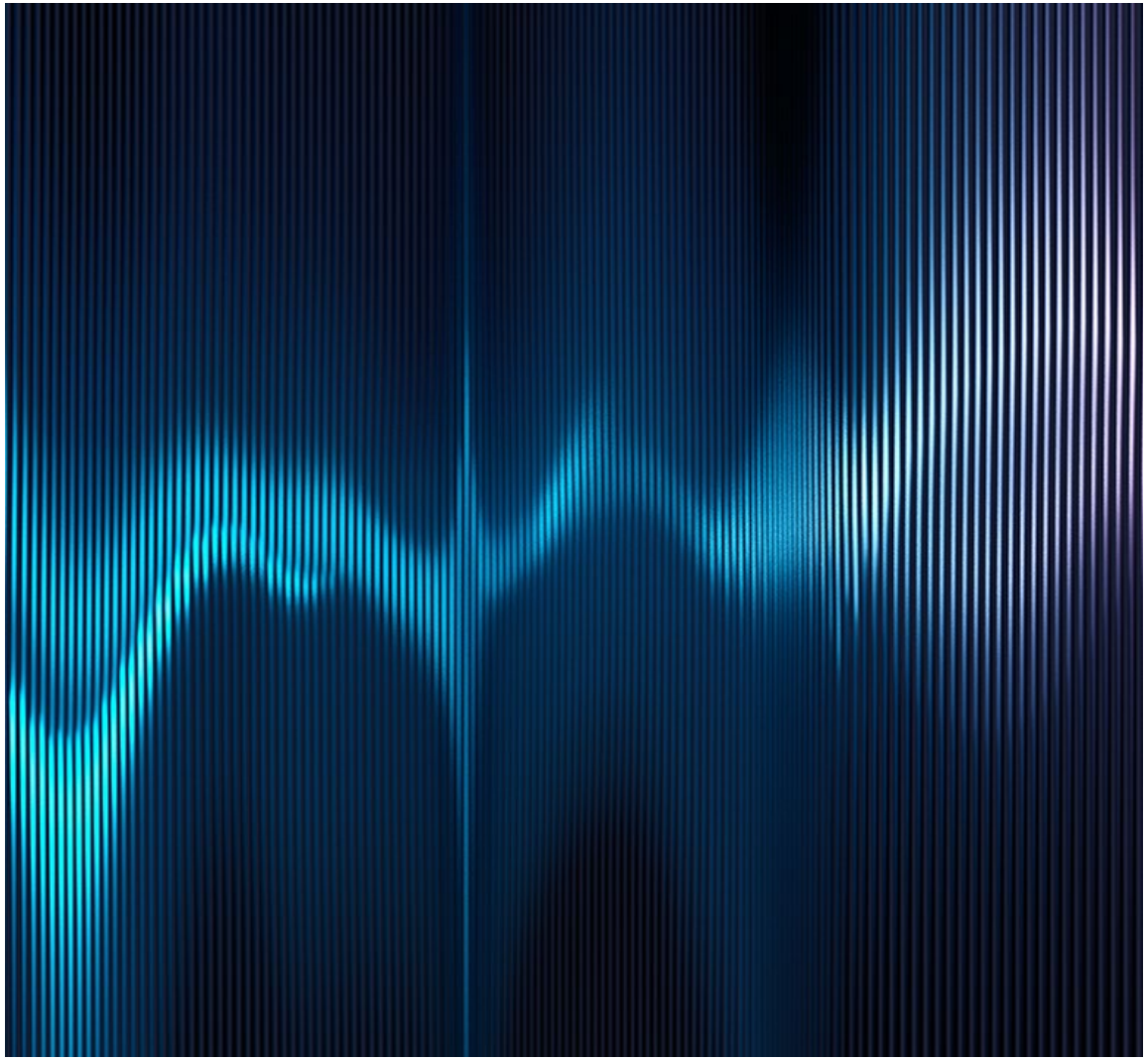
- MI Health Link ended December 2025
- MI Coordinated Health (MICH) launched January 2026 (regions 1, 8, 10, 12)
- 2027 statewide expansion is uncertain



Provider Challenges

- New contract terms, rates, and process
- Provider load, potential payment delays, care coordination & utilization management

How has your organization's payor strategy changed over the last 3 years?



Pressures & Influences

WHAT DOES THIS MEAN?

Managed Care Challenges

Provider

Administrative Burden

Financial Pressures

Restricted Autonomy

Collaboration

Patient

Access to Care

Navigation of Plan Rules

Denial

Managed Care Plan

Network Management

Quality & Predictability

Provider Compliance

Communication

Financial Pressure

Reimbursement

- Reimbursement is set by the plan – Medicare, Medicaid, Commercial products
- Market reimbursement remains variable – methodology and rate

Margin Pressure

- Many nursing homes report an operating loss
- Managed care plans seek to control costs and limit variability

Impact

- Lower reimbursement on a growing volume
- Reimbursement structured to remain static and predictable

Administrative Burdens

High Denial Rates

- Managed care denial rates continue to remain high – payor/provider attributed
- Admission or continued stay medical necessity determinations

Documentation Demands

- Authorization requirements – portal use; third party conveners
- Audit and risk adjustment documentation requests

Impact

- Increased administrative work to substantiate care need and reimbursement
- Increased number of appeals - intensive appeal and reconsideration process

Care Coordination & Operational Impact

Care Coordination Issues

- Delays in authorization approval and care transitions
- Changes in care management and communication protocols

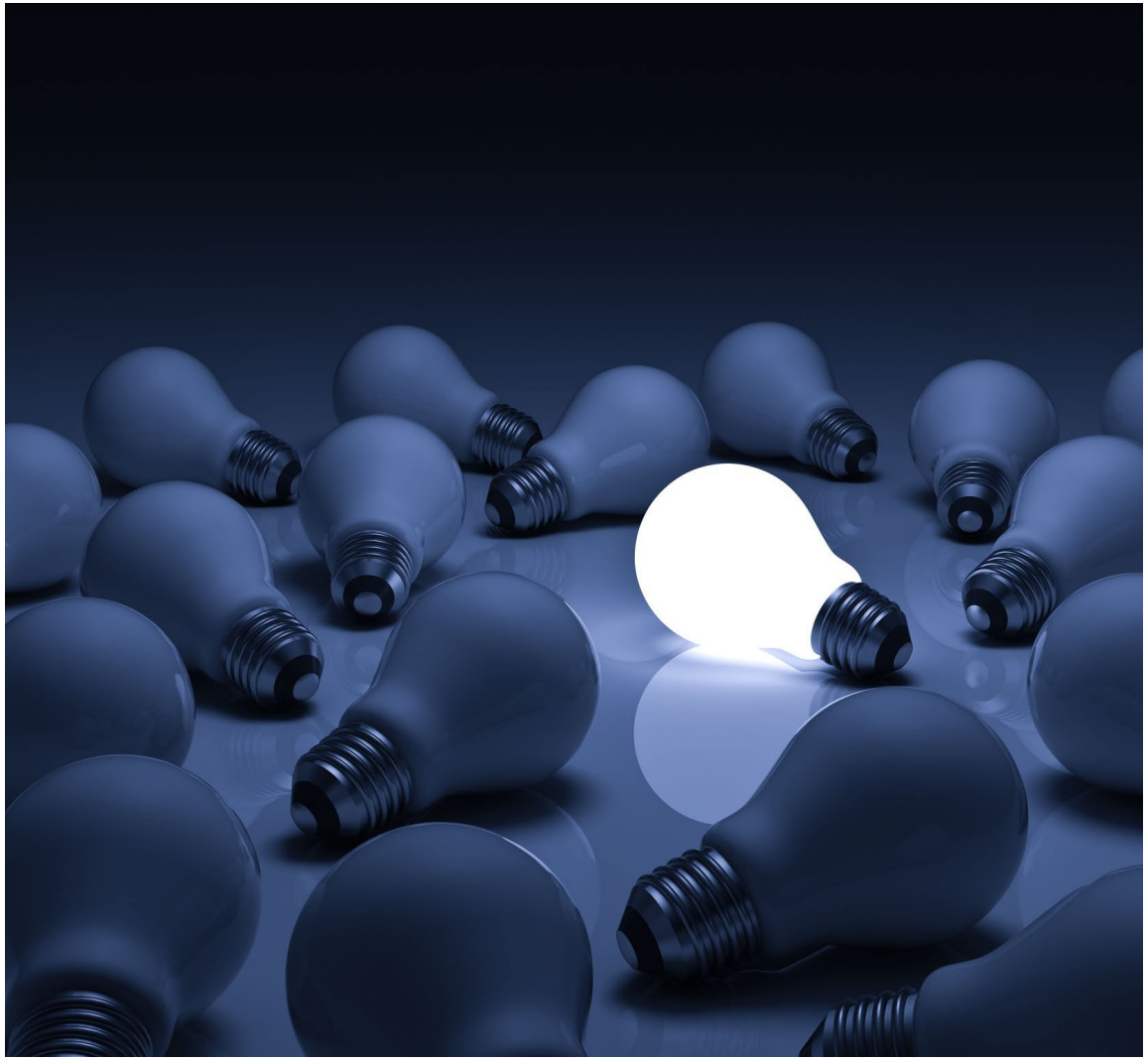
Operational Adjustments

- Increase in administrative functions with multiple managed care plans
- Managed care process requirements

Impact

- Staff training on unique plan procedures for care coordination and utilization management
- Workflow expansion to satisfy managed care requirements

What is your biggest challenge with managed care today?



Opportunities & Options

WHAT ACTIONS CAN WE TAKE?

Provider Opportunities

Accountable Care Organization (ACO)

Institutional Special Needs Plan (I-SNP)

Provider Network

Accountable Care Organizations (ACO)

- Accountable Care Organizations are groups of providers who deliver coordinated care in an efficient and effective manner to a defined population to improve outcomes and reduce overall spending.
- Outcomes and the total cost of care are key performance indicators.
- CMS has tested and continues to test variations of ACOs.
  - Medicare Shared Savings Program (MSSP)
  - ACO Realizing Equity, Access, and Community Health (ACO REACH)
  - Long-term Enhanced ACO Design (LEAD)

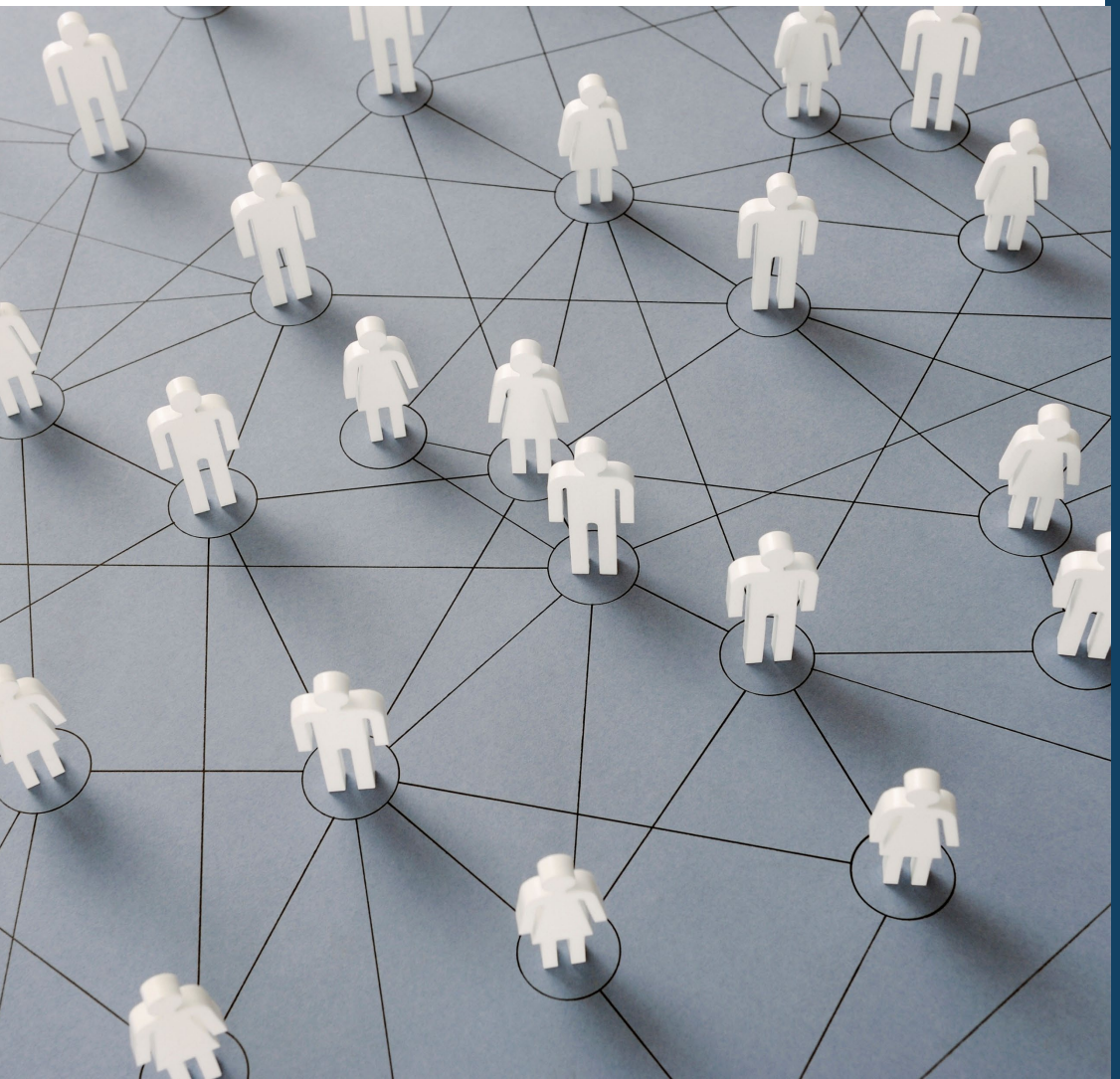
ACO Programs

Description	MSSP	ACO REACH	LEAD
Program Name	Medicare Shared Savings Program (MSSP)	Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH)	Long-term Enhanced Accountable Care Organization (ACO) Design (LEAD)
Program	Federal ACO program for groups of providers to coordinate care for Medicare FFS beneficiaries; rewards quality and cost savings	Advanced ACO model emphasizing health equity, flexible risk, and capitation; successor to Direct Contracting	10-year voluntary ACO model with enhanced benchmarking, capitation, and focus on high-needs and rural populations
Effective Date	2012 (current structure 2019)	2023	2027
End Date	Ongoing	December 31, 2026	December 31, 2036 (10-year period)
Number of Participants (2024)	476 ACOs; 10.3M beneficiaries	115 ACOs; ~1.9M beneficiaries	N/A
ACOs with Savings (2024)	76%	83%	N/A
ACO Earned Savings (2024)	$4.14B	$1.52B	N/A

Institutional Special Needs Plan (I-SNP)

- Institutional Special Needs Plan (ISNP) are a type of Medicare Advantage plan designed for people who are in a long-term care setting
- Medicare A & B eligible long-term care residents
- Provides additional benefits to the resident and provider
- Opportunity for care coordination and incentive programs
- Potential access to Medicare Advantage and Commercial Plans

Provider Network



Structure

A *Clinically Integrated Network* (CIN) is a structured collaboration of health care providers working together to deliver coordinated, high-quality care while optimizing costs and patient outcomes

Key Components

Hospitals, physicians, and post-acute care providers, data warehouse and analytics, care coordination management, and value-based managed care arrangements

Goals

Support and maintain active and ongoing collaboration that incentivizes providers to evaluate and modify practice patterns that: (1) monitor and control utilization of services, (2) control costs, and (3) ensure quality of care

Network Solutions

Challenges

- *Interoperability*: Data integration and sharing across different EMR/EHR systems
- *Clinical:* Aligning care delivery to VBC demands
- *Cultural*: Shifting from competition to collaboration
- *Funding*: Financial and resource investment
- *Antitrust*: Legal and regulatory compliance

Solutions

- *Collaboration*: Development of value-based contracts with data sharing arrangements
- *Coordination*: Data-driven care coordination through utilization of a data warehouse with data analytics
- *Efficiency*: Clinical integration through a post-acute provider network
- *Performance*: Financial integration across a provider network to maximize shared savings

Senior Care Resources

Purpose

A clinically and financially integrated network that works together to maximize the health and well-being of seniors in member communities through innovative, cost-effective care management practices, and quality improvement activities with entities involved in managed care.

Structure

Developed as a for-profit LLC in Michigan to meet the needs of members who desire to work together to improve quality and share resources

A wholly-owned affiliate of LeadingAge Michigan

Network Functions

- Develop collaborative relationships
- Establish credentialing requirements
- Share best practices for performance improvement
- Develop quality and cost effectiveness standards
- Collect and analyze quality data for improvement
- Contracting entity for performance incentive programs

Membership Responsibilities

Adhere to the Participation Agreement

Participate in quality improvement

Designate the network as an agent

Ensure compliance with health plan contracts

Participate in data collection

Comply with the network anti-trust compliance program

Provider Network Membership Benefits

- Contracting support
- Provides access to network level contracts
- Value-based and incentive opportunities
- Evaluation of critical contract terms
- Quality support to improve performance
- Enhanced relationships with managed care plans
- Credentialing support
- Access to managed care contracting experts
- Claim payment issue escalation

Value-Based Care & Incentive Programs

- Emphasis on the quality component of payment
- Encourages efficient and effective care delivery for better outcomes
- Rewards healthcare providers who devote resources to quality improvement and effectiveness strategies
- Promotes accountability
- Utilizes quality and outcome improvement to impact payment
- Compensates providers for achievement of metrics that influence quality, efficiency, and well-being

What gaps could SCR fill within your managed care strategy?

Questions to ask your team

- How do we train staff on managed care requirements?
- What is our managed care strategy?
- Do we have a centralized, up-to-date repository of all managed care contracts?
- What managed care plans are we contracted with and who is our provider representative?
- How are denials tracked and categorized by payor and type?
- What are our days in accounts receivable by payor?
- What is our process for reviewing and negotiating managed care contracts?
- Does our average reimbursement rate correspond with our managed care contract?

Questions?

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STRATEGIC HEALTH CARE
MANAGED CARE SOLUTIONS

SeniorCare Resources