



## **Integrating Acute and Post-Acute Care: The Emerging Merging of the Sectors**

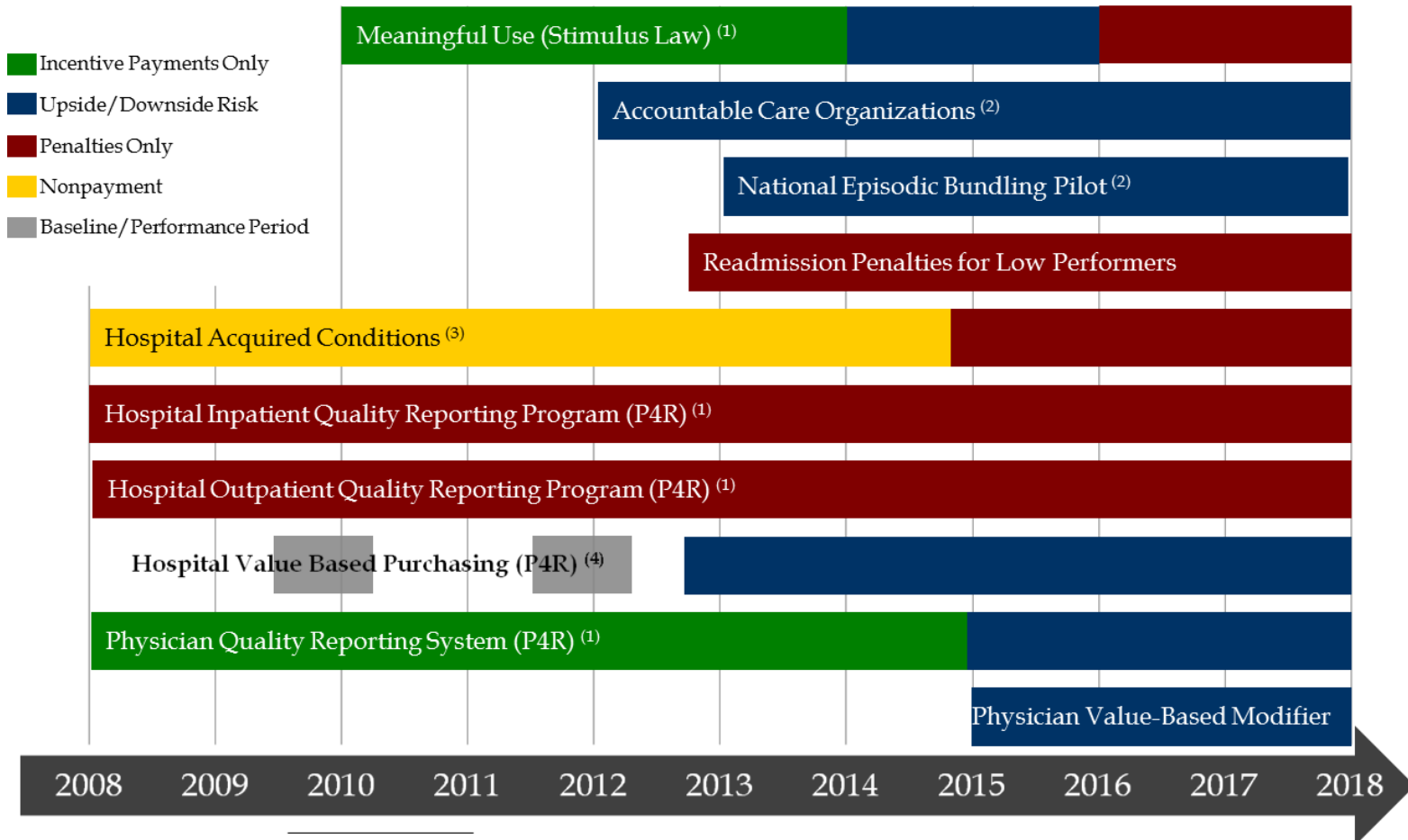
April 18, 2014

## Post-Acute Care (PAC) - A Driver of Medicare Costs

- PAC Medicare FFS spending is growing at unsustainable levels given the projected rise in enrollment
- While MA PAC utilization statistics are not available, MA tends to mimic FFS PAC usage patterns – 10% annual MA growth means that between 40-50% of all Medicare will be MA capitated by 2025
- PAC revenue growth is due to several factors. To control utilization, CMS’s policy is evolving from FFS, to payment methodologies that reward care coordination, stability and are venue neutral; possibly combining the acute care and PAC payments into one bundled payment
- MA utilization patterns are likely to follow Medicare Bundled payment initiatives
- Acute and SNF readmission penalties were CMS’s first PAC reform effort, causing hospitals to move from “laissez faire” patient discharging, to establishing more meaningful SNF and HHA networks
- Hospitals are quickly moving to establish fewer/but tighter SNF networks
  - Advocate in Chicago reduced SNF referrals from 42 SNFs to 12 over a 2 year period with their hospitalists being the SNFists at the 12 SNFS
  - Advocate’s ACO-like model provides a 90% of Medicare FFS rate with bonuses for quality, reduced readmissions and shortened SNF ALOS
- CB recommends that hospitals form networks with area SNFs in advance of these pending changes to help better organize the PAC continuum for more cost-effective PAC utilization and patient recovery

# CMS Is Advancing New Value-Driven Payment Paradigms

## Links PAC-Acute Primary Care Service Levels



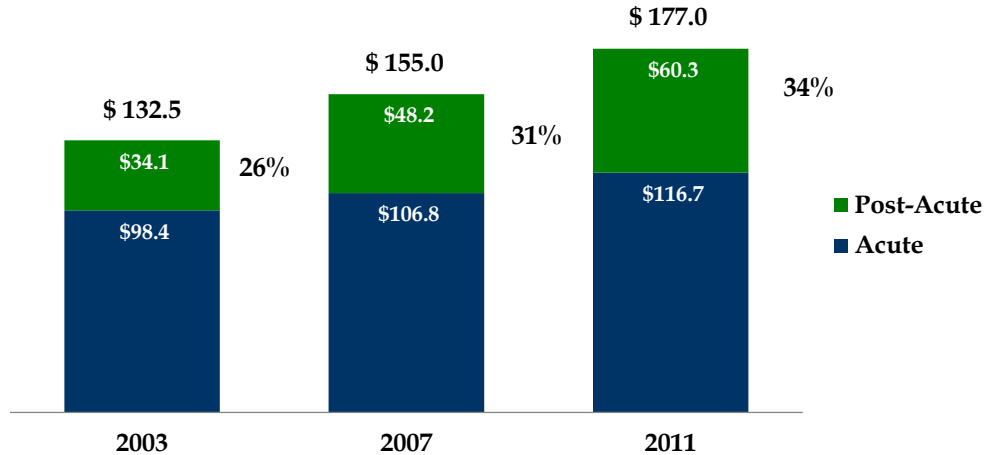
Source: Avalere Health, Centers for Medicare & Medicaid Services

(1) Program is voluntary, but penalties are/will be in place for nonparticipants; (2) Program is voluntary; (3) Nonpayment for Hospital Acquired Conditions (HACs) began in 2008; HAC penalties of up to 1% of Inpatient payments begin in FY 2015; (4) The Hospital Value-Based Purchasing Program (VBP) begins in FY 2013 by affecting payments for discharges occurring on or after 10.1.12. The Baseline period for the program was from 7/1/09 to 3/31/10; the Performance period for the FY 2013 program payment determination is from 7/1/11 to 3/31/12. The ACA mandates that the Secretary develop Value-based Purchasing plans for skilled nursing facilities, home health agencies and ambulatory surgical centers.

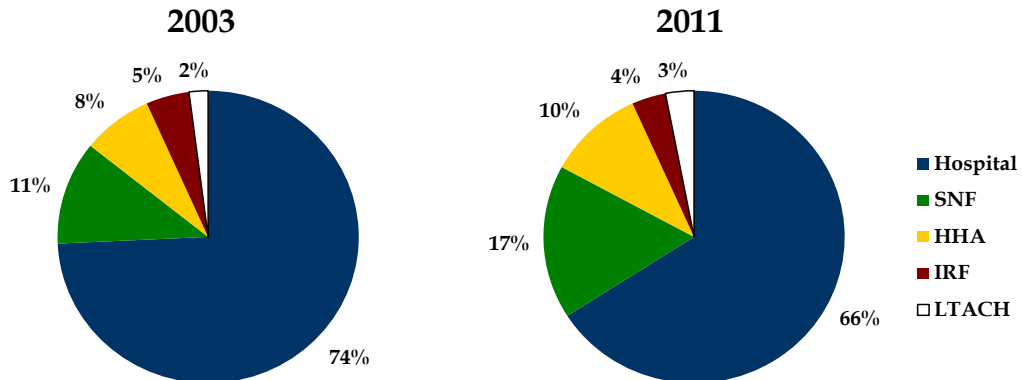
# Acute and Post-Acute Care Trends

CMS is highly concerned with slowing PAC revenue growth as it is out-pacing all other Medicare services

Medicare Expenditures (fee-for-service only)



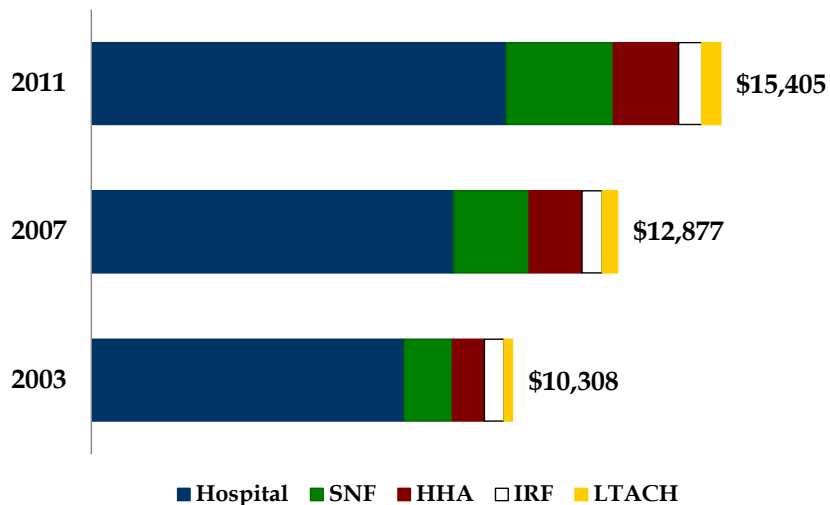
Distribution of Medicare Expenditures by Venue of Care



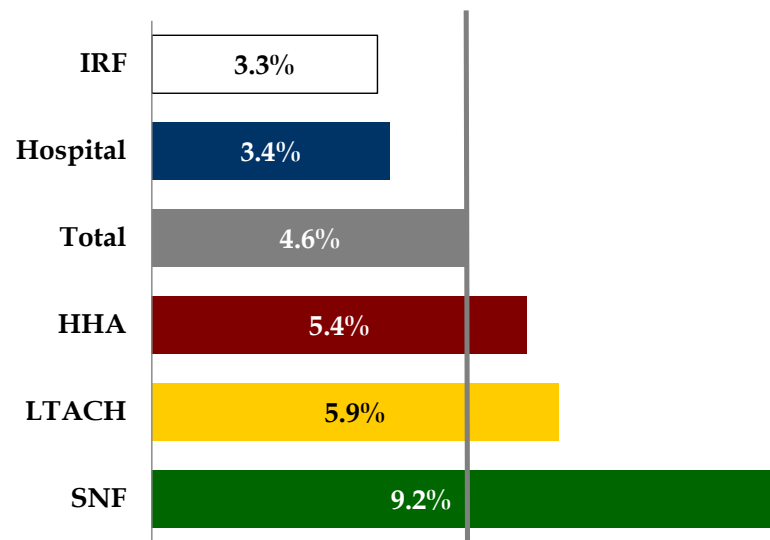
# Total Cost of PAC Medicare Care is Increasing

Higher expenditures with little to no improvement in patient health as each PAC silo wants to maximize its revenues and seldom collaborates with other PAC providers or other System providers (isolated both vertically or horizontally).

Per Acute Discharge



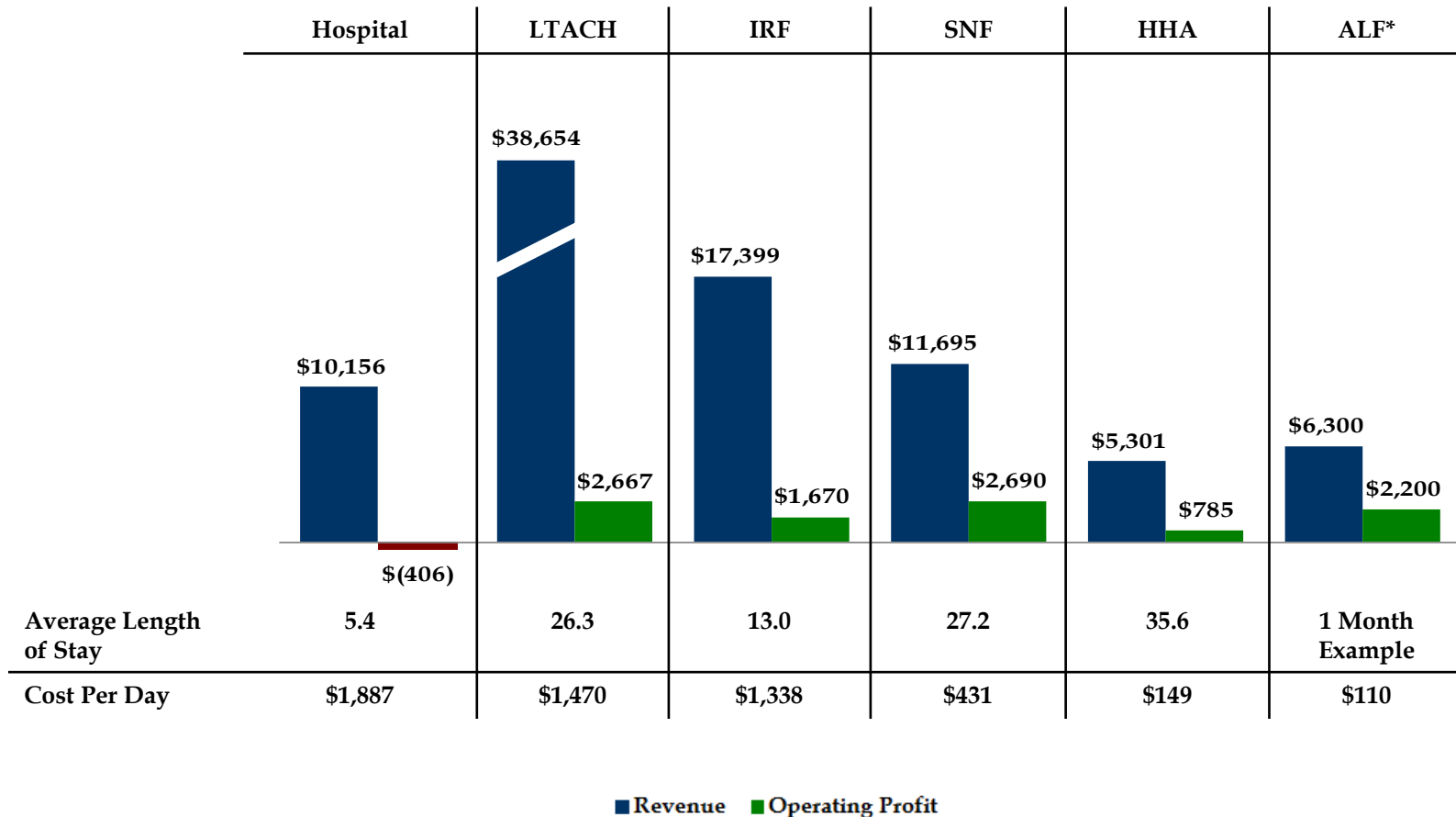
Average Annual Growth ('07 - '11)



## Venues of Care (PAC is More Profitable Than Acute)

Disparity in expenditures and Medicare specific margins - Medicare SNF remains the most profitable

Average Medicare Expenditures and Margins Per Case by Venue of Care



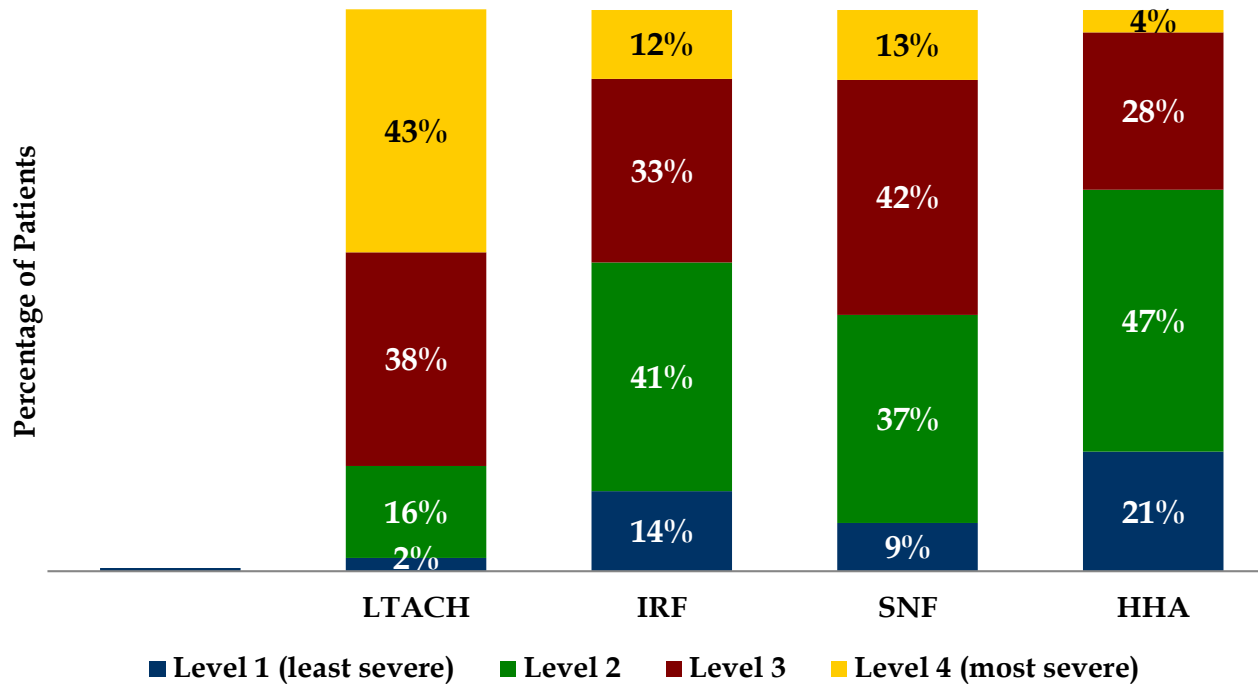
Source: CMS, 2011 data  
\*Non-Medicare

# CMS is Questioning LTACH/IRF Usage

Finding equilibrium between service, care needs, cost and outcome (or quality)

- While robust data is minimal, there is little correlation between costs and service
  - Providers are going to have to manage costs to appropriate service level and outcomes, not reimbursement

Severity of Illness by Venue\*



# Hypothetical Implications of Reimbursement Change

## Bundled Payment and ACO Profit Sharing Debate

- Medicare patients discharged from an acute care hospital can represent operating losses to the hospital, and significant earnings to post-acute providers
- Allocating bundled payments to the various constituents will be challenging – with Acutes wanting a piece

### Bundled Payment: Example Hospital – Medicare Inpatient Revenues and Associated Post-Acute Revenues

Medicare Inpatient Activity		Related Post-Acute Discharges	
<i>Assumptions:</i>		<i>Assumptions:</i>	
Average Medicare Inpatient Census	150	% of Medicare Inpatients Discharged to Post-Acute	35% <sup>4)</sup>
Total Annual Medicare Patient Days (365 days)	54,750	Total Post-Acute Discharges	3,992
Average Medicare Length of Stay	4.8 <sup>1)</sup>	Post-Acute Revenue Per Post-Acute Discharge	\$ 13,600 <sup>2)</sup>
Total Medicare Discharges Per Year	11,406		
Inpatient Revenue Per Discharge	\$ 9,900 <sup>2)</sup>		
<i>Implied Inpatient Revenue &amp; Profitability:</i>		<i>Implied Post-Acute Revenue &amp; Profitability:</i>	
Total Medicare Inpatient Revenues	\$ 112,921,875	Total Medicare Revenues	\$ 54,293,750
Inpatient Medicare Margin (per MedPac)	-2.4% <sup>3)</sup>	Average Post-Acute Medicare Margin (per MedPac)	17.9% <sup>3)</sup>
Inpatient Profitability	\$ (2,710,125)	Post-Acute Profitability	\$ 9,718,581

"Bundling The Payment"			
Medicare Inpatient Revenues	\$ 112,921,875	Total Medicare Discharges Per Year	11,406
Medicare Post-Acute Revenues	54,293,750		
Total Medicare Revenues	\$ 167,215,625	Acute & Post-Acute:	
		Revenue Per Medicare Discharge	\$ 14,660
Inpatient Profitability	\$ (2,710,125)	Profit Per Medicare Discharge	614
Post-Acute Profitability	9,718,581		
Total Profitability	\$ 7,008,456	Medicare Margin	4.2%



# Industry Dynamics

## Medicare FFS Policy is Rearranging the Post-Acute Landscape

Medicare has seen significant increases in expenditure and utilization of post-acute care services, driven in part by the movement of patients between venues of care without coordination and oversight

### Medicare's Response

- Significant activity with respect to payment reform (ACOs, MA bundled payments, etc.)
- Interim penalties to address immediate re-hospitalization concerns

#### Old Paradigm

- Silo'd payment systems with different rates by site of care
- Payments based on service type, intensity and volume
- Limited coordination of shared risk among providers
- Maximize visits/services with little linkage to patient conditions



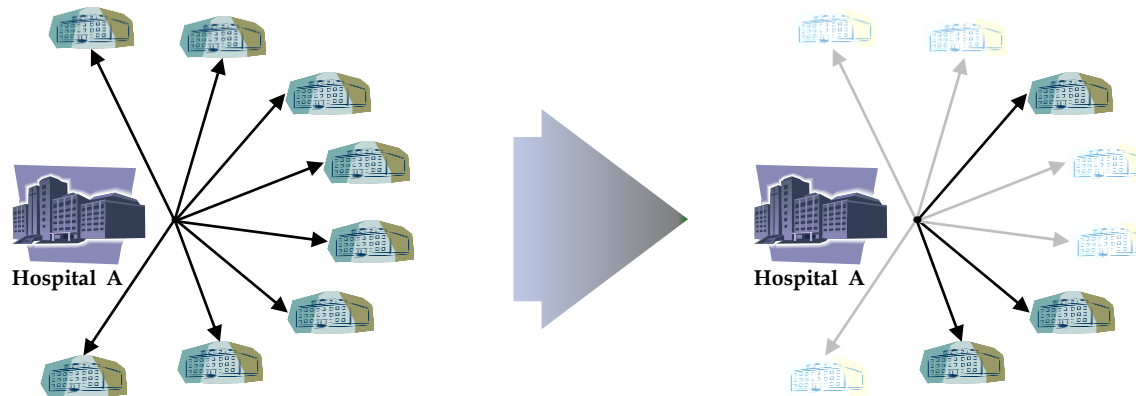
#### New Paradigm

- Combined acute/post-acute bundled payments across settings for most providers in Medicare
- Profit influenced by patient outcome
- Encourage care coordination throughout the PAC continuum and with primary care
- Incentives to move patients to the lowest appropriate PAC level

## Market Response – Acute Facilities Evolving Response to Readmission Penalties

Referral networks are narrowing

- Clinical integration and shared incentives

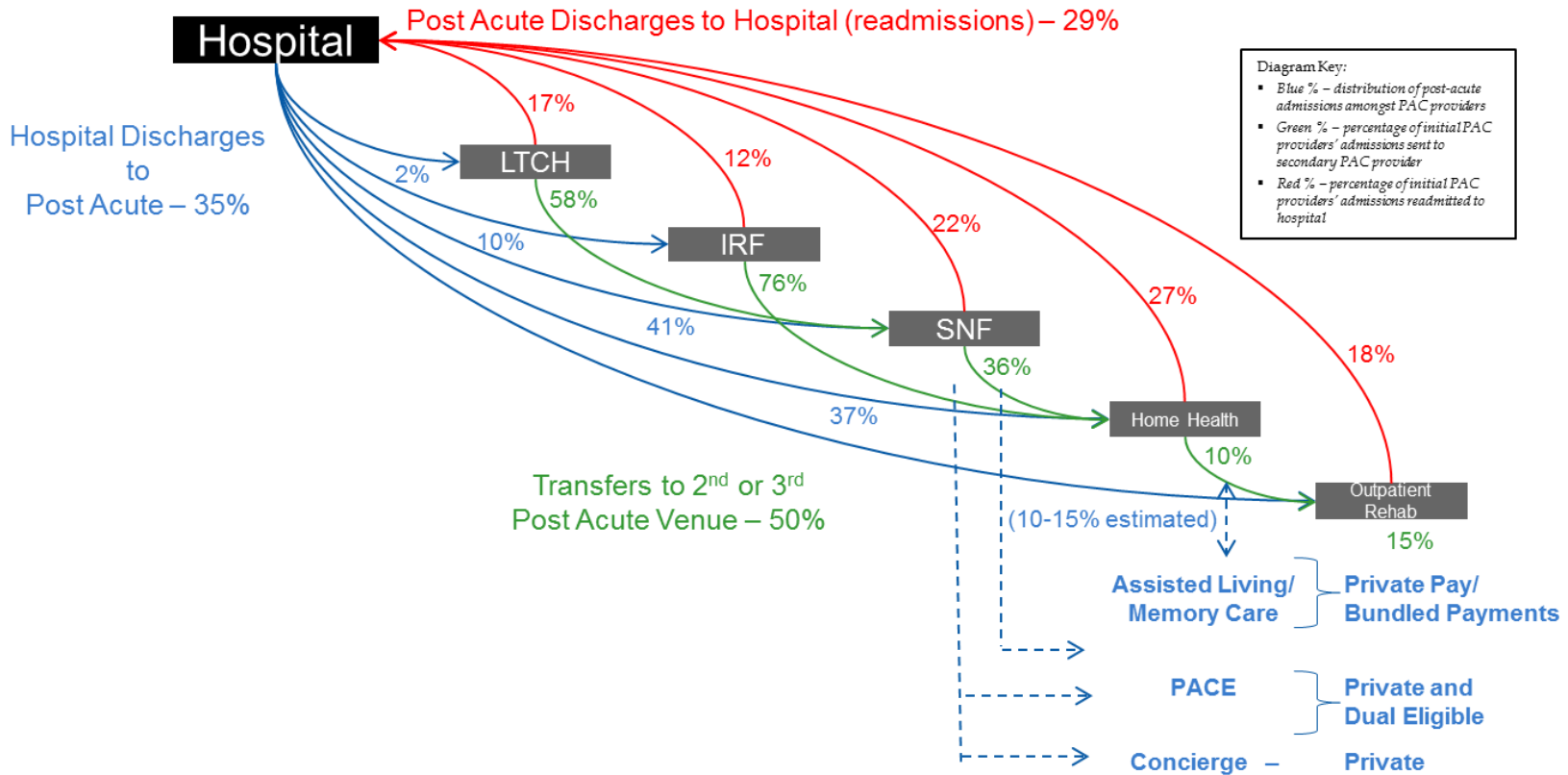


- Health System Hospitals will reduce their referrals from “any willing bed” to those facilities they have strong clinical and business relationships
- Shared IT for better patient care and tracking
- SNF partners will provide dedicated beds/24 hour admissions for Hospital System Partners
- Tightened linkage to Hospital System-owned Home Health Agencies for follow-up care
- Imaginative use of bundled payments/ ACO shared savings/MA capitation to pay for needed non-traditional Medicare services that keep complex, chronic patients stabilized
  - For example, link assisted living with home health to convert a 3-4 week SNF stay to a 6 week combined ALOS

# The Evolving Health System PAC Continuum Prototype

## Current Industry Issues

- Economic incentive for acute care providers to increase PAC patient volume and rapidly discharge
- No coordination of patients over episode of care
- No incentives to actually improve a patient's health care condition
- No economic penalty for poor performance



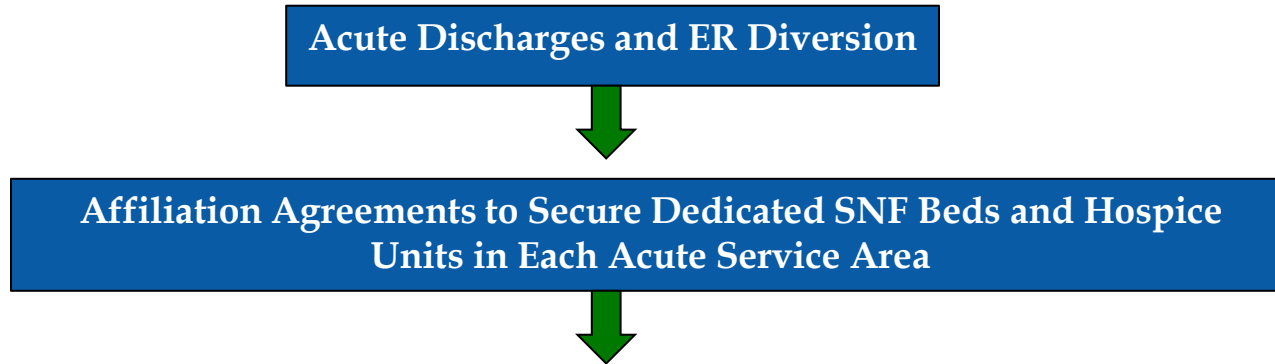
## Potential Next Steps

- Review hospital's internal SNF capacity and referrals out of the organization
- Prepare Criteria Inclusion List for SNF partner(s) – criteria may include:
  - Nurse Staffing ratios – total hours and licensed levels for dedicated short-stay units
  - Admission criteria – health conditions, payment type, 16 to 24 hour a day admissions, etc.
  - Highlight facility appearance and/or willingness to expedite facility modifications
  - Willingness to integrate system's skilled therapy and medical direction, possibly adding an out-patient skilled therapy and chronic care clinic on-site
  - Willingness to enter into innovative payment mechanisms - possibly including capitated risk-sharing, quality of care bonuses, etc. - in addition to per diem reimbursement
  - Willingness to invest in real-time EMR/IT and cost-center accounting transparency
  - Willingness to work with competitive SNFs to provide additional capacity, possible with ALF and residential hospice, to strengthen the PAC continuum and to test research findings

## PAC Out-Reach Goals

- Negotiate network affiliation and bed-hold agreements, and possibly shared-risk or bonus linked per diem contracts
- Strike agreement, create joint quality committees, enhance admission policies and make IT upgrades
- Hold monthly and/or quarterly quality-care meetings to track progress on all key quality indicators and implement agreement upgrades
- Create joint-medical directorships and make care delivery adjustments as needed
- Make joint-quality committees open to two-way communication where hospital/docs learn how to better prepare acute patients for SNF transfer
- Create compensation methodologies, legitimate under Medicare, for serving the most-difficult to serve patients that are “losers” under the current reimbursement systems
  - Annual Grants
  - In-kind Supplies/Services
  - IT support, etc.

## Potential Hospital PAC Delivery System (2014-2018)



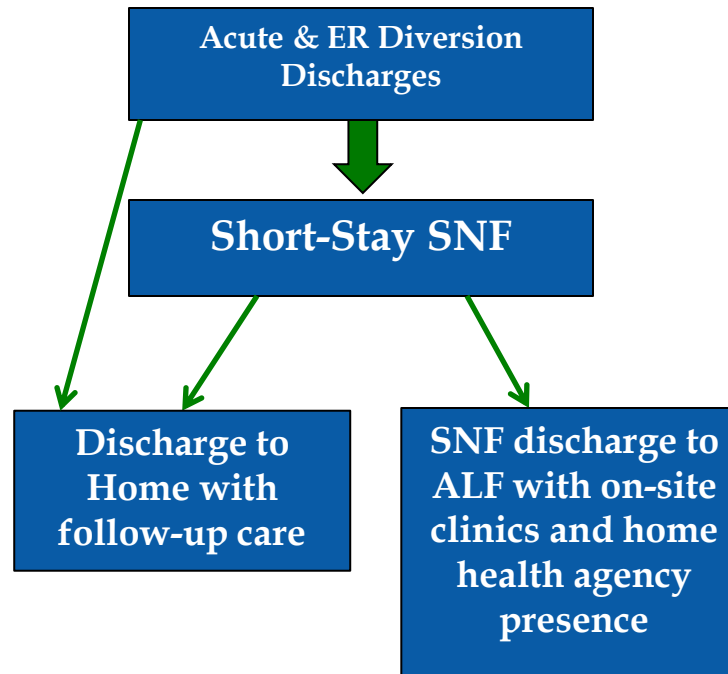
- Initial Strategy is to create tight SNF/acute networks capable of 21<sup>st</sup> Century SNF care
- Competitive SNF linkages may be needed to provide full coverage in some markets
- Dedicate nursing units fully dedicated to short-stay patients, as managing varied acuity levels and different reimbursement formats in a single unit is difficult
- Test both basic SNF “bed-hold agreements” and more formal SNF affiliations with shared risk
  - Overall PAC costs should decline as vendor orientation shifts from arms-length FFS contracting, where vendors maximize per episode reimbursement, to a more health management oriented payment system
  - Several sites should include SNF linked ALF and residential hospice to assess whether costs are reduced or health status is improved through linking ALF care with home care, and/or an on-site primary care clinic
  - Create home health and transitional staff care management linkage for SNF discharged patients
- **The above should be considered prerequisite conditions for major facility capital upgrades**

## Possible Areas of 1-4 Year Research Study (A Sample)

- 30-60-90-180 Day Readmission Rates by Major Diagnostic Groups
- Reduction in LTAC/Acute Rehabilitation Bed Usage Replaced by High Level SNF Care
- Shortened SNF ALOS
- Ability to track second and third level PAC referrals and usage to establish base-lines
- Increase in Hospice Benefit Selection and Usage
- Assess progress in creating tight Home Health and out-patient therapy follow-up linkages
- Whether ALF linkage reduces SNF stays and/or makes home health care delivery more cost-effective
- Whether greater PAC control results in overall utilization costs for the top 25% PAC patient utilizers
- Best practices/strategies for compensating SNF for quality care delivery and shared savings
- Other areas...

## A Second Stage - Adding Assisted Living

Short Stay SNF Beds  
+  
ALF and Memory Facilities  
(Co-Located Sites)  
+  
Health System-Operated Out-Patient Clinics Linking  
Care Levels and Serving as Chronic Care Day Centers



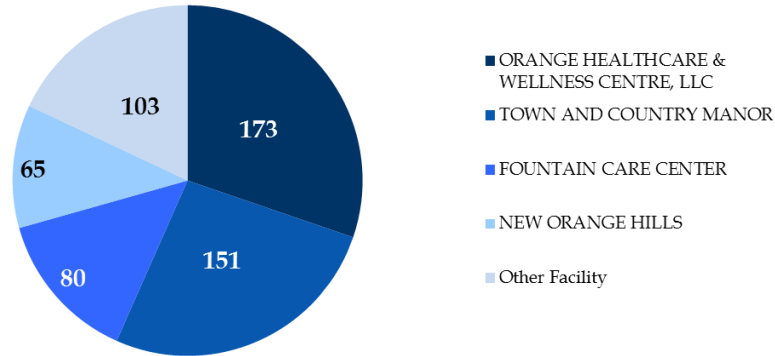


## **Exhibit A: Example Medicare FFS Discharges to SNFs**

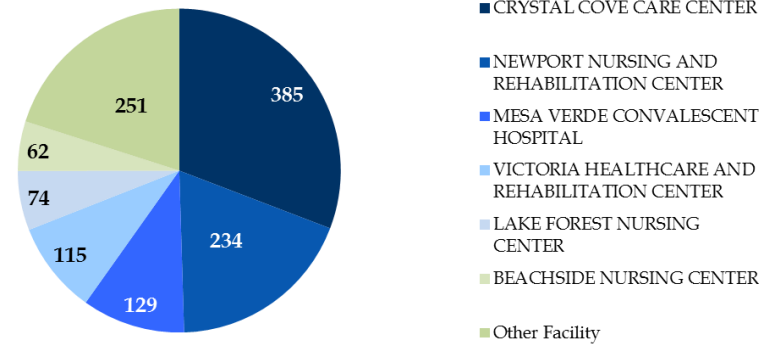
# Example Medicare FFS Discharges to SNFs

## St. Joseph's Health – Select Southern California Locations

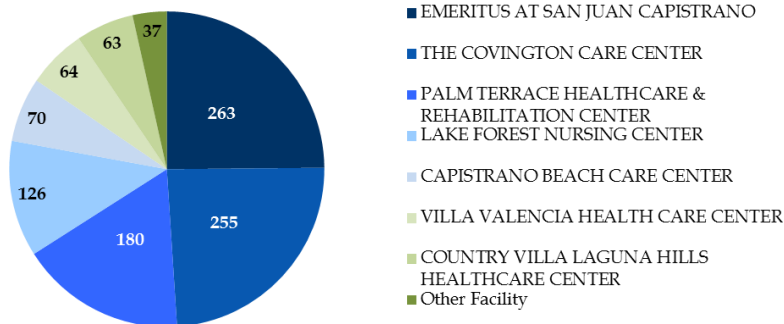
### St. Joseph Hospital



### Hoag Memorial Hospital



### Mission Hospital Regional Medical Center



### St. Jude Medical Center

