hfma hawaii chapter
healthcare financial management association

Honolulu, HI

Bottom Line Success Through Post-acute Care

April 16, 2013

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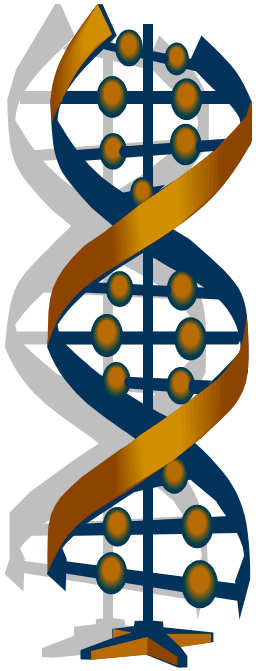
Focus of Today's Presentation



- Introduce Walter Consulting
- Review post-acute basics
- Discuss Hawaii-specific post-acute issues and trends
- Identify potential impact to health reform initiatives in Hawaii
- Discussion

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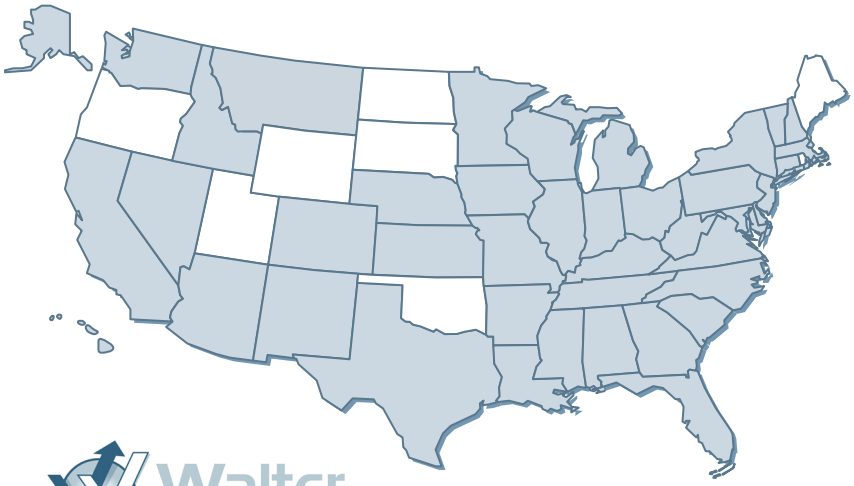
National Post-acute Consulting Background

- Acute and post-acute clients in 40+ states
- Major academic medical centers and integrated health systems
- Community hospitals and faith-based organizations
- Proprietary and NFP providers
- Freestanding and hospital-based SNFs, HHAs, IRFs, hospice
- Other

Post-acute Clients



Program Focus
Skilled care/subacute care
Acute rehabilitation
LTCH
Home health
Hospice
Assisted living
Outpatient rehabilitation
Other

Practice Areas
Strategic planning
Demand analysis
Program feasibility
Financial impact analysis
Operational improvement
CON/Regulatory Support
Board/leadership education
Other

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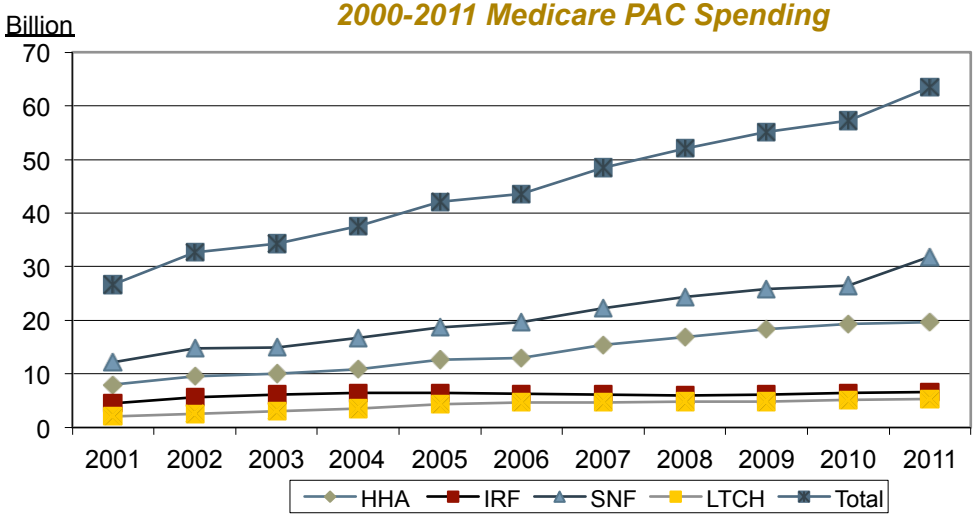
Post-acute Overview

Medicare Post-acute Definition
• Inpatient Rehabilitation (IRF, IRU)
• Skilled Nursing (SNF, subacute)
• Long-term Care Hospital (LTCH, LTACH)
• Home Health

Note: Hospice not considered post-acute by CMS, but is a close cousin to HHA

- Each PAC program predominantly Medicare (65%+)
- Virtually all of the IRF, SNF, and LTCH patients originate from the acute care setting (90%+)
- +/- 60 percent of HHA and hospice originate from acute care
- Approximately 20 percent of all PAC patients are discharged to a second PAC program

2000-2011 Medicare PAC Spending



- From 2000 to 2010, CMS spending for PAC increased an average of 8 percent per year
- Over the same time period, spending for acute care increased just 3 percent per year
- The CMS PAC expenses have increased from 12 percent of all fee-for-service spending in 2000 to 15 percent in 2011
- As a comparison, in 2011, acute care expenses represented 32 percent Medicare FFS

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Post-acute Payment Basics

Level of Care	Payment Basis	Est. 2012 Medicare Margin (a)	Comment
Skilled Nursing (SNF)	• RUG Payment • Per Diem	14.6% (a)	• Patient must require "skilled service" • Does not include long-term care/custodial care
Inpatient Rehabilitation (IRF/IRU)	• CMG • Per Disch.	8.0%	• An "acute" level of care • Patient must also require intense rehabilitation
Long-term Care Hospital (LTCH)	• LTCH-DRG • Per Disch.	4.8%	• Hawaii one of only 5 states without LTCH
Home Care (HHA)	• HHRG • 60-day Episode	13.7%	• Patient must require "skilled service"
Hospice	• Per Diem	5.1%	• Both at-home and inpatient covered benefit

(a) Freestanding SNFs only; does not include HB-SNFs.

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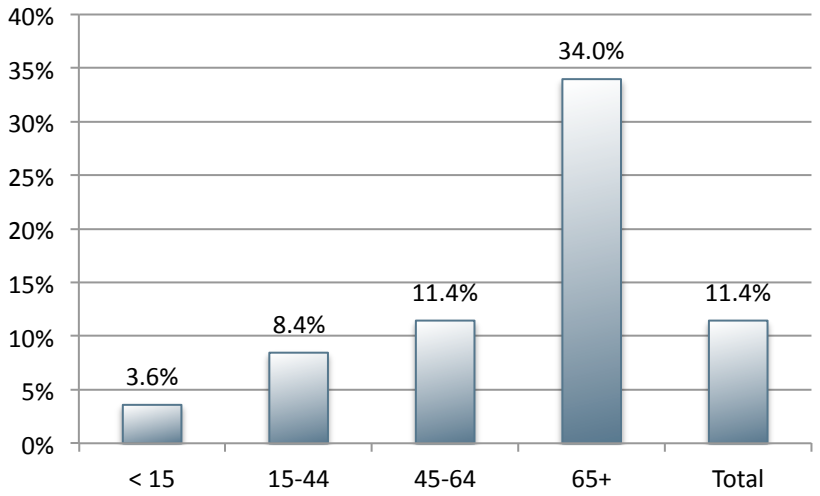
Post-Acute Utilization Rates

Nationally, approximately 40 percent of all Medicare acute care discharges utilize post-acute services

"Best Practices" for effective systems is in the 42 – 50 percent range

2007 US Acute Care Admission Rate by Age Cohort



2006 National Post-acute Utilization Rates

Discharge Disposition	All Medicare (a)	Best Practices (b) Low	Best Practices (b) High
IRF	3.2%	4.0%	6.0%
SNF	17.3%	12.0%	15.0%
HHA	16.0%	22.0%	24.0%
LTCH	1.0%	1.5%	2.0%
Hospice	2.1%	2.5%	3.0%
Total	**39.6%**	**42.0%**	**50.0%**

(a) Source: MedPAC June 2008 Annual Data Book.
(b) Source: Walter Consulting.

- *34 percent of the total age 65+ population will likely require an acute care admission each year*
- *40%-50% of those patients will require PAC services*
- *As such, about **15 percent** of any shared risk Medicare populations will likely require post-acute care*

Current PAC Objectives For Most Health Systems

- Historically, the **three primary objectives** for post-acute care
  1. Reduce acute care **ALOS,** in order to
     - *Improve acute care financial margin*
     - *Increase through-put with existing beds*
     - *Reduce need for bed expansion*
  2. Improve **clinical outcomes** and functional status
  3. Generate **additional revenue stream** if provided internally – PAC profitable if done properly

- PAC programs are typically a **"pressure valve"** for the acute care chassis
- Additionally, at their best, PAC programs should help manage those acute care patients that present the **greatest risk** to health systems (chronic, high cost, high readmissions, etc.)

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PAC Services Even More Critical With Health Reform

FFS reimbursement models are clearly ending, and whether the payor is Medicare or Managed Care or Other, providers will be **assuming greater financial risk** linked to both cost and quality

Any type of shared-risk payment, such as ACOs, bundled payments, readmission penalties, etc., demand that providers transition patients to the **least expensive** and most **clinically appropriate** setting, which is frequently NOT acute care

All levels of care **are not created equally**, however

- The least expensive PAC setting may have high readmission rates for higher acuity patients, or may not achieve the same clinical outcomes as an alternate setting
- The "least expensive" setting may actually cost more in the long run if attention is not paid to actual clinical need

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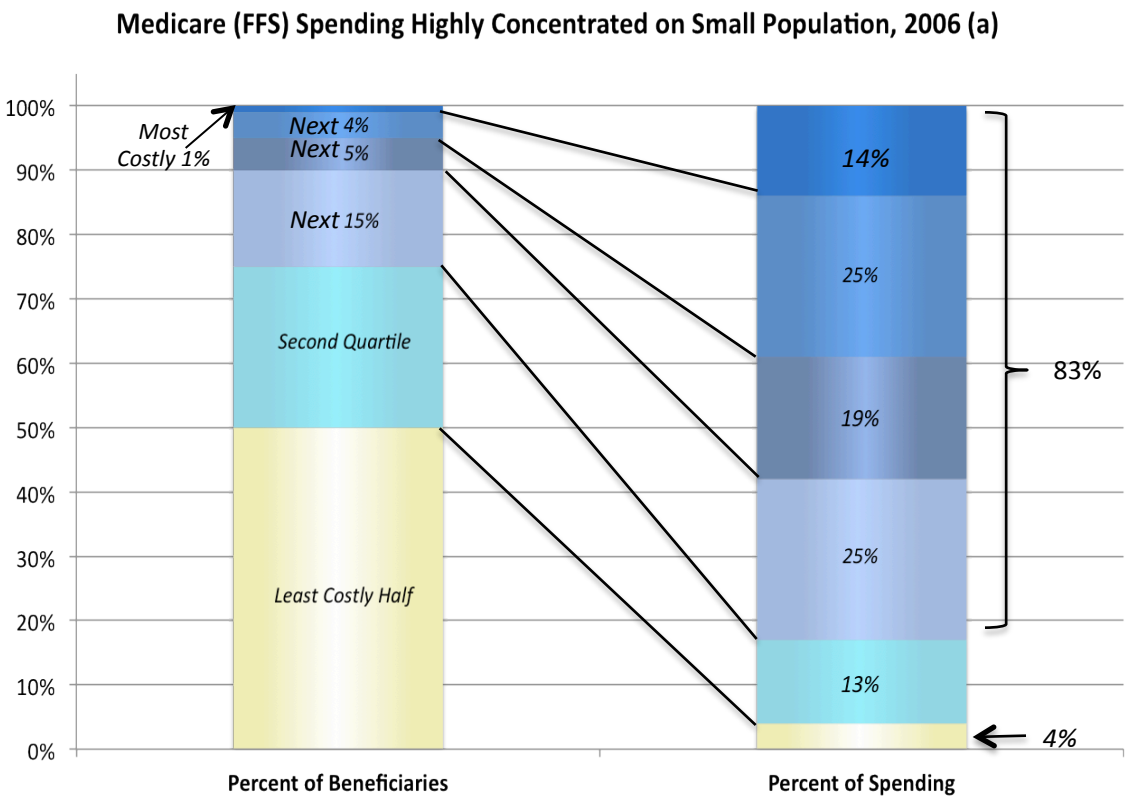
Health Reform and Shared-Risk Provider Challenges In The Local Market

- With any type of shared-risk financial model a provider's **greatest challenge** will be managing the low volume patient populations requiring high-cost and long-term medical/ ancillary support
- Along with efforts to improve compliance and routine health maintenance, **PAC programs will be instrumental** in managing the cost of this patient population
  - *Improve independence*
  - *Reduce readmissions*
  - *Other*



(a) MedPAC; Data Book – Healthcare Spending and the Medicare Program, June 2010.

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How Does Hawaii Compare?

Estimated Hawaii PAC Utilization Compared to National Benchmarks

Discharge Disposition	All Medicare (a)	Best Practices (b) Low	Best Practices (b) High	2010 HI Est. (c)
IRF	3.2%	4.0%	6.0%	+/- 2.0%
SNF	17.3%	12.0%	15.0%	+/- 11.0%
HHA	16.0%	22.0%	24.0%	+/- 7.0%
LTCH	1.0%	1.5%	2.0%	0.0%
Hospice	2.1%	2.5%	3.0%	NA
Total	**39.6%**	**42.0%**	**50.0%**	**20% - 25%**

(a) Source: MedPAC June 2008 Annual Data Book.
(b) Source: Walter Consulting reflecting Best Practices of leading PAC systems
(c) Walter Consulting estimate utilizing multiple CMS, MedPAC, and other reports.

- Hawaii appears to have **significantly lower** PAC utilization compared to national data and other norms
- But, how does Hawaii **rank nationally** in its PAC utilization?
- And, how does this impact current and future **operational and financial performance** for State providers?

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Skilled Care (SNF) Services

2010 Medicare-Certified SNF Beds

Rank	State	SNF Beds	SNF Beds/ 1,000 (a)
50	Alaska	682	11.7
49	**Hawaii**	**3,184**	**16.3**
48	Nevada	5,862	17.5
47	Arizona	16,083	19.7
46	New Mexico	6,707	22.1
45	Oregon	12,293	22.7
44	Florida	82,423	24.7
43	Washington	21,900	25.1
42	Utah	7,661	27.1
41	California	119,826	27.6
	US	**1,663,445**	**40.1**

(a) Per 1,000 population Age 65+.

Source: Kaiser Family Foundation
http://www.statehealthfacts.org

- Besides Alaska, Hawaii has fewer Medicare **SNF beds and admissions** than any other state

2010 Medicare SNF Admissions

Rank	State	Admits	Admits/1,000 Beneficiaries
50	Alaska	1,229	19
49	**Hawaii**	**3,384**	**28**
48	Arizona	25,381	43
47	Nevada	11,071	45
46	New Mexico	9,119	40
45	S Carolina	34,373	53
44	Oklahoma	31,116	61
43	Georgia	52,699	55
42	Alabama	41,831	64
41	West Virginia	18,550	63
40	Oregon	15,143	42
	US (000)	**2,540**	**73**

Skilled Care (SNF) Services

Because there is a three-day hospital stay requirement for SNF services, by definition, virtually all SNF patients **come from acute care**

- As such, significantly lower admission rates suggest that some of these patients may be “backing up” in acute care

If a significant volume of potential SNF patients are “backing up” into acute care, could at least some of these acute care beds be **converted to SNF bed** capacity?

SNF programs could both **generate revenue** and potentially provide **clinical programming** that improves functional level and reduces ALOS

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Home Health Service

2010 Medicare FFS HHA Admissions

Rank	State	Admits (000)	Admits per 1,000 (a)
50	Hawaii	3	24
49	Alaska	2	34
48	S Dakota	4	35
47	N Dakota	4	42
46	Wyoming	3	45
45	Montana	7	48
44	Iowa	24	52
43	Wisconsin	33	52
42	Washington	40	54
41	Arizona	34	57
	US	**3,380**	**96**

(a) Per 1,000 Medicare FFS beneficiaries.

Source: Kaiser Family Foundation
http://www.statehealthfacts.org

- Hawaii has the **lowest HHA utilization** of all 50 states
  - Both patients accessing HHA and the number of visits/admission are the **lowest in the nation**

2010 Medicare FFS HHA Visits/Admit

Rank	State	Visits/Admit
50	Hawaii	16
49	Oregon	20
48	N Dakota	21
47	S Dakota	22
46	Montana	22
45	Washington	22
44	Minnesota	22
43	Maryland	22
42	Arizona	23
41	Delaware	23
	US	**37**

Home Health Service

The current (2010) Hawaii HHA use rate is the **lowest in the country**, and is only **one-forth** the national rate

With the island nature of the State, the limited real estate available for development, and the high cost of construction, Hawaii could be a **national leader** in HHA program development

- *Telemonitoring*
- *High-tech home services*
- *Other*

Of all PAC services, HHA is likely the one area that will experience the **highest growth** with health reform, because it offers the lowest cost site of care, and has the highest potential to keep patients out of a bed

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Inpatient Rehabilitation

2011 IRF Beds and Utilization

All Patients

Rank	State	Beds/ 100K	ADC/ 100K
50	Alaska	2.7	1.6
49	Maryland	2.2	1.6
48	Oregon	3.5	2.1
47	Delaware	5.5	2.8
46	Connecticut	5.0	3.3
45	California	5.4	3.4
44	Washington	6.1	3.7
43	Minnesota	6.7	3.8
42	**Hawaii**	**5.5**	**3.8**
41	Utah	9.3	3.9
	US	**11.7**	**7.2**

Source: American Hospital Directory.

In addition to having the 49th lowest number of SNF beds and SNF utilization, Hawaii also in the **bottom 10** among all states for its utilization of inpatient rehabilitation

Unlike SNF services, where there may not be sufficient capacity, there is currently **unused capacity** of IRF beds – *more IRF referrals would likely relieve pressure on both acute care providers and SNFs*

Note: Because this data source utilizes individual providers' Medicare Cost Reports, rather than CMS patient files, in reality Hawaii probably ranks as # 45 or 46, as many residents of CT, DE, and MD frequently cross state boundaries to receive care (which would be reflected in statistics from neighboring states…)

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Hospice Services

- Hawaii has the **5th lowest utilization** of hospice services in the country (ranked 46)
  - This is not too surprising, given that Hawaii had the **lowest HHA utilization** in the country
    - Hospice is a separate Medicare benefit, but in many markets there is a parallel between home health and hospice services
  - Nationally, hospice has seen **tremendous growth** in recent years, with Medicare admissions into hospice more than doubling from 2000 - 2010

2010 Medicare Hospice Utilization

Rank	State	Persons Served	Rate/1,000 Beneficiaries
50	Alaska	550	7.9
49	Vermont	1,555	13.2
48	New York	41,252	13.3
47	Wyoming	1,219	14.5
46	**Hawaii**	**3,293**	**15.1**
45	North Dakota	1,878	16.9
44	Wash DC	1,386	17.1
43	S Dakota	2,509	17.8
42	Kentucky	14,392	18.1
41	Connecticut	11,416	19.5
	US	**1,151,358**	**23.3**

Source: Kaiser Family Foundation
http://www.statehealthfacts.org

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LTCH Services

- Hawaii is one of only five states **without any LTCH services**, and as such is tied for 50th in utilization
  - The lack of LTCH services should generate **additional referrals** into either SNF or IRF, as there is often overlap in these areas, but the low Hawaii SNF and IRF utilization suggests this is not the case
  - Many of these LTCH patients are therefore likely **backing up into acute care**

2011 LTCH Utilization - All Patients

Rank	State	Beds	ADC/100,000 Pop
50	**Hawaii**	**0**	**0**
50	Maine	0	0
50	New Hampshire	0	0
50	Vermont	0	0
50	Wyoming	0	0
45	Alaska	60	4.5
44	Alabama	253	3.0
43	Arkansas	283	6.5
42	Arizona	585	3.4
41	California	1905	3.4
	US	**33,610**	**5.6**

Source: American Hospital Directory.

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Acute Care ALOS

In addition to having some of the nation's lowest PAC utilization, Hawaii has among the **highest acute care ALOS** – both for Medicare and for All Patients

Although several rural states have a higher ALOS (all populations), these states have many Critical Access Hospital that provide cost-based swing bed services

2010 Medicare FFS Acute ALOS

Rank	State	Discharges	ALOS
50	New York	828,675	**6.7**
49	**Hawaii**	**26,115**	**6.6**
48	Wash DC	26,585	**6.1**
47	Rhode Island	42,740	**5.9**
46	New Jersey	423,905	**5.9**
45	Mississippi	171,515	**5.8**
44	Delaware	44,690	**5.8**
43	Connecticut	165,520	**5.6**
42	S Carolina	213,040	**5.6**
41	Louisiana	201,110	**5.6**
	US	**12,284,510**	**5.4**

2010 Acute ALOS – All Patients

Rank	State	Discharges	ALOS
50	South Dakota	99,539	9.3
49	Montana	96,401	8.7
48	Wyoming	48,840	8.0
47	North Dakota	92,466	7.6
46	**Hawaii**	**106,078**	7.5
45	Wash DC	133,406	7.0
44	Nebraska	206,578	7.0
43	New York	2,487,381	6.9
42	Kansas	294,713	6.4
41	Georgia	948,999	6.4
	US (000)	**188,699**	**5.4**

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Source: Kaiser Family Foundation
http://www.statehealthfacts.org

Is There A Connection?

- **Fact:** Hawaii has among the **highest acute care ALOS** of all states
  - Obviously related to this, there are presently over 190 patients on the acute care "Waitlist" *(Source: HAH Dec 2012 Survey)*
- **Fact:** Hawaii also among the **lowest PAC utilization** in the country for each level of care

Although multiple factors influence the acute care ALOS, clearly, the **high acute care ALOS and the low PAC utilization are linked**….

- Hawaii has among the longest acute care ALOS in the country, and is the only State besides Alaska that ranks in the **bottom ten utilization** rates for all **5 levels of post-acute care**

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Does The High Managed Care Penetration in The State, Particularly Medicare Managed Care, Reduce PAC Utilization?

- Even though all previous comparisons (except IRF& LTCH) were comparing only Medicare FFS populations, does the **high presence** of Medicare Managed Care suppress overall PAC utilization – since PAC utilization is predominantly older populations?
- At 44 percent Medicare Managed Care, Hawaii has a higher **Medicare managed care penetration** than all other states except Minnesota (47 percent)
- **Probably not**…
  - Recent anecdotal information from other markets suggest that while Managed Care companies may not utilize all PAC levels at the same rate as FFS (especially LTCH services), most often the **variances are not too significant**

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Three Recent Post-acute Market Studies

2012 Post-acute Utilization – Three Sample Markets and Health Systems

Market	Discharges	Discharge Disposition				
		SNF	IRF	LTCH	HHA	Hospice
Health System A - Texas						
Medicare	35,000	12.4%	5.1%	10.2%	13.4%	3.1%
Medicare HMO	12,000	11.0%	3.2%	3.9%	16.9%	3.2%
Health System B - Arizona						
Medicare	8,700	12.8%	5.6%	1.0%	16.6%	7.4%
Medicare HMO	8,000	12.9%	3.0%	0.5%	17.7%	5.5%
Health System C - Illinois						
Medicare	12,000	23.4%	6.5%	2.0%	18.6%	3.3%
Medicare HMO	3,000	21.1%	6.0%	0.5%	22.2%	3.2%

Should The PAC Practice Patterns Be A Concern to State Providers?

- ***Yes…***

1. Increased PAC utilization would significantly **reduce** the acute care ALOS
2. The **waitlist patient population** would also be reduced with increased PAC utilization
3. Acute care providers, and post-acute providers, would both **benefit financially** from increased referrals
4. Health systems, and other entities that assume greater risk with ACOs and other shared-risk models of reimbursement, will need adequate access to these services to ensure **appropriate clinical care** at the **lowest cost** level of care

If Hawaii could reduce its Total ALOS by 1.0 days, this would reduce the acute care ADC by **290 patients** – and *significantly improve acute care margins*

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Preliminary Guesstimated Financial Impact

- Very dangerous to attempt an estimate of the State-wide financial impact of an improved PAC continuum, but a preliminary guesstimate would suggest a potential order of magnitude of **several hundred million dollars**…

Estimated Hawaii PAC Financial Market Potential (a)

2010 Nat'l Avg Medicare PAC Spending/FFS Beneficiary	$1,700	
HI 2012 FFS Beneficiaries	121,000	
Est. HI PAC Potential - Medicare FFS		$205,700,000
Est. 2012 HI Medicare Mgd Care	96,000	
Est. Avg Medicare Mgd Care Spending/ Beneficiary (b)	$1,122	
Est. HI PAC Potential - Medicare Mgd Care		$107,712,000
Est. HI Non-Medicare PAC Spending (c)		$161,455,000
Total Est. HI Potential PAC Revenue		$474,867,000
Estimate Current Market to Be +/- 50% of Potential		**$237,434,000**

(a) Note: Only includes Medicare covered services, and does not include custodial/ long-term care, home health aides, assisted living, etc.
(b) Assumes 2/3 Medicare FFS
(c) Assumes 1/3 Total PAC Non-Medicare

Estimated Potential Acute Care Impact

2010 HI Acute Care Discharges	106,000
HI 2010 ALOS	7.5
Nat'l 2010 ALOS	5.4
Days Saved By 1.0 Day Decrease	106,000
Reduced ADC	*290.4*
Days Saved By 2.0 Day Decrease	212,000
Reduced ADC	*580.8*
Avg HI Acute Cost PPD (a)	$2,000
Est. Direct Cost - 50% (b)	$1,000
Reduced Cost 1.0 Day Decrease	**$106,000,000**
Reduced Cost 2.0 Day Decrease	**$212,000,000**

(a) Becker's Hospital Review, April 2012.
(b) Walter Consulting

Note: Acute care impact does not include benefits from
- *Increased throughput*
- *Reduced capital requirements*
- *Reduced readmissions*
- *Other*

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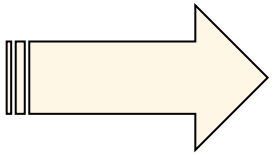
Where Do We Go From Here?
How Do We Improve Hawaii Post-acute Utilization?

- Improvement will require effort on the part of both **acute care and post-acute providers** in the State
- Acute care providers must assess their post-acute needs, and then either demand that post-acute care providers meet this need, or create alternative programs internally
  - It is likely, that because PAC current utilization is so low, most acute care providers do not know how these services could be and should be utilized



If you have never used a service (or used it much), how do you know you need it?

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Where Do We Go From Here?
How Do We Improve Hawaii Post-acute Utilization?

- Post-acute providers must ensure that they have the **program depth**, **clinical skills**, and **marketing/communication skills** to meet the needs of the local acute care providers
- Any post-acute development, however, must be within the constructs of the **unique nature of the Hawaii market**
  - De Novo bed development/new construction may be prohibitive due to lack of land and cost
  - Alternative programs utilizing existing space and home-based programs may be the best approach in Hawaii

→ Acute care systems at **greatest risk** with low PAC utilization

→ PAC providers may miss incremental referrals, but acute systems will not be successful with any **shared-risk reimbursement models** without effect PAC programs

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Acute Care Providers To-Do List

1. Complete an internal assessment to determine how **many PAC referrals** your system should likely generate on an annual basis
   - NOT what is currently referred to PAC, but what SHOULD BE going to PAC based upon national norms and Best Practices standards of care
   - By level of care, by diagnosis, by geography, etc.
2. Determine **current barriers** to successful PAC referrals
   - Internal or external?
   - Lack of programs? Lack of staffing? Geographic issues?
3. Assess the impact of the health system's initiatives related to **payment reform** will have on utilization
4. Identify 1-year, 3-year, and 5-year **post-acute targets**
5. Develop **post-acute strategic plan** to achieve volume and financial targets
   - Significant input required from medical staff, clinical staff, case managers, social workers, etc.

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Acute Care Decisions – Build? Buy? Partner?

- If the health system's PAC needs cannot be met with existing internal or community programs, a **new approach** will have to emerge

A build or buy analysis will have to reflect

- The **critical mass** of patients that the acute system can generate
  - A sufficient critical mass must exist to support the economics of development
- The **cost of development**
  - Outpatient and home-based programs obviously less capital-intensive than bedded services (IRF, LTCH, SNF, etc.)
- **Certificate of Need** and other regulatory constraints
- A **partnership** with existing providers might be a good **win-win** strategy to ensure appropriate services, although caution must be exercised

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Case Study – Partnership With Community PAC Provider

- **Situation:** Two hospital health system in Midwest; 50,000 discharges; 60-bed IRF; no SNF services; preference to use system capital for other growth needs rather than SNF development; desires SNF partner to help with acute care throughput and to manage difficult-to-place patients (i.e., Self-pay)
- **Process:** Initial screen identified 5-6 local SNF partners that would meet system needs: bed capacity; reputation; physician preference; other

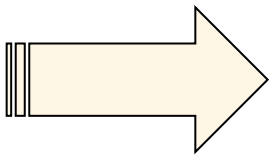
RFP sent to these targeted providers

Partner Requirements	Partnership Requirements
Measureable quality metrics: ▪ Readmission rates ▪ ED visits ▪ Mortality rates ▪ Five-star Rating ▪ Patient satisfaction	Improved **clinical integration** between acute care and SNF: ▪ Selection of SNF facility/program Medical Directors ▪ Staff education ▪ Information exchange
Solid financial position; **ability to invest** in programs and services as needed	Acceptance of some level of **unfunded patients** (although potential for limited subsidies)
Willingness to create **new business model**	**Financial incentives** based upon specific targets, including readmission rates compared to targets

A similar approach could be used to assess partnerships for any PAC program

Potential Partnership Approach

- *"You get all of the good ones, you take some of the bad ones…."*
- An acute care facility can place an unfunded patient, but agrees to pay the equivalent of the Medicaid rate and any Part B expenses the patient may incur
- A "bed hold" amount could be paid to hold a certain amount of beds for a referral source to use for "difficult to place" patients
- Acute care provider medical staff could serve as program medical director, and/or clinical staff could provide training to PAC staff



Any agreements must still provide patient choice, and comply with all appropriate regulations

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Post-acute Care Providers To-Do List

1. Assess clinical and program needs of **top 2-3 referral sources**, specific to your level of care
2. Identify **gaps in referrals** and reasons for variance
   - Clinical competencies or staffing
   - Financial or payor mix
   - Bed capacity (for bedded services)
   - Other
3. Determine **financial impact** of increased volume on referral source, and initiate discussions with acute care referral sources to improve care coordination
4. Be prepared to **assume financial risk** for program performance
   - Financial bonuses for surpassing targets
   - Financial penalties for poor performance
5. Develop three year and five year **strategic plans**, and annual targets to ensure progress

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Conclusions

- At this time, Hawaii clearly **under utilizes** every level of post-acute care
- Improved utilization would not only **reduce** the State **acute care ALOS**, but would free up **a minimum of 200-300** acute care beds, potentially addressing many of the Waitlist problems as well
  - This would have a financial impact to acute care hospitals in the tens of millions to hundreds of millions of dollars
- State providers, particularly the acute care health systems, **MUST address this gap** in its health care continuum to be successful in any of the emerging payment models that reward low cost and clinical outcomes following the acute care stay
- There is a **"Burning Platform"** to begin to address this problem that includes both the current unmet PAC need, and the high acute care ALOS, as well as the increasing financial pressures due to the health reform initiatives

Conclusions

- There is obviously **tremendous opportunity** to increase the State's utilization of post-acute care
  - Most programs could **double or triple** in volume
- The particular **unique characteristics** of the State will likely drive unique solutions – lack of land, remote locations, etc.
- However, just as Hawaii leads the nation in so many other health areas, such as life span and health status, Hawaii could also emerge as **a leader in post-acute care innovation**, integrating all levels of care more effectively than other locations

Questions?

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