Creating a Winning Post-acute Continuum for the Future

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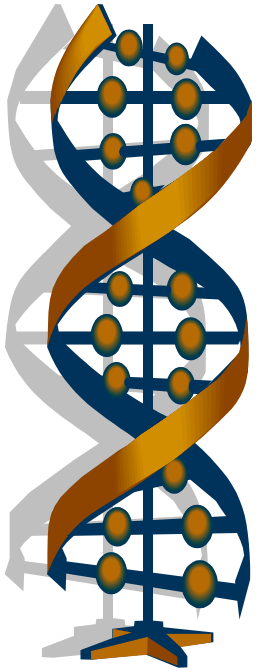
Focus of Today's Presentation



- Speaker introductions
- Review baseline post-acute trends and utilization
- Discuss critical health reform initiatives and strategic implications
- Present case study – Memorial Hermann Health System
- Discussion

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- National post-acute practice -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, LTCHs, 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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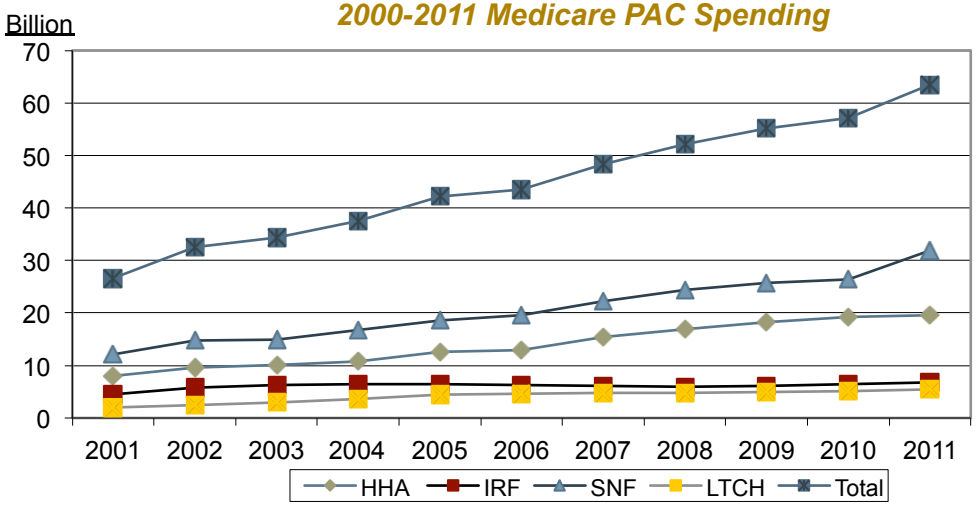
Post-acute Overview

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%	• Great pressure by feds to restrict LTCH growth
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

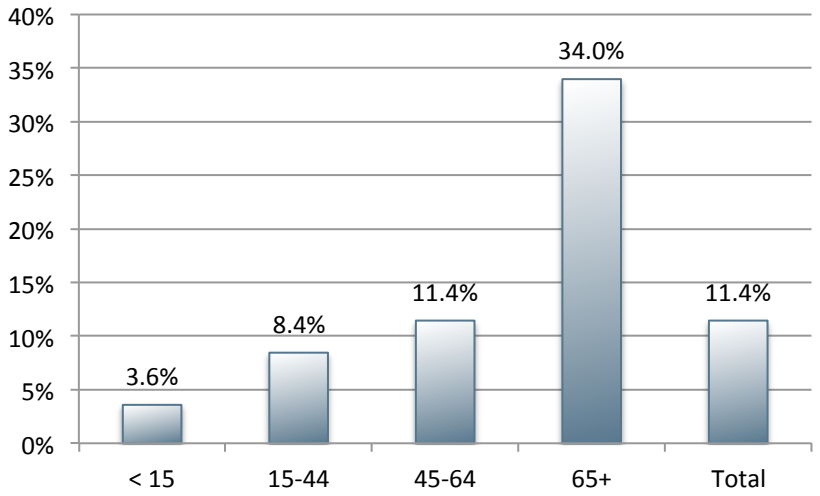
(a) Freestanding SNFs only; does not include HB-SNFs.

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*

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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.)

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

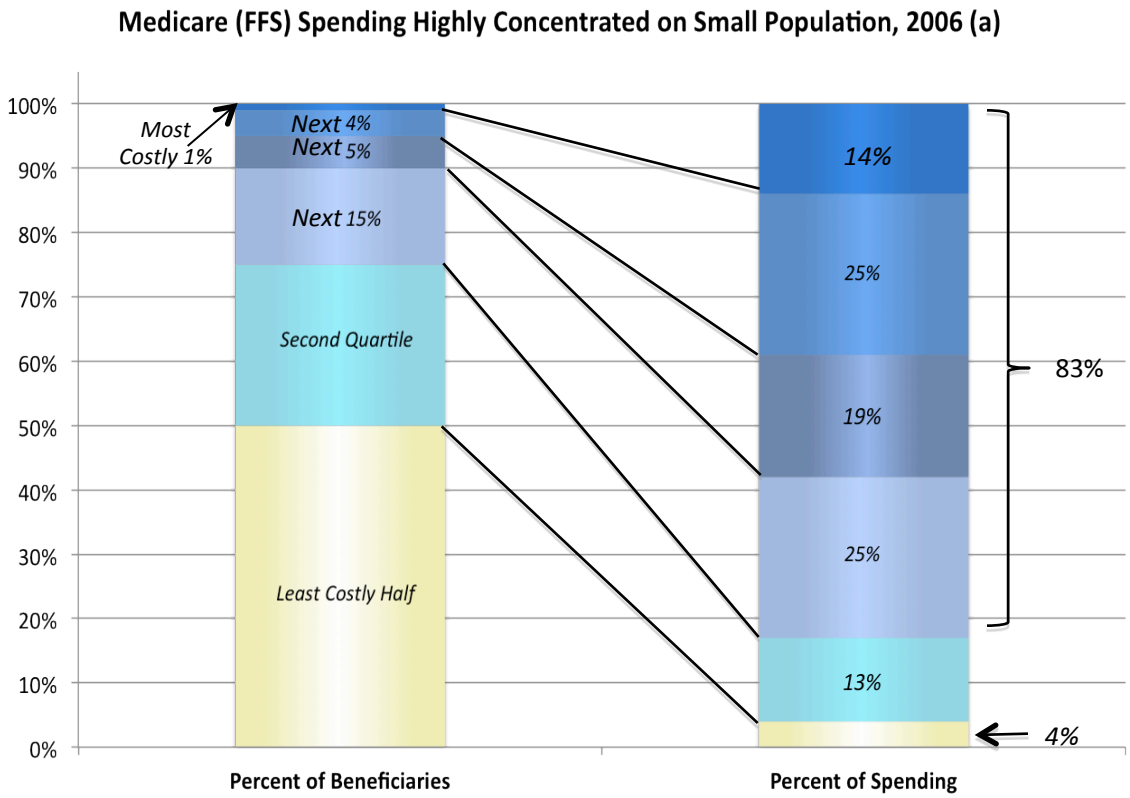
Any type of shared-risk payment, such as ACOs, bundled payments, readmission penalties, etc., demand that providers transition patients to the **least expensive** and most **clinically appropriate** setting, which is frequently NOT the case today

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

Shared-Risk and Population Health Management

- 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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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	Total
Health System A - Florida							
Medicare	35,000	12.4%	5.1%	10.2%	13.4%	3.1%	**44.2%**
Medicare HMO	12,000	11.0%	3.2%	3.9%	16.9%	3.2%	**38.2%**
Health System B - Arizona							
Medicare	8,700	12.8%	5.6%	1.0%	16.6%	7.4%	**43.4%**
Medicare HMO	8,000	12.9%	3.0%	0.5%	17.7%	5.5%	**39.6%**
Health System C - Illinois							
Medicare	12,000	23.4%	6.5%	2.0%	18.6%	3.3%	**53.8%**
Medicare HMO	3,000	21.1%	6.0%	0.5%	22.2%	3.2%	**53.0%**

Creating A Successful Post-acute Continuum

1. Complete post-acute **demand analysis**
   - Internal and external
   - Current and projected
2. Prepare integrated **financial impact** analysis
3. Complete **build or buy** decision
4. Create **organizational structure** and assign **accountabilities**
5. Prepare **post-acute action plan** to achieve strategic, volume and financial objectives
   - Significant input required from medical staff, clinical staff, case managers, social workers, etc.

Post-acute Demand Analysis

Assess not what is **CURRENTLY referred to PAC**, but what **SHOULD be going to PAC** based upon national norms and Best Practices standards of care

FY 2012 Regional Health System Post-acute Demand Analysis

	IRF			Subacute/SNF			LTCH			HHA			Hospice			Total		
Hospital	**Potential**	**Actual**	**Variance**	**Potential**	**Actual**	**Variance**	**Potential**	**Actual**	**Variance**	**Potential**	**Actual**	**Variance**	**Potential**	**Actual**	**Variance**	**Potential**	**Actual**	**Variance**
Hospital 1	421	185	(236)	865	706	(159)	155	70	(85)	2,851	1,872	(979)	340	450	110	4,631	3,283	(1,348)
Hospital 2	179	28	(151)	371	248	(123)	47	34	(13)	1,287	970	(317)	137	192	55	2,021	1,472	(549)
Hospital 3	959	392	(567)	1,727	1,522	(205)	329	167	(162)	6,021	4,211	(1,810)	649	889	240	9,684	7,181	(2,502)
CAH	31	0	(31)	133	99	(34)	3	1	(2)	362	165	(197)	43	41	(2)	571	306	(265)
Total	**1,590**	**605**	**(985)**	**3,096**	**2,576**	**(520)**	**533**	**272**	**(261)**	**10,520**	**7,218**	**(3,302)**	**1,168**	**1,572**	**404**	**16,908**	**12,243**	**(4,665)**

Trends to Assess

- Is there “substitution” in current referral patterns?
- In addition to utilizing the appropriate level of care, is there “leakage” or out-migration to competitive programs for system services?

Ensure Sufficient Depth in Demand Analysis

Post-acute demand analysis should include **sufficient detail** to actually change practice patterns if opportunities exist

- Develop **target volume levels** for both acute care case managers as well as post-acute program managers

FY 2012 Regional Hospital HHA Internal Market Potential

MDC	Diagnosis	Potential	Actual	Variance	% Capture
1	Neurology	293	180	(113)	61.4%
4	Respiratory	471	169	(303)	35.8%
5	Cardiology	1,587	629	(958)	39.6%
6	Digestive	317	148	(170)	46.6%
8	Orthopedics	827	807	(20)	97.6%
9	Skin	153	72	(81)	47.0%
10	Endocrine	162	76	(85)	47.2%
11	Kidney	182	129	(52)	71.3%
18	Infect. Dis.	191	132	(59)	68.9%
	All Other	432	243	(189)	56.2%
	Total	**4,614**	**2,584**	**(2,030)**	**56.0%**

- Recommend similar analysis for **all PAC programs**
- Should also include referrals to internal PAC programs, if provided, to **assess out-migration**

Post-Acute Demand Analysis

- It is as critical to assess not just what the current PAC demand is, but what long-term demand will be as **shared-risk financial incentives increase**, particularly for Medicare beneficiaries
  - Most important for capital intensive services, such as inpatient rehabilitation, SNF, LTCH, etc.

Regional Health System Rehabilitation Bed Need

Hospital	Potential Admits	ADC Low	ADC High	Bed Need Low	Bed Need High	Post-FFS Bed Need Low	Post-FFS Bed Need High
Hospital 1	421	15.0	17.4	18	20	12	13
Hospital 2	179	6.3	7.3	7	9	5	6
Hospital 3	959	34.1	39.4	40	46	28	32
CAH	31	1.0	1.2	1	1	1	1
Total	**1,590**	**56.5**	**65.2**	**66**	**77**	**45**	**52**

(a) Bed need assumes 85 percent occupancy.

Post-acute Financial Impact Analysis

Once opportunities have been identified, assess potential for incremental program revenue and **incremental operating income**

- For reasonableness, compare financial analysis with **industry norms** *(adjusted to reflect direct expenses instead of total expenses)*

FY 2012 ABC Health System Post-acute Financial Impact Analysis

PAC Program	Hospital 1	Hospital 2	Hospital 3	Total
		Rehabilitation		
Inc Net Rev	$3,825,000	$2,550,000	$2,125,000	$8,500,000
Inc Direct Exp	$1,779,000	$1,186,000	$988,000	$3,953,000
Inc Operating Inc	**$2,046,000**	**$1,364,000**	**$1,137,000**	**$4,547,000**
		SNF/Subacute		
Inc Net Rev	$1,147,500	$765,000	$637,500	$2,550,000
Inc Direct Exp	$1,090,000	$727,000	$606,000	$2,423,000
Inc Operating Inc	**$57,500**	**$38,000**	**$31,500**	**$127,000**
		HHA		
Inc Net Rev	$7,200,000	$5,400,000	$3,300,000	$15,900,000
Inc Direct Exp	$4,860,000	$3,645,000	$2,228,000	$10,733,000
Inc Operating Inc	**$2,340,000**	**$1,755,000**	**$1,072,000**	**$5,167,000**
		Total		
Inc Net Rev	$12,172,500	$8,715,000	$6,062,500	$26,950,000
Inc Direct Exp	$7,729,000	$5,558,000	$3,822,000	$17,109,000
Inc Operating Inc	**$4,443,500**	**$3,157,000**	**$2,240,500**	**$9,841,000**

If possible, financial impact should also include acute care reduced LOS and increased utilization if opportunities exist

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

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

Organizational Structure And Accountabilities

Significant success will be limited without an appropriate internal organizational structure and staff accountabilities for program growth

- Post-acute care often small part of health system structure without support for growth or staff incentives to implement and manage change
- Ideally, if there is not one senior post-acute executive (VP/Post-acute Care), then all post-acute programs should report to the same senior executive

Clear volume targets should be given to each post-acute program, by referring hospital and by diagnosis, if possible

- Sales force/outreach coordinators must be part of any growth strategy
- Performance of hospital-based programs must be at least equal to community providers, in order to ensure success

Conclusions

- There are **tremendous opportunities today** for most health systems to improve utilization of post-acute services, and the integration between acute care and post-acute care
  - *Reduce ALOS*
  - *Improved clinical outcomes*
  - *Financial opportunities*
  - *Other*
- Additionally, there is an imperative to focus efforts on the post-acute component of the healthcare continuum under any **shared-risk financial arrangements**
  - Financially, the most highest risk patients for the health system will likely require post-acute care, and these patients most be managed effectively to ensure a solid system bottom line

Monica Carbajal
Director Strategic Planning

- **Memorial Hermann**
  - 12 Hospitals including TIRR Memorial Hermann
  - Academic Affiliation with the University of Texas Health Science Center
  - Level 1 Trauma Center with *Life Flight* air ambulance service
  - Ambulatory network:
    - *Outpatient Imaging Sites: 32*
    - *Sports Medicine & Rehab Clinics: 24*
    - *Diagnostic Lab: 24*
    - *Ambulatory Surgery Centers: 19 (JV with USPI)*

  - Memorial Hermann ACO with 2,000+ physicians (employed and independent)

- **Located in greater Houston**
  - Projected population growth of > 500,000 lives by 2018
  - Strong, diverse economy
  - Inpatient use rate holding steady at 87 - 88/1,000 population
  - Competitive provider and payor landscapes

MH system generates nearly 25,000 post-acute referrals per year – identified potential for nearly 35,000

Memorial Hermann Post-acute Portfolio

2 Rehab Hospitals	***4 Hospital-Based Rehab Units***	***Outpatient Rehab Services***	***1 Home Health Agency***	***1 SNF***	***Hospice Care***
TIRR Memorial Hermann	Memorial Hermann TMC	Varying Locations	Memorial Hermann Home Health	Memorial Hermann SW	Varying Locations
Memorial Hermann Rehab Hospital Katy	Memorial Hermann SW				
	Memorial Hermann SE				
	Memorial Hermann NW				

Additional Unit Pending..

No Owned LTCH solutions….

TIRR Memorial Hermann
#3 in the Nation
and Best in Texas

BEST HOSPITALS U.S.News NATIONAL 2013-14

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Why did MH focus on post-acute?

- Healthcare reform requires cost management across the continu care
  - Throughput efficiencies
  - Placement to the most appropriate level of care
  - Minimizing inappropriate outmigration
  - Understanding network adequacy

We also quickly learned, there are FFS opportunities *today*.

CMS national average costs by setting*:

LTCH: $34,000
IP Rehab: $16,500
SNF: $9,300

Where did we start?

- Post acute planning was a new endeavor for the system
  - Different factors and services than traditional acute care

- System chief executive officer and rehab hospital CEO enlisted strategic planning to identify consulting assistance
  - Signed agreement with Walter Consulting in winter 2010 to identify current post acute situation and identify strategic solutions

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* Data provided by Walter Consulting from CMS actuals 2011/2012

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Some of the key findings…

Discharges didn't match *expected* volumes by setting

LTCH 3 X's greater than expected, Rehab and SNF lower than expected

Significant Outmigration:

40% rehab *'leakage'* ;

70% home health *'leakage'*

Partly due to processes, partly due to competitive forces

Need to standardize nursing and operational protocols for all rehab providers throughout the system, including creation of consistent admission criteria and protocols. Work with physicians on protocols by discharge level.

Similar recommendations for home health. In addition, recommendation was *'to develop specialty programs or other avenues for differentiating their service in the marketplace.'*

Projected long-term potential financial impact of several million dollars (by FY 16) per consulting analysis and MH review

Additionally… post-acute cost savings opportunities now emerging under our ACO agreements

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* Data provided by Walter Consulting from CMS actuals 2011/2012

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Consultant recommendation was to create *'Post-acute Services Division'*

For just completed FY 13…

All rehab services placed under CEO, TIRR
Home health division placed under Chief, Care Management
Year of staff restructuring, 'right sizing' operations, standardizing intake protocols, medical director recruitments, etc.
Capital obtained to build an IP rehab unit at TWL, to capture north Houston outmigration

FY 14…

Dashboard creations to monitor volumes, outmigration
"Discharge to post-acute"
Operating reviews with System COO

Long term?

- Additional restructuring as reform influences emerge*?*
- Ability to capture post acute referrals from ***external*** parties

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Lessons Learned

- Post-acute is a different business
  - *Education curves for various stakeholders*
  - *Not traditionally high on CEO priorities due to comparatively lower margins*

- Post-acute planning can be helpful both for creating financial efficiencies under population health and for *optimizing current fee for service revenues*

- Tough questions remain around system organizational structures, including post acute, as the industry transforms

- Important to understand your "post-acute network" including partner physicians

- Not a short term process
  - Accountability mechanisms

Questions?

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