



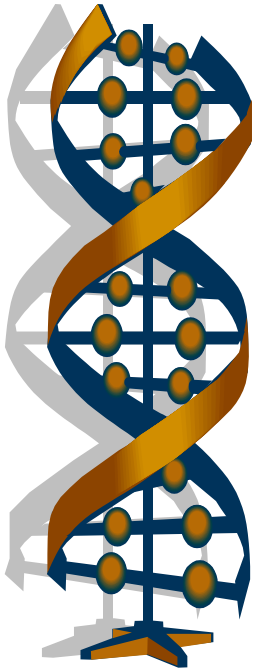
Eye on Post-acute: Trends, Issues, and Strategies

September 11, 2018

Atlanta, GA



Focus of Today's Presentation

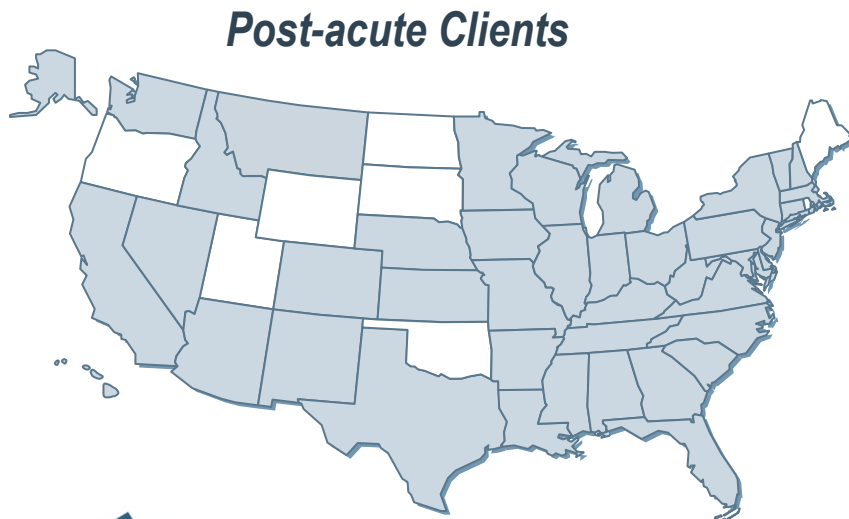


- Introduce Walter Consulting
- Review PAC trends and issues nationally
- Discuss emerging PAC trends and their financial impact
- Review potential PAC strategies
- Questions and discussion



Walter Consulting

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



| Program Focus |
|----------------------------|
| Acute rehabilitation |
| Skilled care/subacute care |
| 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 |

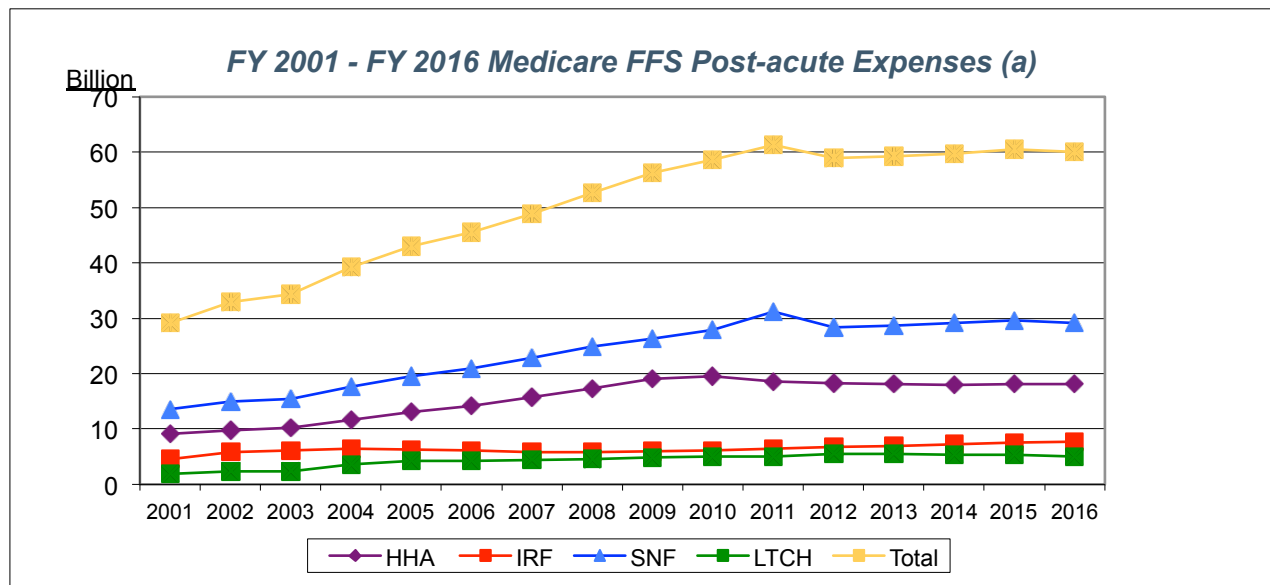
Post-acute Overview

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 + Medicare Advantage (65%+)
- Virtually all of the IRF, SNF, and LTCH patients originate from the acute care setting (90%+)
- 50 - 60 percent of HHA admissions originate from acute care
- Approximately 20 percent of all PAC patients are discharged to a second PAC program

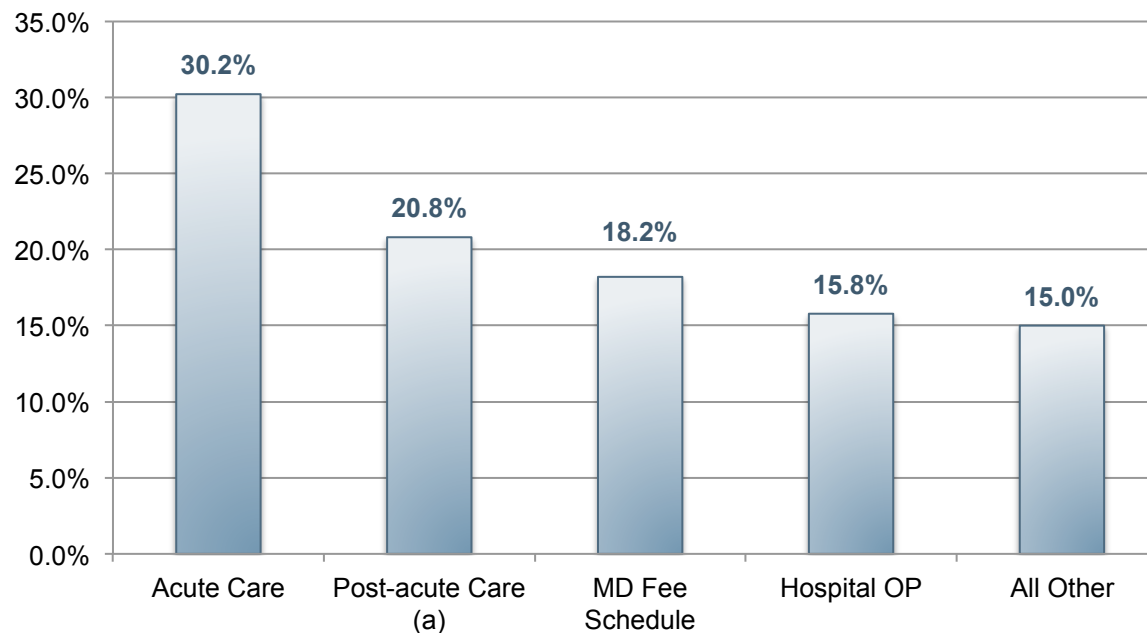


- From 2001 to 2010, CMS spending for PAC increased an average of 9.0% per year
- Over the same time period, spending for acute care increased just 3.0% per year
- Steep SNF & HHA cuts following the ACA reduced spending in 2010 - 2011, but modest annual spending increases since that time

Post-acute Care a Major Component of Medicare FFS Payments

- Post-acute expenses represent **almost 21 percent** of all Medicare FFS payments and are greater than most every other major expense component
- As health systems assume more financial risk with Bundled Payments, Population Health Management, etc., a **successful PAC strategy will be as important** as acute care and physician alignment strategies for the older patient populations

FY 2016 Medicare FFS Expenditures



Source: March 2018 MedPAC Report to Congress
(a) Includes hospice, which represents 3.0% of total FFS payments.



Post-Acute Utilization Rates

*Nationally, approximately **46 percent** of all Medicare FFS acute care patients are discharged to some level of post-acute care*

*“Best Practices” for effective systems is in the **47 – 54 percent range***

*PAC use rates have shown **consistent annual increases** for most of the last 10+ years*

- 2016 saw the first decrease in PAC utilization in 10+ years and this decrease was due **solely to a 1.0 percent decrease in discharges to SNF***

National Post-acute Utilization Rates (a,b)

| Discharge Disposition | Medicare FFS (nat'l rates) (a) | | | | | | | Best Practices | |
|-----------------------|--------------------------------|--------------|--------------|--------------|--------------|--------------|--------------|----------------|--------------|
| | 2006 | 2009 | 2012 | 2013 | 2014 | 2015 | 2016 | Low | High |
| SNF | 18.8% | 19.8% | 20.3% | 20.7% | 21.0% | 21.2% | 20.2% | 16.0% | 18.0% |
| HHA | 13.8% | 15.2% | 15.9% | 16.5% | 16.8% | 16.9% | 17.5% | 22.0% | 24.0% |
| IRF | 3.4% | 3.3% | 3.5% | 3.6% | 3.8% | 3.9% | 4.0% | 4.5% | 6.0% |
| LTCH | 0.9% | 1.1% | 1.2% | 1.2% | 1.2% | 1.2% | 1.2% | 1.5% | 2.0% |
| Hospice | 1.6% | 2.1% | 2.7% | 2.7% | 2.9% | 3.0% | 3.0% | 3.0% | 3.5% |
| Total | 38.5% | 41.5% | 43.6% | 44.7% | 45.7% | 46.2% | 45.9% | 47.0% | 53.5% |

(a) June 2018 MedPAC Data Book, pg 76.

(b) Best Practices – Walter Consulting

Georgia Post-acute Utilization Rates

- Overall, the Georgia PAC use rate of **44.6 percent** slightly less than national rate of **45.9 percent**
- While every local market in Georgia and the other Southern States will be different, the greatest PAC growth opportunities in Georgia appear to include:
 - Transitioning a larger number of **patients from SNF to HHA service** (*GA SNF use rate higher than nat'l and “Best Practices” target, while GA HHA rate is lower than both of these metrics*)
 - **Increasing IRF/IRU referrals** which has lagged national use rates for years

2016/2017 National PAC Use Rates vs. Georgia Use Rates

| Discharge Disposition | National | Georgia (a) | Best Practices | |
|-----------------------|--------------|--------------|----------------|--------------|
| | | | Low | High |
| SNF | 20.2% | 20.8% | 16.0% | 18.0% |
| HHA | 17.5% | 16.6% | 22.0% | 24.0% |
| IRF | 4.0% | 3.1% | 4.5% | 6.0% |
| LTCH | 1.2% | 0.9% | 1.5% | 2.0% |
| Hospice | 3.0% | 3.3% | 3.0% | 3.5% |
| Total | 45.9% | 44.6% | 47.0% | 53.5% |

(a) Estimates based upon multiple resources inc: Kaiser Health Foundation, American Hospital Directory, MedPAC, and the Georgia Hospital Association.

Wide Variations in IRF/IRU Use Rates Among States

Although the national rate of Medicare FFS acute discharges to IRF/IRU is 4.0%, there are **wide variations** among states, including the Vizient Southern States Region

- This suggests that many providers in **states with low conversion rates** likely have short-term opportunities to **increase referrals and admissions**
- Additionally, from 2016 to 2017, the Medicare use rate increased in all **but 8 states**

FY 2017 Estimated Medicare FFS Acute Care Discharges to IRF/IRU

| State | Rate | Annual Chg | State | Rate | Annual Chg | State | Rate | Annual Chg |
|--------|------|------------|--------|-------|------------|--------|------|------------|
| AK | 1.2% | ↓ | KY | 3.6% | ↑ | NY | 2.5% | ↑ |
| AL | 4.9% | ↑ | LA | 6.5% | ↑ | OH | 3.7% | ↑ |
| AR | 8.1% | ↑ | MA | 3.4% | ↓ | OK | 3.4% | ↓ |
| AZ | 6.7% | ↑ | MD | 1.1% | ↑ | OR | 0.9% | ↑ |
| CA | 2.6% | ↓ | ME | 3.7% | ↑ | PA | 6.8% | ↓ |
| CO | 4.4% | ↑ | MI | 2.5% | ↓ | RI (b) | 2.7% | ↑ |
| CT (a) | 1.3% | ↑ | MN | 2.5% | ↑ | SC | 5.3% | ↑ |
| DC (b) | 5.4% | ↑ | MO | 3.9% | ↑ | SD | 2.6% | ↑ |
| DE | 4.1% | ↑ | MS | 2.1% | ↑ | TN | 4.5% | ↑ |
| FL | 4.5% | ↑ | MT | 1.3% | ↑ | TX | 9.4% | ↑ |
| GA | 3.1% | ↑ | NC | 2.2% | ↑ | UT | 4.3% | ↑ |
| HI | 3.1% | ↓ | ND | 3.0% | ↓ | VA | 3.7% | ↑ |
| IA | 1.7% | ↑ | NE | 2.5% | ↑ | VT | 2.0% | ↑ |
| ID | 3.0% | ↑ | NH (b) | 7.8% | ↑ | WA | 1.8% | ↑ |
| IL | 3.1% | ↑ | NJ | 4.2% | ↑ | WI | 2.4% | ↑ |
| IN | 4.8% | ↑ | NM | 5.0% | ↑ | WV | 5.6% | ↑ |
| KS | 5.1% | ↑ | NV | 10.5% | ↑ | WY | 4.3% | ↑ |

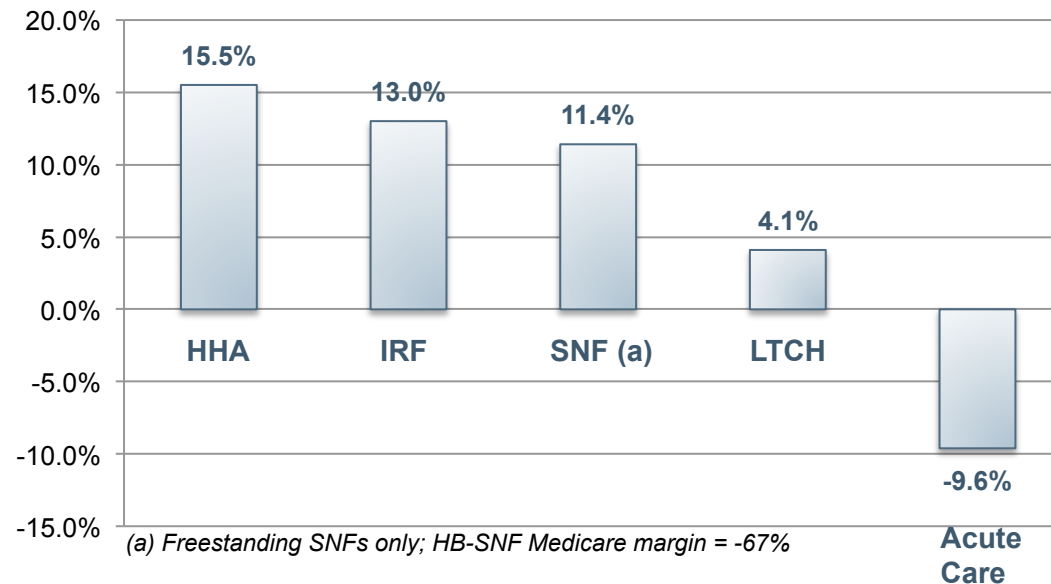
Source: Kaiser Foundation and American Hospital Directory.

(a) May be understated due to out-migration to neighboring states.

(b) May be overstated due to in-migration from neighboring states.

Medicare PAC Margins Remain Strong

- For most health systems, while the overall PAC business is smaller than acute care, the **PAC programs tend to generate higher Medicare margins than acute care**
 - All Payor/Total PAC margins **also tend to be strong** for most providers
 - *Note: There are significant profit margin variances among among PAC providers – larger programs generally generate margins that exceed national averages and smaller programs having lower margins*



Post-acute Utilization and Acute ALOS

A recent client post-acute engagement highlights the ability of post-acute programs to **manage acute LOS**

FY 2016 Medicare Acute ALOS and PAC Utilization Recent Client Analysis - 8 Acute Care Hospitals Within Same Market

| Provider | Acute Discharges (a) | | % Medicare Discharges to PAC | Medicare ALOS | | Variance from Medicare Target LOS (Pt. Days) (a) |
|-------------------|----------------------|--------------|------------------------------|---------------|-------------|--|
| | Total | Medicare | | Target (a) | Actual | |
| Hospital 1 | 9,600 | 3,000 | 55.9% | 4.66 | 4.50 | -0.16 |
| Hospital 2 | 19,000 | 8,000 | 49.1% | 4.79 | 4.89 | 0.10 |
| Hospital 3 | 12,700 | 4,000 | 45.1% | 4.34 | 4.82 | 0.48 |
| Hospital 4 | 17,600 | 7,000 | 44.6% | 4.59 | 5.36 | 0.77 |
| Hospital 5 | 11,200 | 5,000 | 44.1% | 4.57 | 5.38 | 0.81 |
| Hospital 6 | 11,200 | 6,000 | 43.3% | 4.48 | 5.57 | 1.09 |
| Hospital 7 | 32,300 | 9,000 | 41.2% | 4.86 | 5.82 | 0.96 |
| Hospital 8 | 8,900 | 4,000 | 40.6% | 4.48 | 5.88 | 1.40 |

Source: MedPAC and client data.

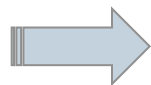
(a) Target case mix adjusted.

➤ While anecdotal, multiple data sources suggest strong correlation between PAC utilization and low acute care ALOS



FY 2019 PAC Payment and Regulatory Updates

| Program | 2019 Medicare Update | Other Updates |
|---------|---|--|
| SNF | <ul style="list-style-type: none"> 2.0% payment increase | <ul style="list-style-type: none"> Beginning 10/1/18, SNF Value Based Purchasing Program will apply either positive or negative financial incentives based upon readmission Beginning 10/1/19, the Patient-Driven Payment Model (PDPM) to replace RUGs |
| IRF/IRU | <ul style="list-style-type: none"> 1.2% payment increase | <ul style="list-style-type: none"> As of 10/1/19, FIM being replaced by functional assessment data collected on the Quality Indicators section of the IRF-PAI |
| LTCH | <ul style="list-style-type: none"> 0.9% payment increase | <ul style="list-style-type: none"> Eliminates 25 Percent Rule that limited admissions from referring hospitals Allows LTCHs to develop IRU programs |
| HHA | <ul style="list-style-type: none"> 2.1% payment increase (proposed rule) | <ul style="list-style-type: none"> As of 1/1/20, reduce Episode of Care payment from 60 days to 30 days, and replace HHRGs with Patient-Driven Groupings Model (PDGM) |
| Hospice | <ul style="list-style-type: none"> 1.8% payment increase | <ul style="list-style-type: none"> Changes to Hospice Compare and other data collection initiatives |



MedPAC has for years recommended a single PAC payment that is based upon diagnosis rather than site of care

Medicare Advantage PAC Use Rates

- **No national data** exists that summarize PAC utilization by Medicare Advantage plans
- Anecdotal information from multiple markets suggests Medicare Advantage PAC total use rates **not significantly different** from FFS use rates
 - **Significant differences in where patients are placed**, however, with fewer patients discharges to bedded programs (IRF, SNF, LTCH) and more patients discharged to HHA
- The Medicare Advantage referral patterns likely reflective of how many health systems will transition patients **as they assume greater financial risk** for patient care/patient health

2017 Post-acute Utilization – Four Sample Health Systems and Markets

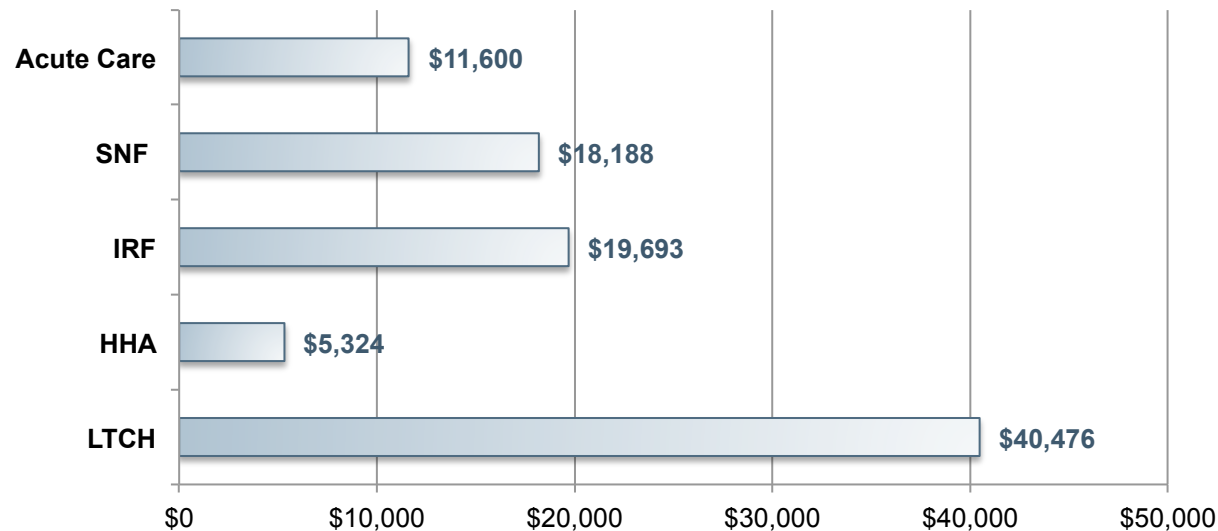
| Market | Discharges | Discharge Disposition | | | | | Total |
|---|------------|-----------------------|------|------|-------|---------|--------------|
| | | SNF | IRF | LTCH | HHA | Hospice | |
| <i>Health System A - Texas</i> | | | | | | | |
| Medicare | 35,000 | 15.5% | 4.5% | 6.8% | 14.2% | 3.7% | 44.8% |
| Medicare Advantage | 20,000 | 14.1% | 3.1% | 2.0% | 18.2% | 3.3% | 40.7% |
| <i>Health System B - Florida</i> | | | | | | | |
| Medicare | 10,700 | 23.6% | 2.1% | 2.0% | 18.4% | 3.0% | 48.9% |
| Medicare Advantage | 4,300 | 23.4% | 1.8% | 1.0% | 20.6% | 3.1% | 49.9% |
| <i>Health System C - Illinois</i> | | | | | | | |
| Medicare | 12,000 | 23.4% | 6.5% | 2.0% | 18.6% | 3.3% | 53.8% |
| Medicare Advantage | 3,000 | 21.1% | 4.0% | 0.5% | 22.2% | 3.2% | 53.0% |
| <i>Michigan – All Hospitals > 10,000 Medicare Discharges</i> | | | | | | | |
| Medicare | 171,000 | 20.7% | 2.9% | 1.0% | 22.1% | 2.9% | 49.6% |
| Medicare Advantage | 103,000 | 18.9% | 2.5% | 0.6% | 23.4% | 3.1% | 48.5% |

However, All Post-acute Placement Options Are Not Equal

Under any shared-risk/non-FFS reimbursement (Bundled Payments, etc.), placements into post-acute care must balance both patient **clinical needs and program quality with cost of care**

- Significant **differences in cost among** post-acute settings

FY 2016 Average Medicare Cost Per Discharge by PAC Setting



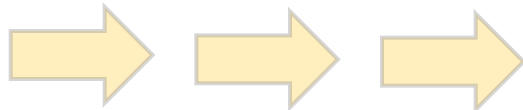
Population Growth to Offset Most Use Rate Changes in PAC

- Despite decreased use rates forecasted for IRF, SNF and LTCH, the continued growth of the age 65+ population **will offset much of the potential volume decrease**
 - *While the use rate for IRF & SNF may decrease 10 – 20 percent, the 65+ population is expected to **increase by 30 percent by 2025***

2010 – 2025 Age US Population Projections

| US Population | Estimated (000) | | | Projected (000) | | % Chg 2017-2025 |
|---------------|-----------------|---------|---------|-----------------|---------|--------------------|
| | 2010 | 2015 | 2017 | 2020 | 2025 | |
| Pop 65+ | 40,268 | 47,734 | 50,802 | 56,441 | 65,920 | 29.8% |
| Total | 308,758 | 321,369 | 325,719 | 334,503 | 347,335 | 6.6% |
| % Pop 65+ | 13.0% | 14.9% | 15.6% | 16.9% | 19.0% | NA |

(a) Age 65+ population represents approximately 85% of all Medicare beneficiaries



*The population growth will **not likely offset decreases in LTCH utilization rates**, which are expected to decrease more dramatically as reimbursement continues to shift away from Fee-For-Service*

The Role of PAC Within Health Systems Changing Dramatically

Prior to ACA PAC essentially a “**Pressure Valve**” for Acute Care services. Now PAC is a **Strategic Requirement** for health systems.

Post-acute Care Strategic Role in an Integrated Health System

| PAC Objective | Pre-ACA | Post-ACA 2018 - 2025 |
|--|---------|-------------------------|
| Reduce Acute Care ALOS | ✓ | ✓ |
| Improve Acute Care Financial Performance | ✓ | ✓ |
| Generate New Revenue Stream | ✓ | ✓ |
| Manage Financial Risk for Value Based Payment <i>(Reduce readmissions, etc.)</i> | | ✓ |
| Achieve Functional & Clinical Quality by Payors | | ✓ |
| Support System Strategic Objectives for Growth <i>(Contracting, Pop Health Mgmt, etc.)</i> | | ✓ |

Common Strategic Initiatives

Nationally, acute care providers and health systems are creating deliberate **post-acute strategic plans** and initiatives, including:

Strengthening referral linkages so that post-acute patients remain **within their own continuum** whenever possible in order to most effectively control cost and quality

Assessing **Build-or-Buy decisions** for PAC programs not currently offered to ensure access to each level of care for their patient populations

Where programs are not provided internally, **developing partnerships with select post-acute providers** to meet the health systems needs

- Today, most of these partnerships are essentially “**referral relationships**”, although they are laying ground work for **shared financial risk** as FFS reimbursement decreases

Creating **Post-acute Divisions** with PAC Administrator to coordinate and manage all post-acute programs and initiatives in a unified manner

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 financial class, etc.
 - Should include **1-year, 3-year, and 5-year PAC projections** reflecting population changes, acute care volume growth, and impact of reimbursement/regulatory changes.
2. Determine **current barriers** to successful PAC referrals
 - Internal or external?
 - Lack of programs? Lack of staffing? Geographic issues?
3. Complete **operational assessment** to ensure efficient operations as annual reimbursement increases likely to be modest
4. Complete **financial impact analysis** to assess impact of incremental volume in order to prioritize growth initiatives and justify add'l resource requirement
5. Develop **post-acute strategic plan** to achieve volume, quality and financial targets
 - Significant input required from medical staff, clinical staff, case managers, social workers, etc.
 - Must have measureable objectives, accountabilities, and time frames

Sample PAC Demand and Need Projections

- Recent PAC Strategic Planning engagement with **two-hospital health system** in Midwest
 - Approximately 40,000 acute care discharges; 40% Medicare FFS + Medicare Advantage
- Initial PAC projections suggested that while overall the health system was discharging about as many patients into PAC as expected, there was a **significant opportunity to shift patients from the SNF setting into HHA**
 - Additional growth opportunities included incremental IRF/IRU referrals

Figure 1
FY 2017 Health System Post-acute Demand

| Hospital | LTCH | | | IRF | | | Subacute/SNF | | | HHA | | | Hospice | | | Total | | |
|--------------|------------|------------|-------------|--------------|------------|--------------|--------------|--------------|--------------|--------------|--------------|----------------|------------|------------|------------|---------------|---------------|--------------|
| | Potential | Actual | Variance | Potential | Actual | Variance | Potential | Actual | Variance | Potential | Actual | Variance | Potential | Actual | Variance | Potential | Actual | Variance |
| AMC 1 | 480 | 467 | (13) | 820 | 649 | (171) | 970 | 2,219 | 1,249 | 4,900 | 3,921 | (979) | 350 | 436 | 86 | 7,520 | 7,692 | 172 |
| Hosp 2 | 50 | 45 | (5) | 220 | 93 | (127) | 860 | 1,189 | 329 | 2,100 | 1,500 | (600) | 180 | 231 | 51 | 3,410 | 3,058 | (352) |
| Total | 530 | 512 | (18) | 1,040 | 742 | (298) | 1,830 | 3,408 | 1,578 | 7,000 | 5,421 | (1,579) | 530 | 667 | 137 | 10,930 | 10,750 | (180) |

Sample PAC Demand and Need Projections

Five-year projections suggested likely volume decreases in LTCH, IRF, and SNF, with expected increases in HHA and Hospice

Figure 2
FY 2017- FY 2022 Health System Post-acute Demand

| Hospital | LTCH | | | IRF | | | Subacute/SNF | | | HHA | | | Hospice | | | Total | | |
|--------------|------------|------------|--------------|--------------|------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|------------|------------|-----------|---------------|---------------|------------|
| | FY 2017 | FY 2022 | Variance | FY 2017 | FY 2022 | Variance | FY 2017 | FY 2022 | Variance | FY 2017 | FY 2022 | Variance | FY 2017 | FY 2022 | Variance | FY 2017 | FY 2022 | Variance |
| AMC 1 | 480 | 290 | (190) | 820 | 700 | (120) | 970 | 860 | (110) | 4,900 | 5,730 | 830 | 350 | 390 | 40 | 7,520 | 7,970 | 450 |
| Hosp 2 | 50 | 25 | (25) | 220 | 150 | (70) | 860 | 770 | (90) | 2,100 | 2,460 | 360 | 180 | 200 | 20 | 3,410 | 3,605 | 195 |
| Total | 530 | 315 | (215) | 1,040 | 850 | (190) | 1,830 | 1,630 | (200) | 7,000 | 8,190 | 1,190 | 530 | 590 | 60 | 10,930 | 11,575 | 645 |

Figure 3
FY 2017 – FY 2022 Post-acute Bed Need (ex. HHA)

| Program | 2017 | | 2022 | | Change | |
|--------------|--------------|------------|--------------|------------|---------------|-------------|
| | ADC | Bed Need | ADC | Bed Need | ADC | Bed Need |
| LTCH | 45.1 | 52 | 26.6 | 31 | (18.5) | (21) |
| IRF | 42.0 | 49 | 31.1 | 37 | (10.9) | (13) |
| SNF | 91.2 | 101 | 81.0 | 90 | (10.2) | (11) |
| Total | 178.3 | 203 | 138.7 | 158 | (39.6) | (45) |

Sample PAC Demand and Need Projections

The demand for each PAC program must be broken down **by diagnosis and financial class** in order to develop a comprehensive action plan

Figure 4
FY 2017 Health System IRF/IRU Demand by Major Diagnostic Category

| Hospital | Neurology/BI | | | Orthopedics | | | SCI/MMT | | | All Other | | | Total | | | |
|--------------|--------------|------------|--------------|-------------|------------|--------------|------------|------------|--------------|------------|-----------|--------------|--------------|------------|--------------|--------------|
| | Admits | | | Admits | | | Admits | | | Admits | | | Admits | | | |
| | Potential | Actual | % | Potential | Actual | % | Potential | Actual | % | Potential | Actual | % | Potential | Actual | % | Variance |
| AMC 1 | 441 | 401 | 90.9% | 74 | 86 | 115.7% | 142 | 123 | 86.6% | 164 | 39 | 23.8% | 820 | 649 | 79.0% | (173) |
| Hosp 2 | 76 | 19 | 25.1% | 102 | 51 | 50.2% | 27 | 14 | 51.4% | 15 | 9 | 58.7% | 220 | 93 | 42.3% | (127) |
| TOTAL | 517 | 420 | 81.2% | 176 | 137 | 77.9% | 169 | 137 | 80.9% | 179 | 48 | 26.8% | 1,040 | 742 | 71.2% | (300) |



How Do You Select A PAC Partner?

The process to select a PAC partner should include a screen of potential partners, by level of care, assessing **clinical quality**, **financial strength**, and **willingness to assume risk**

| Potential Partner Requirements | Potential Partnership Requirements |
|---|--|
| <p>Measureable quality metrics (as appropriate):</p> <ul style="list-style-type: none"> ▪ Readmission rates ▪ ED visits ▪ Mortality rates ▪ Five-star Rating ▪ Patient satisfaction | <p>Improved clinical integration between acute care and PAC:</p> <ul style="list-style-type: none"> ▪ Selection of facility/program Medical Directors ▪ Staff education ▪ Information exchange |
| <p>Solid financial position; ability to invest in programs and services as needed</p> | <p>Acceptance of some level of unfunded patients (although potential for limited subsidies)</p> |
| <p>Willingness to create new business model</p> | <p>Financial incentives based upon specific targets, including readmission rates compared to targets</p> |



Final Thoughts

PAC is **Front & Center** in all markets, and is only **growing in importance** as the population ages and reimbursement shifts away from Fee-For-Service to other shared-risk payment models

PAC services are critical component to the **strategic and financial success** of every health system, whether they have a strong PAC continuum within the health system or rely upon community partners

Every health system should develop a **PAC Strategic Plan** that parallels the health system Strategic Plan, and supports each of the system's growth objectives

- This process may be time consuming, but this business segment is too important to **“manage by the seat of the pants”**



Questions?



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