SELLING THE FINANCIAL VALUE OF HOSPICE

November 1, 2013
National Association for Home Care and Hospice Annual Meeting

AGENDA

* Speaker Background
* Relevant Legislation
* Financial Value Buyers
* Solution Selling – Executive Sales Process
* Opportunities for Selling of Financial Value
* Organizational Implications
SPEAKER BACKGROUND

* Over 20 years in home care
* 35 years of experience in planning and marketing
* MBA from the Sloan School of Massachusetts Institute of Technology
* President, Healthcare Market Resources, a market intelligence providing customized market research to home health agencies and hospices, including MD/facility referral trends

PATIENT PROTECTION & AFFORDABLE CARE ACT

* Medicare Re-admission Penalties
  * Three DRG sets subject to potential penalties in FY2013, based on FY2012 results
    * Acute Myocardial Infarction (AMI)
    * Pneumonia
    * Chronic Heart Failure
  * Additional DRG sets in 2015
    * Chronic Obstructive Pulmonary Disease (COPD)
    * Coronary Artery Bypass Graft (CABG)
    * Percutaneous coronary intervention (PTCA)
    * Vascular Procedures
* Hospitals judged by all hospital re-admissions in thirty (30) day period following discharge, regardless of hospital
PATIENT PROTECTION & AFFORDABLE CARE ACT

* Medicare Re-admission Penalties
  * Worst-case Scenario
    * 1% of ALL Medicare re-imbursement in 2013
    * 2% of ALL Medicare re-imbursement in 2014
    * 3% of ALL Medicare re-imbursement in 2015
  * Penalties based on prior year results

PATIENT PROTECTION & AFFORDABLE CARE ACT

- Reimbursement of bundle “manager” under Bundled Payment
  - Based on expected costs for all Medicare providers
    - In proportion to their usage
    - Covers clinically-defined episodes of care
    - Specific to the geography involved

- Focused Capitated Payment

- Of 4 options, only Bundles 2 & 3 include post-discharge services
PATIENT PROTECTION & AFFORDABLE CARE ACT

* Bundle 2-Episode of Care
  * Single geographic specific payment per episode
  * Includes all inpatient, physician and post-discharge services
  * Initial hospital stay and 30, 60 or 90 day period post-discharge
  * Choice of 48 clinical conditions
  * Retrospective reconciliation; must offer Medicare at least 3% discount on projected costs for 60 days or 2% on 90 days

PATIENT PROTECTION & AFFORDABLE CARE ACT

* Bundle 3-Episode of Care
  * Single geographic specific payment per episode
  * Includes ONLY post-acute services (excludes hospice)
  * Triggered by inpatient hospital stay and includes 30, 60 or 90 day period post-discharge
  * Choice of 48 clinical conditions
  * Retrospective reconciliation; must offer Medicare at least 3% discount on projected costs for 60 days or 2% on 90 days
PATIENT PROTECTION & AFFORDABLE CARE ACT

* Bundled Payments Participants

<table>
<thead>
<tr>
<th>Model</th>
<th>Organizations</th>
<th>Hospitals</th>
<th>Post-Acute</th>
<th>Other</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>34</td>
<td>34</td>
<td>0</td>
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</tr>
<tr>
<td>2</td>
<td>192</td>
<td>188</td>
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PATIENT PROTECTION & AFFORDABLE CARE ACT

* PPACA gave the Sec’y of HHS the ability to create Accountable Care Organizations (ACO’s)

* ACO’s are
  * Local organizations
  * Bring together physicians and hospitals, usually
  * Better manage the costs and quality for at least 5K lives
PATIENT PROTECTION & AFFORDABLE CARE ACT

* Accountable Care Organizations
  * Payment and delivery healthcare reform model
  * Seeks to tie provider reimbursements to
    * Quality metrics
    * Reduction in total cost of care
  * Managed care for an assigned population
  * Usually led by a hospital-physician coalition
* Many participants shied away from participating because of upfront costs
  * Medicare is subsidizing this investment in exchange for smaller returns

PATIENT PROTECTION & AFFORDABLE CARE ACT

* Participation
  * 32 Pioneer ACO’s started operation in Jan 2012
  * 27 Shared Savings ACO’s started operation in April 2012
  * 87 Shared Savings ACO’s started operation in July 2012
  * 106 Shared Savings ACO’s started operation in Jan 2013
* While almost half appear to be physician led, many of those have strong insurance involvement
* Most Pioneer ACO’s have re-upped but using a less risky approach
PATIENT PROTECTION & AFFORDABLE CARE ACT

* Medicare Advantage Plans
  * Saw a 15% reduction in per-member per month fees and mandated medical loss ratio

* Hospice Concurrent Care Demonstration
  * Instructed HHS Sec’y to create a concurrent care hospice demonstration project
  * Include up to 15 hospices, both urban and rural
  * Allow patients to receive hospice care while also being treated with other Medicare services

PATIENT PROTECTION & AFFORDABLE CARE ACT

* Hospital Value-Based Purchasing
  * For FY2014, 1.25% of all Medicare inpatient payments withheld and put into pool
    * Hospitals scored in three domains—Clinical Process, Patient Experience and Outcomes
    * Numerous metrics in each category
    * Monies re-distributed based each hospital’s score
  * For FY2015, withholding increased to 1.5%
    * New domain added—Efficiency
    * Metric: Medicare spending per beneficiary post 30 days discharge—worth 20% of score
PATIENT PROTECTION & AFFORDABLE CARE ACT

* 2014 Hospital value-based Purchasing
  * Outcomes Domain Score (25% of score)
  * Based on 30 day mortality rate, post hospital admission for key diagnoses
    * Acute Myocardial Infarction
    * Congestive Heart Failure
    * Pneumonia
  * Can include deaths occurring post-discharge, even on hospice

PATIENT PROTECTION & AFFORDABLE CARE ACT

* Dual Eligible Demonstration Projects
  * Combine Medicaid and Medicare expenditures for individuals covered by both payors into one pool of funding
  * Dual eligibles have historically been intensive users of medical services.
  * Socioeconomic issues complicate healthcare delivery
  * California, Washington, Illinois and Ohio have signed agreements with CMS; 22 states on the waiting list
  * Long term care not usually included
HEALTHCARE REFORM

* Key Concepts
  * Value-Based Purchasing
  * “Tearing Down the Silos”
  * Outcomes-Based Reporting
  * Post-Acute Integration
* Goal
  * Reduce spending
  * Improve Quality of Care
  * Increase Access

ROLE OF HOSPICE/PALLIATIVE CARE

* Original Mission
  * IMPROVE LIFE QUALITY AT END OF LIFE

* Added Mission
  * PROMOTE VOLUNTARY RATIONING OF CARE
  * REDUCE EXPENDITURES AT END-OF-LIFE

* MEANS JUSTIFY THE END
“NEW BUYERS”

* Hospital Administration
  * Re-Admissions
  * Bundled Payments
* Accountable Care Organization (ACO) Management
* Managed Care (MCO) Management
  * Medicare Advantage
  * Dual Eligibles

THESE ARE ECONOMIC BUYERS

REFERRAL SOURCE MOTIVATION

<table>
<thead>
<tr>
<th>MASLOW’S HIERARCHY OF NEEDS</th>
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<tbody>
<tr>
<td>SELF-ACTUALIZATION</td>
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<tr>
<td>ESTEEM</td>
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<tr>
<td>LOVE/BELONGING</td>
</tr>
<tr>
<td>SAFETY</td>
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<td>PHYSIOLOGICAL</td>
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BARRIERS TO HOSPICE

* Attitudes towards dying
* Medical professional uncomfortable talking about death
* Medical professional does not have time to discuss subject
* Medical professional not knowledgeable about hospice
* Hospice not easily available

POWER OF “NEW BUYERS”

* Change way healthcare is delivered
  * Protocols
  * Organizational structure
  * Access to patients and information
* Change incentives for medical professionals
  * Reward and encourage preferred behavior
* Change organizational metrics
  * Monitor hospice utilization
“OLD” SALES PROCESS
SIMPLE

Sales

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Referral

“NEW” SALES PROCESS
COMPLEX

Complex “Buying” Team

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Sales

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Referral
**SIMPLE VS. COMPLEX SALE**

* Numerous individuals to sell each with different agendas
* Gaining access to decision participants or committee can be difficult
* Fewer chances to sell; buyers collectively control/influence more business than an individual
* Communicating, getting feedback
* and implementing decision can be more time consuming; need to work thru various layers of the organization

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**DIFFERENCES**

<table>
<thead>
<tr>
<th>SIMPLE</th>
<th>COMPLEX</th>
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<tbody>
<tr>
<td>Relationship Focused</td>
<td>Solution focused</td>
</tr>
<tr>
<td>Target Users</td>
<td>Target Business People</td>
</tr>
<tr>
<td>Product/Service Education</td>
<td>Product Usage</td>
</tr>
<tr>
<td>Ask for the Business</td>
<td>Ask for the Next Step</td>
</tr>
<tr>
<td>Single Decision-maker</td>
<td>Multiple Decision-makers</td>
</tr>
<tr>
<td>Spontaneous Access</td>
<td>Scheduled Gated Access</td>
</tr>
<tr>
<td>Single Agenda</td>
<td>Different Agendas &amp; Motivations</td>
</tr>
<tr>
<td>Can make decision @ sales call</td>
<td>Longer time frame for the decision</td>
</tr>
<tr>
<td>Implement decision with the</td>
<td>Work thru organization to implement</td>
</tr>
<tr>
<td>next patient</td>
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</table>
QUESTIONS TO ASK

* Does your customer have a well-defined decision/buying process?
* Is the approval process different from the “buying” process?
* To what extent does your customer understand the problem?
* To what degree do they understand your solution?
* What are the risks involved in implementing your solution and how can you mitigate them?

EXECUTIVE SALES JOB DESCRIPTION

* Relationships/face-to-face contact – Executive/C-level
* Budgetary responsibility-Account P&L
* New program development-Conceives & Develops
* Education/Background-Business Bachelors Degree
* Key Skills – Independent thinker; able to manage process & account relationship
* Measurement – Account Penetration
SALES TEAM OF THE FUTURE

* The Executive Sales effort will obtain the “hunting license”
* Clinical Sales effort will obtain the patients
* Clinical Sales effort will need to sell both “quality” and “value”

REASONS NOT TO “BUY” HOSPICE

* Don’t have time to explain
* Not sure if patient is hospice appropriate
* Don’t want to deal with emotionality
* Palliative care is sufficient
* Need to fill my clinical trial
* Don’t want to miss teaching opportunity for residents/medical students
INFLUENCES ON THE “BUY” HOSPICE

* Don’t have time to explain
* Not sure if patient is hospice appropriate
* Don’t want to deal with emotionality
* Palliative care is sufficient
* Need to fill my clinical trial
* Don’t want to miss teaching opportunity for residents/medical students

FINANCIAL VALUE OF HOSPICE

* Reduce hospital LOS and reduce ICU usage
* Reduce hospital re-admissions
* Reduce per beneficiary spending
* Reduce bundled payment costs
FINANCIAL INTEREST OF BUYERS

<table>
<thead>
<tr>
<th>BUYER</th>
<th>Hospital LOS</th>
<th>Re-Admissions</th>
<th>Spending</th>
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<tbody>
<tr>
<td>Hospital Administration</td>
<td>Secondary</td>
<td>Primary</td>
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<tr>
<td>Accountable Care Organization Management</td>
<td>Secondary</td>
<td>Secondary</td>
<td>Primary</td>
</tr>
<tr>
<td>Bundled Payment Manager</td>
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<td>Primary</td>
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<tr>
<td>Medicare Advantage Network Management</td>
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<td>Primary</td>
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<tr>
<td>Dual Eligible Organization Management</td>
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<td>Primary</td>
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DATA REQUIREMENTS

* Hospital Mortality Rate by DRG
* Hospital Expired Patients Length of Stay by DRG
* Hospital Re-admission Rate by DRG
* Hospital Cost per Day per DRG
* Hospice Utilization Rate
* Hospice Referral Rate by DRG
* Per Beneficiary Spending by DRG
FINANCIAL VALUE OF HOSPICE

* **Reduce** hospital LOS and reduce ICU usage
  * **By reducing hospital mortality**

* **Reduce** hospital re-admissions

* **Reduce** per beneficiary spending

* **Reduce** bundled payment costs
HOSPITAL MORTALITY

* Research if institution has issue
  * Hospital Compare
  * State Dept of Health and Hospital Association
  * Commercial firms
* Identify patients
  * Expiring at rates greater than norm
  * LOS longer than norms
* Calculate benefit in earlier discharge to hospice in terms of lower mortality rate, shorter LOS and lower spending

REDUCED LOS BENEFIT

* Determine LOS for all patients who died in-house for top 25 DRG’s
* Subtract 2 days from each average LOS
* Multiply this result by total number of patients who died in-house
* Take this result(potential hospice days) and multiply this by the cost per day for the respective DRG’s
* This represents the savings
* If the organization is responsible for all spending subtract cost of inpatient hospice benefit times the potential hospice days to determine net savings
FINANCIAL VALUE OF HOSPICE

- **Reduce** hospital LOS and reduce ICU usage
- **Reduce** hospital re-admissions
  - *For End-of-Life CHF, Pneumonia and soon COPD patients*
- **Reduce** per beneficiary spending
- **Reduce** bundled payment costs

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**Hospital Re-admission Rate Analysis**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cases</th>
<th>Re-admissions</th>
<th>Death Rate</th>
<th>Death Ratio</th>
</tr>
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<tbody>
<tr>
<td>Congestive Heart Failure</td>
<td>1000</td>
<td>2000</td>
<td>24.5%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>400</td>
<td>800</td>
<td>30.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Other Miscellaneous</td>
<td>600</td>
<td>1000</td>
<td>22.0%</td>
<td>18.0%</td>
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</table>
HOSPITAL RE-ADMISSIONS

- Research if institution has issue
  - Hospital Compare
  - Commercial firms
- Identify patients
  - Chronic Heart Failure
  - Pneumonia
  - Secondary Penalty DRG’s – COPD
- Determine how many patients who are discharged alive die within 30 days
- Calculate benefit in eliminating re-admissions

HOSPICE RE-ADMISSION RESEARCH

- Hospital Discharges to Hospice
  - Almost 6x lower re-admission rate than overall
  - 78% of hospitals had NO re-admissions from hospice
  - 91% of hospitals had no hospice re-admissions for CHF patients
  - 94% of hospitals had no hospice re-admissions for Pneumonia patients
HOSPITAL RE-ADMISSIONS BENEFIT

* Determine how many discharges there are for CHF and pneumonia and the re-admission rate for each.
* Calculate the number of re-admissions for each DRG
* Determine the percentage of discharges who die within 30 days for each DRG
* Multiply these percentages by the DRG discharges to determine hospice potential patients
* Apply the re-admission percentage to each set of hospice potential patients to determine re-admission potential instances.
* Take the instances for each DRG and divide the number of pneumonia and CHF discharges to determine how much impact referring to hospice could have.

HOSPITAL RE-ADMISSIONS STRATEGY

* Hospitals are being measured by CMS as we speak
* Focus on CHF and pneumonia on dementia patients; worry about COPD in 2014
* Does the hospital have a problem? Quantify it.
* Hospice is only one of many solutions
* Explain how hospice prevents re-admissions
* Show the re-admission rate for hospice patients
* Agree on how to identify target patients
HOSPITAL RE-ADMISSIONS STRATEGY

* Set up policies, procedures and protocols regarding these patients.
* Offer to in-service cardiac unit physicians and nurses on terminal criteria
* Commit to be available for initial hospice consult within a given time frame. Must a clinician initiate the process?
* If unsuccessful initially, commit to follow up with patient within 2 weeks

30 DAY MORTALITY

* Based on same 3 diagnoses as for hospital re-admissions
* Rewards calculated based on absolute performance and improvement

INCENTIVE TO REFER PATIENTS TO HOSPICE PRIOR TO THEIR “LAST” ADMISSION
FINANCIAL VALUE OF HOSPICE

* **Reduce** hospital LOS and reduce ICU usage
* **Reduce** hospital re-admissions & 30 day mortality
* **Reduce** per beneficiary spending
  * By reducing hospitalizations
* **Reduce** bundled payment costs

HOSPITAL DISCHARGE RESEARCH

* Almost 7% of all Medicare patients discharged alive from hospitals die within 30 days
* Less than 2% of all Medicare patients discharged are referred to hospice
* Patients who were discharged alive from a hospital, but died within 30 days, spent, in their last 30 days,
  * $22016 w/o a hospice claim
  * $19695 with a hospice claim
END OF LIFE SAVINGS RESEARCH

* Don Taylor of Duke University published a study which showed that hospice saved over $2300 per patient for patients in the last 2 months of life.
* Mt. Sinai study found over $2500 in savings for patients enrolled in hospice between 53-105 days prior to death
* Even greater savings were achieved for patients with shorter lengths of stay, prior to death.

<table>
<thead>
<tr>
<th>LENGTH OF STAYS (DAYS)</th>
<th>SAVINGS($)</th>
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<tbody>
<tr>
<td>1-7</td>
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<tr>
<td>8-14</td>
<td>5,040</td>
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<tr>
<td>15-30</td>
<td>6,430</td>
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</table>

PER MEDICARE BENEFICIARY SPENDING

* Calculates spending per Medicare beneficiary
  * Can be calculated over a time frame (30, 60, 90 days) or for a given subset of Medicare eligibles (Dual eligibles or everyone discharged from a specific hospital).
  * Facility level (hospitals, SNF’s, HH agencies, hospices) data is easier to obtain
  * Other Part B provider claims including physicians much more difficult to obtain
  * Likely proportionate to the facility level spending
HOSPICE UTILIZATION BENEFIT

* Determine number of population served by organization for “managed care” situation
* Determine hospice utilization for specific geography covered and for the state.
* Calculate the number of hospice admissions
* Choose a target rate and calculate number of hospice admissions
* Utilize savings from Mt. Sinai and Duke studies

KEY TO ACO’S

* All about behavior change
* Care about the patient across all settings of care
* Will make money by
  * Reducing unnecessary services
  * Substituting less expensive services
* The tail that directs the rest of the organization’s referral flow
ACO SALES APPROACH

* Show hospice utilization for geographic market of ACO and compare to potential
* If ACO is affiliated with hospital, show hospice referral rate and compare to potential
* Show per day savings for a patient’s last 30 prior to expiration in terms of using hospice versus not.
* Calculate potential savings for each percentage point of increased penetration

ACO STRATEGY

* Demonstrate cost savings for using hospice in lieu of curative care
* Utilize Duke and Mt. Sinai Medicare End-of-Life research
* Request names of primary care physicians, who are part of the ACO, and specialists & determine who are under-utilizers of hospice
* Agree to make joint sales calls with ACO representative to educate physicians about hospice
* Request ACO support in working with their network home health agencies in to jointly identify terminally ill Medicare patients
* 60-70% of these patients could be transferred to hospice; less than 40% are
* Request “real-time” access to ACO patient management database to monitor for terminally ill patients
FINANCIAL VALUE OF HOSPICE

* **Reduce** hospital LOS and reduce ICU usage
* **Reduce** hospital re-admissions
* **Reduce** per beneficiary spending
* **Reduce** bundled payment costs
  * Substituting hospice for hospitalizations

BUNLED PAYMENT STRATEGY

* Focus on Model 2 – Inpatient and Post Discharge Services
  * Hospice’s value-eliminating costly, unnecessary hospitalizations
  * Identify specific patient populations, where hospice is being under-utilized. Conduct literature review for support
  * Aetna lung study
* Determine if potential hospital partner has sufficient volume to warrant interest
* Position proposal as opportunity to learn about “bundled payments”.

AETNA CONCURRENT HOSPICE CARE

* Since 2004, Aetna has been allowing terminally ill patients with a 12 month prognosis to receive curative care and hospice care simultaneously
  * Saw a reduction in medical costs on these patients by 22% and a 70% increase in hospice admissions

MCO’S

* Offer to assist MCO in getting their members to sign living wills and health care proxies
  * Offer to educate health coaches on the benefits of hospice
  * Discuss concurrent care pilot with MCO to allow members to “try” hospice before committing and still receive curative care
HOSPICE IN MCO’S

* Medicare Advantage plans (MCO’s) lose money on terminally ill patients because of expensive re-hospitalizations
* An average ICU day costs $7,000-$15,000, depending on the level of equipment and length of stay in the unit
* MCO generally pays hospital on a per-day basis
  * Assist MCO in transferring patient to GIP bed

MCO SALES APPROACH

* Quantify savings using per beneficiary spending savings
* Utilize hospice medical director to broach topic with MCO medical director
  * Provide articles on success of concurrent care to make case
* Determine if MCO has “complex case management” capability and understand their scope
* Determine financially viable concurrent care services package
  * Goal is breakeven proposition pre-hospice election
DUAL ELIGIBLE SALES APPROACH

* Use approach similar to managed care
* Show hospice utilization for dual eligibles and for ethnic groups (Black and Hispanic)
* Quantify savings thru increased usage

BRAND SELECTION

* No standard to judge quality; all public figures are self-reported
* Low-cost concurrent care program will be vital to offer to MCO’s and Dual Eligible organizations
* Inpatient capacity will be critical to prevent re-admissions
* Ability to admit patients during the “sweet spot” will be key
HOSPICE “SWEET SPOT”

ORGANIZATIONAL IMPLICATIONS

* Need to re-vision hospice from calling to an economic vehicle, which improves quality of life and lowers costs
* Required resources
  * Rainmaker
  * Research
  * “Complex” Sales Process
  * Operational flexibility-No Medicare mindset
CONCLUSIONS

* PPACA created the “economic” motivation for organizations to enable the use of hospice
* End-of-life care will be a major focus of cost savings for Medicare, MCO’s and all managed care-like organizations
* It requires a different sales process and resources to sell this “buyer”
* Hospice will need numbers to sell the concept and their “brand”

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