QUANTIFYING THE THREATS & OPPORTUNITIES UNDER HEALTHCARE REFORM

NAHC Annual Meeting
Phoenix AZ
October 21, 2014

AGENDA

* Speaker Background
* Re-Admissions
  * Home Health
  * Hospice
* Economic Incentivized Situations
  * Home Health
  * Hospice
* Market Implications
  * Home Health
  * Hospice
* Conclusions
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,

HEALTHCARE MARKET RESOURCES

* Leading market research firm serving post-acute
* Helps home health agencies, hospices and SNF’s better understand their market, competitors and referral sources
* Clients use our data in strategic/market planning, benchmarking, sales targeting and key account development
* Referral data on hospital, SNF’s and MD’s
PURPOSE

* Quantify the benefits to executive buyers
  * Change referral patterns to use more home health or hospice
  * Change referral patterns to use your organization versus your competitors
  * Quantify the impact of healthcare reform on your organization going forward

EXECUTIVE BUYERS

* Under healthcare reform, executive buyers are senior hospital mgmt, ACO mgmt, bundled payment conveners, & managed care organizations
* Financial incentives/penalties based on post-acute and pre-acute performance
* Complex sale – numerous “buyers” and different agendas
* Like to see quantification of impact of proposals on their organization
DATA CREDIBILITY HIERARCHY

| * PUBLICLY AVAILABLE DATA (Websites) |
| PUBLICLY AVAILABLE DATA (Downloads) |
| THIRD PARTY REPORTS (Commercial firms) |
| INTERNAL DATA |

MEDICARE RE-ADMISSION PENALTIES

* Hospital penalties - up to 3% of Medicare inpatient revenues
* Triggered – lowest quartile of re-admission rate on 3 diagnoses
  * Chronic Heart Failure (CHF)
  * Simple Pneumonia
  * Acute Myocardial Infarction (AMI)
* Adding 2 diagnoses next year
  * Chronic Obstructive Pulmonary Disease (COPD)
  * Joint Replacements
2015 MEDICARE PENALTIES

* REAL MONIES AT RISK
* 2610 hospitals – 55% of all eligible hospitals penalized in FY2015
  * 39 hospitals – 3% penalty
  * Weighted average penalty - .63%

<table>
<thead>
<tr>
<th>STATE</th>
<th>AVERAGE PENALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kentucky</td>
<td>1.02%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>1.00%</td>
</tr>
<tr>
<td>Virginia</td>
<td>.97%</td>
</tr>
</tbody>
</table>

HOSPITAL PAIN ANALYSIS

* Go to [http://www.kaiserhealthnews.org/daily-reports/2014/october/03/medicare-and-seniors-issues.aspx?referrer=search](http://www.kaiserhealthnews.org/daily-reports/2014/october/03/medicare-and-seniors-issues.aspx?referrer=search) to see if a specific hospital is being penalized and how much
* Go to [http://www.hospitalcompare.gov](http://www.hospitalcompare.gov) to see how a specific hospital’s re-admission rates compare
* Determine which quartile a specific hospital is

HOW MUCH PAIN?
RE-ADMISSION OPPORTUNITY

* Re-admission rates for competitors & hospital market share
* Current weighted re-admission rate v. yours
* Number of re-admissions prevented

<table>
<thead>
<tr>
<th>Agency</th>
<th>Hospital A Mkt Share</th>
<th>HHCompare Re-admission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Agency</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Competitor 1</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Competitor 2</td>
<td>30%</td>
<td>25%</td>
</tr>
<tr>
<td>Competitor</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td>Hospital A(weighted)</td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td>Penalty Cases</td>
<td></td>
<td>300</td>
</tr>
<tr>
<td>Reduced Re-admissions</td>
<td></td>
<td>30</td>
</tr>
</tbody>
</table>
HOSPITAL DISCHARGES BY DRG

RE-ADMISSION RISK REDUCTION

* Similar patients going home unsupported v. going to home health
  * Former has greater likelihood to be re-admitted
* Top Performers’ home discharge % becomes goal
* Opportunity Calculation
  * 50% Penalty DRG cases go home – 500 cases
  * Top Performers home % - 30%
  * 200 cases @ unnecessary re-admission risk
HOSPICE RE-ADMISSION REDUCTION

* HMR Research
  * 7% of Medicare patients discharged from hospital alive die within 30 days
  * Less than 2% get referred to hospice
* Opportunity Calculation
  * Hospice impacts only CHF and Pneumonia
  * Assume 3.5% of Penalty DRG patients die within 30 days & are not discharged to hospice & go home
  * If Hospital A has 700 Penalty DRG discharges yearly, then new hospice patient potential is 25.

SNF RE-ADMISSION THREAT

* SNF’s have a lower re-admission rate than home health (21% v 28%)
* Site of care discharge patterns vary dramatically across the country
* Understand your target hospital preferences for penalty DRG patients
* SNF’s adding NP’s/PA’s onsite and improving care coordination

IF NO ECONOMIC INCENTIVES, SNF’S ARE PREFERABLE TO HOME HEALTH TO REDUCE RE-ADMISSION RISK
PATIENT EXPENDITURE OWNERSHIP

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>TIME FRAME</th>
<th>AT RISK</th>
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</thead>
<tbody>
<tr>
<td>Hospitals Value Based Purchasing</td>
<td>30 days post-discharge</td>
<td>.3% of all Medicare inpatient reimbursement for each factor</td>
</tr>
<tr>
<td>- Per Beneficiary Spending</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Mortality Rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bundled Payment</td>
<td>60/90 days post admission</td>
<td>All $ saved after 3%/2% off the top reduction</td>
</tr>
<tr>
<td>Accountable Care Organizations/Managed Care Organizations</td>
<td>Annual</td>
<td>Expenditures above regional per beneficiary Medicare costs plus overhead</td>
</tr>
</tbody>
</table>

ECONOMIC BUYER APPROACH

* How can you make us money?
  * Home Health
    * Shift post-acute discharges to lower-cost site of care
    * Prevent re-admissions
  * Hospice
    * Reduce expenditures during end-of-life
* Quantify your proposal
  * “Gain Has To Be Worth The Pain”
HOSPITAL SITE OF CARE REFERRALS

* Research study ratioed Medicare discharges for home health vs. SNF referrals by hospital

<table>
<thead>
<tr>
<th></th>
<th>SNF</th>
<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>52%</td>
<td>48%</td>
</tr>
<tr>
<td>South Dakota</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>34%</td>
<td>66%</td>
</tr>
</tbody>
</table>

Upper Midwest has high SNF usage; Southeast has high HH usage

HOME CARE v. SNF -STATE

The Percentage of Patients Discharged to Skilled Nursing Facilities (SNFs) Compared to the Percentage of Patients Discharged to Home Health Agencies (HHAs) and Both Combined on a State Level

<table>
<thead>
<tr>
<th>State</th>
<th>SNF Percentage</th>
<th>HH Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Dakota</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>34%</td>
<td>66%</td>
</tr>
<tr>
<td>Upper Midwest</td>
<td>52%</td>
<td>48%</td>
</tr>
<tr>
<td>Southeast</td>
<td>48%</td>
<td>52%</td>
</tr>
</tbody>
</table>

Source: 2014 Medicare Services
SITE OF CARE SHIFT JUSTIFICATION – HOME HEALTH

* Calculated per DRG set or bundle
* Time frame can be 30, 60 or 90 days
* Compare cost of current discharge pattern to benchmark site of care mix for Part A services

<table>
<thead>
<tr>
<th>DRG XXX</th>
<th>IRF/LTAC %</th>
<th>SNF</th>
<th>Home Health</th>
<th>Community</th>
<th>Avg Cost/Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>5%</td>
<td>38%</td>
<td>12%</td>
<td>45%</td>
<td>$6,085</td>
</tr>
<tr>
<td>Benchmark</td>
<td>2%</td>
<td>25%</td>
<td>28%</td>
<td>45%</td>
<td>$5,546</td>
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</table>

FINANCIAL VALUE OF HOSPICE/PALLIATIVE CARE

* 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(including inpatient $)
  * $19695 with a hospice claim(including inpatient $)

* Medicare Care Choices Model eligible patients spent nationwide during the eligibility period

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>SNF</th>
<th>Home Health</th>
<th>Hospice</th>
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</thead>
<tbody>
<tr>
<td>$4.6 billion</td>
<td>$1.06 billion</td>
<td>$368 million</td>
<td>$894 million</td>
</tr>
</tbody>
</table>
MAKING THE FINANCIAL CASE FOR HOSPICE

* For bundlers, calculate average cost of Part A services for patients who are discharged alive from a hospital and then die within 30, 60 or 90 days with & without hospice
* For MCO’s & ACO’s, calculate average cost of Part A services for patients who die in their last 30, 60 or 90 days with & without hospice.

THREAT – HH PROVIDER CONSOLIDATION

* Post-Acute Networks
  * “Economic Buyers” - limits on number of chosen agencies (LTAC’s, IRF’s and SNF’s)
  * Need 12K+ agencies with 1400 health systems?
  * MedPAC estimates that post-acute discharges represent 58% of initial episodes, but only 34% of total episodes.
POST-ACUTE MARKET CONSOLIDATION ANALYSIS

* Understand agency market share by hospital, SNF, LTAC & IRF
  * Hospital-based/hospital affiliated agency?
    * Efficiency
    * Outcomes
    * Geographic coverage
    * Hospital “purchasing” strategy
* Develop agency market share & potential system wide
  * Weighted average based on hospital volume
  * Evaluate post-acute facilities volume

NETWORK SELECTION CRITERIA

* Performance
  * Re-hospitalizations/Emergent care
  * Patient Satisfaction
  * Resource Utilization
* Clinical expertise, sophistication & resources
* Compliance
* IS integration
* Financial “staying” power
* Cultural fit
THREAT – DUAL ELIGIBLE SHIFT

* 20 States indicated interest in demonstration; 16 states approved
* Varying levels of geographic coverage by state; plagued by delays, application withdrawals and member disenrollment
* Increasing movement of states into Medicaid managed care

**THE TRAIN HAS LEFT THE STATION; IT IS ONLY A MATTER OF TIME WHEN IT ARRIVES IN YOUR MARKET**
DUAL ELIGIBLE IMPACT ON HOME HEALTH

* Lower reimbursement rates per case & shorter LOS (fewer re-certs)
* Dual Eligibles represent 34% of all Medicare FFS reimbursement nationwide
  * Wide geographic variation
    * California - 49%
    * North Dakota – 10%
  * Driven by dual eligible population, home health utilization & prior managed care efforts (Part D)
KEY ISSUES-HOME HEALTH

* Can I join a post-acute network?
* Can I convince local hospital/health system to employ multi-provider referral policy?
* Can I survive as a community-based provider?
* Can I position my skilled home health business as an adjunct to a personal care business?
* Can I become low-cost provider and focus on managed care business?

* HOW CAN I SURVIVE?

OPPORTUNITIES & THREATS HOME HEALTH

* **Opportunities**
  * Increased post-acute referrals—regional variation
  * Participate in shorten referral lists for hospitals, ACO's and bundled payment conveners
  * Enable VBP incentives thru site of care discharge shift and reduced re-admissions
  * Integrate personal and skilled care for dual eligibles

* **Threats**
  * Reduced reimbursement per case for dual eligibles
  * **FEWER PROVIDERS**
  * Downward pressure on margins & increased scrutiny
HOSPICE OPPORTUNITY ANALYSIS

- Benchmark post-acute admissions vs. community admissions
- Benchmark % of hospitals discharges to hospice
- Benchmark hospice utilization for MCO’s & dual eligibles compared to overall market levels
### Managed Care & Dual Eligible Summary Report

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Managed Care Enrollee</th>
<th>Dual Eligible Enrollee</th>
<th>Managed Care &amp; Dual Eligible Enrollee</th>
<th>All Hospice Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DSH</td>
<td>PFS &amp; OAS</td>
<td>DSH</td>
<td>PFS &amp; OAS</td>
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<tr>
<td></td>
<td>TOT</td>
<td>% of div.</td>
<td>TOT</td>
<td>% of div.</td>
</tr>
<tr>
<td>Admissions</td>
<td>102</td>
<td>100.0%</td>
<td>94</td>
<td>100.0%</td>
</tr>
<tr>
<td>Discharges</td>
<td>102</td>
<td>100.0%</td>
<td>94</td>
<td>100.0%</td>
</tr>
<tr>
<td>CAS</td>
<td>47</td>
<td>46.2%</td>
<td>44</td>
<td>46.8%</td>
</tr>
</tbody>
</table>

### Summary Data

- **HEALTHCARE MARKET RESOURCES, INC.** THE Source of Local Market Data for Home Care
  
  215-467-2373 x HealthMR.com

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**Note:** This report does not meet Medicare standards reporting requirements.

Unpublished data, Healthcare Market Resources. This report is confidential. The contents of this report may not be disclosed to any third party, or provided to any or maintained persons, only as it is to be used in connection with any other use.
IMPACT OF HEALTHCARE REFORM ON HOSPICE

- Post Acute Networks
  - Value of hospice in economic situations
  - Easier to work with a few providers
- Dual Eligible Shift
  - Like a MCO, makes money by reducing
  - unneeded treatments at EOL
  - Dual Eligibles have cultural bias against
    - hospice
  - Regulatory/Reimbursement Changes

HOSPICE COMPETITIVE ANALYSIS

- Hospital Admission from Hospice
  - Sentinel Event/Service Failure under Six Sigma approach to quality
- “Sweet Spot” of Hospice
  - % of Discharges w/LOS of 30-89 days
  - Marriage of Clinical & Financial Outcomes
HOSPICE “SWEET SPOT”

HOSPICE REGUALTORY CHANGES

* PPACA authorized Secretary of HHS to subject to medical review all claims of hospices with an excessive % of patients discharged after 180 days.
  * 40%?
* Implementation delayed by flaw in PPACA which would have put patient at risk for denied claims; IMPACT corrected.
* CMS knows these “bad boys”—200+ hospices; concentrated in high CAP states—AL, MS, OK
* In 2008, 45 hospices would have been subject to this review.
HOSPICE REIMBURSEMENT CHANGES

* PPACA mandated change in reimbursement methodology
* CMS delayed for 2 yrs recently to collect more data
* Will likely see “U” shaped method
  * Lower rates as LOS increases
  * Different rates by diagnosis, possibly
* Targeting long LOS patients

| Hospice Spending LOS> 180 days | $7.9 B 58% |
| Hospice Spending LOS> 180 days – Days 181+ | $5.3B 38% |
| Hospice Spending All Beneficiaries | $13.8B 100% |

HOSPICE REIMBURSEMENT OPPORTUNITY

* Determine for each hospice competitor how many days are in each LOS category
  * Overall
  * By Diagnosis
* If more than 30% of competitor’s days are above 180 days or 40% are above 90 days, survivability is questionable
THREATS & OPPORTUNITIES
HOSPICE

* Opportunities
  * Position hospice as a solution to reduced LOS, re-admissions, and ICU usage
  * Promote early referral to hospice as way for hospitals to earn value-based purchasing bonus
  * Show how increased hospice usage can aid ACO’s and bundled payment conveners
  * LEAD WITH PALLIATIVE CARE TO DRIVE HOSPICE REFERRALS

* Threats
  * New reimbursement system = fewer long stay patients
  * Inclusion of hospice in Medicare Advantage
  * FEWER HOSPICES

NEXT STEPS

* Understand how your market will be impacted by the changes driven by healthcare reform

* Decide on “who you want to be when you go up”

* Take steps to position your organization for the future
CONCLUSIONS

* PPACA brought “economic” motivation to the post-acute referral process
* 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”
* Post-acute providers will need numbers to sell the concept and their “brand”
* A better understanding of future market dynamics will critical to agency/hospice survivability

CONTACT INFORMATION

* Rich Chesney
* President, Healthcare Market Resources
* rchesney@healthmr.com
* 215.657.7373
* 215.657.0395(f)
* www.healthmr.com