Post Acute Care

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Sources:

2019 08 27 SHHG Board LTC Facility Restructure (3) (for RNC – Fuller)

Market Overview – Outpatient Rehab Location Analysis July 2019

Chad Tuttle Interviews: August 14, 2019, January 6, 2020

Post Acute Landscape: Guidehouse

Master Plan Summary for Post Acute Care

RNC Fuller Replacement Strategy

- New construction: 80 bed SNF and 120-bed LTC-SNF with 12 acute care beds for hospice
- Cost: $40,000,000 (additional $16M from Foundation)

RNC Kalamazoo Ave

- The reimbursement model for the six neuro residential homes is changing beginning July 2021
- Analysis has started to determine the future sustainable model of care

Outpatient Rehabilitation

- Nine sub-markets in the Grand Rapids region have been identified with a positive market attraction for new facilities. These will be carried in the Strategic System Master Facility plan
- Seven should be 2,500 sf and two should be 5,000 sf to accommodate pediatrics and other specialty care

Hospital SNFs

- Reed City: Demand is there for more beds if needed but won't add more
- United: Sized appropriately
- Kelsey: Hospital and SNF unit closing

Home Health and Post-Acute Operations

- Home health will continue to grow
- Cedar St. administrative location is being designed right now but expect it to run out of room due to growth
- Home infusion service will be expanded now that Lakeland is in system

RNC Fuller Campus, Grand Rapids

RNC – Fuller Replacement Plan Investment Overview

Investment/Return	
Capital Costs – Facility 1	$38.1M
Capital Costs – Facility 2	$16.9M
Total Capital Costs	**$55.0M**
One-time Operating Costs	$1M
Total Costs	**$56M**
10 Year EBITDA Improvement	$42.6M
IRR (10 Years)	-4%

KCH Foundation funds requested to cover $26M

Return does not include 'value' benefits to Delivery System. (i.e. Hospita cost avoidance, reduce length of stay)

RNC – Fuller Replacement Plan Benefits

- Drives value to delivery system via complex patient care
- Improve patient and staff experience
- Increase CMS Quality ratings
- Reduces regulatory risk
- Improve amenities available to residents
- Reduce plant maintenance and utility costs
- Allow for more efficient staffing models
- Introduce operational and cultural changes to more closely match a standalone nursing home
- Increase sub-acute rehab keepage
- Eliminates patient wards for long-term care

Grand Rapids Outpatient Rehabilitation Market Attractiveness Assessment

COMMUNITY	RANKING
Comstock Park/Walker	16.5
Kentwood	10.5
Wyoming	7.5
Coopersville/Marne	6.0
Jenison	6.0
Forest Hills	4.5
Hudsonville	4.5
Byron Center	3.0
Downtown Grand Rapids	1.5
Lowell	0.0
Wayland	-3.0
Caledonia/Middleville	-4.5
East Grand Rapids	-4.5
Grandville	-4.5
Cedar Springs	-6.0
Kent City	-7.5
Sparta	-7.5
Allendale	-10.5
Rockford	-12.0

Ideal Locations In Order of Importance

1. Near a SH primary care office or ICC
2. Near a health club or fitness center
3. Near a busy retail or traffic intersection

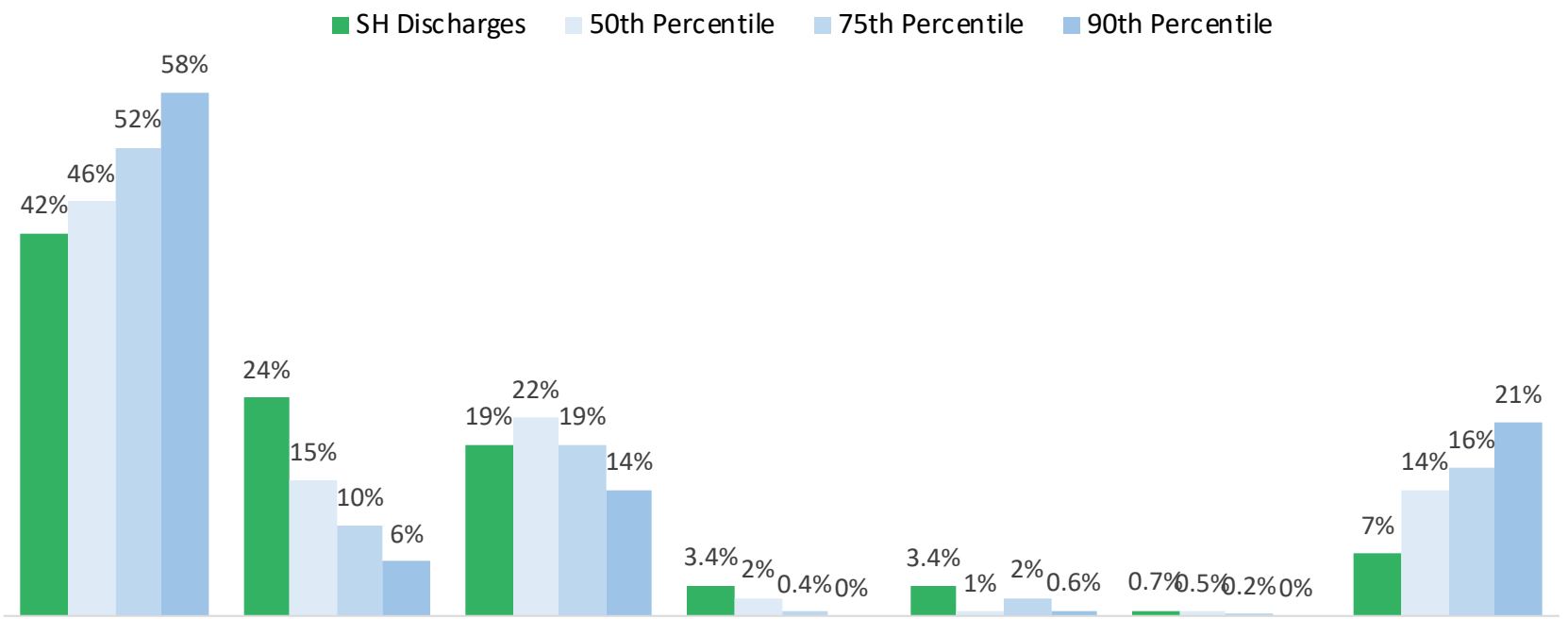
Seven should be 2,500 sf and 2 should be 5,000 sf to accommodate pediatrics and other specialty care

Note: Only the nine locations with positive market attractiveness are being carried in the Strategic System Master Plan

Appendix: Post Acute Care Landscape

Spectrum Health discharges fewer Medicare patients to home / self-care and more patients to Home Health than MedPar benchmarks

SH 65+ Patient Discharge Disposition vs. MedPar Percentile Benchmarks



	Home / Self Care	Home Health	SNF	IRF	Hospice	LTCH	Other
SH Vols.	35,257	20,118	15,846	2,860	2,812	555	5,728

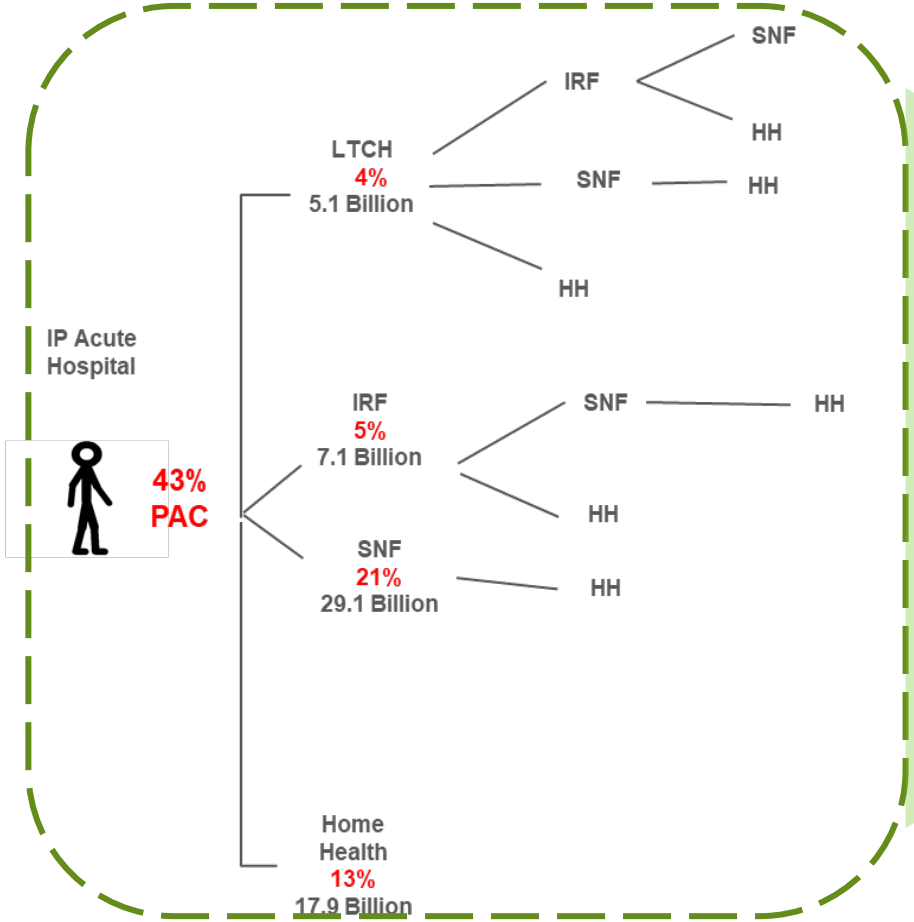
SH Post-Acute Volumes

Facility / Program	Admissions*	Patient Days	Visits
Blodgett / Select (IRF)	981	-	-
Reed City (RNC)	838	17,598	-
United (RNC)	1,103	23,169	-
Kalamazoo (RNC)	2,864	51,837	-
Fuller (LTC)	3,626	76,154	-
Hospice Days		127,797	-
VNA South	-	-	5,943
VNA North	-	-	2,864

Source: (1) SH Internal IP database and State IP database (2) SH Financial Reports *Financial statements only provide patient days. Assumes 21 day ALOS for RNC/LTC facilities from SH LTC report.

Overview: Lack of standardized pathways guiding post-acute utilization has significant quality & spend implications

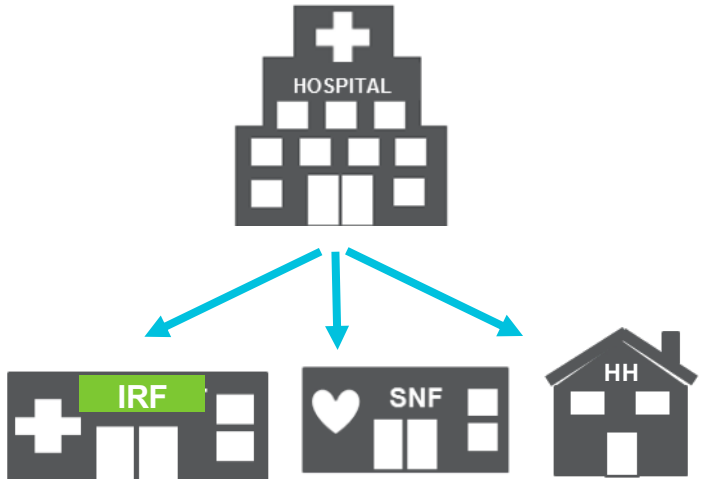
Post-Acute Patient Journey & Market Size



Goals of Developing a High Performing Post-Acute Preferred Partnership Network

DEVELOP care pathways across the continuum

IMPROVE transitions of care from acute to post-acute



REDUCE clinical variation within the same PAC for similar types of patients

REDUCE hospital readmissions

INTEGRATE post-acute providers within an episode of care relative to value-based reimbursement models

ALIGN with post-acute care (PAC) partners across the continuum that are committed to the "Triple Aim"

Source: American Hospital Association, June 2016 Med PAC Report

How does transition of care fit into Strategic System Master Plan?

Impact	SMP Implication
• Proper sizing of transition of care options can have a significant impact on inpatient LOS	• Increased throughput at facility reduces bed need
• Medicare and other payors continue to work to drive transitional care to lowest cost option	• Calculate proper levels of rapidly changing transition options
• Options such as home health provide alternative to IP stay	• Reduce the need for beds at other levels of transitional care
• Not all transitional care capacity needs to be owned	

Examples

EVCTP

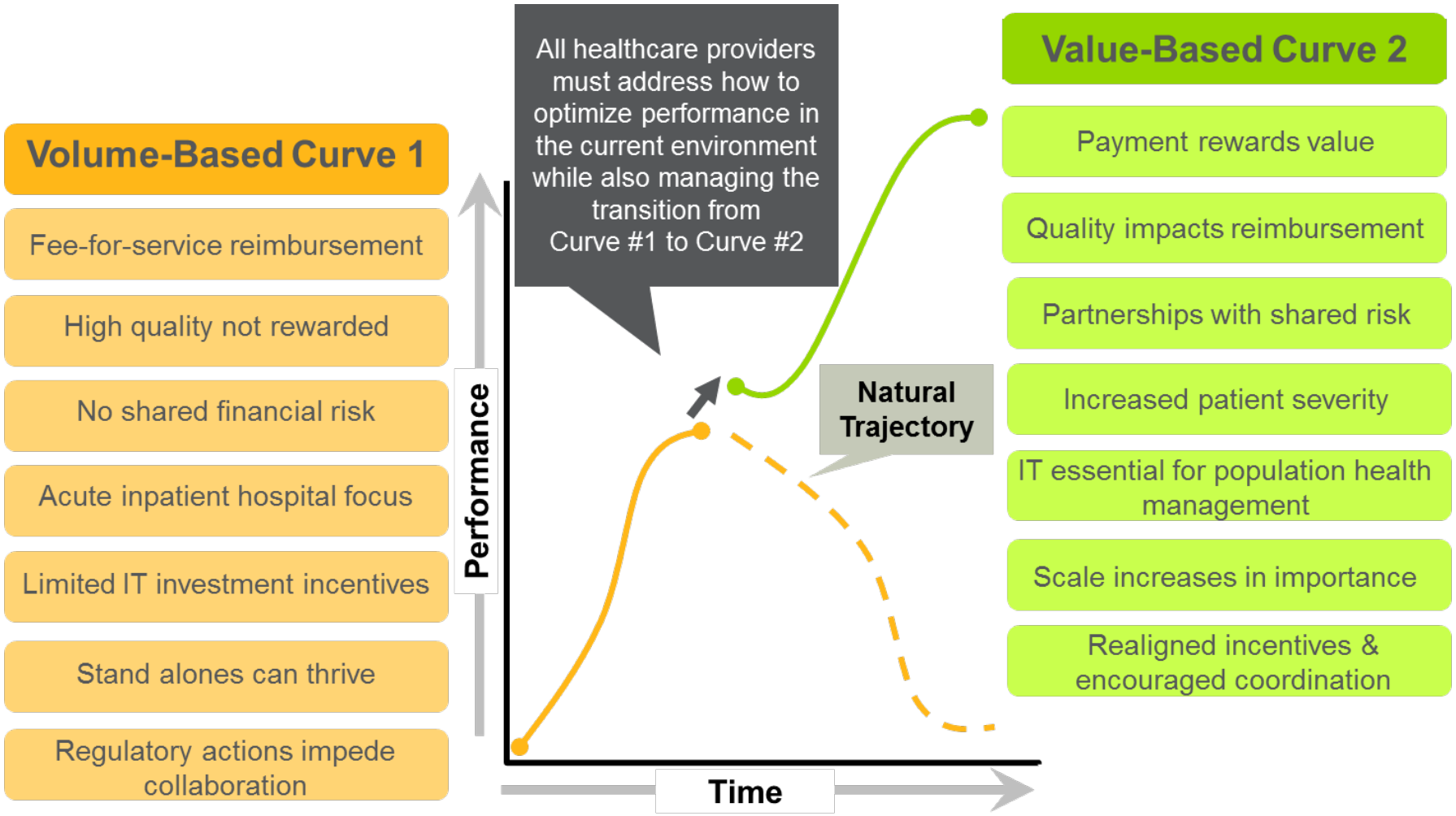
Cincinnati Children's

UnityPoint Health

Strategic Questions

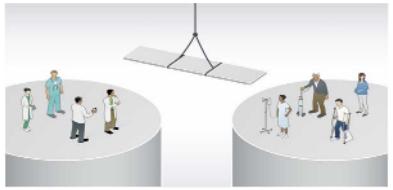
- What is the status of the relationship with Mary Free Bed?
- What infrastructure is needed to support the transition of care workers (e.g. home health providers)?
- What community partnerships does Spectrum currently have or need to support transition of care services?

Competing on Value



Building capabilities across the care continuum: In order to manage population health, providers are building their capabilities across the care continuum

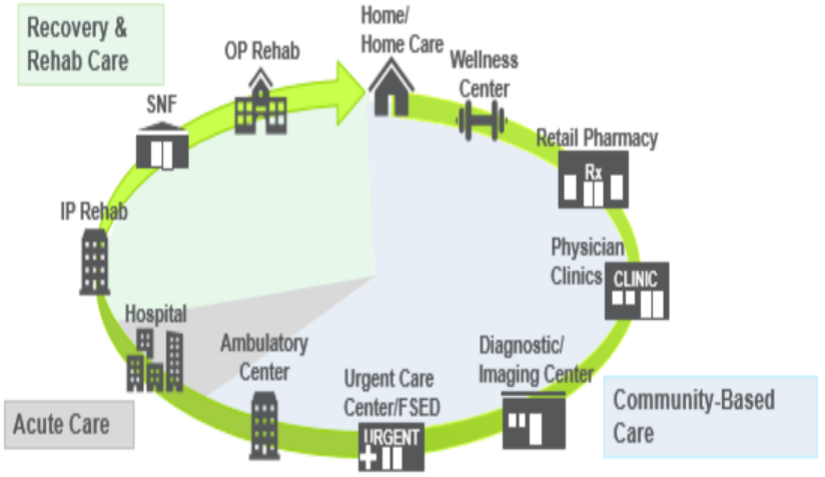
Healthcare of Yesterday: Acute Care Focus



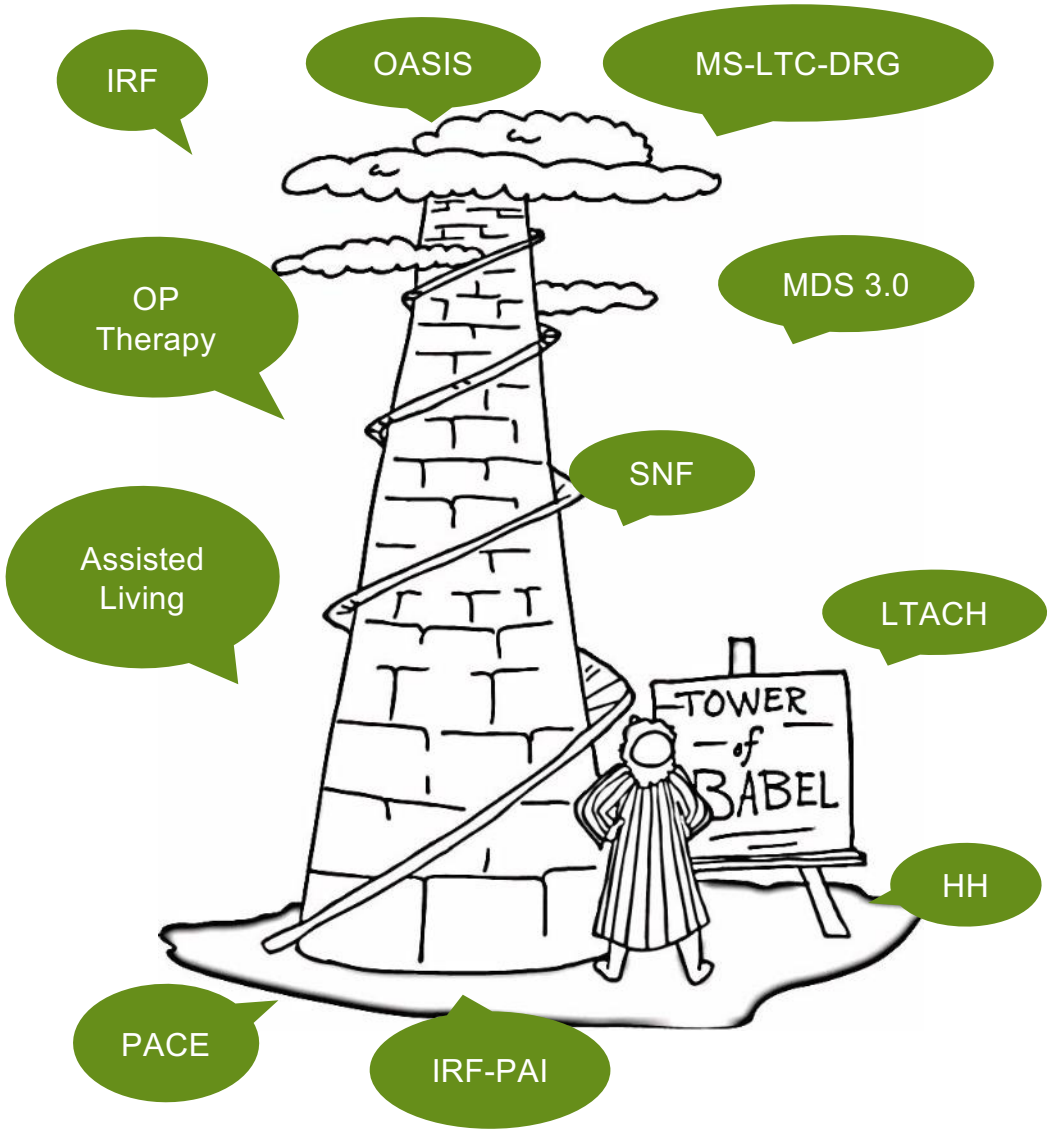
- Acute care focus
- Volume-driven incentives
- Little attention paid to quality of life
- Limited quality and price transparency
- Limited coordination across care continuum
- Expensive

Healthcare of the Future: Focus on Managing Health Across the Care Continuum

- Reduce lifetime burden of illness by delaying the onset of chronic illness
- Minimize interactions with the acute care system & incorporate prevention and disease management into clinical care plan
- Focus on interventions in the community



Post-Acute Continuum: Multilingual and Often Misunderstood



SOME OF THE ALPHABET SOUP:

ALF: Assisted Living Facility

HH: Home Health

IRF: Inpatient Rehabilitation Facility

IRF-PAI: Inpatient Rehabilitation Facility Patient Assessment Instrument is collected on all Medicare patients who receive services on an acute rehabilitation hospital or unit

LTACH: Long-Term Acute Hospital

LTC: Long-Term Care; Custodial; "Nursing Home"

MDS 3.0: The Long-Term Care Minimum Data Set is a health status screening and assessment tool used for all residents of nursing facilities

MS-LTC-DRG: Medicare Severity-Long Term Care-Diagnosis Related Groups; Codes used to classify care in a LTACH setting

OASIS: Outcome and Assessment Information Set - The Home Health assessment that measures health status and functionality

OP Therapy: Outpatient Therapy

PACE: Program of All-Inclusive Care for the Elderly

SNF: Skilled Nursing Facility

Key Definitions

Acute Care refers to care that occurs in an inpatient hospital setting.

Post-Acute Care Continuum refers to a range of services and levels of care required to support a patient's continued recovery from illness, or management of a chronic illness or disability.

Post-Acute is more often used as a term to refer to any services required "after a hospital stay".

Long-Term Care more often refers to the placement of patients in facilities to live out the remainder of their lives, as they are not able to return to their community living. This is often paid for by Medicaid.

Evolving Thinking:

Many PAC services can be used to prevent and keep patients out of the hospital in the first place

Key trends driving focus on post-acute care

1. TRIPLE AIM

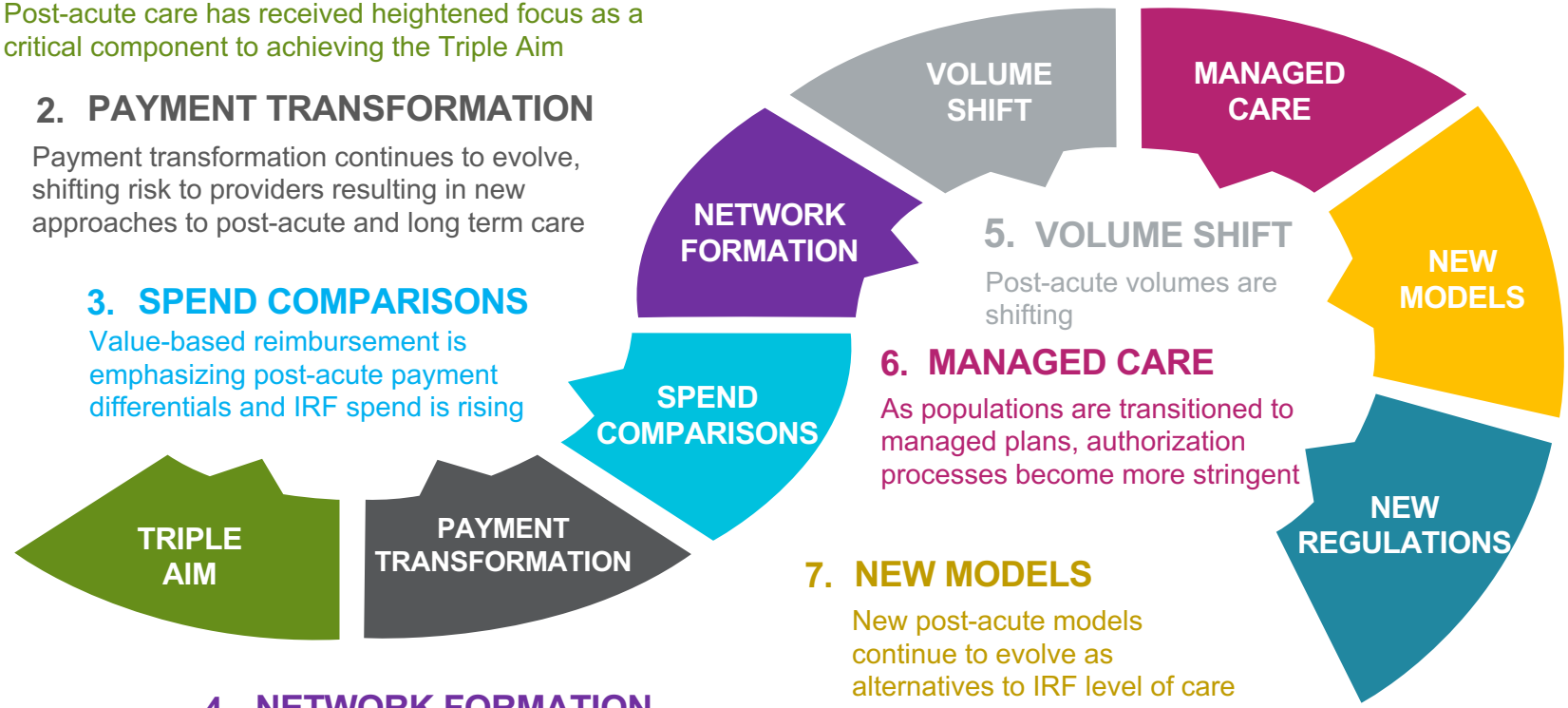
Post-acute care has received heightened focus as a critical component to achieving the Triple Aim

2. PAYMENT TRANSFORMATION

Payment transformation continues to evolve, shifting risk to providers resulting in new approaches to post-acute and long term care

3. SPEND COMPARISONS

Value-based reimbursement is emphasizing post-acute payment differentials and IRF spend is rising



5. VOLUME SHIFT

Post-acute volumes are shifting

6. MANAGED CARE

As populations are transitioned to managed plans, authorization processes become more stringent

7. NEW MODELS

New post-acute models continue to evolve as alternatives to IRF level of care

4. NETWORK FORMATION

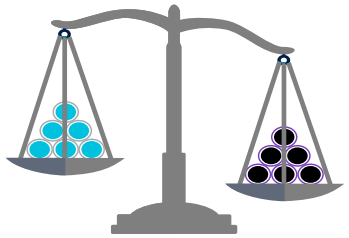
Post-acute networks are being developed to align with providers for improved performance / development of preferred post-acute networks and are influencing patient informed choice

8. NEW REGULATIONS

Ongoing changes in IRF regulations will continue to significantly impact historical work processes and use of PM&R Physician Extenders

Triple Aim: The lack of standardized pathways guiding post-acute utilization has significant quality & spend implications

Factors Impacting PAC Placement

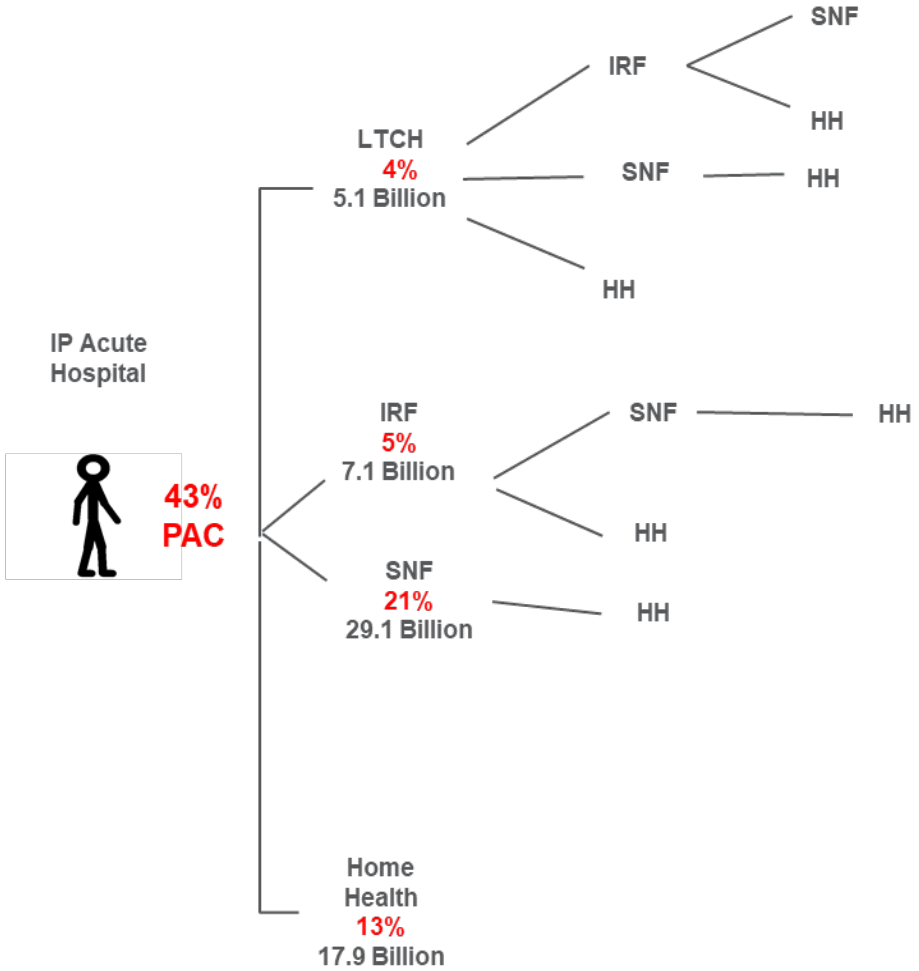


Clinical

- Patient's diagnosis
- Acuity
- Functional status
- PAC capability to care for patients

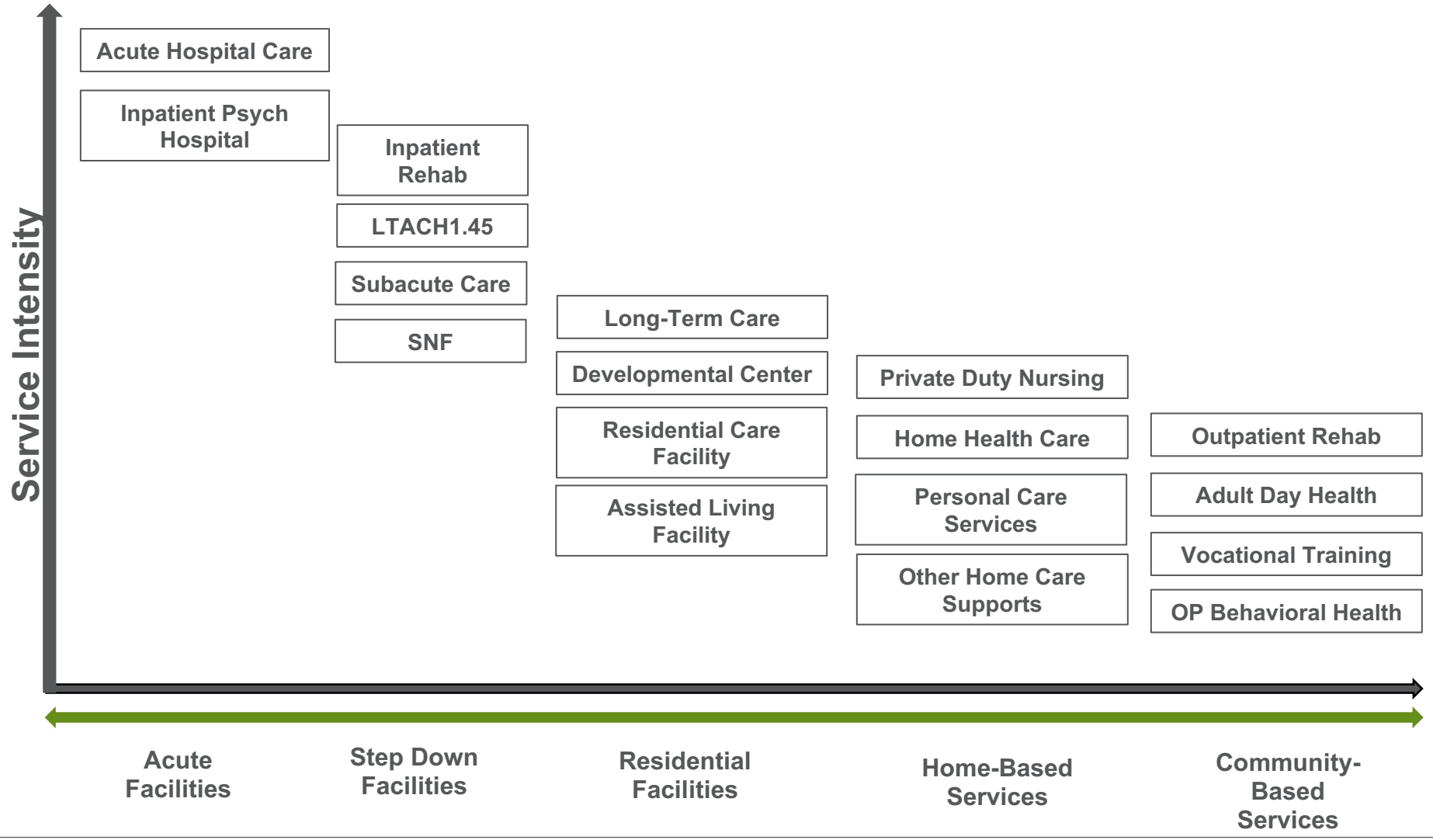
Non-Clinical

- PAC options in the community
- Payment ability
- Bed availability
- Physician preferences
- Relationships between the referring hospitals and other providers
- Family preferences



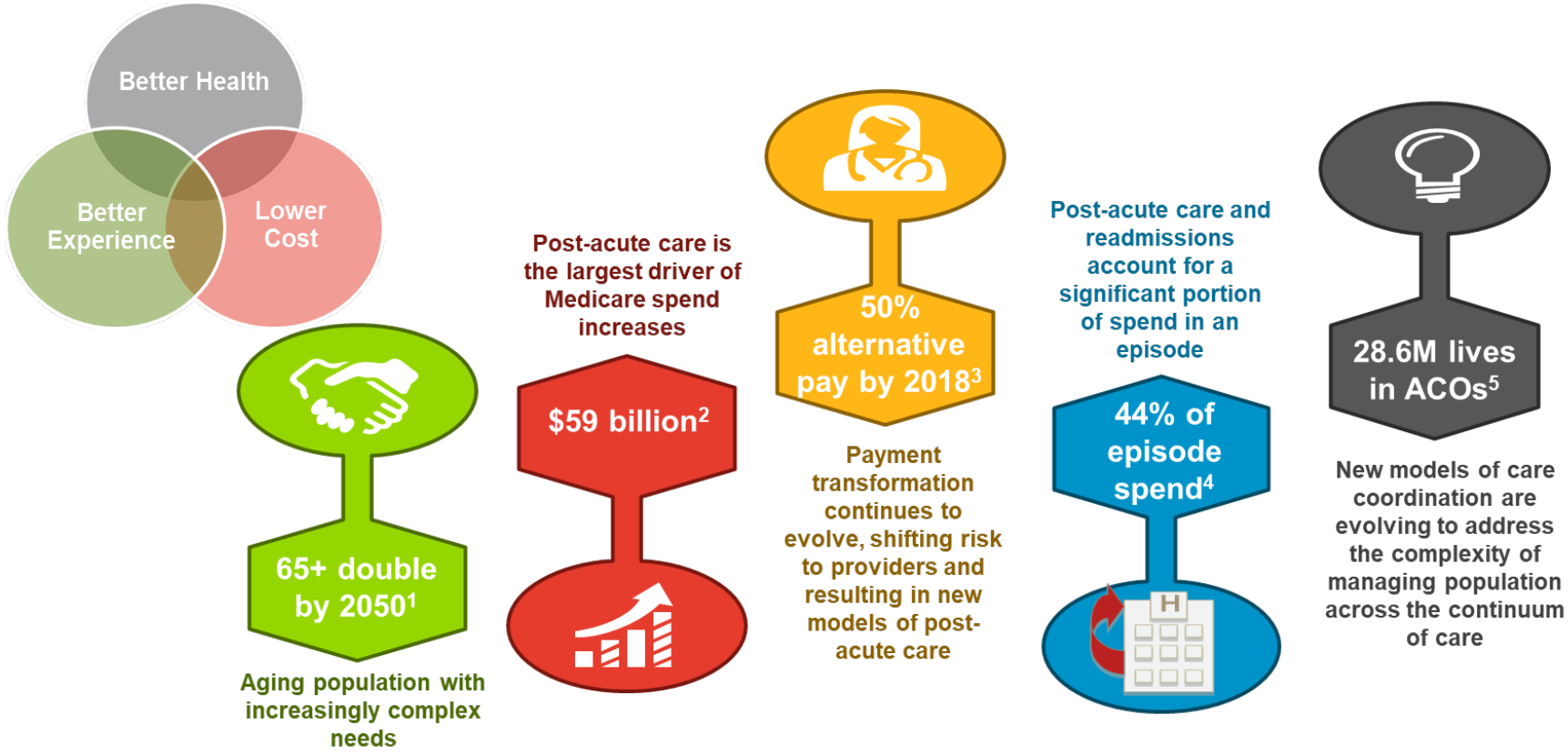
Source: American Hospital Association, June 2016 Med PAC Report

Post-acute care continuum illustrated



Triple Aim: Post-acute care has received heightened focus as a critical component to achieving the triple aim

A survey of healthcare executives conducted by NEJM Catalyst found that only 30% said post-acute care their patients received upon discharge was mostly coordinated, and a mere 7% said they were fully coordinated (n=375)



Source: [1]US Census, [2]MedPAC, [3]JAMA, [4]NEJM, [5]Leavitt Partners

Post Acute Care Interrelated Services

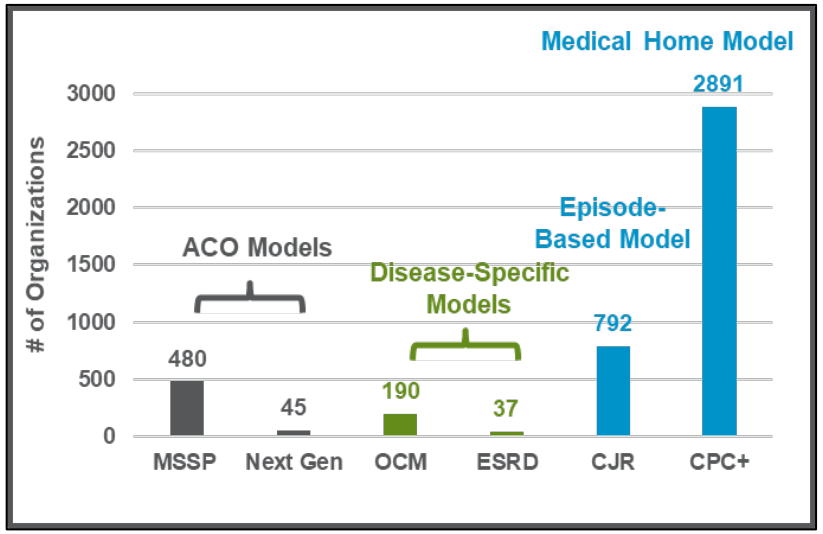
Level of Care	Acute Hospital	Long Term Acute Care Hospital (LTCH)	Acute Inpatient Rehab Hospital (IRF)	Skilled Nursing Facility (SNF)	Long Term Care (LTC)	Home Health/Hospice (HH)	PACE	Assisted Living Facility (ALF)	Outpatient (OP)
Definition	Facility that provides short-term IP acute care services, OP services, "typical hospital"	Facility that provides long-term acute care, targets the most chronic and medically complex patient populations	Facility that provides intensive rehab in a resource intensive hospital environment; requires 2 or more therapies & physician management	Facility-based care for patients with rehabilitative and/or medically complex needs who require physiological monitoring	Facility-based care for patients who do not need 24-hour care, but are unable to function independently – also referred to as ICF	Provides a wide range of services/care for patients who are homebound and require assistive devices or assistance in the home	Program of All-Inclusive Care for the Elderly	Communities that allow residents to live independently, but also provide assistance with basic ADLs and some medication management	Facility that provides care for patients who are able to travel for treatment without hardship
License	Hospital	Hospital	Hospital, PPS Exempt	Skilled Nursing	Nursing Facility	Home Health-State & Federal Licensure		State licensure	Outpatient, CORF
Services	IP, OP, Surgical, Diagnostics, Emergency	Multidisciplinary complex care with the focus being Medical Care	Interdisciplinary care with a focus on Rehab and Medical	Multidisciplinary care focused on function and restoration, clinical stabilization, or avoidance of complications	Nursing Care provided mostly by nurses aides and LPNs, and has RN supervision	Care provided in the home by Nurses, Aides, Therapists	Interdisciplinary team providing social and medical services in a variety of settings (Adult Day, Home, PACE location)	Long-term care option that combines housing and support services/home health as needed	Therapy care provided by a licensed therapist and certified by a physician – documentation needed to support services
Average Length of Stay	4-6 days	> 25 days	12-13 days	35-42 days	2-3 years	Varies based on need / 71 days	Varies	5 days-lifetime	Varies based on need
Clinical Indicators	Patient must require medical intervention, diagnostic work-up, documented need for daily Dr. intervention	Medically complex patient requiring LOS > 25 days and daily Dr. intervention	Patient must be able to tolerate 3 hours of therapy/day and require a Dr. a minimum of 3x/wk	Patient must require Nursing intervention, therapy services daily, ancillary or tech. services Dr. visits at least every 30 days	Patients require significant assistance with ADLs, Long-term or custodial care Dr. visits required every 90 days	General Medical supervision, treatment plans reviewed and renewed; Hospice requires a terminal diagnosis	Must be at least 55 years old, live in a PACE service area, and be nursing home eligible by state agency	Able to live independently with minimal assistance with daily activities, meal preparation, medication assistance	Able to make functional progress, requires certification of a Dr. every 30 days

Payment Transformation: Risk is shifting to providers resulting in new models of post-acute and long-term care

A growing number of organizations are participating in alternative payment models and these new models are showing impact

Medicare Alternative Payment Model Participation

As of Q1 2017[1]



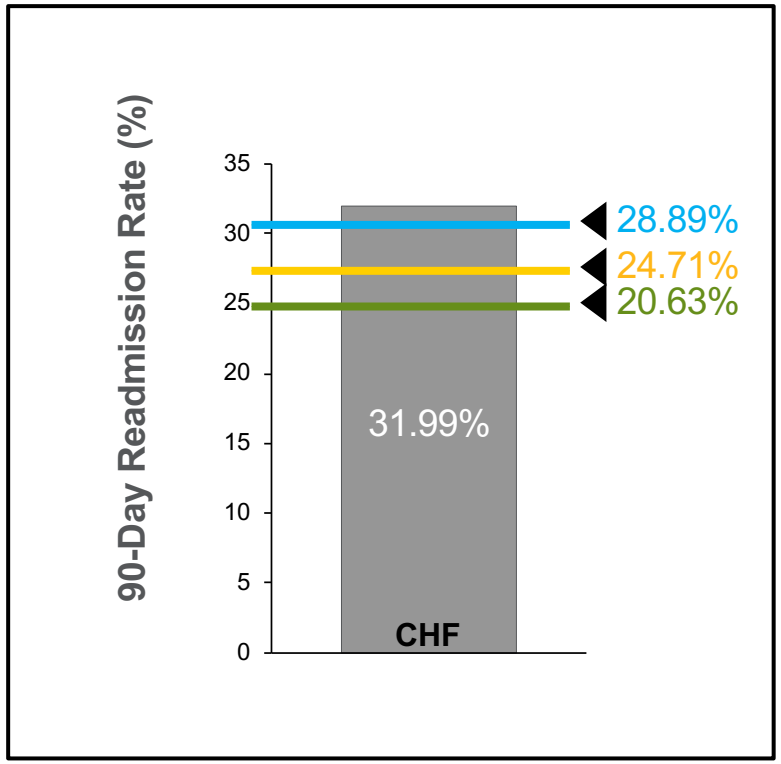
*This does not include BPCI estimates

Case study: Baptist Health System (San Antonio) BPCI Joint Replacement

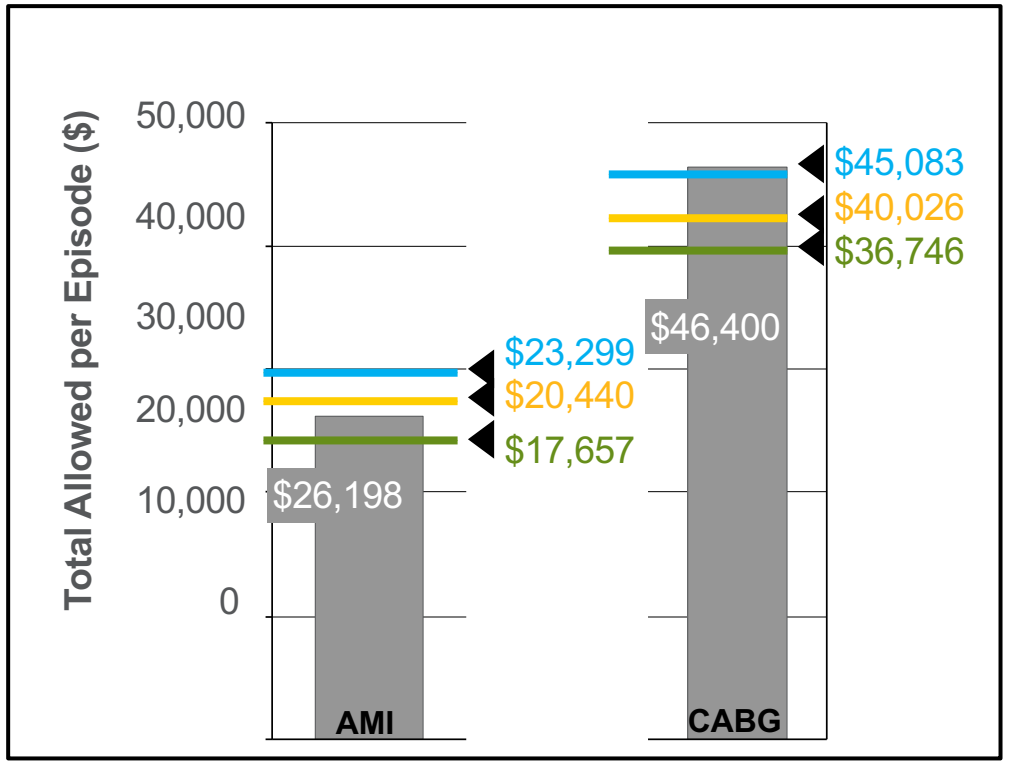
- Between 2009 and 2015, the average episode spend declined by 22.6% from $23,936 to $18,517
- Readmissions declined 1.4% and ED visits 0.9%
- Post-acute care costs fell by $1,415 per case, or 54% per case

Payment Transformation: Total cost of care is variable, highlighting much opportunity to leverage Post Acute care

90-Day Readmission Rate with National Benchmarks



Total Spend Per Episode with South Atlantic Regional Benchmarks



90th Percentile 75th Percentile 50th Percentile

Source: MSSP Data

Spend Comparisons: Cost across the continuum highlights need to pick best level of care

Medicare Spend on Post-Acute Care per Episode is Significantly Higher in IRFs Compared to SNFs and Home Health

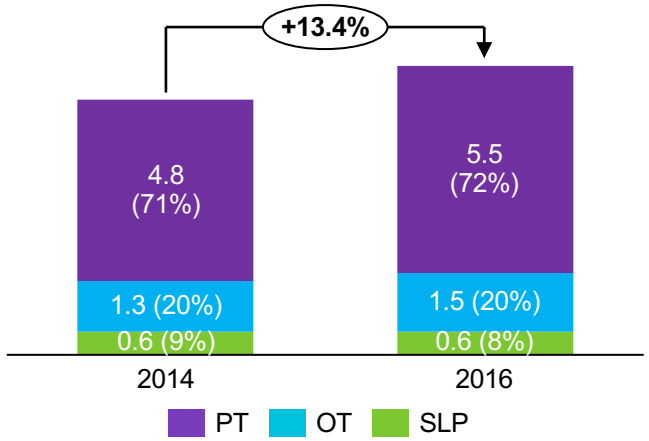
Metric	IRF	SNF 1st - 4th quartile	HH
Average Payment / Day	$1,552	$441 - $510	$171 / Visit
Average Payment / Episode	$19,714	$15,940 - $22,472	$2,988
Average Margin	13.0%	11.2%	15.5%
Average Length of Stay (visits per episode)	12.7 days	36 - 42 days	17.5 visits

Source: MedPAC, March 2018, http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch10_sec.pdf?sfvrsn=0

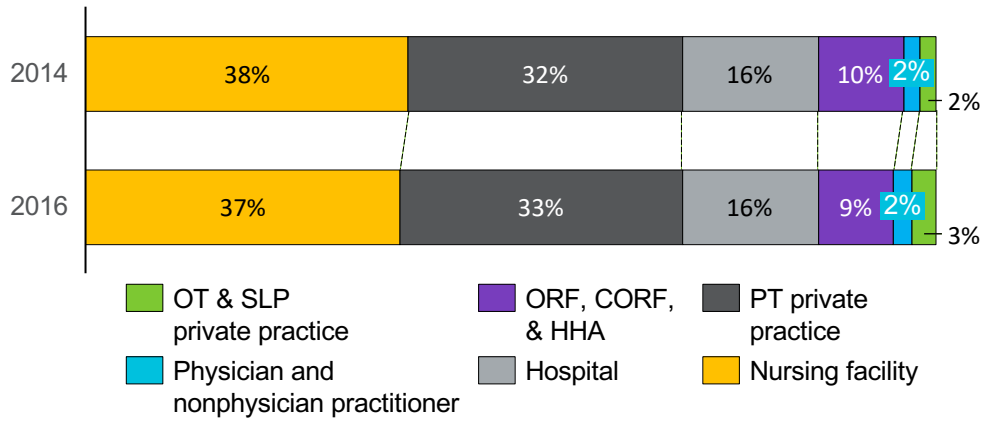
Spend Comparisons: Outpatient Therapy Medicare spending continues to increase

Medicare spend for outpatient therapy primarily focuses on physical therapy and is largely in the nursing facility and PT private practice setting

Medicare Spending on OP Therapy ($ in Billions)



Distribution of Outpatient Therapy Spending



Medicare OP Therapy Thresholds

Annual outpatient therapy caps unrelated to patient characteristics were repealed in 2018; however, providers still must certify medical necessity after certain thresholds:

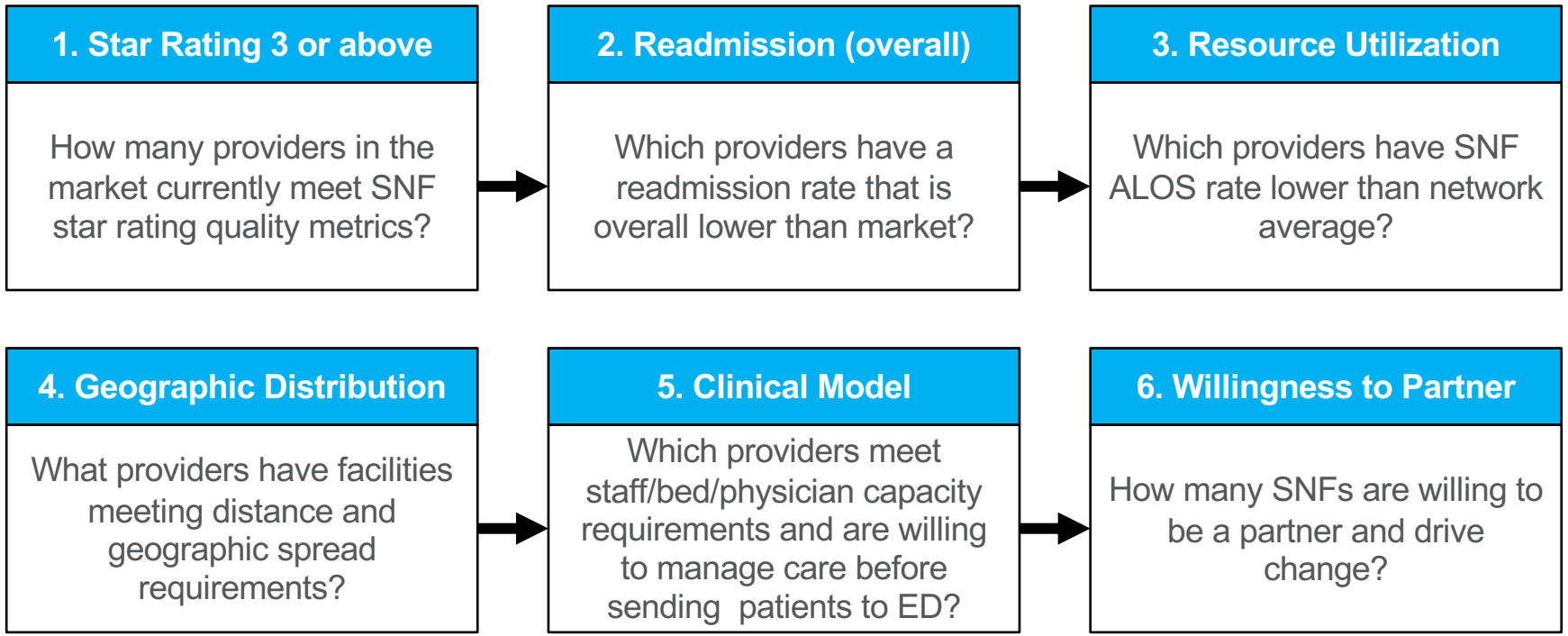
- $2,040 for PT and SLP services combined annually
- $2,040 for OT services annually

Source: MedPAC Outpatient Therapy Services Payment System (October 2016 and 2017), CMS

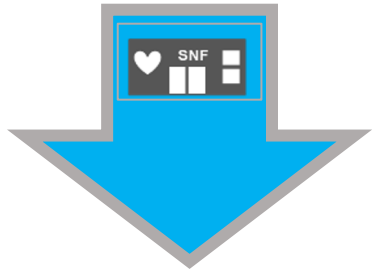
Network Formation: Development of Post-Acute Networks controls referral volume, cost and quality

Leverage referral volume for high quality and low cost

Example of Criteria to narrow a SNF Network



Volume Shift: Post-acute volume is shifting from SNF to home health in response to provider, patient, and payer demands



SNF Admissions Declining in Response to Cost Pressures

- As of 2016, SNF volumes are slightly declining[2]
- SNF occupancy reached its lowest in Q4 2016 at 81.8%, likely caused by decreased revenue from MA plans, as well as other effects from payment policy changes[3]
- To improve quality and trust from hospitals, SNFs want to secure volumes from MA plans by demonstrating improvements to readmission rates

Home Health Agencies Growing to Meet Increased Demand

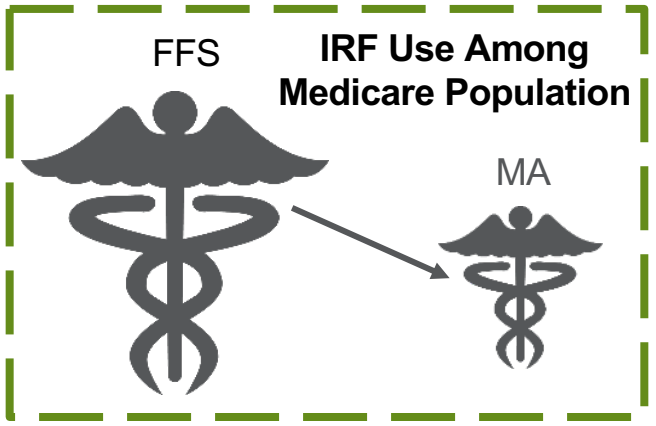
- The number of HHAs increased significantly in the past ten years, reaching its all-time peak in 2015
- In 2016, 97.5% of all HH recipients lived in a zip code served by two or more HHAs[1]

Non-Skilled Home and Community-Based Services

- Non-skilled home health services are now offered as a benefit, which will influence the shift from skilled nursing facilities, to home health, to non-skilled services provided in the home or other community-based settings

Source: (1) MedPAC, March 2018, http://medpac.gov/docs/default-source/reports/mar18_medpac_ch9_sec_rev_0518.pdf?sfvrsn=0
(2) MedPAC, March 2018, http://medpac.gov/docs/default-source/reports/mar18_medpac_ch8_sec.pdf?sfvrsn=0
(3) NIC, March 2017, http://www.nic.org/news-press/new-nic-data-skilled-nursing-properties-show-occupancy-rates-continue-decline-despite-early-significant-2016-flu-season/

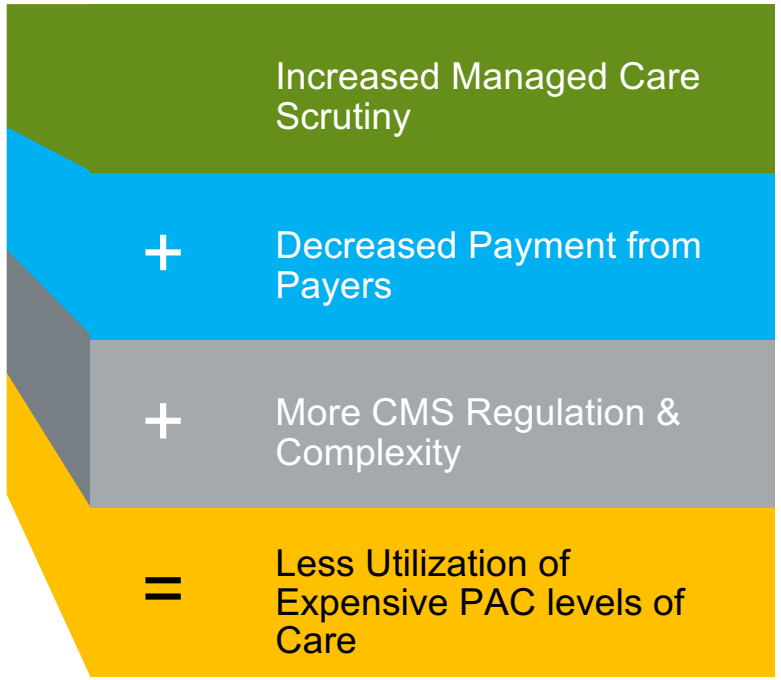
Managed Care: As populations are transitioned to managed care plans, authorization processes become more stringent



As of 2018, 2/3 of Medicare recipients are in FFS.[1] As the shift to MA occurred, we saw a 2x reduction in IRF stays.

WHY?

Medicare Advantage Plans are MANAGING the use of IRF through the prior authorization process.



1. www.kff.org/medicare/

New Models: Innovations of New post-acute models evolve as alternatives to high cost settings: SNF PLUS

SNF PLUS is programmatic model that offers enhanced services above a typical SNF level of care.

Typically, SNF PLUS programs can serve patients with higher medical complexity and/or higher intensity of therapy services.

Payers are willing to consider rates that are higher than SNF but less than IRF or LTACH.

Metric	SNF	IRF	SNF PLUS
Average Payment / Day	$438	$1,415	$590
Average Payment / Episode	$11,357	$18,528	$15,340

New Regulations: Regulation trends indicate opportunity to expand, but expansion will need to consider new models of care

Nationally, post-acute care reimbursement is shifting to value, and changes continue to shift PAC to a unified payment system

- **Patient Driven Payment Model (PDPM) is the new Medicare reimbursement rule for SNF** becoming effective October 1, 2019
- **PDPM is separating therapy time from reimbursement** by allocating therapy dollars to each SNF patient to be managed appropriately
- MedPAC continues to call for implementation of a **unified prospective payment system for post-acute care providers (PAC-PPS)**
- The unified payment structure will redistribute payments among types of stays and settings; **payments will decrease for rehabilitation care unrelated to patient conditions and increase for medically complex care**
- **Rehabilitation providers can expect a further focus on intermediate levels of care** shifting volumes away from IRF