



Health Care Reform, Medicare Reimbursement Cuts and What They Mean for the Skilled Nursing Provider

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Investment Forum
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SNF's Greatest Challenges 2010–2015: Medicare Cuts

- ◆ Annual Medicare reductions
 - ◆ Market Basket reductions
 - ◆ Productivity adjustments
- ◆ Additional revenue reductions
 - ◆ Medicaid shortfalls (more for Medicare payments to offset)
 - ◆ More dollars to HCBS-NF transitions (occupancy)
 - ◆ Possible realignment of SNF Medicare payment (more dollars to medical, less to rehab)

SNF's Greatest Challenges 2010–2015: Bundled Payment

- ◆ Accountable Care Organizations
 - ◆ Integration of physicians, hospitals, post-acute providers, outpatient
 - ◆ Responsible for all care for more than 5,000 Medicare beneficiaries
 - ◆ Share in cost savings
- ◆ Bundling
 - ◆ Episodic payment related to acute hospitalization:
-3 through +30 days
 - ◆ Hospitalization, re-hospitalization, post-acute care, outpatient, physicians
 - ◆ SNFs will be in or out—not everyone will play in Medicare space

Strategies for the Future

- ◆ Become your hospitals' preferred or only partner in the care continuum
- ◆ Diversify your revenue base by extending your care continuum
 - ◆ *Yesterday*: Adding companies to serve your multi-state SNFs
 - ◆ *Today*: Owning the post-acute continuum in your targeted market
- ◆ Achieve scale within your targeted markets by deepening and extending your care continuum—the cluster continuum



*In the new health care delivery system, skilled nursing providers who are lone rangers in the institutional long-term care business will be—
in the Medicaid business*

How One Company is Preparing Strategically

- ◆ Starting with a core business of 21 SNFs in major metropolitan areas of one state
- ◆ Three urgent strategic imperatives

Address hospitals' biggest concerns today:

- ◆ Length of stay (LOS)
- ◆ Pending re-admission penalties

Create a cluster care continuum market by market

Cement hospital partnerships (with shared risk if possible)

Address Hospitals' LOS and Re-admission Concerns: Point 1

- ◆ Customize subacute programs to hospitals; and learn to use hospital MedPar data

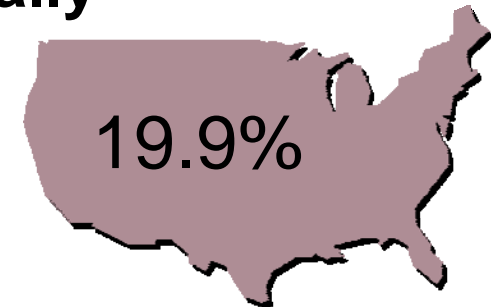
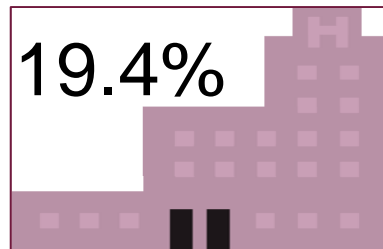
LOS Issues by MS-DRG (Conditions)

MS-DRG	MS-DRG Description	SNF Discharges	Acute Hospital Days	CMS GMLOS Days	ALOS at Hospital	CMS GMLOS	Total Excess Hospital Days	LOS Over (Under) GMLOS
480	Hip and femur procedure except major joint w/mcc	50	400	380	8.0	7.6	20.0	0.40
193	Simple pneumonia and pleurisy w/mcc	40	245	212	6.1	5.3	33.0	0.83
286	Circ disorder except ami, w/card cath w/mcc	35	180	175	5.1	5.0	5.0	0.14
291	Heart failure and shock w/mcc	30	135	150	4.5	5.0	(15.0)	(0.50)
640	Nutritional and miscellaneous metabolic disorders w/mcc	28	124	104	4.4	3.7	20.4	0.73
Total		183	1,084	1,021	5.9	5.6	63.4	0.35

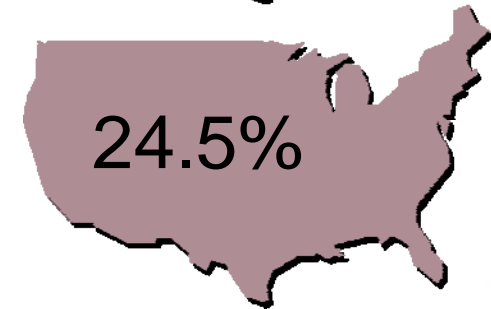
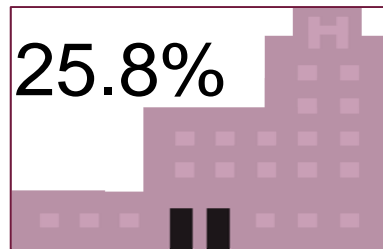
Address Hospitals' LOS and Re-admission Concerns: Point 1 (continued)

30-Day Re-admission Rates Comparison by Condition: Hospital Versus Nationally

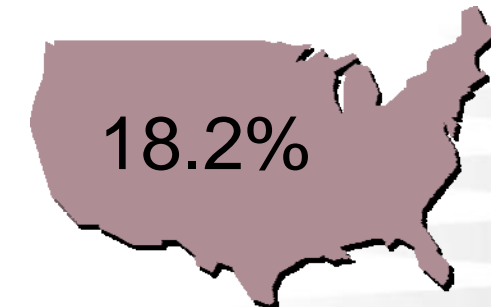
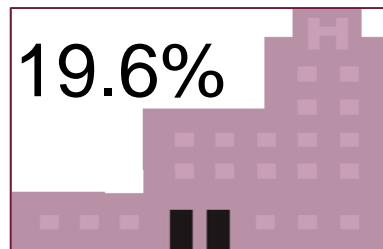
Heart Attack



Heart Failure

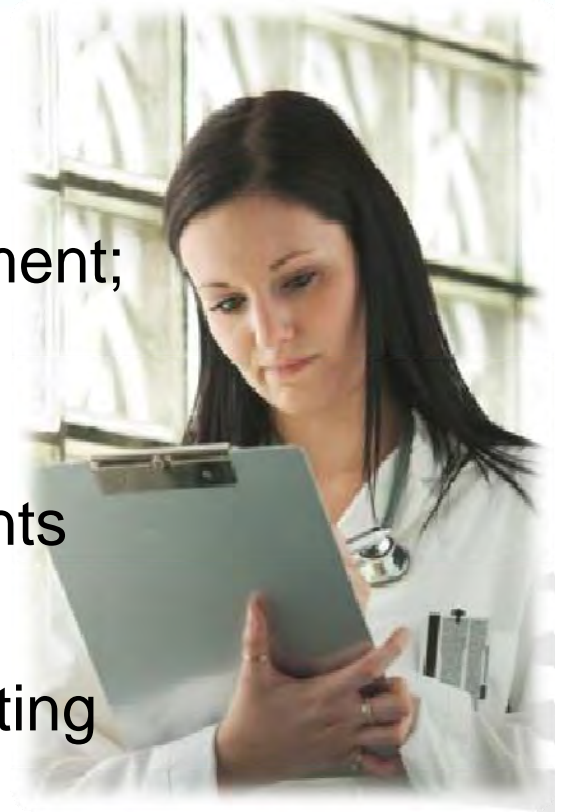


Pneumonia



Address Hospitals' LOS and Re-admission Concerns: Point 2

- ◆ Upgrade physician-NP coverage
 - ◆ Train attending physicians on coding, documentation “musts” and reimbursement; provide cheat-sheets
 - ◆ Train nurse managers to round with physicians/NPs/PAs on Medicare patients and coach on coding
 - ◆ Implement procedures to simplify reporting to physicians' billers to mitigate risk of noncompliance and assure that attendings and consultants receive proper Medicare payment



Address Hospitals' LOS and Re-admission Concerns: Point 3

- ◆ Create TRABHs (Transitional Rehab All But Hospitals)
 - ◆ Look like, feel like a rehab hospital in a Marriott hotel
 - ◆ Tailor programs to most important referring hospitals' needs
 - ◆ Upgrade nursing clinical skills, integration
 - IV starts, trach management, isolation, assessments, acute care or acute rehab protocols
 - Study clinical requirements in IRF CoPs and imitate
 - ◆ Track re-admissions, time, nurse, physician, reason; analyze and implement procedures to reduce
 - 24-hour NP coverage
 - Most qualified nurses in TRABH at night
 - Clinical protocols for key conditions

PAC Acute Hospital Readmissions, 2007

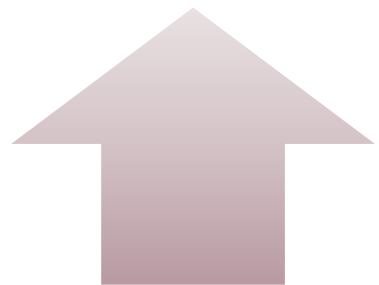
- ♦ 22% of SNF patients are re-hospitalized within 30 days—a Medicare revenue killer for hospitals starting in 2012

PAC Setting	Percent Discharged from Hospital to PAC Setting	Percent Re-hospitalized After Using PAC Setting
SNF	17.3%	22.0%
Home Health	15.0%	18.1%
Inpatient Rehabilitation	3.2%	9.4%
Long-term Care Hospital	1.0%	10.0%
TOTAL	36.5%	18.0%

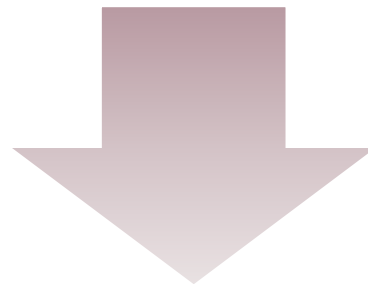
Source: MedPAC June 2008 Data Book

Create a Cluster Continuum Market by Market

- ◆ Extend post-acute continuum in each key market, through integrated TRABH–home health continuum
 - ◆ *Why?* SNF and HHA discharges account for 88% of Medicare post-acute admissions



Average Medicare
post-acute episode
cost = >\$30,000



SNF-HHA
combination cost =
\$12,000–\$15,000

Create a Cluster Continuum Market by Market (continued)

- ◆ Cluster post-acute continuum in same ZIP codes as your preferred hospital-health system partner
- ◆ Create care transitions intervention program by converting referral development nurses to care coordinators (see Strategy 3, next slide)

Cement Hospital Relationships

- ◆ Assess your hospitals' ability to become ACOs, take risk—pick most likely winners
- ◆ Message your strategic readiness to hospital C-suite
- ◆ Provide value-added care transitions intervention (evidence-based NQF approved program)
 - ◆ Care transitions coordinator facilitates patients' readiness for hospital discharge
 - ◆ One SNF/home visit to assist in developing personal health responsibility/record, medication management, understanding of red flags for condition and what to do when they occur, follow-up visit to PCP
 - ◆ Same process for discharge from SNF to home
 - ◆ Four weeks of telephonic coaching

Cement Hospital Relationships

- ◆ Seek opportunities for shared risk
 - ◆ Joint ventures
 - ◆ Medicare Advantage episodic payment
 - ◆ CMS pilots



Future Strategies

- ◆ Physician network ownership and integration
- ◆ Home-based chronic care management
- ◆ Home-based technology services

*If everything seems under control,
you're just not going fast enough.*

Mario Andretti

Thank You

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