Capital Markets

Evolution of the Post-Acute Continuum

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Introduction

- Managing Director in BB&T Capital Markets Senior Living and Healthcare practices
- Manages senior living relationships in the mid-Atlantic
- Began career in the provider setting in finance and planning functions at Methodist Health System (TN) and University of Michigan Health System
- Worked as a NFP Healthcare Bond Rating Analyst at Moody's Investors Service
- Investment Banker at Alex. Brown and Wheat First Securities serving Senior Living and Healthcare clients
- Previously ran independent financial advisory firm
- Mr. Quynn received his undergraduate degree in Economics from William & Mary and masters degrees from the School of Public Health and Business School at the University of Michigan

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Key Topics

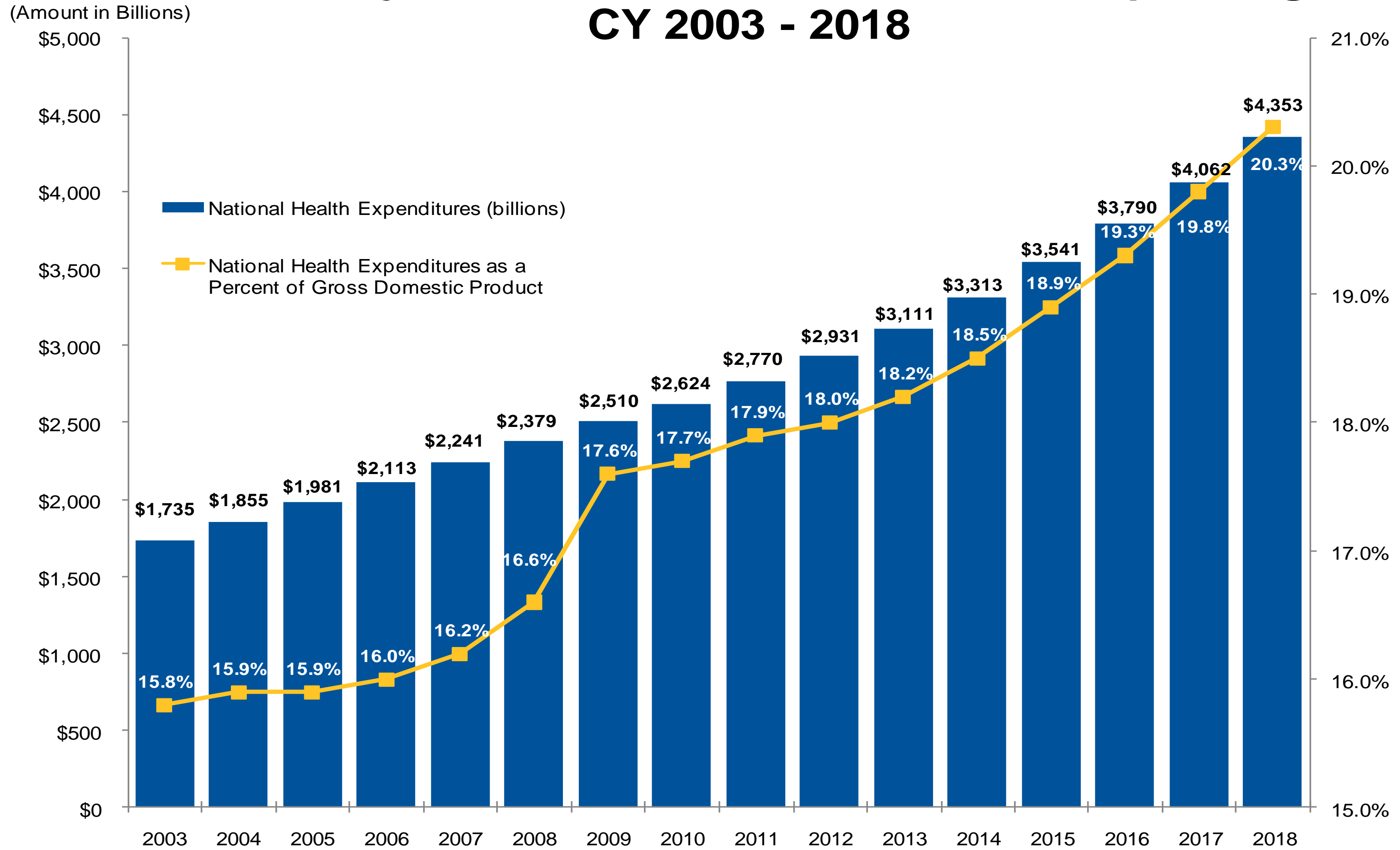
- Increasing Healthcare Costs

- Changing Financial Incentives

- Potential Impact on Senior Service Providers

Changing Financial Incentives

- Driven by the combination of:
  - Unsustainable cost increases
  - Poor outcomes
- Providers will be placed at risk for higher quality and lower costs
- Post-acute continuum reform process will have parallels to Medicare cost containment initiatives for acute care that started in the mid-late 1980s


CMS Projections for National Healthcare Spending
CY 2003 - 2018
(Amount in Billions)
$5,000
$4,500
$4,000
$3,500
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$0
21.0%
20.0%
19.0%
18.0%
17.0%
16.0%
15.0%
National Health Expenditures (billions)
National Health Expenditures as a Percent of Gross Domestic Product
$1,735
$1,855
$1,981
$2,113
$2,241
$2,379
$2,510
$2,624
$2,770
$2,931
$3,111
$3,313
$3,541
$3,790
$4,062
$4,353
15.8%
15.9%
15.9%
16.0%
16.2%
16.6%
17.6%
17.7%
17.9%
18.0%
18.2%
18.5%
18.9%
19.3%
19.8%
20.3%
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2018
Source: Centers for Medicaid & Medicare Services - NHE Projections 2008-2018, Forecast Summary and Selected Tables

Medicare Costs Are Unsustainable

- Nearly 1 in 5 Medicare patients discharged from the hospital return there within 30 days

- Between 50 and 70 percent are considered avoidable

- Medicare pays about $1.7 billion annually for 2.5 million re-hospitalizations and others pay the same amount for all re-admissions of non-Medicare patients

- End-of-Life care costs are estimated at $170 billion per year

U.S. Treasury to President Obama: Medicare's Current Policy 'Is Unsustainable'

With a federal budget debate taking center stage on Capitol Hill, Washington's rhetoric is once again crowding out reality. Federal analysts show dire, economic consequences of not reining in spending in order to close our ever-growing deficit. Yet, you wouldn't know that from listening to the talking points out of D.C. press conferences.

In his inaugural address, President Obama suggested that his opponents aimed to eradicate Medicare for future generations under the guise of controlling spending and boosting U.S. growth. White House spokesman Jay Carney then took it a step further—suggesting spending naysayers had it wrong altogether and, in fact, entitlement programs such as Medicare and Medicaid were boons rather than burdens to the economy.[1]

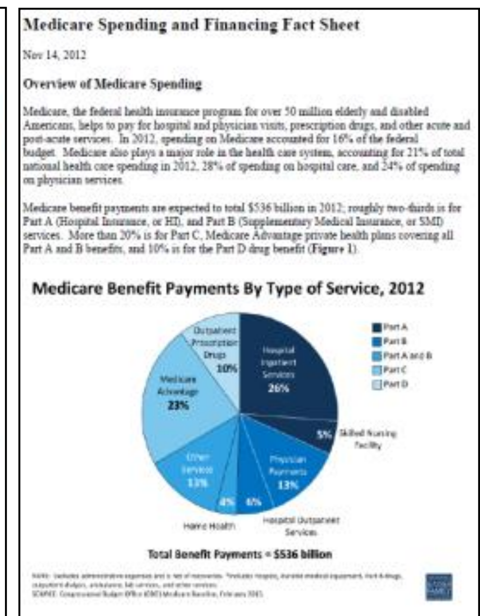
This partisan posturing distracts from the actual question at the core of this debate: whether we can make the same Medicare promise to future generations that we've made to current seniors.

We cannot.

Current policy consists of guaranteeing seniors on Medicare a package of defined benefits, regardless of their cost. We cannot afford to make the identical promise to future generations. In the words of the most recent *Financial Report of the U.S. Government* just released by the Department of Treasury, "current policy is unsustainable."

But you don't have to believe me or Treasury. Take a gander at these figures and use your own common sense. First, Medicare costs are going through the roof both because the number of beneficiaries will more than double by 2080, but more importantly because the cost per beneficiary will more than quintuple![2]

The accompanying chart demonstrates that the cost of Medicare in 2080 will be more than 10 times as big as it was in 2011 in current dollars (i.e., today's purchasing power). Only about one fifth of this increase is the result of growing numbers of Medicare enrollees. The lion's share of the increase relates to explosive growth in Medicare costs per enrollee.



Medicare Spending and Financing Fact Sheet

Nov 14, 2012

Overview of Medicare Spending

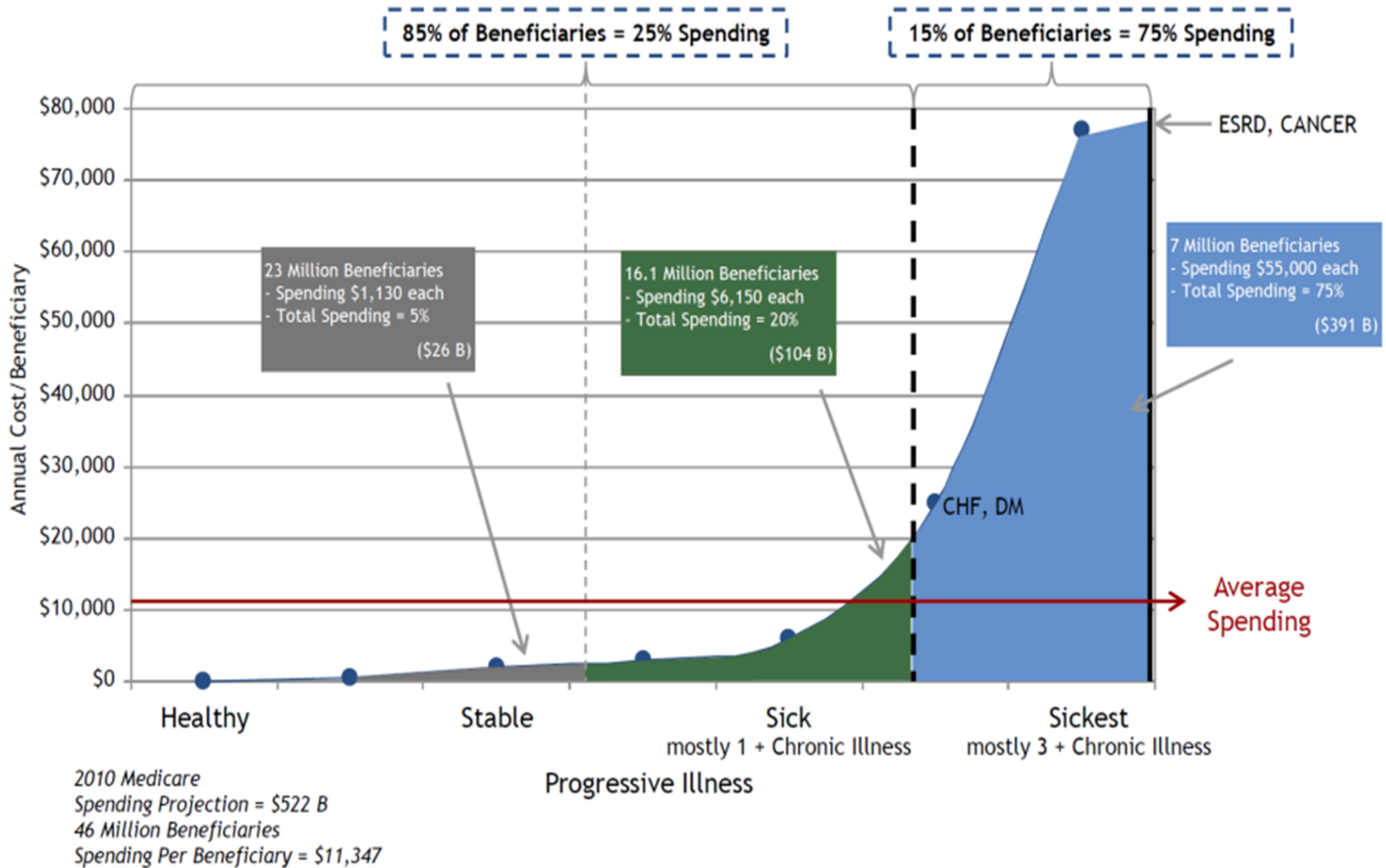
Medicare, the federal health insurance program for over 50 million elderly and disabled Americans, helps to pay for hospital and physician visits, prescription drugs, and other acute and post-acute services. In 2012, spending on Medicare accounted for 16% of the federal budget. Medicare also plays a major role in the health care system, accounting for 21% of total national health care spending in 2012, 28% of spending on hospital care, and 24% of spending on physician services.

Medicare benefit payments are expected to total $536 billion in 2012; roughly two-thirds is for Part A (Hospital Insurance, or HI), and Part B (Supplementary Medical Insurance, or SMI) services. More than 20% is for Part C, Medicare Advantage private health plans covering all Part A and B benefits, and 10% is for the Part D drug benefit (Figure 1).

Medicare Benefit Payments By Type of Service, 2012

Total Benefit Payments = $536 billion

Healthcare Costs Are Concentrated in Chronic Illness



Annual Per Capita Healthcare Costs by Age

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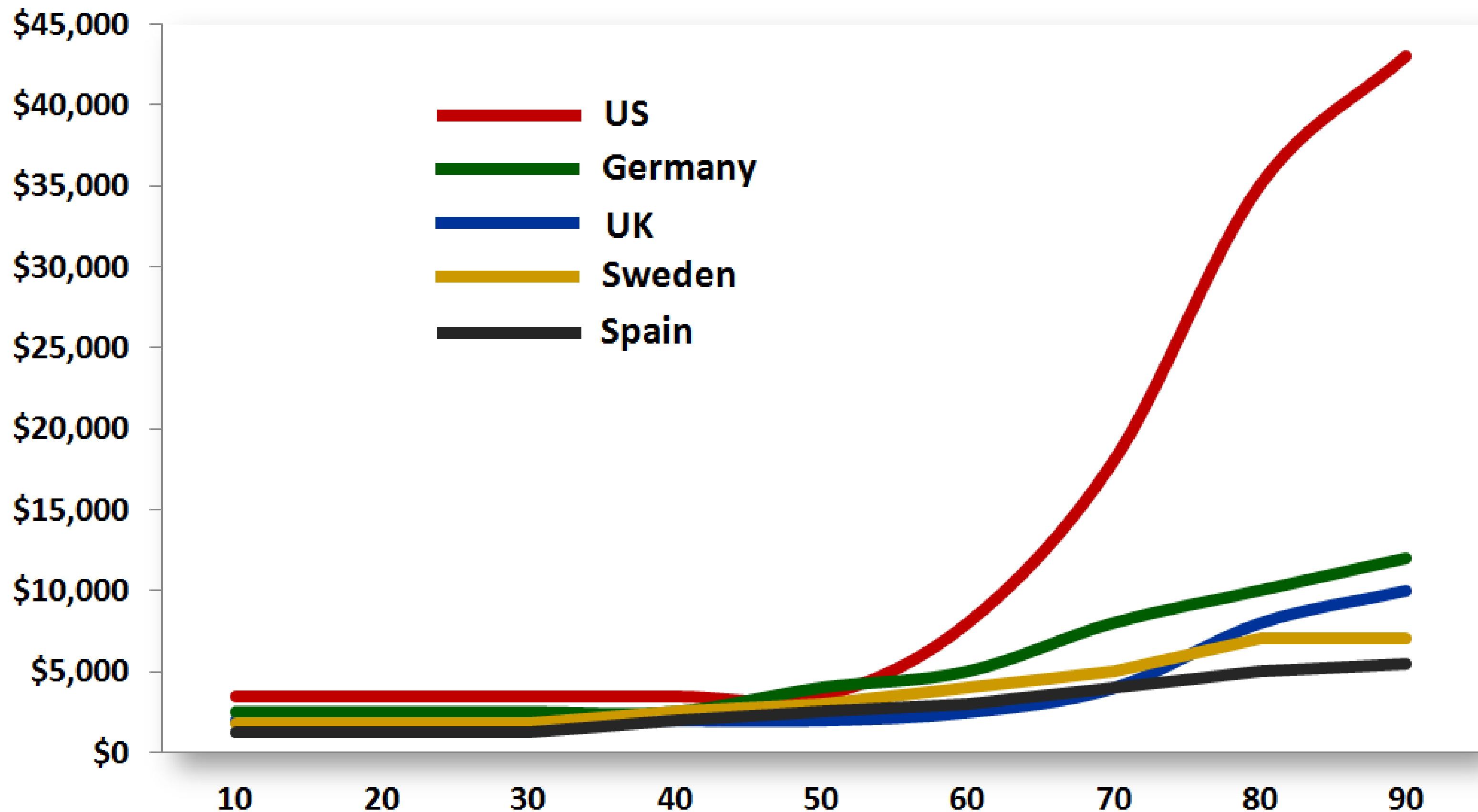
Cost by Age – An Upside Opportunity



Healthcare Costs by Provider / Setting

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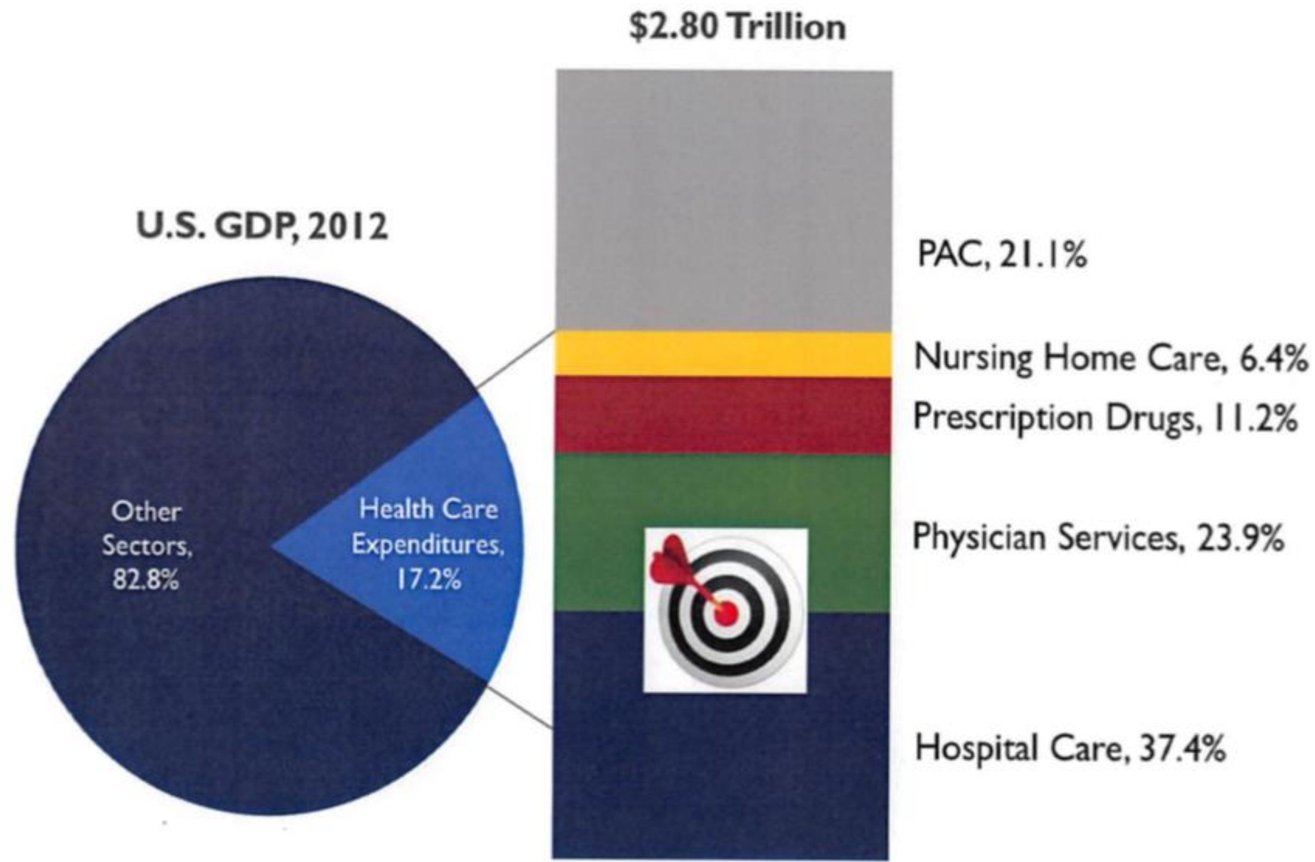
- Hospital and Specialist Physician Utilization were Historical Focus
- Post-acute Care and Pharmacy Costs are the Emerging Challenges



Average 2013 Medicare 90-Day Price

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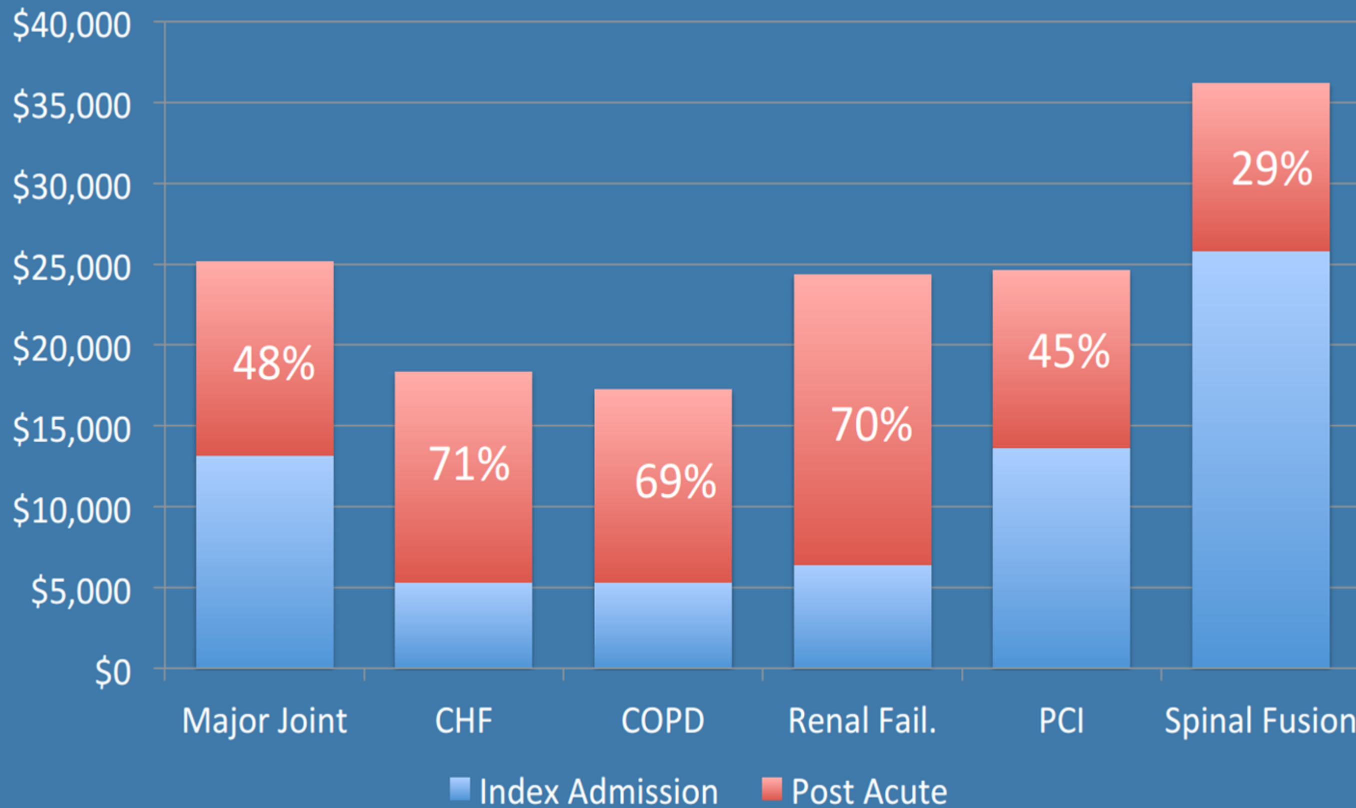
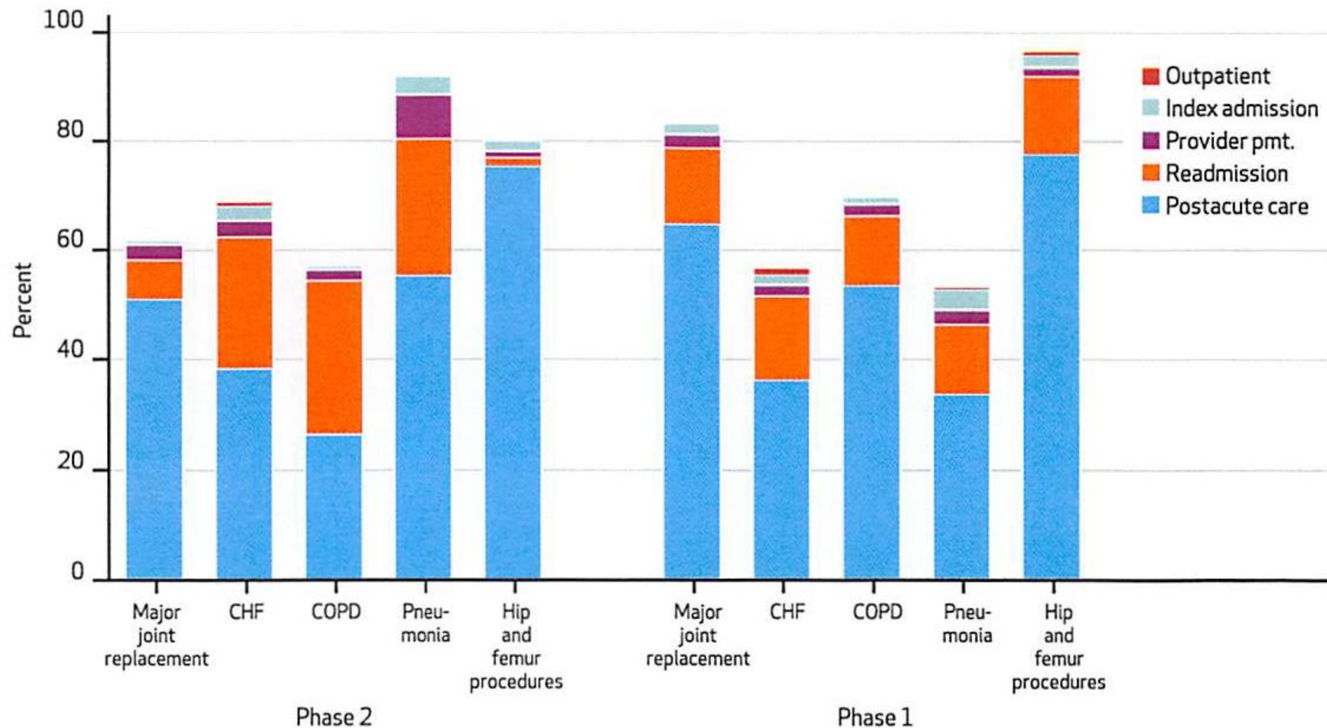


Cost Variations – 30 Day Episode Bundled Payments

- **In Bundled Payment Care Initiative (BPCI) Opportunity for Cost Savings is Largest in Post-Acute Setting:**



Source: Authors' analysis of standardized payments from 2011 Medicare claims. NOTES Each component of the histogram represents the amount of variance, in percentage terms, explained by each component of spending, using a generalized linear regression model with total thirty-day spending as the dependent variable. Percentage of variance explained does not sum to 100 percent because of covariance terms. CHF is congestive heart failure. COPD is chronic obstructive pulmonary disease.

Medicare Cost Containment Approach

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- Identify delivery system components most responsible for cost / quality issues
- Design, test, select, communicate and phase-in new payment models
- Track and analyze provider behavior
- Focus on variances in quality and cost metrics by provider
- Adjust incentives to pursue “best practices” demonstrated by certain providers

Comprehensive Care For Joint Replacement

- Mandated for 800 participants in 67 designated MSA

- Financially responsible for 90 day episode including the following Post Acute Care services / settings:
  - Coordinate Care MD Services
  - Hospital and any re-admission costs
  - LTAC
  - SNF
  - HHA
  - Laboratory
  - DME
  - Part B Drugs
  - Hospice

Provider Financial "Warning Signs"

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- Downward pressure on revenues
- Upward pressure on costs
- Operating results and cash flow decline
- Liquidity shrinks
- Compliance with debt covenants becomes more difficult
- Capital needs increase to respond to new industry incentives and competitive pressures
- Access to future capital becomes more challenging

Providers at Greater Risk

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- Smaller, single site providers
- Limited range of services vs multiple points along the delivery continuum
- Overly reliant on external referrals
- In markets with excess capacity
- Less attractive quality / efficiency metrics
- Limited Liquidity
- Aging plants
- Retiring CEOs

Post-Acute Care Industry Consolidation

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- Likely to result in fewer but larger providers

- Consolidators may vary depending on the market
  - Hospital driven (*MedStar, INOVA, Hopkins, UMMS*)
  - Physician driven (*Mayo, Marshfield, Oschner*)
  - Insurer driven (*Kaiser, Highmark, possibly Sentara*)

- Pace of change will depend on:
  - Relative size / concentration of buyers and sellers
  - Excess capacity in the market

- Preferred provider “narrow networks” will form based on a range of formal and informal agreements

- **Key Q**: Do you need to “own it” or just “have access” to it?

What Do Payors Want?

- Value = Quality / Cost
- "Better, Cheaper, Faster"

Population Health Management Approach

- Strategically and proactively manage clinical and financial parameters of care to improve health and patient engagement while decreasing cost

- GOAL: Keep population as healthy as possible and minimize need for expensive intervention (ED visits, Tests, Hospitalizations, etc.)

  - What people need
  - When they need it
  - No more, no less

The Future Is On Us

"The only effective way to lower medical care costs is to experience less sickness in the population"

"If we do not do better in education, prevention, and lifestyling, the battle is lost"

Leland Kaiser, Health Futurist

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