The Industry is Evolving: Why Affiliation isn't a Bad Word

LeadingAge RI

March 23, 2012

Objectives

1. Understand Industry Drivers
2. Explore Reasons Organizations Consider Affiliation
3. Talk About the Data
4. Identify Forms and Examples of Affiliation
5. Look to the Future, both Certain and Uncertain

HEALTH CARE REFORM: NOW WHAT?

“Leaders must emerge who regard themselves as defenders not of organizations but of the underlying purposes that have temporarily created those organizations in their current forms. Leaders will have to be willing to unmake the very organizations they hold in trust. That’s a big job. It requires a kind of courage that is rare among human beings, including organizational leaders.”

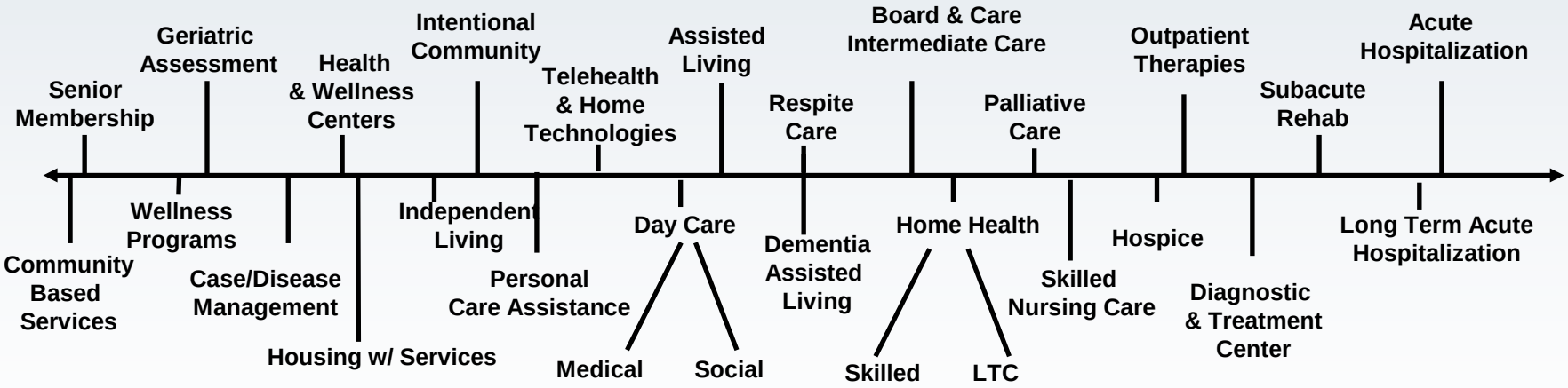
Don Berwick MD
“Seeking Systemness,”
Healthcare Forum Journal,
March/April 1992

Are you ready to dive into uncertain waters??

CliftonLarsonAllen

The Field Of Aging Services Is Evolving: *Where will YOU focus?*

Today's Spectrum of Services



Source: Adapted from previous Greystone and LarsonAllen LLP presentations

CliftonLarsonAllen

Reform at the Core: The Triple Aim Goals

- **Better Care**
  - Improve/maintain quality and patient outcomes
  - Eliminate avoidable re/admissions
  - Eliminate potentially preventable conditions (e.g., never events)
- **Better Health**
  - Primary Care Driven
  - Focus on Prevention & Wellness
- **Reduce Cost**
  - Reduce/eliminate duplication
  - Improved coordination

According to CMS…

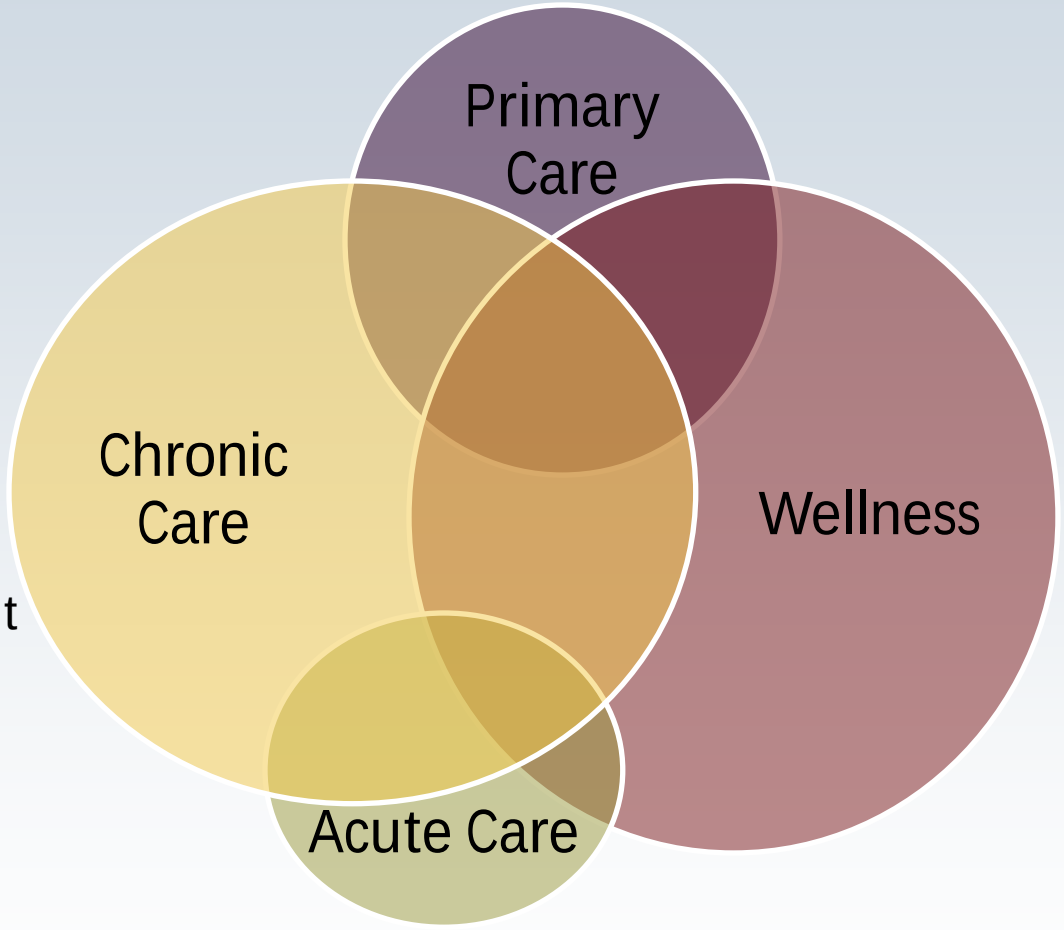
The person-centered post-acute care system of the future will:

- Optimize choice and control of services;
- Ensure that placement decisions are based on patient needs;
- Provide coordinated, high quality care with seamless transitions between settings;
- Reward excellence by reflecting performance on quality measures in payment;
- Recognize the critical role of family care giving; and
- Utilize health information technology.

Source: CMS Policy Council Document, "Post-Acute Care Reform Plan", **September 2006**

Reformed Health System – Service Delivery

- Home care
- SNF
- Assisted Living
- Hospital
- Physician office
- Group visits
- Self management
- RN, Care Coach
- Online/social networking (e.g. diabetes group)
- Telehealth monitoring



- Hospital
- SNF
- At Home
- Telehealth

- Health risk assessment
- Independent senior housing
- Adult day programs
- Community clinic for vaccines
- Local fitness center
- Smoking cessation program
- Weight loss program
- Personal wellness coach
- Senior Center
- Online social networking groups/tools
- Labs, diagnostics

Threads of Reform

- Reduce hospital readmissions
- Patient-centered care/experience
- Improved care transitions
- Health information sharing/exchange
- Prevention/wellness
- Chronic care management
- Total cost of care
- Integrated, coordinated, seamless care
- Higher quality, cost effective care
- Value-based payment to replace FFS
- Targeting high-cost, high-risk patients

What's Next?

Of late, a lot of people seem to keep asking the same things:

"What's the next BIG thing in healthcare reform?"

or

"What should we be doing next?"

Focus on Quality

Outcomes and Measurement.

<u>Here's why:</u>

Accountable Care Organizations (ACOs)

Bundled payment and CMMI's Initiative

Value-Based Purchasing for SNFs

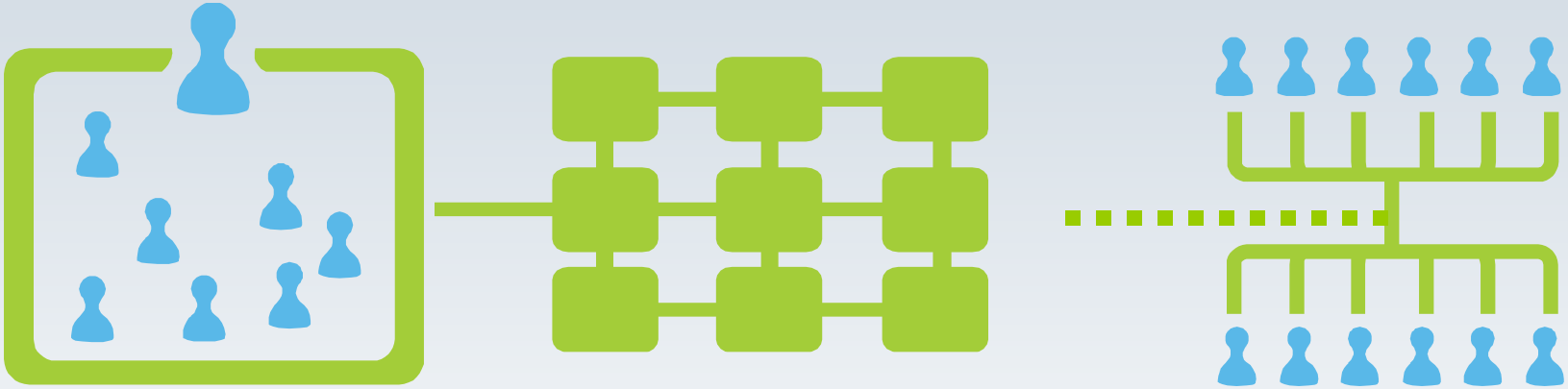
Preferred or Select Provider Networks

ACOs: General Definition

A group of health care providers working together to manage and coordinate care for a defined population, that share in the risk and reward relative to the total cost of care and patient outcomes.

Health Care Delivery: ACO Network

ACO Network



ACO Providers: Bonus-Eligible	Non-ACO Preferred Providers	Non-Preferred Providers
Primary Care Practitioners Hospitals	"Value" Providers	Low Quality, High Cost Providers

Medicare ACOs – Two Programs

Medicare Shared Savings Program

- Original intent – to be established no later than January 1, 2012
- Program requires the participating providers to form an Accountable Care Organization
- Final implementing rules published October 2011
- Two 2012 start dates: 4/1/2012 & 7/1/2012

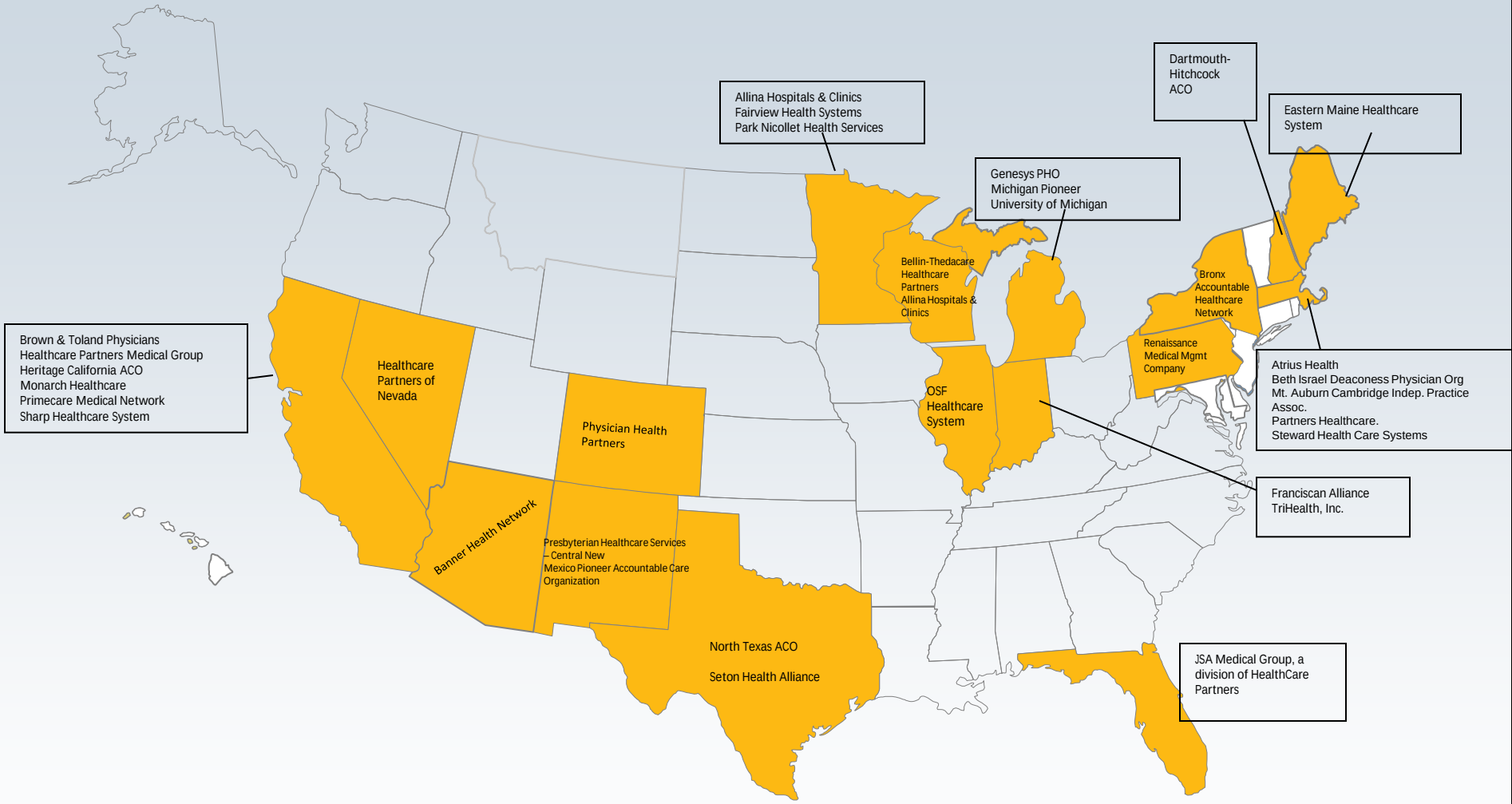
Pioneer ACO Program

- Designed for organizations with experience in ACO-like delivery and payment arrangements.
- Requires participants to enter into outcomes-based contracts.
- Assignment of minimum of 15,000 Medicare beneficiaries
- Model transitions to greater financial accountability faster.

Pioneer ACOs Announced – 12/19/2011

1. **Allina Hospitals & Clinics** (MN/Western WI)
2. **Atrius Health** (East and Central MA)
3. **Banner Health Network** (Phoenix)
4. **Bellin-Thedacare Healthcare Partners** (NE WI)
5. **Beth Israel Deaconess Physician Organization** (E. Mass.)
6. **Bronx Accountable Healthcare Network** (BAHN) - (NYC – Bronx + Lower Westchester Co.)
7. **Brown & Toland Physicians** (San Francisco, CA)
8. **Dartmouth-Hitchcock ACO** (NH + E. VT)
9. **Eastern Maine Healthcare System** (Central, East, North ME)
10. **Fairview Health Systems** (Minneapolis Metro)
11. **Franciscan Alliance** (Indianapolis + Central IN)
12. **Genesys PHO** (SE MI)
13. **Healthcare Partners Medical Group** (Los Angeles + Orange Counties, CA)
14. **Healthcare Partners of NV** (Clark + Nye Co. NV)
15. **Heritage California ACO** (CA - So., Central + Coastal counties)
16. **JSA Medical Group, a division of HealthCare Partners** (Orlando, Tampa and surrounding So. FL)
17. **Michigan Pioneer ACO** (SE Michigan)
18. **Monarch Healthcare** (Orange Co., CA)
19. **Mount Auburn Cambridge Independent Practice Association (MACIPA)** (E. MA)
20. **North Texas ACO** (TX - Tarrant, Johnson and Parker Co.)
21. **OSF Healthcare System** (Central IL)
22. **Park Nicollet Health Services** (Minneapolis Metro)
23. **Partners Healthcare** (E. MA)
24. **Physician Health Partners** (Metro Denver, CO)
25. **Presbyterian Healthcare Services – Central NM Pioneer ACO**(Central NM)
26. **Primecare Medical Network** (CA)
27. **Renaissance Medical Management Company** (SE PA)
28. **Seton Health Alliance** (11-county area in Central TX, including Austin)
29. **Sharp Healthcare System** (San Diego Co., CA)
30. **Steward Health Care System** (E. Mass.)
31. **TriHealth, Inc.** (NW Central Iowa)
32. **University of Michigan** (SE MI)

Pioneer ACOs



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What are the Pioneer ACOs Doing?

- **Many of the Pioneer ACOs are focused right now in two major tasks:**
  1. **Attribution** – sorting out which Medicare beneficiaries may be "IN" or "OUT' of the ACO.
  2. **Physician Participation** – figuring out which primary care physicians are going to participate**.**

<u>Secondarily</u>

Some are still sorting out IT/EMR issues, quality management, communication and so on.

Post-acute care, while recognizably important, is not far up on the priority list for many.

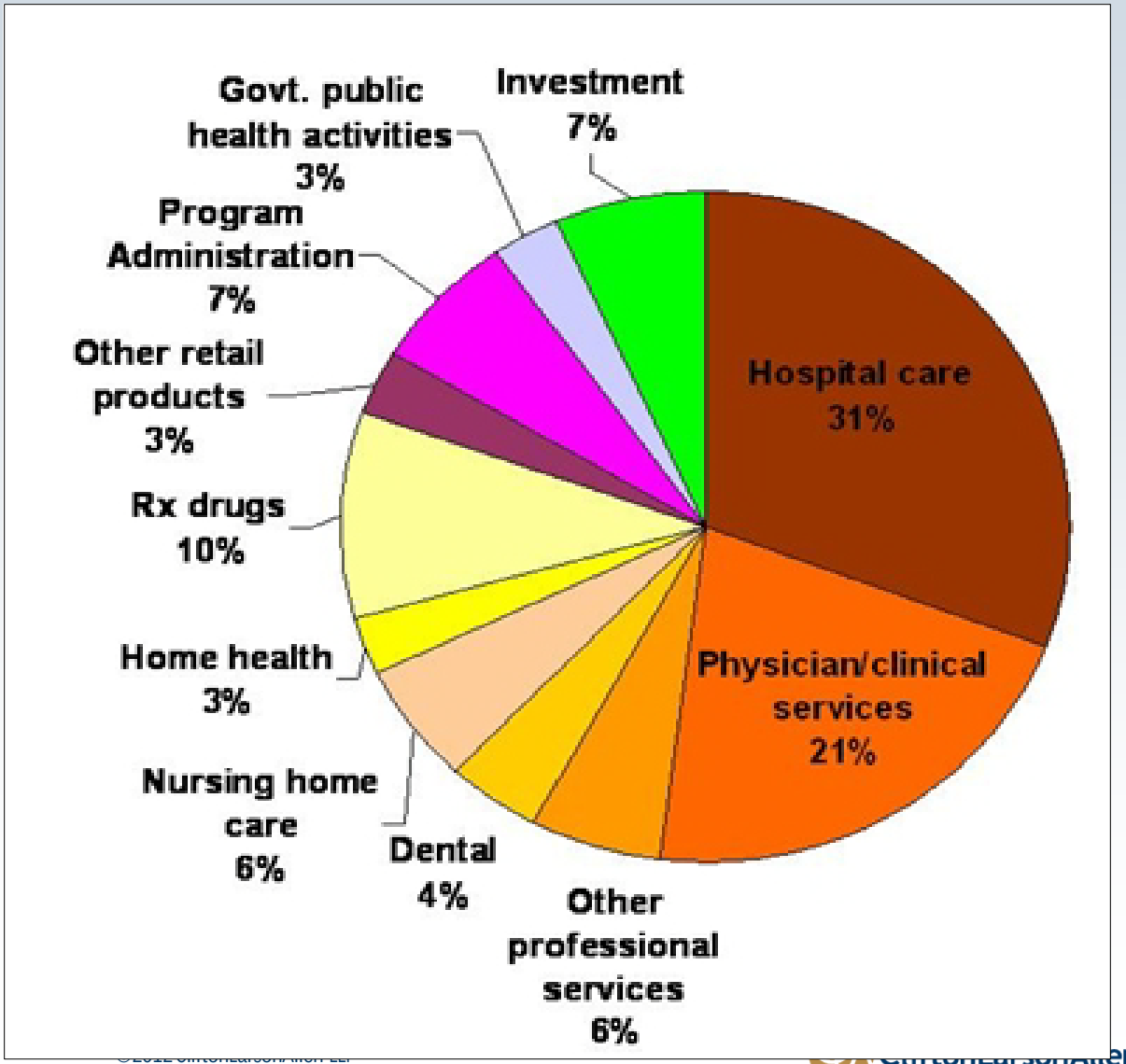
Why Isn't Post-Acute a Burning Issue?

Here's Why:

SNF care (or home health for that matter accounts for very small fraction of the total healthcare dollar in any given market.

They'll get to us.

Will you be ready?



Bundled Payment: General Definition

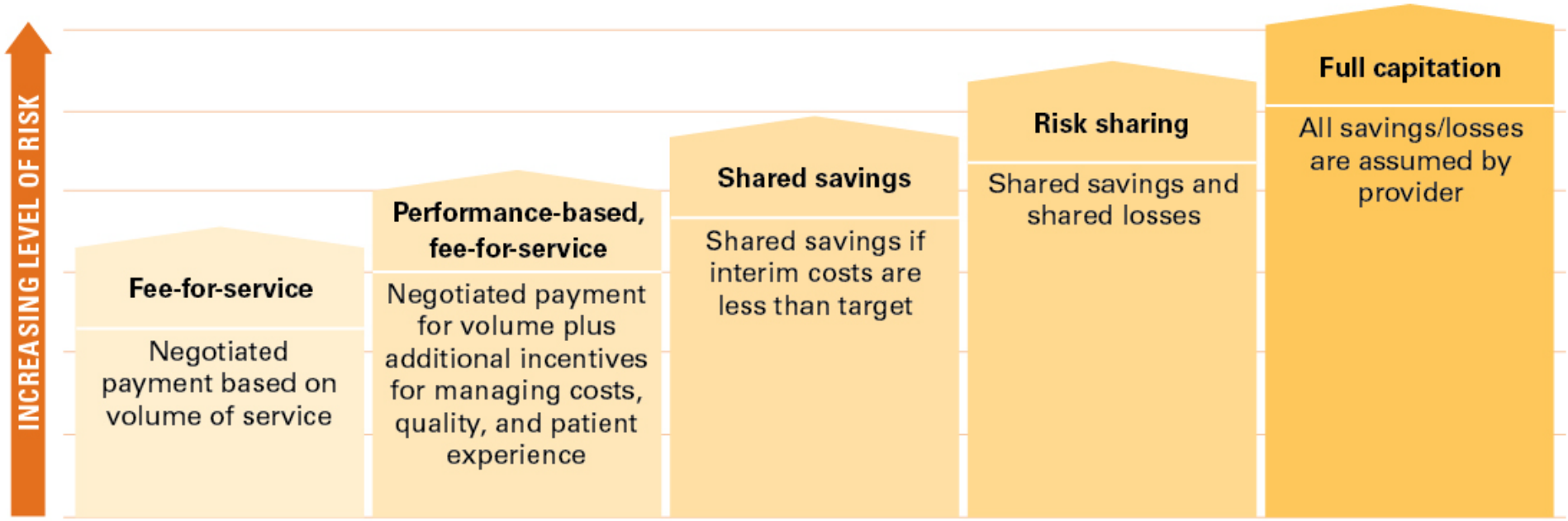
A single, fixed per person payment paid to provider(s) for the provision of all services and expenses for an episode of care or for the management of a chronic condition for an individual.

Desirable Characteristics of Post Acute Providers Considering Bundled Payment

- Patient Volume
- Multi-site presence (unless already part of acute hospital/physician system)
- Current outcome measure system
- Operating EHR platform
- Evidence-based practices
- Established or evolving clinical pathways
- Staff resources to devote to bundled payment project
- Sufficiency of experience with distinct patient types (i.e., CHF, COPD, CVA, etc.)
- Strong physician affiliation or collaboration
- Sufficient reserves to embrace risk
- Willingness to embrace care redesign

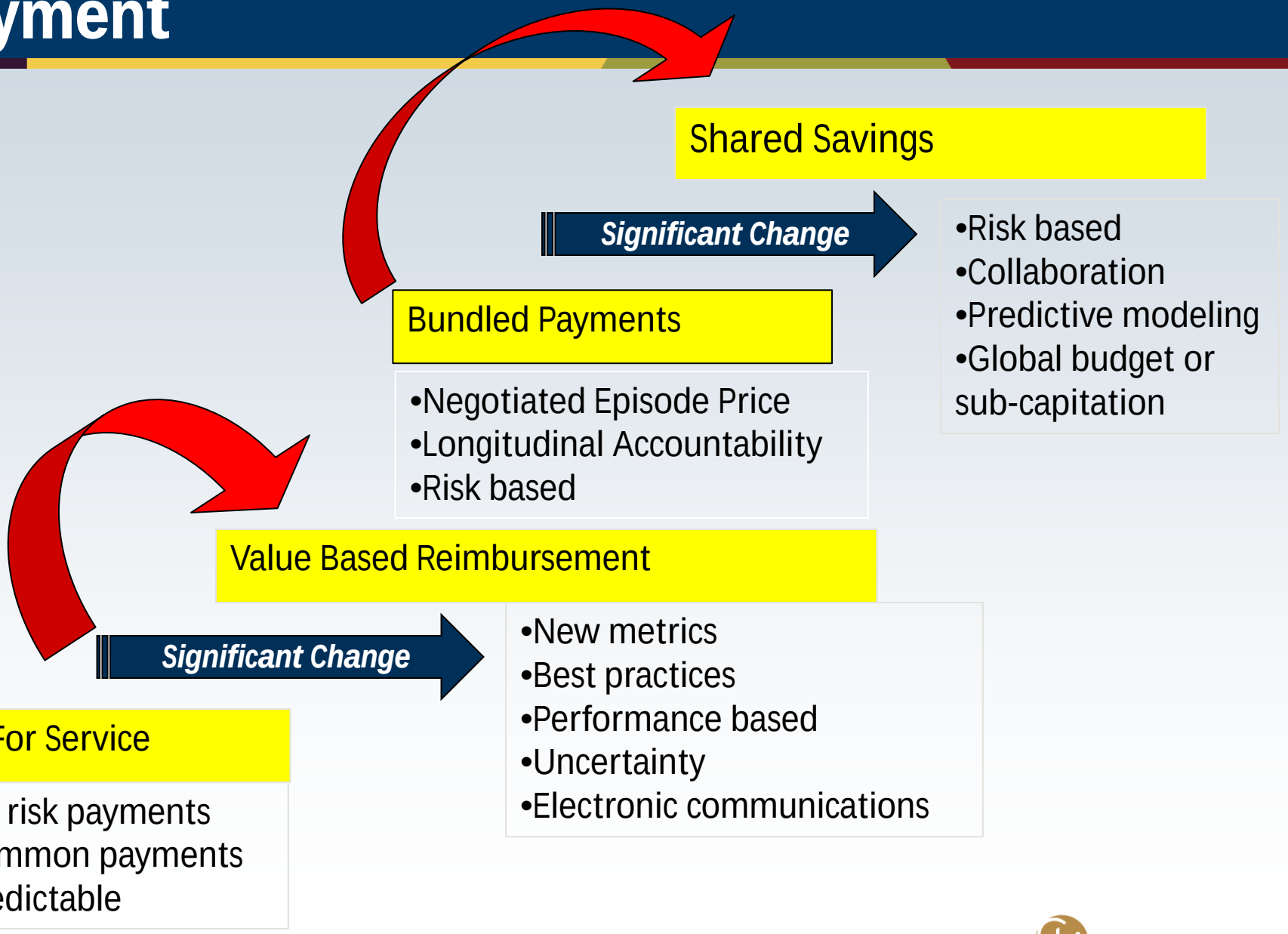
New Payment Models
Spectrum of Payment Options

Spectrum of Payment Models for Health Plans and Providers



Increasing Risk & Uncertainty, Enhanced Collaboration & Communication, Increasingly Complex Metrics and Business Practices

Making the Transition to Performance Based Payment



The Foundation: Value-Based Payment

Value Based Payment: *"a reform initiative whereby health care providers will receive payment for service based on their performance or the potential outcomes of the service"*

Tying payment to performance is perhaps the most significant aspect of health care reform.

The de facto definition of "value" in health care reform is the intersection of lower cost and improved quality.

Providers who can lower costs and deliver quality will be measured as "value-based providers"

Value-Based Purchasing for SNFs

- **Value-Based Purchasing for SNFs**
  - Payment based on achieving certain thresholds for quality measures; plan to Congress for SNFs and HHAs by FY2011
  - MedPAC 2010 suggestion:
    - ◊ SNFs report on avoidable re-hospitalizations and percentage of Medicare discharged home; assessment at admission and discharge; actual direct nursing costs
  - CMS Value-Based Purchasing Demonstration:
    - ◊ Underway in three states (AZ, NY, & WI); focused on nurse staffing, rates of potentially avoidable hospitalizations, outcomes for selected MDS quality measures and state survey results.

Value-Based Purchasing for SNFs

What's the word on street about VBP for SNFs?

No one really knows for certain.

But scuttlebutt sounds like this:

CMS will lop 1-2% of current Medicare rates

Those providers who meet certain quality thresholds and **outcomes** will get some of it back.

Maybe 1-2% if you're in the 50th or greater percentile.

Maybe more if you're in the 90th.

It is also beginning to look as if the program will be implemented in October of this year will little preparation or warning for SNF operators.

Caveat Emptor

These assumptions are pure speculation.

WHY ORGANIZATIONS AFFILIATE

Some Typical Drivers for Affiliations

- Financial Salvation
- Efficiencies or economies of scale
- Enhance access to capital
- Expand intellectual capital and people resources
- Create a safety net – or 'spread' risk
- Diversify market base – or solidify market base
- Growth – for financial, mission, programmatic or other reasons

Shift Happens
FOCUS!

- Evolving markets
  - Market has evolved to higher expectations than your product offers
  - Market has shifted ethnically or income-wise in such a manner that your community no longer “works” in its location
  - Shrinking affinity population
- Evolving organizations
  - Organization has refocused, and particular assets are no longer strategic
  - Could be location, unit mix, income level, etc.
  - Example is divestiture of freestanding SNF by a multi-level system

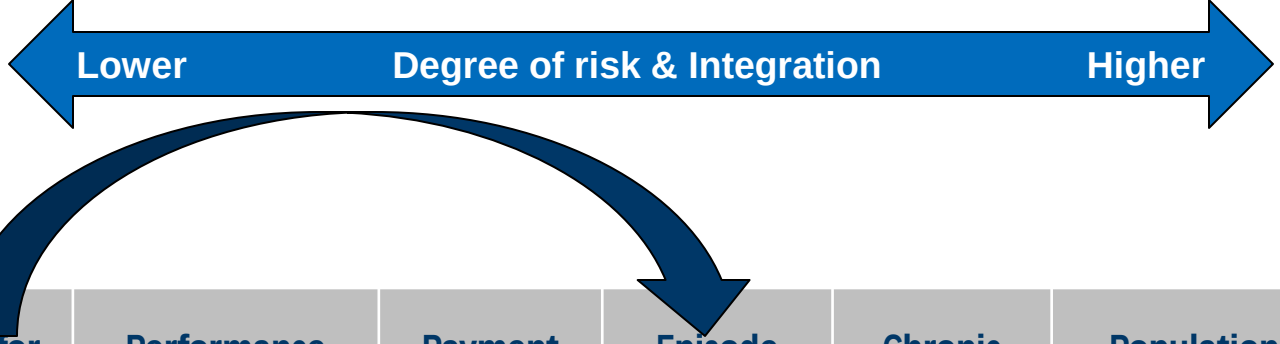
“Affiliators” Seek Value

- **To become value-based providers, we must develop platforms for both capturing and trending outcome data.**
  - Surveillance tools to monitor readmission issues, identify high-risk patients and establish protocols for intervention
  - Effective surveys or consumer interfaces to gather real-time (or near-to-real-time) data about patient perceptions of care and quality
  - Systems that can measure and report actual patient improvement from admission to discharge: functional status improvement

Capabilities	Focus Area	Fee for Service	Performance Based Payment	Payment Penalties	Episode of Care	Chronic Care Mgmt	Population Health
Area #1 People and Culture	***Culture***	Learning Culture	Leading with Quality			Mgmt of Illness	Clients Engaged
	Mgmt & Governance	Informal Dr. Leadership	Formal Acute-Care Dr Leadership		Communities of Practice		
	Operations	Department Structure		Episode Product Lines		Cross Sites of Service	Community Collaboration
	Performance and Pay	Productivity Based		Outcomes Based			

How would we redefine the People & Culture systems, data and processes for Affiliation?

Source: Adapted from HFMA's Value Project: Value in Health Care: Current State and Future Directions; Final Report; accessed via the web, October, 2011; pg 29.



Capabilities	Focus Area	Fee for Service	Performance Based Payment	Payment Penalties	Episode Bundling	Chronic Care Mgmt	Population Health
Business Intelligence	***Financial Reporting & Costing***	Procedure Metrics		Activity Level	Time Specific	Per Member Per Month	
	Quality Reporting	Core Measures	Process Measures	Outcome Measures		Condition Measures	Population Indicators
	Business Case	Supply/Drug & Productivity		Med/Surg Interventions		Lifestyle Interventions	
	Decision Support Systems	Financial Data	Quality Data	Ambulatory Indicators	Claims & Drugs Info	Health Risk, Predictive Modeling, etc.	

How would we redefine the Business Intelligence information and processes for Affiliation?

Source: Adapted from HFMA's Value Project: Value in Health Care: Current State and Future Directions; Final Report; accessed via the web; October, 2011; pg 29.

Capabilities	Focus Area	Fee for Service	Performance Based Payment	Payment Penalties	Episodes of Care	Chronic Care Mgmt	Population Health
Performance Improvement	***Process Design***	Identify Variability	Increase Reliability w/in Clinical Value Bundles		Optimizing Care Pathways across Sites of Services		
	Evidence-Based Medicine	Increasing Patient Safety	Developing Clinical Care Bundles			Manage Conditions	Improve Wellness
	Stakeholder Engagement	Creating Transparency		Informing Patient Alternatives		Developing Accountability	

How would we redefine the Performance Improvement processes and data for Affiliation?

Source: Adapted from HFMA's Value Project: Value in Health Care: Current State and Future Directions; Final Report; accessed via the web; October, 2011; pg 29.

Capabilities	Focus Area	Fee for Service	Performance Based Payment	Payment Penalties	Episodes of Care	Chronic Care Mgmt	Population Health
Contract & Risk Management	***Contract Management***	Negotiating Pricing	Balancing Cost & Quality Aims		Network Development Fund Distribution		
	Risk Modeling & Management	Profit & Loss Analysis	Estimating Exposure			Predicting Outcomes	

How would we redefine the Contract & Risk Management processes and data for Affiliation?

Source: Adapted from HFMA's Value Project: Value in Health Care: Current State and Future Directions; Final Report; accessed via the web; October, 2011; pg 29.

Concerns and Observations

- While partnerships and affiliations among organizations sponsored by the same denomination seem to make sense – they tend not to happen as frequently as one might think
  - **Politics and history seem to get in the way**
- The amount of control given up in a partnership or affiliation has a direct relation to the ultimate value of the affiliation
  - **Retaining current level of control or autonomy is antithetical to the notion of a partnership or affiliation – yet frequently ends up being the key point of discussion**

Concerns and Observations (continued)

- Clear measurement of success can only be accomplished when the initial goals have been articulated and understood
  - **Generally, if the only goal is cost saving – it may be difficult to call the affiliation a success**
  - **An important comparison (following an affiliation) – is where we are today versus where we would have been**

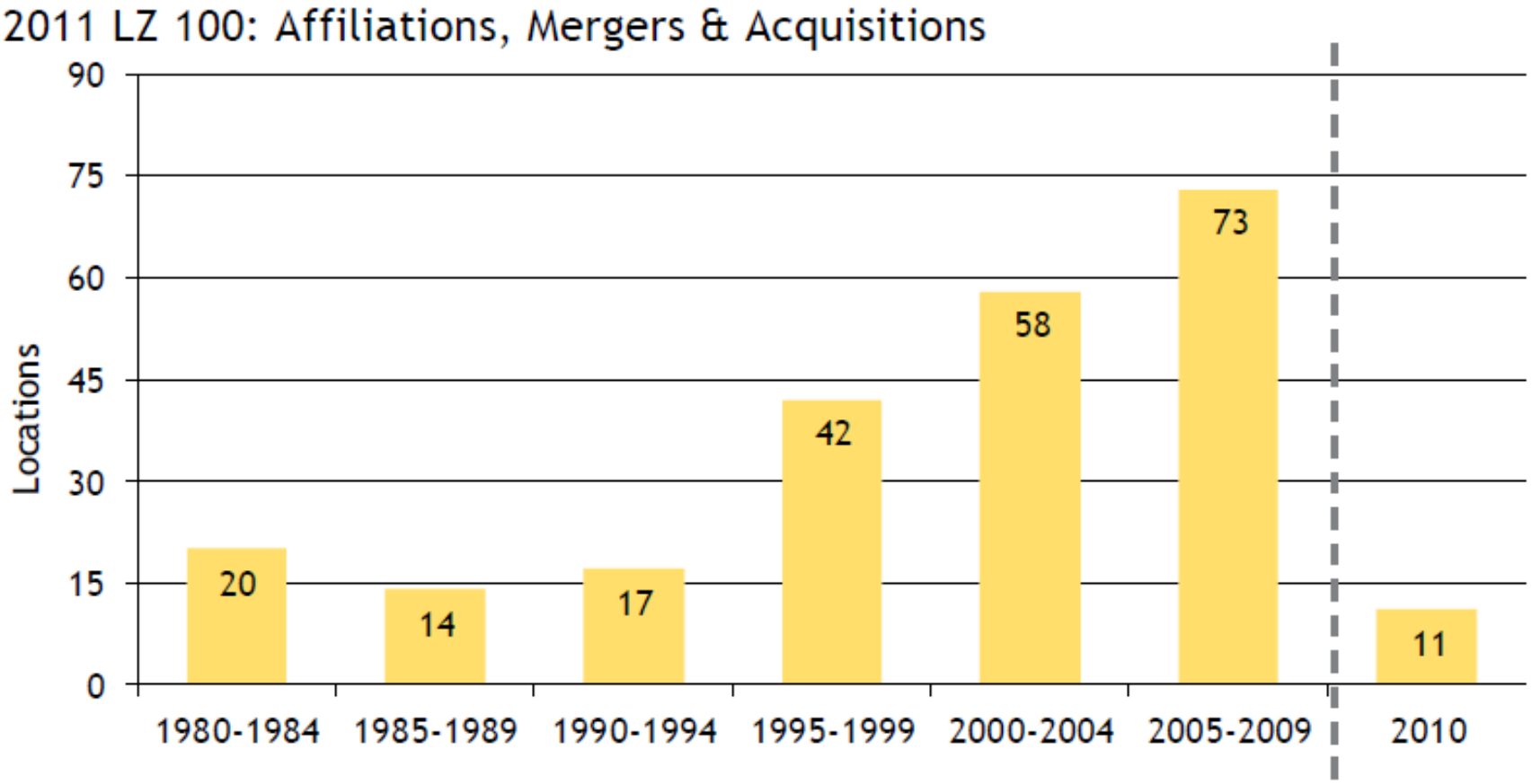
- Affiliation decisions come easy when there's not enough cash for the next payroll
  - **Strong organizations may have the most potential to benefit from the affiliation but tend to be the least motivated to complete the "deal"**
  - **Identifying the 'compelling reason' is an important – maybe 'the' most important step**

JUST THE FACTS

Senior Living & Long-Term Care Market
Notable Trends

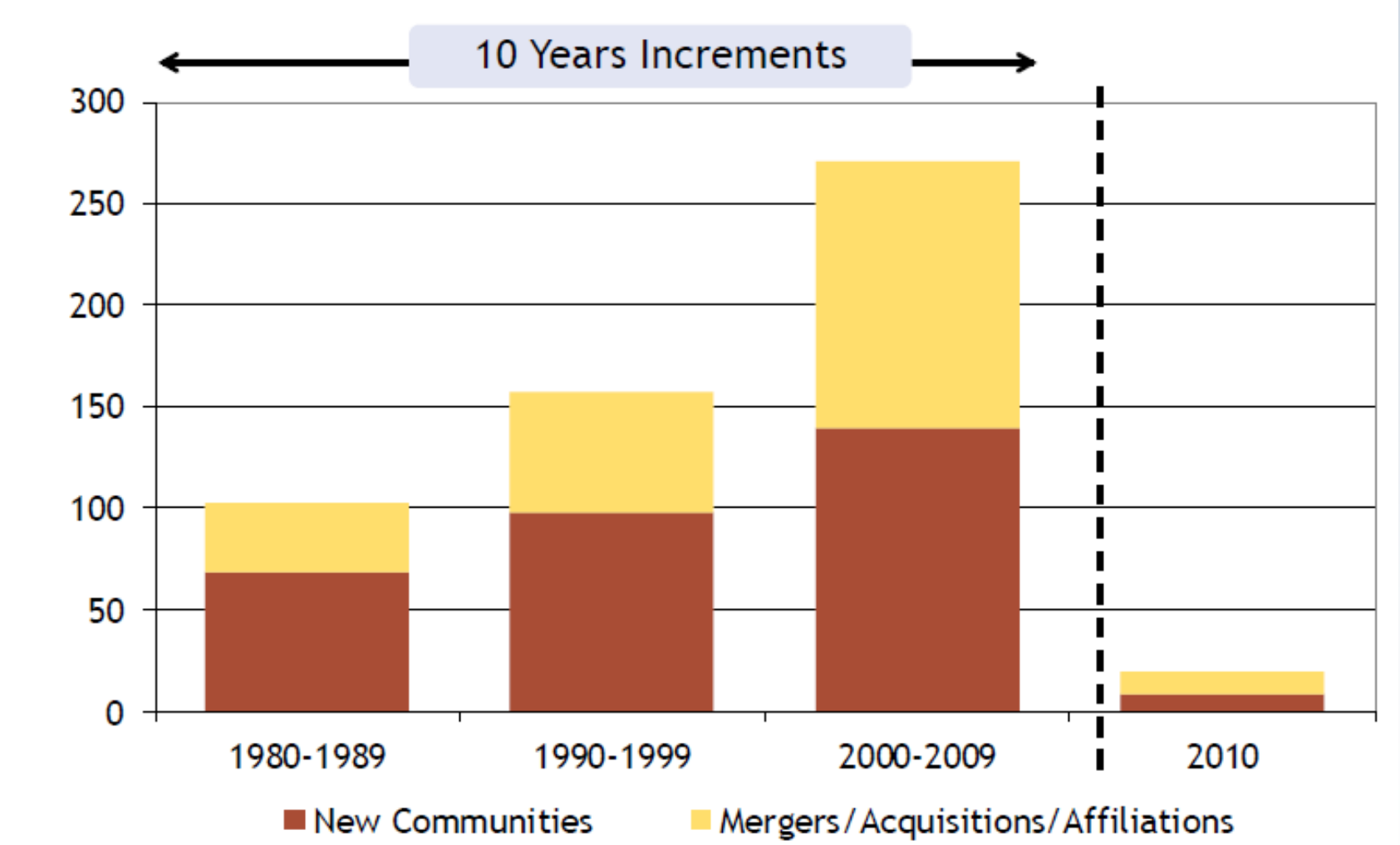
- Shifting resident acuity scale
  - Seniors moving into communities at older ages
  - Higher acuity patients staying in AL, IL settings
- Increased usage of home health alternatives
  - Growing appeal of “non-institutional” care from a reimbursement standpoint (i.e., Family Care)
- Replacement Facilities; aging physical plants (SNF avg. age » 35 years) creates opportunities in some markets
  - Shorter Term Stay
  - Memory Care Units
- Cap rates probably coming up a bit (valuations stabilizing) but there are not many transactions to support this view
- Little new, for-profit development occurring as lenders pull back; opportunity to develop stand-alone ALFs in some markets

Affiliation can be a Growth Strategy



Merger/Acquisition/Affiliation: Growth of a multi-site organization by the addition of units through merger, acquisition or affiliation.

Growth Through Affiliations, Mergers and Acquisitions: *Outnumbering New Communities*

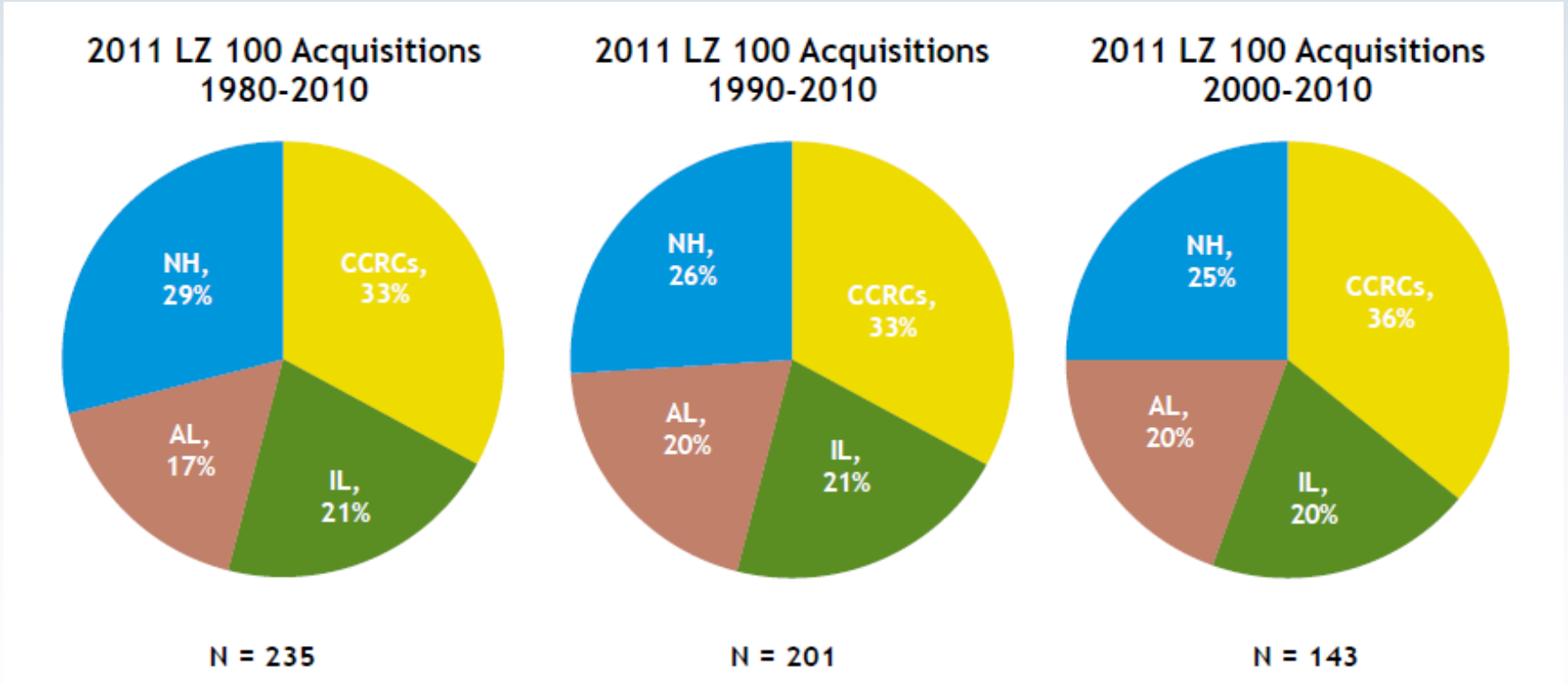


Source: 2011 LeadingAge Ziegler 100 Publication (data as of 12/31/10)

Acquisitions are one form of Affiliation

CCRCs (and other property types) are increasingly on the market

- Drivers are: single-sites who are raising their hands, credit challenged situations, hospital dispositions



Source: 2011 LeadingAge Ziegler 100 Publication (data as of 12/31/10)

AFFILIATION SUCCESS STORY

What Allows for Successful Affiliations

- Common or compatible goals:
  - Growth
  - Mission/Vision Fit
  - Financial Necessity
- Strong Leadership
  - Stable governance, or the ability to build it
  - Strong brand recognition
- Understanding that Affiliation is not one-size fits all
  - Affiliations take all shapes and sizes
  - Careful attention to detail, small and large, is paramount

D'Youville Life & Wellness Community

An Affiliation Success Story
through Growth and Partnership

D'Youville Life & Wellness Community

- Established in 1960 ("D'Youville Manor") by Sisters of Charity of Ottawa
- 208-bed SNF building opened in 1998 (dually certified)
- 63-apartment HUD 202 (2006 & 2009)
- Adult Day Health Program (since 1970's)
- St. Joseph Residence for retired Sisters

Source: LeadingAge/Ziegler MA, 2012, "Partnerships"

D'Youville: Expansion to Therapy

- New 50,000 sq ft building
- Tax-exempt bond funding supported by state and local institutions
- 33-bed SNF (Medicare only)
- Kitchen to serve entire growing campus
- Opening early March 2012

Source: LeadingAge/Ziegler MA, 2012, "Partnerships"

D'Youville: Partnership with a rehab hospital

- 22-bed inpatient acute rehab satellite
- In Lowell since 1994
- Shell only
- Ancillary services desired (dining, housekeeping, maintenance, laundry, reception, etc)

Source: LeadingAge/Ziegler MA, 2012, "Partnerships"

Synergies between D'Youville and New England Rehabilitation Hospital

D'Youville Life & Wellness

- Revenue stream (lease plus ancillaries)
- Opportunities for synergies (clinical, marketing, etc)
- Enhanced public image

New England Rehab

- New physical plant, top location
- Joins D'Youville campus continuum of care
- Cost-effective provision of ancillary services

Source: LeadingAge/Ziegler MA, 2012, "Partnerships"

D'Youville Considerations

- Mission alignment
- Neighborhood concerns
- Determination of fair market value
- Tax implications
- Termination clauses and Plan B
- Tenant waiver
- Building design
- DoN process

Source: LeadingAge/Ziegler MA, 2012, "Partnerships"

This is just one example....

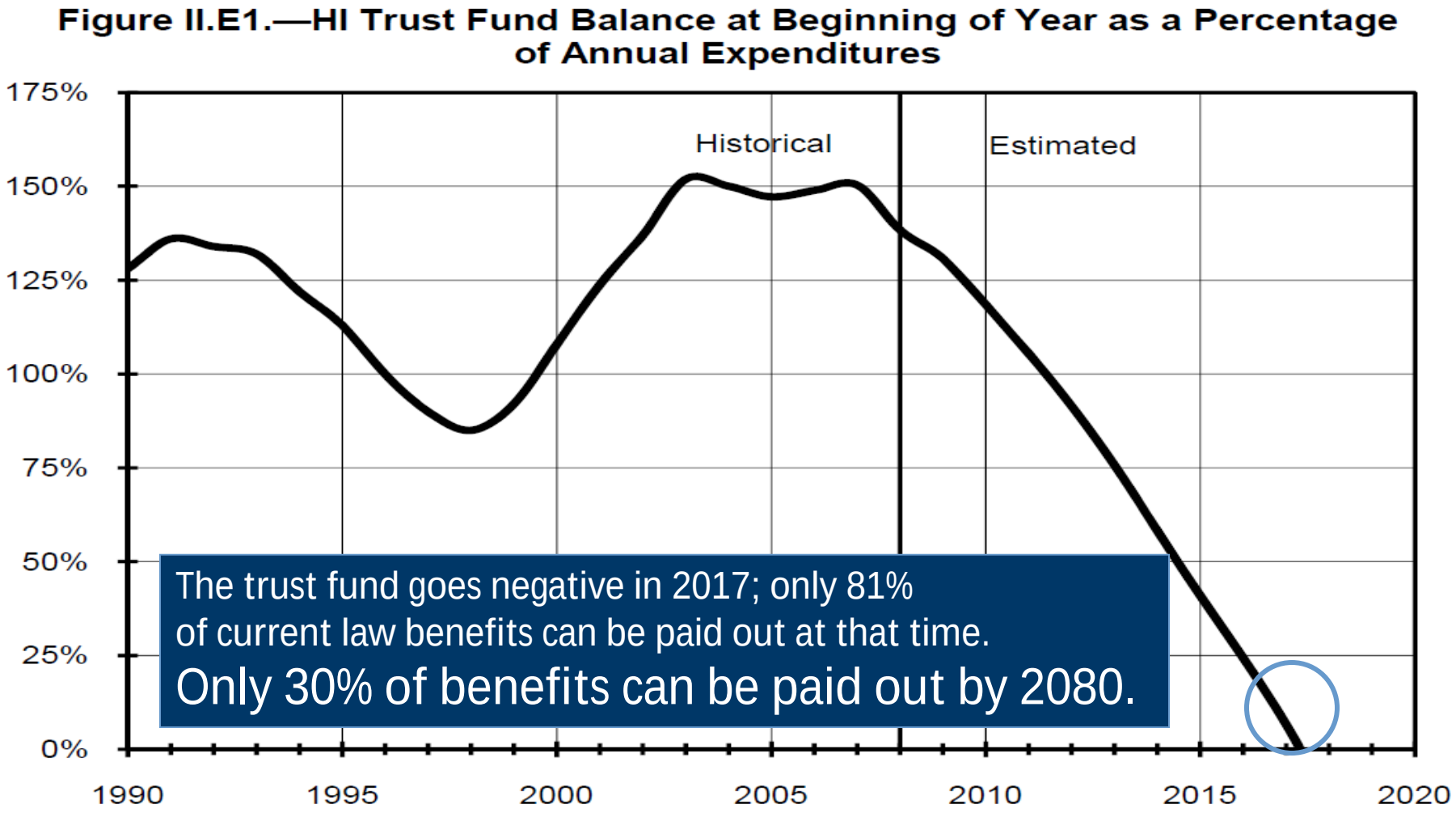
- A community raised their hand and believed they could do more
- They have expanded their footprint
- BUT they were methodical in how they went through the affiliation process
- AND affiliation was only one way in which they achieved their goal to do more

Do you have other examples?

THE CERTAIN AND UNCERTAIN FUTURE

...we've been looking pretty good on Medicare

Until Medicare Runs Out of Money…



Source: 2009 Trustees Report, CMS, page 17


Reform in Some Form
PPACA or Otherwise…
…Is Unavoidable

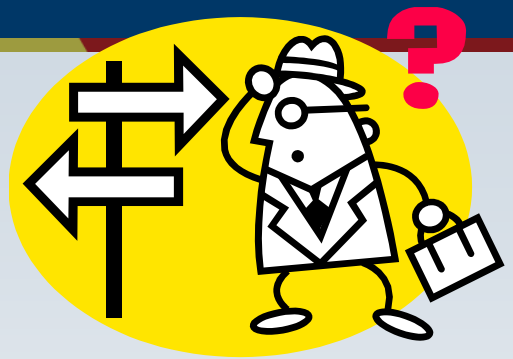

…so stop doing this.

BECAUSE...

"In the middle of difficulty lies opportunity"

- Albert Einstein

Could You Be/Become a Hand-Raiser?



- Effects of the "Great Recession"
  - Temporary or permanent?
  - Occupancy decline, investment losses
- Lack of capital access in our asset-intensive business, with aging physical plants, has become a catalyst for hand-raising
- Complex redevelopment projects remain a catalyst as well
  - Expensive and risky
  - Risks are tough for single-site boards to digest
    - ◊ Pre-construction capital
    - ◊ Working capital
    - ◊ Complexity of staging project

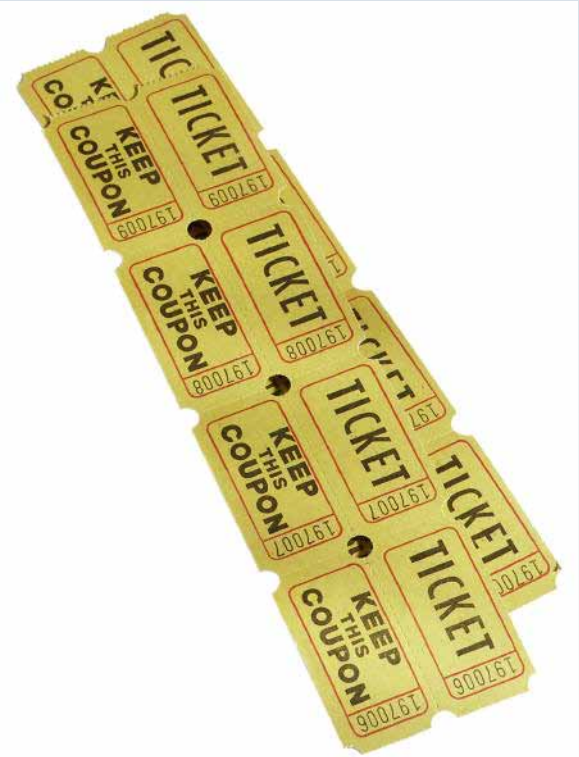
Could You Be/Become a Hand-Raiser?

- Operational/financial issues
  - Occupancy declines
  - Expenses out of alignment with revenues
  - Dependence on cash reserves that "dry up" for various reasons

- Leadership turnover
  - CEO change can precipitate a desire to affiliate
  - Major board change

Could You Be/Become a Consolidator? Strategic Affiliation Drivers

- Desire to grow without needed capital available
- Desire to add services already being capably provided by another organization
- Desire to grow in a market with high barriers to entry (acquisition may be the cheapest admission ticket)



What Style Transaction is for You?

- Strategic Considerations
  - Long-term goals (market expansion, etc.)

- Governance Considerations

- Financing Considerations
  - Do existing debt terms facilitate transaction?
  - Tax law issues
  - Is target a weaker or stronger credit?
  - Distribution of sale proceeds
  - *Not-for-profits often establish value as the debt target currently owes*

- Any impact on tax-exempt status?

Strategic Options - Affiliation

Courtesy of Rick Stiffney

CliftonLarsonAllen

Strategic Future: On Your Own or With Partner(s)?

- Mission Goals
  - Geography
  - Resident income focus
  - Types of care provided
  - State of physical plant, now and desired
  - Others…

- Operational and Financial Goals
  - Margins
  - Access to employees
  - Market strength
  - Review trend lines periodically
  - Set financial performance goals for management and staff

- *Do mission, operational and financial goals suggest raising your hand?*

THE BIG PICTURE

Decide: lead, follow, resist

Prepare to assume risk

Use technology better

Align providers interests

Connect quality to value

Build new relationships

Responding to Your Market

What are the acute providers doing?

Health systems are preparing their organizations for reimbursement changes.

Four broad areas have been identified through the HFMA Value Project:

- ***People & Culture***
- ***Business Intelligence***
- ***Performance Improvement***
- ***Contract & Risk Management***

The Post-Acute Provider Value Proposition

Hospitals and ACOs need to know what differentiates you from your competitors. How can you be their low cost, high quality value provider of post-acute services?

Mine Your Data

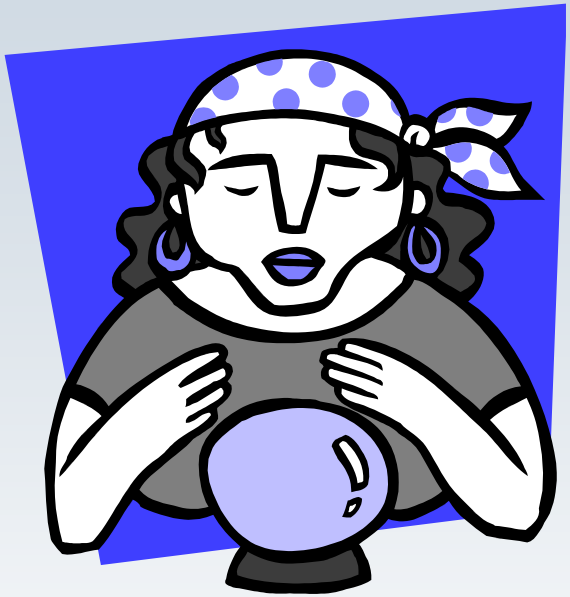
- 30-Day Readmission Rates
  - By MS-DRG
- Average time to place patient
- Average LOS
- Quality Measures
  - Ex., Pressure Ulcers, UTIs, Restrains
- Programmatic foci
- Chronic Disease Management Outcomes
- Resident and Family Satisfaction

Tell Your Story

- Where do your referrals come from?
- What MS-DRGs do your referral sources send you?
- How do your currently admit and discharge patients?
- How many MD or mid-level hours are available to your patients?
- How do you prepare patients for discharge?
- How do you monitor patients after discharge?
- ***Ask about and listen to their needs.***

So What Does All of This Mean?

While none of us has a perfect crystal ball, here are some of the expectations for the next few years:



1. We expect a decline in hospitalizations by up to 30% over the next ten years.
2. More care will likely move to home care & SNF; it is likely that remaining post-acute volume will be spread across fewer providers.
3. At present, SSP ACOs will not have the authority to waive restrictive payment rules; Pioneer ACOs, however, have been afforded some greater flexibility
4. Bundled payments will change models of care, reduce length of stay, increase integration before & after services & change relationships w/ physicians
5. Volume of “care” provided in typically “residential” settings (like AL or even IL) will likely increase.

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