POST–ACUTE CARE INTEGRATION
TODAY AND IN THE FUTURE
The shift from traditional fee-for-service to risk-based payment models requires effective alignment among acute and post-acute care providers. In 2013, a total of 2,213 hospitals were charged $280 million in readmission penalties. A hospital readmission nearly doubles the cost of an episode, so the financial implications for organizations operating in risk-bearing arrangements are significant. Successful alignment with post-acute care providers is certainly necessary to reduce readmissions, but ultimately, this alignment is critical to financial success in global or capitated payment environments.

As organizations move toward becoming fully risk-capable, it is necessary to develop referral networks of high quality post-acute care (PAC) providers to achieve the best clinical outcomes, reduce readmissions and lower costs. Currently, incentives among providers are disparate – even contradictory – and as payment models continue to evolve, it will be essential for providers to develop PAC integration strategies where incentives are aligned.

Many organizations have proactively begun to develop strategies and today’s voluntary payment models – bundled payments, shared savings and accountable care organizations – provide an opportunity for providers to work together to better manage care across the continuum. Mandatory programs like quality reporting and value-based purchasing will compel providers to ensure the coordination of care well beyond the walls of the hospital.

Today’s PAC sector includes long-term acute care hospitals (LTACH), inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF), home health agencies (HHA) and other important but less impactful providers. In 2012, 12.6 percent of Medicare beneficiaries used some form of post-acute care, totaling $62.1 billion in Medicare spending, a 90 percent increase from $32.8 billion in 2002. The graph below shows the acute care discharges by post-acute care setting for patients age 65 and older.

**ACUTE DISCHARGE DESTINATION**
Hospital Discharge Disposition by Post-Acute Care Site, Patients 65+

- **3.4%** Home
- **1.2%** SNF
- **18.1%** HHA
- **22.7%** IRF
- **54.6%** LTACH

The need for PAC services is not always clear. Some patients can benefit from a PAC stay, but there is overlap in the types of patients being treated in the various settings. While different PAC settings can provide similar services, Medicare uses different payment structures and rates depending on the setting. For example, Medicare’s total payments per stay to an LTACH can be more than double the payment to a SNF for the same condition.

Three of the four PAC settings – HHAs, IRFs and SNFs – are required by CMS to use different patient assessment tools. A common assessment tool could assist providers and beneficiaries in determining the need and the appropriate setting for post-acute care. The Medicare Payment Advisory Commission (MedPAC) recommended in its March 2014 Report to the Congress that common patient assessment items be added to existing tools used by HHAs, SNFs, IRFs and LTACHs by 2016, maintaining that the implementation of a common assessment tool will identify a core set of patient characteristics that could establish a common payment system. The graph below shows Medicare national per user standardized costs by setting.

**MEDICARE PER USER STANDARDIZED COSTS BY SETTING**

- **$14,173** Inpatient Care
- **$13,962** Post-Acute Care
- **$18,131** IRF
- **$43,015** LTACH
- **$16,794** SNF
- **$5,639** HHA

Pressure due to declining reimbursement has driven hospitals to discharge more patients to PAC at increasing severity of illness. Between 2002 and 2009, inpatient discharges decreased 8.3 percent, yet SNF admissions increased 12.9 percent as the average length of stay increased from 24.6 days to 27.3 days. The number of persons served by HHA increased 29 percent while the average number of visits per person increased from 30.7 to 39.7.
The chart below shows the economic growth in individual PAC services over the period 2001-2012. Home health and skilled nursing together are the primary post-acute care drivers of cost, accounting for nearly 79 percent of the total $62.1 billion total spend in 2012.

**HOME HEALTHCARE AND SKILLED NURSING FACILITIES HAVE FUELED GROWTH IN MEDICARE’S POST-ACUTE CARE EXPENDITURES**

![Chart showing economic growth in PAC services from 2001 to 2012](chart.png)

Note: These numbers represent program spending only and do not include beneficiary co-payments.
Source: CMS Office of the Actuary

**Long-Term Acute Care Hospitals**
LTACHs are most similar to acute care hospitals, serving patients requiring hospital-level care for extended periods of time. LTACH patients include those with complex medical problems like multi-system organ failure or those who are ventilator-dependent. Medicare payment rules require the average length of stay at an LTACH to be greater than 25 days.

While LTACH utilization is lowest compared to other PAC settings at 4.1 per 1,000 Medicare beneficiaries, per user standardized costs are significantly higher. The per user standardized cost for an LTACH stay is $43,015, which is three times the standardized cost of an inpatient stay and nearly two and half times the standardized cost of a SNF stay. Medicare accounts for about two-thirds of LTACH discharges.

Innovations in care delivery could represent an opportunity for LTACHs to care for patients following an emergency room visit without an acute care hospitalization.

**Inpatient Rehabilitation Facilities**
IRFs provide care to patients who require intensive rehabilitation following events such as stroke and brain, spinal cord and other traumatic injuries. Nearly all IRF patients are admitted directly from an acute care hospital.
Utilization of IRFs is low among Medicare beneficiaries (10.6 per 1,000), the majority of whom are admitted for strokes and other neurological disorders. To qualify for Medicare coverage, IRF patients must be able to tolerate and benefit from intensive rehabilitation therapy—at least three hours of therapy a day for at least five days a week.

Despite low utilization, Medicare is the principal payer for IRF services, with more than $6.7 billion in payments in 2012, accounting for about 60 percent of total IRF discharges. Approximately 80 percent of IRFs are hospital-based and the remaining 20 percent are freestanding. However, hospital-based units accounted for only 55 percent of Medicare discharges to IRFs in 2012.

Skilled Nursing Facilities
SNFs provide short-term skilled nursing care and rehabilitation services, including physical, occupational and speech therapy. Nearly 23 percent of total acute care discharges in 2012 were to a SNF. SNFs account for the largest portion of Medicare’s post-acute care spending—$30.4 billion for 1.7 million beneficiaries in 2012.

Readmission rates from SNFs declined from 15.6 percent to 14.9 percent between 2011 and 2012, which may be the result of hospitals working more closely with SNFs to lower their own readmission rates. Since 2013, hospitals have been penalized for readmissions for three conditions: acute myocardial infarction (AMI), congestive heart failure (HF) and pneumonia (PN). In 2015, the readmission penalty will increase and the number of conditions will be expanded. Many hospitals and SNFs are working together on clinical pathways and protocols around these and other conditions to reduce readmissions. This collaboration is paving the way for more deliberate and effective alignment among providers.

BEST PRACTICE
Mercy Health Partners in Toledo has deployed their medical clinic-based nurse practitioners to round on Mercy’s skilled nursing patients four days a week at three nursing homes. The nurse practitioner sees the patient upon admission, follows them throughout their stay and sees them again at discharge. They have implemented a process to identify and monitor patients who are at high risk for readmission and are providing ongoing education to the nursing home staff. As a result, readmissions have been reduced significantly.

Because most skilled nursing units are located within facilities providing long-term nursing care, providers rely on Medicare margins to offset Medicaid losses. SNFs are competing for volume in their markets and proactive organizations are positioning themselves as preferred providers or network partners.

BEST PRACTICE
Bon Secours Virginia Health System (BSVHS) developed a post-acute care integration strategy. BSVHS consists of seven acute care hospitals across three geographic markets, two free-standing skilled nursing facilities, a transitional care unit located within one of its acute care hospitals, and a home health agency operating across the three markets. In 2013, BSVHS signed a three-year agreement with CMS to become an ACO responsible for managing the care of 45,000 Medicare fee-for-service beneficiaries. In addition, Bon Secours St. Mary’s Hospital entered into a three-year bundled payment program with CMS and 27 post-acute care entities to provide care for total hip and knee patients for a 90-day episode of care. Analysis of discharge volumes by service line, referral patterns and readmission results was instrumental to the completion of the strategy. This “current state analysis” created a foundation for the ongoing planning and implementation of a SNF Quality Collaborative designed to improve the health of patients through patient-centered, cost-effective, high-quality healthcare across the continuum.
Home Health Agencies
Patients use home health agency services as part of their post-acute care more than any of the alternative PAC options (196.3 per 1,000 beneficiaries), but total HHA costs per associated DRG episode of care are lowest of all PAC options. In 2012, about 3.4 million Medicare beneficiaries received home health care totaling $18 billion at an average cost per patient of $5,639.

The home health care industry is highly fragmented due to low capital costs and low barriers to entry. There are an estimated 310,000 different home health care agencies in the U.S., with about 12,000 participating in Medicare in 2012. Over the past five years, the industry has seen consolidation and the large providers are focused on delivering specialized services such as orthopedics, cardiopulmonary and chronic disease management programs. Since chronically ill individuals account for about 75 percent of all hospitalizations, medical and technological advances will create growth opportunity for home health providers.

A four-year 3.5 percent per year reduction to the Medicare base payment for home health services was implemented in January 2014. Since Medicare payments comprise approximately 50 percent of home health industry revenue, small providers may not be able to sustain the base payment reductions. The National Association for Home Care and Hospice estimates that as many as three-quarters of current operators will be unable to sustain profitable operations by 2017.

Among the PAC settings, home health readmission rates are highest, at about 29 percent, and there is significant variation in performance among providers.

As the lowest cost PAC setting, payers will increasingly seek quality home health care providers. Many hospitals and health systems own or are in partnerships with home health care agencies, and should seek to optimize the performance of their home health care assets—analyzing volumes, internal capture rates, readmissions and outcomes. Owning the asset is not necessary, but partnering with a quality, stable provider is key to achieving consistent outcomes and ultimately, cost savings.

Evolving Partnerships and Payment Models
At present, fee-for-service reimbursement does not incentivize hospitals to refer patients to the most efficient setting. Placement decisions are typically made based on the availability of PAC options in the market, as well as the availability of a bed within a certain setting; geography; patient or family preference; and historical relationships with post-acute care providers and referring physicians.

Evolving payment models will continue to apply pressure to providers to work more closely together to achieve the best outcomes in the most appropriate setting at the lowest cost. But there is no standard set of criteria by which to evaluate potential partnerships. Suggested criteria to consider are in the areas of quality, clinical capability, ability to care for complex patients, admissions criteria, technology readiness, geography and other qualitative considerations such as mission and operating philosophy, physical plant and amenities, etc.

The definition of “partnerships” in today’s environment ranges from simple referral relationships (being on the hospital discharge planner’s list of providers) to “care networks” of providers working closely together under non-binding agreements to joint ventures where organizations pool resources into a shared legal entity, and in some cases, the hospital’s ownership of the SNF.

Organizations that are deliberate about narrowing their network of providers are also deliberate about presenting the choices to their patients, highlighting the benefits of choosing a network provider, including continuity of care programs, outcomes and patient satisfaction results.

Risk-capable organizations will find partners and define innovative ways to provide care in different settings. For example, while Medicare historically has required a three-day acute care hospitalization in order for a post-acute care stay to be covered, this requirement is being waived in certain bundled payment programs. In the not too distant future, expect to see the acute care hospitalization eliminated altogether under a scenario in which the patient goes directly from the Emergency Room to an LTACH or a SNF.

Entering into a Bundled Payment or other performance-based risk-sharing arrangement is an important step toward becoming a fully risk-capable organization. A bundled payment arrangement provides an opportunity for an organization to test their capabilities in select episodes of care and monitor quality and revenue performance.
Participation in the program also provides organizations access to rich and valuable data for their market. Bundled payment arrangements require increased financial and performance accountability, and therefore represent real opportunities to align incentives for providers while increasing care quality and coordination.

Organizations considering participation in a bundled payment or other risk-based arrangement should assess the following:

- Clinical capabilities
- Technology
- Capacity for risk
- Local market dynamics
- Competition
- Risk-based contracting expertise
- Business intelligence and analytics
- Structures that align incentives across the continuum of care
- Existing relationships/alliances

**Post-Acute Care Reforms**

In March 2014, The Office of Management and Budget released President Obama’s budget for fiscal year 2015, which includes provisions for reducing Medicare spending by more than $400 billion between 2015 and 2024. These Medicare spending reductions represent nearly 25 percent of all reductions in federal spending included in the budget. One third of the proposed savings ($132 billion) are to result from reductions in Medicare payments to providers, of which 26 percent is reduced payments to post-acute care providers.

- On October 1, 2016, the CMS measurement period for “risk-adjusted” hospital readmissions begins for SNFs.
- On October 1, 2017, SNF readmission information will be publicly available on Medicare’s Nursing Home Compare website.
- Beginning in 2019, at least half of the payments to SNFs, IRFs, LTACHs and HHAs will be restructured using a bundled payment approach.
- Beginning in 2019, SNFs will be penalized for hospital readmissions.
- Payment updates for certain post-acute care providers will be reduced and payments will be equalized for certain conditions commonly treated in IRFs and SNFs. This “site neutrality” would help to ensure that beneficiaries receive the appropriate care in the least costly setting.

**Beyond Post-Acute Care**

Medicare’s current fee-for-service payment system is not a platform for aligning incentives. Providers are paid for the volume of services delivered, with no additional payment for coordinating care or keeping beneficiaries well. Those organizations who take on these initiatives are doing so at their own risk until the payment structure is modified to provide compensation for effective population health management. But population health management happens long before an acute or post-acute care stay. Continuing care retirement communities (CCRCs) and other retirement housing settings represent a significant opportunity for impacting population health.

CCRCs in particular are uniquely positioned to operate in a risk-capable environment. They offer a continuum of care, from independent living, assisted living, skilled nursing and rehabilitation to long-term care. Many CCRCs also operate home health and home care services that extend beyond their campuses into the surrounding communities. CCRCs that offer residency contracts with a long-term care insurance benefit already are operating as risk-capable organizations, managing long-term care risk for their resident population.

CCRCs typically offer amenities designed to promote an engaged lifestyle: wellness and fitness facilities; cultural and spiritual opportunities; lifelong learning; activities, events and more. Most CCRCs offer clinical services including primary and specialty care and represent a significant opportunity for collaboration among hospitals, physicians and other healthcare providers. Studies have shown that residents of CCRCs experience fewer ED visits and fewer readmissions following a post-acute care stay.

Other retirement housing communities represent similar opportunities for physicians and hospitals to impact population health, especially among the dual-eligible population residing in the hundreds of thousands of affordable and HUD-subsidized senior housing units across the country.

>“Post-acute care is undergoing fundamental changes that will create challenges for providers, including campus-based CCRCs, and they need to understand these changes and begin to prepare now. They literally cannot afford to ‘wait and see’ what the changes will mean, by then it will be too late.”

Stephen J. Maag J.D. | Director, Residential Communities

LeadingAge
BEST PRACTICE
As the largest provider of elder care in the Boston metropolitan area, Hebrew Senior Life (HSL) is proactively taking steps to succeed in a risk-based environment. HSL evaluated its capacity to assume risk in multiple care delivery settings within the organization, including home health, skilled nursing and its long-term acute care hospital. Market analyses—along with an assessment of quality measures, technology infrastructure and operational efficiency—demonstrated opportunity to align with acute care providers in the geographic region as a preferred provider. HSL acquired a skilled nursing facility, expanding its geographic reach and increasing its partnership potential to acute care providers and payers. HSL’s skilled nursing facilities were recently approved as three-day stay waiver providers for three of the ACOs in which they are participating. Perhaps most notably, HSL operates primary care physician practices that serve the residents of its two CCRCs, three independent senior housing communities and long-term care facilities. Data analysis is currently underway to demonstrate outcomes among its resident population with regard to health status, utilization of services, emergency room visits, hospitalizations and readmissions compared to other Medicare beneficiaries in the Boston metropolitan area and nationwide.

Summary
As fee-for-service reimbursement is replaced by new payment models, expect tomorrow’s PAC to be redefined. Even the term “post-acute” may need to be reconsidered as these care settings are simply part of the healthcare network, less frequently predicated on an acute care hospitalization.

A bundled or capitated payment system enables the creative use of what we know of today as PAC services – existing Medicare-reimbursed services – combined with other supportive care such as assisted living, Program of All-Inclusive Care for the Elderly (PACE), adult day care and similar services to provide quality care while lowering costs.

Acute care providers should have a sense of urgency to assess and create formal alignments with the most effective PAC providers in their markets. Similarly, PAC providers should demonstrate a sense of urgency to position themselves as the partner of choice to acute care providers in their markets. The organizations that align and learn to deliver value – defined as measured quality at the lowest cost – are the organizations that will succeed in the future delivery of healthcare in a fully risk-capable environment.