Advisory Board | Post-Acute Care Collaborative

PAC 101: The Rationale for a Post-Acute Network

Understanding the health system incentives and market challenges driving collaboration with post-acute care providers

PART 1: *Why focus on post-acute care?*

RESEARCH REPORT

Why Focus on Post-Acute Care?

New (and old) financial incentives warrant a cross-continuum approach

Acute care health systems' interest in post-acute care partnerships has surged since the Affordable Care Act, and with good reason. Post-acute care (PAC) has always played a critical role in health care, providing the rehabilitation and long-term care services necessary to return patients to health. But the divide between hospitals and PAC providers, created by fee-for-service payment, has led to a system where post-acute providers hold vendor-like referral relationships with hospitals rather than relationships that maximize potential for care coordination.

Furthermore, acute care administrators have historically lacked significant financial rationale for stronger PAC relationships. Under fee-for-service, preventing readmissions requires administrators to cannibalize hospital volumes, and hiring care coordination staff adds to hospital overhead without generating additional revenue.

The Affordable Care Act has, however, increased the incentives for acute care systems to work closely with post-acute providers. Incentives to reduce hospital length of stay combined with an overall commitment to improve patient outcomes have generated basic alignment with post-acute providers. But readmission penalties, value-based purchasing, and risk-based payment models such as bundled payments and Accountable Care Organizations (ACOs) have raised the importance of post-acute alignment.

Notable financial incentives for hospitals to align with post-acute providers:

1. DRG[1]-based hospital payments
2. Readmission penalties
3. Mortality penalties
4. Federal meaningful use requirements
5. Patient satisfaction
6. Cost accountability programs

Incentive 1: DRG-based hospital payments

The DRG-based hospital payment system has long incentivized acute care providers to discharge patients as soon as possible, and partnerships with post-acute providers can help reduce unnecessary hospital days. Relationships with PAC providers affect the following length of stay drivers:

- **Discharge readiness:** If a post-acute providers are unwilling or unable to take patients when referred, hospital case managers require additional time to place the patient safely.
- **Discharge appropriateness:** If post-acute providers are clinically incapable of taking specific patients, the patient may require extra days in the hospital.

By partnering with post-acute providers who have the operational alignment (e.g., 24/7 referrals) and clinical capabilities (e.g., ventilator care units) to admit patients sooner, hospitals can limit length of stay in a clinically appropriate manner.

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Access our **Post-Acute Resources for Hospital Discharge Planners** for an overview on how discharge planners make PAC referrals safe, easy, and efficient. Available on advisory.com.

1) Diagnosis-related group.

Incentive 2: Readmission penalties

While preventing readmissions has always been an objective of high-quality care, Medicare and private insurers now cut reimbursement for hospitals with high risk-adjusted readmission rates. Information on hospital readmission penalties and Value-Based Purchasing metrics can be found on Advisory Board's Value-Based Purchasing Payment Map.

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Our **Value-Based Purchasing Payment Map** estimates the net revenue impact of all three pay-for-performance programs based on the final FY2017 adjustment factors and penalty flags from CMS. Available on advisory.com.

Post-acute providers affect readmission rates because care errors in PAC settings commonly result in hospitalizations. Miscommunication between hospitals and PAC providers, for example regarding medication lists, can cause also readmissions.

Incentive 3: Mortality penalties

The CMS Hospital Value-Based Purchasing program penalizes health systems with high hospital mortality rates. Partnerships with post-acute providers to help patients access hospice services in a timely manner can help hospitals limit their mortality rates.

Incentive 4: Federal meaningful use requirements

Health systems can receive Medicare payment bonuses and prevent Medicare reimbursement shortfalls by fulfilling government-established Meaningful Use criteria for their electronic health records. Select criteria require stronger partnerships with post-acute care. For example, to meet Stage 2 Meaningful Use, hospitals must send at least 10% of their summary-of-care transfer documents electronically to the next level of care. To achieve this, a hospital's post-acute care partner must be technologically equipped to receive summary-of-care transfer documents from the hospital's IT systems.

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Access our **Meaningful Use Audit Checklists** to stay up-to-date on changes to Meaningful Use and understand how to navigate these changes. Available on advisory.com.

Incentive 5: Patient satisfaction

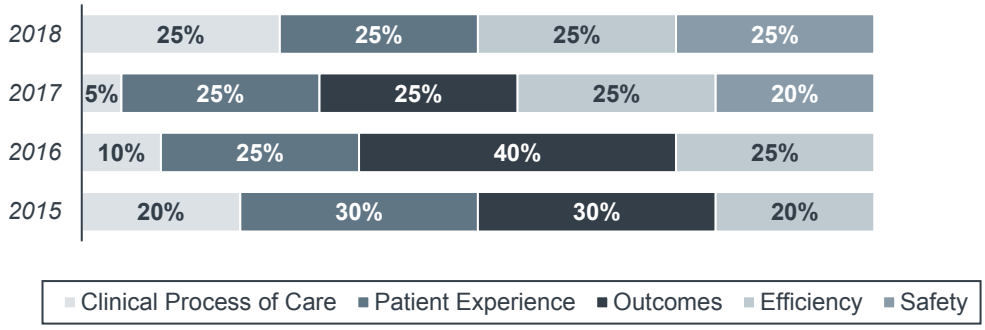
Many patients associate their follow-up care with their initial hospital stay when completing satisfaction surveys, and health systems commonly receive payment adjustments based on satisfaction ratings. Accordingly, hospitals must ensure patients have high satisfaction not just within the acute care hospital, but also when receiving post-acute services after discharge.

Note that the patient experience accounts for a fourth of a hospital's Value-Based Purchasing performance, with efficiency (cost) measures rising in importance with time.

6%

Of Medicare revenue is at risk from mandatory pay-for-performance programs, FY2017

Medicare Value-Based Purchasing Program Domain Weights[2]



Incentive 6: Cost accountability programs

Several Medicare and private payer-driven programs have given all hospitals a stake in post-acute costs.

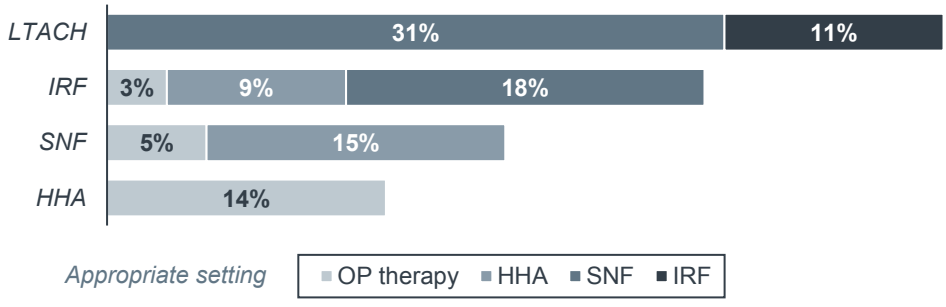
- **30-day efficiency penalties:** As part of the Hospital Value-Based Purchasing program, hospitals with high Medicare spending 30 days after discharge receive a reimbursement penalty.
- **Bundled payments:** Hospitals participating in private or public bundled payment demonstrations are at-risk for post-acute costs, often 90 days after hospital discharge.
- **Accountable care organizations and hospital-owned Medicare advantage plans:** Hospitals participating as accountable care organizations and hospitals with Medicare Advantage plans are at-risk for all post-acute spending for their beneficiaries or enrollees.

Post-acute care can affect health care costs in three primary ways:

- **Readmissions:** Post-acute providers create costs when failing to address preventable hospitalizations.
- **In-setting utilization:** Long post-acute stays in select settings or over-utilization of therapy can increase post-acute costs across an episode.
- **Post-acute setting placement:** Referring patients to higher-cost PAC settings (e.g., skilled nursing vs. home health) when not clinically appropriate can increase health care spending. The graph below showcases the national opportunity to place post-acute patients more appropriately.

Proportion of Medicare Patients Placed in an Avoidably High-Cost Setting

Study Findings by Post-Acute Setting[3,4]



2) "Mortality Rates Are Only One of Many VBP Changes to Come," The Advisory Board Company, advisory.com; CMS, "Request for Information on Specialty Practitioner Payment Model Opportunities," February 2014, www.innovation.coms.gov.
3) Study excludes diagnoses with fewer than 100 home health cases.
4) Dobson, DaVanzo and Associates, "Clinically Appropriate and Cost Effective Placement," www.healthreformgps.org/wp-content/uploads/cacep-report.pdf.

Hospitals need to address the cost drivers of PAC (readmissions, in-setting utilization, and post-acute setting) together. Focusing on a single factor won't work. For example, avoiding time in a LTACH to save at the SNF level may be valuable in some cases, but it may lead to readmissions or poor rehabilitative outcomes in others.

To see if there is an opportunity to inflect significant spending change through partnerships with post-acute care, examine a few primary variables:

- **High readmission rates by post-acute setting:** Readmissions signal an opportunity to partner for clinical quality improvements or decrease relationships with low-performing providers.
- **Low hospice and palliative care utilization:** Low hospice and palliative care utilization may signal an opportunity for closer alignment with hospice providers. When used appropriately, these services have been shown to reduce overall health care costs. High proportions of hospice patients with six-month stays or longer may indicate inappropriate hospice utilization.
- **High relative spending on post-acute care:** Experts note that in many markets, post-acute care has the greatest opportunity for cost-control initiatives given its national cost variability. For example, the Institute of Medicine found that between 2007 and 2009, 40% of all Medicare spending variation could be explained by variation in utilization of PAC services.[5]

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Access our **Post-Acute Pathways Explorer** to compare post-acute utilization and costs within a defined market, and compare utilization and cost profiles of individual providers within that market. This tool can examine risk-adjusted regional cost data by post-acute service type as well as regional statistics for hospice utilization. Available on advisory.com.

Conclusion

While incentives exist to promote the coordination and alignment between health systems and post-acute care providers, few organizations know how to most efficiently create these relationships. There are strategies not only on how to structure efficient post-acute relationships, but also on how to identify the best partners.

Read the next installment in our PAC 101 series**,** *How can you benefit from a post-acute network?,* and learn about the two main approaches for achieving results with a post-acute network.

5) J Blum, Testimony Before House Committee on Ways and Means, June 14, 2013, http://www.hhs.gov/asl/testify/2013/06/4481.html#ftn3.

Interested in more information?

For more information on the topic of post-acute care network development, explore the Advisory Board's Post-Acute Care Collaborative.

We provide best-practice research and market-level analytics to advance post-acute business performance and population health impact.

Sample resources providing further support on this topic include the following:

Understand your market:

- Post-Acute Pathways Explorer: View post-acute dynamics for a given market, including patient volumes, post-acute utilization, and outcomes data.
- Skilled Nursing Facility Performance Profiler: View individual SNF performance, including cost of care metrics by diagnosis and DRG.
- Home Health Performance Profiler: View individual home health agency performance and utilization data, including the ability filter by diagnosis or DRG.

Drive change in your market:

- Post-Acute Resources for Hospital Discharge Planners: Access sample forms and templates to improve transitions between hospitals and post-acute providers.
- Post-Acute Cheat Sheets for patients: Get our cheat sheets for educating patients on the transition to post-acute care and detailed information on each type of post-acute care provider including SNFs, LTACHS, IRFs and more.
- Post-Acute Consortium Toolkit: Learn how to build and operate a successful consortium, and get sample resources and templates that you can use to develop and improve your own.

Visit the Post-Acute Care Collaborative's webpage at **advisory.com/pacc.**
Or contact **programinquiries@advisory.com** for more information.