Higher Growth and Lower Reimbursement for Post-Acute-Care Providers

Turning Challenge into Opportunity with Health IT

Post–acute care (PAC) is the fastest-growing segment of healthcare in the United States, with home health services and durable medical equipment leading the way. Despite growing demand, post-acute-care providers face an uncertain future. A recent Black Book survey revealed that all segments of the post-acute-care continuum—including inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), long-term-care hospitals (LTCHs), home health agencies (HHAs), and durable medical equipment (DME) suppliers—face major challenges because of declining reimbursements and a shift to value-based payments. More and more pressure from payers, health systems, and accountable care organizations (ACOs) to improve quality—particularly by reducing preventable readmissions and emergency room visits—while simultaneously reducing costs is causing those seismic changes.

Proactive PAC providers are making changes that will fundamentally alter how they deliver care. All aspects of the PAC-provider business are affected. Significant investments in information technology (IT) that will facilitate more-active coordination of care and data-driven care decisions are required—and at the same time that the PAC organization must reduce the cost of care to remain competitive. The aim of this paper is to help executives of PAC-provider companies, ACOs, payers, and investors understand the role that IT plays in strategies for responding to post–acute care’s changing landscape.

Major Change Is under Way

That a healthcare payment system based on volume is unsustainable is the general consensus of leaders in the payer and provider communities. The CEO of a large insurer reflects the general sentiment by saying, “We really need to look at how healthcare is delivered and how we pay for it. Today, we pay for each piece of work done, and so we get a lot of pieces of work done.” The Centers for Medicare & Medicaid (CMS) and commercial payers are on the offensive to reduce the cost of post–acute care by ratcheting down reimbursement rates, aggressively auditing claims, and implementing value-based payment models. Three significant trends have placed PAC in the crosshairs of payment reform:

- **Growth in spending**: Medicare spending for post-acute-care services more than doubled during the decade from 2001 to 2011, making it the fastest-growing sector of healthcare. The most recent major payment reform—prospective-payment systems for PAC—has not had an impact on controlling spending. A growing chorus of policy makers and government officials are calling for more-aggressive payment reforms to reduce what is viewed as an unsustainable growth trajectory.

- **Spending variations**: PAC is the healthcare sector with the greatest geographic variation of fees across the country. Forty percent of the variation in Medicare spending is attributed to PAC service reimbursements. Wide variances signal the
possibilities of (1) duplication of services and (2) waste as well as a need for stricter compliance with care guidelines.

- **Changing demographics:** As the US population ages, demand for PAC services will increase. The number of people 65 years or older will double to 81 million and constitute one-fifth of the population by 2040; 17% of that segment will be at least 85 years old.\(^7\) Within the next 10 years, more than half of the total US population will have at least one chronic medical condition. And those trends will lead to added pressure on PAC providers to provide efficient, high-quality care, because the cost of the US healthcare system will continue to grow.

As payers cope with the financial impacts of these trends, downward pressure on reimbursement rates for all types of PAC providers will persist, joined by renewed efforts to shift PAC away from volume-based payment. Recent changes to case mix and market basket indexes causing lower base rates for payments to SNFs, IRFs, and HHAs are harbingers of adjustments to come. For instance, CMS recently rolled out two dozen payment reforms that affect PAC providers.\(^8\) Proposed federal budgets and CMS rules call for rate increases through 2023 for many PAC providers to be tamped down with annual reductions in base rates.\(^9\) In addition, CMS is targeting 2018 as the year when 50% or more of payments to PAC providers will be in the form of bundled payments.\(^9\) Financial models used by PAC providers for business planning will look drastically different by 2019.

Bundled payments represent one of several payment reforms that will have major, long-term impact because the 2010 Patient Protection and Affordable Care Act (ACA) includes levers whereby CMS can broaden the reforms’ scopes. Five ACA-related programs in particular will redefine the PAC provider landscape, especially as commercial payers adopt reforms that produce significant savings.

- **Medicare Shared Savings Program (MSSP).** These ACA provisions are among the best known because they call for the creation of ACOs, quality performance standards, and shared-savings/risk contracts. Effective management of post–acute care is a crucial factor in an ACO’s ability to achieve the goals of the MSSP or commercial payers’ ACO contracts. In fact, many health system and physician organization sponsors of ACOs are working to integrate PAC providers into the ACO’s preferred network.\(^10\)

- **Bundled payments.** The bundled-payment model is gaining traction because it aligns the incentives of payers and providers across all treatment settings for an episode of care.\(^11\) CMS’s Bundled Payments for Care Improvement (BPCI) initiative is a major reason behind the growing momentum of this payment approach. CMS recently announced that 232 provider organizations consisting of acute-care hospitals, SNFs, physician group practices, LTCHs, and HHAs had entered into BPCI agreements. Two of the four bundled-payment models include postdischarge services, making this the only large-scale bundling project involving PAC services to date.\(^12\) Model 2 requires discounts from historical prices—a practice that if widely adopted as payers roll out bundled payment arrangements will be another pressure point for PAC providers.

- **Value-based purchasing.** The ACA requires the creation of a Medicare value-based purchasing implementation plan for SNFs and HHAs. For SNFs, this new pay-for-performance program will require the reporting, collection, and validation of quality data. Eventually, it will determine the structure of value-based payment adjustments, including the determination of quality measure thresholds that would substantiate payment adjustments and the sizes of such payments.\(^13\) It also will provide financial incentives for facilities that reduce avoidable hospitalizations and achieve certain quality targets or specified improvements. The value-based purchasing program for HHAs has similar requirements.

- **Expanded DME competitive bidding pilot.** The ACA expands the previously existing DME competitive bidding pilot project from 70 to 91 metropolitan statistical areas across the country; around 800 suppliers will participate in round 2.\(^14\) This expanded scope suggests that all areas of the country will experience the effects of lower rates resulting from competitive bidding in so many metropolitan statistical areas. Furthermore, DME suppliers without significant market share will likely find themselves excluded from the program.\(^15\)

Mandates stipulated in the ACA that are intended to strengthen safeguards for prevention of inappropriate care coupled with more-aggressive Recovery Audit Program contractors’ practices have spotlighted claim payment denials and appeals. The adverse impact on revenues and administrative costs is seen in the dramatic increase in the number of Medicare claim appeals by PAC providers; HHA appeals increased by 700% from 2008.
to 2012, with 95% of appeals denied in 2012. Medicare claim appeals by SNFs and DME suppliers have also surged; most of them are denied.\textsuperscript{16} Such unfavorable trends suggest that many PAC providers are plagued with process breakdowns that result in inaccurate or incomplete documentation to support assessments, treatment authorizations, transfers of care, and medical coding.

On top of CMS’s drive to reduce rates and shift PAC providers to new payment models is the movement of traditional Medicare and Medicaid beneficiaries to managed care plans operated by commercial payers. Medicare Advantage and other forms of managed care plans, which typically reimburse at rates 10 to 40% less than traditional Medicare rates, constitute a rapidly growing portion of the payer mix for PAC companies across the country.\textsuperscript{17} To survive in this environment, PAC providers need to position themselves as other than the lowest-cost solution by demonstrating better-quality outcomes compared with the competition.

**Outlook for Post–Acute Care: Risk and Opportunity**

Without fundamental changes to the organization’s structure and the ways services are delivered, many PAC providers will find themselves in a downward spiral: facing (1) lower fees, (2) diminished quality of their products and services, and (3) shrinking market share. Competitive bidding, participation in bundled-payment programs, and shared-savings contracts are particularly fraught with risk.

Inherent in the design of bundled payments is the potential for a bundled-payment entity to cut corners on medically necessary post-acute-care services so as to achieve cost targets. PAC companies bidding for managed care contracts and DME vendors participating in the Medicare competitive-bidding process might submit artificially low bids to preserve business and then might subsequently reduce product quality or even exit markets to stanch financial losses. Undesirable consequences of those tactics include (1) patients who seek avoidable acute-care services such as emergency room visits and readmissions, (2) an uptick in quality and safety issues, and (3) PAC providers of all types exiting markets, thereby reducing options for payers, physicians, and patients.

The effects of the declining quality of PAC as providers grapple with the changing payment landscape may ripple far beyond this sector, which would increase costs for health systems and payers. PAC providers are essential to hospitals’ efforts to reduce the rate of preventable readmissions because the quality of follow-up care is a major factor in preventable readmissions.\textsuperscript{25} PAC companies must have the resources to invest in the necessary infrastructure for support of the integration of clinical pathways with hospitals and other PAC providers. Otherwise, industry efforts to significantly reduce avoidable emergency room and hospital readmissions will fail.

As health systems and physician organizations assume risk through ACO or bundled-payment arrangements, providers that can coordinate care across all post-acute-care settings will be the preferred PAC partners.\textsuperscript{18} A PAC company offering a comprehensive solution—through either an integrated portfolio of services or collaboration with other PAC providers—delivers distinct value to ACOs and other integrated delivery system models in three ways: (1) as the navigator—by placing a patient in the most clinically appropriate and cost-effective post-acute-care setting; (2) as the manager—by assuming responsibility for coordinating care among multiple PAC providers and managing care transitions between acute and post-acute-care settings; and (3) as the one-stop PAC provider—by being accountable for patient outcomes regardless of the PAC setting and services delivered. For many PAC providers, these are new functions requiring substantial change to all aspects of the organization.

Nowhere is the necessary change more evident than in the information infrastructure of the PAC organization. The future of PAC management is based on a data-driven-care model. Quality is managed to specific quantitative measures; gaps, overlaps, and unnecessary care are proactively avoided by means of systems that monitor adherence to care guidelines. Successful partnerships between acute-care and post-acute-care providers require alignment of performance-based systems and demonstration of the improvement in quality that results from such alignment.\textsuperscript{19} Variances in delivery of the most-appropriate, lowest-cost service are identified and quickly remedied. A robust health information infrastructure is the underpinning to the new data-driven PAC organization.

**Electronic Health Records, Health Information Exchange, and Data Analytics: Three Pillars of Successful Transformation**

To succeed in today’s increasingly challenging market environment, companies offering PAC services must become more wired for digital healthcare than ever before. But levels of adoption of electronic health record (EHR) technology among PAC providers remain low; relatively few PAC providers are connected to health information exchanges (HIEs).\textsuperscript{20} More than one-half of PAC providers that participated in the previously cited Black Book survey indicated that their health IT structure is either poor or nonexistent (n = 410).\textsuperscript{3}
Despite financial margin pressures, PAC providers need to make significant investments in health IT as part of a broader strategy to improve productivity, reduce costs, and demonstrate continuous improvement in quality metrics. Innovations in PAC are emerging that use health IT to enable four crucial functions of PAC providers that are poised to work in an integrated delivery, risk-based model: care transitions, coordination of care, proactive care management, and performance reporting. Figure 1 shows how three pillars—EHRs, HIEs, and data analytics—support those important functions.

Care transitions
The decision-making process during the management of a patient’s transition from one care setting to another is undergoing change that will have a dramatic impact on referrals to post-acute-care providers. The choice of a PAC provider by health systems and payers is becoming more selective and driven by a systematic review of appropriateness of the care setting, the PAC provider’s performance on key quality-oriented performance indicators, and information-sharing and communication capabilities.

Using powerful analytics software and historical data warehouses, payers and ACOs are directing patients to PAC providers scoring high on an effectiveness index that is based on patients’ satisfaction, health status, rehospitalizations, mortality, and so on.21,22 To be a preferred provider in this environment, PAC providers must efficiently collect, analyze, and report performance data to ensure that these analytics programs that drive navigation are using accurate and complete data. Possessing these data analytics capabilities so as to become established as the primary navigator when a patient is discharged from a hospital is an even more powerful strategy.

Seamless and efficient coordination of care
Demonstrating the effectiveness to be a preferred PAC provider is only the beginning. With hospitals and physicians being held to increasingly rigorous standards for meaningful use of EHR technology as a determinant of reimbursement rates, those hospitals and physicians will be less tolerant of paper- or fax-based modalities for processing referrals, issuing authorizations, and sharing clinical documentation. PAC providers will be expected to have HIE capabilities and to adhere to standardized formats for sharing the key components of a patient’s health record, including assessments, care plans, medications, and change-in-condition notifications.20 Automating these processes and improving the flow of information between all of the PAC provider’s partners and patients also produce cost savings for the organization by improving productivity, reducing administrative overhead, and detecting redundant care before it gets provided.

Proactive care management
To improve patient outcomes and control costs, all members of the care team need real-time access to a dashboard and shared-care plans showing a patient’s health status and summary of care at each post-acute-care setting. For example, clinicians at Brooks Rehabilitation use the Care Compass application, which enables them to track a patient’s vital signs, key clinical indicators, and functional status through the complete episode of care.11 For ambulatory patients, an accurate picture of health requires connectivity to telemonitoring devices for submission of biometrics. Using
intelligent analytics, the dashboard can highlight changes in vital signs and other key measures of health status that indicate potential risks and need for care intervention. Readmission rates have dropped substantially for a heart failure population since a certain health system’s home health service connected patients in the home with a telehealth application.

The detection of potential problems by analyzing biometric data is just one example of how data analytics plays an important role in proactively managing a patient’s care. Algorithms that predict future care needs by analyzing the past care patterns of individual patients and comparable cohorts can stratify patients’ risk of needing more-intensive interventions. A patient’s care team can monitor the patient’s risk level and intervene before the patient’s condition deteriorates enough to require acute care.

Clinicians can also be alerted when lower-risk patients show adherence problems or missed activities in their care plans. Such notifications help clinicians be more productive and deliver higher-quality care. Instead of reacting to a problem reported by the patient or caregivers, the nurse or physician receives a message about a potential problem along with recommended actions that can usually be initiated at the same time the message is read.

Even delivery of basic supplies and treatments (e.g., home health intravenous therapy) now requires proactive care management. For example, rules-based authorization applications ensure that Medicare DME requirements get met (e.g., medical necessity, patient request for refill) before the equipment gets ordered. The traditionally cumbersome and complex process of requesting prior authorization for specialty medications is replaced with an electronic data interchange that links the ordering physician, pharmacy benefit manager, pharmacist, and patient in order to streamline the request, the submission of the clinical documentation required, the authorization, and the dispensing of the medication. Such automation of authorization processes improves the quality of care and patient satisfaction while reducing administrative costs for the PAC provider.

Performance reporting

The era of value-based reimbursement calls for a new set of key performance indicators to complement traditional financial measures of a post-acute-care company’s health. One useful framework for this purpose is the Institute for Healthcare Improvement Triple Aim: improve the health of the defined population, enhance the patient care experience (including quality of care and satisfaction), and reduce, or at least control, the cost of care. Because of its broad recognition, the Triple Aim serves as an effective construct for measures to monitor performance. For maximum impact, these key performance indicators are continuously monitored and presented in the form of online dashboards at each level of the organization (e.g., clinician, care team, line of service, company). And staff accountable for performance can make adjustments on a continuous basis in response to unfavorable trends and variances.

Systems that monitor and report quality and patient satisfaction measures are also required to effectively participate in ACO, bundled-payment, and other kinds of value-based contracts. Most such agreements include a quality-reporting requirement, and many are designed to adjust reimbursement based on performance against quality and patient satisfaction metrics. Those measures and related data sets must be standardized across care settings to accommodate comparisons of the effectiveness of care in different settings and to align with the integrated model of care that payers and provider partners will increasingly demand.

Winning Strategies Start with Health IT

The post-acute-care market is on the verge of major and disruptive change. A convergence of increasing demand, pressures on reimbursement, and the move to value-based payment models is creating an environment of high uncertainty and risk. PAC-company leaders who recognize the crucial role of health information technology in strategies designed to respond to those environmental forces will be in a position to succeed. However, that recognition is only the essential first step. To develop strategic and operational plans that will realistically produce tangible results in the near term and strengthen an organization and its position in the market for the long term, the following questions need answers.

- Do we have health IT capital budget and acquisition processes in place? Is our organization accustomed to identifying IT investments that could strengthen non-IT strategic priorities?
- Do we have an EHR system in place that supports interoperability with other providers’ EHRs via health information exchange?
- Are we taking advantage of the HIE connectivity that is available in the communities we serve?
- Do we know who our highest-risk patients are at any given moment? Do we know the likelihood of high-risk patients needing acute services in the future? Are interventions planned or in progress to mitigate that risk?
Are tools available for our managers to accurately determine the cost of care for achieving quality targets for specific types of episodes or conditions?

What steps in our clinicians’ daily processes can be streamlined through better automation and better delivery of the high-quality information those clinicians need for making decisions about their patients’ care?

Are we applying the claims and clinical data that we have in order to deliver the highest-quality services at the lowest cost?

Do we have an evidence-based understanding of the root causes of the most-common claim denials and unfavorable appeals?

Answers to those questions and additional ones that surface during an in-depth assessment of health IT requirements, current capabilities, and gaps needing to be filled will provide a PAC organization with a map of the IT investments needed to not only survive but also thrive in the future. Progressive PAC organizations and their partners are already on the move to create opportunities in this difficult environment. Now is the time to develop and execute a well-informed IT strategy with multiple horizons. Revenue improvement and cost savings realized in the near term can help fund additional IT investments longer term to establish a company as a preferred PAC provider in the new era of value-based care.

The opinions expressed are those of the authors and do not necessarily reflect the views of AlixPartners, LLP, its affiliates, or any of its or their respective other professionals or clients.

5. A. Chandra et al. (2013 May). Large increases in spending on postacute care in Medicare point to the potential for cost savings in these settings. Health Affairs 32(5), 864-872.
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