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Going vertical
Opportunities for hospitals to embrace post-acute care

What's at stake?

Hospitals should assess new service lines to remain viable

The transformation of the U.S. health care system is causing hospitals to reexamine their place in the market and investigate new service lines for potential growth opportunities.

As acute hospitals look ahead to the next wave of alignment, one potential option deserves special attention: post-acute care.

Hospital margins have been declining in the past several years and are expected to tighten further.[1] Driven by the 2010 Affordable Care Act's (ACA) initiatives, other government spending cuts, and shifts in care models:

- Hospitals are expected to face more than $300 billion in Medicare spending cuts through 2019.[2]
- Revenue growth for hospitals is "well below" historical levels being driven primarily by growth of outpatient services.[3]

Value-based care models, such as Accountable Care Organizations driven by the ACA, require new relationships between hospitals, physicians, and payers, as well as the supporting infrastructure that can facilitate achieving bonus payments. ACA-mandated financial penalties and incentives are likely to continue to drive alignment efforts among providers and payers.

- Medicare has levied fines against 2,225 acute hospitals for avoidable readmissions in FY 2013.[4]
- Eighteen hospitals will lose 2% of their base Medicare reimbursement, with 154 losing 1% or more. The average fine is 0.4% of total Medicare reimbursement over the year.[5]

Faced with declining income and narrower revenue streams, greater pressure for coordinated care, and payment systems that shift risk to the hospital, hospitals may need a new strategy to survive. Involvement with post-acute care should be considered in order to remain viable in the new landscape.

Post-acute care providers—including long-term acute care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health agencies—accounted for $62 billion of Medicare spend in 2012, and have grown steadily in recent years.[6]

Our take

Post-acute care may offer growth opportunities

Hospitals may seek to undertake multiple service line strategies to successfully navigate health care transformation, depending upon local market, competitor, and internal environments. The impending value-based payment models will focus on the patient's entire care, not just episodic care, and therefore force hospitals to consider an entire continuum approach, which may include post-acute service lines. Alignment between acute hospitals and post-acute care providers may help meet multiple goals:

- *Financial survival.* Post-acute service lines may help strengthen a hospital's financial performance, given its growing market demand and historically attractive margins (see Figure 1).

- *Growth and value-based care.* Post-acute service lines may position hospitals for future bundled payments, readmissions prevention, and value-based care imperatives.

Financial benefit of post-acute service lines

Post-acute services have the potential to benefit an acute hospital's margins. Hospitals with struggling performance (financial or operational) or who seek portfolio diversification should consider post-acute alignment. Financial pressures are growing for hospitals as well as the immediate requirement by the ACA for improved quality and outcomes, and post-acute services can be important components for such initiatives.

The volume opportunity

40% of Medicare acute care patients were discharged to a post-acute care setting in 2011.[7] This is a significant portion of a hospital's population that requires continued services, and having a diverse portfolio of service lines that includes post-acute would enable a hospital to capitalize on the captive volume. Conversely, the post-acute population can be fragile, and may often need acute services not located at post-acute facilities, such as diagnostic testing.

Market demand is growing

As the U.S. population ages, and illness and injuries that require post-acute care grow, the market demand for post-acute will increase substantially. Post-acute care targets an elderly population, and this population is growing dramatically. The population 65 and over increased 15%, to 40.2 million, between 2000 and 2010. By 2020, this population is projected to rise to 54.8 million, nearly 41% of which will be 75 and older.[8]

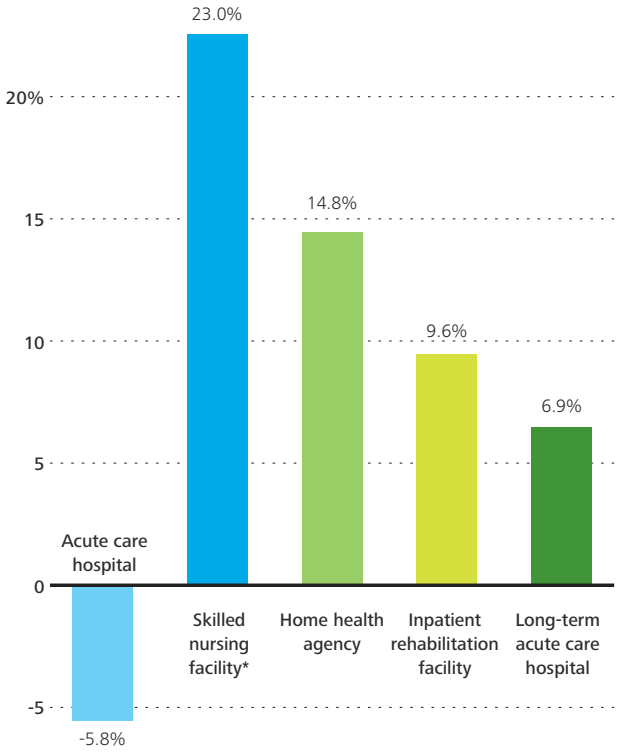
Attractive financial performance may bolster bottom lines

Acute hospitals often struggle financially with Medicare (Figure 1). Post-acute providers, in general, have stronger Medicare margins than acute hospitals (Figure 1) due to factors such as lower cost structures, lower nurse to patient ratios, and less capital intensive equipment and services. Even when potential Medicare cuts are considered, gains from post-acute service lines could still bolster a hospital's bottom line.

Post-acute integration may ease length of stay (LOS) issues

A common LOS issue for acute hospitals is to have inpatients waiting on a discharge location. Such alignment may lead to lower LOS for acute care inpatients awaiting transition to post-acute, which in turn may lead to quicker bed turnover and better health outcomes as patients receive the most appropriate care in the most appropriate setting.

Figure 1
Average Medicare margins (2011)[9]



* Margins for only Skilled Nursing Facilities and service lines, not long-term care service lines that may be located in the same building. Source: *Medpac*. Health Care Spending and the Medicare Program. June 2013.

Minimizing health system leakage

Despite demand for post-acute service lines, "few (health systems) have the full range of post-acute care resources."[10] Acute hospitals without post-acute in their system see patients discharged to independent post-acute providers or post-acute providers in competitor health systems. Medicare patients frequently leave a health system for continued care.

- Only approximately 45% of hospitals have a post-acute facility within their local system.[11]
- 50% of hospitals refer patients to 18 or more post-acute providers.[12]

Positioning for value-based care

Future value-based care models and reimbursement methods focus on quality and cost of the entire patient/illness and subsequent care, not just an episode. This may overlap directly into a patient's post-acute care, and drive acute hospitals to consider better alignment with post-acute providers. Value-based payment models will focus on the entire arc of patient care, not just episodic care, and therefore may force hospitals to consider an entire continuum approach, which includes post-acute.

Acute hospitals may become "payers" to post-acute providers due to bundled payments

Current bundled payment efforts group payment for the acute care episode and 30-days post-discharge. Most post-acute care occurs during that 30-day period post-discharge, so acute care hospitals will "own" the payment for a post-acute provider. While some hospitals may already have health plans as part of their system, more acute hospitals may find themselves in the position of "payer" for post-acute providers' services.

Bundling acute and post-acute care payments is expected to "encourage care coordination between providers, encourage more efficient resource use across an episode of care."[13] Lack of full control over another provider's cost and quality could result in tough decisions by acute hospitals. Acute hospitals should consider determining how they will:

- Financially distribute a portion of the bundled payment for post-acute services.
- Clinically coordinate with post-acute providers on intended quality and cost savings outcomes from bundled payments.

Tighter coordination with post-acute care providers may reduce readmissions

Nearly 20% of Medicare patients are re-admitted to an acute-care hospital within 30 days of discharge.[14] Coordination of care, and especially coordinating the transfer of patient information along with the patient, may help reduce "fragmentation" of care that happens when patients are transferred between providers and care settings. Having access to patient information that is accurate and timely as patients move between acute and post-acute care may increase overall quality of care. It may also reduce future readmissions as well as overall cost.[15] Coordination of acute and post-acute care is seen as a leading cause of readmissions, and majority of recently polled health care executives agree that having a post-acute strategy is indispensable.[16] When providers share information, re-hospitalization rates have been shown to drop, but only when relationships are in place and providers work together.[17]

Figure 2
Post-acute settings of care

Post-acute care setting/CMS certification	Average length of stay[18]	Medicare payer mix	Typical patient
Long-term acute care hospital (LTACH)	26.7 days	66%[20]	Respiratory care, pulmonary care[24]
Home health agency (HHA)	36 visits[19]	41%[21]	Chronic, medically unstable
Inpatient rehabilitation facility (IRF)	13.3 days	60%[22]	Stroke, major joint replacement, hip fracture, neurological diagnosis[25]
Skilled nursing facility (SNF)	27.0 days	52%[23]	Orthopedic injury

The path forward

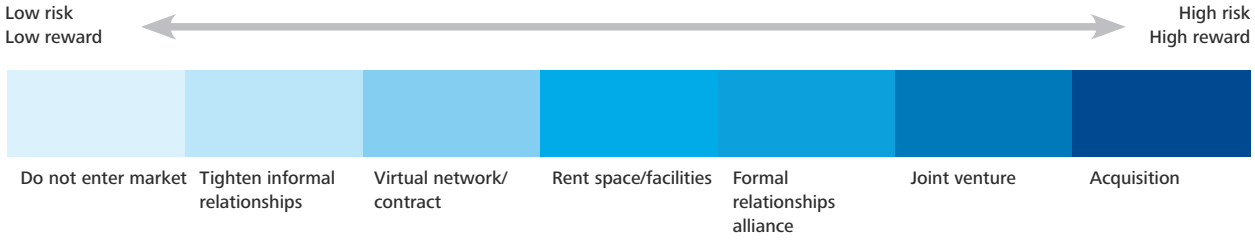
Assess your post-acute approach

At a minimum, acute hospitals may want to shore up their current post-acute provider relationships or declare that they are not entering the post-acute business. On the other end of the spectrum, acute hospitals may want to add post-acute service lines, which have important challenges and considerations.

Framework to assess post-acute approach
To best assess their own needs and their post-acute opportunities, acute hospitals should consider employing a framework that takes the most relevant issues into account, including:

- Financially implications (cost and benefit).
- Organizational structure/integration complexity.
- Strategy/market position, competitive/partner environment.
- Quality, outcomes, and expense decision-making.
- Regulatory implications.

Figure 3
Potential post-acute strategies



The new alignment paradigm

When considering alignment between acute hospitals and post-acute care, it is important to recognize the differences between today's health care environment and the past. Post-acute care profitability and growth rose dramatically in the 1980s and 1990s, thanks largely to cost-based reimbursement. Between 1990 and 1996, home health payments alone grew from $3.9 billion to $18.3 billion.[26] This period ended abruptly following passage of the Balanced Budget Act of 1997 and subsequent post-acute payment reform. In one survey, for-profit nursing home systems saw an average $97 million drop in revenue between 1997 and 1998, to a loss of $64 million. The systems cited the switch to a prospective payment system for the downturn.[27]

The post-acute care market has stabilized since that time. Growth in both the number of post-acute providers and their margins has been steady in recent years.[28] As the industry grows, aspects of the business become more complex. The increasing popularity of Medicare Advantage and other managed care plans have post-acute providers finding themselves in the same position with payers that hospitals did in the 1990s.[29] This position is new for post-acute providers, who have traditionally billed Medicare for the bulk of their services, and some are finding the transition difficult. Acute care hospitals with more experience negotiating and coordinating billing with multiple plans may be able to assist post-acute providers in this area as part of their partnership agreements.

In today's environment, hospital alignment with post-acute providers should balance factors beyond the potential for volume and revenue growth. Any alignment strategy should consider the different operational, economic, and financial realities of hospitals and post-acute care.

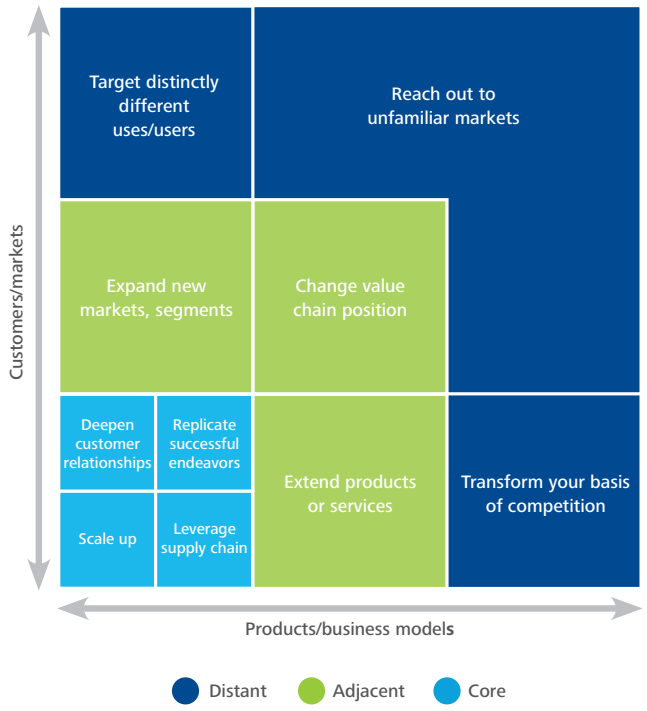
Follow a growth framework

Organizations across industries use a customer vs. product growth framework, derived from Igor Ansoff's "Product-Mission Matrix," to help determine growth strategies (Figure 4). To navigate current transformation of the U.S. health care system, hospitals may seek a mix of growth strategies in each of the Core, Adjacent, and Distant zones for overall organizational strategy as well as a specific service line (including post-acute) to help diversify risk, leverage competencies, and capitalize on market opportunities. Hospitals with the following characteristics may want to consider expanding into an "adjacent" quadrant, where post-acute care opportunities may lie, including:

- System size (sufficiently large enough patient volume, procedural mix, across multiple sites).
- Competition (fragmented local market).
- Leakage (significant portion of referrals/discharges to providers without a formal relationship).

Additionally, hospitals may want to consider which specific components of the post-acute care settings (see sidebar) are of most benefit to their system. Opportunities and challenges differ across the post-acute settings, but many do have links to each other.

Figure 4
Growth framework



Acute hospital and post-acute relationship examples

Joint venture

Hospitals can offer an entire post-acute continuum while sharing financial risk and the benefit of expert post-acute partners to oversee quality, costs, operations, and regulations through partnerships.

- Penn State Hershey Rehabilitation Hospital is a joint venture between the Penn State Milton S. Hershey Medical Center and Select Medical, a post-acute chain. In 2013, the facility expanded from 54 to 98 IRF beds. While Select manages the IRF, the IRF creates a full continuum of care on the medical center's campus.[30]
- Dignity Health expanded its home health services to San Bernardino, California in partnership with Kindred Health. Community Home Health (60% owned by Kindred, 40% owned by Dignity), has the goal to expand services for Dignity in a broader geographic region.[31]

Rental of space

Acute hospitals can have access to post-acute service lines with shared financial and regulatory risk by renting out space within their hospitals.

- Trinitas Regional Medical Center leased space to CareOne for a 25-bed LTACH. The LTACH is a separate entity from the acute hospital, but it is located within the hospital and uses the hospital's ancillary services.[32]
- Methodist Charlton Medical Center leased space to Select Medical for a 69-bed LTACH. While owned by Select Medical, the LTACH is located within the Methodist Charlton Medical Center. Select Medical operates 77 such LTACHs in hospital rented space.[33]

The bottom line

Margins are shrinking, and hospitals are required to do more with less. At the same time, advances in technology, including electronic medical records and health information exchanges, allow levels of coordination and collaboration that were not possible twenty and thirty years ago.

Acute hospitals can take steps to help ensure their survival and growth by beginning to plan their larger organizational strategy with post-acute care. With a full spectrum of possibilities to work with, hospitals should consider defining their strategies soon—whether, shoring up current post-acute relationships, establishing new formal relationships, or acquiring a post-acute provider. The next alignment wave is starting, and acute hospitals do not want to be left out of the game.

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