OPTIMIZING POST-ACUTE CARE STRATEGY FOR YOUR MEDICARE BID
Submitting a bid for Medicare Advantage in a way that is competitive and actuarially responsible is as much an art as a science. Product management leaders and their financial teams must balance cost savings not only with regulatory and compliance considerations, but also patient satisfaction, member choice, and clinical outcomes.
Medicare Advantage (MA) plans have long focused on reducing unit costs and negotiating rates in areas that drive a substantial portion of expenses (e.g., inpatient stays, emergency department use). Strangely, Post-Acute Care (PAC), which accounts for one out of every four dollars spent by Medicare Advantage plans, remains significantly under-managed. This translates into millions of dollars of missed savings opportunities for the average plan – as it is estimated that 20 to 25 percent of PAC costs can be eliminated with better management. As such, an integrated PAC strategy may be the best path for Medicare Advantage plans that are looking for better ways to manage plan trend and spend.

Industry definitions of Post-Acute Care vary wildly, a fact that often muddies where true savings opportunities lie. At its broadest, Post-Acute Care is defined as care that a patient needs after (or in some cases, instead of) a hospital stay. PAC may be comprised of care in other inpatient settings (e.g., Skilled Nursing Facilities, Inpatient Rehabilitation Facilities), outpatient therapy at a facility (e.g., Comprehensive Outpatient Rehabilitation Facilities), or delivered at home (e.g., home health care, nursing visits, Durable Medical Equipment).

Integrated Post-Acute Care strategies allow plans to deliver on a true value-based approach: in addition to cutting costs, integrated Post-Acute Care can also improve care transitions, reduce gaps in care, and improve patient engagement and outcomes. Solid management of PAC allows MA plans to deliver coordinated, efficient and cost-conscious care for the duration of a 90-day episode by managing patients across the healthcare continuum. As more MA plans turn their financial focus to risk arrangements and pay-for-performance, the ability to deliver on value-based initiatives takes on increased importance; doing so in a way that also improves the patient experience allows plans to reinforce patient satisfaction and member retention efforts.
Medicare Advantage plans seek new sources for savings

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An integrated approach to Post-Acute Care is particularly impactful for MA plans because it addresses:

• **Under-management and waste** – 20 to 25 percent of current post-acute spend is waste that could be eliminated with better management,\(^2\) including evaluating the performance of higher-cost settings such as Skilled Nursing Facilities (SNFs).

• **Fragmented care** – Each patient has unique needs, but few plans address the entire episode of care post-hospitalization, leading to an entirely fragmented approach. Conversely, a truly integrated strategy goes beyond the transactional care needs of an individual patient and the misaligned incentives that often dominate the PAC supply chain to develop consistent care that transforms the post-acute journey, leading to better outcomes and lower total cost.

• **Insufficient home care** – Despite best efforts to safely discharge patients home, underutilization of home care is a significant problem. The problem isn’t the home; it’s the level of support – an issue underscored by the fact that 50 to 60 percent of readmission costs are driven by patients sent home without any post-acute orders,\(^3\) directly leading to adverse events and readmissions.

Post-Acute Care – From fragmentation to integration

Every post-acute journey is defined by transitions – from hospital to a skilled nursing facility (SNF), or to inpatient rehab (IRF), long term care (LTC), home health, or straight to home. In fact, there are 46 different documented paths a patient may take on their journey home from the hospital.\(^4\)

Importantly, each patient’s journey is unique. The transitional needs of a healthy patient with a hip replacement are different than for a hip patient who also has diabetes; the patient with a spouse at home who can help with rehabilitation may need different support than one who’s closest caregiver lives in the next state. One is a candidate for home health and the other, because of risk of infection, may not be.
Most post-acute transitions are not guided by standardized protocols that holistically assess the patient’s needs. Some hospital discharge planners make discharge decisions based on incomplete or inaccurate estimations of readmission risk or patient needs, and may overestimate risk and discharge a patient to a SNF who could have gone home, or send a patient home without services who is at high risk of readmission.

The problem with the “next-setting-of-care” post-acute approach is that it is inefficient, wasteful, and not patient-focused. In contrast, an integrated, patient-focused approach offers opportunities for post-acute savings.

**Where are post-acute cost savings likely to be found?**

**1. Network management — across the full continuum of providers**

It’s been long known that Medicare per capita costs are greater in the South, Midwest and mid-Atlantic than in Northern and Western states. Post-acute expenses drive much of this variation, which often are the result of regional differences in utilization – more people using post-acute services, or for longer periods, or being directed into inappropriate or ineffective facilities within the network.

MA Plans in areas with higher costs for and utilization of post-acute services may want to examine their network strategies to optimize the approach to Post-Acute Care. In some cases, plans may want to consider implementing a preferred network, based on cost/quality evaluations. In others, a broad network may be preferable, but optimization is possible through streamlined coordination and transitions between care providers (e.g., hospital to SNF, SNF to home health), and by aligning financial incentives across network providers.

CareCentrix estimates that an optimized network strategy may result in 4 to 5 percent savings, depending on the strategies implemented.

**2. Appropriate setting for care**

Perhaps it’s obvious: More intensive care is more expensive than less intensive care. The average cost to heal from a hip procedure in a Long-Term Acute Care Hospital is over eight times more than healing with home health support. (See table below, from the Medicare Payment Advisory Commission, which demonstrates how the choice of site of care influences post-acute costs.)

Interestingly, a 2012 study found patients with clinically similar conditions often receive different intensities of post-acute care. This makes sense: different patients often need different levels of intensity for their recovery. However, and
importantly, the study found that 40 percent of the patients who were discharged to a Long-Term Acute Care Hospital did not need this level of care, meaning that they could have safely and effectively healed at a lower-intensity setting (such as IRF, SNF, or with home health).

Consider, for example, patients who undergo a hip or knee replacement. A recent CareCentrix analysis shows that approximately 57 percent of these patients recover in a SNF, but of these, 23 percent have no comorbid conditions. Without these potential complicating factors, nearly a quarter of those patients are discharged to a SNF may be good candidates for healing at home.

Integrated post-acute care uses pre-discharge coordination and advanced analytics to differentiate, at the patient level, the level of intensity that a patient needs to heal effectively, including if a “home first” approach may be clinically appropriate. According to the study, optimizing patient care settings alone would yield $35 billion in savings to Medicare over ten years.7

<table>
<thead>
<tr>
<th>Condition</th>
<th>Average</th>
<th>Home Health</th>
<th>Skilled Nursing Facility</th>
<th>Inpatient Rehab Facility</th>
<th>Long Term Care Hospital</th>
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<tr>
<td>Stroke</td>
<td>$10,680</td>
<td>$2,478</td>
<td>$8,527</td>
<td>$18,923</td>
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<td>Hip and femur procedures for trauma</td>
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<tr>
<td>Cardiac bypass with catherization</td>
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<td>$1,778</td>
<td>$5,737</td>
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<tr>
<td>Heart failure</td>
<td>$4,144</td>
<td>$1,611</td>
<td>$6,462</td>
<td>$14,698</td>
<td>$20,236</td>
</tr>
</tbody>
</table>

This table is from the Medicare Payment Advisory Commission, and demonstrates how the choice of site of care influences post-acute costs.

3. Length of Stay

CareCentrix estimates show that between 17 to 20 percent of patients with Post-Acute Care needs will benefit from a SNF stay. Given this significant percentage, managing how long patients stay in a facility becomes a major factor in post-acute cost.
A recent report prepared for the Centers for Medicare & Medicaid Services discovered that SNF length of stay dropped 1.3 days when orthopedic patients were in the Bundled Payments for Care Improvement program.\textsuperscript{8} In other words, reimbursement rates affect SNF length of stay rather than clinical need alone. The challenge for payers is to closely manage length of stay and identify patients who can thrive with home health.

CareCentrix estimates that managing length of stay to optimal levels may save 10 to 15 percent of total PAC costs.

4. Readmissions

Despite the best efforts of healthcare advocates and organizations to reduce readmissions, many patients who are discharged from the hospital ultimately return to the hospital – a “revolving door” where patient experience, quality of care, and cost containment all suffer together. A MedPAC study estimated that 17 to 20 percent of Medicare patients discharged from the hospital were readmitted within 30 days. Among these hospital readmissions, 76 percent were considered potentially avoidable and associated with $12 billion in Medicare expense.\textsuperscript{9,10}

To stem this avoidable expense, Medicare implemented the Hospital Readmission Reduction Program. Despite being in its fifth year, 79 percent of participating hospitals still face a penalty for their rate of readmissions. The penalties increased to $528 million in 2017, $108 million more than in 2016.\textsuperscript{11}

Who are the likely candidates for readmission? CareCentrix has found that:

- Patients who are released from the hospital with no support at home. A recent CareCentrix study found that 50 to 60 percent of readmission costs are driven by patients sent home without any post-acute orders.

- Patients who have been in the hospital for more than seven days, or those that have been readmitted at least twice in the last six months, are more likely to be readmitted.

- Patients who are readmitted also share certain characteristics, such as a high number of medications (eight or more), and have multiple services prescribed post-discharge.

While many readmissions are unavoidable, the variation in readmission rates suggests that provider coordination, post-discharge support, and medication management could play a strong role in reducing readmissions – especially for patients who live alone and lack adequate post-acute support.
5. Fraud, waste, and abuse

The Centers of Medicare & Medicaid (CMS) estimates that $60 billion in payments, or more than 10 percent of Medicare’s total budget, was lost to fraud, waste, abuse and improper payments. Medicare fraud investigations tend to uncover fake doctors billing from fake addresses – an expensive problem. Often overlooked – but nonetheless important – is the small-dollar/high volume fraud characterized by unnecessary services, overpriced supplies, and creative coding.

MA plans may gain further clarity in the type of waste the Centers for Medicare & Medicaid Services is focusing on by reviewing recent documents such as the December 2016 Medicare Improper Payments Report. In original Medicare, over 16 percent of nursing home visits are improperly paid, and some items of DMEPOS (Durable Medical Equipment, Prostheses, Orthotics and Supplies) have improper payment rates of over 50 percent (e.g., Lower Limb Orthoses are paid improperly 69.6 percent of the time).

CareCentrix estimates that up to 10 percent of many plans’ PAC spend may suffer from inflated pricing and services. Aggressive oversight can recover between 3 to 8 percent of the total.

An Integrated Approach

Ultimately, Post-Acute Care is interconnected. Reducing costs in one area, without careful planning, can have unanticipated impact in another area. For example, reducing over-utilization of skilled nursing facilities must be augmented by carefully-managed home care to lower readmissions. Otherwise, the total cost of care will increase despite efforts to manage utilization.

CareCentrix has developed an integrated approach to post-acute care that is patient-focused, home-centric when appropriate, and fills the gaps between fragmented services. The integrated approach identifies the best path for the patient’s care, engages the highest-performing providers, intervenes for patients most at-risk for readmissions, and connects providers, patients, and caregivers through technology.
1. Internal CareCentrix Analysis.


