

# Optimize Your Post-Acute Network

by Andre Maksimow and Dawn Samaris



***KaufmanHall***

## INTRODUCTION

As hospitals and health systems look to enhance their delivery networks, post-acute care (PAC) services are emerging as one of the top emphases for improving both the quality and cost of the patient care experience. A well-organized and smoothly functioning PAC network that improves care coordination, quality, and outcomes, while lowering costs, is particularly important to health systems in the following instances:

- Under all types of quality incentive or outcomes-based payer requirements
- When participating in Medicare or Medicare Advantage bundled or capitated payments, ACOs, and other shared-savings arrangements
- For service line-specific comprehensive offerings, such as total joint replacement programs, which are designed to meet consumer demand, increase physician alignment, and differentiate the organization from regional competition
- For inclusion as a highly efficient and effective provider in networks that span the care continuum, from wellness programs to end-of-life care (network arrangements will “tier-out” or otherwise exclude higher-cost health systems by steering patients to organizations that can offer quality services at a lower cost)

The Sidebar identifies some of the many benefits of a tighter link between hospital systems and PAC providers.

Creating an enhanced network that ensures the right care in the right place, as appropriate to the patient’s condition, takes time; it cannot be built overnight. With the goal of helping organizations develop an optimized PAC network, this article covers the national context for post-acute care, factors critical to successful network development, and issues related to whether health systems might wish to own, partner, or contract with PAC providers.

## THE NATIONAL POST-ACUTE CARE CONTEXT

Spending nearly \$60.3 billion in 2015, Medicare is the nation’s largest single purchaser of PAC services.<sup>1</sup> For the federal government, PAC represents a major savings opportunity, particularly due to the high average margins in most PAC settings, spending growth, and variation in care patterns cited by the Medicare Payment Advisory Commission.<sup>2</sup>

Medicare margins in 2015 for skilled nursing facilities, inpatient rehabilitation facilities, and home healthcare agencies were 12.6 percent, 13.9 percent, and 15.6 percent respectively.<sup>3</sup> In comparison, hospital overall Medicare margins averaged -7.1 percent in 2015 (with an “all-payer margin” of 6.8 percent).<sup>4</sup>

### Sidebar. Benefits of Close Relationships between Hospital Systems and Post-Acute Care Providers

- Directs the patient to the right level of care and care site
- Improves quality with better clinical communication across care settings, whether in a facility or home
- Improves patient/provider experiences and reduces costs related to uncoordinated care transitions between acute and post-acute care sites
- Enables differentiated programmatic offerings with consistent patient experience and aligned physician incentives across the continuum of care
- Reduces avoidable readmissions and their associated stress to patients and families, and financial penalties to hospitals

*Source: Kaufman, Hall & Associates, LLC.*

Additionally, according to the Institute of Medicine, PAC utilization variation accounts for 73 percent of overall Medicare geographical spending variances.<sup>5</sup> Such variances are associated with increased costs and lower quality and outcomes.

Efforts to improve overall value of post-acute care generally have not been effective to date. However, bundled and episode-based payment models are starting to eliminate traditional setting silos, thereby reducing problematic care-setting transitions, and improving cost, service, and quality dimensions across ambulatory, inpatient, and PAC settings.

Health systems are well positioned to improve the overall value of post-acute care given: 1) their importance as the primary source of PAC referrals; 2) their clinical capabilities to direct patients to the lowest-cost, highest-quality care setting appropriate to the patients’ conditions; and 3) their central role in organizing service offerings, including both network development and contracting.

## DEVELOPING THE NETWORK

Four key planning activities—market assessment, network evaluation, network design, and consideration of strategic alignment options—are critical to effective post-acute network development and operations. A description of each follows.

### Market Assessment

A thorough fact-based market assessment sets the stage for future PAC initiatives. Top considerations about the network and its current and future performance include:

**Current utilization patterns and likely trends.** Where patients seek care today and how far they are willing to travel are important data points. For example, in-depth analysis showed one health system that 90 to 94 percent of its Medicare patients seek post-acute skilled nursing care solely within the zip code where they live. Patients and families typically prefer conveniently located facilities. This preference limits the potential skilled nursing care partners this hospital system might seek.

Insights about future use rates can be gained by comparing use of PAC services in a health system's area to that of regional and national norms. Exposure to changes in incentives, such as site-neutral payments, and Medicare Advantage penetration, could put downward pressure on PAC use. For example, one organization learned that its inpatient rehabilitation utilization was 20 percent above regional levels. Significant downward pressure on its utilization, therefore, could be expected. This fact informed the outlook for the rehabilitation business line; more rehab units would not likely be needed.

Additionally, changes in medical technology may substantially reduce skilled nursing and home care usage. One example is less invasive techniques that enable additional orthopedic procedures to take place in outpatient settings with outpatient physical therapy follow-up.

**Referral sources and the health system's relative importance to PAC providers.** Major referral pathways differ by provider type and primary service area. Skilled nursing facilities typically rely more heavily on referrals from acute care facilities; home health agencies draw more heavily from physician referrals. A health system's importance to key regional PAC providers and analysis of competitors in the region inform the conversation about the level of motivation to put in place a "preferred" relationship.

**Quality and costs of regional providers.** Performance of a health system's owned assets can be compared to that of regional post-acute providers using criteria such as collaboration with the health system, quality, outcomes, costs, communication, ease of access, responsiveness, and other measures. An opportunity analysis typically includes financial quantification of PAC improvements in each dimension. For example, a partnership with a home health agency with more effective operations can reduce the number of patients that need to be readmitted to the hospital. Projections can quantify savings from lower hospital penalties for 30-day readmissions.

### Network Evaluation

Data-driven network evaluation typically includes the following items.

#### **Identification of needs and gaps in the current post-acute network.**

Gaps may include care of particularly vulnerable individuals, such as older patients with psychiatric diagnoses and needs, and "pain points" such as long-term ICU utilization. Challenges may include care management of high-acuity patients and clinical conditions, standardization of care pathways, appropriate use and distribution of services, quality and consumer experience, financial and operational performance, and willingness of local PAC providers to collaborate. Modality gaps in the current network may include an aligned skilled nursing network and/or other PAC modalities. IT connectivity typically is a significant consideration due to the need to monitor results and identify areas requiring continued improvement.

**Appropriate patient placement.** Placement should be in the lowest-cost setting appropriate to the patient's condition, without barriers or delays, as achieved through consistent and comprehensive discharge planning and coordination with PAC providers. Care navigators ensure that care planning commences upon hospital admission and that overall patient and family experience, quality of care, and use of assets are optimized. Patient and family support needs must be identified and planning and education provided to the family. For example, some families may not be aware that home healthcare personnel can perform many of the functions provided in skilled nursing facilities, thereby allowing the patient to receive care at a lower cost in his/her home. Level of success of hospital discharge planning for the right level of care in the right place can be assessed against benchmarks.

PAC spending reduction opportunities are significant with active management that drives utilization to the correct PAC modality. Figure 1 illustrates how one health system identified the cost differential between patients with secondary behavioral health diagnoses and those without such diagnoses. The former incurred \$2.7 million more costs in the inpatient setting than the latter. The ability to place such high-cost patients in a more appropriate setting in a timely manner, such as a long-term acute care hospital or skilled nursing facility, could result in material savings.

Numerous private equity-sponsored companies operate a business model based on right care/right place. Similar to the role played by a pharmacy benefit manager with prescription drugs, the firms function as post-acute care managers, contracting with hospitals and insurers to coordinate their PAC needs. They typically embed care managers and use analytical technology to connect patients to the most appropriate care at a reduced cost. Average costs per member per month for long-term acute care, skilled nursing, and inpatient rehabilitation can be 50 percent less than the national fee-for-service average.

**Figure 1: Impact of Behavioral Health Diagnosis on Inpatient Cost and Length of Stay**

Note: Based on Kaufman Hall analysis of Medicare claims data for patients transferred to a post-acute care setting at the end of the inpatient stay.  
Source: Kaufman, Hall & Associates, LLC

|  | Medicare Cases | ALOS Days | Avg. Total Cost | Avg. Per Diem Cost | Cost Impact vs. Base Population |
|--|----------------|-----------|-----------------|--------------------|---------------------------------|
| <b>Cases Without Behavioral Health Diagnosis</b> | 12,578         | 3.4       | \$9.6 K         | \$1.8 K            |                                 |
| <b>Behavioral Health Comorbidity</b>             | 167            | 3.7       | \$10.6 K        | \$2.9 K            | \$0.2 M                         |
| <b>Psychoses Comorbidity</b>                     | 721            | 9.5       | \$13.0 K        | \$1.3 K            | \$2.5 M                         |

Numerous highly advanced, forward-thinking health systems are achieving such results as well through use of care managers and analytical technology.

**Identification of strategic priorities.** Based on market, network, and internal fact bases, strategic priorities can be identified and quantified.

For example, for a health system that owns numerous skilled nursing and inpatient rehabilitation facilities, the market assessment and planning process pointed to three strategic priorities in both clinical and operational areas (Figure 2).

Particularly important would be standardization of referral pathways to high-performance providers in PAC modalities across the submarkets, and right-sizing utilization of specific bed types, such as memory care beds in skilled nursing facilities. Expectations of PAC partners for areas such as protocols, patient placement guarantees, and communication should be articulated and can be incorporated in alignment agreements.

Strategic priorities must be based on a strong business case that will best position the organization for success under current and proposed value-based care and payment initiatives.

**Figure 2. Strategic Priorities for Post-Acute Network Development**

Source: Kaufman, Hall & Associates, LLC

|                   | Priority Area                       | Opportunity Summary   |
|-------------------|-------------------------------------|---|
| Operational Focus | PAC Operating Structure             | Allow partners to coordinate and collaborate on PAC care delivery across markets through committees such as quality, operations, and medical management   |
|                   | Service Distribution                | Evaluate opportunities to right-size utilization of specific bed unit types within SNF or other PAC setting (e.g., use of long-term, memory disorder beds, etc.)  |
|                   | Cost Reduction                      | Identify opportunities to improve operational performance   |
| Clinical Focus    | PAC Referral Management             | Standardize referral pathways to high-performance, efficient providers, as appropriate; enhance utilization of system-owned PAC businesses for appropriate levels/types of care   |
|                   | Discharge Planning/ Care Navigation | Standardize inpatient discharge planning protocols across key clinical conditions; implement best practices related to referrals, case management, patient follow-up, and other practices; ensure access to right sites of care/setting for difficult-to-place patients |
|                   | “SNFist”/Extensivist Program        | Use hospitalists and advanced care practitioners to design a SNFist/extensivist/transitionalist program to manage and coordinate patient care outside the hospital  |

**Network Design**

Proactive network design and performance management planning builds on the market assessment and evaluation. The first building block involves quantification of the size, scale, and geography required for the health system’s post-acute network. This is based on current and projected utilization/demand trends, which influence the size and scope of network components.

Network design is further informed by analyses of patient flows, competition, and how competitive dynamics may influence the distribution and strategic position of network components. For example, value-based exposure in the marketplace, consumerism, and managed care design (i.e., Medicare Advantage vs. a commercial ACO), will impact utilization of network components.

Distribution and strategic positioning of specific network components involve consideration of a range of strategic options. Health systems should not allow their networks to form haphazardly, but rather, identify priorities and gaps early in order to direct resources to where they are most needed.

**Consideration of Strategic Alignment Options**

As with partnership possibilities in all healthcare sectors, a range of alignment options are available to health systems and PAC providers. An organization’s overall strategy for improving its post-acute network should be shaped by competitive dynamics in its local market, the strength of the existing PAC services, and the organization’s relative essentiality in that market.

A hybrid of arrangements will be required of most health systems (Figure 3). Options include ownership and management of PAC assets, joint venture/management services partnerships with external PAC providers, development of a preferred/affiliated network, and sale of PAC assets to another provider. The broadest possible range of potential partners should identified, and their capabilities evaluated related to fit with, and supplement to, the health system’s abilities.

Health systems can pursue multiple options simultaneously, depending upon the post-acute business. Owning everything

**Figure 3.** Strategic Options for Post-Acute Care Network Development

Source: Kaufman, Hall & Associates, LLC



typically is not a desired or viable option, as discussed below. The business case for a health system venture with a PAC provider must be based on quantitative and qualitative analyses of the following:

- Geographic coverage and access offered by the PAC provider
- The PAC provider’s ability to ensure the efficient delivery of required care
- Management factors, such as depth and breadth of the management team
- The strategic-financial impact of a collaborative or ownership arrangement

Whichever alignment option is pursued, these selection criteria are the same.

**WHICH PIECES SHOULD HEALTH SYSTEMS OWN?**

Kaufman Hall generally does not recommend health system ownership of all PAC assets. Incentives will change as payment models evolve, but having an effective home health/hospice business is emerging as a likely “must have” for many health systems in order to manage PAC utilization. “Must have” may involve ownership or joint venture partnerships. As appropriate to the needs and conditions of a patient, health systems may be able to use home health services to reduce utilization that would otherwise go to a more costly skilled nursing facility or inpatient

rehabilitation facility. This can be a big value driver for payers, providers, and patients.

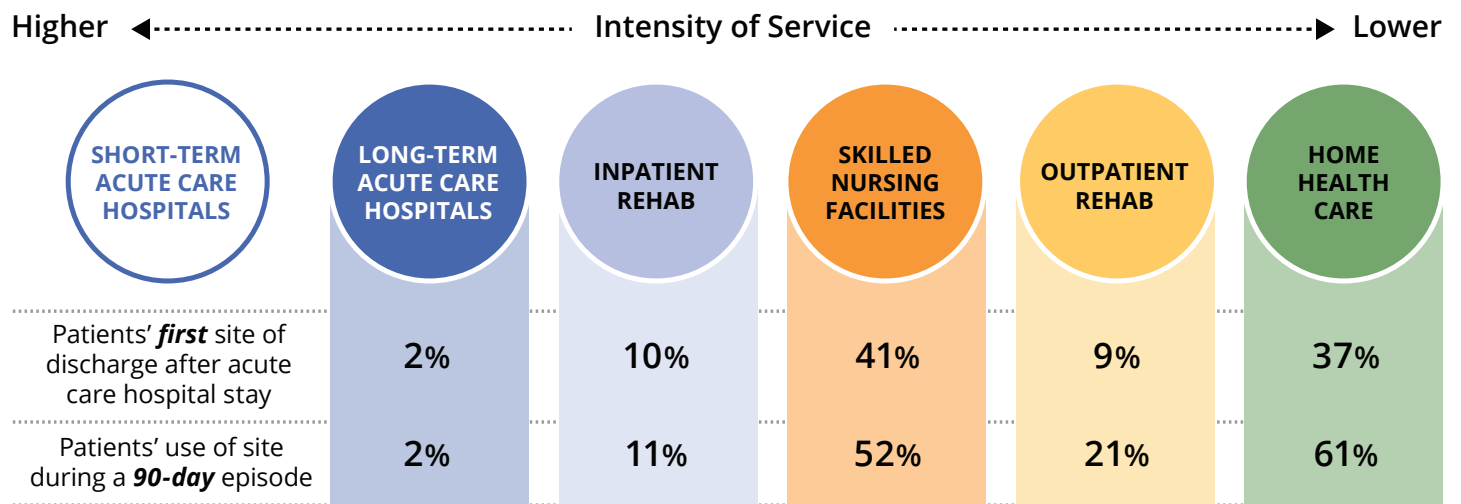
For example, approximately 40 percent of Medicare beneficiaries who are discharged from an acute-care hospital use post-acute services.<sup>6</sup> One study indicated that 41 percent of a system’s Medicare patients entered skilled nursing facilities as the first site of care after hospital discharge, while 37 percent accessed home health services<sup>7</sup> (Figure 4). Medicare payment per discharge from a freestanding skilled nursing facility was approximately \$16,000 to \$22,000 in 2015; average payment per episode for home health care was approximately \$2,700.<sup>8</sup> If fewer discharged Medicare patients entered skilled nursing facilities and more accessed home health services, a hospital could reduce Medicare costs by \$13,000 to \$19,300 per discharged patient.

Many health systems own a piece of a home health business, often through joint venture arrangements whereby the health system retains a minority interest. The traditional driver was to improve financial performance of the home health business, but with many such arrangements, the existing business still lacks the operational expertise that yields efficiently provided services.

The current driver for ownership is more strategic in nature: health systems want to control the home health business to ensure the intellectual capital and capabilities necessary to reduce higher-cost facility-based utilization and drive quality improvements and outcomes.

**Figure 4. Medicare Patient Use of Post-Acute Services during an Episode of Care**

Source: Gage, B., Morley, M., Spain, P., Ingber, I.: “Examining Post-Acute Care Relationships in an Integrated Hospital System.” Waltham, MA: RTI International, 2009. <http://aspe.hhs.gov/health/reports/09/pacihs/index.shtml>.



For example, eight-hospital Allegheny Health Network (AHN), with its own home health and hospice assets in western Pennsylvania, partnered via a joint venture with Celtic Healthcare, a comprehensive home health and hospice organization in November 2014.<sup>9</sup> They created a fully integrated post-acute service provider, operating under the AHN brand and managed by Celtic's nationally recognized support service and leadership team. The newly formed joint venture became the second largest provider of home care and hospice services in western Pennsylvania. One year later, a program launched by AHN (Healthcare@Home) announced a 5 percent decrease in hospital readmissions within a month of discharge among AHN's home care patients—from 19 percent to 14 percent. This improvement yielded approximately \$5 million in savings from avoided hospital readmissions.<sup>10</sup>

A Sidebar provides key considerations for owning, partnering, or contracting.

### Sidebar: Own, Partner, or Contract?

#### Key considerations include:

- Financial results and/or return-on-investment opportunity for existing operations
- Quality and management of existing regional PAC providers
- Excess or lack of capacity in specific modalities
- State of owned and regional PAC facilities
- PAC provider openness to collaboration
- Health system skills and expertise in post-acute care
- Competing strategic and capital priorities

Source: Kaufman, Hall & Associates, LLC

## GOING FORWARD

Post-acute services must be included in the strategic-financial plans of hospitals and health systems going forward. Through detailed market assessment and planning, and proactive network design, organizations should determine where they can have a material effect on the quality and cost of post-discharge patient care in their communities. They then should focus on those areas to develop and maintain an aligned post-acute network. Building a sustainable PAC network involves detailed analyses, coordination of program development and contracting initiatives, due diligence in evaluating potential partners, and exploration of an appropriate range of alignment options. Partnerships with PAC providers likely will be the most viable and fiscally smart option pursued by proactive health systems during the next decade.

## REFERENCES

1. Medicare Payment Advisory Commission: *Health Care Spending and the Medicare Program: June 2017 Data Book. Section 8: Post-Acute Care.* [www.medpac.gov/documents/-data-book](http://www.medpac.gov/documents/-data-book) (accessed Aug. 29, 2017).
2. Medicare Payment Advisory Commission: *Report to Congress: Medicare Payment Policy*, March 2014.
3. Medicare Payment Advisory Commission (June 2017).
4. Medicare Payment Advisory Commission (June 2017), Section 6: Acute Inpatient Services.
5. Institute of Medicine: *Variance in Health Care Spending: Target Decision Making, Not Geography.* Washington, D.C.: National Academies Press, 2013. [www.nap.edu/download/18393](http://www.nap.edu/download/18393) (accessed Aug. 29, 2017).
6. Carter, C., Garrett, B., Wissoker, D.: "A Unified Medicare Payment System for Post-Acute Care Is Feasible." Health Affairs Blog, Sept. 28, 2016. <http://healthaffairs.org/blog/2016/09/28/a-unified-medicare-payment-system-for-post-acute-care-is-feasible> (accessed Aug. 29, 2017).
7. Gage, B., Morley, M., Spain, P., Ingber, I.: "Examining Post Acute Care Relationships in an Integrated Hospital System." Waltham, MA: RTI International; 2009. Feb. Prepared for the Office of the Assistant Secretary for Planning and Evaluation. <http://aspe.hhs.gov/health/reports/09/pacihs/index.shtml> (accessed Aug. 29, 2017).
8. Medicare Payment Advisory Commission (June 2017).
9. Celtic Hospice & Home Health: "Celtic Healthcare, Allegheny Health Network Announce Joint Venture to Combine Home Health and Hospice Assets in Western Pennsylvania." *Press release*, Nov. 11, 2014. [www.celtichealthcare.com/5819/celtic-healthcare-allegheny-health-network-announce-joint-venture-to-combine-home-health-and-hospice-assets-in-western-pennsylvania](http://www.celtichealthcare.com/5819/celtic-healthcare-allegheny-health-network-announce-joint-venture-to-combine-home-health-and-hospice-assets-in-western-pennsylvania) (accessed Aug. 29, 2017).
10. Liepelt, K.: "Health Network Saves \$5 Million through Home Care Program." Home Health Care News, Nov. 30, 2015. <https://homehealthcarenews.com/2015/11/health-network-saves-5-million-through-home-care-program> (accessed Aug. 29, 2017).

## ABOUT THE AUTHORS

**Andre Maksimow** is a Senior Vice President of Kaufman Hall and a member of the firm's Mergers and Acquisitions practice. He has 20 years of experience, including mergers and acquisitions, private equity and operations. Mr. Maksimow provides strategic financial advisory services related to merger, acquisition, sale and divestiture, joint venture, and minority interest transactions. Mr. Maksimow has particular expertise in post-acute care sectors, including skilled nursing facilities, continuing care retirement communities, Medicare-certified home healthcare agencies, and other senior living providers. Clients have included not-for-profit, for-profit and faith-sponsored organizations.

Prior to joining Kaufman Hall, Mr. Maksimow was a Director in FTI Consulting, Inc.'s healthcare practice. During his tenure at FTI, he provided financial, strategic advisory, and performance improvement services to for-profit and not-for-profit companies in the senior living, managed care, home healthcare, skilled nursing, and hospital sectors.

Prior to this, Mr. Maksimow worked in a specialized investment management firm focused on investing private equity capital in senior housing communities on behalf of the largest U.S. public pension fund and other equity investors. As Vice President of Acquisitions and Finance, he closed approximately \$450 million in senior housing acquisitions during a seven-year period.

Mr. Maksimow earned an M.B.A. and a B.S.B.A. from Boston University. He is a member of the American Institute of Certified Public Accountants and is a certified public accountant.

*Mr. Maksimow can be reached at [amaksimow@kaufmanhall.com](mailto:amaksimow@kaufmanhall.com) or 224.724.3159.*

**Dawn Samaris** is a Senior Vice President of Kaufman Hall and a member of the firm's Strategic and Financial Planning practice. Ms. Samaris' expertise includes developing strategic and financial plans, redesigning long-range capital planning processes, acting as a financial advisor for bond issues, and advising on merger, acquisition, and partnership transactions.

With more than 15 years of healthcare consulting and financial advisory experience, Ms. Samaris has extensive expertise spanning finance, strategy, capital markets, and partnership planning with a variety of organizations including regional health systems, academic medical centers, and community hospitals. Prior to joining Kaufman Hall, Ms. Samaris was an auditor with Deloitte & Touche.

Ms. Samaris is a regular speaker at healthcare industry conferences and organizational boards on the topics of strategic financial planning, the evolution of the healthcare industry, and how industry trends inform the planning process.

Ms. Samaris has an M.B.A. with distinction from Northwestern University's Kellogg School of Management, and a B.S. in Business Administration summa cum laude from the University of Arizona. Ms. Samaris also is a certified public accountant.

Ms. Samaris can be reached at [dsamaris@kaufmanhall.com](mailto:dsamaris@kaufmanhall.com) or 224.724.3149.

## ABOUT KAUFMAN HALL

Kaufman Hall provides management consulting and software to help organizations realize sustained success amid changing market conditions. Since 1985, Kaufman Hall has been a trusted advisor to boards and executive management teams, helping them incorporate proven methods into their strategic planning and financial management processes, and quantify the financial impact of their plans and strategic decisions to consistently achieve their goals.

Kaufman Hall services use a rigorous, disciplined, and structured approach that is based on the principles of corporate finance. The breadth and integration of Kaufman Hall advisory services are unparalleled, encompassing strategy; financial and capital planning; cost transformation; treasury and capital markets management; and mergers, acquisitions, partnerships, and joint ventures.

Kaufman Hall software includes the Axiom Healthcare Suite, providing sophisticated, flexible performance management solutions that empower finance professionals to analyze results, model the future, and optimize organizational decision making. Solutions for long-range planning, budgeting and forecasting, performance reporting, capital planning, and cost accounting deliver decision support, reporting, and analytics within an integrated software platform. Kaufman Hall's Peak Software empowers healthcare organizations with clinical benchmarks, data, and analytics to provide a higher quality of care for optimized performance and improved patient outcomes.

More information is available at [www.kaufmanhall.com](http://www.kaufmanhall.com).