



The Role of Post-Acute Care in New Care Delivery Models

Post-acute care (PAC) providers play an essential role in ensuring that patients receive the care they need to heal and have a smooth transition back to a community-based setting, typically after a discharge from a hospital.

These providers face an increasingly complex regulatory and market environment as health care transforms from a system that rewards volume to one that encourages and rewards value. This report

highlights case examples from PAC innovators and their partners as they adapt to the early stages of delivery system reform; it also examines the current and potential future landscape for long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and home health agencies (HHAs). The Addendum, available online at www.aha.org/research, provides background on each of these care

settings, including their clinical scopes of services, current payment methodologies and regulatory changes.

This *TrendWatch* is designed to provide guidance to PAC providers and their partners as they evaluate new models of care delivery and payment. With the wide range of experiences in mind, selected case examples from lead innovators include lessons from a range of provider types that are pursuing care delivery reform.

The Role of PAC in Care Delivery Redesign

The Affordable Care Act (ACA)¹ has heightened providers' focus on the Triple Aim² of improving the patient experience (including quality and satisfaction), improving the health of populations and reducing the per capita cost of health care. Many have concentrated their efforts on integrating and improving the overall continuum of care—including the post-acute care experience. PAC has been of increased interest to policymakers as a result of a 2013 Institute of Medicine (IOM) report that identified the sector as the source of 73 percent of the variation in Medicare spending.³ As a result, hospitals, health systems, PAC providers, payers and other stakeholders have taken steps to learn more about and improve PAC services, which are used by almost 42 percent of Medicare beneficiaries discharged from a hospital.

PAC leaders have focused their attention on a variety of approaches to optimize the use of their services and improve care coordination. These have included targeted interventions to reduce readmissions, campaigns to improve transitions between settings of care and participation in the development of new PAC bundled payment approaches. As a result, there is greater awareness about the nature of PAC service delivery, the need to improve the process of deciding which patients need post-hospitalization care and, for those patients who need it, the types, quantities and sequencing of such care.

Recognizing the importance of post-acute care to improving the overall experience of care for Medicare beneficiaries, policymakers are increasingly testing episode-based payment models that go beyond a single provider setting.

For example, Medicare's value-based purchasing (VBP) program has begun to monitor cost performance for a patient's entire episode of care and penalizes hospitals with high levels of spending. Most recently, the Centers for Medicare & Medicaid Services (CMS) finalized a mandatory hip and knee replacement bundled payment program in selected marketplaces that will begin on April 1, 2016. The payment bundle will include the hospital admission for the joint replacement surgery and all additional care provided during the 90-day period following discharge. These and other efforts to deliver, assess and pay for episodes of care that cover multiple settings are expected to reduce the overall volume of PAC services.

There is wide variation in the speed of adoption of new payment and delivery

models across the country, with less adoption in rural markets. Engagement of post-acute care has increased in markets where hospitals and other partners are implementing bundled payments,

accountable care organizations (ACOs), provider networks and other initiatives that shift the focus from a single provider to a broader episode during which multiple providers deliver services to

the same patient. However, concerns about the ability to apply these types of models universally have arisen due to the low volume of patients served in rural settings.

Factors Driving PAC Change

The increasing proportion of Medicare patients discharged to PAC settings, combined with the geographic variation in PAC spending noted by the IOM report, has increased awareness about the need to develop and use evidence-based care pathways and tools for selecting and managing post-acute placements. The growth of alternative payment models with risk-sharing among hospitals, payers and PAC providers places even greater importance on developing a robust base of knowledge so that providers and other entities that drive or influence discharge decisions are guided by evidence-based practices and data on performance.

Variation in Use of PAC Services

While the magnitude of the variation in PAC spending is well documented, understanding how to best limit variation is less clear. The following are key drivers of PAC spending variation:

- Volume of patients discharged to post-acute settings following a short-term acute-hospital stay;
- Initial PAC setting following hospitalization;
- The wide variety of conditions, comorbidities and medical severity of PAC patients;
- Number and type of PAC services received during the episode of care; and
- Whether a readmission occurs.

Between 2008 and 2013, the percentage of Medicare beneficiaries discharged from a hospital to an LTCH, IRF, SNF or HHA increased from 37.5 percent to almost 42 percent.⁴ Over this period, the

percentage of hospital patients discharged to IRFs, SNFs and HHAs increased while the percentage of discharges to LTCHs remained about the same (Chart 1).

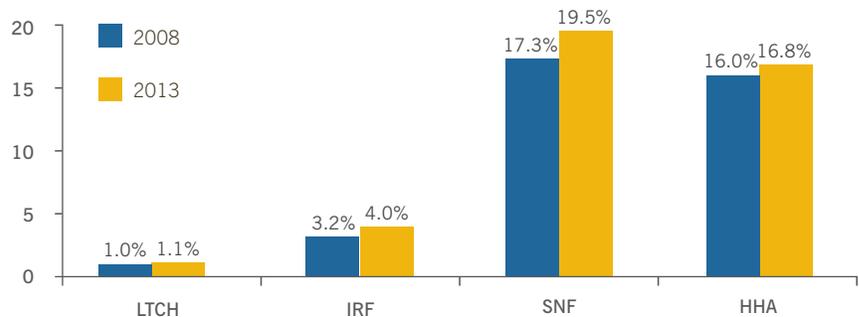
A primary cause of the variance in PAC payments relates to the initial care setting that follows hospitalization in a short-term acute-care hospital. Average per discharge payments to PAC providers vary considerably by venue. For example, average Medicare payment for a 30-day episode for a patient with congestive heart failure (CHF) whose post-acute discharge site was an LTCH was more than twice the payment for a patient who was discharged to a SNF, and about 27 percent more than that for a patient whose initial post-acute venue is an IRF.⁵ However, these data do not account for differences in severity of illness across the PAC settings.

More often than not, a patient discharged to an institutional post-acute setting (LTCH, IRF and SNF) will be transferred to a second post-acute setting for additional care. From 2008 to 2013, the volume of SNF patients referred to an HHA increased by 13.6 percent, and LTCH to SNF referrals increased by 6.8 percent. (Chart 2). A recent Dobson DaVanzo analysis found more than 8,800 unique clinical pathways after an inpatient hospitalization, underscoring the lack of standard post-discharge protocols guiding utilization of post-acute medical, rehabilitation and other services.⁶

Additionally, a readmission to the hospital during the post-acute episode more than doubles the average Medicare payment. Readmissions to other prior settings also increase cost. The rate varies

The percentage of Medicare beneficiaries discharged from a hospital to a PAC setting increased between 2008 and 2013.

Chart 1: Patients Discharged from Hospital to PAC Setting, 2008 and 2013



Sources: Medicare Payment Advisory Commission. (June 2008). *A Data Book: Health Care Spending and the Medicare Program*. Washington, DC. Medicare Payment Advisory Commission. (2015). *March Report to the Congress: Medicare Payment Policy*. Washington, DC.

across MS-DRGs and patient demographic characteristics.⁷ To address the issue of readmissions, PAC providers have found they need to target interventions differently for patients with various diagnoses and demographic characteristics.

Multiple Factors Influencing PAC Placements

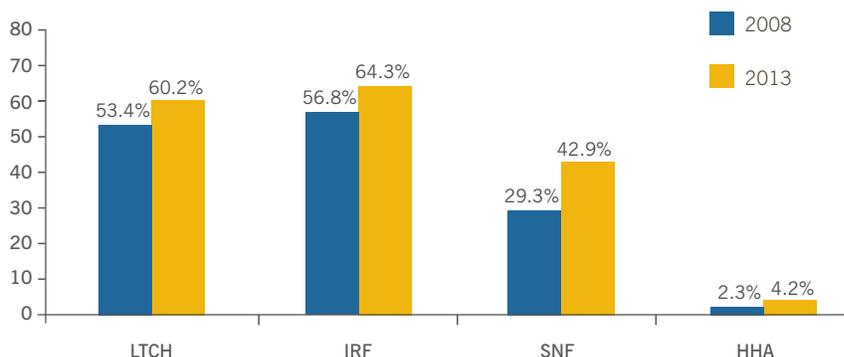
Many factors influence PAC placement decisions, including clinical and non-clinical factors. Key clinical factors include a patient's diagnosis, acuity and functional status. Non-clinical factors include PAC options available in the community, bed availability and relative clinical capacity of PAC providers in a given market. Further, physician preferences, relationships between the referring hospitals and other providers, as well as family preference, can influence placement decisions.

In addition, Medicare admissions criteria for each PAC setting are often key determinants of post-hospitalization placement. To provide more flexibility to providers developing new treatment protocols for PAC patients, CMS has waived one such regulatory obstacle, the SNF three-day stay requirement for certain ACOs and providers participating in CMS's Center for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR) initiatives. PAC stakeholder organizations are advocating for further regulatory relief for organizations testing new payment and care delivery approaches.

Given the limited evidence base to guide PAC placement decisions, some hospitals and other entities, such as ACOs and vendors, have developed discharge tools to guide post-hospitalization planning. These efforts are often motivated by the need to select the first PAC setting in a more systematic manner to reduce

A majority of patients admitted to PAC are later transferred to a second PAC setting.

Chart 2: Percent of Patients that Progress to a Second PAC Setting, from Initial PAC Setting, 2008 and 2013



Sources: Medicare Payment Advisory Commission. (June 2008). *A Data Book: Health Care Spending and the Medicare Program*. Washington, DC. Medicare Payment Advisory Commission. (2015). *March Report to the Congress: Medicare Payment Policy*. Washington, DC.

readmissions, variation in post-hospital care and overall cost. In a January 2015 report, the AHA highlighted five private-sector discharge tools developed by the Cleveland Clinic, Partners Continuing Care, Advocate Health Care, naviHealth, and Geisinger Health System. In general, these organizations have developed low-burden tools to support the discharge process in a manner that improves the overall episode of care—although each organization's tool and development process are unique.⁸

Increasingly, hospitals, ACOs and payment bundlers are seeking to guide patients to high quality, low-cost PAC settings by creating preferred provider networks that meet established performance and quality metrics. The Medicare Payment Advisory Commission (MedPAC) referred to the process of guiding, but not dictating, choice as “soft steering.”⁹ Ultimately, each Medicare beneficiary maintains the right to choose a PAC provider. Later, this report will highlight common preferred network criteria for PAC providers.

Care Redesign and PAC

Care redesign is key to achieving improved outcomes and reduced spending under bundled payment, ACOs and other value-based care models. CMS has recognized that success under bundled payment requires a series of new organization-wide activities to improve outcomes and reduce spending. The CMS framework for care redesign is shown in Chart 3.

To emphasize the importance of care redesign, CMS requires each BPCI applicant to develop a comprehensive plan that can offer beneficiaries a seamless continuum of PAC and home-based services. This plan can include approaches such as standardized medical management, transitional care nurses, linkages of electronic medical records across the acute/post-acute/ambulatory continuum and other programs that offer clinical integration across the care continuum. Each applicant's care redesign plan must include the following five domains:

- Redesign of care pathways;
- Enhancements in care delivery;

Care Redesign Is Key to Achieving Bundling Success

Chart 3: CMS Tool—Care Redesign Components and Relationship to Bundling

- Success under bundled payment requires a series of new organizational-wide activities—with care redesign as a major undertaking and driver of success; bundlers must actively change their current health care model to improve quality and reduce costs
- This diagram captures the relationship between care redesign and the other important activities to be undertaken concurrently by bundlers as well as the components of care redesign



Data Sharing Supports All Activities and Exchanges

Source: Centers for Medicare and Medicaid Services. (2011). Contracting for Bundled Payment. Washington, DC.

- Patient activation, engagement and risk management;
- Care coordination; and
- System changes to support care.^{10, 11}

Bundled Payment and PAC

In a bundled payment model, a designated entity is responsible for a targeted spending level that covers the expected costs of all services needed to treat a patient for a specified condition or episode of care. If actual spending is below the targeted level, the at-risk entity keeps the difference as savings. If actual costs exceed the target, the at-risk entity may

need to return the difference to the payer. Policymakers are looking to bundled payment models that include PAC services to reduce overall health care spending.¹² For example, the Administration’s budget for the past three years has proposed to bundle 50 percent of PAC payments by 2020.¹³ Since 2013, CMS has been testing several different bundled payment models through the CMMI. For CYs 2013 and 2014, CMS accepted applications for voluntary participation in the Bundled Payments for Care Improvement (BPCI) initiative. Today, of the original 6,700 entities that engaged in BPCI to

review data and explore participation, more than 1,500 providers are actively testing a specific model through an at-risk relationship with CMMI either directly or through an awardee convener. These providers include hospitals (411), SNFs (709), physician practices (291), HHAs (101), IRFs (9) and LTCHs (1). Within BPCI, Model 2 tests bundled payments for hospitals, physicians and PAC, while Model 3 tests a PAC-only bundled payment arrangement. CMS has since taken steps to further increase the prevalence of bundled payment by proposing a mandatory, hospital-led bundled

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from the field

“We saw that the real opportunity presented by bundled payment is the opportunity to design the post-acute care delivery system of the future. While we are working now with the CMS bundled payment model, our redesigned care models will allow us to fit into a future payment system that has yet to evolve.”

– Michael Spigel, President and COO, Brooks Rehabilitation

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from the field

“We chose to accept risk directly as a Model 2 awardee because bundling must be a core competency. If we turn over bundling to another entity, then what do we have to offer? By managing our own bundle, we will make mistakes, learn from them, and, ultimately, we will perform better.”

— Lynn Jones, President, Christiana Care Home Health & Community Services, Senior Vice President, Post-Acute Services, Christiana Care Health Services

payment model for joint replacement cases. For more information on this separate initiative, the Comprehensive Care for Joint Replacement (CJR) program, please access the AHA’s Regulatory Advisory at www.aha.org.

The vast majority of PAC participation in BPCI involves SNF and HHA

providers that have chosen to participate in bundling through an external awardee convener. A external awardee convener bears risk for each episode and typically plays an administrative role, provides care management support (which may affect post-acute placement) and perform claims analysis. Under this

arrangement, PAC providers share gains and losses with the external awardee convener. However, other PAC providers have chosen to take on financial risk in BPCI independent of a convener and are learning how to manage patient populations in an episode-based reimbursement model.

PAC Innovations

Leading PAC providers are adjusting current business models and creating new business models that will further their sustainability and success in a value-based payment system. However, these innovators represent a small segment of the PAC field, as many smaller PAC providers lack the resources to develop and launch such initiatives. Current innovations involving PAC generally take two forms: those led by a PAC organization and those led by a health system or other risk-bearing entity, such as an ACO. This section highlights both categories of initiatives.

PAC-led Innovations

This section focuses on the strategies and innovative models that are being implemented by leading PAC providers as they move their organizations into a value-based future. The strategic approaches and innovative models include a complete strategic realignment by market, organizational strategies to adopt bundled payment

approaches, development of niche clinical services and collaborative models to manage patients across post-acute settings of care.

[RML Specialty Hospital Specializes in Treating Chronically Critically Ill Patients](#)

RML Specialty Hospital (RML), an LTCH in Chicago, is a partnership between Loyola University Health System (a part of Trinity Health) and Advocate Health Care. RML has two LTCH sites, serving approximately 140 patients each day.¹⁴

In the Chicago market, many hospitals are forming ACOs with narrow post-acute networks and are seeking ways to reduce *annual* Medicare spending per beneficiary (MSPB)—a focus that differs from bundled payment conveners focusing on shorter episode lengths. RML realized that this key distinction provides the opportunity to establish their LTCH’s value proposition within local ACO networks.

RML and other LTCHs are challenged because ACOs and bundled payment

conveners tend to focus on the initial post-acute placement, which is immediately more costly when LTCHs are included in the care pathway compared to other post-acute venues. However, a 12-month episode length for ACOs provides an opportunity to demonstrate long-term value. RML analyses indicate that the true value of LTCH care for high-acuity patients is realized when Medicare spending is measured over a 180-day period. Those high-acuity patients, who are outliers from the expected MSPB for attributed ACO lives, present an opportunity for RML by highlighting the organization’s specialized staff and clinical programs that are designed for patients with a high level of medical severity.

The first component of RML’s three-part strategy to demonstrate its value to ACOs is its commitment to focus on and provide highly specialized care only for the highest-acuity patients, who were admitted to the LTCH from a hospital and required three days in an

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from the field

“If you follow chronically critically ill patients out to 180 days and beyond, you will see the true cost benefit of the LTCH.”

– James Prister, President & Chief Executive Officer, RML Specialty Hospital

ICU and/or 96 hours of continuous ventilation. RML’s historical focus has primarily been on patients who meet these criteria, thus allowing the LTCH to continue to specialize in care for chronically critically ill (CCI) patients.

Second, RML has actively sought and will continue to pursue membership in PAC continuing care networks (PAC-CCNs) now being developed by ACOs in Chicago. RML is a preferred partner in PAC networks for Advocate, one of its sponsoring organizations, as well as in two other ACOs in Chicago, including the University of Illinois Hospital and Health Sciences System’s PAC-CCN.

RML is in the initial stages of tracking and gathering data on patients discharged from the LTCH for 180 days, which will allow the ACO to compare long-term patient outcomes and MSPB for CCI patients who were discharged from an LTCH versus comparable CCI patients who were admitted to another type of post-acute venue.

This three-part strategy—i.e., specialization in highest-acuity CCI patients, membership in ACO post-acute preferred provider networks, and tracking patient outcomes and Medicare spending over an extended period—is designed to support RML’s continued financial viability in a value-based payment environment.

Christiana Care Health System’s Visiting Nurse Association Implements Virtual Telemonitoring Program in Community SNFs

Christiana Care Health System (Christiana Care) includes two hospitals with more than 1,100 patient beds, an HHA, a network of primary care physicians and

an extensive range of outpatient services. Its HHA, the Christiana Care Visiting Nurse Association (CCVNA), is the largest accredited home care agency in Delaware.

To develop successful partnerships that improve transitions among settings,¹⁵ the system is developing a Medicare ACO that will begin in January 2016. One focus of the ACO will be to improve transitions between the system’s successful HHAs and non-system SNFs, which will be part of Christiana’s continuing care network (CCN).

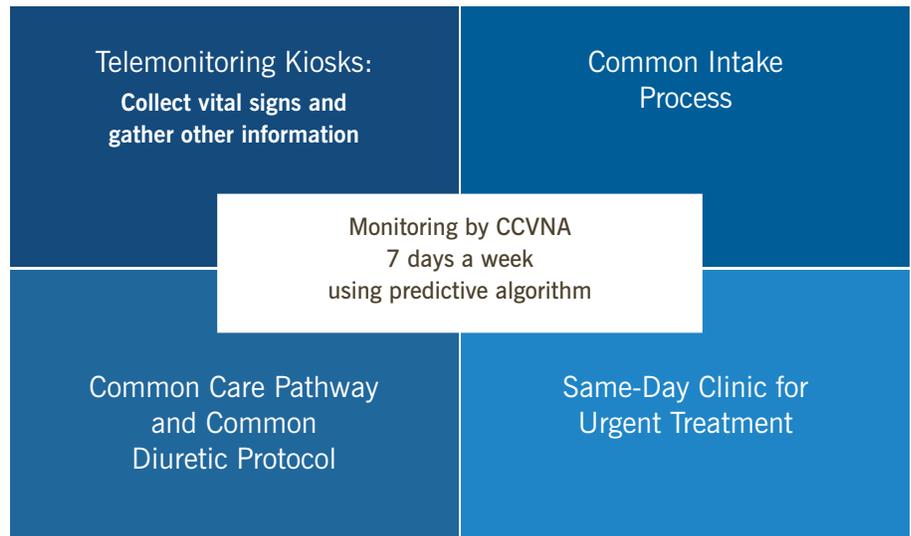
To improve a pattern of preventable readmissions from local SNFs, CCVNA and Christiana Care’s heart

failure program created an innovative partnership with six SNFs to use remote telemonitoring and other creative approaches to reduce readmission rates in this high-risk population (Chart 4). Using a virtual model launched in September 2014, Christiana’s home health nurses monitor CHF patients in community SNFs on a daily basis, applying an algorithm to identify significant changes in condition.

If such a change is identified, a CCVNA nurse contacts the SNF to report concerns and suggest interventions. However, the SNF’s clinical team makes the final determination regarding appropriate medical interventions. CCVNA sees its role as

Christiana Care Health System utilizes telemonitoring and common processes across care settings to improve care for heart failure patients.

Chart 4: Christiana Care CHF Readmission Reduction Approach



a collaborative partner to SNFs, where both parties have much to contribute to improve care transitions and the overall quality of care for patients.

Performance data on CHF patients in participating SNFs show a reduction in all-cause readmission rates from 18 percent to 12.5 percent for this high-risk population. Beyond the successful outcomes, the SNFs have come to appreciate the clinical expertise provided by CCVNA nurses. Christiana Care has found it can utilize CCVNA as a focal point of collaboration with non-system SNFs to achieve the system’s goals of reduced costs and improved patient outcomes.

[Brooks Rehabilitation Enters Bundled Payment as a Catalyst for Clinical and Organizational Transformation](#)

Brooks Rehabilitation (Brooks) in Jacksonville, Fla., the largest IRF in the nation, offers a complete post-acute system of care, including SNF and HHA services, outpatient clinics, assisted living and physician practices, and other clinical programs.

To improve its alignment with the five health systems in its market, Brooks entered the BPCI bundled payment demonstration and accepts risk in both Model 2 and Model 3 of the program. Specifically,

- Since October 2013, Brooks has participated in BPCI’s Model 3 demonstration for two PAC-only 60-day bundle types (hip and pelvic fractures and total knee and hip replacements). In April 2015, Brooks implemented three additional

post-acute Model 3 bundles (spinal fusions, spinal procedures and congestive heart failure).

- In January 2014, Brooks accepted risk for the post-acute portion of a BPCI Model 2 bundle with St. Vincent’s Health System. This single, 60-day bundle includes hospital, physician and PAC services for total hip and knee replacement cases.

As outlined in Chart 5, Brooks embraced a four-pronged care redesign model to design its programs for BPCI and other accountable models of care.

Between October 2013 and March 2015, Brooks managed 1,300 Model 2 and Model 3 episodes. On a financial level, Brooks experienced a positive gain.

On an operational level, Brooks found that change management was a major challenge—getting a team across multiple settings to collaborate, work together and standardize care had not been done previously. However, the benefits emerged quickly. Within the first six months of bundled payment, readmissions dropped by nearly 15 percent and patients reported more than 96 percent satisfaction with the site-of-care transitions. Additionally, assessments of functional improvement using the Patient-specific Functional Scale tool put Brooks in the top decile of facilities using that tool.¹⁶

Brooks’ bundling strategy is part of a larger strategy that involves taking

Brooks’ care redesign model focuses on the longitudinal needs of a patient and collaboration across multiple provider types.

Chart 5: Brooks Care Redesign Approach

Select the Right First Setting	Patients are placed in the least-expensive setting that will meet their needs
Standardize Care Across Settings	Tests are standardized so that the patient is monitored against the same assessments no matter where they receive care
Longitudinal Care Planning	A 60-day care plan takes into consideration patients’ needs across every setting of care
Nurse Care Navigators	Nurse care navigators help patients transition from one setting to the next and ensure that all care is coordinated

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from the field

“What began as a dialogue with SNFs on how to reduce the high rate of readmissions of heart failure patients has become a mutually beneficial relationship between all parties. Our success with the telemonitoring program in SNFs has created the basis for scaling a broader set of collaborative initiatives with SNFs and other community post-acute providers.”

– Mitchell Saltzberg, M.D., Medical Director, Heart Failure Program, Christiana Care Health System

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from the field

“We wanted to be at the forefront of payment reform and we saw this opportunity as a way to prove that post-acute providers have the sophistication to work at a higher level, including accepting financial risk, redesigning care and managing complex systems to avoid the vendorization of PAC.”

– Michael Spigel, President and Chief Operating Officer, Brooks Rehabilitation

a longer view of the patient, pursuing multiple forms of integration (clinical, technological, business and risk), redefining the role of PAC settings and creating partnerships designed for long-term success. Brooks President and COO Michael Spigel noted that their goal in BPCI participation was to test how a post-acute provider can take a leadership role in designing a future delivery system that optimizes the use of each care setting as a patient moves through the continuum to ensure it will work within future payment systems.

[Kindred Healthcare Provides Integrated Care in Target Markets Through Comprehensive Acute/Post-Acute Partnerships](#)

Kindred Healthcare (Kindred) is a national post-acute service provider offering a comprehensive array of integrated services in target markets, using partnerships with hospitals and PAC providers.¹⁷ Kindred operates 97 LTCHs, five IRFs, 90 SNFs, 12 hospital-based skilled nursing units and seven assisted living facilities. In addition, Kindred has HHAs and hospice agencies at 634 sites in 41 states, as well as contract and outpatient rehabilitation services at 2,311 sites.

The increasing prevalence of alternative payment structures such as ACOs, bundled payment and managed care has been accompanied by a greater focus on spending and patient outcomes. Kindred realized that it would be easy for individual PAC providers to become marginalized and not have a voice in best practices for patients’ outcomes throughout the acute/

post-acute continuum.

In order to assure that Kindred would be successful in alternative payment programs, Kindred’s leadership determined the company would create integrated markets for acute care and PAC, and seek ways in which Kindred’s integrated networks could assume risk in markets where they had a significant market presence that would allow for care delivery redesign across multiple PAC settings.

Kindred’s strategy in Cleveland, Ohio, demonstrates its integrated model, which, in this case, includes participation in the local BPCI bundling initiative and its relationship with the Cleveland Clinic, which began in 2010. The partnership is designed to reinforce both organizations’ quality and outcome-based goals. Key aspects of the partnership include:¹⁸

- **Joint operating committee:** Cleveland Clinic and Kindred’s joint Quality and Care Management Committee serves as the coordinating entity and provides stewardship for quality and outcome improvement.
- **Electronic medical record linkage:** Kindred and Cleveland Clinic’s medical record systems are electronically linked, allowing caretakers easy access to a patient’s medical history.
- **Performance improvement:** Condition-specific care management programs such as *Heart Care to Home* promote successful transitions home, and the *Connected Care* program links acute and PAC services.

- **Physician communication:** Weekly interdisciplinary team meetings held in Kindred’s post-acute venues and led by Cleveland Clinic physicians promote patient-specific planning and best practices to avoid unnecessary readmissions.

In addition, Cleveland Clinic hospitals and physicians are engaged with Kindred in coordinating care for seven clinical episode types within Kindred’s post-acute venues: two LTCHs, a hospital-based skilled nursing unit, a freestanding SNF and an HHA.

The integrated care market strategy is not without challenges. William Altman, executive vice president for Strategy, Policy and Integrated Care for Kindred, discussed three major challenges faced by Kindred and other PAC providers developing new partnerships:

“We remain in an environment that is still predominantly fee-for-service, but we must prepare for fee-for-value. The definition of post-acute care has been very narrow; as a result, post-acute venues have been commoditized rather than aligned with payers, ACOs and health systems clinically and in relation to payment. Post-acute care providers have been asked by ACOs and health plans to share risk, but often have not had the opportunity to share savings.”

Despite these challenges, Kindred plans to continue to pursue linkages with leading health care systems and ACOs, with the goal of becoming a population health manager.

Partner-led PAC Innovations

At this time, many local initiatives to improve the care delivery system are led by health systems through their ACOs or provider networks. Among these health systems, there appears to be a varying degree of focus on PAC. These case examples highlight initiatives that have a distinct PAC element and include a sample of common criteria hospitals and other entities use to select PAC partners. While these models provide an environment for engaging in new care models, at the current time, PAC providers are typically not at-risk in these types of relationships and do not share in financial gains or losses.

Catholic Health Initiatives

Like other health systems and ACOs, Catholic Health Initiatives (CHI),¹⁹ one of the nation's largest health systems with more than 100 acute hospitals, implemented ACOs as an alternative payment model in each of its 10 multi-hospital markets. In addition, CHI is engaged in BPCI's Model 2 in six markets, crossing seven states. Although some CHI markets own institutional PAC venues, CHI does not intend to focus on acquiring these types of venues. Instead, CHI is developing post-acute care continuing care networks (CCN) in all 10 multi-hospital markets, with the goal of reducing PAC variation, lowering

SNF lengths of stay and generating savings.

These three different types of PAC networks—ACOs, bundled payment and CCNs—have operated for a year or more. Thus far, 30-day hospital readmissions have been reduced by 10–30 percent, and average length of stay (ALOS) in SNFs has dropped by 10 percent. In these markets, SNF ALOS for post-surgical joint patients is 10–11 days, while overall ALOS for SNF patients is 17–20 days. Even though patients are given control of their choice of PAC provider, 75–90 percent of patients choose one of CHI's PAC-network providers.

Although CHI has a number of rural hospitals and critical access hospitals (CAHs), it has not yet expanded PAC network development to rural areas. A key reason is that many rural hospitals and CAHs have skilled nursing units or swing beds, which serve as the post-acute discharge site for local patients that receive medical care or surgery at a hospital in a nearby metropolitan area. Nevertheless, CHI is contemplating how to implement the best of the care redesign programs into the swing beds or skilled nursing units of its rural hospitals and CAHs.

CHI and other ACOs typically have two types of standards that guide their creation of a PAC network: The first are *credentialing criteria*, which are conditions

that PAC providers are expected to meet in order to be selected for the network; and the second are *achievement metrics* for quality indicators. Once a provider becomes a member of an ACO's PAC network, the provider members are expected to report monthly on their achievement of quality metrics. When an ACO or health system develops a PAC network, the number of individual PAC providers to which patients are discharged can be significantly contracted, by as much as 75–80 percent.

One of CHI's PAC networks in Lincoln, Neb., initially focused on SNFs for its PAC-CCN. In this community, SNF providers responded positively to the requirement for achievement of quality metrics and requested that the CHI hospitals also be subject to achievement of quality metrics to enhance patient transitions from the short-term acute-care hospital to the SNF. Metrics for the hospitals' monthly reports included:

- Number of patient transfers from CHI hospitals that occur after 3 p.m., seven days a week: expected achievement level at or less than 20 percent.
- Nurse-to-nurse hand-off for each discharge to SNF from CHI hospitals: expected achievement level at or greater than 80 percent.

Lessons Regarding PAC Provider Networks

Catholic Health Initiatives:

“We view the PAC-CCN as a partnership and an opportunity for learning, both for hospital personnel and for post-acute providers. We also use this opportunity to unify cultures and standardize care protocols and IT support systems.”

– Deidere Miller, National Director, Acute/Post-Acute Care Management, Catholic Health Initiatives

Advocate Health Care:

“In establishing a PAC-CCN, we make the hospital's goals and intentions clear through our achievement metrics (quality, LOS, readmissions and other metrics) for post-acute providers.”

– William Adair, M.D., Vice President, Clinical Transformation, Advocate Christ Medical Center

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from the field

Typical Post-acute Care Criteria for Provider Networks:

A compilation of common PAC criteria used by health system and ACO provider networks:

- Easy access for hospitals' patient discharges:
 - Geographic access for all patients
 - Admissions allowed 24/7
 - Start of home care within 24 hours of hospital discharge
- Compliance with federal and state regulations
- Lower-than-average survey deficiencies
- For SNFs:
 - At least three-star quality rating
 - Separate unit for PAC patients, with ACO or health system physician serving in the SNF
 - 24/7 RN care provider and at least one RN for every 15 patients in post-acute unit
- Use of INTERACT 3.0 tools—these tools, developed by Joseph Ouslander, M.D., under a contract with CMS, include forms and processes designed to enhance critical thinking among nursing staff in SNFs to reduce hospital readmissions and improve patient outcomes
- For HHAs:
 - Equal to or better scores than state average on Medicare Home Health Compare website
 - Recertification rates at state average
 - Patient satisfaction ratings at or better than median reported on the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAPHS)
- Common outcomes measures, that may be collected monthly, and may be aggregated for comparison purposes
 - 30-day hospital readmission rates
 - Patient/family satisfaction ratings
 - Emergency room visits, especially within three days of admission to the PAC venue
 - Scheduling of primary care visit within seven days after discharge from the PAC venue

PAC providers that have difficulty meeting expected achievement levels may receive additional staff education, and/or may be suspended from the network until they can comply.

Advocate Health Care

Advocate Physician Partners Accountable Care, a Chicago-based ACO composed of Advocate Health Care and a large physician group, has developed a preferred provider network of 37 SNFs.²⁰ Although Advocate owns a large HHA, as well as one SNF, the ACO realized that additional unaffiliated SNF partners would be necessary to meet the needs for its expanding volume of Medicare beneficiaries. Advocate initiated the SNF network in advance of entering into a commercial ACO relationship and the Medicare Shared Savings Program (MSSP) in 2011.

Advocate's partnership with high-quality SNFs has paid off as measured

by readmission rates and average length of stay. Between 2010 and 2015, 30-day hospital readmissions from partner SNFs dropped from 25 percent to 15 percent, while ALOS in these SNFs dropped from over 30 days to 17 days.

However, Advocate still faces the major challenges of reducing patient care services outside of their network, and understanding the great variance in 30-day hospital readmissions from their network SNFs. Only 30 percent of the ACO's hospital discharges to SNFs go to their network SNFs. In order to understand the reasons for the variance in hospital readmissions that do utilize network SNFs, Advocate began developing a risk of readmission score

for each patient, which has been built into their electronic medical record. The score translates to an expected number of readmissions from each of the network SNFs. By the end of 2015, Advocate hopes to augment its risk tools with its electronic health record (EHR) vendor to identify the most appropriate PAC setting for patient discharges.

“ ”
from the field

“We are looking forward to working with PAC providers in new and creative ways to achieve the goals of value-based payment using the payment structure in the new ACOs. We see a future emerging where post-acute providers can share in the risk and reward for creating new models of care that move a patient along the continuum and provide care in the most appropriate setting. Right now, we do not know exactly what these care pathways should look like. However, we know that successful post-acute providers of the future will need to be very good at what they do now, become very good at managing transitions and become creative with the use of home care.”²¹

– Jordan Asher, M.D., Chief Medical Officer and Chief Integration Officer, MissionPoint Health Partners, Ascension Health

SNF Strategies to Become High-value Partners

Many SNFs, particularly those in markets with an ACO, are modifying their physical plant and clinical operations to demonstrate they are a high-value provider. Such SNF initiatives include:

- Sub-acute units with private rooms and separate gyms and dining areas;
- All registered nurse (RN) coverage for PAC units or buildings, as opposed to a mix of RNs and licensed practical nurses (LPNs).
- Rehabilitation therapies provided six or seven days a week and physical or occupational therapy home visits to determine modifications necessary in order for the patient discharged to home to be successful in maintaining functional status.
- “SNFist” physician management of PAC units or buildings, with daily on-site coverage by Advanced Practice Nurses (APNs) and at least weekly visits by the primary care physician.
- Transitional care nurses who help patients and families navigate between hospital and SNF, and between SNF and home.
- Telephonic communication between the hospitalist and SNF physicians during the hospital discharge process, and between the nurse manager of the hospital unit and the nurse manager in the SNF.
- Cross-setting linkages for electronic medical records.
- Specialty rehabilitation programs for joint replacement, cardiac care or respiratory care.
- Standardized clinical care protocols for hospitals and PAC partners
- SNF acquisition of home health and hospice providers to improve patient transitions.

Next Steps for Post-acute Care

As the movement toward the Triple Aim brings increasingly more attention and change to the PAC field, we encourage policymakers and other stakeholders to focus on the following policy issues and protocols, which are very influential in determining which patients receive PAC services, as well as the nature of those services.

Strengthen Evidence Base for Next Stage of Delivery System Reform

Given the magnitude of difference between the current fee-for-service system and the alternative models being tested, it is essential that the eventual payment and care delivery paradigms for both hospital and PAC services be based on tested and proven principles. Many of

the models being tested are providing preliminary lessons, but their initial results and relatively brief existence do not yet support expansion. For example, BPCI is still too young to provide comprehensive lessons on bundled payment, with the majority of bundled payment entities entering the at-risk phase during 2015. Indeed, the BPCI evaluation

released by CMS in February 2015 lacked conclusive findings since the quantitative results were too limited.²² Further, the first two years of the MSSP program demonstrate that the model may be difficult to sustain in its current form given the low percentage of organizations that are able to generate savings. As a result, all of the parties involved in testing new payment models—policy-makers, payers, third party administrators and providers—are still in pursuit of the best practices upon which to build the next generation of payment systems that will strive to achieve the Triple Aim. These stakeholders and partners must avoid applying short cuts to this critical learning process that could ultimately impede the achievement of a reliable system. Instead, the current group of reforms must be allowed to run their course and be thoroughly evaluated prior to further expansion. Further, CMS should help ensure that stakeholders—including post-acute care providers—have the information needed to optimize the next stage of delivery system reform.

Increase Patient-centered Focus of Delivery System Reform

As the health care system continues to transition to value-based models, many hospitals are modifying protocols that pertain to patients who receive follow-up PAC services. Some of these reform efforts, such as the implementation of PAC provider networks, largely focus on cost-reduction. To implement patient-centered approaches, hospitals should consider non-clinical metrics as well as clinical outcomes data. Further, PAC outcomes data should be risk adjusted to avoid penalizing providers that appropriately allocate additional resources for sicker patients. The absence of risk adjustment can result in the undervaluation of PAC providers that are actually delivering high-value services for

patients with greater medical complexity, although at times, doing so may contribute a higher cost to the episode of care.

Streamline Data Collection Requirements for PAC Providers

Under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, CMS has begun to implement new reporting infrastructure to standardize the collection of patient assessment and quality data for all PAC settings. However, CMS has not yet articulated its overall vision for this important undertaking. CMS has, thus far, proposed piecemeal changes to begin to implement the IMPACT mandate. We encourage CMS to not only share its overall plan for IMPACT, but to consider how the IMPACT reforms will fit with the quality reporting requirements associated with other reform efforts, such as the BPCI and proposed CJR initiatives. The net result of this coordination should yield a more targeted and streamlined reporting infrastructure.

The AHA believes that, at least initially, the IMPACT mandate should be executed without a single PAC assessment instrument. Since an adequate scientific basis for a single, risk-adjusted tool is not yet available, in the interim, it is appropriate for CMS to focus on collecting common PAC data via consistent data metrics that replace the assorted measures in the existing PAC data collection programs. This approach should be implemented in a manner that does not expand the overall reporting burden for PAC providers, in contrast to some of CMS's duplicative PAC reporting requirements that have been finalized for fiscal year (FY) 2016.

If the IMPACT mandate ultimately yields a common PAC assessment tool, such a tool should:

- Include risk-adjusted metrics that facilitate a patient-centered and more

consistent process for developing a post-hospital plan of care and produce meaningful data on PAC outcomes. Such risk adjustment should include adjustment for socio-economic factors, such as poverty, education and the availability of food and housing, that are beyond the provider's control.

- Refrain from adding to the substantial reporting requirements of PAC providers.

With regard to the Medicare quality reporting programs for the PAC payment systems, there is a need to streamline the overall reporting infrastructure to tighten the focus on concrete national priority areas or goals for improving and lightening the overall reporting load. For this reason, the AHA supports adopting the recommendations to streamline and focus the national quality measurement efforts outlined in the IOM's recent *Vital Signs* report.

Improve Hospital-to-PAC Discharges

To help reduce PAC variation and improve patients' transitions of care, policymakers and stakeholders must closely examine the current discharge process to identify opportunities for improvement and allocate resources to develop the necessary policy fixes. Currently, multiple parties engage in a single discharge, in ways that vary from hospital to hospital, and patient to patient. To improve hospital discharges to PAC settings, the distinct parts of this multi-faceted process need to be studied as a comprehensive whole to pinpoint particular protocols that are incompatible, ineffective and confusing. To simplify this complex and highly variable process, it would be helpful for policymakers to clarify the current scope of roles for these parties and their prescribed interactions, including specifying which entities are authorized to lead the various steps involved with discharging a patient from a hospital to PAC.

The AHA recommends that any future efforts to simplify this process include the following components, in order to ensure the discharge process is streamlined and patient-centered:

1. Statute establishing the right of beneficiaries to choose where they receive hospital and medical services.
2. Medicare conditions of participation that set standards for the hospital discharge process.
3. A clarification of other related requirements or prohibitions that pertain to the discharge process and decision-making regarding the selection of the next setting of care, including how third-party administrators hired by health systems and ACOs fit within this process.
4. Additional requirements for the hospital discharge planning process, including mandatory information to be shared with discharging patients and the next setting during the discharge—as well as any information that is prohibited.
5. Meaningful use requirements mandating that hospitals transfer certain medical information to the discharging patient and first post-hospital setting.
6. Medicare guidelines establishing the treating physician as the director of care provided during a hospital admission, and in particular, the nature of this role as it pertains to a discharge and the development of a post-hospital plan of care.

Develop Alternative Approaches for Low-volume Providers, Including PAC Providers

Low-volume providers face challenges when participating in alternative payment approaches. Often, these providers have less access to capital resources. Less capital, in combination with a smaller patient population, makes these providers

especially vulnerable in alternative payment models where organizations are at financial risk. In these initiatives, one or two high-cost “outlier” patients may expose the provider to potentially devastating financial losses. Therefore, policymakers should take steps to enable such providers to participate in, help design and bear risk in such approaches. In particular, some PAC providers report great difficulty in identifying hospital and other partners that will allow PAC providers to assume risk.

One element that may support greater participation of selected PAC providers is the design of models that use longer episode lengths. Initial research indicates that longer episode periods—such as 180 days or greater, as utilized in the RML model—may identify gains in clinical outcomes and financial efficiency for certain medically complex patients. Allowing a segment of bundled payment demonstration participants to experiment with longer episode lengths may allow PAC providers to show the value and experience in treating certain long-stay, high-acuity patients.

Develop More Effective Risk Adjustment Methodologies

The emerging payment models that pay providers for an episode of care or according to patient characteristics, rather than by care setting, require effective risk adjustment to account fully for the numerous factors that affect spending and are beyond providers’ control. Such factors include severity of illness and co-morbid conditions. Given their widely acknowledged limitations, if current risk adjustment approaches are used in the next generation of payment models, Medicare would inappropriately penalize hospitals and PAC providers treating the sickest, most complicated and most vulnerable patients. In the final rule on the upcoming CJR bundled

payment program, CMS adopted some basic risk stratification, but not comprehensive risk adjustment because it does not believe that a sufficiently reliable approach exists for robust risk adjustment. Other policymakers face this same challenge, such as MedPAC in its work to develop a commonPAC payment system prototype, per the mandate of the IMPACT Act.

Enhance Regulatory Relief

Today, organizations testing bundled payments, ACOs and other new approaches must do so with very limited relief from Medicare’s regulatory criteria for PAC admissions. They largely must comply with many legacy regulations that were designed to fit with the fee-for-service model. This limitation greatly restricts the ability of these organizations to craft and test innovations that depart from the fee-for-service structure. To enhance this important period of learning about new clinical and payment methodologies, policymakers should:

- Expand waivers of key PAC regulations that inhibit the design of new partnerships and clinical pathways, and, ultimately, the lessons that can be gathered through BPCI and similar initiatives. CMS has recognized barriers these waivers present by lifting the SNF three-day stay requirement within BPCI Model 2, the CJR, and for certain ACOs. However, using the same policy rationale that justifies three-day stay relief, additional regulations, such as those listed in Chart 6, also warrant a waiver to allow PAC providers and their partners to design and field-test new protocols that accelerate movement toward the Triple Aim.
- Allow hospitals testing new models to direct patients to high-quality PAC settings to accelerate advances in high-quality care and movement toward the Triple Aim of health

Additional regulatory waivers in emerging care models would reduce barriers to innovation.

Chart 6: Requested Regulatory Policy Waivers for BPCI and ACO Participants

PAC Type	Current Policy that Would be Waived
HHA	Homebound Requirement: In addition to having a skilled need, Medicare requires that a patient be homebound in order to qualify for HHA services (waivers available for next-generation ACOs)
IRF	<p>Three-hour Rule: IRF patients must receive at least three hours of therapy at least five days per week</p> <p>60% Rule: At least 60 percent of all IRF patients (both Medicare and non-Medicare) must have conditions or diagnoses that fall within the list of 13 specific diagnostic categories, either as a primary diagnosis or as a qualifying co-morbidity</p>
LTCH	<p>25-day LOS Rule: LTCHs are required to have an average length of stay of greater than 25 days</p> <p>25% Rule: LTCHs receive a reduced payment for certain patients based on the volume of patients transferred to an LTCH from a particular general acute-care hospital</p>

reform. Specifically, as it has in prior demonstrations, CMS should allow health systems, ACOs and hospitals to test beneficiary incentives that attract, but not require, beneficiaries to utilize preferred networks, which could facilitate the benefits of coordinated care for beneficiaries who would be open to staying within a network. While the CJR model provides some key regulatory relief by waiving the SNF 3-day stay in some instances, this is a very limited, introductory step which should be expanded upon in this and other initiatives that seek to improve the discharge process. Another approach to test is to allow an ACO or health system to direct Medicare beneficiaries to a network of post-hospital providers that meet pre-set criteria that ensure quality and variety—which would align with the flexibility currently granted to Medicare Advantage

plans. To support the testing and development of these reforms, policy-makers also should develop risk adjustment methods that can help identify higher-quality PAC providers, rather than relying solely on cost, length of stay and readmissions.

- Consider providing flexibility for alternative payment models built on a fee-for-service foundation. Specifically, while IRF PPS *per-discharge* payments are based primarily on a patient’s clinical status, SNF PPS *per diem* payments enable SNFs to alter the payment per case by changing the days of service. This uneven playing field means that any new IRF efficiencies produced through care redesign, care coordination or other improvement cannot be reflected in the per discharge payment amount and cannot contribute to a bundler’s objective of producing episode savings. Therefore, bundlers and other

entities paid via an episode payment, when referring patients for PAC services, are incentivized to avoid IRFs—even for conditions and patients for whom this setting could provide unique clinical value. CMS should consider ways to level the playing field and help ensure patients receive the right care at the right time in the right place.

Summary

Selected PAC organizations are taking a leadership role in new payment models that are being tested to determine how care can be provided more effectively and efficiently. Early returns from these organizations show promising findings on improving care quality and reducing costs for selected conditions. At the same time, there are serious questions about how these models could be applied in PAC settings and rural locations where there is less volume, fewer patients and relatively lower capital reserves, as ongoing financial solvency in many of these models will be predicated on spreading financial risk across a patient population.

Moving forward, policymakers should ensure that the provision of care after a hospital discharge—often occurring in a PAC setting—can be supported as a core competency in care redesign models. Providing the option for PAC providers to accept risk or to limit financial risk, as necessary, in various models will be important, as will exercising the patience to await substantial, multi-year data findings before transitioning any payment changes from voluntary to mandatory. As shown by the organizations in this report, PAC providers are engaged and interested in new payment models; however, it is up to health care leaders to ensure that PAC providers are able to actively participate and continue to provide essential care services to patients.

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