POST-ACUTE CARE

Savings for Medicare Advantage Plans
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Post-acute care (PAC) comprises one of every four dollars spent by a Medicare Advantage plan. For certain conditions, such as congestive heart failure (CHF) or chronic obstructive pulmonary disease (COPD), post-acute care contributes nearly 70 percent of the total cost of care.1 Particularly as health plans seek additional savings to make their Medicare bids more competitive, taming PAC costs represents an important approach to bending the cost curve in healthcare.

Homing In: The Roles of Care Management and Network Management

Post-acute care spending can be controlled by closely examining two major areas: care management and network management. CareCentrix estimates that plans can reduce PAC costs by 20 to 25 percent through better management of these two major elements.

Care Management Opportunities

Care management involves evaluation and collaboration to ensure that effective and appropriate care is delivered to the patient. In post-acute care, CareCentrix recommends analysis in five categories; taken together, these areas represent significant cost-savings opportunities for Medicare Advantage plans.

1. Identify the Most Efficient Care Setting.

The cost of post-acute care is highly dependent on the location where that care is delivered. For example, care in a long-term acute care hospital (LTACH) costs more than in a skilled nursing facility (SNF), and SNF care is more costly than care delivered at home (approximately $1,500 per day, $440 per day, and $72 per two-hour visit, respectively). Higher-intensity care does not always bring better results, and studies show that patients do not always need the level of intensity to which they are discharged. Indeed, a recent study for knee replacement indicated “the use of inpatient rehabilitation compared with a monitored home-based program did not improve mobility at 26 weeks after surgery.”

**Recommended Action Item:** Evaluate your health plan’s discharge patterns against regional benchmarks and national averages (see Table 1). Consider implementing utilization management (UM) guidelines for higher-intensity facilities to ensure that patients who are discharged to higher-intensity settings are likely to benefit from that type of care.
As part of evaluating efficient care settings, health plans should pay particular attention to how the home may be used as the first site of care post-hospitalization.

### Setting of Care

<table>
<thead>
<tr>
<th>Setting of Care</th>
<th>Sample Health Plan Experience</th>
<th>State Average (OH)³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional Rehab Facility (IRF)</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>27%</td>
<td>23%</td>
</tr>
<tr>
<td>Home with Care</td>
<td>4%</td>
<td>12%</td>
</tr>
<tr>
<td>Home without Care</td>
<td>65%</td>
<td>63%</td>
</tr>
</tbody>
</table>

Table 1. Percent of Patients Discharged to Provider Type

2. **Focus Point: Consider “Home First” after a Hospitalization**

Over the past 30 years, the proportion of Medicare patients discharged from the hospital to a SNF instead of the home increased from 5 to 20 percent.⁴,⁵ As part of evaluating efficient care settings, plans should pay particular attention to how the home may be used as the first site of care post-hospitalization. Members without comorbidities and those who have support at home may be ideal candidates for a “home first” approach.

A recent analysis by CareCentrix indicated that 50 percent of patients who undergo a knee or hip replacement recover in a SNF. Of these patients, 23 percent had no comorbidities, which is an indicator that they may have been excellent candidates for a “home first” approach. A recent study indicated that most patients can be sent directly home after a joint replacement without increasing complications or adverse clinical events, even if they live alone.⁶ Sending patients home as the first setting post-discharge may have an accumulative impact; a 3-year study by Dobson DaVanzo and Associates discovered significant differences in costs for Medicare patients depending on their first setting post-discharge.⁷

**Recommended Action Item:** Consult with your clinical team and other specialists to determine if there are certain patients who would thrive with a “home first” approach. With proper program support, home care is significantly less costly than facility care.

3. **Care within Facilities: Monitor Length of Stay and Level of Care.**

Monitoring how long patients stay in facilities is important to controlling costs, but encouraging patients to be discharged too early can have negative impacts (such as readmissions). A sound post-acute care strategy must balance the risks accordingly.
An analysis by CareCentrix shows consistent patterns when analyzing the timing of SNF discharges. Patients tend to be discharged at days 8, 15, and 21—all tied to a standard seven-day approval cycle driven by historical reimbursement mechanisms. This pattern is amplified for Medicare patients, who often have higher cost-share amounts after staying 20 days in the SNF.

Similarly, not all patients need the same intensity of care when staying within a facility. Many plans have introduced UM and other clinical documentation requirements to ensure an appropriate level of care for each patient. SNFs are paid according to Resource Utilization Groups (RUGs) that provide higher payments for patients needing increased rehabilitation or nursing resources. Not all patients need to be at a higher RUG level and a program that evaluates this can be effective in assuring the right level of payment.

**Recommended Action Item:** Analyze the impact that standard lengths of authorization have on discharge patterns, and determine if more regular checkpoints are warranted to validate medical necessity during a SNF stay. Determine qualification, if you have the appropriate patient-classification indicators (e.g., RUGs or other coding), to evaluate if the level-of-care intensity being delivered to the patient is appropriate. If needed, craft new UM policies based on conditions or other relevant factors.

4. **Reduce Readmissions: Those Who Go “Home Alone”**

Twenty percent of Medicare patients discharged from the hospital are readmitted within 30 days. Of that group, 76 percent of readmissions were considered potentially avoidable.8,9

A recent CareCentrix analysis (see Figure 1) indicated that over 50 percent of all readmission costs could be attributed to one group: patients sent home without any post-acute care. This group that goes “home alone”, which can be mistakenly assumed to be able to manage the transition home safely, is at significant risk for readmission.

![Figure 1. Percentage of readmission costs incurred across discharge groups](image-url)
Studies show definitively that receiving home health services can reduce the likelihood of readmissions. In one study, 280,000 patients receiving home health experienced 24,000 fewer readmissions compared to a comparison group without home health. Medicare-per-member savings ranged from $4,588 to $10,725 for the period of care, depending on the severity of illness.10

**Recommended Action Item:** Analyze how many patients are sent “home alone” without any home health services or post-acute care. Increasing home health support—even if that means increasing spending allocated to this area—may help reduce readmissions, resulting in a dramatically lower overall cost of care.

5. **Reduce Fraud, Waste, and Abuse**

With the right tools and a systematic approach, plans can reduce Fraud, Waste, and Abuse (FWA) while realizing significant savings. Leveraging specialists in this area may be advisable, as FWA in post-acute care is typically a high-volume, low cost-per-unit business.

A recent analysis found that over 16 percent of nursing home visits are improperly paid in traditional Medicare. Some DME and orthotic items have improper-payment rates of over 50 percent and account for $3.7 billion in improper payments.11

**Recommended Action Item:** Consult with a specialist for typical problem areas, which may include oxygen service, continuous positive airway pressure (CPAP) costs, orthotics, wound dressings, and others. Artificial intelligence (AI) tools can often identify areas of across-the-board pricing abuse that add up to significant savings.

**Opportunities for Better Post-Acute Care Network Management**

Network strategies center on designing and managing a provider network that is capable of delivering the best care at the lowest possible cost. This task is particularly complex in post-acute care, where providers often deliver care in silos that are rife with conflicting incentives. Optimizing this complex web—for both patient outcomes and cost reduction—becomes an increasingly daunting endeavor.
In post-acute care, CareCentrix recommends network analysis in two categories:

1. **Network Optimization**
   The composition and experience of post-acute care facilities and home providers in the network are key drivers of cost-effectiveness. Not only does CareCentrix find significant variability in the quality and cost that post-acute care providers deliver, but this variability in PAC costs is the largest driver of overall variation in Medicare spending.\(^{12}\)

   Studies show that post-acute care providers who have more experience with a given condition are more likely to help patients heal successfully (potentially decreasing unnecessary utilization). Consider this finding: “Rehab facilities that handle more than two dozen hip fractures a year were more than 2x as likely to successfully discharge seniors within a month.”\(^{13}\)

   Furthermore, high-performing SNFs have lower lengths of stay than other SNFs by an average of 10 days, resulting in a $4,000-per-admission difference.\(^{14}\)

   Clearly, PAC network optimization is more than simply negotiating rates or supporting star ratings; plans must continuously seek to identify the right provider for each patient, guide care through proven pathways, and coach lower performers in the best practices that result in meaningful change.

   **Recommended Action Item:** Analyze both SNFs and home health providers based on the cost and quality of care they deliver for the specific conditions present in your population. Areas to consider are length of stay, readmission rate, total episode cost, and quality ratings. You may want to develop an action plan based on providers you identify as having high volume and low quality (see Figure 2), for example, sharing best practices to reduce quality variability.

2. **Preferred Providers**
   Developing networks of preferred providers, or a narrow network strategy, may also reduce costs. A recent study found that hospitals using narrow networks of SNFs had lower readmission rates compared to hospitals that did not create or use narrow networks.\(^{15}\)
Unfortunately, only 4 percent of patients receive information about post-acute care provider quality, and most patients are sent to the facility closest to their home,\textsuperscript{16} rather than where their care needs are best met. Almost uniformly, patients indicate they would be willing to travel further for a higher-quality provider.

By implementing a preferred network of providers with demonstrated high quality, plans may be able to optimize patient care and reduce costs.

**Recommended Action Item:** If your health plan has preferred provider relationships in place, look at strategies to decrease out-of-network leakage, including quality incentives if appropriate. A CareCentrix analysis indicates that typical out-of-network rates may be over 50 percent for SNFs, which indicates room for improvement. Health plans should leverage information tools that help patients and their care teams identify the best facilities and post-acute care providers to meet their needs.
Implementing an Integrated Approach

Ultimately, post-acute care is intensely interconnected. CareCentrix has developed an integrated approach to post-acute care that is patient-focused and home-centric. This integrated approach fills the gaps between fragmented services by identifying the best path for the patient’s care, engaging the highest-performing providers, and intervening for patients most at risk for readmission. This CareCentrix integrated approach is possible through proprietary technology that keeps patients, providers, and caregivers connected throughout the healing journey.

Most importantly, closely managed care coordination of the post-acute healing journey delivers untapped savings. With the integrated approach from CareCentrix, health plans can:

- Apply big data, advanced analytics, and predictive intelligence to identify the optimal path of care for the patient being discharged.
- Leverage specialized post-acute-provider networks to identify the providers with the best quality outcomes for the patient's condition.
- Reduce hospital readmissions and improve quality of care while allowing patients to heal in the comfort of home.
- Capture untapped post-acute care savings that allow Medicare Advantage plans to become more competitive and profitable in the bidding process.
References

3. Medicare fee-for-service data.
12. Institute of Medicine of the National Academies. Variation in health care spending