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Post-Acute Partnerships to Support Bundled Payments: Risk or Opportunity?

By Richard Bajner, Eric Logue, and Donna Cameron

Our analysis suggests significant cost-containment opportunities in the post-acute realm and suggests that providers are in a unique position to partner with such organizations to coordinate and manage care to improve outcomes and achieve efficiencies.

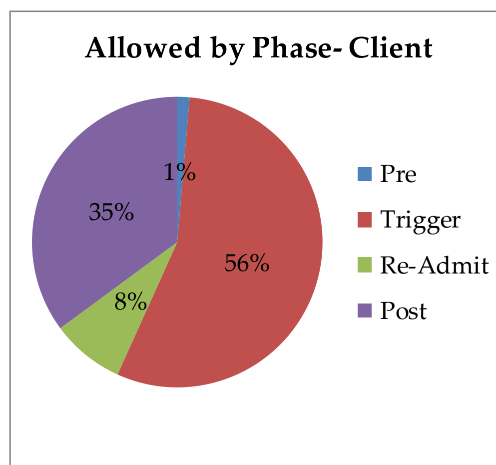
Due in part to the growth of accountable care organizations (ACOs) and bundled payments, many providers are developing post-acute partnerships that align hospital, physician, and post-acute interests around improving quality and reducing (episodic) costs. New payment models are shifting post-acute performance risk to an episode level of care, requiring hospitals and post-acute providers to work together to manage care across an episode.

Healthcare finance leaders are understandably cautious of these new partnerships, given the historical fragmentation of post-acute providers, the lack of relationships between hospitals and post-acute facilities, and the lack of “control” over post-acute processes and outcomes. Despite these risks, there are great potential opportunities in post-acute partnerships.

Post-Acute Opportunities and Risks

As shown below, several analytics that we preformed demonstrate the rationale and opportunity to align with post-acute providers. The analysis also points to a key take-away: Comparison of post-acute performance trends by provider highlight opportunities to align and improve quality and cost through clinical coordination efforts.

Analytic 1: Post-acute costs. Post-acute providers account for a large portion of episode-based costs for the most common conditions in bundled payments, including joint replacement, congestive heart failure, and stroke. The exhibit below illustrates that post-acute care accounts for 35 percent of episode cost in a joint replacement example. When added with readmission costs, post-discharge services accounted for 43 percent of episode costs.



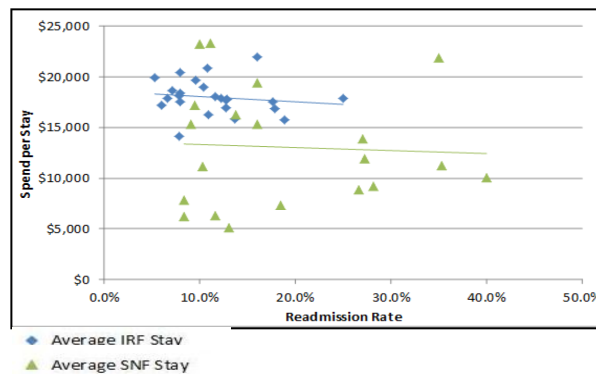
Source: Navigant Consulting, Inc. with data Medicare LDS Metadata Files.

Analytic 2: Variability in performance. Performance across post-acute providers varies significantly by both type of facility and by *individual* facility often with no correlation between cost and performance. The exhibit below compares the average post-acute cost per episode for stroke patients in a blinded market when discharged to a home health provider, skilled nursing facility, or inpatient rehabilitation facility (IRF). According to the analysis below based on a single market, post-acute costs at IRFs are approximately $9,000 more expensive than SNFs; however, have a 6 percent lower readmission rate back to an acute care hospital within 30 days.

	Initial Discharge Status (All Markets)		
Market Average	**Home Health**	**Skilled Nursing Facility**	**Inpatient Rehabilitation Facility**
Percent Discharged to Initially	15%	28%	23%
Total Post-Acute Spend Per Discharge	$3,139	$16,856	$25,965
Readmission Rate	10.1%	14.8%	9.5%
Allowed per Readmission	$8,086	$9,628	$8,457
Total Readmission Allowed Per Episode	$814	$1,426	$802

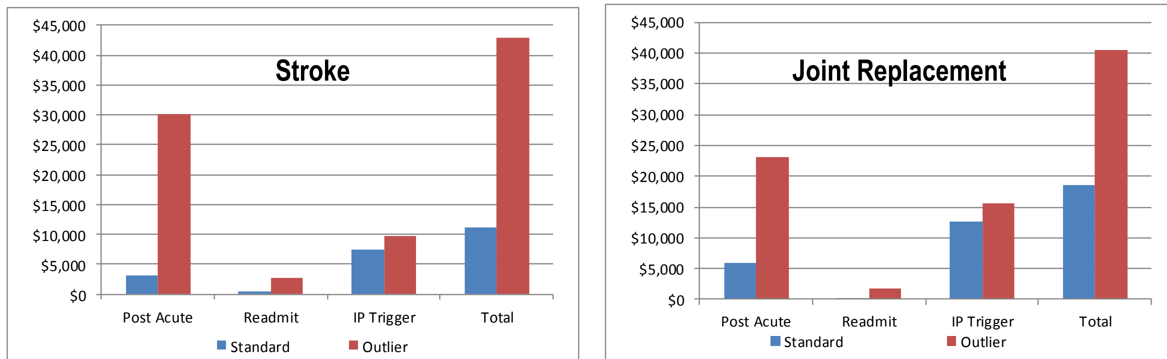
Source: Navigant Consulting, Inc. with data Medicare LDS Metadata Files.

However, as the exhibit below shows, individual cost and quality performance within a single market can vary widely. This exhibit illustrates the lack of correlation between cost and quality (readmissions) — and shows that individual performance varies widely.



Source: Navigant Consulting, Inc. with data Medicare LDS Metadata Files.

Analytic 3: High-cost outliers. Post-acute care costs drive the largest difference in costs of outlier versus non-outlier cases. When outlier cases are compared to standard cases, post-acute care drives upwards of 90 percent of the overall cost difference. As providers develop increasing sophisticated predictive analytics to identify drivers of outlier cases, specific initiatives need to be focused on managing care outside of the traditional inpatient setting to manage these high-cost outliers.



Source: Navigant Consulting, Inc. with data Medicare LDS Metadata Files.

Infrastructure Required

Most post-acute providers are often not prepared to assume performance risk associated with bundled payments and/or ACOs. In addition, post-acute providers have not historically been required to develop a value proposition to be the "provider of choice" following the acute care stay. Thus, hospitals should lead the process to developing the relationships and infrastructure required to coordinate with post-acute providers.

A number of best practices are emerging to engage post-acute providers in the care delivery model.

1. Build the architecture to support the collection and analysis of data across an episode on a continuous basis to measure quality and costs of care.
2. Develop clinical pathways and protocols, inclusive of post-acute providers.
3. Manage the transition of care from hospital to post-acute by limiting the number of personnel in the process and improving information flow across providers.
4. Engage physicians in care delivery across the post-acute environment.
5. Develop processes to engage and maintain communication with patients post-discharge to monitor health status to prevent readmissions.

Data-Oriented Winners

Achieving high-quality care from the perspective of the patients we serve does not end with their hospital discharge. While the 'system' has not been developed to coordinate care across a full episode, there are new incentives, including new payment models, to identify and develop relationships with post-acute providers. The winners will be those providers that create a high-functioning continuum of care, in part by using data and process improvement to lower costs, improve clinical outcomes, and achieve a high level of patient satisfaction.

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- Is your hospital partnering with a post-acute facility in a bundled payment or similar arrangement? Please share your experiences.
- What financial risks do you foresee in post-acute partnerships?