



Opportunities & challenges: The transformation of post-acute care in America



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About the data in this report

Data in this report comes from CarePort®, powered by WellSky®, a market leader in care transitions. CarePort's proprietary Admission, Discharge, and Transfer (ADT) and referral data is sourced from over 1,000 hospitals and 130,000 post-acute care providers across the United States. Payroll Based Journal (PBJ) staffing data and other data from Medicare.gov was also used. This report analyzed data generated between January 2019 and May 2022. Key analysis was led by Tom Martin; Gouri Chakraborti, MS; Terry Hawk, MS; and Kalon Mitchell.



About the author

Sharon Harder has over three decades of executive management experience in the healthcare industry and recently authored the book, *Face to Face Answers, 2022* (a comprehensive guide to home health and hospice face-to-face requirements). Sharon is the former Vice President of Finance and Administration for the Healthcare Financial Management Association (HFMA) and the former Chief Financial Officer for Help and Home, Inc. Currently, as President of C3 Advisors, LLC, Sharon helps clients develop the strategic vision required to improve their profitability and competitive position in the rapidly transforming healthcare marketplace.

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Executive summary

Since the Public Health Emergency (PHE) was declared in 2020, much has changed for healthcare providers. But it wasn't just COVID-19 that precipitated that change; providers went from not worrying much about procurement of equipment, supplies, and biologicals to worrying about it almost constantly as supply chains were weakened and prices rose precipitously due to the global impact of the pandemic.

Many hospitals throughout the country found themselves at capacity without enough staff to fill needed shifts. Skilled nursing facilities were overwhelmed with admissions and the need to keep both family members and other visiting professionals out of buildings to protect residents from infection. Patients who might have previously agreed to facility-based care following an inpatient stay insisted on going home for fear of exposure to the virus. Nurses exited the industry in droves, either through early retirement or in pursuit of other, less stressful ways to make a living. Non-skilled staff members (needed by all types of providers) seemingly disappeared from the labor market overnight, and those that were left began to lobby, often very successfully, for higher wages.

Even now, as the pandemic has begun to wind down, patients are still more likely to end up at home rather than in a post-acute facility. Nurses are still in short supply and the staffing crisis is affecting the ability of many post-acute providers to accept and care for patients as quickly as needed.

The looming question is how — and how long — the changes brought on by COVID-19 will linger. Will new, innovative programs such as the Hospital at Home experiment become permanent fixtures along the continuum of care? Will the healthcare workforce recover — and if so, when? Will hospital admissions and inpatient population characteristics go back to what they were before the PHE? Will SNF referrals and admissions grow, or will they plateau at pre-pandemic levels due to changing patient preference about where care is received? Will looming post-acute reimbursement cuts, together with other pressures, impact access to care in 2023 and beyond? All these questions and more are relevant as we explore where post-acute care is headed.

Introduction

In early 2020, not a day went by when we did not think about, hear about, or ponder the COVID-19 pandemic and its lasting effects on daily life and healthcare in this country. In America, the PHE that resulted will be remembered as the perfect storm that caught the entire healthcare industry — and most of the people we serve — completely off guard. More than 84 million people in the U.S. contracted COVID-19, and more than a million of them died from the virus or its complications — something that was unthinkable in March 2020 when the PHE was declared.

Since then, we've collectively focused on returning to "normal." We're making progress; however, "normal" looks and feels a bit different — especially for those who offer healthcare services. They say change is inevitable. Healthcare providers are certainly in the midst of fundamental change right now. The looming question is how much of the paradigm shift imposed by COVID-19 will become our permanent "new normal."

It's important to understand the full impact of the pandemic on how and where care will be delivered in the future as well as underlying conditions that are simultaneously shaping multiple trends. This paper will focus on five key, interrelated facts that are impacting post-acute care providers now and likely into the future:

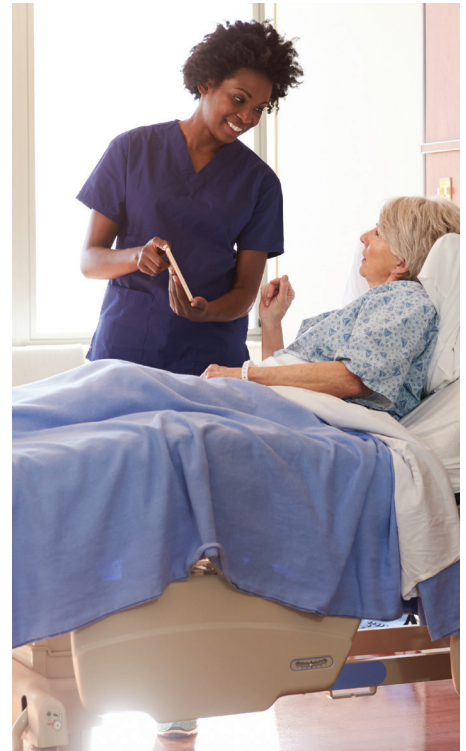
- 1. While hospital inpatient admissions have rebounded following the declaration of the PHE, the characteristics of hospital inpatient populations have changed, with a probable material effect on post-acute providers.** Before the pandemic, hospitals depended heavily on elective surgical procedures that fed both revenue and the bottom line. However, as the pandemic intersected with prior CMS rulemaking, some orthopedic procedures previously performed exclusively on an inpatient basis have gradually migrated to outpatient settings. During the early months of the PHE, this — together with the temporary curtailment of elective surgeries — had a major effect on both hospitals and post-acute providers that will last well into the foreseeable future.
- 2. There is high demand for post-acute services, but capacity constraints are preventing some individuals from accessing necessary care in a timely way.** This is a classic supply-and-demand problem that has the potential to not only affect patient wellbeing and outcomes of care, but also the total cost of care



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for patients who are hospitalized longer or discharged without the safety net provided by post-acute services.

- 3. The pandemic has solidified preferences for receiving healthcare at home.** This trend began before the pandemic but gained significant momentum as patients and their families avoided institutional healthcare settings, especially skilled nursing facilities (SNFs) and other post-acute venues, for fear of contracting the virus or spreading it. Recent studies suggest that this trend toward healthcare at home is only getting stronger.
- 4. Intensifying labor shortages are negatively impacting the ability of post-acute providers to improve revenue and financial viability.** Labor shortages and consumer preferences for avoiding facility-based care are causing significant concern for the survival of some SNFs as they contend with shrinking occupancy and increased labor costs. Home health providers are similarly affected as they are forced to turn down or delay services to new patients based on staff shortages. Both SNFs and home health providers are also coming to grips with CMS recommendations related to 2023 reimbursement cuts, which will not make it any easier for these post-acute providers to engage additional, highly competent professional staff.
- 5. PAC providers are dealing with higher acuity patients more than before.** The average length of stay at hospitals increased throughout 2020 and 2021, along with various acuity index values, suggesting that patients being discharged from hospitals to post-acute venues are sicker than they were in 2019. Especially as hospitals worked to make room in 2020 and 2021 for incoming COVID-19 patients, post-acute providers with resource constraints were providing care for these patients. In some cases, especially for home health, even though the patients were sicker, care intensity (as depicted by service volume) counterintuitively decreased.





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The growing shift from institutional care to healthcare at home

In healthcare, we often talk about the progression of a patient through high-intensity institutional care modalities (for example, short-term acute care hospitals or STACH) to post-acute care facilities (SNFs, inpatient rehab or IRFs, and long-term acute care hospitals or LTACH) followed by home health, and later, non-skilled assistive care, for some.

The traditional continuum of care was challenged well before the PHE with the introduction of care-bundling experiments, such as the Comprehensive Joint Replacement model through which hospitals were given a set amount of dollars intended to cover both the inpatient procedure and post-discharge care. The result was not surprising. Participating hospitals largely ignored inpatient post-acute care and transferred patients directly to home health in order to save money and preserve their margins. The practice arguably placed some patients — especially those who were older, more frail and contending with multiple comorbid health problems — back in their homes too soon; a fact that the SNF community was quick to point out.

Baby Boomers, as the newest group of Medicare beneficiaries, are also influencing the shift away from institutional services as they opt to stay in their homes longer instead of moving into organized care communities as they age. This group — heavily impacted by the 2008 recession, loss of investment earnings and damage to the housing market that left many with fewer retirement resources than planned — has fueled not only the growth in Medicare-managed care in the last decade but also preferences for how and where they receive healthcare services. As this demographic continues to age, many are predicting significant growth for home-based post-acute services driven in large measure by this beneficiary group.

Post-acute care in the future

Since the beginning of the PHE, we have seen mounting evidence that the continuum is shifting away from institutional care toward less expensive home-based alternatives. Patient preferences have accelerated the momentum. Examples can be found in the Hospital at Home waiver program that may become permanent through the passage of the Hospital Inpatient Services Act. Large home health providers have also



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begun to tout SNF-at-Home programs of their own to attract higher acuity patient referrals through health system relationships. Another legislative initiative is the Choose Home Care Act of 2021 (S. 2562/H.R. 5514) aimed at bypassing facility-based care in lieu of similarly intensive post-acute service at home (subject to a new set of Conditions of Participation that will guide service delivery). CMS also added to the trend through prior rulemaking that adjusted its Inpatient Only procedure list with an incremental elimination of certain orthopedic procedures, including knee and hip arthroplasty. This will have a lasting effect on the reimbursement of downstream post-acute services.

It's been estimated by McKinsey & Company that within the next three years, as much as \$265 billion (representing a quarter of all Medicare expenditures, including fee-for-service and Medicare Advantage) could move from institutional and facility-based care to healthcare at home¹. In healthcare, three years is as brief as a heartbeat. The same article also notes that provider viability will be an important factor in the shift, which will likely require significant work to develop formal and informal care networks, partnerships, and joint ventures among all providers in the care continuum. If CMS continues to erode post-acute reimbursement to achieve budget neutrality, the financial strength of providers may become an even bigger concern. Public policy in the form of CMS rulemaking efforts will need to evolve and take advantage of the shift toward providing more care at home with an expected result of significant cost-of-care reductions for the Medicare Hospital Trust Fund (which pays for Part A services). The concept of budget neutrality for a particular industry sector may have to take a backseat to lowering the total cost of care. This is exactly why private equity is more interested than ever in home-based care alternatives but with a preference toward highly integrated care offerings designed to lower the total cost of care rather than the traditional, single focus of home health or SNF care as a standalone service.

¹McKinsey & Company, "From facility to home: How healthcare could shift by 2025," Oleg Bestsenny, Michelle Chmielewski, Anne Koffel and Amit Shah, February 2022.



All these things are influencing the answer to the major healthcare question arising in the aftermath of the worst of the pandemic. Whether — or more to the point, the degree to which — pandemic-related shifts in care delivery will permanently shape post-acute care in the future and the resulting ramifications for Medicare payment policy. The key to preserving Medicare and controlling the total cost of care will be to place all patients in the right setting at the right time based on their individual health needs, moving them along the care continuum as quickly as possible toward a healthy state at home.

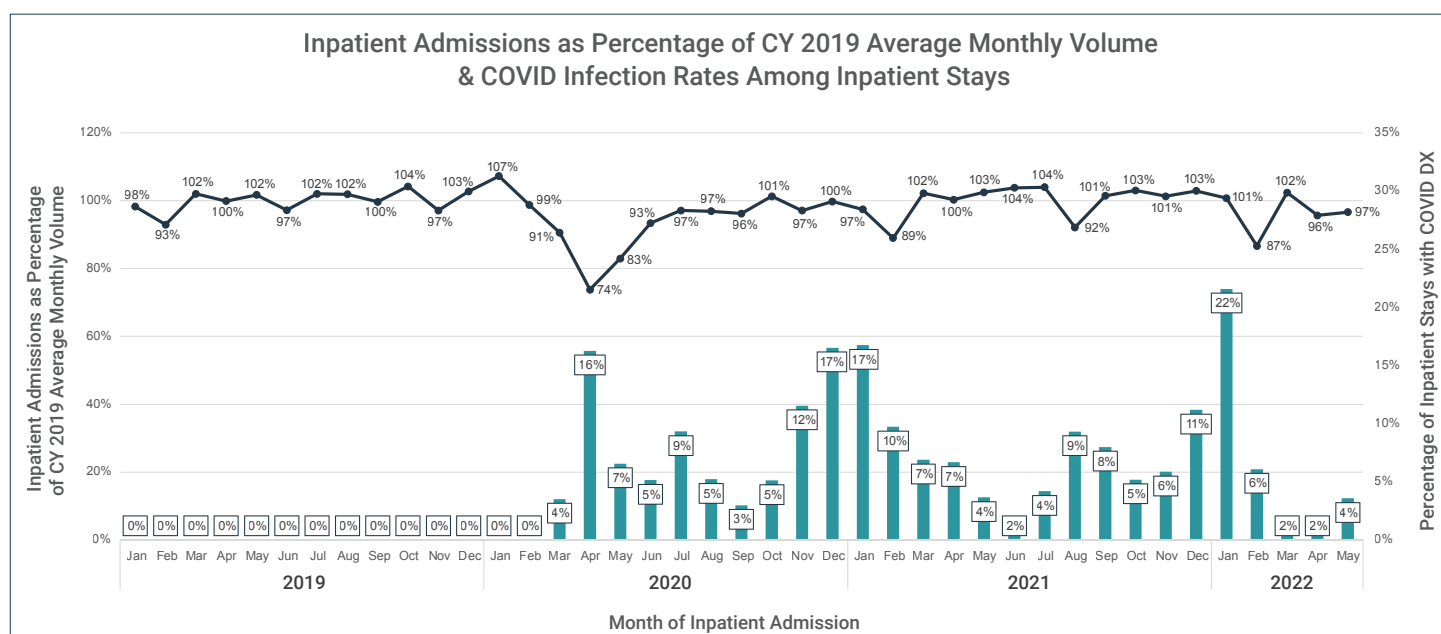


Fact #1

Hospital inpatient population characteristics have changed

The demand for post-acute services directly correlates with hospital admission activity, both in terms of volume and the types of patients admitted. As the following graph (using WellSky data²) shows, hospital inpatient admissions declined in 2020 as COVID-infection rates grew and elective procedures were temporarily curtailed. As the PHE began, 4 percent of patients admitted to WellSky client institutions² had a diagnosis of COVID-19. Later, hospitals took action to free up capacity for expected admission surges brought on by anticipated COVID-19 outbreaks. The result was that inpatient volume decreased to only 74 percent of the prior year's admission volume as surgical procedures were cut back to preserve available bed capacity.

² The data comes from CarePort, a WellSky company providing services to hospitals and health systems, physicians, post-acute providers, ACOs and payers regarding utilization, coordination of care, network management, discharge planning and effective care transitions, value based programs and quality. CarePort data is drawn from more than 1,000 hospitals and 130,000 post-acute provider organizations across the U.S. Data used for this graph and the one following was taken from 97 health systems that provided continuous data on admissions by major diagnostic category between January 2019 and May 2022.



Inpatient admissions had fully recovered a year later as hospitals began to see volume increases, but the characteristics of the patient population had shifted dramatically. It also became clear in early 2022, as variants of the COVID-19 virus emerged, that any recovery may be interrupted from time to time in response to rising infection rates. One example is the doubling of hospital admissions for patients with serious respiratory conditions in January 2022, followed by a drop in admissions the following month — presumably related to another, more informal postponement of certain elective procedures that could be safely delayed for a short period.

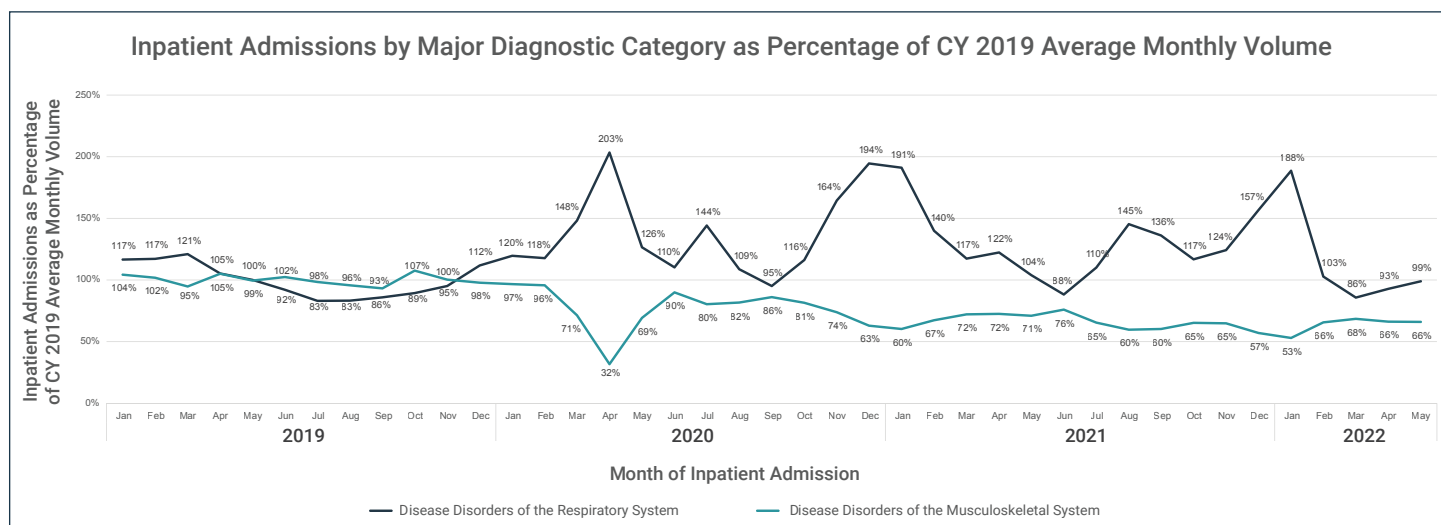
As we think about hospital admission trends during the pandemic, it's important to remember that even with the changes to inpatient-only orthopedic procedures, CMS recommended a complete cessation of elective surgery in March 2020. The agency released new guidelines allowing for the gradual resumption of elective procedures based on hospital discretion and patient need about two months later³. Nonetheless, during the PHE, hospitals and their post-acute counterparts experienced a significant change related to the temporary stoppage of elective surgical procedures, both in terms of revenue and associated profit. In a study published in *International Orthopedics* in July 2020, it was estimated that elective musculoskeletal (MSK) surgery accounted for somewhere between \$65.6 and \$71.1 billion in annualized hospital reimbursement, yielding a net income between \$15.6 and \$21.2 billion per year⁴. That equated to a profit loss between \$1.3 and \$1.8 billion per month between March and May 2020 related to elective MSK procedures that had previously contributed 23 percent of hospital net income for encounters among all specialties. The halt of elective surgeries significantly affected hospital operating results, particularly in the face of rising costs for personal protective equipment, increased staffing and other expenses associated with COVID-19.

WellSky data used for the graph below shows exactly how the nature of inpatient admissions changed due to the shift between patients admitted with respiratory conditions and those with MSK conditions from 2019 through May 2022. The reality is that admissions with Major Diagnostic Categories related to MSK conditions and procedures have not entirely recovered their prepandemic levels, and, most likely never will, as providers deal with the shift toward outpatient service venues⁵. In fact, by examining the trend from the following graph, it's clear that while pent-up demand for MSK procedures drove a small surge in demand by January 2021, the trend has been slowly declining since, with orthopedic services dropping to 66 percent of the corresponding 2019 volume by May 2022.

³ Center for Medicare and Medicaid Services. Non-emergent, elective medical services, and treatment recommendations. <https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf>

⁴ International Orthopedics (2020), Economic implications of decreased elective orthopaedic and musculoskeletal surgery volume during the coronavirus disease 2019 pandemic, Matthew J. Best, Keith T. Aziz, Edward G. McFarland, Gerard F. Anderson and Uma Srikumaran, <https://link.springer.com/article/10.1007/s00264-020-04713-8>

⁵ Even though CMS reversed itself in January 2021 and reinstated most of the 2020 Inpatient Only List of procedures, which had earlier been slated for removal in 2021, certain orthopedic procedures that had been previously eliminated were left off the list, along with spinal infusion, shoulder reconstruction, and ankle reconstruction, which were not added back. Total knee arthroplasties were removed from the list as of January 2018 (with continued hospital discretion as to whether procedures would be performed on an inpatient or outpatient basis). Total hip arthroplasty was removed in 2020. Orthopedic procedures have been referral mainstays for both SNFs and home health agencies for many years; however, outpatient procedures do not confer patient eligibility for SNF services in the absence of a §1135 waiver and also have the effect of reducing reimbursement for home health services under PDGM due to admission source reimbursement differentials.



Fact #2

Post-acute service demand is strong

As we think about the role of post-acute providers in the care delivery spectrum, it's useful to understand some of the relevant statistics that pertain to each type of provider and the share of Medicare dollars consumed by each⁶.

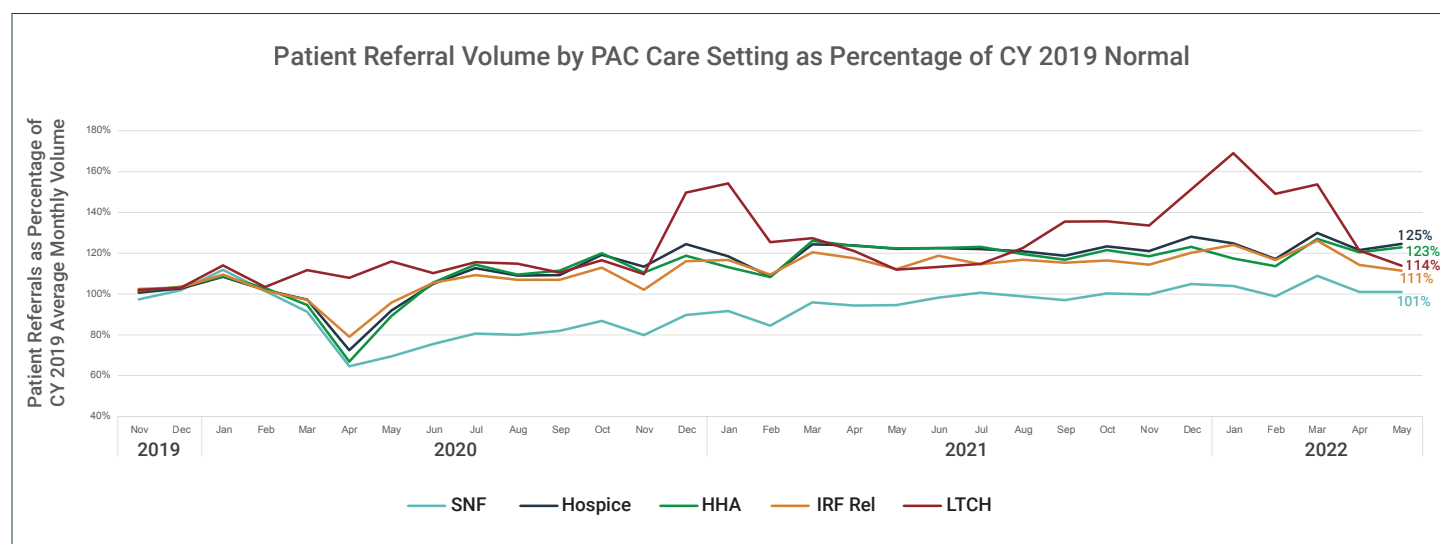
- According to CMS, there are 6,214 hospitals in the U.S., and this number includes the 347 LTACHs and 314 IRFs. Hospitals, in the aggregate, accounted for more than \$130 billion in Medicare reimbursement in 2020.
- There are 15,015 SNFs that received \$28.6 billion in Medicare fee-for-service reimbursement in 2020.
- Home health agencies numbered 11,221 in 2020 and received a total of \$17.1 billion in Medicare reimbursement under Parts A and B. Approximately \$6.3 billion (37 percent) was attributable to Part A for patients who had been previously hospitalized before being admitted to home health.
- Hospices accounted for \$22 billion in Medicare reimbursement during 2020.

Clearly, when it comes to post-acute care destinations, SNFs and home health agencies lead the pack in terms of hospital discharges where there is an expectation of follow-up therapeutic care.



⁶ CMS Fast Facts, March 2022

As depicted in the graph below, when the pandemic surged in the second quarter of 2020, IRF and hospice referrals increased while SNF referrals dropped precipitously to only 69 percent of their 2019 average. In later quarters, though SNF referrals rebounded somewhat, referrals to all other post-acute venues increased even more, confirming that there was strong ongoing demand (especially for services at home rather than in a facility setting). By May 2022, home health referrals were up 123 percent compared to 2019. By May 2022, SNF referrals had recovered — but only to pre-pandemic levels.



Interestingly, even with the drop in SNF referrals between 2019 and 2020, Medicare fee-for-service expenditures rose for SNF services. The opposite happened for home health as referrals increased and reimbursement dropped — a fact that is both surprising and confusing in light of the proposed 4.2 percent decrease in the home health standard payment rate (based on reasoning that the home health Patient Driven Grouping Model accounted for an estimated \$2 billion overpayment to home health providers during 2020 and 2021⁷).

⁷ The 2023 Home Health Proposed Rule estimates that Medicare payments in 2023 would decrease by \$810 million based on an overall 4.2% payment decrease. The overall decrease reflects a 2.9% home health payment update (a \$560 million increase) together with a 6.9% decrease (amounting to \$1.33 billion) reflecting a behavioral adjustment that is proposed to become permanent followed by a 0.2% decrease related to the fixed dollar loss ratio calculation. The net effect is a 4.2% reduction of the standard payment rate that is used, together with applicable wage index values, to calculate case-mix reimbursement.

Table 1
SNF Medicare FFS statistics | 2019 through 2020

Description	2019	2020	Trend
Covered admissions	2.2 million	2 million	10% decline between 2019 and 2020
Program payments	\$27.1 billion	\$28.6 billion	5% expenditure growth from 2019 to 2020
Program payments per person	\$16,708	\$19,541	17% increase in reimbursement per beneficiary
Payments per day	\$489	\$534	9% increase in reimbursement per day
Expired prior to discharge	55,506	84,636	52% increase in mortalities from 2019 to 2020

It's worth mentioning that not all SNFs fared equally during the first years of the PHE. The bulk of Medicare SNF payments — \$17.6 billion (62 percent) in 2020 — went to facilities with between 50 and 149 beds, with an average payment of approximately \$13,458 per stay. In comparison, larger facilities with at least 200 beds gleaned about 12 percent of total payments but with an average per-stay reimbursement of \$17,029 — about 26 percent more than their smaller counterparts (representing approximately three additional days per stay). The aggregated result was that even though SNF referrals declined by 10 percent, total Medicare fee-for-service reimbursement increased by 5 percent (\$1.5 billion).

There was also a 52 percent increase in the number of mortalities that occurred in SNFs during 2020. Proof of this can be seen in the COVID-19 mortality statistics showing that 31 percent of all COVID mortalities through the end of May 2021 occurred in nursing homes. The mortality rate is also supportive of the premise that patients who were discharged to SNFs as the pandemic surged — and later to self-care or home health — were sicker than they had been in prior years and more likely to die.

On the other hand, home health referrals increased every quarter (starting in the third quarter of 2020), even though program expenditures declined by 5 percent during the first year of PDGM. This speaks to a related WellSky finding that a high percentage of patients who were referred for home health did not receive services, either because home health agencies were unable to take the referral or because patients elected not to allow visits in their homes in the earliest days of the pandemic for fear of exposure.



From the CMS data, it's clear the average cost of a SNF stay at \$19,541 was more than three times more expensive than the average \$5,592 cost of home health in 2020. The question is whether SNFs are better at preventing hospital readmissions than their home health counterparts. Some of the data is surprising.

Table 2 HHA Medicare FFS statistics 2019 through 2020			
Description	2019	2020	Trend
Covered admissions	3.3 million	3 million	10% decline in actual admits
Program payments	\$17.9 billion	\$17.1 billion	5% decline in reimbursement
Program payments per person	\$5,440	\$5,592	3% increase in payments per person
Payments per visit	\$178	\$203	14% increase in per visit payments
Percentage of nursing visits	46%	50%	4% increase in nursing visits
Percentage of therapy visits (PT, OT, SLP)	46%	42%	Offsetting 4% decrease in therapy
Percentage of aide visits	7%	6%	1% decline in Aide visits

In a study published in the [Journal of the American Medical Association Internal Medicine](#), using claims data from 2011 through 2016, it was observed that “unadjusted patient outcomes were significantly better among patients discharged to home care: 15.8% were readmitted to the hospital within 30 days vs 17.8% of those discharged to a SNF; 2.3% died within 30 days compared with 6.9% of those discharged to a SNF; and 80.2% had an improvement in activities of daily living vs 29.3% of those discharged to a SNF”⁸. (Note: The study did not appear to take patient acuity or severity of illness into account.)

It's expected, especially considering Medicare Value Based Purchasing programs and hospital readmission penalties, that post-acute referrals from hospitals will remain strong as a hedge to control unplanned readmissions — each of which costs an average of \$15,500. To meet program expectations, facility-based post-acute providers will want to increase the rate at which they discharge their patients to a lower level of care to ensure that patients remain stable and out of the hospital following their departure from the facility.



⁸ JAMA Internal Medicine, Patient Outcomes After Hospital Discharge to Home with Home Health Care vs to a Skilled Nursing facility, Rachel M. Werner, MD, PhD; Norma B. Coe, PhD, Minguy Qi, MS, R. Tamara Konetzka, PhD, March 11, 2019

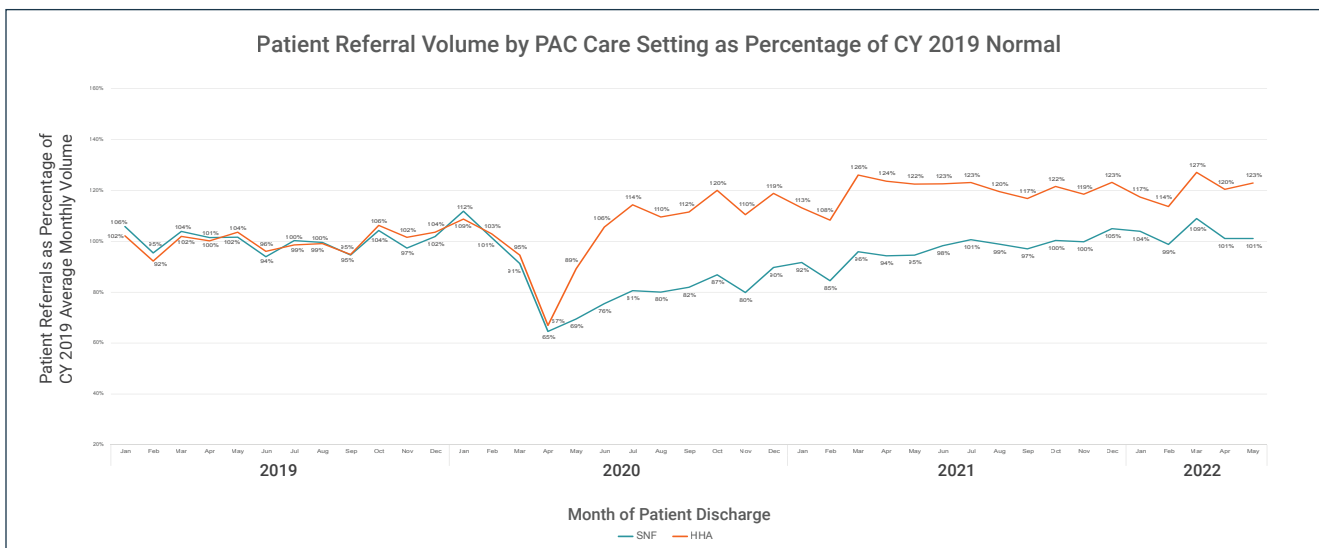


Fact #3

Patients prefer care at home

Patient-expressed preferences for receiving healthcare services at home did not originate because of the pandemic, but it appears that the sentiment was significantly strengthened by it.

The following graph illustrates how patient preferences materialized once the pandemic was in full swing, with home health referral volume significantly outpacing SNF referrals every month after April 2020. Even as SNF referrals recovered, home health referrals still accounted for most of the new post-acute destination volume, with home health referrals coming in at 123 percent of the 2019 levels and SNF referrals at 101 percent by May 2022.



In a poll conducted by the Partnership for Quality Home Healthcare in August 2021, 86 percent of adult respondents said that they would prefer to receive post-hospital, short-term healthcare services at home, while 5 percent indicated a preference for care in a nursing home⁹. Nine out of 10 respondents indicated that it was important to be able to choose the setting in which they or a loved one received care following a hospitalization, and 87 percent of the respondents also said that expansion of healthcare options (such as those embodied in the Choose Home Care Act of 2021 (S. 2562/H.R. 5514)) should be a priority.

The focus on patient preference is also driving other legislative initiatives aimed at care offerings at home. The Acute Hospital at Home Waiver is

⁹ Morning Consult, Partnership for Quality Home Healthcare, Choose Home Care Act, Polling Presentation, August 2021, http://pqhh.org/wp-content/uploads/2021/09/PQHH-Logo_Home-Health_Final_8.19.pdf

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a prime example of CMS's willingness to support more intensive care in a home setting. The waiver was first announced in November 2020 as a tool that could divert patients away from hospital settings more quickly to make room for new COVID-19 cases. Under the ongoing waiver, hospital-at-home services are now being offered by 203 hospitals in 34 states. The waiver precipitated a pending Senate bill, the Hospital Inpatient Services Act (S. 3792/H.R. 7053), that would extend the program for two years following the end of the PHE with a requirement that CMS issue regulations to govern the program standards and reimbursement within one year. The current version of the bill also requires that the Secretary of Health and Human Services conduct research that could lead to permanent reimbursement and program adjustments for home-based services. As economist Milton Friedman once said, "Nothing is so permanent as a temporary government program," and it is not outside the realm of possibility that other waivers will also follow the same path. Indeed, many home health advocates hope that legislation enabling the reimbursement of telehealth services under the home health benefit will be next.

Finally, on the patient choice front, physicians are also weighing in. Forbes magazine recently made reference to a widely touted survey performed by William Blair in 2020, in which 81 percent of physicians responsible for hospital discharge planning indicated a preference for sending their patients to home health rather than a SNF upon hospital discharge. Before the pandemic, only 54 percent of surveyed physicians felt that way¹⁰.

¹⁰ Forbes, Home Health is a Bright Light During COVID-19 with an Even Brighter Future, Seth Joseph, August 5, 2020.

Patient preferences for care at home are probably here to stay. The imperative for both hospital discharge planners and post-acute admission teams is to ensure that the right patient gets to the right post-discharge destination to maximize potential health outcomes.



Fact #4

Intensifying labor shortages are impacting post-acute admissions and access to care

As with our observation concerning shifting patient and physician preferences, the labor shortages that are affecting virtually all healthcare organizations are not new. However, they did get worse as the pandemic has worn on, and recovery is unlikely for several years for many different reasons. If there is a “good news/bad news” story for post-acute providers, it is that demand is up, but capacity has never been more tenuous than it is now due to inadequate staff resources. ECRI, a company that assesses patient safety concerns around the world, has published its 2022 report that designates the staffing shortage as the leading patient safety concern in 2022, followed by the overall mental health of clinical field staff as they continue to deal with COVID-19¹¹. And, there is more than anecdotal evidence to suggest that patient safety and care quality are two factors that are influencing some nursing professionals to retire or find alternate employment opportunities that do not involve direct patient care.

The underlying reasons for the shortage of nurses differ somewhat from the reasons attributable to the shortage of people willing to work as aides/personal care workers. For this reason, we will examine each group separately.

Nurses

The World Health Organization, well in advance of the emergence of COVID-19, declared 2020 as the Year of the Nurse and Midwife in an attempt to bring attention to the need for 9 million more nurses. But then the pandemic began. From March through October 2020, thousands of nurses experienced job loss or curtailment of their hours as their places of employment either shut down entirely or drastically reduced workloads. There were hot spots in the early days, especially in the Northeast, where nurses could get a job anywhere, but that was not the case for others in the Midwest, South, and West, where COVID-19 was not yet rampant. Even in the absence of widespread outbreaks in some states, shutdowns

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¹¹ Top 10 Patient Safety Concerns in 2022, ECRI, <https://www.ecri.org/top-10-patient-safety-concerns-2022>

simply brought healthcare to a screeching halt. Some nurses elected to travel, but others could not due to family constraints. Those who were under-employed or unemployed suffered financial and emotional distress, which caused many to leave the profession altogether. Others who remained fully employed suffered significant mental health issues related to traumatic work events, lack of sleep and anxiety. The exodus was also worsened by early retirements because nearly a fifth of all RNs were at or over the age of 65 when the pandemic started. As nurses have retired or exited the profession, fueling a turnover rate of more than 18 percent, there have been too few replacements waiting in the wings. Those who are in the market are able to entertain multiple offers that substantially exceed what some post-acute providers are able to pay. As an added deterrent, CMS has also acknowledged that home care workers were not correctly classified as “essential workers” during the PHE, which limited the ability of home health and private duty agencies to acquire sufficient supplies of PPE, COVID tests, and vaccines — thus, creating additional concern among those workforces¹².

The need for nurses remains intense. Some hospitals and health systems have been offering very significant sign-on bonuses for the last several years, and there are few post-acute providers in the position to compete

¹² CMS, COVID-19 Intensified Home Care Work Challenges, <https://aspe.hhs.gov/reports/covid-19-intensifies-home-care-workforce-challenges-policy-perspectives-issue-brief>

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with upfront payments that approach a large percentage of an annual salary. The salary differentials among different types of providers are also significant. Using average annual wage rates published by the Bureau of Labor Statistics (BLS), RNs in a hospital setting can expect to make an average annual salary of \$85,000 per year. Those working in outpatient care centers can expect to receive, on average, just over \$93,000, while home health nurses earn just over \$78,000. Moreover, other studies suggest that actual RN hourly rates between 2020 and 2022 have increased by more than 28 percent, while LPN hourly rates have risen by a third¹³.

Adding to the gap, more than 80,000 qualified nursing school applicants were turned down in 2019 – the year before the pandemic started – due to inadequate faculty, clinical sites, classroom space, and an absence of funding to support expanded enrollment. And, the gap is only expected to get bigger as BLS expects there to be demand for an additional 175,900 positions for nurses every year until 2029.

Aides and personal care workers

Between now and 2026, nursing aides and those working as personal care workers will be the positions post-acute providers need the most, according to both BLS and the ECRI 2022 Patient Safety Report. There will be 678,300 job openings by 2026, and it's expected that 368,100 aides and/or personal care workers will move on to other occupations that are perhaps higher paying and less stressful in the interim. BLS projects a growth rate for these workers of 33 percent between 2020 and 2030, with home health being the second largest employment sector for this group. Individuals in that sector can expect to earn, based on government averages, about \$28,000 per year. Other reports peg CNA wages in SNFs at closer to \$25 an hour in 2022, which would yield a full-time equivalent wage of \$52,000 a year¹¹.

A result of the labor shortage – Turning away referrals

Demand for post-acute care is up. Unfortunately, the referral rejection rate is also up. By the first quarter of 2022, the rate of referral rejection among SNFs had climbed to 88 percent, even as the number of referrals grew. Diminished staff capacity is the reason cited most often.

Home health referrals doubled from 2019 to 2022 for the same period, and rejection rates grew to a high of 71 percent among WellSky's client base, compared to a low point of 49 percent as the PHE began in the second quarter of 2020.



¹³ Clifton, Larson, Allen State of the Skilled Nursing Facility Industry, May 2022, <https://www.ahcanca.org/News-and-Communications/Fact-Sheets/FactSheets/2022%20State%20of%20the%20SNF%20Industry%20Report.pdf>

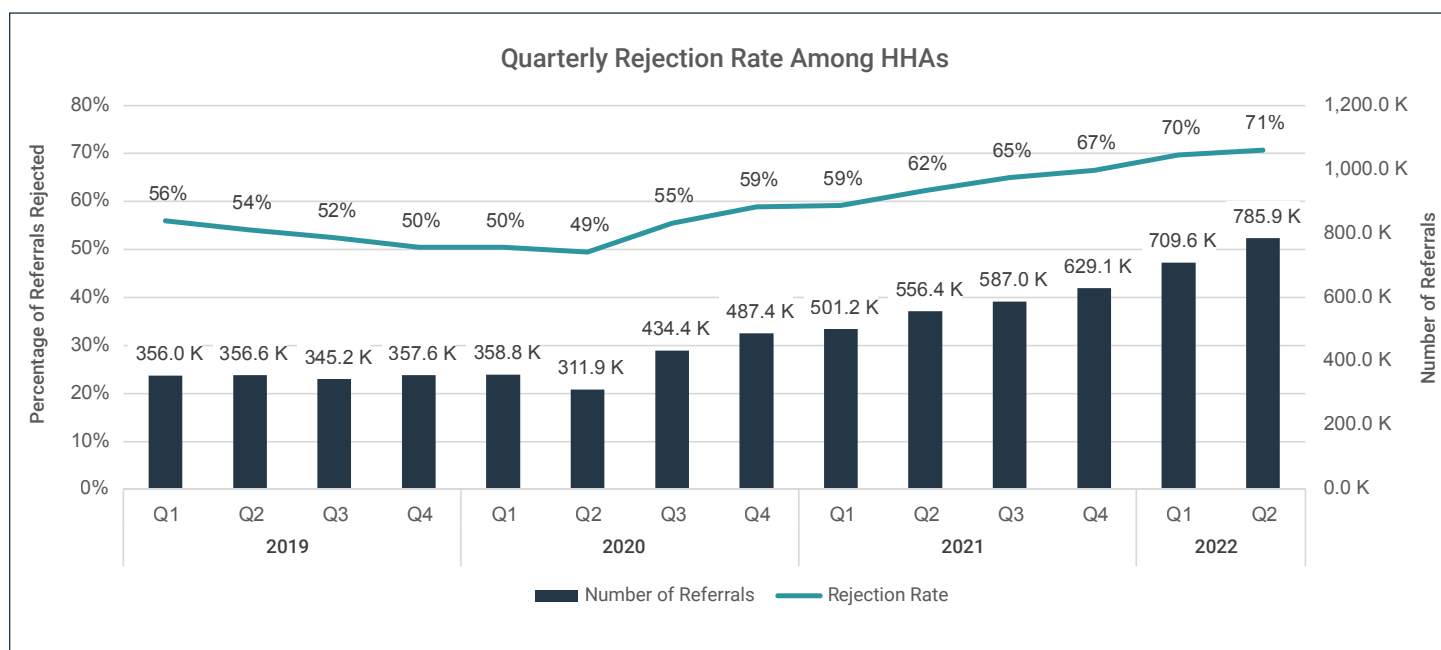
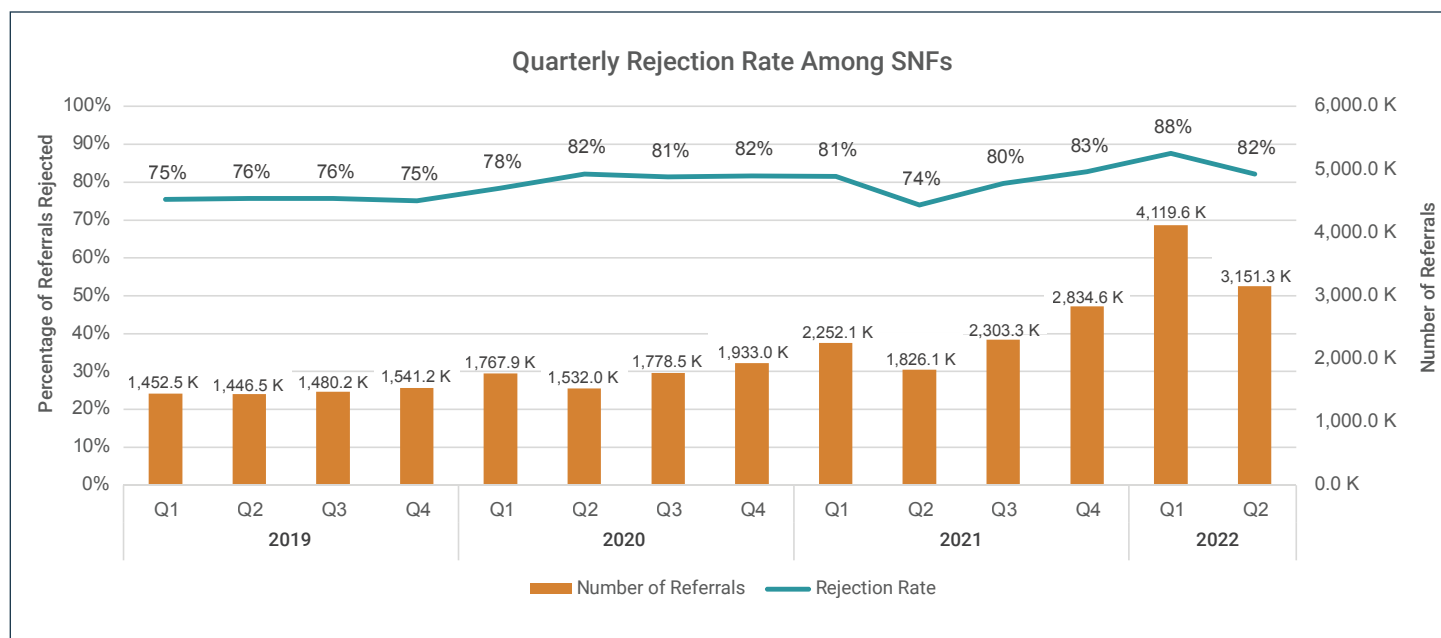
The labor crisis is most clearly evidenced in the refusal by providers to admit patients who are being referred for post-acute services upon leaving the hospital. For the entirety of 2021 through most of the first half of 2022, as staff resources became more and more scarce, referral rejections, as shown in the graphs below, exceeded 50 percent in every quarter.

In fact, based on WellSky client data, the SNF rejection rate was 88 percent by the end of the first quarter of 2022 — the highest it has ever been and 6 percent higher than the rejection rate during the second quarter of 2020 (when nursing homes were essentially locked down). Other sources, including AHCA, in a report released in September 2021, suggest 14,000 nursing homes have had to limit new admissions due to lack of staff. BLS illuminates the problem even further by noting that nursing homes lost 234,000 employees — about 15 percent of the workforce — from the beginning of the pandemic through November 2021. In comparison, hospitals lost only 2 percent of their workforce.

Home health rejections increased from 56 percent in early 2019 to 67 percent by the end of 2021, reaching 71 percent by the end of the second quarter of 2022.

The referral rejection rates point to two key facts: Patients who need care are not necessarily getting it, and providers who need to grow their revenue streams are unable to do so. Moreover, as post-acute providers are increasingly unable to accept patients — particularly those coming from hospital stays — access to needed care becomes threatened. If Medicare reimbursement rates for both SNFs and home health agencies are cut, providers will not be able to compete for competent staff in the marketplace. Access to care and quality outcomes are very likely to be adversely affected. Additionally, gaps in access contribute to potential readmission problems for hospitals faced with the choice of either keeping patients longer due to lack of available discharge destinations or discharging patients to the community without an adequate post-acute safety net.



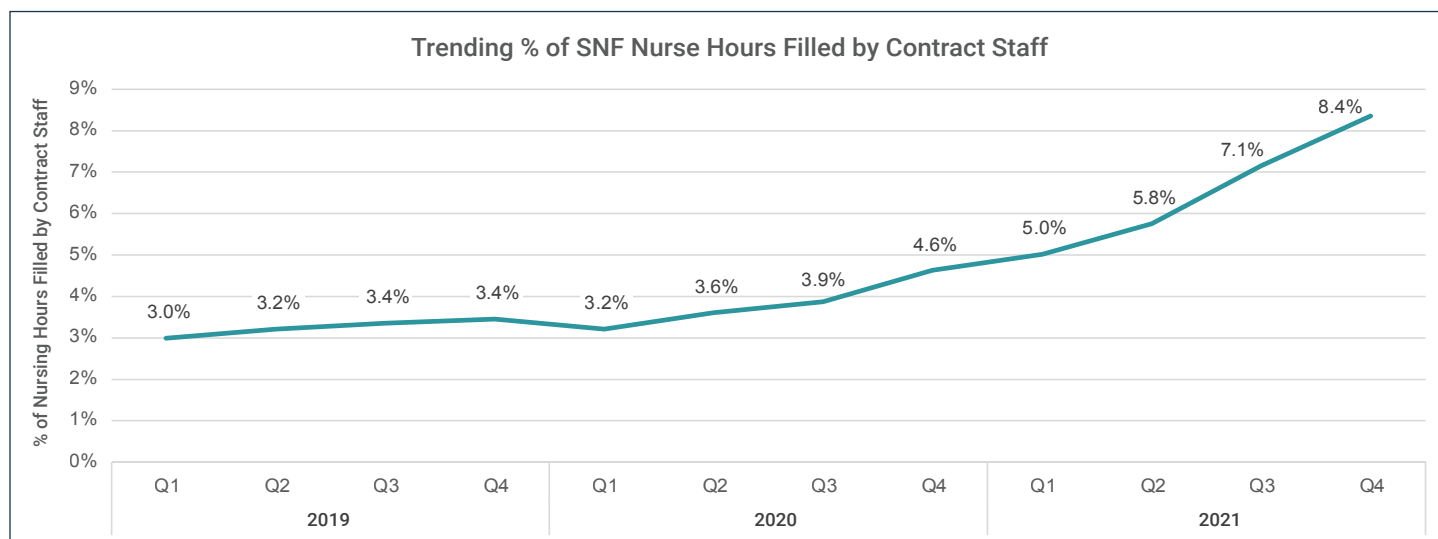


Contracted services are becoming more prevalent in SNFs

While home health agencies are less likely to turn to contracting agencies for staff relief, SNFs regularly use contracted nurses and aides. Every study of the skilled nursing industry that covers the pandemic period shows the same trend — the prevalence of contracted services is rising, and right along with it, the costs associated with staffing, which can often add 25 percent or more to staffing expenses. In 2019, WellSky nursing home clients were using contracted staff for about 3 percent of their

staffing needs, and by the close of 2021, the rate of contractors providing staffing had more than doubled to 8 percent.

Some have suggested that the need for contracted services correlates somewhat with nursing home star ratings — such that lower-rated facilities rely more on contractors than they do on highly rated providers. This is based on the theory that staff is more likely to be retained in higher quality care settings.



A closer look at the details of hours per resident day also tells an interesting story. Total contract hours by the third quarter of 2021 were 216 percent of an average quarter during 2019, with the largest increases attributable to LPNs at 230 percent. Notably, staffing agencies charge fees that are often four times higher than average compensation for employees. Aide hours in the third quarter of 2021 were only 83 percent of an average quarter in 2019, constituting the largest decrease among the three measured disciplines. The average total hours per resident day was 324.3, and by the third quarter of 2021, the same measure had dropped to 277 hours — a 15 percent reduction, which incontrovertibly complicated efforts to maintain quality of care.



Fact #5

Patients coming to post-acute care are sicker

As staffing shortages and reimbursement changes continue to influence SNF staffing levels and home health service volume, it's also clear that the patients being discharged from hospitals are sicker than they were in the past. Some of this can be attributed to the lingering effects of COVID-19 on so-called "long haulers," who have struggled with the aftereffects of the virus. Other patients may be sicker because they voluntarily or involuntarily waited longer to deal with pressing illness or functional decline during the pandemic, allowing infirmities to worsen over time. WellSky data shows several examples of shifts in 2022 patient acuity compared to prior years:

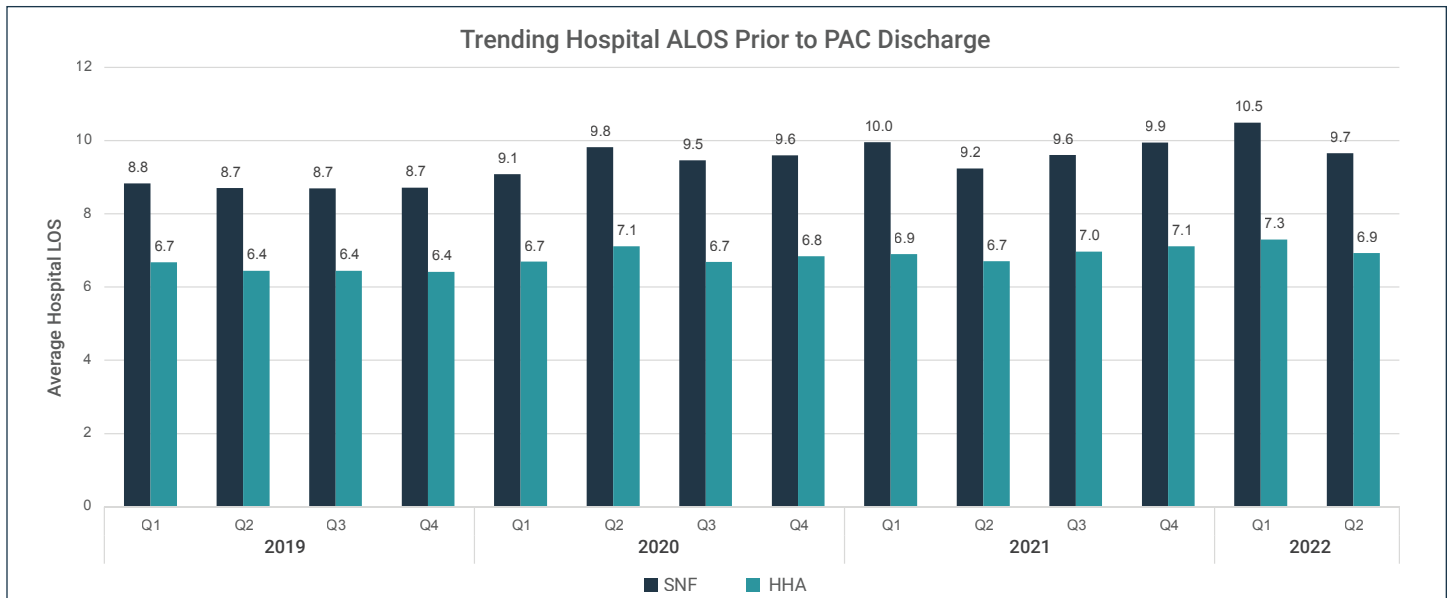
- Obesity is up 11 percent in 2022 among SNF residents, and this metric is also prevalent among home health patients
- Drug abuse and alcohol abuse among SNF residents increased by 14 and 15 percent respectively in 2022, with similar percentages among home health patients
- Complications of hypertension and diabetes among home health patients are up by 25 and 34 percent respectively

Longer hospital lengths of stay also signify a sicker patient population, and it's notable that average lengths of stay (ALOS) have been increasing since the beginning of the PHE. Hospital leaders have made clear that hospitals have needed to keep some patients longer than anticipated, only because post-acute discharge opportunities are scarce, given the staffing shortages and other factors. Length of stay for hospital patients going to



Hospital leaders have made clear that hospitals have needed to keep some patients longer than anticipated, only because post-acute discharge opportunities are scarce, given the staffing shortages and other factors.

SNFs rose by a full day between the start of the PHE and January 2022. Patients referred to home health were not far behind in terms of the ALOS increases.



Lack of access to care clearly impacts quality, and extended hospital stays have their own detrimental side effects, particularly with respect to patient deconditioning and a need for more post-discharge therapy for strengthening and restoration of function. For every extra day of hospital care, even under the most altruistic circumstances, there is a need for more post-discharge patient care to reverse the effects brought on by lack of activity that is so often the hallmark of a hospital stay for an elderly person (who could conceivably not be called upon to ambulate any further than the distance from the bed to the bathroom for days on end).

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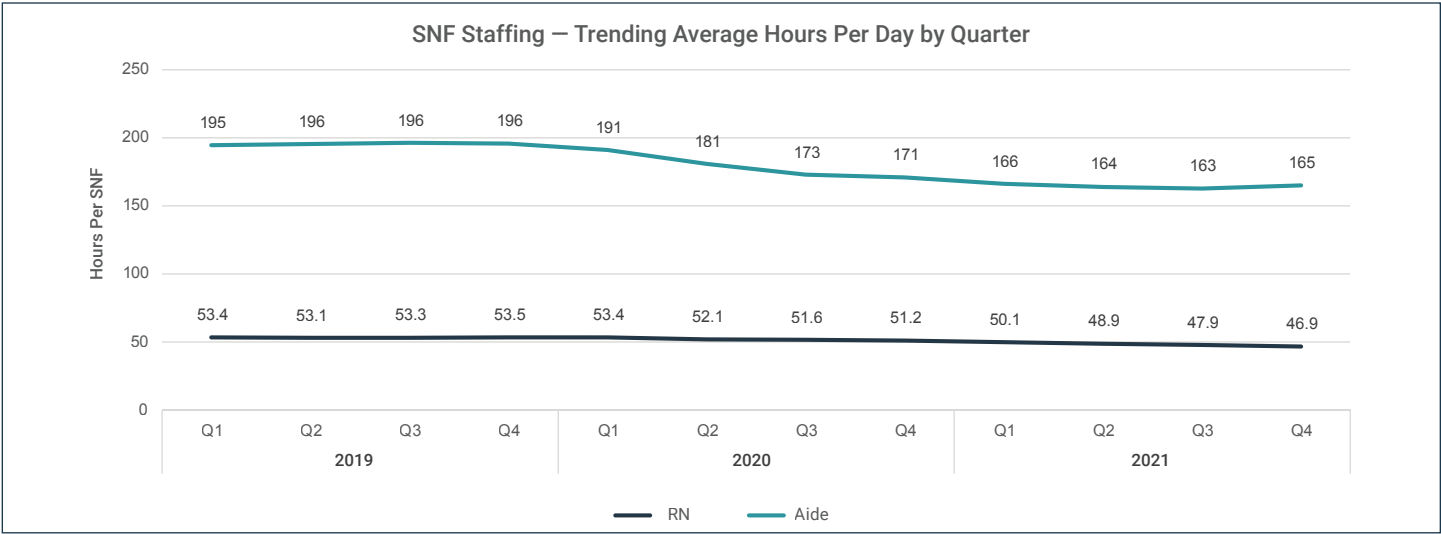




As staffing and service volume decline, patient quality goes with it — at least in theory, and in the absence of other tools that can be used to mitigate the gaps resulting from fewer staff hours or visits.

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A look at SNF staffing trends illustrates this point. Using 2019 as the baseline, SNF services represented by average hours per day throughout 2020 and through the third quarter of 2022 consistently eroded for both nursing and aide services. Aide hours dropped by 12 percent while nursing hours went down by 15 percent. When staff is not present, patients are not receiving the level and quantity of needed care motivating some to suggest that the quality of care is suffering, which can be a difficult argument to overcome as providers work to maintain quality and optimal care outcomes. The conundrum presented by lack of staff and the continuing need to protect and preserve quality of care is a nearly insurmountable hurdle.



¹⁴ Health Affairs Blog, Navigating Care: Transitions from SNF to Home During a Pandemic – Lessons Learned, Joan Guzik, May 6, 2021.

The result has been an increase in SNF readmission rates from 20.8 percent in 2019 to 22.9 percent in 2020, compared to very stable ALOS of 25.1 days in 2019 and 25.8 days in 2020. Adding to the problem is the issue of ineffective discharge coordination and patient education among all types of providers. As staffing resources diminish, this is one operational area that often suffers. National data from CMS reveals that only 50 percent of patients discharged from SNFs were able to successfully transition home or to their communities. Upon discharge, many patients had inadequate information concerning their medications, inadequate identification of social needs that could have resulted in referrals to community-based organizations, and inadequate understanding of their symptoms and post-discharge follow up¹⁴. This presents an opportunity for improvement through better coordination of care at discharge and a safety net in the form of services at home for patients coming back to the community after an inpatient stay.

SNFs are not alone in terms of service and staffing challenges. Home health agencies, in anticipation of PDGM, were expected to shift their service mixes away from a heavy reliance on therapy toward more nursing, beginning in 2020. In fact, that is exactly what they did, as Medicare statistics show a 13 percent collective decrease in therapy visits compared to a 1 percent drop in nursing visit volume. While nursing visit volume declined during the height of the PHE, home health agencies used alternate tools to provide ongoing care and to monitor patients remotely. A survey conducted by the National Association for Home Care and Hospice in 2020 showed that 44 percent of home health agencies were making use of remote services, including telehealth and remote patient monitoring, especially to monitor those patients who wished to limit home visits as a means of controlling unwanted exposure to the virus. Any evaluation of home health service levels during the most intensive months of the PHE should take that into account.

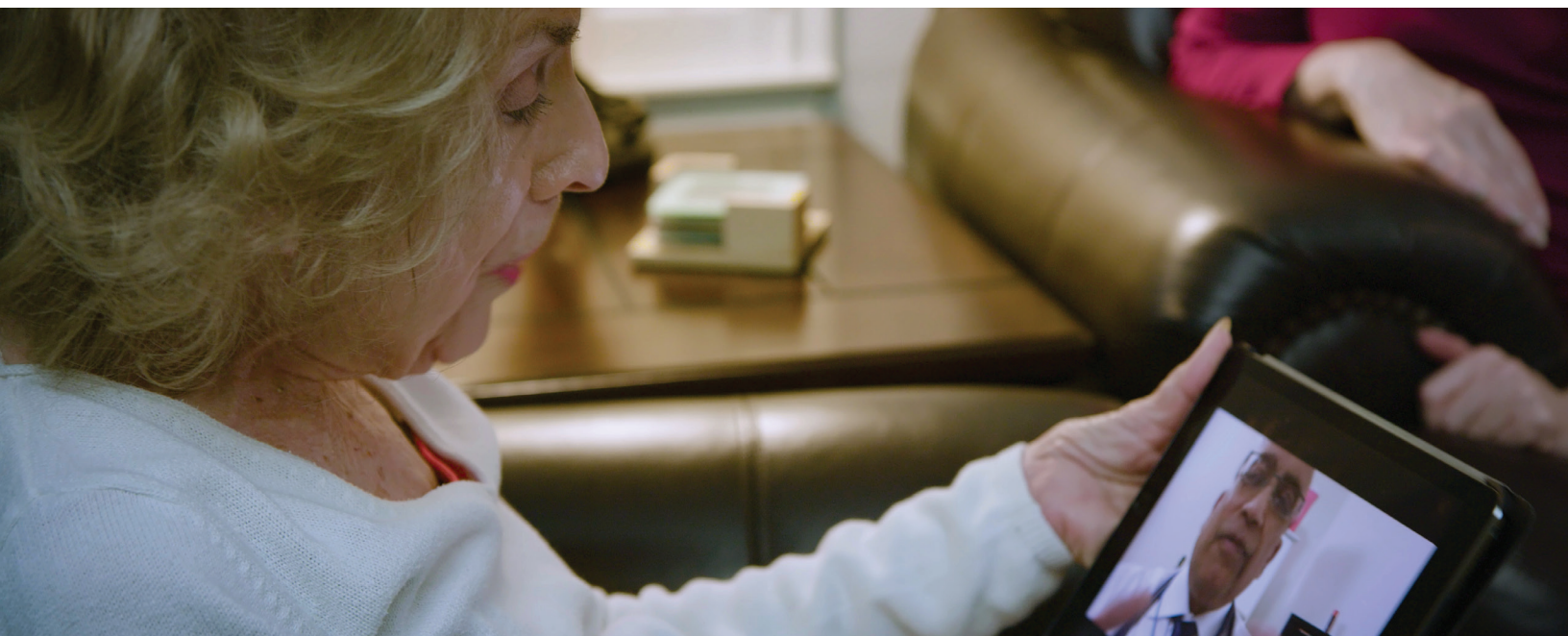
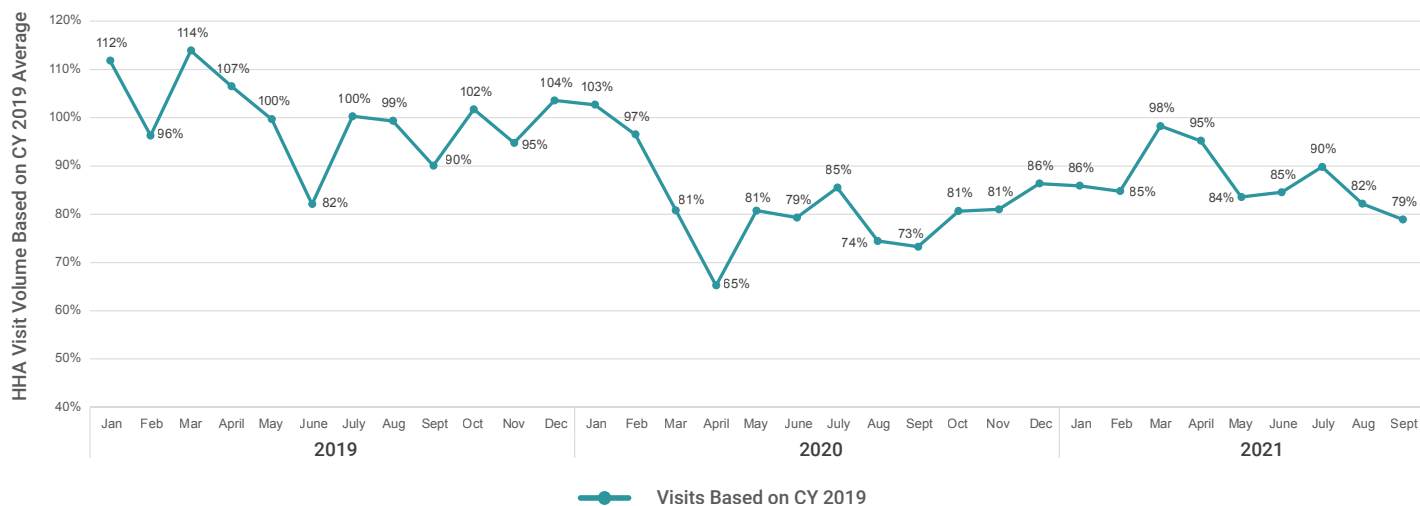


Table 3

Home health skilled services per beneficiary 2019 and 2020

Visit discipline	2019	2020	% Change
Skilled nursing per beneficiary	16.33	16.15	- 1%
Physical therapy per beneficiary	12.47	10.87	-13%
Occupational therapy per beneficiary	7.19	6.12	-15%
Speech language pathology per beneficiary	6.85	6.00	-12%

Trending Total HHA Visits to Medicare Beneficiaries Based on CY 2019



Looking ahead to the future of post-acute care

As part of the post-acute care industry, we have some work to do, but we're not the only ones. As technology becomes more advanced, and innovation continues to expose new ways to provide effective care in different, less expensive settings, our government — Congress, the Department of Health and Human Services, as well as CMS — has some work to do as well. Here are a few recommendations for all stakeholders:



We need to think in terms of national policy that will advance the use of technology across the provider spectrum. A good example of needed change is the current inability of home health providers to use — and to be reimbursed for — telehealth services as an extension of care between visits. This takes legislative change and should be pursued.



We need to abandon budget neutrality as the basis for post-acute reimbursement methodology in favor of finding ways to measure and lower the total cost of care. It's not economically feasible for post-acute providers to serve more patients with fewer dollars and still be expected to maintain quality patient outcomes that result in fewer avoidable — and expensive — hospital admissions.



We need to have more access to relevant data as well as better tools in place to make use of it. We can't close quality and care gaps that we don't know about or fully understand.



We need to think about how we can collectively address the significant shortage of nurses and nursing assistants to meet all future care needs — not just some of them. This may involve reimbursement or other compensatory adjustments that would enable post-acute providers to better compete with their institutional counterparts to attract and retain competent, qualified professional staff.



We need to evaluate and adopt innovative programs capable of lowering the total cost of care while still maintaining an approach to alternatives designed to address individual patient health needs rather than a one-size-fits-all approach to services.



Conclusion

Shifting to home-based care alternatives and away from post-hospital care in a facility isn't as simple as it sounds. Some patients will still need more intensive services — more complex interventions for longer durations and in a facility where they can be continually monitored and treated. Moreover, when they leave the facility, many will need additional organized services at home to maintain health stability. That may require effort on the part of SNFs that have not traditionally been good about discharging patients to home health even though there are many valid reasons to do so — and a chief reason among them is to keep patients out of the hospital.

There will be other high acuity patients who will be appropriate for one of the more intensive in-home service offerings that will likely be routinely available in the future. And, there will be patients, as they emerge from hospital stays, who may be younger with fewer or less severe comorbid conditions, fewer functional limitations and better support systems at home — such that they will be clear and immediate candidates for short-term care at home. The relevant point is that we have an obligation to get the right patients to the right care modality at the right time. Though that is a tall order, it can be done.

As we consider the breadth and depth of external forces and factors driving the transformation of post-acute care, it is of paramount importance to clearly understand all the related intricacies of what is happening. We need to prepare for a very different, perhaps slightly uncertain, future and position ourselves to benefit from the seismic shifts taking place. We are facing challenges, but we also have enormous opportunity to more positively influence patient care outcomes. Let's take advantage of it.

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