WellSky®

Improving Post-Acute Care Management:

How health plans can lower costs and achieve better health outcomes

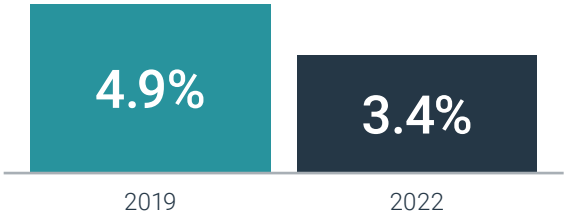
By **Sharon Harder,** President of C3 Advisors, LLC

Introduction

Fee-for-service healthcare is nearly extinct, and in its place, the industry has been grappling with what has been euphemistically dubbed "value-based" care. While the concept is simple, successfully implementing it has proven to be a challenge. CMS has proposed complex, formula-based, value-based purchasing models for nearly all types of providers serving Medicare beneficiaries under traditional Medicare (TM) and it has adopted separate quality incentives for managed Medicare plans — all intended to help reduce costs and elevate patient outcomes in a new pay-for-performance environment.

However, even with annual base rate increases and the quality incentives, health plans appear to be struggling to maintain profitability. Moody's Investor Service reported in January 2024 that profit margins for most plans have been on the decline in recent years with average profits of 4.9% in 2019 and 3.4% in 2022.[1] Even with burgeoning member enrollment over the last few years, plans have not been able to translate member growth to higher profit margins. With looming adjustments to capitated risk calculations stemming from concerns over Medicare solvency issues, it is widely expected that margins for many plans, particularly smaller ones, will thin even more as base payment rates are scaled back in the future.

Declining health plan profit margins[1]



As plans deal with membership expansion and erosive economic pressures, one thing becomes clear — it is time to focus on lowering costs by raising efficiency to produce better and far less expensive health outcomes for beneficiaries enrolled in Medicare Advantage plans. That means, at a minimum, examining current patient-focused processes to improve efficiency, looking at ways to improve case management, and adopting new data tools that will help to reduce costs all along the care continuum. In this paper, our focus is on what can be done to shrink post-acute care costs, particularly those related to post-acute care management functions.

About the author

Sharon Harder is a healthcare financial expert, author, and educator with over three decades of executive management experience. She has served in financial and operational leadership roles in a variety of healthcare organizations, including as the former Vice President of Finance and Administration for the **Healthcare Financial Management Association (HFMA)** and as the former Chief Financial Officer for **Help at Home, Inc.** Currently 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.

[1] Moody's Investor Service, January 23, 2024, Fierce Healthcare Report, https://www.fiercehealthcare.com/payers/moodys-why-medicare-advantages-profitability-may-be-decline

The post-acute landscape

Acute care is generally defined as the treatment of patients in a short-term acute care hospital. Broadly defined, post-acute care (PAC) refers to the array of services a patient receives after being discharged from an acute care institution — those provided in settings like skilled nursing facilities (SNFs), long-term acute care hospitals (LTACHs), inpatient rehabilitation facilities (IRFs), or at home. The PAC price tag is high, amounting to $2.7 trillion a year[2] and accounting for approximately 15% of all Medicare expenditures,[3] according to the American Hospital Association and the Medicare Payment Advisory Commission (also known as MedPAC).

A separate compilation of peer-reviewed reports published in 2019 found that between $27.2 billion and $78.2 billion per year of wasteful healthcare expenditures can be attributed to care coordination failures, while somewhere between $75.7 billion to $101.2 billion is spent unnecessarily on overtreatment of patients, or, conversely, low-value care.[4] A portion of that is most certainly attributable to post-acute services, where plans encounter care coordination and treatment intensity miscues each and every day.

As we consider these escalating costs and the wasteful spending, it is important to recognize that with the exception of some home health services, post-acute care received by Medicare beneficiaries is entirely paid for through the Hospital Insurance Trust Fund, which is on the verge of insolvency. When the fund runs dry, both TM and Medicare managed-care services will be in jeopardy unless Congress steps in to preserve the viability of the program for the nearly 66 million people who depend on Medicare to underwrite their health services. Therefore, it is imperative for the government, managed care plans, and providers alike to prioritize more efficient management of services that produce higher quality patient outcomes to lessen the need for avoidable prolonged care. Better use of Medicare funding, with a focus on elimination of wasteful spending, could definitely improve the bottom line for Medicare managed care plans, but, more importantly, it could also improve long-term survival for them.

The annual cost of post-acute care is **$2.7 trillion**[2] and accounts for approximately **15%** of all Medicare expenditures[3]

[2] Post-acute Care | AHA. (2019). American Hospital Association. https://www.aha.org/advocacy/long-term-care-and-rehabilitation

[3] July 2021 Data Book: Health Care Spending and the Medicare Program – MedPAC. (n.d.). www.medpac.gov. Retrieved June 7, 2022, from https://www.medpac.gov/document/http-medpac-gov-docs-default-source-data-book-july2021_medpac_databook_sec-pdf/

[4] Shrank, W. H., Rogstad, T. L., & Parekh, N. (2019). Waste in the US Health Care System. JAMA, 322(15). https://doi.org/10.1001/jama.2019.13978

What is post-acute care (PAC) management?

Before we explore the challenges with PAC management, we must clearly explain what is meant by the term. PAC management refers to the effective transition of a patient into the most appropriate post-acute care setting(s), such as moving the patient along the continuum to incrementally less intensive care settings, as appropriate, to provide the right type and amount of care at the right time. It is not destination-specific and is, rather, patient-centric. The single most important objective of effective PAC management is very simple — we need to provide the right type and amount of care that will work to restore patients' health status and eliminate avoidable hospital readmissions. Effective PAC management relies on in-depth knowledge of the patient and their available financial, social, and caregiving resources, the data analytics to guide appropriate care decisions, and payer/provider collaboration across care settings to improve patient health outcomes.

PAC management is multi-dimensional and involves thorough knowledge of the patient and their circumstances at discharge, a clear understanding of in-network PAC providers and their capabilities in the context of the patient's current health needs, and use of data-based tools to guide a comprehensive care planning and coordination process. Effective PAC management is increasingly important for payers because of the high spend in the post-acute care space, the variable performance of PAC providers in geographic proximity to the patient, and an increasing array of risk-sharing, value-based care initiatives that directly impact overall operating results. Under risk-sharing and value-based care models, payers and providers share accountability for care outcomes, putting greater emphasis on streamlining transitions of care, focusing on effective care planning and coordination, and ensuring that members receive the **right care**, at the **right time**, and in the **right setting**.

Under risk-sharing and value-based care models, payers and providers share accountability for care outcomes.

PAC management challenges

Inefficient care, transition, and service utilization patterns contribute to rising costs and can be found throughout the healthcare sector. Virtually all types of health services are affected, but some would argue that the problems of inefficiency and waste are especially pronounced for post-acute care. One reason for this is that patients typically being discharged from a hospital are not being discharged to the most efficient and least-intensive PAC option — based on their health needs — at the time. At times, patients can also be discharged to the right PAC setting but in the care of a PAC provider not necessarily able to deliver on the promise of health improvement and satisfactory patient outcomes. This can be due to a variety of factors.

1. **The adequacy of hospital discharge planning processes has certainly been called into question over the years, causing the Centers for Medicare & Medicaid Services (CMS) to finalize new discharge planning rules in late 2019.** The new rules have not negated the fact that discharge planners are often overworked, juggling several discharges simultaneously and not always well-informed about a patient's resources at home (including available caregivers, economic status, care preferences or the intensity of post-discharge care requirements). Often, they are also not well informed — or even objective — about the capabilities of similar PAC providers located near the patient, including their particular strengths and weaknesses in the context of the patient's immediate skilled care requirements. This leads to hasty, sometimes ill-advised discharge recommendations and decisions that can later backfire in the form of an avoidable readmission.
2. **Sometimes the reason patients are not discharged to the most appropriate PAC setting is their own lack of understanding about care alternatives, and, occasionally, preconceived negative impressions about the quality of care in various PAC venues.** One needs only to consider the precipitous drop in SNF admissions between 2019 and 2020 in the midst of the recent public health emergency after nursing home patient deaths from COVID-19 to demonstrate this point.[5]
3. **PAC transition gaps can also be traced to significant lapses in long-term comprehensive care planning for fragile patients who face a lengthy recuperative process that may involve multiple PAC providers.** After the first stop out of the hospital, instead of being moved on to the next step in the continuum per a comprehensive long-term plan for the patient (for example, from a SNF to home health), patients are often simply discharged to the community by the first PAC provider in line without further skilled support. This can lead to an unstable patient, not yet ready to be independent at home and a subsequent, unplanned readmission. Unfortunately, this happens frequently because many providers tend to be rather myopic about their obligation to participate in facets of extended care planning beyond those related to their own services, and there is no one else overseeing the patient's ongoing care needs.

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[5] Opportunities and Challenges: The Transformation of Post-Acute Care in America, p. 12, Wellsky.

4. **Another reason for ineffective PAC transitions is simply the level of competition that is present among different PAC provider types — each vying for the same patient referral without sufficient consideration as to the care setting most appropriate for that patient and their skill needs.** An example of this is the degree to which skilled nursing facilities and home health providers have historically ended up competing for the same referrals when, in theory, if a patient is appropriate for care in a SNF setting, they are unlikely to be as appropriate for skilled care at home — and vice versa.
5. **Finally, there is the issue of data visibility and fragmentation that further complicates PAC management efforts. Healthcare data is often siloed across several different providers — especially physicians and mid-level providers who may have long-term, in-depth information about the patient but keep it housed in automated systems not accessible to other providers who could benefit from that data.** Medicare claims data shows that two-thirds of Medicare beneficiaries have two or more chronic conditions and that they routinely receive outpatient care from multiple providers or specialists. In practical terms, this means that in addition to seeing a primary care physician or mid-level provider, a beneficiary may also be a patient of one or more specialists dedicated to the management of one of several chronic illnesses. Even so, data exchange among medical practices can be fraught with difficulty due to time constraints and a lack of interoperability among disparate EMRs, and the same can be said about voluntary data exchanges between practices and PAC providers. To add to that, as patients are leaving a hospital to a PAC destination for continued care, the likelihood that fragmented or incomplete patient histories will follow them is relatively high unless all the patient's providers are affiliated in some way, have interoperable data exchange capabilities, or are using the same EMR. This can lead to transition gaps that neglect active diagnoses, result in redundant diagnostic tests and labs, foster adverse medication interactions and lead to omissions of information about allergies, ultimately creating higher readmission risk. As a result, primary care providers, physician specialists, plan case managers, and post-acute providers are constantly trying to coordinate care for patients across the continuum but are hindered because of incomplete historical data concerning the patient's medical history.

A 2017 study published in the Joint Commission Journal on Quality and Patient Safety found that several barriers can interfere with effective transitional care. These barriers include poor integration of transitional care services, unmet patient or caregiver needs, underutilized services, and a lack of physician buy-in. Another common barrier highlighted by the study was **technology**. Study participants noted that the lack of integrated solutions, like an electronic medical record (EMR), was a significant barrier to coordinating transitions of care.[6]

[6] Scott, A. M., Li, J., Oyewole-Eletu, S., Nguyen, H. Q., Gass, B., Hirschman, K. B., Mitchell, S., Hudson, S. M., Williams, M. V., & Project ACHIEVE Team. (2017). Understanding Facilitators and Barriers to Care Transitions: Insights from Project ACHIEVE Site Visits. Joint Commission Journal on Quality and Patient Safety, 43(9), 433–447. https://doi.org/10.1016/j.jcjq.2017.02.012

Rethinking PAC management strategies

If plans are to be successful in reducing the total cost of care while still improving patient outcomes, optimization and coordination of PAC services must become a high priority for them.

Coupling traditional utilization management with population health tools

In simple terms, utilization management focuses on managing and controlling (often through authorizations for service) the amount and type of care provided to patients at a given point in time. Conversely, population health management relies on large scale data trends to drive patient interventional strategies with a focus on disease prevention, transitions of care, and patient engagement. Both utilization management and population health management aim to mitigate the total cost of care using different tactics and approaches and neither should be used to the exclusion of the other. Utilization management aims to ensure patients are transitioned to the right care setting with the right amount of care, whereas population health management aims to improve care coordination through development of care-process models that eliminate waste and duplication of services and focus instead on highly targeted care management.

To bring post-acute care management strategies into the future, payers must invest in ways to refine their approach to utilization management and authorizations for care while also finding ways to gain real-time insights into care and population health trends that will impact both care needs and costs.

Improving payer/provider collaboration to lower cost and raise quality

The working relationship between managed care plans and providers serving their members has historically been purely transactional in nature. Plan case managers, as service authorization gatekeepers, have been predominately focused on approving minimum levels of service for discrete PAC services in isolation, as opposed to considering the ideal mix of services over time from several different providers, each providing less intensive (and, in theory, less expensive) care as the patient's condition and functional capacity improves and stabilizes. This lack of long-term care planning and coordination often leads to higher risk of rehospitalization, and, in the end, higher total cost of care. Another aspect of the transactional approach to service authorizations is the fact that many plans end up dealing with multiple PAC providers with varying levels of performance and quality rather than a smaller network of high-quality providers who are attuned to the plan's mission and expectations.

An end-game approach to relationship building between payers and providers — with possibilities of risk-sharing and accountability for results — will almost always yield better outcomes when both parties have "skin in the game." A network of known, high-quality providers (some of whom have specific areas of specialty or experience) can be used in a collaborative way to plan out care, create sight lines into clinical data upon which transition decisions can be made, minimize readmission risk, and ultimately improve both patient outcomes and patient satisfaction with the payer organization and those rendering care. Such a collaboration requires continuity of case management across PAC disciplines and transparency through data-sharing. The use of predictive analytics based on clinical and service characteristics for similar patient populations can also help to achieve more effective, proactive care planning and coordination among providers with plans at the helm as patients move along the care continuum.

A case study published in Health Affairs looked at how payer and physician collaborations were able to reduce utilization and improve quality for 750 Medicare Advantage plan members. The study highlights how the health plan was able to partner with physicians to improve data-sharing, risk-based incentives, and care management. Patients in the study had 50% fewer hospital days, 45% fewer admissions, and 56% fewer readmissions than statewide, unmanaged Medicare populations.[7] The same concept can be applied to PAC management.

[7] Claffey, T. F., Agostini, J. V., Collet, E. N., Reisman, L., & Krakauer, R. (2012). Payer-Provider Collaboration In Accountable Care Reduced Use And Improved Quality In Maine Medicare Advantage Plan. Health Affairs, 31(9), 2074–2083. https://doi.org/10.1377/hlthaff.2011.1141

Technology-enabled solutions help elevate PAC management strategies

PAC management strategies must evolve to overcome escalating and often wasteful costs of care. Key to that evolution are technology-enabled solutions designed to optimize care through real-time clinical insights, eliminate redundancy, and minimize total cost of services among different types of providers. Technology-enabled solutions, coupled with care optimization services, are critical in helping payers manage costs and member outcomes.

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Using technology to build and maintain high-performing post-acute networks

To be successful in PAC management, payers must build and maintain a high-performing network of facilities and home-based care providers.

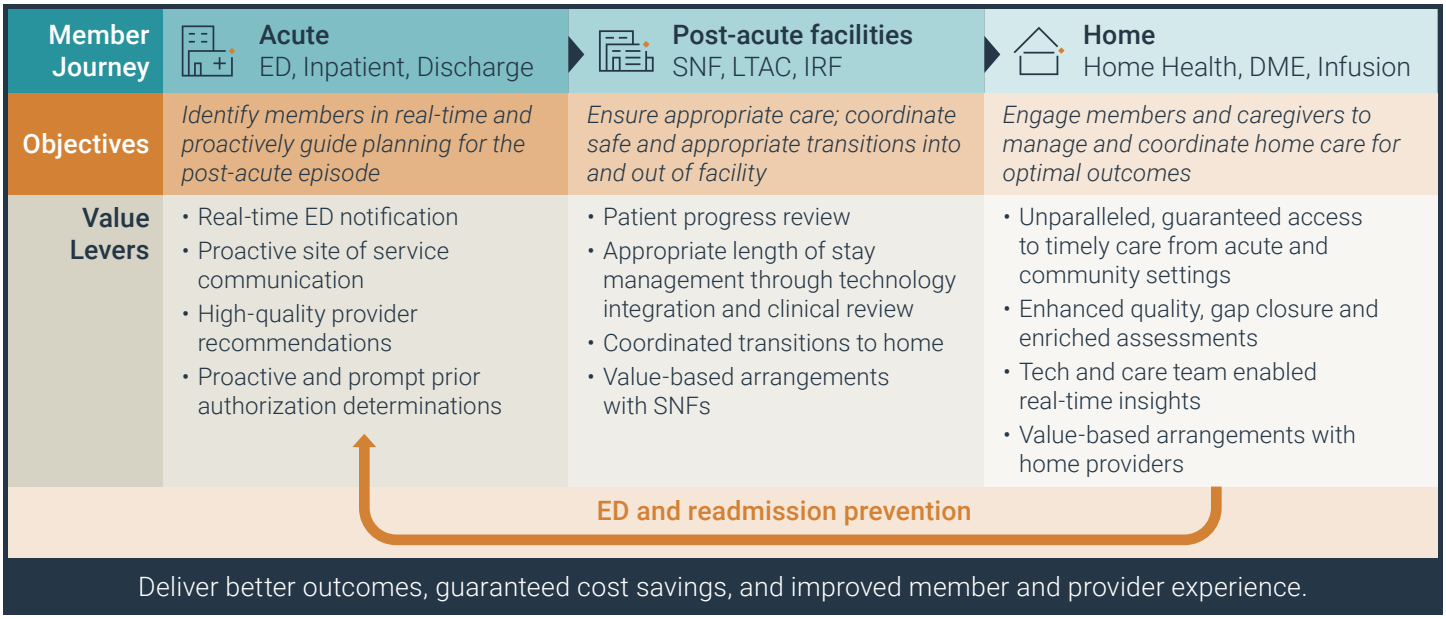
This boils down to an ongoing analysis of quality metrics that support the network relationship based on key quality indicators. Quality indicators based on patient age and primary diagnosis (at a minimum) should include a comparative analysis of:

- Patient populations served
- Length of stay
- 30-day unplanned readmission rates for same or new causes
- ED encounters without admission/readmission during home health episodes
- Avoidable events (such as UTIs)
- Total cost of care
- Discharge destinations

And, in the spirit of value over volume, a key component of a network arrangement should be mutual accountability for outcomes in the form of risk-sharing between the plan and network providers caring for patients. In this way, the plan has an obligation to authorize a sufficient level and volume of care, and the provider has an obligation to deliver on the care plan and intervention driven goals.

To adequately monitor network performance — both in terms of individual provider performance as well as the total network — plans should adopt solutions that provide risk-adjusted, post-acute performance metrics that are as close to real time as possible. These solutions will have access to critical data across the entire spectrum of care, allowing plans to identify the highest and lowest performing PAC providers in their networks.

Technology-enabled coordination across care settings, combined with WellSky clinical services, reduce avoidable readmissions.



Using technology to scale care management teams and prioritize efforts

Payers are responsible for managing thousands of members, so it's important to prioritize those who are at the highest risk — those who are age 80 and older with multiple comorbid chronic conditions and prior hospitalizations within the last 12 months. Technology-enabled solutions allow care management teams to focus their efforts on these high-cost, high-risk members.

Using technology to influence comprehensive PAC planning before the hospital discharge

Optimization of end-to-end post-acute care to ensure that patients are not unnecessarily readmitted is critical to reducing the total cost of care. Technology-enabled tools designed to guide patients to the most appropriate care setting and manage ideal length of stay and subsequent care transitions will lead the charge. Such tools will be able to:

- Identify geographically proximate, high-performing, in-network facilities and home care providers to facilitate PAC provider selection.
- Provide real-time analytical insights that will help to gauge ideal care planning interventions and length of stay based on patient medical history.
- Facilitate prior care authorizations to pave the way for timely and smooth care transitions.
- Coordinate communications and post-discharge care arrangements to ensure smooth transitions from one provider to the next.
- Connect members to special care programs to manage high-risk or multiple comorbid health conditions in order to maximize their understanding of their condition(s) and how to optimally care for themselves and prevent future hospitalizations.

By influencing a member's care **before they leave the hospital**, a payer can be proactive about PAC management and more successful in reducing overall costs. This ensures members receive the appropriate level of care and services needed to safely recover and prevent future adverse events. ◆

Improve post-acute episodic care management with WellSky® PAC Advance

As a leader in health and community care technology, WellSky is paving the way in PAC management with a technology-first approach that leads to **reduced readmissions**, **guaranteed cost savings**, and **better member outcomes**.

WellSky offers a range of proven software solutions, analytics, and services that are transforming healthcare through real-time connectivity, greater visibility, and relentless innovation. This empowers payer partners to:

- Optimize care delivery through industry-leading, purpose-built solutions and services
- Connect the healthcare ecosystem from acute to post-acute, home and community, using interoperable technology
- Enable whole-person care and drive enterprise outcomes across clinical, operational, and financial levers
- Outperform in value-based care and emerging care models employing population-level analytics and care coordination

This approach, powered by the unique capabilities and technology from WellSky, allows payers, providers, health systems, and community organizations to communicate, collaborate, and continuously improve.

Payers can delegate their post-acute management risk to WellSky for greater visibility and influence, better automation, and more informed decisions. The WellSky solution for advanced PAC management helps payers with:

Emergency department and inpatient discharge optimization

- Members are proactively identified for diversion opportunities and potential observational stays incorporating clinical data and patient profiles
- Real-time insights enable accelerated discharges to the appropriate level of care and improve timely transition of care
- Members are intelligently matched and referred to the best-fit, highest performing provider to ensure optimal outcomes

Home health management

- Accelerates a home-first approach, while ensuring quality care
- Visit appropriateness results in fewer unnecessary services rendered
- Member satisfaction is improved as care is moved into the home more quickly
- Technology supports real-time network and member insights
- Timely access to care — direct access to all points of the care continuum

PAC facility management

- Proactive site of service recommendation and targeted length-of-stay goals at point of discharge improves facility alignment and ensures member goals of care progression
- Member-specific DRG appropriateness recommendations or delegation reduces average length of stay
- Quality of care is improved across the PAC network, ensuring member progression towards targeted discharge date and their plan of care

Emergency department and readmission avoidance

- Members receive care within 24 to 72 hours of a discharge and are connected to their PCP
- Members avoid costly and time-consuming emergency department and inpatient stays while remaining at home
- Members can more easily access community-based services and address risk factors

With intelligent coordination, clinical services, advanced analytics, and a connected ecosystem, WellSky enables effective post-acute care (PAC) management, guaranteed cost savings, improved quality, and an overall better member experience.

WellSky is one of America's largest and most innovative healthcare technology companies leading the movement for intelligent, coordinated care. Our proven software, analytics, and services power better outcomes and lower costs for stakeholders across the health and community care continuum. In today's value-based care environment, WellSky helps providers, payers, health systems, and community organizations scale processes, improve collaboration for growth, harness the power of data analytics, and achieve better outcomes by further connecting clinical and social care. WellSky serves more than 20,000 client sites — including the largest hospital systems, blood banks, cell therapy labs, home health and hospice franchises, post-acute providers, government agencies, and human services organizations. Informed by more than 40 years of providing software and expertise, WellSky anticipates clients' needs and innovates relentlessly to build healthy, thriving communities. For more information, visit wellsky.com.

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