Challenges and Opportunities for Post-Acute Care

David C. Grabowski, PhD
Harvard Medical School
Chart 8-2. Medicare’s fee-for-service post-acute care expenditures have been relatively stable since 2012

MedPAC, Data Book, 2019
Challenges/Opportunities for PAC

• Alternative Payment Models
• Medicare Advantage
• New payment models for SNF/HHA & possible move to site neutrality
Medicare Increasingly Moving from Fee-For-Service to Alternative Payment Models (APMs)

Fee-for-Service

Alternative Payment Models

Physician Services
Hospital Services
Post-Acute Services

Physician Services
Hospital Services
Post-Acute Services
In theory, APMs can...

- Improve care coordination
- Encourage use of better providers
- Lower use of inappropriate services
  - Hospital (index/readmissions)
  - EDs
  - MDs
  - Post-acute
We Have Strong Evidence from Three Major APMs...

• Medicare Shared Savings Program (MSSPs)
• Comprehensive Care for Joint Replacement (CJR) model
• Bundled Payments for Care Improvement (BPCI) initiative
PAC is primary source of APM savings

- Push PAC “downstream” (e.g., SNF to HHA)
- Cut PAC length of use

No impact on quality (mortality/readmissions)

No change in choice of provider
SNFs are not happy...

The goal from the SNF perspective was to keep referral volumes at least as good as they were before ACOs, and hopefully gain market share by improving the relationships. But ACOs have turned out to be from the perspective of the SNF provider a complete, utter failure. Patient outcomes have not improved. There is absolutely zero evidence that patient outcomes are any better or any worse. Rehospitalization rates have actually gone up, and the reason they’ve gone up is that lengths of stay have gone down.

The ACOs have turned out to simply be a vehicle for whoever the convener of the ACO is to reduce post-acute volume in the SNF setting. It’s an easy target for ACOs with a weak partner. SNFs don’t have a strong seat at the table, because SNFs have always been the poor sister in the discussion.

ACOs have simply taken advantage of the SNFs, and our organization realized it very early on, when the first couple of ACOs we did business with immediately started with the idea of skipping the SNF. So it’s the double-whammy of: Skip the SNF, and for the SNF stays we do have, we’ll reduce the lengths of stay.

All those things were designed to create surpluses, and the surpluses never came to fruition, because the money got spent somewhere else, or the money went out the door in rehospitalization penalties.

The ugly truth is that ACOs have been a disaster for SNFs.
Why is PAC the Piggy Bank?

- PAC is rarely the accountable entity
  - First rule of APMs: better to push down on someone else’s revenue than your own

- Potential waste in PAC
Spending variation across HRRs largely driven by PAC.

Newhouse and Garber, NEJM, 2013
Concerns with using PAC as Piggy Bank

• Piggy bank is not limitless

• Risk of cutting high-value PAC services

• Unintended consequences for SNF industry & families
Post-Acute Care Under Siege?

- Alternative Payment Models
- Medicare Advantage
- New payment models for SNF/HHA & possible move to site neutrality
Enrollment in Medicare Advantage has nearly doubled over the past decade

Total Medicare Advantage Enrollment, 1999-2019 (in millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Enrollment (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>6.9</td>
</tr>
<tr>
<td>2000</td>
<td>6.8</td>
</tr>
<tr>
<td>2001</td>
<td>6.2</td>
</tr>
<tr>
<td>2002</td>
<td>5.6</td>
</tr>
<tr>
<td>2003</td>
<td>5.3</td>
</tr>
<tr>
<td>2004</td>
<td>5.6</td>
</tr>
<tr>
<td>2005</td>
<td>6.8</td>
</tr>
<tr>
<td>2006</td>
<td>8.4</td>
</tr>
<tr>
<td>2007</td>
<td>9.7</td>
</tr>
<tr>
<td>2008</td>
<td>10.5</td>
</tr>
<tr>
<td>2009</td>
<td>11.1</td>
</tr>
<tr>
<td>2010</td>
<td>11.9</td>
</tr>
<tr>
<td>2011</td>
<td>13.1</td>
</tr>
<tr>
<td>2012</td>
<td>14.4</td>
</tr>
<tr>
<td>2013</td>
<td>15.7</td>
</tr>
<tr>
<td>2014</td>
<td>16.8</td>
</tr>
<tr>
<td>2015</td>
<td>17.6</td>
</tr>
<tr>
<td>2016</td>
<td>19.0</td>
</tr>
<tr>
<td>2017</td>
<td>20.4</td>
</tr>
<tr>
<td>2018</td>
<td>21.6</td>
</tr>
<tr>
<td>2019</td>
<td>22.0</td>
</tr>
</tbody>
</table>

% of Medicare Beneficiaries

- 1999: 18%
- 2000: 17%
- 2001: 15%
- 2002: 14%
- 2003: 13%
- 2004: 13%
- 2005: 13%
- 2006: 16%
- 2007: 19%
- 2008: 22%
- 2009: 23%
- 2010: 24%
- 2011: 25%
- 2012: 27%
- 2013: 28%
- 2014: 30%
- 2015: 31%
- 2016: 31%
- 2017: 33%
- 2018: 34%
- 2019: 34%

Source: Kaiser Family Foundation, 2019
MA Accounts for Increasing Share of SNF Revenue Mix

---

National Investment Center for Seniors Housing & Care, Skilled Nursing Data Report, 2019
Skilled nursing providers actually saw across-the-board gains in Medicare margins between 2016 and 2017, but the effects were mitigated by a familiar foe: Medicare Advantage plans.

The average provider saw a profit of $102 per patient day for residents covered under Medicare Part A in 2017, according to a new analysis from accounting and advisory firm Plante Moran, for a net margin of 20%. That figure represents a gain of $8 per patient day from 2016, or a boost of 9%.

When extrapolated over the entire cost of care, the average Part A profit clocked in at $3,900, the difference between revenue of $19,500 and costs of $15,600.
### Table 8-9

Comparison of Medicare fee-for-service and managed care daily payments in 2018 to three companies

<table>
<thead>
<tr>
<th>Company</th>
<th>FFS</th>
<th>Managed care (MA)</th>
<th>Ratio of FFS to MA payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversicare</td>
<td>$455</td>
<td>$397</td>
<td>1.15</td>
</tr>
<tr>
<td>Ensign Group</td>
<td>616</td>
<td>462</td>
<td>1.33</td>
</tr>
<tr>
<td>Genesis HealthCare</td>
<td>525</td>
<td>458</td>
<td>1.15</td>
</tr>
</tbody>
</table>

Note: FFS (fee-for-service), MA (Medicare Advantage). MA makes up the majority of managed care payments. The Genesis rate is reported as “insurance,” which includes managed care but excludes Medicaid managed care and private pay.

Source: Third quarter 10-Q 2018 reports available at each company’s website.

MedPAC, Report to Congress, March 2019
MA Enrollees Use Less Institutional Post-Acute

Huckfeldt et al. *Health Affairs*, 2017
MA Enrollees Use Less Home Health

• Fee-for-service beneficiaries had:
  • 1.83 greater odds of receiving any home health
  • 34% longer length of stay conditional on use

• Differences in clinical outcomes were small and inconsistent
MA Enrollees Use Worse Quality SNFs/HHAs

Meyers et al. Health Affairs, 2018

Schwartz et al. JAMA Network Open, 2019
MA versus FFS within a common SNF?

For patients hospitalized with hip fracture:

– MA patients had 5 fewer SNF days, 460 less therapy minutes
– Yet, similar/better outcomes of care in terms of ADL score, readmissions and transition to long-stay nursing home resident

Kumar et al. PLOS Medicine, 2018
Post-Acute Care Under Siege?

- Alternative Payment Models
- Medicare Advantage
- New payment models for SNF/HHA & possible move to site neutrality
Can we incentivize high-value PAC directly?

- New SNF Patient Driven Payment Model (2019) and HHA Patient Driven Groupings Model (2020) models diminish role of therapy in payment
  - PDPM/PDGM change incentives within settings but don’t directly address value of these services...

- PDPM is budget neutral, PDGM contains 6.42% behavioral adjustment cut
Unified PAC PPS

• Creates a unified payment system for similar patients treated in any PAC setting
• Bases payment on patient characteristics, not where patients are treated
• Similar to PDPM/PDGM, changes PAC incentives but may not directly address overall value of these services...
Summary

• Post-acute providers are facing headwinds
  – APMs/MA have used PAC as piggy bank
• New SNF/HHA payment models will change incentives around admissions, therapy
• Unified payment would go even further
Acknowledgments

• **Coauthors:** Michael Barnett, Michael Chernew, Arnold Epstein, Lauren Gilstrap, Haiden Huskamp, Karen Joynt Maddox, Michael McWilliams, Ateev Mehrotra, John Orav, David Stevenson, Andrew Wilcock

• **Funding:** NIA P01 AG032952
Thank You

grabowski@med.harvard.edu

@DavidCGrabowski