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# Evolution of the Post-acute Care Continuum and its Impact on Long Term Care and Senior Living Providers

**Eva Bering, RN, MHA, MSN, NHA, Chief Operating Officer, Landis Homes** *Eva has spent her entire career as a clinician and senior administrator in both acute care and long term care settings. She was recently recognized as 2015 "Leader of the Year" by LeadingAge Pennsylvania.*

**As U.S. healthcare costs continue to rise**, the portion of GDP consumed by healthcare expenditures has pushed into the high teens and may well account for fully one-fifth of total economic activity in a few years. The raw demographics of an aging America will continue to increase demand for both acute care and downstream post-acute care providers. In addition, recent research highlighting how financially ill prepared many in their 50s and 60s are for retirement is alarming. The uncomfortable reality is we cannot afford our healthcare system in its current form.

Hospitals have been subjected to another round of major structural changes in reimbursement and financial incentives by the Affordable Care Act (ACA) aimed at reducing cost and improving quality. By redefining an episode of care for hospital reimbursements to include three days prior to admission and 30 days after discharge, Medicare has placed hospitals financially at risk for how their patients fare in the post-acute care continuum (outside of the hospital). Higher risk-based Medicare incentives for hospitals that participate in shared savings plans and bundled payment arrangements will intensify pressure on downstream long term care and senior living providers as the focus becomes managing the total cost and quality of care in a wider range of post-acute care delivery settings.

Medicare continues to phase in the ACA shift from volume-to-value-based (quality/cost) hospital payments, with the percentage of reimbursement based on quality measures planned to increase from 20% in 2011 to 90% in 2018. Hospitals can be penalized up to 3% of their base Medicare per discharge (DRG) payment for high readmission rates within 30 days for patients discharged with certain diagnoses. The list of diagnoses for readmission penalties will continue to expand.

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Post-acute providers can gain valuable insight into their future by understanding the impact DRGs had on hospitals starting in the mid-1980s. For hospitals not prepared to deal with these new incentives by doing more with less, the reduction in revenues led to lower profitability and cash flow, weaker liquidity, diminished debt capacity and limited access to capital for investment in facilities, equipment, IT and other business opportunities. Both Medicaid and private payors followed Medicare's lead. By the mid-1990s, financial stress on providers unable to manage care and costs under the new leaner and meaner payment environment were forced to merge, affiliate, cut back services or close. Acute care industry consolidation continues today, and it presents difficult decisions for nonprofit management, boards and the communities they serve.

Relative to acute care hospitals, the current financial profile of long term care providers appears less durable, characterized by smaller revenue streams, thinner margins, leaner balance sheets and older plants, which place them at greater risk and with less cushion to absorb the coming industry changes.

As the practice of discharging "sicker and quicker" flows down the post-acute continuum, providers will need to increase their capacity to manage residents with more complex conditions, requiring greater clinical and management resources. The shift to "value-based reimbursement" versus "volume-based reimbursement" will require a population health approach and more intensive case management. When DRGs were introduced, hospitals were driven to develop the financial, IT and other resource capacity to identify case-specific revenue, cost and profitability information by DRG, by payor and by physician, in addition to the clinical/quality measures that cause or correlate with "good" and "bad" outcomes. Long term care and senior living providers will need to develop resource capacities to capture, track, analyze and manage quality and cost metrics at a much more granular level. Of course, all of

these tasks are to be accomplished at a time when the cost of care and reimbursement are moving in opposite directions.

ACA financial incentives will drive hospitals to develop post-acute care preferred provider networks; some segments may be owned, but the majority will be arranged via formal or informal agreements. Hospitals and health care systems will focus on larger organizations that develop interoperable IT systems and can demonstrate improved outcomes in various areas. To meet these demands, post-acute care providers will need more robust case management and IT decision support. Systems will be required to monitor resident admission and discharge, predict and manage lengths of stay, confirm insurance coverage and expected payment, and ensure all efforts and resources are orchestrated to minimize deviations from the optimal care plan. Adherence to the optimal care plan often suffers during these transfers due to lost or delayed information, poor communication and incompatible systems, resulting in a longer length of stay, higher costs, lower quality and most importantly a slower recovery for the resident.

Long term care providers will be fighting to defend their existing referral base and market to new referral sources. Although where to go after discharge is nominally the patient's choice, hospitals will exercise influence to direct referrals by facilitating easier access to its medical staff, that actively follow residents in their post-acute preferred provider network. The ability of long term care providers to educate their market and demonstrate their value will be enhanced by critical information on length of stay, costs by diagnosis / RUG / payor type, and key quality indicators relative to competitors.

In addition to focusing on upstream acute care providers, nonprofit post-acute providers need to examine the potential range of "partnering" relationships with similar organizations. These relationships create an opportunity to gain many of the benefits from being part of a larger system while still maintaining some level of local control over a community asset. Economies of scale regarding certain "system" functions can generate a higher level of performance at a lower cost. These partnering alternatives include acquisitions, mergers, joint ventures, shared services, management contracts and other looser forms of partnerships.

Managing the shift from going it alone to joining forces can be challenging on many fronts, and turning historical competition into future collaboration can be a tricky proposition. The key is to find compatible organizations with shared missions, visions and values to explore and build durable relationships with strategies and structures that are responsive to the market and safeguard the organization's future.

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