



# Research Insights

## ■ Post-Acute Care and Beyond: Responding to the Growing Need for Chronic Care

### Summary

Several factors, including an aging population as well as successes in treating acute conditions and extending lives, have led to an increase in the number of Americans with chronic conditions. This development poses a significant challenge for both the health care system in general and for post-acute and long-term care systems in particular. Spending for post-acute and long-term care is high, and evidence about the quality of care remains uneven. Policymakers are keen to understand how to achieve higher-quality care at lower costs.

Although the tendency has been to describe post-acute and long-term care services in terms of care settings—hospitals, skilled nursing or long-term care facilities, and community-based providers—individuals often receive care in more than one setting and often “bounce” among settings. In addition, some settings provide more than one type of care. As with other parts of the health care system, the organization and delivery of acute and chronic care services are evolving as payers and providers respond to new programs, new payment models, and market consolidation. As a result, consumers face new choices in managing their own care.

This brief summarizes key points from a meeting convened by AcademyHealth in December 2016. Research and policy experts reviewed current strategies to improve care and lower costs for post-acute and chronic care, especially as related to the Medicare and Medicaid programs. They were asked to think about the

implications of research findings related to current strategies and to consider opportunities for better meeting patient user needs in a cost-effective manner.

Presenters described ongoing initiatives and potential opportunities to promote value-based payment reforms for post-acute and chronic care. They discussed innovations to enhance care and improve outcomes—including more effective care coordination, new information technologies, linking with social services, and strategies for better educating and engaging consumers. They also noted that successful implementation of new payment and care models requires sophisticated financial and management skills. Throughout the meeting, they stressed the need for improved quality measures with an emphasis on both outcomes and cost. Given that information about the efficacy of new and evolving payment and service delivery models will be limited in the near term, they called for more rigorous evaluations.

### Overview

As the American population continues to age, those with chronic conditions will assume greater importance in the health care system, and patients may cycle between post-acute and chronic care services as they manage their conditions. Post-acute care (PAC) includes rehabilitation or other services that are provided after, or instead of, a stay in an acute-care hospital. Treatment may include one or more stays in a skilled nursing facility (SNF), inpatient

### Genesis of this Brief:

This brief is based on a meeting of federal policymakers and researchers that took place in Washington, D.C., on December 2, 2016. AcademyHealth convened the meeting as part of its Research Insights Project. Funding for the conference was made possible by Grant No. 2R13HS018888-04A1 from the U.S. Agency for Healthcare Research and Quality (AHRQ). The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the U.S. Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government. The Research Insights Project convenes invitational meetings, holds webinars, and produces reports and issue briefs to foster discussion of existing, relevant research evidence among policy audiences that need to implement health reform and develop new policy. Additional information and publications may be found on the project's website at <http://www.academyhealth.org/about/programs/research-insights>.

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rehabilitation facility (IRF), long-term care hospital (LTCH), or care provided at home under the auspices of a home health agency (HHA) or an outpatient center. Chronic, or long-term care, generally refers to ongoing medical care to manage medical conditions and encompasses an array of health-related social services that help older adults and individuals with disabilities live as independently as possible. Services may be delivered in institutional settings such as nursing homes or in community-based settings, including the home. Given that spending may be high and that evidence about quality is uneven, policymakers are keen to understand more about how to achieve higher-quality care at lower cost. Researchers are evaluating interventions in post-acute and chronic care, including efforts to integrate these services more effectively with hospital and primary care services.

In December 2016, AcademyHealth's Research Insights project convened a meeting of leading academic researchers and policy experts to discuss the current state of research on innovations in post-acute and chronic care. The goal of the meeting was to examine the effectiveness of strategies to improve care and lower costs for the continuum of care ranging from post-acute to chronic care provided in the community and in institutions. Participants discussed new payment models and other strategies designed to coordinate and integrate these services more effectively. Participants also considered opportunities for better meeting patient needs in a cost-effective manner.

This brief summarizes the December meeting. Because the session was "off-the-record," this document conveys the general content of the meeting without attributing specific comments to particular participants. The discussion was informed by existing research, though neither the discussion nor this brief incorporates a systematic review of the literature on post-acute or chronic care. A bibliography of relevant, current literature is included at the end of the brief.

### Innovations in Post-Acute Care

Discussions about post-acute care cited the transition between hospital and post-acute care as a prime example of fragmentation in the health system and a situation ripe for improvement. Policies designed to limit fragmentation and encourage coordination address both formal and informal integration between hospitals and entities such as skilled nursing facilities or home health agencies, which then have common objectives such as providing more coordinated care, reducing unnecessary care and transitions, and improving information flow.

The hope is that integrated systems will promote efficiency, thereby lowering costs. One speaker observed that economists are skeptical about the benefits of integration, noting that prices are higher in markets with more hospital consolidation. Others agreed about

the potential tradeoffs of integration, noting that integration might be anticompetitive, with health care entities seeking to establish linkages with other organizations in order to capture market share and maximize income. One person referred to these arrangements as "legal forms of collusion." Thus, several experts suggested that improving outcomes while saving money may be difficult and that cost savings depend on aligning payment policy to counter anticompetitive effects. Others noted that, even though health system and market consolidation might increase pricing power, such consolidation also offers advantages by, for example, promoting the use of shared information systems.

Between 2005 and 2013, formal hospital and post-acute care integration declined, according to cost report data (Figure 1). Informal integration among hospitals and PAC providers that routinely share patients, even without a formal financial arrangement, also declined during the same period, but with a slight uptick in 2013. Discussants suggested that data from later years might show an increase in hospital and post-acute integration in response to new policies to promote coordination.

Meeting participants agreed that, while experimentation is occurring and hopes are high for more efficient, lower-cost care, knowledge about the most effective use of post-acute care is limited. Several pieces of legislation contain provisions related to improving quality and lowering costs of post-acute care. In particular, value-based payment reforms tie provider reimbursement to quality and cost goals related to the delivery of post-acute care. The reform initiatives all recognize that payment drives practice, though different approaches involve different levels of financial risk for providers. Early assessments of new payment and delivery models and related vehicles for managing post-acute care are discussed below.

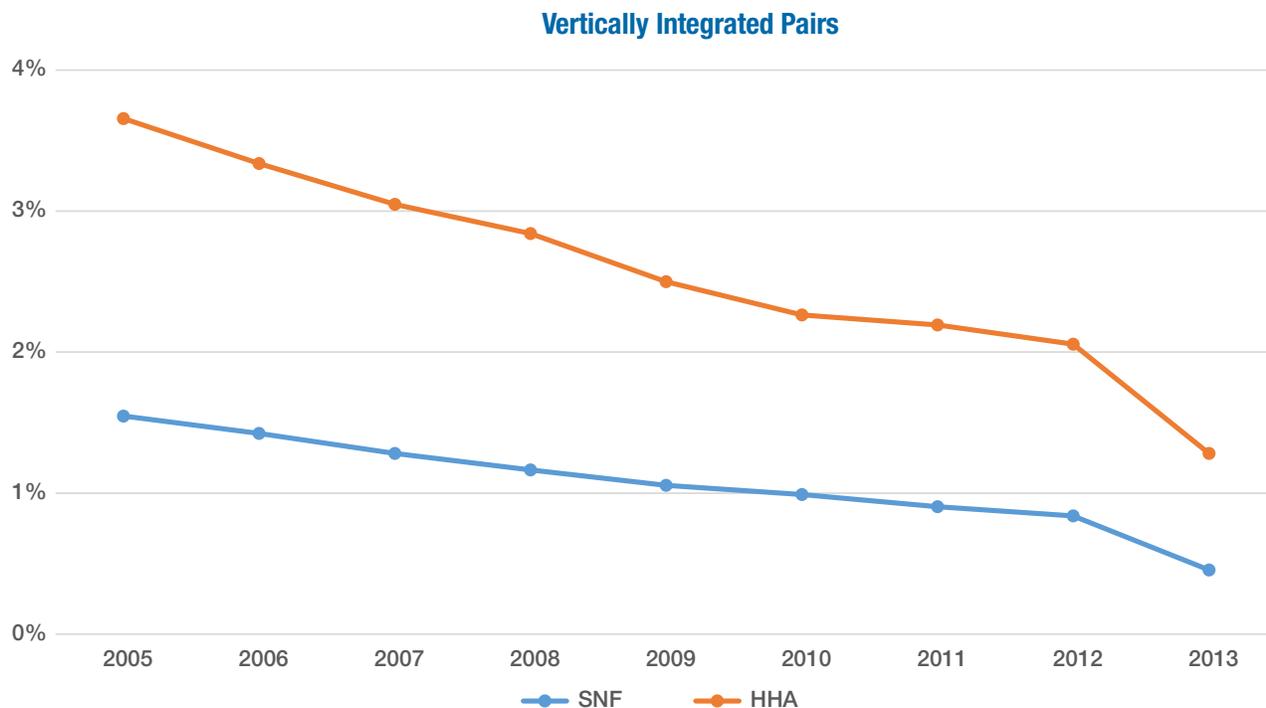
### The Affordable Care Act

The Affordable Care Act of 2010 (ACA), described by one participant as "a robust initiative to turbo-charge quality and outcome measurement," gave the Centers for Medicare & Medicaid Services (CMS) the authority to develop a series of quality measures and introduced models for value-based payment reform.

### The Hospital Readmission Reduction Program

Research findings on the Hospital Readmission Reduction Program are mixed. The program imposes financial penalties on hospitals with relatively higher rates of Medicare readmissions. Formal hospital-PAC integration appears to reduce rehospitalizations from skilled nursing facilities, but not from home health agencies. One study demonstrated lower Medicare spending associated with integrated systems. Another showed that lower lengths of stay for hospitals were associated with longer SNF stays and higher Medicare spending for SNFs.

**Figure 1: Rates of Formal Hospital-PAC Integration**



Source: Konetzka RT, Stuart EA, Werner R. The Effect of Integration of Hospitals and Post-Acute Care Providers on Medicare Payment and Patient Outcomes. Social Science Research Network 2016: 1-36.

An analysis of data from CMS indicates that Medicare hospital readmission rates for patients admitted initially for heart failure, heart attack, or pneumonia began to fall in 2012, suggesting that the Hospital Readmission Reduction Program had an impact on providers’ behavior.

**The Bundled Payments for Care Improvement (BPCI) initiative**

The BPCI links payments for the several services that Medicare beneficiaries receive during an episode of care. Organizations, such as hospitals, enter into payment arrangements that include financial and performance accountability for episodes of care, typically for 90 days. Results from a study of the initiative appear promising and show a meaningful decrease in spending per episode of care—mainly from reduced use of institutional post-acute services. The study detected no detriment to patient outcomes.

**Accountable Care Organizations (ACO)**

ACOs rely primarily on informal integration. In this population-based arrangement, providers assume responsibility and potentially some financial risk for costs and quality for a panel of patients—for all of their care, including post-acute care. Results on the impact of ACOs have been mixed. Speakers cited reports of improvements in quality tied to bonuses and of some behavior change on the part of providers by, for example, referring patients to lower-cost providers and attempting to reduce unnecessary care. They noted that Medicare cost savings to date have been negligible, however.

**The IMPACT Act of 2014**

The IMPACT Act of 2014 requires the reporting of standardized and interoperable patient assessment data with regard to measures of quality and resource use. The goal is to help improve quality of care and health outcomes for Medicare beneficiaries. As one speaker explained, “The ACA already authorized CMS to do much of what IMPACT requires.” An essential element of quality measurement is uniform patient assessment. The Act relies on an established assessment tool, the Continuity Assessment Record and Evaluation, or CARE tool, and specifies core measures, including both process and outcome measures, required of all settings (Figure 2).

One presenter observed that new reporting requirements have induced providers to make large investments in retooling their electronic medical records (EMR) and in training both their administrative and clinical staffs in the new reporting requirements. Another noted that, for two reasons, duplication of functional assessments occurs in some cases; first, providers use the required uniform assessment, and, second, they must use another assessment that is tied to their payment systems. Speakers were of the opinion that CMS has been highly systematic in its vetting, training, and implementation processes. Others felt that providers need more information.

The IMPACT Act also directs CMS to work with the Medicare Payment Advisory Commission (MedPAC) to develop a site-

**Figure 2: IMPACT Act Quality and Resource Measures: Reporting Timelines for SNFs and IRFs**

Measure	Provider Reports	Feedback Reports	Public Reports
<i>For quality measures:</i>			
Functional status	10/1/16	10/1/17	10/1/18
Skin integrity	10/1/16	10/1/17	10/1/18
Medication reconciliation	10/1/18	10/1/19	10/1/20
Major Falls	10/1/16	10/1/17	10/1/18
Transfer of pt. info to next set.	10/1/18	10/1/19	10/1/20
<i>For resource use measures:</i>			
Medicare spend/beneficiary	10/1/16	10/1/17	10/1/18
Discharge to community	10/1/16	10/1/17	10/1/18
All cause readmission rate	10/1/16	10/1/17	10/1/18

Note: The timetable for LTCHs is +2 years; for HHA's it is + 2¼ years.



Source: DeJong G. Coming to Terms with the IMPACT Act of 2014. The American Journal of Occupational Therapy 2016; 70(3): 1-6.

neutral payment system for post-acute care. MedPAC has reported that reform of the PAC payment system will likely have to rely on episode-based payments, such as bundled payments. Meeting participants agreed that a focus on episode-based bundled payment would provide better incentives for care coordination and greater interoperability and integration of quality measures across settings. And, by making acute care hospitals and other upstream providers more accountable for more distal outcomes, episode-based bundled payments would induce upstream providers to partner with the best downstream providers.

**The Medicare Post-acute Value-based Purchasing Act of 2015**

The Medicare Post-acute Value-based Purchasing Act of 2015 was designed to accompany the IMPACT Act. The pending legislation ties a portion of payment to the amount of Medicare spending per beneficiary (MSPB) at the site of care and for the subsequent 30 days. One speaker noted that, by defining value only in terms of costs and not in terms of patient outcomes, the proposed payment formula could encourage stinting and could encourage providers to push costs to the other side of the 30-day window. Another speaker raised the issue of whether the 30-day episode should more appropriately be 90 to 100 days.

**Medicare Advantage**

Speakers remarked that another program in the Medicare arena, Medicare Advantage (MA), can drive innovation in the delivery of post-acute care. Because Medicare Advantage plans are at risk for all of a beneficiary's covered health care costs, the plans have finan-

cial incentives to coordinate acute and post-acute care. Researchers observed, however, that Medicare Advantage plans lack experience in managing post-acute care. They thought that Medicare Advantage plans have made progress over the last few years, but they note that PAC has not been a high priority for the plans. Until recently, most did not have well-established networks of post-acute providers, were not managing SNF days, and did not help enrollees make choices that could optimize outcomes and cost. Participants also discussed the role of post-acute care "conveners" who take on some of the risk for managing the care of MA plan members following a hospitalization. Some noted that allowing MA plans to offer social services and supports to enrollees who need them could be helpful in managing care.

**Policy Considerations for Innovations in Post-Acute Care**

Meeting participants were most interested in discussing the financial incentives in new payment models, how the quality of services is measured, and how consumer engagement and behavior affect the success of the models.

**Financial incentives**

Researchers agreed that use of the right financial incentives is pivotal to ensuring success in value-based payment models. They noted that more research is needed to determine how providers respond to the various combinations of upside and downside risk for both outcomes and costs in order to better calibrate payment formulas. Some discussants felt that, if post-acute providers take on more risk for both outcomes and costs, they should be given more regulatory

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flexibility to move from a “culture of compliance” to a “culture of innovation and experimentation.” They noted that increased flexibility also would reduce the need for regulatory oversight and reduce compliance costs.

Meeting participants noted that “getting the price right” is necessary, but not sufficient. Citing the backlash against managed care organizations in the 1990s, they explained that, if financial incentives are to be effective, providers also need supports to encourage positive changes in service delivery. One participant had been involved in evaluating a demonstration that did not meet cost containment goals. He reported that, in that instance, the demonstration did not pair payment incentives with delivery system innovations. He emphasized that both must be well designed.

The issue of whether systems are voluntary or mandatory for providers and patients also will have an impact on the success of any payment model, according to some participants. One participant observed that, if providers do not like the price in a voluntary system, they will not participate in demonstrations. Discussants mentioned a significant weakness of the ACO model with respect to cost savings: patients are not required to see ACO providers. Thus, the ACO cannot control care or costs if patients do not comply with hospital discharge recommendations to receive post-acute care in the ACO network. Several people said that population health initiatives will not succeed financially unless they include bundled payments tied to episodes of care that commence with an acute care hospitalization.

Speaking more philosophically, one person suggested that, rather than using a “care follows money” approach, money should follow optimal care. He contended that payers have not been clear about exactly what they pay for such that providers have to scramble to follow the money. He advocated for the development of new models of care, followed by the development of payment systems that reward providers who implement the models well.

### Consumer engagement and behavior

Participants discussed the role that consumer behavior can play in promoting optimal post-acute care. Discussants pointed out that consumers faced with the need for post-acute care often do not have adequate time or information to make choices. Most are unfamiliar with available options or with the advantages and disadvantages of each. In a recent study, for example, new nursing home entrants indicated that they would have been happy to travel farther for a better-quality facility when choosing a place for care; however, they did not have, or understand, information about the quality of the available facilities. On the other hand, colleagues noted that planning and choice often are possible with elective procedures. For example, one speaker described how a hospital system uses PAC co-

ordinators, particularly for specific procedures such as joint replacement, spinal fusion, or cardiac care, to help consumers understand their options and “navigate the system.”

Participants noted that, in general, providers have been wary of engaging in any behavior that might be interpreted as collusion with other providers, such as “steering” patients to post-acute care providers. Consequently, they simply give patients long lists of facility names. Noting that consumers want to know more about quality, experts said that there are options for making more information available without recommending specific providers.

Participants also considered whether consumers need more information about price. One person pointed out that considerable effort would be required to obtain, interpret, and explain information about pricing. Thus, he concluded that, for now, achieving price effects should target providers rather than consumers.

### Quality measures

Arguing that payment should be tied not to models of care but rather to the results of those models, one participant argued for devoting resources to developing more robust quality measures. He noted that patient-reported outcomes can provide results-oriented measures but observed that such measures are just in the beginning stages of development. One speaker pointed out that professional groups sometimes advocate for process measures because they “own” a particular process and see particular quality metrics as validating the profession’s role. Several people emphasized that new models will not have the desired effects without the specification of strong outcome measures as opposed to the specification only of process measures.

Discussants spoke about the challenge of developing and using good outcome measures to differentiate quality when sample sizes are small, especially in markets with few providers or for procedures that few people undergo. Researchers also spoke about the difficulty in finding statistically different outcome results when, except for outliers, everyone clusters at the same performance levels. They noted that this is not a problem if the measure clusters at high performance levels, but such clustering can make it difficult to identify meaningful cut points when attempting to differentiate levels of quality, particularly if the goal is a simple five-star summary.

Speakers touched on several other aspects of quality measurement. They pointed to the need for more consistent definitions of what constitutes an outcome measure. They spoke about the need for appropriate quality measures for elective and non-elective procedures. They also suggested that care settings should be taken into account. One person mentioned that the use of different measurement instruments for different settings is problematic. Another added that

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episodes of care for individuals may span several settings or that a particular setting, such as a nursing facility, may provide more than one type of care.

Researchers were concerned about the representation of several users in a single broad measure, as is the case with Nursing Home Compare and HEDIS measures. They pointed out that, as a practical matter, the measures do not adequately measure the quality of care for small, but important groups, such as older frail people. In a Medicare Advantage plan, for example, measures for the neediest group of people may be masked when data are reported for all enrollees.

The discussion ended with a reminder from one participant that, despite the difficulties raised during the meeting, researchers have made progress in developing quality measures. She advised her colleagues to be optimistic about quality measurement and observed that consumers' use of information has been disappointing to date but noted that it is improving. She made a plea not only for developing new measures but also for helping consumers interpret information that is already available.

### Innovations in Chronic Care

As with hospital and post-acute care, interest in coordinating chronic care and other services has been keen. Payer-specific changes have set the stage in this area. In Medicaid, managed long-term service and support (MLTSS) programs are more popular. Given the high levels of spending for beneficiaries with both Medicaid and Medicare coverage (dually eligible beneficiaries), particularly for long-term services and supports, policymakers are interested in new service delivery approaches designed to improve quality and reduce costs.

One speaker reminded the group that, increasingly, Medicare and Medicaid will become chronic care programs as the population ages. Presenters spoke about three models that seek to provide services more effectively and efficiently for dually eligible beneficiaries: Financial Alignment Demonstrations, PACE programs, and Medicare Advantage Special Needs Plans for dually eligible beneficiaries.

### Medicaid managed care

The trend among state Medicaid programs is to contract with managed care organizations (MCO) that provide services for beneficiaries by using a capitated rather than a fee-for-service payment approach. A substantial proportion of Medicaid beneficiaries are enrolled in MCOs. Some 39 states use managed care for Medicaid beneficiaries who do not need long-term services and supports. Through Medicaid waiver programs, states are also tailoring their long-term services and supports. In 2016, 23 states were operating managed LTSS programs, 15 on a statewide basis. Approximately

1.2 million beneficiaries were enrolled in managed care plans for LTSS. By contrast, only eight states operated MLTSS programs in 2004.

MLTSS waiver programs are designed to provide a range of services, including institutional or home- and community-based services, acute and primary care, and behavioral health. While the programs have common features, researchers report that evaluating the impact of MLTSS can be difficult because of differences in program design and implementation across states.

One expert explained that, to date, the evidence about how well managed care works is not compelling. Evaluations often lack comparison groups, making results hard to compare and generalize. There is little definitive evidence about how MLTSS affects overall costs and patient outcomes. Available research findings suggest that MLTSS programs reduce use of institutional services and increase access to home- and community-based services. Currently, one research group is engaged in a rigorous examination of current literature pertaining to waiver evaluations.

### Financial Alignment Initiative demonstrations

Under the Financial Alignment Initiative (FAI), 13 states are working with CMS to sponsor demonstration programs to better coordinate care for dually eligible beneficiaries. Ten states rely on a capitated model that involves three-way contracts among CMS, the state, and managed care organizations. Two states are using a managed fee-for-service model, and one is testing administrative alignment. For the most part, the population eligible for the demonstrations includes the elderly and people with disabilities, but two target the elderly; one targets people with disabilities.

In most states, program enrollment, which is voluntary, has been significantly lower than expected. Large portions of eligible enrollees have chosen not to enroll by opting out of the program or disenrolling after they are passively enrolled. A presenter explained that many providers are not participating in the demonstrations and that those providers' patients have been reluctant to enroll in programs that would require them to switch to a new network provider, even if the programs provide extra benefits. One participant reminded others that providers often are trusted information sources and could play an important role in educating and recruiting patients for demonstration programs. He indicated, however, that the programs are administratively complex and managed by opaque health plans and systems. Thus, providers do not know which of their patients are eligible for or would benefit from the programs. He concluded that providers would be more likely to participate and to convince their patients to participate if they had a better understanding of the program.

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Some process measures have reportedly shown signs of improved coordination between plans and providers and even among plans in the demonstrations. To date, however, little information is available about utilization and financial outcomes. Descriptive results in Massachusetts and Washington suggest some savings on the Medicare side, but researchers caution that it is too early to draw conclusions.

### PACE programs

The Program of All-Inclusive Care for the Elderly (PACE) provides Medicare and Medicaid services for a relatively small number of people. In 2014, the fully integrated program served just 35,000 dually eligible beneficiaries, a very small share of all duals. One speaker, citing the PACE Innovation Act enacted in November 2015, pointed to opportunities for program expansion. The law sets up a new streamlined federal waiver process with tracks for two new populations: younger people with disabilities and “at risk” older adults who have a need for some long-term services and supports but are not yet at a nursing home level of care. Models for the for-profit provision of PACE services are also being tested. Participants thought that more expansion in PACE could be accomplished through regulatory flexibility. They said that the program is administratively complex and incurs substantial infrastructure costs. They also reported that states have been cautious about spending for PACE; some have imposed enrollment caps on the program. One participant emphasized the importance of thinking about how much demand there might be for PACE-type products and pointed out that few such products are currently available even in private markets with wealthy elderly populations.

The most frequently cited positive attributes of PACE include a person-centered approach to care; a longitudinal focus with coverage for medical and long-term services and supports; a direct care relationship involving individuals, family members, providers, and caregivers; and opportunities to assess program participants and make, implement, and monitor care plans.

Studies with strong designs show that PACE is associated with mixed financial outcomes: no effect on Medicare spending and considerably higher Medicaid spending. Positive results reported in a 2014 literature review indicate that PACE improves the quality of care and access to services and is associated with fewer hospitalizations for PACE enrollees than for their fee-for-service counterparts. However, PACE enrollees had higher rates of nursing home admissions. Overall, PACE participants report that they are satisfied with the care they receive, but the research does not indicate whether satisfaction and quality of life are greater than they would be if the participants were not enrolled in PACE. The review described significant limitations to existing PACE evaluations and concluded that “none offers strong evidence on the effectiveness of PACE.”

Some discussants remarked that results could change as projected growth and changes occur in PACE.

### Medicare Advantage D-SNPs

Contracting with Dual Eligible Special Needs Plans (D-SNP) is another approach that states can take to facilitate the coordination of Medicare and Medicaid services. D-SNPs are Medicare Advantage plans that target dually eligible beneficiaries. Some states, especially those with well-established MLTSS programs, chose to pursue alignment by working with D-SNPs rather than by participating in the FAI demonstrations; some states have required MLTSS plans to offer D-SNPs. States cannot, however, require enrollment in D-SNPs as they can in MLTSS. The number of dually eligible beneficiaries enrolled in D-SNPs has grown strongly and consistently since 2006, reaching more than 1.6 million in 2014.

Researchers reported that, as with other aspects of Medicare Advantage, D-SNPs evidence mixed performance, with some doing little to coordinate Medicare and Medicaid. The longstanding Minnesota Senior Health Options (MSHO) relies on Medicaid MLTSS and D-SNP contracting. Available research related to the MSHO program indicates that, compared to beneficiaries enrolled in the Medicaid-only program, people who chose to enroll and stay in MSHO were 48 percent less likely to have a hospital stay; 6 percent less likely to have an emergency department visit; and 13 percent more likely to use home- and community-based services. Researchers caution, however, that outcomes for these groups are difficult to compare because they differ in terms of whether they chose to enroll and stay in the MSHO program.

### Policy Considerations for Innovations in Chronic Care

A major point in discussions about innovations in chronic care pertained to the lack of definitive evidence regarding the efficacy of popular approaches already in use. Participants also spoke about how chronic care services may be enhanced through the provision of more social services and the use of more technology.

### Limited evidence

Participants remarked that, despite a great deal of activity aimed at coordinating and improving care and containing costs by relying on managed care, the evidence base for this approach is not strong. Similarly, several people pointed out that the shift in Medicaid funding from institutional to community-based LTSS is generally viewed positively, but whether such a shift saves Medicaid money overall is still an open question. One speaker explained that, on a per capita basis, home- and community-based services are less costly than institutional care, but she pointed out that total spending does not necessarily decline. Research shows, for example, that hospitalization rates are higher for beneficiaries in community-based settings versus institutional settings.

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Noting that many people prefer to receive care in the community, one speaker suggested that evaluations should focus on overall effectiveness and overall spending in different settings. Researchers noted that more rigorous evaluations of different models of care are underway. They acknowledged, however, that reliance on managed care to provide services for people with chronic conditions will likely continue as will the emphasis on better alignment of incentives across Medicare and Medicaid and the transition of LTSS from institutions to the community.

### Social and support services

Speakers suggested that policymakers should think not only about the services in place now for people with chronic conditions but also about other social services and supports that should be available: greater financial support for family caregivers; easier access to care workers and in-home services; and adapted housing for people with disabilities. One person maintained that the system in place today is not the one needed for a rapidly aging society and argued that, without a broad system change that more fully addresses the social determinants of health, the current hospital and nursing home pattern of care, which is extremely costly, will accelerate rather than reduce spending over the long term.

Regarding the current system, discussants thought that funding for services provided by and through the Aging Network and other community-based organizations is needed to help keep people out of crisis and therefore reduce the need for chronic care. Such services include respite for family caregivers, transportation to medical and other services in the community, meal services, and personal assistance to help maintain independence as well as counseling, legal, and information services. Some experts recommended that policymakers think about adapting Medicare-funded programs so that such programs can offer a wider range of nonmedical social services and supports to beneficiaries who need them.

### Technology

Experts suggested that greater use of telemedicine and remote monitoring could yield efficiencies. Innovations in telemedicine in home care have been associated with reduced hospital admissions and improvements in care, but participants observed that questions about who pays for the innovations and who accrues the savings remain unanswered. A report on technology use in older adults from several years ago showed that the United States lagged behind Europe in that respect and attributed the difference to more challenging regulatory and payment factors. Participants suggested that new financial models, including those that promote the provision of services in the community rather than in institutions, might spur innovation in this area.

On the topic of electronic health records (EHR), discussants agreed that the goal of coordinating care is much easier to achieve if all the parties involved in care can communicate easily, but they noted that the ability to link records, particularly between health and social service providers, is extremely limited. They also spoke about the limited capacity, even among large companies, to use health information technology to track and analyze service use data. One expert reported that nursing homes are ahead of community-based long-term care providers in this regard but stressed the need for more work.

### Post-Acute and Chronic Care: Where the Two Shall Meet

Meeting participants were reminded that patients transition from or cycle between post-acute and chronic care services. The quality of post-acute care often determines, for example, whether patients will need longer-term services and supports. Speakers observed that the overlap between post-acute and chronic care or long-term care is most apparent in the nursing home setting. Most nursing homes provide both short-term post-acute nursing and rehabilitation care and long-term or chronic residential care.

### Nursing home activity/trends

For nursing homes, the length of stay for SNF episodes is declining, but the number of SNF admissions is increasing. Overall, the number of nursing homes in the United States is decreasing, along with the number of residents. From 2000 to 2014, the proportion of days associated with long stays decreased from just over 85 percent to under 80 percent. Currently, nursing homes count fewer than 1 million long-stay residents on any given day.

Experts indicated that interest in post-SNF discharge has increased. Metrics recognize that skilled nursing care is part of a continuum of care. Some reports, for example, point to recent reductions in 30-day rehospitalization for SNFs. One speaker suggested, however, that the risks of rehospitalization continue for 90 days after discharge from an SNF and therefore should be considered as well.

Wide variation was reported in “successful discharge” rates, which measure the percentage of SNF admissions from hospitals that are then discharged to a community setting. Successful discharge rates are seen not only as an important outcome for patients and their families but also as a lower-cost alternative to institutional care. Attendees considered practice patterns or innovations that could affect readmission rates. They asked, for example, what role physician involvement plays in post-acute care. One person explained that the link between physician services and care in facilities is difficult to establish and study because of the way services are billed. Another explained that, given that the current delivery system does not facilitate communication among providers, physicians’ ability to affect outcomes is limited.

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Researchers did provide some evidence of innovations in care that have been helpful. They said that rehospitalization rates are lower when nursing staffs comprise more registered nurses. In one instance, using nurse practitioners in nursing homes was associated with a decrease in hospitalizations. Participants cited telemedicine for its potential to decrease transfers to the hospital. Some evidence suggests that patients' experience is better when nursing homes establish special wings for those admitted directly from an ICU or those with very serious cardiovascular conditions. Researchers cautioned, however, that data regarding nursing home practices and hospitalizations are limited. They stressed that this type of innovation has traditionally not been a high priority among nursing homes because the facilities pay for the innovation as savings accrue to payers. One person suggested that this could change if payers bundle nursing home and other services.

The data show that a higher proportion of dually eligible beneficiaries than Medicare-only beneficiaries become long-stay residents after an SNF admission. Dually eligible beneficiaries who are newly admitted for post-acute care tend to be admitted to "lower-staffed" facilities with fewer nursing care hours per patient per day; in such facilities, a higher percentage of SNF admissions transition to long stay.

### Balancing post-acute and long-term care priorities

Participants discussed the challenges faced by providers in treating post-acute and long-stay patients alongside one another in SNFs. One contended that differences in the goals, orientation, and staff for the two populations argue for specialization. Another reminded the group, however, that specialization would sacrifice service integration, which is generally favored, particularly as patients' needs change. Specialization can also create a conflict of interest for nursing home management because short-term post-acute patients are sometimes seen as a means of cross-subsidizing the Medicaid-eligible patients, who tend to dominate most nursing home populations in the United States.

Speakers observed that Medicaid covers a substantial portion of long-term care residents in nursing homes, providing a stable base for facilities; in most states, however, revenue from Medicaid does not cover costs. Medicaid payment rates, regulations, and concerns about risk for litigation were cited as having played a part in nursing home chains' decisions to leave some states. Higher reimbursement rates are associated with Medicare post-acute care patients, but participants noted that most nursing homes cannot sustain a Medicare-only operation; large numbers of admissions are needed each day in order to do so. Discussants observed that most nursing home executives must currently devote considerable time and attention to cultivating relationships with hospitals, the primary source of referrals for Medicare patients.

According to participants, another complicating factor for facilities providing short- and long-term care is that quality rankings depend, in great part, on inspections that emphasize issues related to long stays. As one participant stated, rankings depend more on what is happening in the "back rather than the front of the house." As a practical matter, however, facilities with poor quality scores could see reductions in Medicare admissions and revenue for post-acute care.

One participant asked about the interface between post-acute and chronic care in the context of home health. The response from colleagues was that home-based care has received less attention than other types of post-acute care. Some hospitals operate their own home care agencies. Otherwise, home health care has historically been a secondary concern of hospital systems. One participant described a new position, vice president for post-acute care, created by a hospital system, noting that hospitals across the country are thinking more about how they might provide outpatient services as an alternative or enhancement to more traditional post-acute services. For example, with the rapid growth of joint replacement patients, some hospitals provide outpatient therapy rather than sending patients to skilled nursing facilities.

### Impact of new payment models

Participants agreed that, until recently, most Medicare Advantage plans had not focused on managing SNF services and most had not developed SNF networks. With an increase in enrollment in both MA plans and enrollees' use of SNFs, however, MA plans are developing networks of post-acute providers. Researchers reported some evidence that the concentration of MA patients from the same plan in an SNF is advantageous and results in more home discharges. Plans can be more efficient and have more input regarding care and cost when their patients are concentrated among fewer SNFs. Some argued that it is currently difficult to achieve concentration because of a lack of data and experience in the industry.

Lack of capital was another contributing factor cited in the slow pace of adopting a managed care model for post-acute and long-term care. One participant contended that upfront investment in EHRs and training is essential if a managed care model is to succeed. Others agreed but cautioned that, even with investment, the use of EHRs poses challenges because hospital and other facility records are not linked and EHRs are not easily modified to accommodate important information related to the provision of post-acute and chronic care.

Speakers observed that, at the same time that payers are considering how to consolidate, nursing facilities focused on referral sources recognize the importance of being associated not only with hospitals and MA plans but also with ACOs or other organizations

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that partner in bundled payment arrangements; these groups have a financial interest in care provided by a range of service providers.

Participants discussed the possibility that a tiered network system of post-acute and chronic care could evolve as providers align. They suggested that a minority of skilled nursing facilities could end up in preferred networks that serve better-reimbursed cases while other facilities might struggle to recruit qualified staff given their relatively low rates of Medicaid reimbursement. One participant warned that, if segmentation develops in the market, nursing home closures will continue.

### Future Considerations for Policy and Research

Participants acknowledged uncertainty about the direction of future policies and accompanying research, given anticipated changes associated with the November 2016 national election. One person suggested that value-based purchasing is an approach that traditionally has appealed to Republican lawmakers and therefore may continue to have traction with the new administration. Most of the discussion about future research concerned the study of current activities with an eye to the future.

### Research design

Several speakers stressed the importance of continuing to conduct well-designed research. In particular, they highlighted difficulties associated with finding appropriate control groups for studies of programs that enroll providers and patients on a voluntary basis. They urged colleagues to be attentive to methods that address provider and patient selection issues as they conduct their own research and appraise others' research. They noted that integrated organizations may differ from non-integrated organizations and that patients who choose integrated providers may differ from patients who do not. They may, for example, be more concentrated in urban areas or be associated with teaching hospitals. Experts also called for studies that capture all of the spending by different payers associated with post-acute and chronic care arrangements, including out-of-pocket payments by individuals and their families.

### Coordination and consolidation

Participants noted that improved care coordination is assumed to lead to better outcomes and lower spending, but they stressed that more research is needed to determine if such an association obtains. In addition, some argued for a longer-term perspective, noting that “[o]ne person’s integration and coordination is another’s lack of competition” and pointing out that highly concentrated markets may give rise to antitrust issues. They advocated for research that examines how concentrated markets affect outcomes. Participants also said that it will be important to study whether trends in consolidation will lead to market segmentation and, if so, what the impacts might be on short- and long-stay patients, Medicare Advantage and fee-for-service patients, and patients across various socioeconomic groups.

### Care settings

Another research priority, speakers said, involves consideration of whether certain care settings offer good value relative to others. Similarly, the question of what occurs across different care settings is of interest. Researchers reported that most comparisons involving settings have addressed one type of condition in one or two settings. For example, some information suggests that orthopedic patients may be treated in several settings with comparable outcomes, but the overall evidence regarding care settings is limited.

### Financial incentives

Researchers caution that integration alone is unlikely to achieve cost savings without also changing underlying payment incentives. As new payment models are introduced, a key research question is how to structure the financial incentives to achieve the desired end. Understanding how providers respond to various combinations of upside and downside risk and the amount of risk associated with each is essential. Another question is whether efforts to align payments and share risk are sufficient to produce desired outcomes.

### Targeted research

Participants called for more research on specific topics. For example, they recommended support for the development of a new generation of simpler patient assessment instruments that use computer-adapted testing. They also spoke about the need to develop a better understanding of why programs to integrate services for dually eligible beneficiaries have not attracted more enrollees. They suggested that researchers should examine design differences and enrollment success across states that have implemented demonstration programs.

### Conclusion

As with other parts of the health care system, payers and providers are experimenting with new approaches to improving quality and controlling costs in the delivery of post-acute and chronic care. The health care system is seeing a shift away from traditional setting-specific approaches to more integrated delivery and payment models that place a strong emphasis on care coordination. Meeting participants endorsed the goals driving these system changes, but they cautioned that data on the impact of the new approaches are limited and the findings are mixed. They pointed out, for example, that the available research indicates that improving outcomes does not automatically lead to cost savings. They acknowledged the challenges associated with conducting research in this area, but pointed to the lack of definitive evidence regarding the efficacy of popular approaches already in use and called for more rigorous research.

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### Bibliography

#### Innovations in Post-Acute Care

Chandra A, Dalton MA, Holmes J. Large Increases in Spending on Postacute Care in Medicare Point to the Potential for Cost Savings in These Settings. *Health Affairs* 2013; 32(5): 864-872.

Chen LM, Meara E, Birkmeyer JD. Medicare's Bundled Payments for Care Improvement (BPCI) Initiative: Expanding Enrollment Suggests Potential for Large Impact. *American Journal of Managed Care* 2015; 21(11): 814-820.

David G, Rawley E, Polsky D. Integration and Task Allocation: Evidence from Patient Care. *Journal of Economics & Management Strategy* 2013; 22(3): 617-639.

DeJong G. Are We Asking the Right Question about Postacute Settings of Care? *Archives of Physical Medicine and Rehabilitation* 2014; 95: 218-221.

DeJong G. Coming to Terms with the IMPACT Act of 2014. *The American Journal of Occupational Therapy* 2016; 70(3): 1-6.

DeJong G. Site-Neutral Payment for Postacute Care: Framing the Issue. *Archives of Physical Medicine and Rehabilitation* 2014; 95: 1212-6.

de Lisle K, Merrill T, Muhlestein D. Defining High-Value Post-Acute Care Providers for ACO Partnerships. *Leavitt Partners*. 2016 October: 1-2.

Dummit L, et al. CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 2 Evaluation & Monitoring Annual Report. *The Lewin Group*. 2016 August: 1-256.

Gozalo P, Leland NE, Christian TJ, Mor V, Teno JM. Volume Matters: Returning Home after Hip Fracture. *Journal of the American Geriatrics Society* 2015; 63(10): 2043-51.

Grabowski DC, Huckfeldt PJ, Sood N, Escarce JJ, Newhouse JP. Medicare Postacute Care Payment Reforms Have Potential to Improve Efficiency, but May Need Changes to Cut Costs. *Health Affairs* 2012; 31(9): 1941-1950.

Health IT in Long-term and Post Acute Care. *Office of the National Coordinator for Health Information Technology*. 2013 March: 1-29.

Huckfeldt PJ, Sood N, Romley JA, Malchiodi A, Escarce JJ. Medicare Payment Reform and Provider Entry and Exit in the Post-Acute Care Market. *Health Services Research* 2013; 48(5): 1557-1580.

Jung HY, Trivedi AN, Grabowski DC, Mor V. Does More Therapy in Skilled Nursing Facilities Lead to Better Outcomes in Patients with Hip Fracture? *Physical Therapy* 2016; 96(1): 81-9.

Keohane LM, Grebla RC, Mor V, Trivedi AN. Medicare Advantage Members' Expected Out-Of-Pocket Spending for Inpatient and Skilled Nursing Facility Services. *Health Affairs* 2015; 34(6): 1019-27.

Konetzka RT. Are Home- and Community-Based Services Cost-Effective? *Medical Care* 2016; 54(3): 219-220.

Konetzka RT, Polsky D, Werner RM. Shipping Out Instead of Shaping Up: Rehospitalization from Nursing Homes as an Unintended Effect of Public Reporting. *Journal of Health Economic* 2013; 32(2): 341-352.

Konetzka RT, Stuart EA, Werner R. The Effect of Integration of Hospitals and Post-Acute Care Providers on Medicare Payment and Patient Outcomes. *Social Science Research Network* 2016: 1-36.

McWilliams JM, Chernew ME, Zaslavsky AM, Landon BE. Post-Acute Care and ACOs—Who Will Be Accountable? *Health Services Research* 2013; 48(4): 1526-1538.

Mor V, Rahman M, McHugh J. Accountability of Hospitals for Medicare Beneficiaries' Postacute Care Discharge Disposition. *JAMA Internal Medicine* 2016; 176(1): 119-121.

Prvu Bettger JA, Stineman MG. Effectiveness of Multidisciplinary Rehabilitation Services in Postacute Care: State-of-the-Science. A Review. *Archives of Physical Medicine and Rehabilitation* 2007; 88(11): 1526-1534.

Rahman M, Grabowski DC, Mor V, Norton EC. Is a Skilled Nursing Facility's Rehospitalization Rate a Valid Quality Measure? *Health Services Research* 2016; 51(6): 2158-2175.

Rahman M, McHugh J, Gozalo PL, Ackerly DC, Mor V. The Contribution of Skilled Nursing Facilities to Hospitals' Readmission Rate. *Health Services Research* 2016.

Rahman M, Norton EC, Grabowski DC. Do Hospital-Owned Skilled Nursing Facilities Provide Better Post-Acute Care Quality? *Journal of Health Economics* 2016; 50: 36-46.

Schoenfeld AJ, Zhang X, Grabowski DC, Mor V, Weissman JS, Rahman M. Hospital-Skilled Nursing Facility Referral Linkage Reduces Readmission Rates among Medicare Patients Receiving Major Surgery. *Surgery* 2016; 159(5): 1461-8.

Tsai TC, Greaves F, Zheng J, Orav EJ, Zinner MJ, Jha AK. Better Patient Care at High-Quality Hospitals May Save Medicare Money and Bolster Episode-Based Payment Models. *Health Affairs* 2016; 35(9): 1681-1689.

Tyler DA, Feng Z, Leland NE, Gozalo P, Intrator O, Mor V. Trends in Postacute Care and Staffing in US Nursing Homes, 2001–2010. *Journal of the American Medical Directors Association* 2013; 14(11): 817-820.

## Post-Acute Care and Beyond: Responding to the Growing Need for Chronic Care

Weeks WB, Rauh SS, Wadsworth EB, Weinstein JN. The Unintended Consequences of Bundled Payments. *Annals of Internal Medicine* 2013; 158(1): 62-64.

Werner RM, Konetzka RT, Stuart EA, Norton EC, Polsky D, Park J. Impact of Public Reporting on Quality of Postacute Care. *Health Services Research* 2009; 44(4): 1169-1187.

Wissoker D, Garrett B. Designing a Unified Prospective Payment System for Postacute Care. Urban Institute. 2016 June: 1-51.

### Innovations in Chronic Care

Anderson WL, Feng Z, Long SK. Minnesota Managed Care Longitudinal Data Analysis. U.S. Department of Health and Human Services. 2016 March: 1-59.

Davy C, Bleasel J, Liu H, Tchan M, Poniah S, Brown A. Effectiveness of Chronic Care Models: Opportunities for Improving Healthcare Practice and Health Outcomes: A Systematic Review. *BMC Health Services Research* 2015; 15: 194.

Ghosh A, Orfield C, Schmitz R. Evaluating PACE: A Review of the Literature. U.S. Department of Health and Human Services. 2014 January: 1-77.

Goldberg EM, Trivedi AN, Mor V, Jung HY, Rahman M. Favorable Risk Selection in Medicare Advantage: Trends in Mortality and Plan Exits among Nursing Home Beneficiaries. *Medical Care Research and Review* 2016.

Grabowski DC. Medicare and Medicaid: Conflicting Incentives for Long-Term Care. *Milbank Quarterly* 2007; 85(4): 579-610.

Grabowski DC. Special Needs Plans and the Coordination of Benefits and Services for Dual Eligibles. *Health Affairs* 2009; 28(1): 136-146.

Grabowski DC, Caudry DJ, Dean KM, and Stevenson DG. Integrated Payment and Delivery Models Offer Opportunities and Challenges for Residential Care Facilities. *Health Affairs* 2015; 34(10): 1650-1656.

Grabowski DC, Stevenson DG, Caudry DJ, O'Malley AJ, Green LH, Doherty JA, Frank RG. The Impact of Nursing Home Pay-for-Performance on Quality and Medicare Spending: Results from the Nursing Home Value-Based Purchasing Demonstration. *Health Services Research* 2016.

Jung HY, Trivedi AN, Grabowski DC, Mor V. Integrated Medicare and Medicaid Managed Care and Rehospitalization of Dual Eligibles. *American Journal of Managed Care* 2015; 21(10): 711-717.

Lynn J, Montgomery A. Creating a Comprehensive Care System for Frail Elders in "Age Boom" America. *The Gerontologist* 2015; 55(2): 278-285.

Medicare Payment Advisory Commission (MedPAC). Issues Affecting Dual-eligible Beneficiaries: CMS's Financial Alignment Demonstration and the Medicare Savings Programs. Report to the Congress: Medicare and the Health Care Delivery System 2016: 263-306.

Montgomery A, Lynn J. The MediCaring Model: Best Plan for Frail Elders in the Longevity Era. *Public Policy & Aging Report* 2014; 24(3): 112-117.

Rahman M, Keohane L, Trivedi AN, Mor V. High-Cost Patients Had Substantial Rates of Leaving Medicare Advantage and Joining Traditional Medicare. *Health Affairs* 2015; 34(10): 1675-81.

Walsh EG, Baron J, Lehman D, Greene AM, Anderson W. Webinar: Dual-Eligible Payment Reforms—Evaluation Findings from the CMS Financial Alignment Demonstration. *AcademyHealth*. 2016 November.

Walsh EG, et al. Financial Alignment Initiative Annual Report: Washington Health Homes MFFS Demonstration. RTI International. 2016 July: 1-161.

Walsh EG, et al. Report on Early Implementation of Demonstrations under the Financial Alignment Initiative. RTI International. 2015 October: 1-40.

Werner RM, Skira M, Konetzka RT. An Evaluation of Performance Thresholds in Nursing Home Pay-for-Performance. *Health Services Research* 2016; 51(6): 2282-2304.

Zainulbhai S, Goldberg L, Ng W, Montgomery AH. Assessing Care Integration for Dual-Eligible Beneficiaries: A Review of Quality Measures Chosen by States in the Financial Alignment Initiative. *The Commonwealth Fund*. 2014 March: 1-20.

Zhang Y, Padman R. Innovations in Chronic Care Delivery Using Data-Driven Clinical Pathways. *American Journal of Managed Care* 2015; 21(12): 661-668.