Hospitals narrowing post-acute networks in greater numbers and partnering with post-acute providers to improve outcomes, lower readmissions

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Abstract This paper discusses the Patient Protection and Affordable Care Act provisions that focus on readmission penalties and lays out a case for reducing penalties by creating a post-acute network and coordinating care with post-acute providers. The paper serves as a tool kit for the reasoning and justification for creating a formal post-acute network around a hospital to improve the care continuum. Hospitals and health systems interested in learning more about creating a formal network of post-acute providers in the community will benefit from reading this paper.

KEYWORDS: post-acute network, care coordination, readmissions, value-based care

INTRODUCTION

The reader may be familiar with a hospital that has its own post-acute network, senior network or community collaborative. These are all different names for a similar approach. The goal is to set an expectation for post-acute providers that encourage a commitment to quality, communication between providers and working together to prevent readmissions.

Current Center for Medicare and Medicaid Services (CMS) regulations require that every home health agency that submits a written request to the hospital be added to that hospital's list of providers. In urban areas such as Los Angeles, a hospital commonly has more than 100 home health agencies listed on its provider list. Similarly, federal regulations require that hospitals provide a 'complete list' of local skilled nursing providers. There is no specificity, however, as to how to interpret the word 'local', as this interpretation is left to the hospital. While hospitals have

traditionally been extremely hesitant to narrow their network of post-acute providers owing to these regulations, the trend is changing as a result of alternative payment models (accountable care organisations [ACOs] and bundled payment programmes).

CREATING A NARROW POST-ACUTE NETWORK

In order to effectively coordinate care with post-acute providers, hospitals realise that they must narrow their network of post-acute providers. Even those hospitals that work with multiple home health agencies are finding it difficult to coordinate with even three agencies. For this reason, it is likely that there will continue to be a trend in hospitals and health systems getting back into the home health business in coming years — even if it is simply a break-even proposition. This comes just a few years after the trend for hospitals and health systems was to get rid of their home health agencies because they were not profitable. Hospitals and health systems will soon be burdened with the expense of multiple post-acute products and services designed to prevent unnecessary readmissions. It is not likely that the health systems will be able to afford all the needed solutions, so the health system will seek to establish new non-traditional post-acute product lines wherever possible, as long as they return even the lowest of margins.

Each hospital and health system uses its own set of criteria to identify who will be included in its narrow network. Hospitals should not feel obligated to identify criteria for the facilities that are included. Quality care, longevity in the community and proximity to the hospital and ancillary providers are all relevant factors. Planning teams should not, however, waste significant time worrying about the selection process.

The Affordable Care Act mandated that hospitals coordinate care and penalised hospitals if their partners provided sub-standard care. That was all the justification hospitals needed to narrow their network. A standard answer if anyone was ever questioned about selection criteria, however, would be: 'These are the providers who agreed to our criteria and we came to an agreement with when we began the initiative.' The author has seen many a client and hospital system get stuck on this issue unnecessarily.

INCLUDING HOME HEALTH AND HOSPICE PROVIDERS IN THE NETWORK

Some hospitals also invite the home health and hospice providers to their post-acute network. In the author's experience, when a hospital includes multiple levels of post-acute care in the meeting, the group becomes too large and has too many competing interests. This clutter can make it more difficult to cover the business at hand. Some organisations have taken to having a post-acute network meeting for skilled nursing facilities (SNFs) and a separate meeting for home health, homecare, hospice, palliative care and assisted living providers. This would also be an effective approach. If a network includes a hospital-owned home health and hospice provider, however, it is much easier to have one post-acute network meeting and include the hospital-based home health and hospice providers along with the SNFs.

TIMING AND LOCATION OF MEETINGS ARE CRITICAL

It is strongly recommended that these post-acute network meetings are either invite-only or require a reply (RSVP). Particularly when lunch is served, there is a tendency for marketers who are rarely

seen, and do not often get significant volume from the hospital, to show up just to participate in the meeting because it helps justify their efforts in doing their job. While it is commendable that marketers want to show up and learn more, it is often not the correct forum for them to be trying to generate referrals and new business. These meetings are designed for existing referral sources and post-acute providers to improve care coordination processes and tactics. It is recommended that those post-acute providers who are not already receiving referrals or currently in the network start generating those referrals before they start regularly attending those meetings.

As a nursing home administrator, the author worked in a community where they had a senior network that met quarterly. This senior network lunch location rotated through different SNFs but was coordinated by the local hospital. While these meetings took place almost ten years before the Affordable Care Act became a reality, the goal then was more to build a sense of community among the providers. That was a commendable approach and well ahead of its years. The fact that the luncheon was hosted at SNFs and open to all providers who wanted to attend in the community, however, made it more of a social event than a business event.

A few years later, when the author became a hospital chief executive officer, he replicated this programme by creating a senior network in the city of Anaheim, California. He made sure, however, that the new network luncheons were hosted at the hospital and tried to keep the invite list to providers the hospital was already working with (to avoid the appearance of a social activity). Even before the Affordable Care Act, these monthly, bimonthly or quarterly meetings proved to move the needle in bringing the care continuum together.

IDENTIFYING RELEVANT TOPICS TO IMPROVE CARE COORDINATION

The author recalls that at the Anaheim Senior Network meeting, in 2006, an SNF administrator raised her hand and asked: 'Why does your hospital tend to send a higher volume of patients to long-term acute care hospitals after discharge, whereas your competitors do not?' The author reflected back to his nursing home administrator days and recalled how frustrating that could be when trying to manage the census and bed availability. He then realised that the administrator who was asking the question did not realise that it was her own medical director, who had a strong relationship with a local long-term acute care hospital (LTACH), who was writing the referrals to the LTACH and fuelling her frustration on this issue. So the author briefly gave a generic answer, explaining that physicians have the ability to bill Medicare every day if they visit a patient in an LTACH, whereas at an SNF, their ability to collect reimbursement is limited to one day a week and then later just one day a month. He also let the administrator know that he would be happy to talk to her afterwards to provide more specific detail, as this was an individual issue.

This story is shared as an example of how effective post-acute network and community collaboratives have been even prior to the Affordable Care Act in helping to exchange ideas and discuss ways to improve the care continuum.

THE PROCESS OF NARROWING THE POST-ACUTE NETWORK

As a result of several of the initiatives in the Affordable Care Act, health plans have once again become more aggressive in narrowing their provider network. Developing a narrow network simply means developing a list of preferred (or contracted) providers. While narrow networks have been evolving over several years, the Affordable Care Act led

to an increase in hospitals narrowing their post-acute provider network as well.

There are several reasons for this. One of the main reasons acute hospitals have begun narrowing networks is to control their ability to coordinate care with post-acute providers. By limiting the post-acute providers within the post-acute network, acute providers are able to work directly with each provider on a weekly basis to manage quality and reduce unnecessary readmissions. With too many SNFs and home health agencies in the mix, the hospital or SNF would not have the resources to meet and share as much data and information with each facility or agency each week.

When a hospital or health system is going to narrow its network of post-acute providers, the author is often asked what essential criteria the hospital should utilise in selecting network members. There is not a simple answer to this question, but the two constants that will be seen when a hospital or health system is looking to narrow its network are (1) consistent quality and (2) a proven long-term track record in the community (longevity). When a hospital and health system can find a provider that has a long history of delivering successful results in the community, and work with them to agree upon a low rate of reimbursement, those post-acute facilities that have been in the community for several years have an advantage and are likely to become the provider of choice.

Unfortunately, those providers who do not get included in narrow networks in the very near future are likely to see a decline in volume and referrals over the next few years. Many will have difficulty staying in business. It is a simple equation if one is in a state that is working to phase out the fee-for-service model by converting dually covered patients into managed care. Many states have simply fast-tracked initiatives to essentially get themselves out of the insurance business as soon as possible. Essentially by forcing everyone who has historically been in the fee-for-service programme into managed care, recent history has shown that there is a saving to the payer and lower overhead for the state and federal government as well. These programmes are commonly referred to as 'dual' programmes, as the beneficiaries are 'dually' eligible for Medicare and Medicaid.

There is no magic formula for how many SNFs to include in a network. Each market and community will be different. Obviously, quality should be the number one factor and can never be compromised. Identifying which quality metrics and standards to adhere to can be tricky, because each of the providers will point to the metric that they do best and suggest that the hospital use that as the benchmark. For example, the author had a client who was narrowing the SNF network, and one SNF of the group was a five-star facility on CMS Compare. A competing SNF had only a three-star rating, but it also had a very effective disease-specific specialty programme with documented success in reducing readmissions. The three-star facility (300 beds) also claimed that it was not on a level playing field with the five-star facility (66 beds) because it took more complex patients in view of the size of the facility. Proximity plays a role, as do physician referral patterns. Each of these things needs to be considered. Competitive pressures such as neighbouring hospitals being physically closer to the facility than the hospital in question should also be considered, as well as contract penetration (aligning managed-care contracts with the SNFs).

PROXIMITY OF PARTNERS IS AN ESSENTIAL FACTOR

The author likes to share the story of the phone call that he received about six months after that client narrowed its SNF network. They had initially toured 13 SNFs in the area before they narrowed the network of SNFs to 7 and launched a post-acute network. When the administrator of one of

the facilities that was not included caught wind of this fact, he called the hospital to inquire why his facility was not included. The hospital deferred to the author as the consultant. The administrator cited their quality initiatives and their long history of partnering with the hospital. The author's response to him, however disappointed he may have felt, was very clear.

The author advised him that not only was he closer to another hospital than he was to the client's hospital, but he was in fact physically on the opposite side of the competing hospital from the client's facility. This meant that the county paramedic requirements would have had to be breached in order to take a patient to the client's hospital if the patient needed acute care. While that specific county does honour patient choice, often the paramedics are required to take the patient to the nearest receiving hospital. The author also mentioned to him that the per diem of that large hospital that he was neighbouring was significantly higher than that of any other hospital in the area, including the client's hospital. Therefore, many health plans try to keep their patients away from SNFs that are in the 911 zone of that specific hospital. The author encouraged the administrator to contact his neighbouring hospital to suggest that they start a post-acute network for the same reasons.

While it was not an easy conversation, the author thinks it is very telling of what is to come in the post-acute sector over the next few years. In short, not only does the Affordable Care Act incentivise hospitals in several ways to coordinate care with post-acute providers, but it also becomes a market share play when a hospital willingly sends its patients into a competitor's primary service area and exposes them to physicians, health plans and other providers who are all anxious to prove that they can care better for the patient. For all these reasons, coordinating care, and narrowing the network of post-acute providers, is important.

HOME HEALTH AGENCIES

The author has talked a great deal about a narrow network of SNFs. It is equally important to narrow the network of home health agencies. In fact, it may be even more critical to narrow the network of home health agencies, as everyone is attempting to care for patients at home who were previously cared for at the acute hospital. For a health plan or hospital to work with more than three home health agencies becomes a significant burden. More importantly, coordinating care with multiple providers will eventually become an unnecessary burden. Historically, although many hospitals owned and operated a home health agency, many made the decision to shut down that service line in the 1990s and 2000s, as home health proved to be a low-margin, high-risk service line. Interestingly, hospitals that in large numbers got out of the home health business several years ago are now turning back to operating their own home health agencies, as it is a more efficient means of managing patients in a coordinated care model.

The author stresses that coordinating care with even one home health agency can be time-consuming and difficult. Being now just a few months and years removed from the strictly fee-for-service model, operators continue to struggle to identify how to consistently coordinate care between providers. To simplify: the fewer providers, the simpler it becomes to coordinate care. As long as the home health providers are exceeding identified quality benchmarks, it is highly likely that this trend towards system-based home health agencies will continue.

It is important that providers communicate to ensure that post-acute providers have aligned managed-care health plan contracts with their referral sources. In states where traditional Medicare fee-for-service patients are being pushed into managed-care organisations' 'dual programmes', this is even more important. The likelihood

that the fee-for-service model of the past will permanently disappear is real in states such as California and New York. While hearing this is a significant threat to many post-acute providers who have only ever known caring for fee-for-service patients, and have not lived in the world of having to get a preauthorisation on a patient before giving care, it is not just a hypothesis any more. It is rapidly becoming a reality and likely to be fully implemented in some states. Providers should ask themselves: Is your business prepared to succeed in an environment where fee-for-service patients no longer exist and you are required to get a preauthorisation on every patient before you can provide care?

This also means lower reimbursement for post-acute providers in coming years. The managed-care provider will be seeking the lowest bidder in selecting post-acute partners within their narrow network. While the health plan and managed-care partners are likely to choose the least expensive post-acute provider, that provider must also have a proven track record of delivering quality care.

The federal government's push towards enrolling all fee-for-service patients in managed care should be viewed as a significant threat to all post-acute providers. It ultimately leads to lower reimbursement than post-acute providers have been receiving in the days of the fee-for-service model, as well as shorter lengths of stay. In addition, post-acute providers will see an increase in administrative costs, as preauthorisations and additional paperwork will become the norm, even with the benefit of electronic medical records. Further, more staff time will be required to get the authorisations and extensions that caretakers need to effectively and safely discharge patients home once that post-acute episode winds down.

CONCLUSION

If the reader takes only one action item from this paper, it should be this: if their organisation is not moving now to become contracted and included in a narrow network with the hospital or payer in their community, it may already be too late. This is especially true for SNF and home health. For the sake of the long-term well-being of their post-acute organisation, readers should align themselves with all payers in their market, and work vigilantly until they have done so.

The payers, hospitals, health systems, health plans and managed-care organisations will not be prioritising this issue. Often, once a health plan already has two or three contracted providers in a certain market, they do not see the need to add additional facilities. Another contract is not a priority to them and just becomes additional, unnecessary work for them. This is also true with home health and hospice agencies. Quality, readmission success and effective disease-specific programmes are in large part all irrelevant to the health plan if they already have enough capacity to handle their patient populations in the particular market area, as value-added quality programmes have essentially become expectations of contract partners. Very rarely are specialty programmes like those described enough to convince a health plan to add an additional post-acute provider when they feel that they already have enough capacity in a market.

The author knows that this is a firm statement that many people may not want to hear and may disagree with. He stresses, however, that adding another post-acute provider simply because they stand out above their peers is rarely a priority for a health system, health plan or managed-care organisation when they already have enough capacity at that post-acute level.