

## Post-Acute Care (PAC) Providers: Strategies for a Value-Based Future

The healthcare industry's transformation from a volume-based environment to a value-based environment is well underway. Health systems and primary care providers are the focus of the transformation right now, but the landscape is quickly shifting and putting increasing pressure on facility-based post-acute care (PAC) providers, including long-term acute care hospitals, inpatient rehabilitation facilities and skilled nursing facilities.

While the degree of urgency varies by geographic market, doing business as usual is not a viable long-term option for PAC providers across the country. They will need to adapt in order to remain relevant and grow their business. In this *Executive Insights*, L.E.K. Consulting considers what actions PAC providers must take to survive and thrive in the evolving value-based healthcare environment.

### Key Macro Trends Affecting PAC Providers

Managed care is rapidly supplanting fee-for-service (FFS) care in government-sponsored health insurance programs, and the PAC landscape is not immune to the effects of this change. For example, deeper managed care penetration, coupled with growth in the aging population, has led to large enrollment increases in the Medicare Advantage and managed Medicaid programs. Medicare Advantage enrollment is projected to reach approximately 35% penetration of the Medicare eligible by 2017, up from 25% in 2010, and managed Medicaid

penetration is expected to increase to 83% in 2017 (from 56% in 2010). Based on these growth projections, managed care will be a fast-growing piece of the reimbursement mix for PAC providers. As Medicare Advantage and managed Medicaid expand, managed care organizations (MCOs) are increasing their influence, and PAC providers are increasingly aware of the need to change their operating models. These changes will subject PAC providers to the following challenges:

- Negotiated rates below government FFS rates
- Increases in utilization management (or utilization review)
- Diversions to lower-cost care settings
- Demands for higher-quality measurement tracking tools
- Increased emphasis on integrated care management

Both MCOs and the Centers for Medicare and Medicaid Services (CMS) are demanding greater provider accountability on quality and patient outcomes while also pushing for value-based care (VBC) contracting. The shift toward reimbursement mechanisms designed to incentivize improved outcomes and patient satisfaction (e.g., bundled payments via the Bundled Payments for Care Improvement (BPCI) initiative) is a good example of how this is playing out.

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PAC providers must intensify their efforts to meet the triple aim of better clinical outcomes, improved patient satisfaction and reduced costs. There is an opportunity for PAC providers to help drive the arrangements with MCOs rather than taking a back seat. For instance, PAC providers should be proactive about setting the metrics for tracking and defining the VBC contractual terms. Despite the challenges of making the transition to VBC, the upside benefits are compelling. According to L.E.K. research, the number of patients treated at PAC facilities under a VBC contract is expected to increase from approximately 10% in 2014 to about 30% in 2019.

PAC providers that are slow to adapt to new MCO requirements leave an opening for third-party conveners (i.e., PAC management companies) to address these unmet needs in the market. CareCentrix, naviHealth and Remedy Partners are just three of the firms that have jumped into the fray. Two factors have spawned third-party conveners to fill the gap: 1) the lack of integration across the care continuum, and 2) misaligned payment incentives for delivering post-acute care. Third-party conveners have been quicker than PAC providers to aggregate capabilities that are attractive to partnering MCOs, and their growing presence could disintermediate PAC providers that are slow to adapt to new MCO requirements.

For example, naviHealth, CareCentrix and Remedy Partners take on risk, and payers are finding that third-party conveners are better equipped than are many PAC providers to manage care transitions and absorb risk, because they have invested in sophisticated technology platforms, data analytics and care management capabilities.

## Strategies for Success

Across virtually all care settings, payers and providers are introducing contracting structures that include pay for performance, bundled payments, risk sharing and capitation. As the preference for value-based contracting becomes more

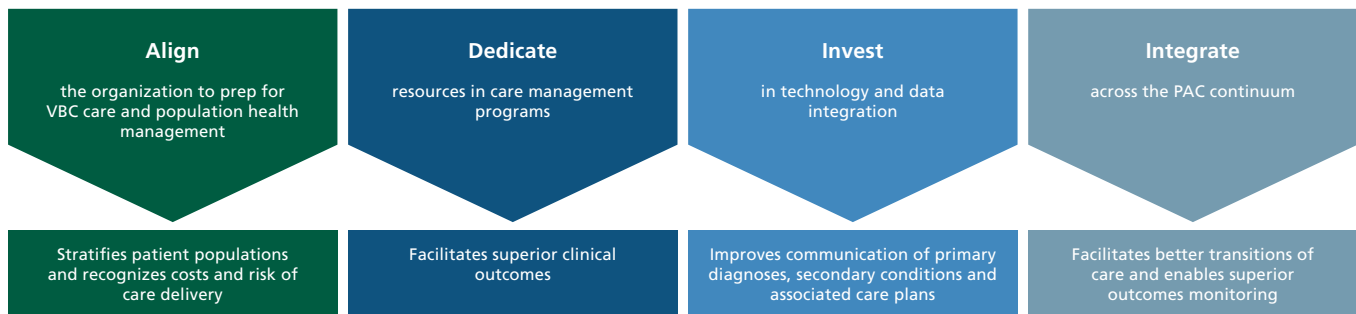
## Case Example: naviHealth

Founded in 2011, naviHealth partners with health plans, health systems, accountable care organizations and post-acute care providers to manage the entire continuum of post-acute care. Using proprietary, evidence-based analytics technology to identify the best treatment regimens, naviHealth has built a database of 750,000 patient outcomes. By applying its algorithm to the functional findings and outcomes of similar patients drawn from its database, naviHealth creates a protocol that determines both the recommended treatment regimen and the recommended care setting for each individual patient. Patients, caregivers and post-acute care facilities receive this information, which enables them to make better-informed decisions. Given its ability to manage the entire continuum of post-acute care, naviHealth has secured contracts with Highland, Cigna-HealthSpring, Golden Living and HCR ManorCare, among others. In addition, Cardinal Health acquired a 71% stake in naviHealth in August 2015. Cardinal Health is a health services company that supplies medical products and services for post-acute care. The acquisition gives naviHealth access to Cardinal Health's wide distribution channels and resources to help accelerate future growth. Cardinal Health plans to acquire the remaining 29% of naviHealth over the next four years in order to continue improving its integrated suite of services.

prevalent in the PAC market, these providers will have to demonstrate a compelling value proposition that includes both improved outcomes and overall cost savings.

Few PAC providers to date have invested to better meet MCOs' unmet needs around value-based care. Nevertheless, rich opportunity exists for PAC providers to align themselves with MCOs' value-based objectives. MCOs will reward PAC providers that engage in more value-based contracting arrangements with potential bonus payments, shared savings and additional volume directed to their facilities.

**Figure 1**  
Four Strategies for PAC Providers to Partner With MCOs



PAC providers still have time to meet outcomes and objectives and achieve cost reduction — and thereby thrive. PAC providers can differentiate themselves by helping MCOs shape the criteria of payer-provider collaborations and demonstrating performance along key clinical and patient satisfaction metrics.

We have identified four specific strategies (see Figure 1) that will help PAC providers engage in partnerships with MCOs.

**1. Align the organization to prepare for value-based care and population health management.** Corporate leadership must drive the cultural realignment by demonstrating a firm commitment to changing business practices. Organizational incentives need to be aligned. For example, facility-level and regional-level leadership bonus structures should be modified to be based on outcomes performance. Everyone in the organization must clearly understand that the healthcare system is shifting away from FFS reimbursement and toward value-based models that align incentives between payers and providers. Finally, PAC providers need to stratify patient populations and recognize the costs and risks of delivering care to their population.

**2. Dedicate resources in care management programs to enable/facilitate superior clinical outcomes.** MCOs will be eager to partner with PAC providers that have the care management

programs and capabilities needed to improve outcomes and control costs. PAC providers should invest in care management programs, including increased investments in clinical staff, in order to deliver superior outcomes. For example, by ensuring adequate staffing to execute care management programs, providers can develop compelling strategies to evaluate and minimize acute readmission risk

### Case example: Kindred

The largest diversified provider of post-acute care services, Kindred Healthcare is aggressively preparing for the value-based evolution. Well known for its set of 18 integrated care markets, Kindred has expanded across the post-acute continuum from long-term acute care hospitals to home care. Kindred's dedicated Care Transition Managers (CTMs) follow high-risk patients for 35 days post-discharge and offer patient/caregiver education, transition plan support and medication management. MCOs have recognized Kindred as a provider that has a clear understanding of its patient population and cost structure. Early results of Kindred's model have been promising; in the Boston market, for example, Kindred's CTMs have helped reduce readmission rates to 5.6% for high-risk patients (compared with the 18-21% national average). Since healthcare systems are now penalized by Medicare if patients return to a facility for the same reason within 30 days of discharge, reducing the readmission rate is crucial to Kindred's integrated strategy.

(a key outcome metric), thereby achieving better patient outcomes. Equally important are the types and range of care management resources (e.g., medical economists, care protocols and patient stratification tools) needed to enable transitions of care, minimize readmissions and improve utilization. Transitions of care, including flexible patient intake from acute care hospitals, are most effective when supported through strong relationships with both referring and community clinicians.

### 3. Invest in technology and data integration. PAC

providers need to enhance their data and reporting capabilities so they can effectively share risk with MCOs and assist in the measuring/modeling of outcomes. They can further distinguish themselves with both MCOs and referring providers by a more vigilant execution of patients' care plans through seamless data flows and improved communication of primary diagnoses, secondary conditions and associated care plans.

Investments in data and technology infrastructure are key enablers of care management programs, allowing the data reporting of outcomes needed to demonstrate performance and support value-based reimbursement mechanisms.

PAC providers should be able to share information with MCOs on patient status and demonstrate the effectiveness of their care management models through clinical outcomes, patient satisfaction metrics and other key performance indicators. They have opportunities to leverage collected data to assist Medicare Advantage plans with risk adjustment and star ratings. (Medicare's Star Rating System

holds Medicare Advantage plans accountable for quality and ties their ratings to bonus payments.)

**4. Integrate across the PAC continuum.** MCOs' ideal PAC partners are providers with integrated care delivery capabilities or partnerships across the post-acute continuum that can facilitate better transitions of care and enable superior outcomes monitoring. Effective integration aligns incentives and expedites cross-facility referrals when patients exhibit changes in acuity levels.

As health systems increasingly focus on these integration efforts, opportunities are emerging for PAC providers to enter into partnerships and joint ventures. In many areas, hospitals are already collaborating with skilled nursing facilities and other post-acute care facilities to reduce readmission rates.

We have identified three main models PAC providers can use to pursue integrated care across the PAC continuum:

1. Expand along the continuum through acquisition, as Kindred Healthcare has done
2. Enter into strategic partnerships to integrate with other PAC providers and/or hospital systems, as Select Medical has done
3. Focus on select portions of the care continuum, and leverage third-party convener partnerships to coordinate care transitions and provide access to the full care continuum

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