OUTSIDE THE LINES

TODAY'S MUST HAVE: A PAC SOLUTION

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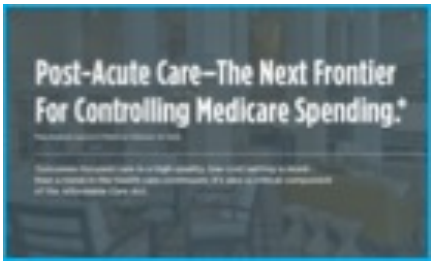
The steps of FFS-to-FFV change are marching forward. Medicare's bundled payments train is running down the track. This week, CMS' new set of rules for cardiac bundled payments was announced. This follows an April 2016 launch of CMS' Comprehensive Care for Joint Replacement (CJR) model. All of this has many implications, including one that points to the need for hospitals and their physicians to figure out their post-acute care solution.

Why? Because CMS is zeroing in on a pot of money to be culled out of the transitions of care and post-acute care parts of the continuum. In February 2014, the *New England Journal of Medicine* published a perspective titled "Post-Acute Care – The Next Frontier for Controlling Medicare Spending" with the following conclusions:



- "In 2012, Medicare spending for post-acute care exceeded $62 billion … and post-acute care had grown faster than most other categories of spending."
- "For patients hospitalized for chronic conditions such as congestive heart

failure, Medicare spent nearly as much on post-acute care and readmissions in the first 30 days after discharge as it did for the initial hospital admission."

- "Most acute care hospitals and physicians pay little attention to post-acute care. Patients are typically discharged to a post-acute care facility or home health care with little coordination or follow-up."
- "Medicare payment reform will eventually shake-up the world of post-acute care."

In October 2014, Medicare introduced MSPB – or Medicare Spend Per Beneficiary – as its new approach for providing one standard payment for all services (Medicare Parts A and B) provided from 3 days prior to a hospital admission through 30 days after the hospital discharge.

In 2015, Strategy Advantage worked with a health system to develop a Post-Acute Care Strategic Plan. It was interesting, in that our data assessment showed that more than 2,500 of the system's Medicare FFS patients were being referred to non-affiliated, community-based skilled nursing facilities (SNFs), resulting in nearly 70,000 patient days (enough to fill a 180-bed SNF) and equating to $30 to $40 million in estimated dollars for post-acute care providers. It didn't take long to convince the CEO at this health system to invest in a PAC Team, a post-acute care narrow network, and a partnering approach with post-acute providers to better manage their patients through the post-discharge transitions and to affect lower costs, improve value outcomes, and better patient experience and overall quality.

We know that you have hundreds of priorities and projects on your plates. A PAC solution is a must-have among them, to address your inpatient throughput today and to ready your organization for the risk-based, value-based, and bundle-based care that is already being felt and is on its way to an even greater extent. Whether hospitals and health systems want to be the bearers of this or not, CMC officials and other payers have tagged your organizations with the influence to manage the episode inside and beyond the four walls of the hospital. Tag, you're it!

Always looking ahead,

Kim Athmann King, MBA, FACHE

NEWS ALERT! WHAT'S HAPPENED THIS WEEK

On July 26, *Modern Healthcare* (and other news organizations) reported that CMS had announced a new set of rules for cardiac bundled payments and rehabilitation, causing a need for hospitals to "pivot to post-acute care to thrive under cardiac bundles." A CMC proposed demonstration program is set to start July 1, 2017 in 98 randomly selected areas. Participating hospitals will be paid a set payment per medical episode – for coronary bypass surgery and treatment for heart attacks – to include hospital services and all post-care for 90 days after discharge. Click here for more information.

WHO WE'RE WATCHING

There are more ways than one to add post-acute care solutions. In June, Cedars-Sinai Health System (Los Angeles) launched what it is calling "Safe Transitions Home" – a program that is being offered in partnership with HomeHero – to transition patients from hospital to home with the goal to

reduce inpatient readmissions. Others are introducing additional more creative options. For example, Vivify Health and the American Heart Hospital have collaborated to advance American Heart Association Care Plans aimed at focusing on post-acute care / preventative care for patients and targeted for use by ACOs and hospitals. Vivify Health, as part of this partnership, provides a remote care management platform for patients in their homes. Both the HomeHero and Vivify Health programs are featured as new ideas and disruptive innovators that we have written about and are tracking in our ZIGZAG Healthcare market intelligence tool. To receive a complimentary copy of either of these innovation packets, or to hear more about ZIGZAG Healthcare, contact our ZIGZAG Healthcare Director, Kala Kascht.

WHAT'S TRENDING

The American Hospital Association produced a *TrendWatch* report in December 2015 on "The Role of Post-Acute Care in New Care Delivery Models." Click here to access the full report.

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