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How Post-acute Care Can Improve Hospital Financial Performance

Daniel Walter and Francine Machisko, for HealthLeaders News, January 30, 2009

Although the current economic environment is negatively impacting the entire healthcare industry, many health systems are realizing that post-acute programs, which often take a backseat in many hospitals, can generate some much needed financial returns for the organization. Today's financial pressures, including tightened access to capital and higher interest rates, increased charity care and bad debt expenses, reduced admissions and elective procedures, and negative returns on investments have hammered many hospitals' bottom lines. For example, hospitals' total margin for the third quarter of 2008 was a -1.6%, down significantly from the 6.1% margin reported just one year earlier, according to an American Hospital Association survey released in November 2008.

These pressures have led health leaders to ask what can be done to improve margins during an economic downturn. Many health systems are justifiably evaluating stop-gap measures, such as postponing capital expenditures and implementing lay-offs, but you must remember that no business ever shrunk its way to success. Clearly, these stop-gap measures are worthy of consideration and may be necessary, but ultimately most organizations will achieve and maintain both short- and long-term success by including in their portfolio a sufficient number of profitable service lines that have both strong community demand and favorable reimbursement.

One profitable area that is often overlooked, but should be assessed by hospital administrators during these challenging economic times, is post-acute care. The March 2008 MedPAC report to Congress projected an overall FY 2008 Medicare acute-care hospital margin of -4.4%, but this same report projected positive operating margins for most post-acute programs. In fact, acute-care providers who have not recently evaluated post-acute care opportunities might be giving away some of their most potentially profitable service lines. For instance, the projected FY 2008 Medicare margin for inpatient rehabilitation was 8.4%, home health was 11.4%, and skilled nursing units were 3.8%, and long-term care hospitals were a -0.9%.

The MedPAC figures are important because for most post-acute programs, Medicare represents at least 65% of all current admissions. And with the exception of Medicaid and self-pay patients who generally make up no more than 10% of admissions, there tend to be positive operating margins for other payers as well.

Nationally, the 65 and over population is projected to increase from less than 13% of the population in 2007 to 14.5% in 2015 and 18.2% of the population by 2025. This aging will continue to increase the demand for post-acute programs, as well as other programs and services meeting the needs of chronic and elderly patients.

The post-acute revenue and operating margin that is at risk is not chump change, either. Each occupied rehabilitation bed represents approximately $300,000 in contribution margin annually, according to the most recent industry information. Increasing the rehabilitation census by just five patients would improve the hospital's bottom line by $1.5 million! In general, the same financial effect holds true for the other post-acute programs. (Although MedPac projected a negative Medicare operating margin for LTCHs, the incremental margin for each additional Medicare admission is estimated to be approximately $19,000. As such, each additional occupied LTCH bed represents almost $250,000 in incremental operating margin annually.)

Unless an acute-care hospital is certain that it's not allowing any post-acute opportunities to slip away, a closer look at this specialty area is warranted. For acute-care providers and health systems that currently offer post-acute services, this means asking the question, "How do we ensure that we are keeping as many patients as appropriate

in-house?" For hospitals that do not offer some or all of the post-acute programs possible, the question to ask is "Why is the hospital letting this business and these margins drift to other providers?"

To answer these questions, the hospital should first assess the size of the post-acute opportunity. This is accomplished by examining both the overall demographics of the community and the actual size of the hospital's acute-care patient population. Using program-specific admission criteria for each post-acute service line, the hospital must determine how many patients should be able to transition to post-acute care from its own facility, as well as the larger community. Because of the high correlation between patient age and post-acute utilization, those providers with a relatively high proportion of acute-care Medicare patients, as well as those located within older communities, will likely have the greatest potential for post-acute admissions. For example, it has been estimated that between 40% and 50% of all Medicare acute-care patients would likely be appropriate for some level of post-acute care, although the actual number of referrals to post-acute programs varies dramatically by provider and by community.

For those hospitals with post-acute services already in place, any sizeable gaps between actual and potential post-acute referrals must be reconciled. Issues that might negatively impact referrals, such as physician practice patterns or case management practices, must be identified and addressed if necessary.

Regardless of whether the hospital currently has post-acute services in place or not, it should develop a competitive profile that details information, such as the number and types of providers in the community, the services offered, and the source of each provider's referrals (to the extent available). For hospitals with existing post-acute services, this review is extremely important in assessing whether there is any referral "leakage" to unrelated providers in the community, and if so, the reason for this phenomenon. For those examining opportunities for new post-acute development, the competitive review is critical in identifying service gaps.

Finally, a financial assessment should be conducted to quantify the impact of pursing new or expanded post-acute opportunities relative to other priorities of the organization. For many health systems, the answer will be to implement a post-acute strategy to capture this business internally rather than let it transition to other providers. For other health systems, however, the better answer may be partnering with other post-acute providers to offer this care. Either way, an informed decision and a clear direction is critical in these uncertain financial times.

For many years, post-acute programs have taken a back seat to the more high profile acute-care service lines like cardiology, oncology, and orthopedics. While post-acute programs have always been one of the most effective ways to reduce acute-care length of stay (resulting in increased acute-care margins on DRG payments), the overall margins for these programs were often too small for many health systems to worry about. But now, with many of the acute services generating negative margins, the time may have come for hospitals to reassess their previous notions regarding their post-acute business. Post-acute programs may not be a panacea for all financially struggling systems, but the long-term demand for these services and the current financial returns suggest that this may be a book of business many health systems want to pursue sooner rather than later.

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