SKILLED NURSING FACILITY STRATEGIES TO SUPPORT THE POST-ACUTE CARE CONTINUUM
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In today’s era of bundled payment initiatives, accountable care organizations, and hospital readmission penalties, hospitals are faced with the challenge of how best to align with the skilled nursing facility (“SNF”) portion of the continuum of care. As the industry continues to move toward risk-based contracting, it will be imperative for hospitals to have a sound post-acute care strategy—and specifically a SNF strategy—that allows it to effectively manage with a fully risk-capable orientation. Many hospitals already own SNFs, many will consider whether to purchase a SNF to make it a part of their network through ownership, and others will partner with existing SNFs to incorporate them into their network through formal or informal affiliation agreements. This can be a particularly daunting decision given the number of hospitals that have owned SNFs historically and have chosen to get out of the business due to underperforming margins and lack of alignment of the SNF services with their core mission – providing hospital-based care. Increasingly, however, their missions are being challenged as reimbursement penalties for readmissions require a closer alignment with post-acute care services.

**OWNING A SNF**

On the surface, the rationale behind owning a SNF is clear. Owning the SNF allows the hospital to closely coordinate and manage patient care and presumably achieve more favorable clinical outcomes. The delivery of better clinical outcomes should result in fewer hospital readmissions, improving the hospital’s margin. The hospital-owned SNF can also contribute additional margin through efficient staffing and enhancing Medicare revenues by recognizing the highest possible Resource Utilization Groups (“RUGS”).

DHG Healthcare’s experience suggests that the two greatest challenges to hospitals owning and operating SNFs are properly managing Medicare revenues and direct care nursing costs.

Hospital-owned SNFs typically realize less revenue per patient day compared to non-hospital-owned SNFs and fewer Medicare days combined with lower acuity levels than the industry. This may be because the hospital-owned SNF does not exercise the marketing acumen and referral source network to the same degree as free-standing SNFs. The lower acuity level relative to the industry is quite often the result of hospital therapists transferring the hospital therapy philosophy to the SNF environment. Both treatment regimens and philosophies may be appropriate, but because the settings are different and have different goals, the treatment protocols are different. The hospital philosophy is to have the patient up and out as quickly as possible—often discharged to home health care or to a SNF where therapy will continue, whereas the SNF philosophy is to provide therapy to help the patient reach the highest functioning level possible before discharge. This difference in philosophy and in practice often results in lower RUG scores for the hospital-owned SNF.

Another significant factor that almost universally results in hospital-owned SNFs achieving less profit than well-operated free-standing SNFs is that direct care nursing cost in a hospital setting is usually higher than in a free-standing SNF. This measurement can be deceiving when benchmarking against industry standards and therefore should not be examined in a vacuum, or for example, by simply looking at nursing hours per patient day. All facets of direct nursing cost (staffing levels, wage rates, benefit program costs and position mix) should be examined in order to understand the reason for any variance from industry standards. While our experience has been that the reason for variance is typically overstaffing (nursing hours) and higher hospital-based wage rates relative to industry standards, often it is simply the fact that the hospital has a tendency to staff its SNF more like a hospital.

Profitability is challenging to verify since most hospital-owned SNFs are provider-based, which means they are included as a part of the hospital’s Medicare cost report, making the SNF-specific data difficult to isolate. Almost without exception, we have found that once hospital-owned SNF revenues and expenses have been “carved out” into their own categories, the result is a loss.

**SO WHY WOULD A HOSPITAL OWN A SNF?**

Today, the desire to reduce hospital readmissions may appear to be the most compelling factor for a hospital contemplating its ownership or purchase of a SNF, but as the hospital organization moves toward becoming fully risk-capable, the long-range goal is to capture more of the healthcare dollar under new payment models, and ultimately to manage population health and “bend the cost curve.”

A hospital system may assume that acute care clinical expertise will translate to higher quality and lower hospital readmissions if it owns and operates the SNF. The reality is that hospital-owned SNFs are not necessarily performing better than the rest of the industry on readmissions and other quality indicators.

We recently reviewed quality measure data from the Centers for Medicare & Medicaid Services (“CMS”) Medicare.gov Nursing Home Compare website for one southeastern state.
This snapshot of a single state does not provide definitive evidence that hospital-owned SNFs deliver lower quality of care, nor does it indicate a direct correlation between these quality measures and hospital readmissions, but it does challenge the notion that hospital-owned SNFs provide better quality of care than their free-standing counterparts.

A hospital-owned SNF is positioned to closely manage patient care and transitions, prevent readmissions and potentially contribute positive margin. A hospital contemplating the purchase of a SNF should consider the SNF’s quality measures, operational efficiency and profitability while providing support to maintain and improve performance (as opposed to imposing hospital operating philosophies). Even if a hospital owns a SNF or multiple SNFs, it will likely need to partner with other SNF providers in order to achieve the necessary geographic coverage and clinical capabilities to serve its patients.

### PARTNERING WITH SNFS

Hospitals are increasingly seeking to align with a SNF, or group of SNFs, that meet certain criteria that would define them as “good” partners. One of the first steps a hospital should take is to gather market intelligence by asking the following questions:

1) What ownership, affiliation or relationships currently exist between SNFs and other hospitals in the market?  
2) What Bundled Payment for Care Improvement (BPCI) programs or other risk-sharing arrangements exist, as these may serve to solidify relationships between SNFs and other hospitals?  
3) What is the hospital’s market share?  
4) What are the discharges to SNF by service line?

Depending on the market, hospitals may find they are referring to as many as 25 or even 50 different SNFs. Understanding volume and existing referral patterns is an important first step in prioritizing conversations. Even absent significant volume, geographic location is an important factor in selecting SNF partners in order to provide full coverage in the hospital’s service areas.

Following are suggested criteria for hospitals to consider when evaluating SNF partners:

### QUALITY

- Clinical Measures/Outcomes  
  - Hospital readmission rates (within 30 days)  
  - Short-term rehab average length of stay  
  - Nursing staff hours per patient day  
  - Infection rates

- Evidence-based protocols (INTERACT3, SBAR tools)  
- Clinical pathways for specific DRGs (cardio-pulmonary, stroke, etc.)

- ED visit rates  
- CMS Quality Rating (star rating)  
- Patient and Family Satisfaction Scores  
- Survey results

### ADMISSIONS CRITERIA

- Response time  
- 24/7 referral availability  
- Clinical capacity to accept complex patients, including Medicaid pending

### QUALITATIVE

- Shared alignment/vision of quality care  
- Physical plant – private rooms, hospitality and dining services, amenities, etc.

### TECHNOLOGY

- Electronic health record  
- Care planning/care management tools/software

### OTHER

- Medical Director relationships  
- Service relationships (wound care, laboratory, transportation, etc.)  
- Geography  
- Multi-facility provider  
- Niche service offerings

There are other criteria that hospitals may want to consider as there is no standard, one-size-fits-all product or approach that can be utilized to evaluate a potential SNF partner. Hospitals must undertake deliberate and considerable planning before arriving at a process and the proper tools from which an informed decision can be drawn. This conclusion is reinforced by the difficulty CMS has had in implementing a value-based purchasing program for SNFs.

### WHICH OPTION IS BEST?

Regardless of whether a hospital owns a SNF or partners with a SNF, one thing is certain: hospitals and SNFs will have to work together closely in managing patient care in the most appropriate setting to achieve better outcomes and cost savings.

While there are benefits for hospitals owning SNFs, partnering with SNFs will still be necessary in order to create a network of
quality providers that achieves service area coverage and honors patient choice.

Hospitals that own free-standing SNFs should employ SNF industry best practices to maximize profitability through revenue enhancement and operational efficiency. Hospitals operating transitional care units ("TCU") or swing beds within the hospital are uniquely positioned to closely manage high-risk patients and reduce ED visits and readmissions. However, historically these units have not operated as profitably as free-standing SNFs.

**FUTURE PRESSURES AND CHANGE**

The Affordable Care Act (ACA) mandated that CMS develop a plan to implement a value-based purchasing program for payments under the Medicare program for SNFs. The ACA further mandated that a report containing the plan be submitted to Congress by CMS no later than October 1, 2011. The CMS report was issued to Congress in 2012. The upshot of this report is that after years of study, debate, and demonstration projects, there is still no consensus on what data points/quality measures to use to implement this program. The fact that CMS has not been able to develop a standard methodology to evaluate SNF performance after years of study reinforces the difficulty a hospital may encounter to do the same.

High SNF Medicare margins continue to draw attention from the Medicare Payment Advisory Commission (MedPAC), whose March 2014 report to Congress calls for broad reforms to post-acute care. Specific SNF recommendations include revisions to the prospective payment system, reduced payments over time until Medicare’s payments are better aligned with providers’ costs, and reduced payments for risk-adjusted hospital readmissions.

President Obama’s FY2015 Proposed Budget includes a number of provisions that will impact SNF providers, including market basket cuts, reduced Medicare coverage of bad debts and beginning in 2018, reduced payments by up to three percent for high preventable readmission rates.

We can expect to see consolidation in the industry, creating opportunity for proactive SNF and other post-acute operators to grow and diversify their portfolios to position their organizations as attractive partners succeeding in a risk-based environment. Hospitals may also take advantage of acquisition opportunities to grow and strengthen their continuum of care, but competing priorities for capital and market strategies may limit these opportunities.