ALLIANCE FOR
RECOVERY CARE

BRIEFING

MAY 10, 2021

Washington, D.C.

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The Post-COVID Health System

With the worst of the pandemic hopefully behind us, we start taking stock of how the American healthcare system performed and how the pandemic may reshape healthcare.

We focus first in the following pages on how post-acute providers performed during the pandemic, and then we look at how the pandemic may shape the broader healthcare sector as it emerges from the year-long ordeal.

Economic forecasting makes astrology look respectable, so we offer these thoughts knowing some ideas may fall short. However, we are also reminded of what writer William Gibson famously said, “The future is already here – it’s just not equally distributed.”

Ten ways the pandemic may change American healthcare

1. Before the pandemic, some commentators talked about the decline of general hospitals. COVID reminded us of their central role.

2. One-third of COVID deaths happened in nursing homes (SNFs). The sector is in free-fall as many SNFs restructure.

3. The pandemic was a catalyst for innovation in the home health sector. President Biden now proposes a new home health benefit.

4. Many IRFs and LTCHs performed admirably during the pandemic and could fill-in emerging gaps in the evolving health system.

5. With Medicare post-acute spending remarkably stable, the IMPACT Act's idea of "unification" looks like a solution in search of a problem.

Ten ways the pandemic may change American healthcare

President Biden's CMS leaders are the most experienced ever assembled, but the debate about cost and quality continues.

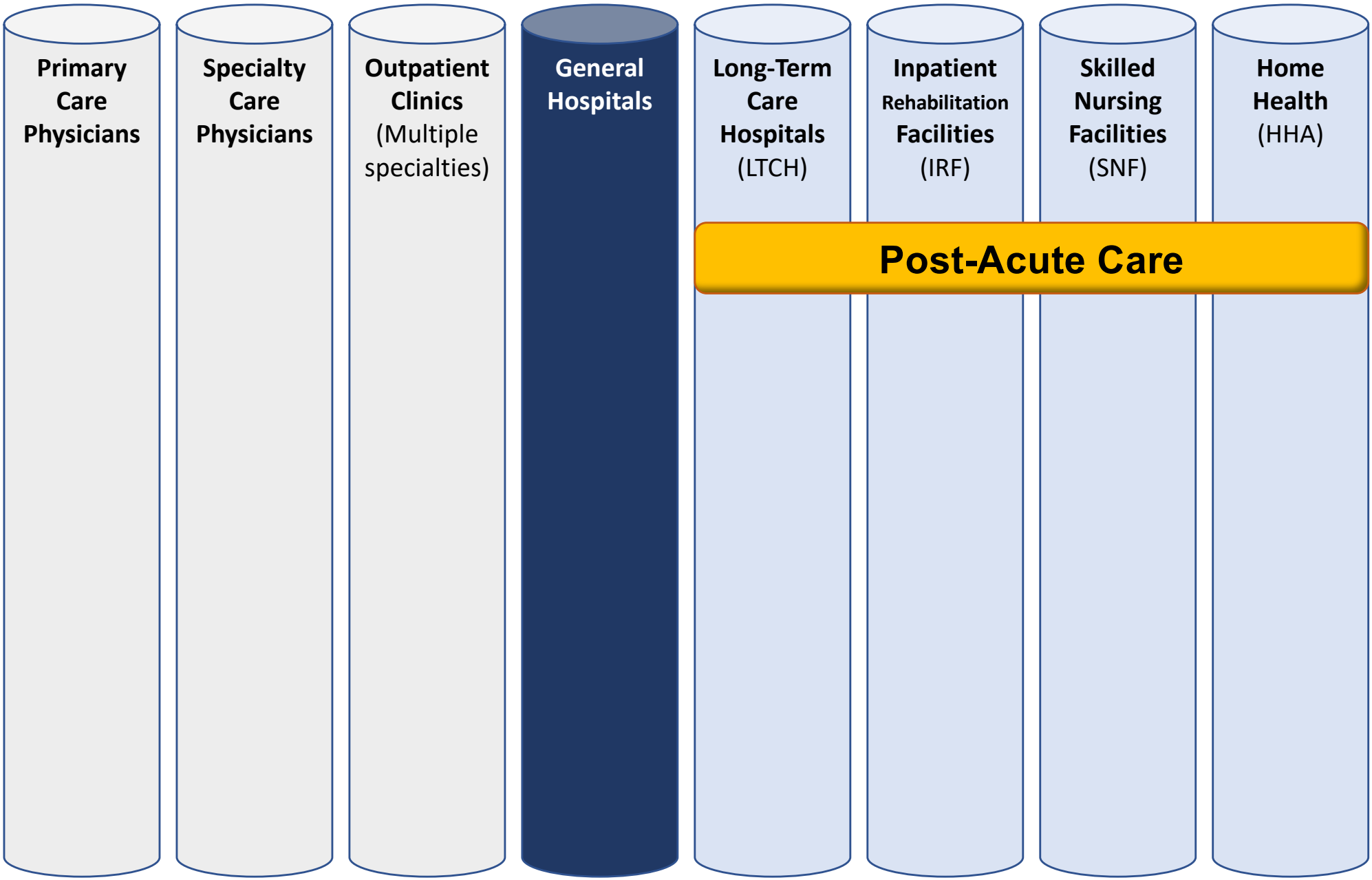
Healthcare deal-making will take off again when the sector emerges from the pandemic. Insurers continue their juggernaut.

Other COVID-related dynamics will have a big influence on the way care is provided after the pandemic.

Technology was impressive during the pandemic, and it will continue to reshape the way care is provided.

The difference in COVID death rates – between white and black Americans – was so extreme that it should not be ignored.

The American Continuum of Care



The debate is being driven by a range of factors, including:

Patient preferences;

Clinical innovations;

Focus on improving quality of care and clinical outcomes;

Electronic health records and telemedicine;

Financial incentives and public policies to reduce the cost of care; and

Value-based payment models

Before the pandemic, some commentators talked about the decline of hospitals. COVID reminded us of their central role.

Before the pandemic, one hospital system CEO famously, half-jokingly said he wanted to close his hospitals, open more ambulatory surgical centers and then, after surgeries, send his patients to special Airbnb homes run by nurses. Things look a little different after a global pandemic where, as of May 1, 2021, 32.5 million Americans contracted the virus and 2.5 million were admitted to hospitals.

But the debate goes on. In one camp are those who still believe that the health system's gravitational pull is inexorably leaving hospitals behind – pandemic or no. This camp argues that the movement towards ambulatory care will march on, and healthcare delivery will continue to move from inpatient to outpatient facilities.

The other camp believes the pandemic should make us reconsider the role of all healthcare providers in the American continuum of healthcare and reawaken an appreciation for the importance of inpatient care. During the pandemic, inpatient hospital beds – especially intensive care unit (ICU) beds – became scarce in many communities. This camp believes hospitals should remain at the center of the healthcare continuum.

For post-acute providers, there is a great opportunity – if CMS will allow them – to step into the breach and fill the new gaps emerging in the continuum of care. With hospitals discharging patients quicker than ever and moving more procedures to outpatient settings, post-acute care is becoming more – not less – important. As such, CMS should support public policy which acknowledges this evolving role.

SUPER SNFs

Some SNFs have tried to market themselves as high-acuity "Super SNFs" – and some states (Maryland, Texas) have incented this – but with the complex Federal-Medicare/State-Medicaid patchwork, it's hard to see how the SNF problem will get sorted out any time soon.

One-third of COVID deaths occurred in nursing homes (SNFs). The sector is in free-fall as many SNFs restructure.

The American continuum of care needs SNFs, but there is no escaping the disturbing track record of some SNFs in dealing with COVID. The problems of the SNF sector are too numerous to list on one page, but it comes down to this: The SNF business model doesn't work because SNF public policy – both federal and state – doesn't work. In other words, the average SNF company could have Steve Jobs or Warren Buffett as CEO and the SNF business would still likely struggle.

One problem: Medicare margins for SNFs remain fairly high (in 2020, more than twice that of LTCHs, for instance), but Medicaid rates vary wildly by state. Some states support their SNFs while it's razor-thin margins for SNFs in other states.

To make the SNF sector easier to oversee, CMS might secretly prefer to "federalize" the sector (and get states out of the SNF business). But CMS has also added to the policy muddle by issuing such conflicting Medicare policy signals. For instance, the old SNF payment system ("RUGs") stressed the importance of therapy in SNFs. The new 2019 SNF payment system ("PDPM") totally reversed that model.

The disarray in the SNF sector makes it even harder for other sectors – IRFs, LTCHs – to trust CMS when CMS says it is developing a new "unified" payment system (authorized under the IMPACT Act of 2014) which could potentially pay all post-acute providers under one, single payment system – with about $60 billion in estimated annual spending.

WHY NOT MEDICARE?

We suspect the national home health companies would have much preferred that President Biden use Medicare, rather than Medicaid, as the platform for expanding home health care.

We suspect part of the reason that the Biden team focused on Medicaid is because Joe Biden has long-sought to develop care options outside of SNFs, which remains a primarily Medicaid-based service.

The pandemic was a catalyst for innovation in the home health sector. President Biden proposes a new home health benefit.

An old expression is that, if a soldier survives a war and does more than just survive, somehow managing to prosper, then the soldier is said to have had *a good war*. Likewise, home health providers can be said to have had *a good pandemic*. Even before the pandemic, they were 'on a roll,' but the pandemic further established their potential. With the SNF sector in freefall and with new technologies making telemedicine more viable, patients have increasingly chosen home health when given the chance.

In April, President Joe Biden proposed a massive expansion of the home health benefit, spending $400 billion on "home and community-based services," representing 20% of his $2 trillion infrastructure plan. Details are scarce, but the new program would likely be done primarily thru state Medicaid programs. If so, the first question is "would the new benefit only be available to lower-income beneficiaries (as most Medicaid programs are now limited)?"

Another objective of the new program is to improve the pay and training of the home health workforce, but details are scarce. The White House proposal says caregivers would receive "a long-overdue raise, stronger benefits and an opportunity to organize or join a union."

This proposal must first get thru a Congress that is growing more reluctant about emergency spending. But one thing is clear: If the new home health benefit is implemented, it could represent a paradigm shift away from institutional care (e.g., nursing homes) and towards a new, not-yet-quite-defined model of home care.

TEACHABLE MOMENT

As Select Medical Executive Chairman Bob Ortenzio has pointed out,

"COVID has ended up being an opportunity for us to demonstrate our clinical capabilities to the hospitals that refer patients to us. Many of our referring hospitals have a newfound appreciation for the types of patients we treat and for the quality of our high-acuity care."

Many IRFs and LTCHs performed admirably during the pandemic and could fill-in emerging gaps in an evolving system.

The early months of the pandemic were terrifying for LTCH and IRF clinicians: Early in the pandemic, it looked as if many COVID patients might need intensive ventilator care and LTCHs specialize in such care. LTCHs across the country bought additional ventilators (when possible), dedicated some wards to COVID patients, and hired every critical care clinician willing to work. IRFs held their breath and prepared for LTCHs to be overrun with patients while also preparing contingency plans for the possibility of IRFs taking on overflow COVID patients.

Fortunately, clinicians deduced early-on that most COVID patients would not need intense mechanical ventilation, and the worst-case scenario was avoided. Throughout the crisis, IRFs and LTCHs had to wrestle, of course, with how best to protect their non-COVID patients from the virus. Excruciating choices were made by all clinicians.

As the pandemic bore on, Congress admirably passed relief from some regulatory rules to allow both IRFs and LTCHs to admit non-traditional patients in order to serve as a safety valve for general hospitals whose ICUs were over-flowing. And so, IRFs and LTCHs settled into these pandemic roles: (1) Caring for a small but vulnerable population of COVID patients who needed 25-day hospital stays, and (2) Caring for non-COVID patients the general hospitals needed to discharge. **Ironically, the need for post-acute hospitals (IRFs/LTCHs) became most evident just as many were closing their doors. Over the past ten years, almost 20% of the nation's LTCHs have closed their doors.**

TRANSFORMATION

For the past ten years, regulators have pushed policies transforming the relationships between hospitals and post-acute providers from vendor-like referral relationships to relationships that maximize potential for partnership and care coordination (e.g., readmission measures, patient satisfaction, electronic medical records, etc.).

With post-acute spending stable, the IMPACT Act's idea of "unification" looks like a solution in search of a problem.

Last week, we dedicated a whole presentation by Chris Carey looking at the issues involved with possible post-acute unification. (The deck is available at www.recovery-care.org/news). **Here are the top things we'd ask CMS to consider as it ponders unifying the four types of post-care:**

1. With general hospitals discharging patients quicker than ever and moving more procedures to outpatient settings, post-acute care is becoming more, not less, important.

2. The existing continuum of post-acute care, while not perfect, represents a rational and logical progression of care, from low-acuity venues like nursing homes and home health to high-acuity venues like IRFs and LTCHs.

3. SNFs have an important role to play, but with the dislocations going on there, it is no wonder IRFs and LTCHs are so reluctant to embrace a clinical model that treats all post-acute care the same.

4. Spending in Medicare post-acute care is quite stable after statutes (new criteria for LTCHs; 60% IRF rule) and regulations (New payment systems for SNFs and HHAs) passed in the past fifteen years. This begs the question, what problem is unification trying to solve? And,

5. The pandemic has surely not helped CMS stay on-track to deliver a new proposed system that could represent more than $60 billion in annual spending each year.

COVID FUNDS

CMS recently started recouping Medicare payments it fronted to healthcare providers last year during the COVID-19 pandemic. CMS provided upfront Medicare payments to providers in the event of a national emergency, like COVID, "in order to accelerate cash flow to the impacted health care providers and suppliers." Congress expanded the program through the CARES Act last March. The program distributed a total of $100 billion to hospitals and other types of providers.

Biden's CMS leaders are the most experienced ever assembled, but the traditional debate about cost and quality continues.

The Biden Administration is assembling one of the most experienced CMS teams ever. CMS Administrator-nominee Chiquita Brooks-LaSure has already spent years at CMS and on Capitol Hill. Deputy Administrator (and CMMI Director) Liz Fowler spent years with the Senate Finance Committee. Other rumored nominees for CMS posts look to be equally experienced – which is a good thing, considering the extent of the challenges facing the agency.

Seema Verma may not have been very diplomatic, but she had a point when she said that many of CMS' efforts to lower costs and improve care had gone nowhere since the **Affordable Care Act** authorized billions to be spent on testing new systems. Accountable Care Organizations (ACOs), bundled payments, and other value-based care models have all experienced, in Verma's words, "very poor return on investment." **CMMI director Liz Fowler gave a speech last month, essentially agreeing, saying that CMMI needs to be reinvented and the number of new models slimmed-down dramatically.**

Meanwhile, the Medicare program is really becoming two discrete programs: Medicare Advantage - which relies on private contracting and restricted provider networks - continues to grow, with almost 40% of current beneficiaries enrolled in an MA plan; and traditional Medicare Fee-for-Service, with its detailed, legacy, and regulatory framework. Another complicating factor is that the Medicare Part A Trust Funds are set to expire in 2025, the shortest runway the program has ever faced. This fact ensures that Congress will soon need to shore-up program finances.

PANDEMIC DEALS

The pandemic has taken a toll on hospital M&A. Some recent deals were abandoned, including (1) Intermountain and Sanford, (2) Advocate-Aurora and Beaumont, and (3) Geisinger and AtlanticCare.

One hospital CEO said that trying to do a merger in the middle of COVID was "like trying to change a flat-tire while driving down the freeway."

Healthcare deal-making will take off again when the sector emerges from the pandemic. Insurers continue juggernaut.

Some commentators believe the pandemic will further hasten healthcare consolidation. It's easy to forget how much the healthcare system has changed over the past twenty years, with health insurers continuing their M&A juggernaut and with non-profit hospitals consolidating at a pace that's hard to keep up with. We briefly note some of the major deals over the past few years.

- This year, **Humana** (4th largest insurer) continued to grow in the home health space, acquiring the remaining interest in **Kindred-at-Home** (Gentiva).
- In 2020, **UnitedHealth** (#1 largest insurer) acquired **Optum**, a PBM with multiple other analytics businesses (including the Advisory Board Company).
- In 2019, **CVS** (which had just acquired PBM **Caremark**) acquired health insurer **Aetna** (#3 insurer) in a $70 billion megamerger.
- In 2019, **CommonSpirit** was created with the merger of **Dignity Health** and **Catholic Health Initiatives** which, today, has 142 hospitals.
- In 2018, midwestern hospital systems **Advocate** and **Aurora** formed a non-profit Midwestern giant with $11 billion in annual revenue.
- In 2018, insurer **Cigna** (#5 insurer) acquired PBM **Express Scripts**, in a deal valued at $71 billion. In 2016, Cigna had tried to acquire **Anthem** (#2 insurer), but the deal was blocked by the Federal courts.

Last week, *the Wall Street Journal* published an essay by historian Niall Fergson on how the US dealt with a near-pandemic in the 1950s:

"The U.S. hospital system was not overwhelmed in 1957-58 for the simple reason that it had vastly more capacity than today. Hospital beds per thousand people were approaching their all-time high of 9.18 per 1,000 people in 1960, compared with 2.77 in 2016."

Other COVID-related dynamics will have a big influence on the way care is provided after the pandemic.

1. **PREPAREDNESS**: COVID-19 has prompted calls for a dramatic scaling-up of the country's disaster readiness workforce. By consensus, America's health care infrastructure wasn't ready for the pandemic — at first incapable of conducting testing, and later short on the workforce required to carry out the Herculean task of contact-tracing tens of thousands of new COVID-19 cases per day.

2. **SURGE CAPACITY**: As the severity of COVID-19 became clear, states scrambled to create surge capacity. While fairgrounds and convention centers were transformed into field hospitals, the big question became how to staff these facilities with clinicians.

3. **SUPPLY CHAIN**: With the pandemic shortages of PPE, we have rediscovered the importance of revitalizing manufacturing in the US as nations shuttered factories during the pandemic, causing shortages for critical medical supplies.

4. **WORKFORCE**: We have a growing shortage of clinicians, both physicians and nurses. There will be growing debate in the coming years about allowing non-physicians – like nurses, nurse practitioners, and physician assistants – to play a bigger role in care.

5. **DEMOGRAPHICS**: Members of the baby-boom generation began aging into Medicare in 2011 at a rate of about 10,000 people per day, a rate that will continue until 2030.

“CONSUMERIZATION”

As patients assume more financial responsibility for their healthcare costs due to higher premiums, co-pays, co-insurance, and deductibles, they have become more concerned with the value of the care they receive as well as cost.

Patients will likely demand improved access to clearer benefits, billing, and network information to improve transparency.

Technology was impressive during the pandemic, and it will continue to reshape the way care is provided.

In general, technological innovation will continue to dramatically and rapidly change the way healthcare is delivered, resulting in more personalized care, improved clinical outcomes and patient experience, and overall quality of life.

1. **TELEMEDICINE**: Health care providers in the U.S. have been inching toward making more services available via telehealth for years. But health care leaders across the ideological spectrum agree: COVID-19 has pushed the inevitable telemedicine revolution forward by a decade, if not more. This transformation will enable providers to better tailor their care to patients’ unique needs, while increasing patient autonomy and engagement.

2. **EMR**: Electronic medical records will not only be able to store patient information but also to provide information on “best practice” instantaneously, whether it is derived statistically from the practice of the physicians, or based on health plan data or nationally generated practice guidelines

3. **DATA PRIVACY**: With growing reliance on technology, protecting the privacy of healthcare data will continue to grow in importance. At the same time, data breaches continue to be reported on a regular basis.

4. **RETAIL**: Health plans and hospital systems are taking more of a consumer-friendly “retail” approach, and that’s why CVS, Walgreens, and Walmart are fast-becoming more important players in the healthcare system.

"Anyone who's been studying equity and justice in health care knows that the vulnerabilities have been there — this has always been true. But COVID-19 has kind-of underlined it, made it more visible. My feeling is: For Pete's sake, can't this country finally get serious about closing racial and socioeconomic gaps in access to health care and health status and being able to lead a good life?"

Dr. Donald Berwick, MD

The difference in COVID death rates – between white and black Americans – was so extreme that it should not be ignored.

Huge racial disparities were further revealed during the pandemic. COVID-19 killed people of color, particularly African-American people, at staggeringly disproportionate rates. For instance, African-Americans represent 6% of Wisconsin's population — but account for nearly half of the state's coronavirus deaths. Similarly, African-Americans account for two-thirds of Chicago's deaths despite constituting only one-third of its population.

To longtime observers of the U.S.'s health care system, the numbers are hardly surprising. But there's hope among some experts that the tragedy could prompt a long-overdue reckoning about health disparities and the social determinants of health. The differences in coronavirus death rates between white and black people in the U.S., many argued, are too dramatic, and too immediate, to ignore.

Risa Lavizzo-Mourey, former president, Robert Wood Johnson Foundation and professor of health policy at the University of Pennsylvania:

> "The stark disparities in COVID-19 infection rates and outcomes among different populations and different parts of the country has been hard to ignore. While there's a rich body of work that has demonstrated this in the past, it's a unique moment where it's happening all at once, and you can see it in real time. I think that the moment is one that hopefully will sort-of force us to address some of the potential policy solutions."

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We are a Washington-based nonprofit, nonpartisan trade association, created under IRC Section 501(c)(6).

We represent hospitals and healthcare providers who specialize in “Recovery Care” – care provided to patients after a stay in an acute care hospital. For this reason, Medicare regulations refer to this as “Post-Acute Care.”

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We welcome comments and suggestions from our readers. To learn more about us, please visit www.recovery-care.org. If you have a press release you would like us to include, please email our editor Rebekkah Johnson at rebekkah.johnson@recovery-care.org.

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