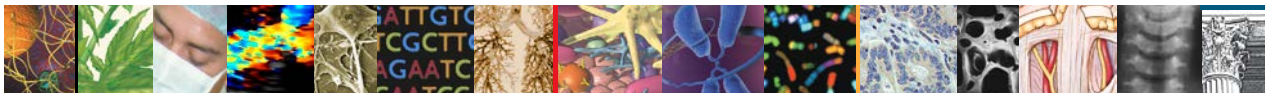

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Perspective

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Post-Acute Care Reform — Beyond the ACA

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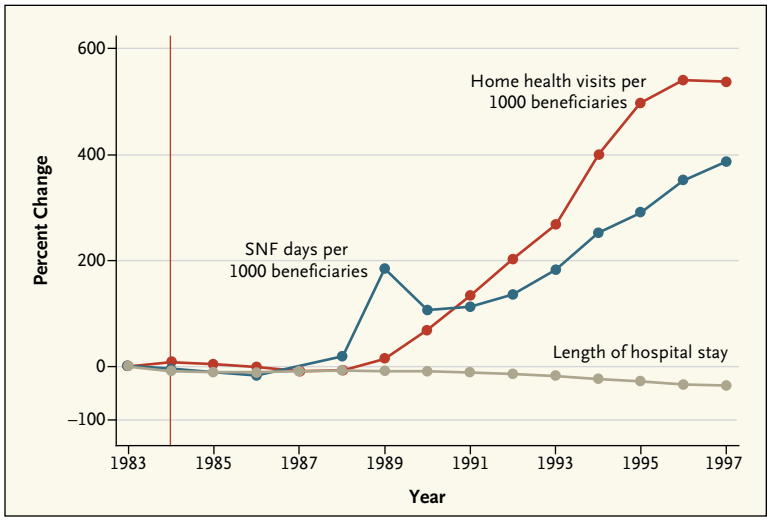
Mrs. T. is an 88-year-old woman who lives alone, has a history of congestive heart failure and osteoarthritis, and has traditional fee-for-service Medicare coverage. One day, she was found lethargic and sent to the emergency department, where she was discovered to be in renal failure and was admitted to the hospital for fluids and monitoring. Her hospitalist concluded that she had accidentally overdosed on Lasix (furosemide). On hospital day 2, Mrs. T. was having difficulty ambulating, although her cognition and renal function had improved and she felt "back to her old self" and was eager to go home.

The hospitalist had two primary options. He could keep Mrs. T. in the hospital another night, although she was medically stable and had no further diagnostic or medical needs. That would cost the hospital money under Medicare's system of fixed payments for diagnosis-related groups, but it would give Mrs. T. more time to recover her strength and extend her stay to the 3 days required to qualify her for a stay in a Medicare skilled nursing facility (SNF) if needed.[1] The hospitalist believed this option was wasteful and potentially harmful, in that it placed Mrs. T. at further risk for hospital-acquired conditions. Equally important, it went against her wishes — particularly if the end result was a SNF stay.

Alternatively, the hospitalist could send Mrs. T. home, holding the Lasix to prevent a repetition of the cause of this admission and arranging for a follow-up evaluation by a visiting nurse. Home health agencies are expected to provide an admission visit within 48 hours after discharge, and they receive a fixed payment from Medicare for a 60-day episode of care — a policy that may neither match the needs of a patient requiring prompt, intensive short-term skilled care nor provide agencies with appropriate reimbursement for that intensive care. This option presented a higher risk of falls and further medication errors, but it served the hospital's interest in limiting lengths of stay and Mrs. T.'s desire to return home.

The hospitalist had few tools to guide this choice or mitigate the risks associated with either option. Both options presented a



Use of Hospital Care and Post-Acute Care over Time.

The vertical line at 1984 represents the start of Medicare's hospital inpatient prospective payment system. Data shown for home health visits and skilled nursing facility (SNF) days are per 1000 Medicare fee-for-service beneficiaries. Data are from the Health Care Financing Administration (*Health Care Financing Review: Medicare and Medicaid Statistical Supplement.* Washington, DC: Department of Health and Human Services, 1999).

high likelihood of readmission, and neither one encouraged the provision of a high-quality, high-value mix of acute and post-acute care services. Why were there no better options?

An obvious answer is that Medicare has paid hospitals and post-acute care providers separately, without regard to the quality and efficiency achieved across an entire episode of care. Patients' discharge plans are often made for financial rather than clinical reasons, which contributes to the inefficient use of post-acute care and the high rate of readmissions.[2,3] A good example of the strong role of financial incentives was the decrease in length of hospital stay and the increase in use of post-acute care after the implementation of Medicare's hospital inpatient prospective payment system (see graph). Demonstrations currently being evaluated under the Affordable Care Act (ACA) incentivize a more efficient mix of acute and post-acute care services. For example, under a bundled-payment system, hospitals and post-acute care providers are paid for a fixed "bundle" of services around a hospital episode, including post-hospitalization care. In an accountable care organization (ACO) with risk-based payment, networks of providers can share in savings if they reduce the total cost of care for a defined patient population and meet a series of quality metrics. Under both approaches, provider systems have incentives to deliver cost-effective acute and post-acute care services and prevent costly readmissions.

Although these payment reforms have promise, substantial regulatory and operational barriers remain. In particular, three issues may impede the delivery of high-value services over an entire episode of care.

First, the ACA reforms retain some burdensome payment regulations and rules that will hinder the delivery of the highest-value mix of services. ACOs cannot change most of Medicare's fee-for-service payment regulations in purchasing post-acute care. These regulations include the 3-day rule for qualifying for Medicare-covered SNF care; fixed payment for a 60-day episode of home health care, which hinders flexibility in tailoring services to patients' needs; and a rule for inpatient rehabilitation facilities requiring that 75% of cases fall within 13 diagnostic categories, which limits the number and types of patients admitted to these facilities.[4] We support the recent efforts by the Centers for Medicare and Medicaid Services (CMS) to waive the 3-day rule for organizations participating in the Pioneer ACO program, but we believe Congress should consider relaxing all these payment regulations.

Second, merely aligning financial incentives between providers of acute and post-acute care will not improve quality and reduce costs for episodes of care. True coordination of care — defined as the organization of services among the hospital, physicians, post-acute care provider, and patient to encourage the delivery of the highest-value services — is required to ensure the best possible outcomes. Potential models for coordinated acute and post-acute care might encompass team-based care and transition programs, cross-continuum case-management interventions, improved patient and family engagement, communication protocols

for providers across settings to share both clinical and social information by means of interoperable health information technologies, and focused investments in clinical coverage in post-acute care settings (e.g., telemedicine or transitional medicine teams). Most of these on-the-ground activities, however, are in their infancy. Thus, we believe that CMS should support research to develop and evaluate various models and then encourage implementation of high-value approaches.

Third, even with payment changes and improved coordination, providers are often "flying blind" when attempting to tailor a care plan to a patient's and family's needs. Simply put, we have insufficient understanding about which post-acute care setting (e.g., home with or without services, SNF, or other care facility) benefits which types of patient — which makes it impossible to match patients to the setting that best suits their needs and maximizes the likelihood of the best outcomes. This lack of knowledge is attributable to both insufficient data and poor quality measures. CMS mandates that all post-acute care providers submit assessment data on patients' medical, functional, and cognitive status, but because each post-acute care setting uses a different instrument, it's impossible to evaluate discharge outcomes such as functioning across settings. Thus, optimizing post-acute care delivery will require a common data instrument but also new quality measures for such care. For example, one important measure of quality would be the risk-adjusted rate of rehospitalization in a given post-acute care setting.[5] With these new data and outcome measures in place, Congress could invest in comparative effectiveness research evaluating the most appropriate mix of acute and post-acute care services.

Merely aligning financial incentives between providers of acute and post-acute care will not improve quality and reduce costs for episodes of care. True coordination of care is required to ensure the best possible outcomes.

In the case described above, the hospitalist was left with our system's only two discharge options. Imagine how Mrs. T.'s care might have been different. With her care covered under an ACO or as part of a bundled-payment program, her providers would have financial incentives to provide the right care, in the right place, at the right time. If the additional efforts we've described above had been successfully implemented, the hospitalist could have used evidence on the comparative value of alternative post-discharge options to choose the most suitable mix of inpatient and post-acute care services without worrying about payment rules and with the support of organizational tools for coordinated care. For example, he might be able to keep Mrs. T. in the hospital for several more days and then discharge her home, where she'd receive intensive home health care services. Or perhaps she could be transitioned to a high-quality SNF and receive longitudinal case-management services to support a more rapid recovery and an ultimate return home. Such options — and the others that we hope will be developed over time — can be "win–win–wins" in that, as compared with the current possibilities, they should reduce Medicare spending, improve health outcomes, and be more consistent with patient preferences.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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