Post-Acute Care — The Next Frontier for Controlling Medicare Spending

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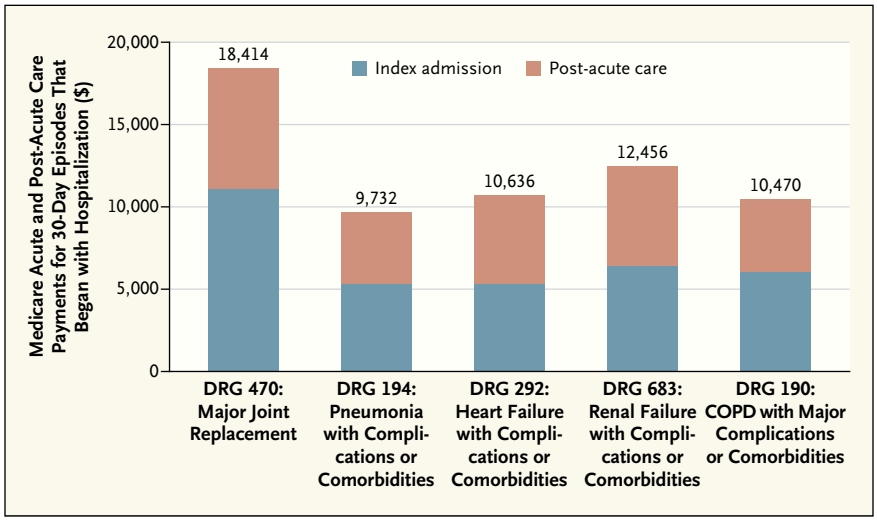
A striking conclusion from the Institute of Medicine's recent report on geographic variation in Medicare spending is that post-acute care is the largest driver of overall variation.[1] Medicare pays for post-acute care — short-term skilled nursing and therapy services for patients recovering from acute illness (typically after a hospitalization), provided by home health agencies, skilled nursing facilities (SNFs), inpatient rehabilitation hospitals, and long-term care hospitals. In 2012, Medicare spending for these services exceeded $62 billion. For patients who are hospitalized for exacerbations of chronic conditions such as congestive heart failure, Medicare spends nearly as much on post-acute care and readmissions in the first 30 days after a patient is discharged as it does for the initial hospital admission (see graph). Post-acute care spending for surgical episodes is somewhat lower but still substantial. Medicare payments for post-acute care have grown faster than most other categories of spending. For example, total Medicare spending for patients hospitalized with myocardial infarction, congestive heart failure, or hip fracture grew by 1.5 to 2.0% annually between 1994 and 2009, while spending on post-acute care for those patients grew by 4.5 to 8.5% per year.[2]

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, reappearing on the acute care provider's radar screen only if they return to the hospital in an ambulance. Under fee-for-service reimbursement, acute care providers have had little financial incentive to invest in systems to ensure effective transitions to post-acute care or to support post-acute care providers when recently hospitalized patients have complications. Medicare's recent readmission penalties have begun focusing hospitals' attention on these issues. But Medicare's new bundled-payment and shared-savings programs provide much stronger incentives to integrate acute and post-acute care.

Hospitals and physicians participating in bundled-payment or shared-savings programs will need to establish meaningful partnerships with all types of post-acute care providers. Partnerships with SNFs are particularly important, since they account for about half of Medicare's post-acute care spending.

There are many opportunities to save money and improve quality through better management of post-acute care. One lies in ensuring that patients are treated in the most cost-effective, clinically appropriate setting. For patients hospitalized with congestive heart failure in 2008, Medicare paid about $2,500 in the 30 days after discharge for each patient who received home health care, as compared with $10,700 for those admitted to a SNF and $15,000 for those cared for in a rehabilitation hospital.[3]

Under a bundled-payment or shared-savings program, health systems have strong financial incentives not to refer patients to high-intensity post-acute care settings that they don't need. There is concern that these incentives could lead providers to inappropriately steer patients away from needed care in more intensive settings. But under bundled payment, health systems are also financially responsible for rehospitalizations, which are a significant component of total spending per episode. In 2008, nearly 22% of patients hospitalized with congestive heart failure



Medicare Acute and Post-Acute Care Payments for 30-Day Episodes That Began with a Hospitalization, 2008.

Data are from Gage et al.[3] Thirty-day fixed episodes include the full amount of all claims incurred within 30 days after discharge, including readmissions. COPD denotes chronic obstructive pulmonary disease, and DRG diagnosis-related group.

were readmitted to the hospital within 30 days, at an average cost of $10,800. Thus, the financial incentive under bundled payment is to use the post-acute care settings that are most likely to efficiently bring about an effective recovery.

Hospitals and physicians participating in bundled-payment or shared-savings programs will need to establish meaningful partnerships with all types of post-acute care providers. Partnerships with SNFs are particularly important, since they account for about half of Medicare's post-acute care spending. Apart from geographic location, hospitals will focus on three basic characteristics when considering SNF partners: capacity to effectively care for Medicare patients with complex needs, ability to provide high-quality care efficiently, and willingness to actively collaborate on care coordination.

Under bundled payment, hospitals and health systems will pursue preferred relationships with nursing homes that are dedicated to post-acute care, with distinct short-stay units and 24/7 on-site skilled nursing staff. They will expect 24-hour coverage by a physician or advanced practice provider with expertise in geriatrics, and many will want their own physicians to conduct rounds. Preferred facilities will need to develop capacity to treat acute exacerbations of common conditions such as cellulitis and congestive heart failure on site in consultation with their acute care partners, rather than routinely sending patients with these conditions to the emergency department.

Hospitals will favor SNFs with a proven record of performance and should assess each nursing home in the context of the complexity of its cases. Under bundled payments, one relevant measure of both quality and efficiency is rehospitalization. In 2011, a quarter of nursing homes had risk-adjusted rehospitalization rates of 23% or greater for five potentially avoidable conditions, while a quarter had rates below 15%.[4]

Average length of stay is another key metric, because Medicare pays nursing homes a daily fee for up to 100 days per spell of illness. In 2010, a quarter of nursing homes had an average Medicare length of stay of less than 24 days, while another quarter had a length of stay of more than 34 days — a difference of about $4,000 per admission given the prevailing Medicare rates.

Equally important for new partnerships is a willingness to actively collaborate on quality improvement and care coordination. Communication between acute and post-acute care providers has historically been poor. Hospital providers need to do a better job of providing complete clinical information to SNFs and responding quickly to requests from their clinicians, and nursing homes should be more willing to collaborate on managing lengths of stay with a robust discharge-planning process. Establishment of a clinical point person at both the hospital and the nursing homes would help facilitate rapid responses to unexpected changes in patient status. Finally, such partnerships will need to establish regular and transparent performance reporting.

In Medicare Advantage, health plans can require that patients use a subgroup of preferred nursing homes. But traditional Medicare patients have free choice of providers — a feature that does

not change under the bundled-payment and shared-savings programs. Nevertheless, physician groups and hospitals will increasingly establish preferred networks of post-acute care providers. Although they cannot require patients to use these providers, they may be able to make a convincing case based on the quality, service level, and continuity of care that a strong partnership can offer.

Hospitals can take other steps to reduce post-acute care spending under a bundled-payment system. Those with extra bed capacity can keep some Medicare patients in the hospital longer and discharge them to home health care rather than a nursing home or rehabilitation facility; the extra cost of extending a hospital stay by an additional day or two is far less than the average cost of a nursing home admission. According to one study involving 12,000 patients, the incremental cost incurred on the last full day of hospitalization was just 2.4% of the average total cost per admission.[5]

Hospitals and physicians have considerable influence over patients' choices of post-acute care settings, and they will increasingly exert that influence under bundled-payment programs. Post-acute care providers need to make a compelling case for their value, and those that establish preferred relationships with major hospitals and physician groups will generate additional volume and thus be able to maintain revenue levels as they shorten lengths of stay.

These changes will, however, create considerable financial stress for post-acute care providers that lack preferred arrangements. Most post-acute care providers rely on Medicare payments to cross-subsidize care for Medicaid beneficiaries. Although the trends discussed above will generally be good for Medicare patients, they will draw resources away from nonpreferred providers. For nursing homes in particular, this will diminish their ability to adequately care for long-term residents for whom Medicaid is the primary source of payment.

Medicare payment reform will eventually shake up the world of post-acute care. Policymakers should track the effects of these changes on patients, particularly Medicaid patients, and be prepared to intervene to ensure that the evolving system is capable of providing all older Americans and those requiring long-term support services with needed care.

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The Hospital-Dependent Patient

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Approximately 20% of Medicare patients who have been hospitalized are readmitted within 30 days,[1] with substantial implications for outcomes and costs of care. Many reasons have been identified, including poor transitions from the hospital setting, lack of medication reconciliation, inadequate access to medical services after discharge (e.g., timely postdischarge appointments with primary care physicians and specialists), and lack of accountability regarding which clinician is responsible after discharge.[2] The problem has been conceptualized as a failure of the health care system to fulfill its responsibility to provide comprehensive, coordinated, and continuous care. Accordingly, the Centers for Medicare and Medicaid Services began to invoke penalties for readmissions of patients who have been discharged after hospitalizations for selected diagnoses. Hospitals and health systems are responding with innovations such as care coordinators, post-