# Postacute Care — The Piggy Bank for Savings in Alternative Payment Models?

Michael L. Barnett, M.D., Ateev Mehrotra, M.D., M.P.H., and David C. Grabowski, Ph.D.

After many years under siege, the edifice of fee-for-service payment is beginning to crumble. Federal, state, and private payers are approaching a tipping point when it comes to implementation of global and episode-based payment models for hospitals. According to the Health Care Payment Learning and Action Network, the proportion of health care spending represented by purely fee-for-service payments decreased from 62% in 2015 to 41% in 2017. This trend puts substantial pressure on hospitals to reduce low-value care and to manage care delivered outside their walls. Thus far, hospitals have found savings by using an unusually consistent strategy: reducing institutional postacute care, primarily in skilled nursing facilities (SNFs).

In Medicare's largest accountable care organization (ACO) model, the Shared Savings Program, reductions in institutional postacute care were the largest single contributor to savings.[1] Over a period of 3 years, for example, one group of ACOs reduced spending on postacute care by 9% more than a control group did. This difference was driven largely by lower rates of discharge to SNFs, which account for the vast majority of postacute care facilities and Medicare spending on such facilities.[2] Similar changes occurred in two of Medicare's episode-based ("bundled") payment programs. A federal evaluation of the Bundled Payments for Care Improvement program found that, for eight of the nine clinical conditions for which significant savings were generated between 2011 and 2016, most spending reductions were the result of decreased spending on institutional postacute care.[3] Similarly, the 3% relative decrease in spending in the Comprehensive Care for Joint Replacement program was driven nearly entirely by lower use of institutional postacute care.[4] A study comparing traditional Medicare with Medicare Advantage found that the largest relative difference in spending and utilization between the programs was in the area of postacute care; Medicare Advantage beneficiaries were significantly less likely than traditional Medicare beneficiaries to use postacute care facilities.[5]

Why is postacute care the "piggy bank" for savings in new payment models? Evidence shows that for most episodes of care involving a hospital admission, money spent on postacute care represents the largest source of variation in spending — possibly owing to our uncertainty regarding when such care improves outcomes. Where patients receive postdischarge care is driven as much by facility availability as by clinical severity, and in many borderline cases, patients can probably be discharged home instead of to a SNF. What's more, postacute care providers typically aren't part of larger health care systems. If hospitals or physician group practices can reduce Medicare spending by lowering SNFs' revenue rather than their own, the result is a financial win–win for them and overall spending, albeit at the expense of SNFs.

It remains unclear whether reducing postacute care represents a short-term cost-saving strategy or whether it could provide long-term savings. Although we believe that there is still more discretionary postacute care to be cut, hospitals will eventually reach the point of diminishing returns from focusing energy on reducing the use of SNFs.

As hospitals continue to slash the use of postacute care, however, various unintended consequences may result. Three such consequences deserve particular attention.

First, in their zeal to avoid institutional postacute care, hospitals may begin to send home patients who need institutional rehabilitation. Payment reforms can be a blunt instrument, and it may become difficult to distinguish low-value from high-value use of postacute care. There is an enormous evidence gap regarding how much and what type of postacute care is best for which patient. Thus far, cuts in postacute care under ACOs and bundled-payment programs haven't resulted in substantial reductions in patient satisfaction or worsening outcomes. But the absence of clear problems several years into these new programs provides only

minimal reassurance. Moreover, few evaluations have assessed the effect of payment reforms on patients' functional status or experience. Patient outcomes should be monitored closely for signs that hospitals may be going too far in cutting postacute care, particularly for vulnerable patients.

The second potential unintended consequence is driven by the structure of the postacute care market. Just as hospitals use high profit margins from treating privately insured patients to cross-subsidize losses on Medicare and Medicaid beneficiaries, many SNFs rely on higher margins from treating Medicare patients to make up for losses on Medicaid patients. Substantially reducing the volume of the most profitable SNF patients could place enormous financial strain on postacute care facilities. Some facilities might be forced to stop accepting vulnerable patients with less generous insurance; others may have to close. Because most SNFs also provide long-term care for residents with disabilities, facility closures could affect the supply of long-stay beds, especially in rural areas.

Third, discharging more patients home could place additional strain on their families. When a patient is sent home instead of to a postacute care institution, caregiving tasks such as bathing, dressing, toileting, cooking, and transportation are typically borne by unpaid family members. Home health staff may visit for only a few hours per week to provide therapy and skilled nursing care. In cases in which families are unable to provide care, patients have to pay for services out of pocket. Respite care, or temporary caregiver services, for patients who don't require SNF-level rehabilitation could be a solution, but such services usually aren't covered by health insurance. This burden is even greater for lower-income families, since family members may be unable to take time off from work or hire private help.

Another consideration is whether future payment reforms should directly target postacute care providers instead of putting financial pressure on ACOs or hospitals to change the way postacute care is delivered. A sweeping reform of SNF payment in Medicare that goes into effect this year may begin to move in this direction. Payments to SNFs are currently based on the amount of therapy provided to a patient, not on the severity of the patient's condition, which therefore creates a strong incentive for facilities to accept patients who can tolerate large amounts of therapy. However, such patients are less likely to require SNF-level care than patients with more complex medical problems. As a result, under alternative payment models, hospitals gain and SNFs lose when healthier patients go directly home from the hospital. Effective October 2019, SNF payments will be based on a patient's clinical condition and functional status. This change should align financial incentives for SNFs with hospital incentives under new payment models to steer patients to the most clinically appropriate level of postacute care.

It may not be clear for several years whether reducing postacute care will be a one-time piggy bank for savings under new payment models or a long-term target for reducing spending. Regardless of long-term trends, however, postacute care has played a crucial role in the early stages of payment reform. Policymakers and health systems planning for future payment reforms should pay attention to the effects of changes in postacute care on patients, families, and the market more broadly.

Disclosure forms provided by the authors are available at NEJM.org.

From the Department of Health Policy and Management, Harvard T.H. Chan School of Public Health (M.L.B.), the Division of General Internal Medicine and Primary Care, Department of Medicine, Brigham and Women's Hospital (M.L.B.), the Department of Health Care Policy, Harvard Medical School (A.M., D.C.G.), and the Department of Medicine, Beth Israel Deaconess Medical Center (A.M.) — all in Boston.

1. McWilliams JM, Hatfield LA, Chernew ME, Landon BE, Schwartz AL. Early performance of accountable care organizations in Medicare. N Engl J Med 2016;374:2357-66.
2. McWilliams JM, Gilstrap LG, Stevenson DG, Chernew ME, Huskamp HA, Grabowski DC. Changes in postacute care in the Medicare Shared Savings Program. JAMA Intern Med 2017;177:518-26.
3. CMS Bundled Payments for Care Improvement initiative models 2-4: year 5 evaluation & monitoring annual report. Falls Church, VA: The Lewin Group, October 2018 (https://downloads.cms.gov/files/cmmi/bpci-models2-4-yr5evalrpt.pdf).
4. Barnett ML, Wilcock A, McWilliams JM, et al. Two-year evaluation of mandatory bundled payments for joint replacement. N Engl J Med 2019;380:252-62.
5. Curto V, Einav L, Finkelstein A, Levin JD, Bhattacharya J. Healthcare spending and utilization in public and private Medicare. Cambridge, MA: National Bureau of Economic Research, January 2017 (http://www.nber.org/papers/w23090.pdf).

DOI: 10.1056/NEJMp1901896