

VIEWPOINT

Beyond ACOs and Bundled Payments Medicare's Shift Toward Accountability in Fee-for-Service

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For all the attention paid to accountable care models, few observers have recognized that Medicare is rolling out the core framework of bundled payments within the hospital fee-for-service payment system. Under its hospital value-based purchasing (HVBP) program, Medicare has established the Medicare Spending Per Beneficiary (MSPB) metric, defined as the average Medicare Part A and Part B spending per patient (eg, all traditional Medicare fee-for-service spending outside of prescription drug coverage) from 3 days prior to admission to 30 days after discharge. Hospital value-based purchasing adjusts each hospital's fee-for-service Medicare reimbursement based on various performance benchmarks, such as MSPB; more than 1400 hospitals will receive reductions in their Medicare payment rates this year.¹ Although Medicare has created a number of pay-for-performance programs over the past decade, MSPB represents the first pay-for-efficiency measure embedded within the

to stabilize the increase in use, including introducing prospective payment systems similar to the inpatient sector. Yet Medicare spending on postacute care has continued to increase, doubling over the last decade and increasing twice as fast as physician and hospital spending without clear evidence of improved outcomes.³ Eliminating geographic variation in postacute care would reduce total Medicare variation by 73%, suggesting that a significant portion of postacute care spending may be unnecessary.⁴

Accountable care models, by rewarding health systems for making measured use decisions across the care spectrum including across acute and postacute care facilities, represent a promising approach for optimizing acute and postacute care spending. But the significant majority of health care dollars still flow through fee-for-service; only about 10% of Medicare beneficiaries receive care through accountable care organizations (ACOs), bundled payments are still limited to demonstration projects, and accountable models are built upon, and do not replace, fee-for-service payment structures. By defining care bundles within traditional Medicare, MSPB brings the concept of accountability to full scale.

Most of the opportunity for MSPB efficiency gains will be in the postacute care period, which accounts for about half of MSPB episode spending, because the majority of hospital costs are

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fee-for-service system to penalize or reward hospitals not just for readmission rates or efficiency within an inpatient stay but for the value of care delivered across the entire continuum.

As inpatient costs increased in the early 1980s, Medicare encouraged hospitals to manage costs (namely via length-of-stay) by moving from cost-based payment to a prospective payment system in 1984. Hospitals were no longer paid each day a patient was hospitalized but rather paid a fixed amount for each admission. As a result, by 1998 the average hospital length-of-stay had declined by almost half. But this decrease in inpatient days was associated with a 4-fold increase in bed days at skilled nursing facilities and a 6-fold increase in home health visits, suggesting that costs had been shifted by substituting postacute care services for inpatient care as patients recovered.²

In response, Medicare implemented payment reforms for postacute care organizations (namely, home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals) to try

fixed under the inpatient prospective payment system. To improve their MSPB performance, hospitals must thus reevaluate their patterns of discharge timing, destination, and execution. Discharge timing and destination are interrelated; although shorter hospital stays reduce costs under the inpatient prospective payment system, shorter stays can result in longer and higher-intensity postacute care that may increase overall MSPB spending. The shorter inpatient lengths-of-stay achieved by hospitalist physicians compared with primary care physicians results in an estimated \$1.1 billion in additional Medicare postacute spending annually.⁵ Shorter lengths-of-stay in some cases could also increase the likelihood of readmissions, which will now have a 2-fold effect on hospital performance on Medicare benchmarks under the readmissions reduction program and MSPB.⁶

The optimal discharge pathway depends on the unique circumstances of each local health delivery system, such as the needs of their particular patient population and the care quality at local skilled nursing facilities. Hospitals must start by studying the cost, use, and

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outcomes of their own patients across acute and postacute care as well as the quality and efficiency of postacute services in their referral region. Skilled nursing facilities differ significantly in their lengths-of-stay, readmission rates, and capacity to care for complex patients. Certain postacute health care entities and clinicians may also have expertise in particular diagnoses and patient needs, whether medical, functional, or psychosocial. Understanding such factors will allow hospitals to make both efficiency gains and the most clinically appropriate disposition decisions for their patients. Hospitals can provide patients with quality and efficiency data when they are picking their desired facility, encouraging competition on care quality.

Clinicians should also become more thoughtful about selecting the most appropriate postacute care setting (home health, skilled nursing, inpatient rehabilitation, or long-term care) when discharging patients. Under the readmissions reduction program, risk-averse physicians may be tempted to err on the side of discharging patients to more intensive postacute care than necessary in an effort to reduce readmissions. But unnecessary postacute care can delay a patient's return to independence and is costly; although the average home health episode is \$2700, the average long-term care hospital stay costs Medicare \$38 600.⁷ Consistent transfer of patients to more cost-effective and clinically appropriate postacute care services could result in significant hospital MSPB gains and save Medicare up to \$34.7 billion over 10 years.⁸

The success of managed care plans in reducing their postacute care spending reflects the size of the savings opportunity in the fee-for-service sector. Kaiser Permanente is reported to have 3-fold fewer skilled nursing days than traditional Medicare, with better outcomes.⁹ Local and national Medicare Advantage plans have achieved 30% to 40% lower postacute care use and 20% to 50% lower readmission rates than in fee-for-service Medicare.¹⁰ These gains have come through a variety of levers: more robust analytical

tools to make evidence-based decisions about discharge timing and destination, innovative care transition and home health interventions, and engagement with postacute service providers to measure and improve their value.

The remarkable difference in postacute care use between fee-for-service and managed care suggests that even modest investments have the potential to yield significant savings. However, Medicare's previous pay-for-performance initiatives have produced inconsistent and transient outcome improvements, causing many observers to be skeptical about the effect of HVBP on Medicare spending and care quality. Designing appropriate performance metrics is difficult, and a more rigorous assessment of the measure's risk-adjustment is needed to ensure that hospitals that treat higher-risk populations are not unfairly disadvantaged. In addition, the HVBP reimbursement adjustment may not be large enough to significantly alter hospital behavior; this year's payment changes will be less than 0.20% of total fee-for-service reimbursement for almost half of hospitals. The maximum penalty will increase each year by 0.25%, from 1% in 2013 to 2% by 2017. By 2015, MSPB will account for 20% of each hospital's value-based purchasing score.

Even though the initial penalties of the readmissions reduction program were similarly modest, they nevertheless spurred outsized attention and investments from hospital leadership who recognized that the program goals were aligned with patient safety and that penalties would likely increase over time. The MSPB program may warrant a similarly robust response; in the future, Medicare will likely tie more and more dollars to clinical efficiency and away from volume through expanding both value-based purchasing and accountable care models. The HVBP program will clearly not bend the curve of health care costs alone, but MSPB represents the right conceptual step forward for creating value across the care spectrum throughout fee-for-service Medicare.

ARTICLE INFORMATION

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