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Accountability of Hospitals for Medicare Beneficiaries' Postacute Care Discharge Disposition

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The Centers for Medicare & Medicaid Services have introduced the Medicare Spending per Beneficiary demonstration to bring more accountability to patient care by focusing hospitals on lowering spending across the continuum of care. This metric reflects consensus from policy-makers and health care professionals that hospitals and health systems should be held accountable for spending and outcomes that occur after discharge.

From a health system's perspective, the following 3 levers can reduce per capita spending on health care: decreasing the volume of services, lowering the price of each service, and/or substituting lower-cost treatments or services (eg, generic pharmaceuticals). In this issue of *JAMA Internal Medicine*, Das and colleagues[1] note that only 3% of total Medicare spending per beneficiary relates to preadmission costs, leaving inpatient hospital and postacute care costs as the only vehicles for reducing costs. Because hospital reimbursement rates are based on prospective payments by diagnosis related group and because hospitals' ability to decrease inpatient length of stay without increasing adverse outcomes is being reached, opportunities for inpatient savings are also limited.

Therefore, hospitals must focus on postacute care as the most viable lever for reducing spending. Some of this focus requires greater preoperative planning for elective admissions to reduce risks of readmission and to speed recovery. However, the greatest opportunity is during the postacute care period. Savings can be achieved in any or all of 3 ways. First, change patients' discharge location to a less costly service (eg, from an inpatient rehabilitation facility to a skilled nursing facility or from a skilled nursing facility to a home health agency). Second, reduce the amount and duration of postacute care services provided. Third, narrow the network of choices (ie, preferred provider networks within a given type) to lower-cost agencies with higher levels of performance.

Postacute care has been one of the fastest-growing components of Medicare spending in the past decade. From 2001 to 2013, annual Medicare spending increased from $12 to $29 billion (7.6% annual growth) for care in skilled nursing facilities, from $9 billion to $18 billion (5.9% annual growth) for home health agency care, and from $4.5 billion to $6.8

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billion (3.5% annual growth) for care in inpatient rehabilitation facilities. More than 40% of all patients in Medicare fee-for-service plans who were discharged from acute care hospitals received postacute care. As Das and colleagues[1] note, postacute care expenditures represent a growing share of all 90-day episode costs, which is one reason why the Centers for Medicare & Medicaid Services added the spending metric to the hospital value-based purchasing program.[1] Indeed, the finding by Das et al that patients served by hospitals with high per-beneficiary spending levels spent $4691 on postacute care services vs $2450 by those with low per beneficiary spending levels reinforces the importance of controlling postacute care expenditures. Furthermore, that temporal changes in per-beneficiary spending levels between hospitals with higher and lower levels of spending were mostly owing to reductions in skilled nursing facility and readmission costs reinforces the point.

Under the bundled payment program, hospitals can achieve reductions in spending levels by reducing the use of costly postacute care services. Changing the acuity mix of patients by targeting a younger patient population in select service lines facilitates deflection of patients to home health agencies or directly home rather than to skilled nursing facilities as suggested by Jubelt and colleagues[2] in this issue of *JAMA Internal Medicine*. This change in patient case mix makes achievement of lower per beneficiary spending possible while reducing the rate of rehospitalizations. This solution is not sustainable or generalizable. Nonetheless, it highlights policymakers' challenges in designing case-mix adjustment models and quality metrics sensitive to changes in acuity of patient care.

Previous research on relationships between hospital and postacute care facilities and the effect of these relationships on rehospitalization[3–5] shows that, since 2000, after the introduction of prospective payment for skilled nursing facilities and home health agencies, the 30-day rehospitalization rates from skilled nursing facilities did not increase as much in those areas that lost fewer hospital-based facilities compared with those areas that lost more such facilities. Because hospitals with their own nursing facilities discharge more than 45% of their patients to them, greater integration between hospitals and free-standing nursing facilities can be reasoned to reduce errors and rates of rehospitalization.[5] Testing of this assumption found that hospitals that concentrated their discharges in fewer skilled nursing facilities experienced lower rates of rehospitalization after controlling for geographic, hospital, and facility characteristics and patient characteristics and selection.[3] Finally, the choice of skilled nursing facilities matters because they vary widely in their rehospitalization rates. Patients discharged to skilled nursing facilities with historically lower readmission rates are less likely to return to the hospital regardless of the rehospitalization rate of the hospital that discharged them.[6] This evidence suggests that some hospitals identify and preferentially discharge their patients to better-performing facilities. Hospitals can also work to improve the transfer of patients to select skilled nursing facilities regardless of their historic readmission rate and, in turn, improve the performance of the skilled nursing facilities. Whether this pattern of findings would apply to home health agencies, which also have considerable variation in their 30-day rates of rehospitalization, remains to be seen.

This pattern of findings with respect to rehospitalization from skilled nursing facilities suggests the following recommendations:

- First, to meet the challenge of fiscal and clinical responsibility that new reimbursement models impose, hospitals should develop preferred provider networks that can mimic a virtual hospital-based skilled nursing facility with rapid exchange of medical record information, constancy of care paths across settings, and active control of the discharge and admission processes, perhaps even with shared staff. Whether this development is accomplished by ownership of the facility or via contractual arrangements should be locally determined because no universal solutions are available and the quality of local facilities varies.[7]
- Second, appropriate financial arrangements will be necessary, including shared risk between the hospital and skilled nursing facility, because these business relations take time to evolve. Premature switching to another partner can be costly given the level of investment necessary to achieve smooth clinical and administrative communication processes.
- Third, the competitiveness of the local hospital market, the influence of Medicare Advantage plans in the area, and the level of adoption of the operating principles of accountable care organizations should greatly influence hospitals' strategies, namely, building a preferred postacute care provider network.

Regardless of how a network is constructed, hospitals and their postacute care partners should be expected to deliver value to the patients in exchange for effectively restricting their choices. One cost-reduction solution is to reduce the use of skilled nursing facilities among patients who could safely receive postacute care at home, but patients want—and tend to trust—hospitals' advice on which postacute care provider to use, as witnessed by the high rate of loyalty of patients to hospital-owned postacute care services. That implicit trust must be rewarded by hospitals' assuming ongoing responsibility long after the arbitrary 30-day rehospitalization period ends. Indeed, consistent evidence suggests that transfer to a poor-quality skilled nursing facility increases the likelihood that patients will inadvertently become permanent residents—something that is a particular problem for Medicare beneficiaries who are dually eligible for Medicaid.[4]

In the face of rapidly evolving Medicare reimbursement models, including increases in Medicare Advantage membership, accountable care organizations, and bundled payments, not to mention the penalties exacted for rehospitalizations, hospitals face a bewildering choice of options. However, all of the options require that hospitals embrace the postacute care experience of their patients by assuming responsibility directly or jointly with trusted partners. During the next decade, hospitals' reputations and measured quality may be based as much on patients' experience after discharge as during a hospital stay.

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Dr Mor reported performing research in a related area to that of several different paid activities; periodically serving as a paid speaker at national conferences where he discusses trends and research findings in long-term and postacute care but never any specific product or service provider; founding and previously owning stock of unknown value and sitting on the board of PointRight, Inc, an information services company that provides advice and consultation to various components of the long-term care and postacute care industries, including suppliers and insurers, and sells information on the measurement of nursing home quality to nursing homes and liability insurers; chairing the independent quality committee for HRC Manor Care, Inc, a nursing home chain, for which he receives compensation ranging from $20 000 to $40 000 per year; serving as chair of a scientific advisory committee for

NaviHealth, a postacute care service organization, for which he also receives compensation ranging from $20 000 to $40 000 per year; serving as a compensated speaker at the nonacademic National Long Term Care Quality Meeting in 2014; serving as a technical expert on several Centers for Medicare & Medicaid Services quality measurement panels; and serving as a member of the board of directors for Tufts Health Plan Foundation, Hospice Care of Rhode Island, and the Jewish Alliance of Rhode Island.

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