PL 111-148 and Amendments: Impact on Post-Acute Care for Health Care Systems

There are three key provisions of the law that will have direct impact on post-acute care needs and utilization:

1. Avoidable hospital readmission penalties.

Effective October 1, 2012, hospitals' Medicare payments will be reduced for avoidable readmissions for three conditions, most likely beginning with those now reported by hospitals (AMI, pneumonia, and congestive heart failure-CHF). In 2015, the number of conditions subject to Medicare payment reductions for avoidable admissions may be increased. Medicare payment reductions will be based on a formula related to avoidable readmissions and aggregate Medicare payments to a hospital and subject to a "floor," that is, the payment reductions will be no greater than the following percentages of aggregate Medicare payments to a hospital:

- FY2013 1%
- FY2014 2%
- FY2015 and beyond 3%

No floor is mentioned in the law for FY2012.

Impact on Post-Acute Care

This section of the new law is highly important for post-acute care, inasmuch as almost 37% of fee-for-service Medicare hospital admissions utilize a post-acute care venue (long-term acute care hospital-LTACH, inpatient rehabilitation facility-IRF, skilled nursing facility-SNF, or home health agency-HHA). Although the overall incidence of 30-day hospital readmissions has been estimated to be 20% (Jencks, et al., NEJM, February 2009), the Research Triangle Institute reported that acute hospital readmissions from post-acute venues was 30% (Bogasky, Research Triangle Institute, February 2009). Acute hospital readmissions from post-acute venues, according to the Medicare Payment Advisory Committee (MedPAC) and based on 2007 data, are most frequently from SNFs, followed by HHAs, LTACHs, and IRFs, as shown in Table 1.

Table 1: Acute Hospital Readmissions from Post-Acute Venues

PAC Setting	Percent Discharged From Hospital to PAC Setting	Percent Rehospitalized After Using PAC Setting	Percent Died in PAC Setting	Percent Discharged to a Second PAC Setting	Most Common Second PAC Setting Used
SNF	17.3%	22.0%	5.4%	29.3%	Home Health
Home Health	15.0	18.1	0.8	2.3	Hospice
Inpatient Rehabilitation	3.2	9.4	0.4	56.8	Home Health
Hospice	2.1	4.5	82.2	2.4	Home Health
Long-Term Care Hospital	1.0	10.0	15.5	53.4	SNF
Inpatient Psychiatric	0.5	8.7	0.4	25.4	SNF
Total	40.0%	18.0%	6.2%	19.8%	

Source: MedPAC 2009

Thus, hospitals that are not able to control the quality of care and avoidable readmissions from post-acute venues are at great risk for Medicare payment penalties that can reach up to 3% of their aggregate Medicare payments in FY2015.

2. Accountable Care Organizations (ACOs).

Beginning January 1, 2012, the new law establishes a shared savings program that promotes accountability for a Medicare fee-for-service patient population and coordinates items and services under Medicare Part A and Medicare Part B to optimize quality and efficiency in health care services delivery. ACOs include physicians and other providers that have a formal legal structure that allows the organization to receive and distribute payments for shared savings to participating providers of service and suppliers. ACOs must be responsible for a minimum of 5,000 Medicare fee-for-services beneficiaries and enter into a three-year contract with the Centers for Medicare and Medicaid Services (CMS) to manage the defined Medicare patient population. An ACO would be eligible to receive payment for shared savings if the estimated average per capital Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified below the CMS benchmark.

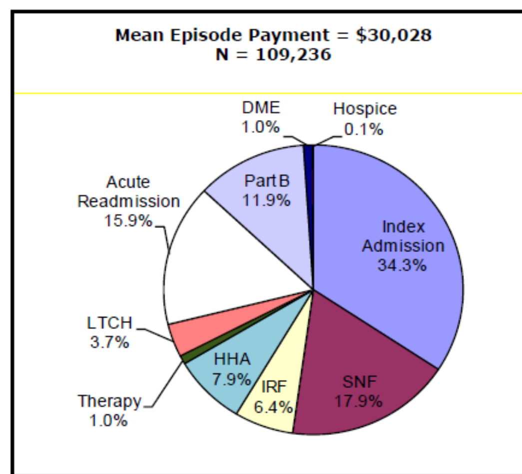
The importance of ACOs cannot be underestimated for hospitals. ACOs provide an opportunity for hospitals to "gain-share" by being efficient and creating high quality patient outcomes. Today, many hospitals have negative margins on Medicare fee-for-service patient admissions. A mandated market basket reduction beginning in FY2014 and extending at least through FY2019 will likely further reduce hospital Medicare margins. Becoming an ACO and becoming eligible for shared savings may be one of the few methods available to hospitals and health care systems to remain financially viable, particularly as the percentage of Medicare admissions increases due to demographic factors, namely, the aging of America.

Impact on Post-Acute Care

According to RTI, 2009, the average payment for Medicare beneficiaries utilizing post-acute care in 2006 was $30,000. A key reason for this amount is the fact that many post-acute patients utilize more than one post-acute venue. Table 2 shows a breakdown of the average payment.

Table 2:

Medicare Payments by Service Type, All Post-Acute Users, 2006



Source: RTI 2009

Thus, in order to ensure that health care systems that develop ACOs can achieve Medicare payment savings for the gain-sharing, not only must the systems effectively manage inpatient, outpatient, and physician costs as well as avoidable readmissions but also they absolutely must be able to control the utilization, cost, quality, and outcome of post-acute venues.

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We estimate that, over time, the percentage of Medicare post-acute LTACH, IRF, and SNF users will decline and the percentage of Medicare post-acute HHA users will increase. Home technologies, telemedicine, chronic care management, and home-based services all are encouraged in the new law; minimally invasive surgeries will create more opportunities for discharge to home, and, increasingly, many inpatient surgeries will continue to transition to outpatient.

Therefore, health systems that anticipate developing ACOs will want to be able to have control of all post-acute venues but particularly home health. Control can occur by means of ownership, joint ventures, management agreements, or preferred provider relationships. Usually, control is most effective if the post-acute entity is fully owned by the hospital or health system that is part of the ACO. However, many hospitals do not have the expertise or financial capability for managing or purchasing a LTACH, IRF, SNF, or HHA. In those cases, preferred provider relationships may be the best vehicle.

Post-acute venues, regardless of their relationship to hospitals and ACOs, must be able to prove that they can manage patients effectively to: ensure there are minimal, if any, avoidable readmissions; create a seamless care continuum that transitions patients to the lowest cost setting; and have the best possible patient outcomes. This evidence of proof will be as important for owned entities as for those that enter into a preferred provider relationship with hospitals and ACOs.

3. Bundled Medicare payment.

A pilot project for bundling Medicare payments for all services related to an acute hospital admission, three days prior and 30 days after discharge, will begin on January 1, 2013. Initial focus will be on one or more of eight conditions and the single payment will apply to all of the following services provided during the episode:

- Acute inpatient services (hospital admissions and readmissions)
- Physician services (in and out of the hospital setting)
- Outpatient hospital services, including emergency department services
- Post-acute services

The pilot is expected to include use of the Continuity Assessment Record and Evaluation (CARE) tool, or a similar tool, to determine the most clinically appropriate post-acute care venue.

Payment will be made either as a single bundled payment or through bids from the entities desiring to participate in the pilot. Such entities must include a hospital, a physician group, a skilled nursing facility, and a home health agency.

Assuming that the pilot program shows spending reductions while maintaining quality of care, the program will be expanded before or at least by January 1, 2016.

Impact on Post-Acute Care

The law implies that the pilot project will focus on the eight conditions found by MedPAC to have a high rate and volume of avoidable hospital readmissions for Medicare fee-for-service beneficiaries. It also is specific about the membership of an entity that desires to pilot bundled payment for one or more of these conditions: hospital, physician group, skilled nursing facility, and home health agency (emphasis added). Other post-acute providers may also become part of the entity; however, Congress appeared to understand that the fastest rate of Medicare cost increases for post-acute care has been in utilization of skilled nursing and home health, as shown in Table 3.

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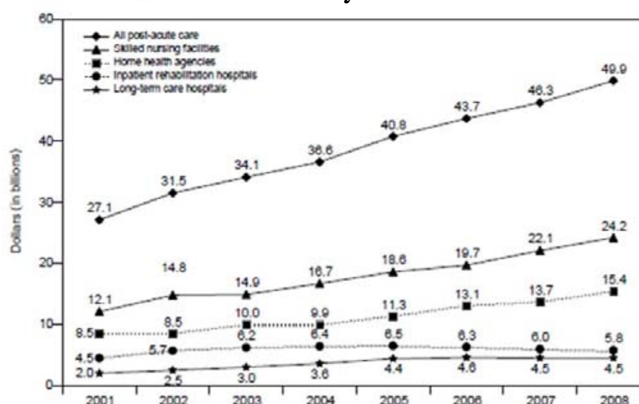
Table 3: **Medicare Post-Acute Spending Increases Fueled by SNFs and HHAs**



Source: MedPAC 2009

A fast moving trend today is seen in acquisition of physician practices by health care systems and formation of physician networks as integrated components of the systems. Hospitals and health systems that also own SNFs and HHAs are well positioned to become pilot projects for Medicare bundling. The motivation for becoming involved in the pilot is that health systems will be able to learn how to manage the care continuum early on, when payment rates are still being established, instead of being required to accept bundled payment once the pilot has been shown to be successful in maintaining quality of patient care and cost savings.

Ownership or well integrated preferred provider relationships are essential for success under bundling. All members of the entity that receives the episodic bundled payment— hospital-physicians-SNFs-HHAs— must be able to demonstrate success with quality measures, including those mentioned in the law:

- Functional status improvement
- Reducing rates of avoidable hospital admissions
- Rates of discharge to community
- Rates of admission to an emergency room after hospitalization
- Incidence of health care acquired infections
- Efficiency measures
- Measures of patient perception of care
- Other measures, including measures of patient outcomes

Thus, each component of the entity that received the episodic bundled payment must rely on each of the other components to achieve the targets for quality measures in order to receive the anticipated amount of bundled Medicare payment for the episode. Adapting a famous quote from John Donne, "no health care provider is an island."

As is true for ACOs, bundled episodic payment requires that hospitals and health systems are able to manage the utilization, cost, quality, and outcomes for patients in any post-acute venue with one of the targeted conditions for bundling. Ownership of the SNF and HHA provides the best guarantee of control; however, as mentioned earlier, may health systems have neither the financial ability to purchase nor the expertise to manage these post-acute venues. Therefore, joint ventures and preferred provider relationships are other methods for integrating these post-acute venues with hospitals and physicians.