

# Leveraging Medicare Spend per Beneficiary for improvement

Learn how members used this data to improve efficiency and patient care

As the health care landscape continues shifting from volume to value-based reimbursement, hospitals are increasingly responsible for more than the acute care experience. Reducing readmissions, utilization and length of stay (LOS) throughout the post-acute care (PAC) space is the expanded lens for health care leaders to plan strategies that improve performance.

## Opportunity

Medicare Spend per Beneficiary (MSPB) is the sole efficiency metric that is part of the CMS value-based purchasing program. In federal fiscal year 2015, the metric began accounting for 25 percent of a hospital's value-based purchasing score and represents the related episode spend to include the three-day prior, the acute stay and 30-day, post-acute care for a Medicare patient. A 2016 Vizient MSPB benchmark study identified that the greatest improvement opportunity for the 210 study participants resided in improving the management of patients utilizing post-acute care. Improvements in this area can lead to improved MSPB efficiency and better performance in the Medicare Value-Based Purchasing program and improved outcomes for patients through reduced length of stay and risk for unnecessary readmissions.

To assist Vizient members in advancing their MSPB performance, a nine-month collaborative began in November 2016 with 90 participating members. The goal of the collaborative was to reduce hospital readmissions and improve the key drivers of performance in the post-acute arena, which includes utilization of skilled nursing facilities (SNFs), home health and inpatient rehabilitation.

## Key learnings from the collaborative

Collaborative participants recommended the following strategies to improve in this area:

- Develop strategic partnerships. Identify providers in the post-acute arena that affect your utilization and spend, create a relational foundation with these entities and work together to identify and establish ways to improve patient care while reducing Medicare spend.
- Evaluate processes and transitions across the care continuum to reduce PAC utilization and related spend.
- Analyze and share data transparently, both internally and externally with strategic partners.
- Leverage the learnings to accelerate alternative payment readiness by articulating how these strategies can assist you in moving toward value-based care.

As the nation's largest member-driven health care performance improvement company, Vizient provides network-powered insights in the critical areas of clinical, operational, and supply chain performance and empowers members to deliver exceptional, cost-effective care.

## Overall collaborative results

Collaborative participants were able to achieve the following results:

- Reducing acute-care readmissions rates, resulting in a total collaborative potential cost avoidance of \$24 million<sup>1</sup>
  - Collaborative participants reduced the overall readmission rate from an average rate of 22 percent at baseline to 21.3 percent at performance, representing a 3.24 percent decline in the readmission rate. The percentage of decline resulted in 1,567 avoided readmissions.
- Reducing skilled nursing facility (SNF) utilization and length of stay
  - SNF utilization decreased from 23.4 percent to 22.4 percent, equaling 2,202 avoided episodes.
  - SNF LOS decreased from 21.7 to 21.5 days.
- Reducing home-health utilization and length of stay
  - Home-health utilization declined from 20.7 percent to 20.3 percent, resulting in 900 avoided home-health episodes.
  - Home-health LOS also declined from 16.69 to 15.88 days, equaling 751 avoided home-health days.

As one collaborative participant said regarding this work: “Post-acute care providers learn from the hospital. The hospital learns from them. Throughout it all, the patient benefits.”

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1. Source: Health Services Advisory Group Partnership for Patients Readmission for Medicare patients: Assumes average cost of \$15,477 per readmission

[Calculation explanation: Using Medicare fee-for-service claims data from the Change Healthcare database, episodes were defined by the anchor inpatient admission date and discharge date. Claims for a 30-day post discharge charge activity were linked to the anchor episode. The dataset used for this effort represents 62 percent of Medicare episodes. As such, the finds for this dimension are directional in nature. The collaborative base line period was defined as quarter four of 2015 through quarter three of 2016. The performance period is defined as quarter four of 2016 and quarter one of 2017.]



For more information about engaging in the PI Collaboratives program, please visit with your network director or email us at [picollaboratives@vizientinc.com](mailto:picollaboratives@vizientinc.com).

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Members of the Vizient Performance Improvement Collaboratives program have access to the [project resource page](#).