Financing Health Care Services: It's the System, Stupid

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Evolution of the LTC Quality Issue

- 1970s-1980s: Complaints largely about low quality providers
  - NH residents “receive very inadequate—sometimes shockingly deficient—care that is liken to hasten the deterioration of their physical, mental and emotional health.” – IOM (1986) *Improving the Quality of Care in Nursing Homes*
- Today: Complaints often about the LTC “system”
  - “We operate a long-term care system that is a national disgrace.” – Kane and West (2005) *It Shouldn’t Be This Way: The Failure of Long-Term Care*

The “Silo” Problem

- Little coordination of payments, benefits or services across key actors
  - MDs, Hospitals, SNFs, HCBS, HHAs, Hospice
- With better coordination, we can (in theory):
  - Improve outcomes
  - Lower costs
- Medicare rehospitalization is an important example

Rehospitalizations are…

- Frequent
  - 19.6% of Medicare discharges rehospitalized within 30 days
  - 34% rehospitalized within 90 days
  - 56% rehospitalized within one year
- Often preventable
  - Only 10% of rehospitalizations were “planned”
- Costly
  - Cost to Medicare of unplanned hospitalizations in 2004 was $17.4 billion

Jencks et al., 2009, NEJM

Medicare Hospital Discharges: 2006

Routine discharge	7,592,231 (51.6%)
Home health care	2,225,971 (15.1%)
Institution (SNF, IRF)	3,822,999 (26%)
Short-term hospital	412,143 (2.8%)
Against medical advice	101,024 (0.7%)
Death	550,857 (3.7%)
TOTAL	14,717,313 (100%)

HCUPnet.ahrq.gov

Spending variation across hospital episodes due to readmission/PAC

TABLE 4–1

Average risk-adjusted spending for selected conditions during and 30 days after a hospital stay

Type of condition and service	Low-resource-use hospitals	Average	High-resource-use hospitals	High-resource-use hospital difference from average	
				Percent	Dollars
COPD					
Total episode	$6,372	$7,871	$9,748	23.8%	$1,877
Hospital	4,408	4,414	4,406	–0.2	–8
Physician	547	569	576	1.2	7
Readmission	671	1,543	2,550	65.3	1,007
Post-acute care	466	998	1,780	78.3	782
Other	280	347	436	25.6	89

Source: 5% sample of 2001-3 Medicare claims; MedPAC, June 2008

Question is how to coordinate?

- Bundled payments
  - MedPAC recommendation (6/2008)
  - Senate finance committee proposal (3/2009)
- Capitated benefits
  - Medicare Advantage, SNPs
- Coordinated service models
  - Transitional care teams

Bundled Payments

- Medicare would pay single provider entity (hospital plus affiliated MDs) a “super DRG” amount to cover all services associated with a hospital episode over some post-discharge period
  - Hospitalization
  - Physician costs
  - Post-acute care
  - Outpatient services
  - Part D costs?

- Ideally, this would lead providers to eliminate wasteful cost shifting across providers
  - Unnecessary MD, PAC, outpatient services
  - Reduce hospital readmissions

Unintended Consequences

- All the problems we currently have under PPS, only more so…
  - Volume response
  - Selection
  - Stinting
  - Upcoding, “super DRG-creep”
  - Distortions to competition
  - Payment complexities (risk adjustment, length of post-discharge period, outlier payments, etc.)

Why Not a Mixed System?

- Current system – provider incentives for cost-shifting
- Single bundled payment – provider incentives for selection, stinting, etc.

- "Mixed" system in which hospital episode is paid partly prospectively (bundle) and partly cost-based (outside the bundle)
  - Ellis and McGuire, 1986; 1990

Mixed System

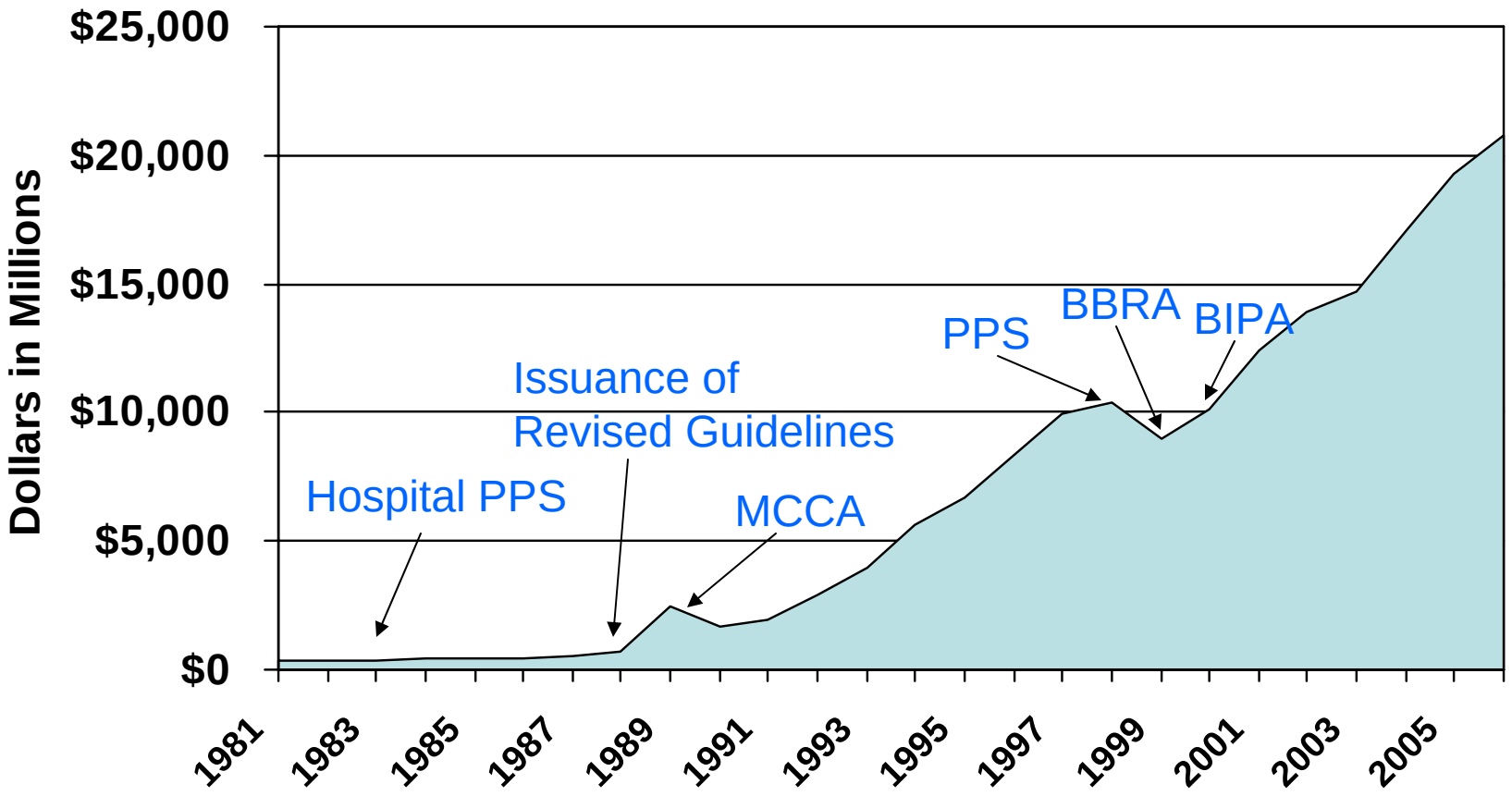
- Payment = Super DRG Bundle + silos

- “Super DRG” might encompass hospital plus MD costs and certain (predictable) services
- “Silos” might include PAC, high-cost outpatient services, etc.
- Generosity of payment for “silos” could be linked to specific super DRGs

SNF PPS is a Mixed System

- Medicare currently bases SNF payment on a *per diem* payment system based on RUGs payment categories
  - "The variability of length-of-stay – and thereby episode cost – is too great to practically implement an episode-based prospective pricing mechanism." – CMS Final Report on NH Casemix Demo, Abt 2002
- RUGs payment increases based on therapy minutes per week
- Research suggests Medicare SNF volume, rehab therapy, length-of-stay all relatively unchanged under PPS

Medicare SNF Expenditures, 1981-2006



Concluding Thoughts

- Bundling of payment can address cost shifting/coordination of care concerns
- However, this bundling will create a number of perverse provider incentives (selection, stinting, etc.)

- Mixed system would balance these issues

No free lunches…

- Every innovation to improve LTC quality currently on the table increases aggregate costs
  - HCBS
  - Assisted living
  - Culture change
  - Cash-and-counseling
  - Capitation
  - Care coordination

- Bundling will likely be similar