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

<table>
<thead>
<tr>
<th>Discharge Type</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine discharge</td>
<td>7,592,231</td>
<td>51.6%</td>
</tr>
<tr>
<td>Home health care</td>
<td>2,225,971</td>
<td>15.1%</td>
</tr>
<tr>
<td>Institution (SNF, IRF)</td>
<td>3,822,999</td>
<td>26%</td>
</tr>
<tr>
<td>Short-term hospital</td>
<td>412,143</td>
<td>2.8%</td>
</tr>
<tr>
<td>Against medical advice</td>
<td>101,024</td>
<td>0.7%</td>
</tr>
<tr>
<td>Death</td>
<td>550,857</td>
<td>3.7%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>14,717,313</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
Spending variation across hospital episodes due to readmission/PAC

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

Source: 5% sample of 2001-3 Medicare claims; MedPAC, June 2008
Question is how to coordinate?

- Bundled payments
  - 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

• 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

Dollars in Millions

1981 1983 1985 1987 1989 1991 1993 1995 1997 1999 2001 2003 2005

Hospital PPS
Issuance of Revised Guidelines
MCCA
PPS
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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