You’re In or You’re Out: Determining Winners and Losers Under a Global Payment System

PRESENTED TO:
Northeast Home Health Leadership Summit

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Presentation Overview

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• Payment System Objectives
• Considerations in Moving Toward Episode-based Payment
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• Definition of a Payment Bundle
• Patient Categorization System
• Payment Accuracy Is Important
• Preliminary Empirical Investigation
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• Current ACH/PAC Systems Are Diverse
• What Preliminary Data Could Tell Us
• What Can We Learn From Existing ACH/PAC Payments?
• Who Will Be the Winners and Losers?
• Issues to Consider
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How the Implementation of IPPS Informs Bundling Prospects

- The President, Secretary of DHHS, and ASPE agreed on a plan to use DRGs as a platform for acute care hospital prospective payment.
- DHHS produced a report to Congress based on 10 years of DRG development, NJ Hospital payment demonstration, and 1-year of extensive HCFA (CMS) policy development activity.
- Congress used this report as a platform for PPS legislation and added numerous transition features to the PPS system.
- DRGs (IPPS) worked because:
  - IPPS was well planned and executed.
  - The unit of payment was easily defined and well understood.
  - DRGs were well researched and statistically explained severity.
  - DRGs were imposed upon an existing delivery structure (the hospital case).
How the Implementation of IPPS Informs Bundling Prospects (cont’d)

• Serious questions remained upon DRG implementation:
  • Who would be the patient advocate in the hospital?
  • What was the role of readmissions?
  • Were sicker patients discharged quicker?
  • How would capital investment and technology be affected?

• In 1983 we thought DRGs would last 5 years and then be replaced with a higher level of bundling aggregation
  • This did not happen – why?
  • PPS systems multiplied under the Balanced Budget Act
    • This silo approach has been detrimental to system integration
Payment System Objectives

• Requirements for developing payment systems
  • Easy to understand
  • Simple to administer
  • Coherent clinically
  • Payment accuracy
  • Appropriate provider incentives for increased efficiency without patient stenting
  • Adequate payment to providers to assure beneficiary access and, at the same time, ensure Medicare is a value-based purchaser
Considerations in Moving Toward Episode-based Payment

- Hussey et al. (2009)\(^1\) outlined important considerations for research and development of post acute care bundling of payments:
  1. How should episodes be defined? Issues include:
     - Number of different settings involved in managing condition
     - Single versus multi-conditional focus
     - Amount of heterogeneity within episodes of the same type
  2. How should accountability be distributed to providers? Issues include:
     - Retrospective versus prospective attribution
     - How to define the accountable entity
  3. How will episode definition and accountability differ in construction of payment systems versus quality and performance measurement?

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SHAPE: Study of Hospital and Post Acute Care Episodes

- Dobson | DaVanzo has been commissioned to perform an exploratory study on ACH/PAC payment bundling

- Key research questions:
  1) How can ACH/PAC payment bundles be defined?
  2) Can ACH MS-DRGs be used to define homogenous ACH/PAC payment bundles?
  3) Can ACH/PAC payment bundles be constructed that are accurate and predictable where accuracy relates to how well ACH/PAC payments would track current PAC payments in terms of winners and losers at the individual facility level and at the ACH and PAC setting level?
  4) What are the practical implications of using ACH/PAC payment bundles across settings (e.g., Who directly receives the Medicare payment? Are different payments required for different PAC settings? Across regions? Across diagnoses?)?
Definition of a Payment Bundle in Proposed Legislation

- H.R. 3590 – The Patient Protection and Affordable Care Act of 2009
  - Bundled episode of care includes services beginning three days prior to ACH admission, length of ACH stay, and services for 30 days following ACH discharge
    - Payments would include inpatient and outpatient ACH services, physician services, HHA, SNF, IRF, and LTCH
  - Payment methods will be developed by the Secretary of Health and Human Services and may include bundled payments and bids from providers
    - Hospitals and other eligible entities would receive the bundled payment for each patient served, regardless of whether the patient receives PAC services
    - Any readmission will result in reduced payments for the hospital that provided initial patient care
    - Hospitals that did not provide initial care will be reimbursed for readmissions
  - Secretary will establish procedures for care after episode ends

1 Introduced on November 19, 2009. Definitions may change due to ongoing and future legislative developments.
Patient Categorization System

- **MS-DRGs**
  - Coded diagnoses are not consistent between the ACH and PAC settings
    - What does this mean?
  - Considerations
    - MS-DRG bundle weights
    - Hierarchical condition categories (HCCs)
    - Readmissions
    - Role of deaths
    - Regional variation
    - Role of hospice
    - Etc.
  - Role of future patient categorization/reporting systems
    - CARE tool
Payment Accuracy Is Important

- Unit of payment = bundle
- Patient categorization system = the acute care hospital MS-DRG (CMI)
- CMI: Alone rarely provides adequate explanatory power of costs
  - Especially true for bundling, given selection across PAC settings?
    - Wage index
    - Teaching hospitals
    - DSH
    - Facility setting
    - Facility characteristics (urban, rural)
    - Death
    - Readmissions/transfers
    - Outliers (short stay / long stay)
Preliminary Empirical Investigation

- We have a history of prospective payments for ACH/PAC settings
  - Each of these has been carefully crafted from a variety of perspectives
  - How can we use this experience?
- How do current payments vary within payment bundle (e.g., congestive heart failure)?
- Does the local area supply of hospice beds influence frequency and intensity of the PAC bundle?
  - Geographic variation in hospice use influences whether terminally ill nursing home residents die in nursing home or in the hospital\(^1\)
    - Use of Medicare hospice benefit has grown dramatically over past 10 years
    - Nursing home patients served by hospice have lower rates of hospital use
    - Hospital mortality has declined as mortality in nursing homes has increased

\(^1\) Mor, Vincent and David Grabowski, Understanding Skilled Nursing Facility Re-Hospitalizations: Variation by Patient Type and Region, unpublished draft, December 12, 2008.
What Might a Bundle Look Like?

<table>
<thead>
<tr>
<th>2007 ACH Discharges</th>
<th>11,309,000</th>
<th>CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaths</td>
<td>3.4%</td>
<td>Jencks 1</td>
</tr>
<tr>
<td>Live Discharges</td>
<td>10,924,494</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stepping Down ACH to PAC Bundle</th>
<th>Percent 2</th>
<th>PAC Admissions % Live Discharges from ACHs</th>
<th>Overall Totals from MedPAC (2006)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL PAC</td>
<td>35.0%</td>
<td>3,823,573</td>
<td></td>
</tr>
<tr>
<td>SNF</td>
<td>41.1%</td>
<td>1,571,488</td>
<td>2,543,000 discharges</td>
</tr>
<tr>
<td>HHA</td>
<td>37.4%</td>
<td>1,430,781</td>
<td>3,700,000 episodes</td>
</tr>
<tr>
<td>IRF</td>
<td>10.3%</td>
<td>394,593</td>
<td>369,000 discharges</td>
</tr>
<tr>
<td>OPD</td>
<td>9.1%</td>
<td>348,710</td>
<td>404,000 visits</td>
</tr>
<tr>
<td>LTCH</td>
<td>2.0%</td>
<td>77,236</td>
<td>130,000 discharges</td>
</tr>
</tbody>
</table>


2 Percents taken from Barbara Gage speaking notes dated 8/10/2009.
Current ACH/PAC Payment Systems Are Diverse and Represent a Vast Public Investment

<table>
<thead>
<tr>
<th>Setting</th>
<th>Unit of Bundle</th>
<th>Payment Bundle (wage adjusted)</th>
<th>Diagnosis</th>
<th>Functional Status</th>
<th>Therapeutic Minutes</th>
<th>Outliers</th>
<th>Provider/ Facility Level Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACH</td>
<td>Case</td>
<td>MS-DRG</td>
<td>✔</td>
<td></td>
<td></td>
<td>✔ ✔ ✔</td>
<td></td>
</tr>
<tr>
<td>LTCH</td>
<td>Case</td>
<td>LTMS-DRG</td>
<td>✔</td>
<td></td>
<td>✔ ✔ ✔ ✔</td>
<td>✔ ✔ ✔</td>
<td></td>
</tr>
<tr>
<td>SNF</td>
<td>Per Diem</td>
<td>RUG</td>
<td>✔</td>
<td></td>
<td>✔ ✔ ✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IRF</td>
<td>Case</td>
<td>CMG</td>
<td>✔ ✔</td>
<td></td>
<td>✔ ✔ ✔</td>
<td>✔ ✔ ✔</td>
<td></td>
</tr>
<tr>
<td>HHA</td>
<td>60-day Episode</td>
<td>HHRG</td>
<td>✔ ✔</td>
<td></td>
<td></td>
<td>✔ ✔</td>
<td></td>
</tr>
</tbody>
</table>
What Preliminary Data Could Tell Us

Mean and Coefficient of Variation across Expenditures per Patient Episode

- SNF
- IRF
- LTCH
- HHA
- All

CV = Coefficient of Variation = Standard Deviation / Mean

CV Mean

High Expenditure $YY

Low Expenditure $XX

Mean

Mean

Mean

Mean

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What Can We Learn From Existing ACH/PAC Payments?

Can we use the results of nearly 30 years of PPS development to inform us?

- Payment per bundle = \( f (\text{MS-DRGs with HCC adjustments, other payment considerations, outliers}) \)
  - We could use outlier flags from current systems, for instance
    - This would represent a type of hybrid payment system
- Payment system changes affect PAC setting admissions
  - Buntin et al. (2009)\(^1\) found that, “choice of post-acute care site does react to Medicare payment system changes and that different post-acute settings do, to some extent, substitute for one other when incentives for admission are changed.”
  - Home health agency admissions fell significantly after interim payment system (IPS) in 1997 and prospective payment system (PPS) in 2000

Who Will Be the Winners and Losers?

- **Investigate “winners” and “losers” on a payment-to-payment basis**
  - Hussey et al. (2009): “Simulations using Medicare data can be used to identify patterns in characteristics of providers expected to win and lose under new payment methods, and to test the level of financial risk under specific configurations.”
  - Given the potential dislocation of bundled payment, this might represent a good first step in understanding how payment bundles might work.

- **Look to evaluation of winners and losers under PPS\(^1\) as a guide for modeling potential winners and losers under bundling**
  - Key issues include:
    - Broader environmental and community factors affecting financial performance
    - Provider-specific characteristics affecting Medicare financial performance
    - Design features that affect winners and losers and responses to incentives

Who Will Be the Winners and Losers? (cont’d)

- How did environmental and community factors affect finances?
  - Environment contributed, but less important than internal factors
  - Winners had more effective managers and more successfully met challenges; losers had weaker management and less responsive medical staffs

- How did provider-specific characteristics affect Medicare financial performance and compare to overall performance?
  - Winners characterized by strong leadership, culture of cost containment, greater efficiency, more productive relationships with physicians, and typically more innovative

- What design features and incentives affected winners and losers?
  - Winners gained by fine-tuning processes; losers less able to adapt
  - Losers required to fundamentally change operations to cut costs, and new strategies and investments took time to realize gains
Who Will Be the Winners and Losers? (cont’d)

- Implications of studying winners and losers
  - Theory of improving performance through PPS was basically sound
  - Opportunities to further improve efficiency exist then and now
  - Not all providers will achieve highest efficiency
  - Short-term turnarounds difficult

- How should we apply evaluation of PPS to design of bundling?
Issues to Consider

• “Bundling” is a vague payment concept
• Can we incorporate existing PPS payment technologies?
  • “Unit of payment” and “who to pay” appear simple but are conceptually and practically very difficult
• What about P4P and other extensions to CMS payment systems?
• The bundle as a payment unit will require careful thought to prevent an enormous amount of financial dislocation in the ACH/PAC industry
• IPPS engendered post-acute care; bundling will engender:
  • Cost savings?
  • Disruption in PAC care?
  • Improved care coordination?
  • Will bundling ever happen?
• How would the PAC industry evolve under a bundling payment system? Will the PAC silos dissolve?

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Conclusion

• A recent *New Yorker* article\(^1\) indicates that deciding who is in charge is critical to future savings in the health care sector

• From this perspective, “Who to pay?” in the development of bundling payment policy as it reflects “Who is accountable?” may be one of the most important questions we will address