Post-Acute Care and Long-Term Care: A Complex Relationship

PRESENTED TO:
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Executive Summary

• Medicare payment bundling of acute care hospital, post-acute, and ambulatory care services could profoundly impact both the financing and delivery of care
  • Long-term care likely will not be included in the Medicare payment bundle, but Medicaid long-term care services could be affected

• Policymakers need to be cognizant of long-term care as Medicare payment bundling is developed – ideally both should work together to achieve efficient health care delivery, increase care coordination, and raise the quality of care
On one hand, Medicare payment bundling could improve inpatient care and reduce patient transitions across settings.

As patients are more medically stable, the need for facility-based long-term care could change.

On the other, Medicare payment bundling must be designed very carefully to avoid unintended consequences that could result in financial dislocation for providers and reductions in patient care quality.
Introduction

• The question, “What happens to long-term care if/when Medicare adopts payment bundling?” raises several fundamental policy issues:
  • How might Medicare payment bundles be defined, what types of providers would be included, and what types of services would be covered and paid for?
  • How would Medicare payment bundling affect Medicaid-funded long-term care providers?
    • Would the restructuring of post-acute care payments cause a shift in care and/or costs to the Medicaid program or could the burden on Medicaid be reduced?
    • Would Medicare bundled payments force a restructuring of care delivery?
  • How would Medicaid, which will be expanded to cover more individuals under the Affordable Care Act, respond to these challenges?
Part I: Payment Bundling
Health Care Reform and Bundling

• The current health care delivery system does not provide for or encourage the coordination of payments or services across providers
  • Medicare and Medicaid each have unique payment systems, with little incentive to coordinate care and every incentive to shift costs from one to the other
• The Affordable Care Act includes many provisions that establish programs and demonstrations to increase care coordination and reduce health care expenditures
  • Center for Medicare and Medicaid Innovation
  • Accountable Care Organizations (ACOs)
  • Community-based Care Transitions Program
  • Federal Coordinated Health Care Office
  • Medicare payment bundling national pilot program
  • Medicaid payment bundling demonstration
Health Care Reform and Bundling (cont’d)

- Post-acute care settings now have separate prospective payment systems, fostering overlap in types of patients across settings and leading to lack of coordination and possibly duplicative care.

- Medicare payment bundling will combine acute care hospital, post-acute, and ambulatory care services across settings into a single bundle:
  - Medicare payment bundling could:
    - Reduce health care expenditures by creating system efficiencies, and
    - Improve patient care quality by reducing rehospitalizations and transitions across settings.
What is a Medicare Payment Bundle?

• As written in the Affordable Care Act, the national pilot program will combine payments for acute care hospital, post-acute, and ambulatory care services into a single bundle, with two major components:
  1) The acute care hospital “index” admission, which triggers the start of the bundle
     • The bundle is clinically defined by the acute care hospital index stay Diagnosis Related Group (DRG)
  2) All care provided within 30 days of patient discharge from the index acute care hospital admission

• The bundle could include inpatient and outpatient hospital, physician, facility-based post-acute care, home health, and hospice services, and can be amended at the discretion of the Secretary
Why Do We Want Payment Bundling?

- Medicare payment bundling could address many efficiency and quality of care concerns
  - Bundled payments could support the formation of multi-entity accountable care-type organizations by locating provider responsibility for the quality and coordination of care across settings within one integrated management/administrative structure

- The ultimate goal of Medicare payment bundling is at least three-fold:
  1) To incent the provision of **quality care** in the most cost-effective setting
  2) To **improve system efficiency**, with less reliance on fee-for-service payments
  3) To **reduce hospital readmissions** and other use of facility-based services (e.g. SNFs/IRFs) through enhanced care coordination
Dobson DaVanzo & Associates, LLC (Dobson | DaVanzo) conducted a study examining the properties of an acute and post-acute care bundled payment using all claims data for a 20 percent sample of Medicare beneficiaries from 2005 to 2008.

Dobson | DaVanzo’s variable length bundle was based on a preliminary definition of payment bundling before the Affordable Care Act was enacted.

- Included all post-acute care initiated within 30 days of patient discharge from the index acute care hospital admission, followed until patient discharge.
- Ambulatory claims (hospital outpatient and carrier) data were not available for this analysis.

What Could a Medicare Payment Bundle Look Like?
What Could a Bundle Look Like?
Distribution of Episodes and Percent of Medicare Expenditures

- Payment bundles represent just over 30 percent of overall Medicare expenditures
- 36 percent of patients are discharged to a post-acute care setting following discharge from the hospital
  - 53 percent of patients were discharged from hospital to community with no additional care; 11 percent of patients were rehospitalized before receiving any post-acute care
- Skilled nursing facilities (SNFs) represent the majority of patients’ first post-acute care setting

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Bundles</th>
<th>Percent of Total Medicare Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>9,804,285</td>
<td>34.8%</td>
</tr>
<tr>
<td>2007</td>
<td>9,473,380</td>
<td>33.0%</td>
</tr>
</tbody>
</table>

First PAC Setting  | Dobson | DaVanzo Episode Distribution |
-------------------|--------|-----------------------------|
HHA                | 38.3%  |
SNF                | 50.5%  |
IRF                | 8.9%   |
LTCH               | 2.3%   |

Source: Dobson | DaVanzo analysis of Medicare claims data
Note: Episodes and Medicare payments extrapolated from 20 percent sample of Medicare beneficiaries to total Medicare population
What Could a Bundle Look Like?
Percent of Episode Payments Represented by Top 20 Percent of MS-DRGs

<table>
<thead>
<tr>
<th>First PAC Setting</th>
<th>Percent of Episodes in Top 20 Percent of MS-DRGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHA</td>
<td>78.4%</td>
</tr>
<tr>
<td>SNF</td>
<td>83.8%</td>
</tr>
<tr>
<td>IRF</td>
<td>88.7%</td>
</tr>
<tr>
<td>LTCH</td>
<td>83.5%</td>
</tr>
<tr>
<td>All First PAC Setting Bundles</td>
<td>81.0%</td>
</tr>
</tbody>
</table>

Source: Dobson | DaVanzo analysis of Medicare claims data
Note: N = 148, data extrapolated to total Medicare population

- Bundles are “defined” administratively by first post-acute care setting after discharge from the hospital.
- Overall, 81 percent of first post-acute care setting bundles are clinically defined by an index stay MS-DRG within the top 20 percent (n=148 MS-DRGs).
Patient Pathways

- Patient pathways describe the sequence of settings (transitions) a patient progresses through during the bundle.

- Our analysis of a 20 percent sample of Medicare beneficiaries from 2005-2008 (nearly 6.8 million bundles) indicated there were 8,860 unique patient pathways.
  - Some index stay MS-DRGs exhibited nearly 1,000 different pathways across bundles over the length of the entire bundle.
Patient Pathways: Average Number of Stops by First Post-acute Care Setting Across all MS-DRGs

<table>
<thead>
<tr>
<th>First PAC Setting</th>
<th>Average Number of Stops per Episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHA</td>
<td>2.5</td>
</tr>
<tr>
<td>SNF</td>
<td>2.8</td>
</tr>
<tr>
<td>IRF</td>
<td>3.1</td>
</tr>
<tr>
<td>LTCH</td>
<td>2.9</td>
</tr>
</tbody>
</table>

**First PAC Setting Average**

Average: 2.7

Source: Dobson | DaVanzo analysis of Medicare claims data

- Across all MS-DRGs, patients discharged from the hospital to a post-acute care setting experienced an average of 2.7 “stops” per bundle
Readmissions by First Post-acute Care Setting

<table>
<thead>
<tr>
<th>First PAC Setting</th>
<th>Percent of Episodes with Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHA</td>
<td>24.6%</td>
</tr>
<tr>
<td>SNF</td>
<td>24.6%</td>
</tr>
<tr>
<td>IRF</td>
<td>21.0%</td>
</tr>
<tr>
<td>LTCH</td>
<td>23.5%</td>
</tr>
</tbody>
</table>

Across first post-acute care settings, the same proportion of bundles have at least one readmission.

Across bundles beginning in a post-acute care setting, the average percent of episodes with readmission is 24.3%.

The average number of readmissions, including bundles with a readmission prior to post-acute and bundles without follow-up care, is approximately 20 percent – consistent with published literature.

Source: Dobson | DaVanzo analysis of Medicare claims data
A series of questions need to be answered in order to design a Medicare payment bundle for acute care hospital, post-acute, and ambulatory care services, and to understand the implications for long-term care patients:

- Who would be paid?
- How would financial risk be accounted for and shared?
- How would success be determined?
- How are financial risk and other payment adjustments made?
Under bundled payment systems, as the bundles become larger, care settings that had previously been revenue centers become cost centers

- How will this shift in incentives affect provider behavior?

What role will ACOs and other integrated providers play?

Mechanisms will need to be developed that fairly allocate bundled payments to providers within the bundle:

- Does sufficient capacity to integrate care currently exist to support payment bundling?
- Who will make allocation decisions?
- What role, if any, will fee-for-service payment play (virtual bundles)?
- Will providers within a bundle be capitated? Will providers within a bundle be subjected to with-holds or eligible for bonuses?
The success of bundled payment will be driven by a variety of factors – some of which are not finance-oriented. Some possible questions are:

- Will cost control objectives be achieved or thwarted?
- Will bundling encourage more bundled units? More hospital care?
- Will delivery system reform be supported/encouraged?
- Will population health be measured and/or improved?
- Will patient care be compromised (patient care “stinting”)?
- Will upcoding occur?
- Will provider selection of “well” patients be encouraged (favorable selection)?
- How will workforce issues be affected (e.g. who will perform clinical management)?
- What type(s) of mid-course corrections will be needed?
## Practical Considerations: How Are Financial Risk and Other Payment Adjustments Made?

<table>
<thead>
<tr>
<th>Setting</th>
<th>Unit of Episode</th>
<th>Unit of Payment (wage adjusted)</th>
<th>Diagnosis</th>
<th>Functional Status</th>
<th>Therapeutic Minutes</th>
<th>Outliers Short</th>
<th>Long</th>
<th>Provider/Facility Level Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHA</td>
<td>60-day Episode</td>
<td>HHRG</td>
<td>✓</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>
<td>✓</td>
</tr>
<tr>
<td>LTCH</td>
<td>Case</td>
<td>LTCH MS-DRG</td>
<td>✓</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>
<td></td>
</tr>
<tr>
<td>Acute Hospital</td>
<td>Case</td>
<td>MS-DRG</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Source: Dobson | DaVanzo analysis of Medicare claims data
Risk adjustments must be linked to the payment bundle so that varying degrees of patient severity are captured and appropriately paid

- Patient case-mix is typically captured through a system that groups patients in terms of clinical severity and resource use, such as MS-DRGs in the Inpatient Prospective Payment System (IPPS)

Three important conclusions can be drawn from reviewing current acute and post-acute care patient assessment tools:

1) Post-acute care services can include long-term care personal assistance components related to the restoration of function

2) No single comprehensive patient categorization system exists that can discern the need for both acute and post-acute care

3) Current post-acute care episodes are defined differently across settings: cases for acute, long-term, and rehabilitative hospitals; per diem for skilled nursing facilities; and episodes for home health agencies
Practical Considerations: How Are Financial Risk and Other Payment Adjustments Made? (cont’d)

- If patient severity and functional status are not captured accurately, payment systems risk “compression”
  - Heavy-use patients may be underpaid
- Other payment adjustments
  - Market adjustments, such as wage index and geographic location
  - Facility adjustments, such as teaching and disproportionate share hospitals
- Cost outliers may need to be used extensively, as well as possible adjustments for disability and dual eligibility status to account for long-term care needs
- A variety of transition strategies should be considered
Part II: Implications for Long-term Care
Who Receives Long-term Care?

- Long-term care comprises a “wide array of medical, social, personal, and supportive housing services needed by individuals who have lost some capacity for self-care because of a chronic illness or disabling condition”
  - Some patients receive long-term care as well as acute care services within Medicare post-acute care settings
  - Patients are especially vulnerable at the time of transition between provider settings
- 10.9 million community residents and 1.8 million nursing home residents (or 4 percent of the total population) need long-term care
- When the Affordable Care Act takes full effect, an additional 21 million people are expected to become covered by Medicaid over the next 10 years

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Relationship Between Medicare and Medicaid Payment and Service Delivery

• There are important connections between Medicare and Medicaid patient care across post-acute and long-term care

• Nursing homes and home health agencies often provide post-acute care to Medicare patients and long-term care services to Medicaid patients under the same clinical and management structure

• There are conflicting payment incentives between Medicare and Medicaid that affect health expenditures and patient care quality
  • Medicare is incented to transfer acute and post-acute care patients to long-term care as quickly as possible to minimize Medicare costs
  • Medicaid is incented to transfer patients who need more intense services back to Medicare acute care
Relationship Between Medicare and Medicaid Payment and Service Delivery (cont’d)

- IPPS led to major growth in the post-acute care industry and also affected the long-term care industry
  - Patients discharged “quicker and sicker” in unprecedented numbers
  - Medicare post-acute skilled nursing facility patients who transitioned to Medicaid long-term care were in worse health after IPPS

- Mor et al. suggest, “Medicare-only payment reforms such as bundling may distort behavior in facilities caring for a sizable population of long stay residents”
Medicare Bundling and Medicaid Long-term Care

- Medicare bundling:
  - Would not explicitly include long-term care services
  - Includes physicians, which could improve chronic disease management and care coordination
  - Assumes that skilled nursing facilities – paid on a per diem basis – can be bundled with other acute or post-acute care services paid on a case or episode basis
  - Assumes that home health services can substitute for SNF and IRF care at some level
Medicare Bundling and Medicaid Long-term Care (cont’d)

• Risk adjustment methodology and payment amounts for Medicare payment bundles have implications for Medicaid long-term care
  • Patient severity adjustments and resultant Medicare payment levels could change the balance of payments for Medicare post-acute and Medicaid long-term care patients in both skilled/nursing facilities and home- and community based care

• Underpayment for complex patients could adversely affect long-term care patients
  • Could Medicare payment bundling lead to patients being moved into long-term care setting “quicker and/or sicker”?

• However, successful care coordination and more efficient delivery of services could reduce patient severity and need for long-term care
Example: Readmissions

- Readmissions are a striking example of how conflicting payment incentives between Medicare and Medicaid lead to increased health care expenditures and reduced care quality.

- For dual eligibles, Medicaid has little incentive to prevent hospitalizations because Medicare is the primary payer of acute care readmissions.

- However, could Medicare payment bundling produce better outcomes by reducing rehospitalizations and medical complications, thereby alleviating pressure on long-term care providers?
How Might the Health Care System Change?

- The Affordable Care Act calls for more home- and community-based services for long-term care patients
- Bundling will force a discussion as to whether “pre-acute” and preventative home- and community-based services should be explored to avoid acute care hospitalizations
- Enhanced coordination of care will very likely result in changes as to where care is provided
  - If hospital readmissions are reduced, there will be fewer transfers of patients between acute care hospital, post-acute care, and long-term care settings
  - Care transition coordinators could reengineer how services are delivered across different settings
- Alternatively, dual eligibles with numerous co-morbidities and clinical/functional needs might be at risk of reduced access
Discussion

- Medicare payment bundling could contribute to the control of health care expenditure growth through increased coordination of care across providers and increased clinical efficiency – both of which could reduce current levels of unnecessary or duplicative medical care

- A series of unintended consequences could result from the implementation of Medicare payment bundling
  - A hospital-based bundle could increase hospital utilization
  - Imposing bundled payments on providers that do not have the capacity to coordinate either care or payments could be counterproductive
  - Patient stinting could occur if efficiencies aren’t realized
  - Coding issues around severity adjustment and “code creep” could occur
**Discussion (cont’d)**

- Medicare bundled payments have the potential to impact long-term care as well
  - Payment bundling that affects Medicare SNF finances and patient care could also affect the Medicaid long-term care services delivered in the Medicaid nursing facility co-located with the SNF
  - Long-term care will most likely be excluded from the bundle, which will further bifurcate Medicare and Medicaid funded services
  - The emphasis on moving patient care into the home and out of facilities could reduce access to facility-based services – could increased use of long-term care at home result?
  - Resources flowing to Medicare payment bundles could have an opportunity cost in terms of resources that could be devoted to improving care delivery and coordination of long-term care services
Conclusion

- Medicaid and long-term care services should be considered in the design of a Medicare payment bundle to avoid any unintended consequences that could destabilize the long-term care industry or hurt patient access and care quality
  - Medicare payment bundling could reduce resources available to long-term care providers
  - Patients could be discharged to long-term care “quicker and sicker” as providers meet bundled payment budget targets
- **However, if the potential benefits of Medicare payment bundling are realized, long-term care could change for the better**
  - Improved post-acute care could produce reduced severity and fewer long-term care patients
  - Bundling could also force a separation of post-acute and long-term care service providers, potentially ending the current practice of cost-shifting
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