Dear Dr. Jeff

By Jeffrey Nichols, MD

The Future of Long-Term Care Looks Scary

In last month’s column, a physician overwhelmed by changes promised or threatened for long-term care raised several important issues, including that, to her, most outside initiatives seem designed primarily to save money for the health care system, rather than to benefit patients. In response, I addressed clinical changes and practice guidelines. Here I will respond to the structural, reimbursement, and organizational changes under discussion.

Dr. Jeff responds: The Centers for Medicare & Medicaid Services projects that the United States will spend $30 trillion ($30,000,000,000,000) on medical care in the next decade. That’s an awful lot of zeros. As most readers of this column are very aware, these gigantic expenditures have not produced fabulous wealth for the doctors, nurse practitioners, unit nurses, psychologists, social workers, dietitians, or nursing assistants. In fact, some on that list are scandalously underpaid. Nor have all these dollars produced luxurious facilities with platinum service and gourmet meals.

Seniors now spend a higher percentage of their income on health care than they did in 1966, before Medicare was enacted. And a prolonged stay in a nursing home is likely to pauperize any but the wealthiest senior.

At the same time, federal, state, and local governments are all facing budget deficits. Even if throwing more money at health care would fix everything (and certainly there are a few areas where it might), the need to control overall medical expenditures is obvious. The response to rising costs and declining resources has been a variety of new acronyms such as ACOs, P4P, MLTC plans, FIDA plans, and some confusing new concepts such as bundled payments.

Let’s start with pay-for-performance (P4P) proposals. They are all based on the theory that health care providers would produce better outcomes for financial rewards. Obviously, many of these proposals also suggest financial penalties for those whose performance doesn’t meet benchmarks.

Although the logic behind paying more to get more seems good, the belief deeper inside P4P is that money could be saved if the slackers were paid less. This argument parallels the idea that malpractice rates would drop if we could eliminate the “bad apples” among physicians. Of course, there is a just enough “scrutiny” to these propositions to make them plausible.

It is relatively easy to measure caregivers’ compliance with various measures, such as tracking the percentage of seniors who get appropriate vaccinations or, if diabetic, receive medications to preserve renal function. Performance – actual outcomes – is not process, but process is easier to measure.

Many states have implemented some form of P4P in the last decade, generally with considerable initial fanfare but minimal evaluation of results. The 2009 CMS P4P demonstration in 15 states provided a small pool of money to reward nursing homes for better staffing and state survey results (both being process measures), reducing avoidable hospitalizations (an outcome measure), and Minimum Data Set measures of quality (both).

This demonstration, grandiosely described as “value-based purchasing,” has proven a failure, as have many other such programs around the world. The literature suggests that rewards for specific, easily documented processes, such as preventive health measures, have been modestly successful, while outcome measures are much less susceptible to improvement. For instance, the British National Health Service attempted a P4P program including 126 specific performance measures. To officials’ surprise, British GPs were able to achieve 97% compliance. Significant bonuses were paid, but health statistics did not improve and physician morale actually dropped: Practitioners were eliminating other aspects of care to complete the measures desired by the system. Government got what it paid for but not what it wanted.

Even Dr. Donald Berwick, the administrator of CMS when the agency’s P4P demonstration began, acknowledged in past writings that “merit” payment systems decrease teamwork and emphasize only the tasks being measured and that attempting to stratify care quality based on limited outcome measures has serious limitations. He titled one article “The Toxicity of Pay for Performance” (Qual. Manag. Health Care. 1997;4:27-33).

Managed Long-Term Care (MLTC) plans and Fully-Integrated Dual Advantage (FIDA) plans follow the model of capitated payments begun decades ago in health maintenance and preferred provider organizations: payment by the numbers of heads being cared for, with adjustments for risk factors. HMOs and PPOs were touted as the answer to America’s health cost crisis.

By 1997, however, the fabulous scene in “As Good as It Gets” in which Helen Hunt denotes her HMO produced raucous cheering in the theater where I saw it. In 1999, Bruce Viladeck, former administrator of the predecessor to CMS and perhaps the sharpest health policy person around, published an article entitled “Managed Care’s Fifteen Minutes of Fame” (J. Health Polit. Policy Law. 1999;24:1207-11).

Having failed to control acute care costs, managed care is now a proposed solution to controlling long-term care costs. MLTC and FIDA plans assume that a “care manager” will apportion long-term care payments and somehow achieve savings (after also setting aside money to administer the system, market it, and provide profits for insurance companies). As with prior managed care experience, without major systemic changes or medical breakthroughs, the only way that much money can be taken out of the system is by paying providers less or restricting patient care.

HMOs were attractive to employers not wishing to directly ration care or restrict employees’ choice of providers. Similarly, managed long-term plans allow elected officials to cut reimbursement rates without accepting blame for the inevitable effects.

Bundled payments and accountable care organizations (ACOs) represent variations of an approach to cost savings of simply setting a price for a unit of health care and letting the providers figure out how to spend it. A bundled payment for an episode of illness would cover every provider, whether institutional or independent practitioner, and the costs of any complications from the illness.

For example, there would be a single payment for a hip fracture that would be divided up among the emergency room and its physicians, the hospital and all its charges, the surgeon and anesthesiologist and internist, the radiologist interpreting films, and the providers of postoperative nursing and rehabilitation, whether in a rehab center, skilled nursing facility, or outpatient rehabilitation center, or at home. In the current CMS initiative, only medication payments under Medicare Part D are exempted.

The government proposes to offer this bundled payment by calculating the average expenditure for this particular diagnosis minus 2% savings for CMS. Obviously, this ends the current gaming of the system in which expenses are controlled in one place to pop up in another. ACOs take the principle one step beyond, to a single total payment to an organization (which doesn’t yet exist) to encompass all the care costs for a patient for a year. This contrasts with the current Medicare system, in which the “accountable” agency is CMS itself.

Bundled payments represent a significant potential risk to the long-term care system. Since all these bundles go initially to the hospital, where the diagnosis related group (DRG) is generated, whatever savings are accomplished will be directed by the hospitals. Obviously, if there were any easily accomplished savings within a hospital, it would already have implemented them. After all, hospitals have been getting bundled payments through the DRG system for years. Furthermore, hospitals have little incentive to try to cut better deals with their attending physicians, who represent referral sources.

The obvious savings would be in post-acute care. Although there is some hope that this would lead to better discharge plans, better communication among providers, and savings from avoiding complications and rehospitalizations, the easier path for hospitals would be to leverage discounts from nursing homes, long-term care physicians, and home care agencies. Although the politics of ACOs remain to be determined, the dominant financial position of acute care hospitals within the current health care system suggests that they will dominate the ACOs as well and perpetuate a status quo, which staves off primary care and chronic care to support an excess of hospital beds and unnecessary procedures.

The Journal of General Internal Medicine has a superb article by Theodore Marmor and Jonathan Oberlander (published online March 13, 2012) that traces the history of passing fads in American health policy, calling them “the search for the holy grail” of cost containment. They argue that there may be no single solution, but rather a series of small solutions.

All of this leads back to the overwhelmed medical director drowning in the alphabet of change. We, as the professionals who have the knowledge to recognize where there is good care, where dollars are well spent, and where there is bad care and waste, need to take a leadership role in this debate. We may not be able to solve all the problems of American health care, but we know a lot of answers regarding the care of the frail and elderly. Health care economists and policy wonks don’t have the answers. Our patients need us to do more than follow the debate. They need us to fight for a better system.

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