ACA’s key themes

1. “Leave good-enough alone”
2. Share the responsibility
   • “Individual mandate”
   • Everybody in the game
   • No free riders; play or pay
3. Use market-based solutions
   • Shift competition from risk and prestige to price and quality, i.e., value
   • Realign incentives
   • Build infrastructure for effective price and quality competition
4. Contain costs by focusing on the 10% to 20% who account for 80+% of the costs
5. Innovate and test before full-scale implementation (Medicare = reform laboratory)
   • Avoid unintended effects
   • Accounts for half or more of legislative text
1. Leave good enough alone

Main consumer markets:
- Large group market
- Small group market
- Individual market
- Medicare
- Medicaid
- Other:
  - Military and Tri-Care
  - Veterans
  - Workers comp
  - Etc.

- Reform aimed mainly at individual and small-group markets, Medicare, and Medicaid
- Not aimed at large group or large employer market (although some new rules, e.g., benefit design, health plan practices)
- You will get to keep what you have
- Will spillover into the large group market, VA, workers comp, etc. markets
What this means for individuals with disabilities

- **Risk neutral.** LwD now in large risk pools. Pre-existing conditions cannot be considered.
  - Health plans cannot compete on risk selection
- **Work neutral.** Guaranteed issue. LwDs no longer have to fret about loss of health benefits when electing to become gainfully employed.
- Offers service providers increased opportunities to test and experiment with new pym’t and service delivery models that affect LwDs.
Market-based solutions

- Health care markets do not compete on price and quality; they compete on risk and prestige
  - Health plans win by making sure that they do not over enroll high risk subscribers, i.e., avert adverse risk selection
  - Health care providers compete on prestige
    - Prestige competition escalates costs
## Today’s prestige competition

<table>
<thead>
<tr>
<th>Healthcare</th>
<th>Higher Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rankings of specialties</td>
<td>Rankings of individual depts.</td>
</tr>
<tr>
<td>Technology</td>
<td>Technology</td>
</tr>
<tr>
<td>Research portfolios</td>
<td>Research portfolios</td>
</tr>
<tr>
<td>Educational pedigree of doctors</td>
<td>Educational pedigree of faculty</td>
</tr>
<tr>
<td>Size of endowment</td>
<td>Size of endowment</td>
</tr>
<tr>
<td>Facility amenities</td>
<td>Campus amenities</td>
</tr>
</tbody>
</table>

MedStar National Rehabilitation Network
ACA-induced shifts for health care providers

- Inputs
- Episodes
- Populations
- FFS
- Bundled pym’t & ACOs
- Capitation
- Volume
- Quality reporting
- Value
- No risk
- Shared risk
- Full risk
- Higher cost settings
- Lower cost settings
- Prestige competition
- Price + quality competition

MedStar National Rehabilitation Network
Post-acute facilities, 1985-2012

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SNFs</td>
<td>6,725</td>
<td>8,688</td>
<td>11,436</td>
<td>14,568</td>
<td>14,765</td>
<td>15,008</td>
<td>15,071</td>
<td>14,938</td>
</tr>
<tr>
<td>IRFs</td>
<td>454</td>
<td>767</td>
<td>984</td>
<td>1,067</td>
<td>1,141</td>
<td>1,227</td>
<td>1,180</td>
<td>1,179</td>
</tr>
<tr>
<td>LTCHs</td>
<td>86</td>
<td>89</td>
<td>113</td>
<td>194</td>
<td>273</td>
<td>342</td>
<td>388</td>
<td>420</td>
</tr>
<tr>
<td>HHAs</td>
<td>*</td>
<td>*</td>
<td>6,497</td>
<td>10,917</td>
<td>6,976</td>
<td>8,205</td>
<td>10,568</td>
<td>12,311</td>
</tr>
</tbody>
</table>

* Data not readily available.

# Post-acute payment systems

<table>
<thead>
<tr>
<th>Feature</th>
<th>Skilled Nursing Facilities (SNF-PPS)</th>
<th>Inpatient Rehabilitation Facilities (IRF-PPS)</th>
<th>Long-term Care Hospitals (LTCH-PPS)</th>
<th>Home Health Agencies (HHA-PPS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unit basis</strong></td>
<td>Per diem</td>
<td>Per case/ per hospitalization</td>
<td>Per Case/ per hospitalization</td>
<td>Per 60-day episode of care</td>
</tr>
<tr>
<td><strong>Case-mix adjuster</strong></td>
<td>Resource Utilization Groups III (RUGs III)</td>
<td>Function-related groups (FRGs) or case-mix groups (CMGs)</td>
<td>Diagnosis-related groups (DRGs) specific to LTCH patients</td>
<td>Home Health Resource Groups (HHRCs)</td>
</tr>
<tr>
<td><strong>No. of case-mix groups</strong></td>
<td>53</td>
<td>92 CMGs X 4 comorbidity subgroups/CMG = 368 groups</td>
<td>540</td>
<td>153</td>
</tr>
<tr>
<td><strong>Input document/ information Source</strong></td>
<td>Minimum Data Set (MDS)</td>
<td>Patient Assessment Instrument (IRF-PAI)</td>
<td>ICD-9-CM codes recorded on pt claims</td>
<td>Outcome &amp; Assessment Information Set (OASIS)</td>
</tr>
</tbody>
</table>
Unintended consequences

“Hardening of the Silos”
- Distinct historic traditions
- Distinct organizational and professional cultures
- Own patient assessment tool & clinical info system
- Own manuals, guidelines, staff training
- Own industry-based databases
- Own trade associations
- Each has made a sizable infrastructure investment associated with its PPS
Payment systems and service delivery

“Tell me how you are going to pay me and I will tell you how I am going to practice.”
Post-acute pathways

Patterns of post-acute care for stroke survivors following discharge from IRF care (N=528)

Source: U Colorado report to ASPE, 2006
ACA/CMS 2-track approach

- **Track 1:** Development of quality metrics to support the notion of “value-based purchasing”
- **Track 2:** Payment reforms (2 sub tracks)
  1. Bundled payment (episodes)
  2. Accountable care organizations, (ACOs, population health)
ACA’s bundled pym’t and ACO initiatives seek to realign financial incentives

- Gainsharing for both outcomes and financial performance
- Different providers accountable for both different outcomes and shared outcomes
- All must have some skin in the game for longer-term outcomes
The road ahead

• Have entered a period of reinventing acute, post-acute, and to some extent, long-term care.
  – Exciting
  – Opportunity for innovation, experimentation
  – Moving from a health care culture of compliance to a culture of innovation and experimentation
Questions?

Discussion
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Appendix: ACOs and bundled pym’t

- Different but closely related concepts
  - ACOs—population-based pym’t
  - Bundled payment—episode-based pym’t
- Differ mainly in target of service, scope of service, period of liability.
- ACO and BP business models are essentially the same
  - Both seek to align payment incentives across episodes or populations—payment incentives design to improve quality/outcomes and reduce expenditures
  - Both seek to rebalance risk and rewards across stakeholders including providers