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Building Bridges … Highlights from AcademyHealth's LTC Special Interest Group Policy Seminar

by Sara Teppema

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AcademyHealth (not to be confused with the American Academy of Actuaries) is a major health services research organization. According to their website:

AcademyHealth represents a broad community of people with an interest in and commitment to using health services research to improve health care. We promote interaction across the health research and policy arenas by bringing together a broad spectrum of players to share their perspectives, learn from each other, and strengthen their working relationships.

AcademyHealth has an LTC special interest group, which sponsors a research paper each year. The paper is presented and discussed at two AcademyHealth meetings—with adjunct seminars called "Building Bridges"—over the course of the year. The first presentation is typically in June at AcadmyHealth's annual Research Conference; the audience is comprised primarily of other health services researchers. The second presentation of the same paper is held in February, at AcademyHealth's annual Policy Conference in Washington, D.C., for an audience of policymakers and researchers.

Exciting news! The SOA's LTCI Section Council has agreed to partner with the ILTCI Conference Board and fund the 2011 "Building Bridges" colloquium scheduled for this June. The focus of the paper will be on rebalancing, with a commissioned paper by researcher Chuck Milligan from The Hilltop Institute.

Exciting news! The SOA's LTCI Section Council has agreed to partner with the ILTCI Conference Board and fund the 2011 "Building Bridges" colloquium scheduled for this June.

I attended the "Building Bridges" seminar this past February. This year's presentation was called "Post-Acute Care and Long-Term Care: A Complex Relationship" by Allen Dobson et al.

Dobson's presentation delved into the many considerations that must be made if Medicare is to incorporate Post-Acute Care (PAC) into Medicare bundled payments. At the highest level, bundling PAC will be very complicated, and will not only impact payment but the delivery of PAC services as well. This is further complicated by the fact that many policymakers may not fully understand the differences between PAC and Long-Term Care (LTC) services.

Bundling PAC payments in with Medicare bundles could be viewed as very good. It could improve care by forcing it to be more coordinated, and can reduce transitions from setting to setting, which can be highly disruptive to an individual patient. On the other hand, bundling PAC may not be optimal, because bundling may shift costs to Medicaid, exacerbating already-strained State Medicaid budget shortfalls. It is difficult to predict the net effect of these various outcomes.

The Patient Protection and Affordable Care Act (ACA) includes a national pilot to bundle payments for acute hospital, PAC and ambulatory care on a Diagnosis-related Group (DRG) basis. Dobson's presentation includes data tables that outline the distribution of claims by a patient's "First PAC" setting (where the patient goes right

after discharge from acute hospital). These "First PAC" settings include home health, Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF) and LTC hospital (LTCH). The data show that 36 percent of patients are discharged to a PAC setting. Of these, 50 percent is SNF, 38 percent is home health, 9 percent IRF and 2 percent LTCH.

Dobson also noted that 81 percent of First PAC episodes come from the top 20 percent of DRGs. This 81 percent doesn't vary too much between each First PAC setting. The presentation discusses the number of "stops," or the number of PAC settings a patient goes through in first 30 days post-inpatient discharge. The average is 2.7.

After Dobson's presentation, a panel discussed some of the implications of the research. Bob Berenson, fellow at the Urban Institute and vice chair of the Medicare Payment Advisory Commission (MedPAC) commented on the paper. The main points follow.

- Because Medicare reimburses SNFs at a higher rate than Medicaid, bundled payment would inherently reward states that underfund Medicaid.
  - Bundling has some additional concerns, such as the incentive to create additional episodes to make up for losses on the per-episode payment. This is evidenced by an estimate that 20- to 30-percent of joint replacement surgeries (e.g., hip, knee) are unnecessary.
  - Most patients have several co-morbidities, and not just the condition with the bundled episode. How can bundling handle these?

The panel also included Diane Justice of National Academy for State Health Policy, and Penny Feldman from Visiting Nurse Service of NY.

Dobson's presentation is available on his company's website at *http://www.dobsondavanzo.com/*. ■