ENGELBERG CENTER for
Health Care Reform
at BROOKINGS

BACKGROUND PAPER | January 2010

Health Care Reform and Older Americans: Achieving Better Chronic Care at Lower Costs

To help address the costs of expanding health insurance coverage, the health care reform bills recently passed by the House and the Senate include a range of new payment and delivery system reforms designed to improve the overall performance of the health care system. These legislative proposals reflect considerable evidence that addressing the overuse, underuse, and misuse of medical therapies could help "bend the curve" of rising health care spending.

For example, both bills grant new authorities to the Centers for Medicare & Medicaid Services (CMS) to develop, implement, and evaluate a range of new provider payment reforms intended to improve coordination and transitions of care, especially for patients who see multiple providers for their complex health care needs. The legislation also encourages greater efficiency in the delivery of care for patients with certain chronic conditions, and fosters greater overall accountability among providers for achieving improvements in quality and slowing health spending on behalf of the patient populations they serve.

Policy debates have focused on steps to improve care and lower costs in acute-care settings, such as hospitals. However, to be successful, these payment reforms should include long-term services and supports, which can make a big difference in helping individuals with multiple chronic diseases that face many preventable complications and duplicative or poorly coordinated services.

EXAMPLES OF PAYMENT REFORMS

Prominent examples of payment reforms in current legislation include:

Accountable Care Organizations (ACOs). ACOs are voluntary collaborations that integrate groups of physicians, hospitals, and other providers around their ability to receive shared-savings bonuses for achieving measured quality targets and demonstrating real reductions in overall spending growth for defined patient populations. Drawing upon lessons from the Medicare Physician Group Practice demonstration, policymakers view establishing and evaluating ACOs in a diverse range of delivery system and market settings as a means of improving care for more Medicare beneficiaries than are included in current demonstrations. Accordingly, legislation in both the House and Senate would establish ACOs as a voluntary program for providers at the local or regional levels.

Enhanced bundled payments. Under current fee-for-service payment systems, health care providers are paid specific amounts for each individual service depending on the treatment setting. Bundled payment programs are intended to encourage providers to reduce the costs of each individual service covered by the bundled payment and to increase the overall efficiency of their provision of medical care. Bundled payments are viewed as a means of reducing the costs of post-acute care services, while also encouraging

hospitals to better organize and coordinate post-discharge and post-acute care in a more cost-efficient manner that holds more care providers in different settings accountable for outcomes. Legislation in both the House and the Senate would test a range of new bundled payment arrangements in Medicare and Medicaid, expanding the units of payment for acute care to include post-acute care provided in both hospital and non-hospital settings.

Advanced medical or "health" homes. These clinical settings serve as a central resource for patients' ongoing medical care.[1] Currently, the vast majority of Medicare dollars are spent on providing care to beneficiaries who have five or more chronic diseases and typically see many different physicians each year. Medical homes are intended to reduce Medicare spending and improve beneficiaries' health by coordinating care for these chronically ill individuals, avoiding unnecessary or duplicative services, and promoting greater primary care-oriented preventive services. Both House and Senate legislation would permit qualifying physicians, nurses, group practices, clinics, and other providers to act as medical or health homes, and thereby would receive enhanced monthly payments to manage patients' overall health and health care.

These and other payment reforms seek to identify and develop better evidence for practical, effective steps to transition away from traditional provider payment systems and move toward payment systems that offer greater support to providers for delivering innovative improvements in care that, in turn, will slow health care spending growth over the long run.

Such payment models also offer an opportunity to expand care-coordination efforts that will improve health-related outcomes beyond the acute and post-acute care episode by including active engagement with providers of home- and community-based services (HCBS). Several programs around the country seek to coordinate delivery and financing of HCBS with medical services to help prevent health complications in older adults, as well as mitigate common causes of costly re-hospitalizations. Strengthened engagement between medical services and HCBS could include social workers in a Medicaid waiver program collecting medication profiles to identify potential medication errors that can be resolved in collaboration with a consultant pharmacist, or smoother care transitions when patients move from one care setting to another. It could also include ensuring that older adults discharged from the hospital to home are well connected to relevant community supports that can help them coordinate outpatient care, reconcile medications, and achieve self-management of their health. However, many initiatives to implement medically-focused payment reforms have not included community-based long-term services and supports, which could limit their overall effectiveness in achieving higher-quality, more coordinated care at lower overall costs.

TRANSLATING PAYMENT REFORMS INTO BETTER CARE FOR OLDER AMERICANS

Despite high service utilization and high costs, significant opportunities exist for improving the quality of care experienced by older adults across the country.[2,3] Some prior Medicare demonstrations and evidence from private-sector initiatives suggest that new payment reform innovations have great potential to "bend the cost curve," while also improving quality. It is critical that new payment and delivery system reforms do in fact translate into better care, especially for older Americans who are particularly vulnerable to many of the existing problems in our highly fragmented health care system.

At a minimum, implementation of new shared-savings or other payment programs that would change incentives for providers should be accompanied by steps to ensure that such reforms do not reduce necessary care for older beneficiaries, compromise their personal experiences with care, or otherwise unintentionally *reduce* quality or access to care. Performance measurement that allows for the continuous monitoring of care quality and patient experience and risk-adjusted payments can help demonstrate that growth in health care costs may be slowed through improvements in care.

Moreover, while encouraging greater experimentation with new forms of payments and evaluating their results is critical to achieving the broader vision for health care reform, the legislative process has been focused mostly on hospital and physician services to achieve better results for older adults with multiple chronic conditions. For payment and delivery system reforms to be as effective as possible, these efforts should extend beyond programs that primarily

affect hospitals and physicians to include post-acute and long-term care services. As previously noted, special consideration should be given to the role of home- and community-based services affecting older Americans, which can play a key role in improving overall outcomes and addressing cost trends.

As the legislative process eventually gives way to implementation, policymakers, providers, consumer advocates, and others should consider several key questions to help ensure that new payment reform pilots and related opportunities do translate into better care for all Americans – including older Americans and those receiving long-term services and supports in a range of settings. These questions include:

- What are the key features of new accountable payment systems and in what ways are they likely to affect care for Medicare beneficiaries, particularly older Americans with chronic conditions?
- What are the best ways to ensure that changes in payment systems and incentives can help drive actual improvements in care quality, including better integration of medical and supportive services?
- As evidence is collected about effectiveness, is there a feasible, effective path for expanding new payment systems over time to coordinate care across a broader range of care settings? For example, what are the key considerations for expanding payment reforms to include long-term services and supports such as home- and community-based services?
- What are the "right" roles of nursing homes, home care agencies, and community-based organizations – such as Aging and Disability Resource Centers – for achieving this expanded vision of payment and delivery system reform? For example, how can we effectively integrate home- and community-based services with medical care, organized around payments increasingly tied to value?
- How can we ensure that best-practice delivery models, including the effective use of health information technology, are carefully supported by and integrated with the new payment incentives created by new accountable care payment reforms?

ADDRESSING THE NEED: AN UPCOMING POLICY FORUM

It is clear that older Americans face unique health care challenges that tend to promote fragmented, high-volume, and high-intensity care and can undermine quality. While health reform legislation before Congress includes a range of new payment and delivery system reforms designed to improve overall care for patients with complex health needs and chronic conditions, more can be done to support care improvements in long-term settings.

An upcoming forum hosted by the Engelberg Center for Health Care Reform at Brookings will address the key questions outlined here, including strategies for improving care for older Americans across a range of institutional and community-based care settings. The January 28, 2010 event, which is supported by The John A. Hartford Foundation and The SCAN Foundation, will bring together a range of experts – those focused on efforts to control costs and improve care and those specializing in aging/geriatric issues, quality measurement, and delivery system interventions in a range of care settings, including a wide array of long-term services and supports.

The event will identify specific, concrete examples of promising payment and delivery system reforms likely to be expanded through new legislation that are designed to reduce cost growth, improve quality, and coordinate care more effectively. Participants will also identify practical next steps that leaders in government, health care, and the private sector can take together to address these issues during the health reform implementation process.

1. Medicare Payment Advisory Commission. "Report to the Congress: Reforming the Delivery System." September 16, 2008. Available WWW: http://www.medpac.gov/documents/20080916_Sen%20Fin_testimony%20final.pdf
2. Jencks SF, Williams MV, Coleman EA. "Rehospitalizations Among Patients in the Medicare Fee-For-Service Program." N Engl J Med. 2009 Apr 2;360(14):1418-28.
3. Wenger, NS et al. "The Quality of Medical Care Provided to Vulnerable Community-Dwelling Older Patients." Ann Intern Med. 2003 Nov 4:139(9):740-747.