ObamaCare Clusterfuck: How ObamaCare's Medicare financial incentives make you you worse off if you're not already well off

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ObamaCare apologists keep saying that ObamaCare -- or, as they like to call it when they don't want to talk about the website debacle, "the health care law" -- is "more than just a website." And it is! It is! For example, it affects Medicare as well, as this article in the New England Journal of Medicine explains. Andrew M. Ryan, Ph.D, "Will Value-Based Purchasing Increase Disparities in Care?", NEJM, December 26, 2013:

> Financial incentives for improving quality and efficiency have gone mainstream in U.S. health care. After years of small-scale pilot projects, demonstrations, and experiments, the Affordable Care Act mandated that Medicare payment to hospitals and physicians must depend, in part, on metrics of quality and efficiency. The first program to do so is Hospital Value-Based Purchasing (HVBP), which began affecting Medicare payments to acute care hospitals in October 2012. ...
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> Lower-performing providers tend to care for poorer patients and have a larger share of patients from racial or ethnic minority groups than do higher- performing providers. If these providers receive lower incentive payments or face payment penalties, they may be less able to fund quality-improvement initiatives ? an effect that could, in turn, increase race- and income-related disparities in care.

And -- Hold on to your hats, folks, because this will come as a shock -- that's exactly what happened. I'll skip the program details and cut to the bottom line:

> These results show that hospitals caring for more disadvantaged patients did in fact fare worse in the first year of HVBP. Thus, the program has not eliminated disparities in payments by rewarding both quality improvement and quality achievement. Because the financial incentives in the program?s first year were relatively small ? equal to the net revenue for a handful of high-margin admissions for most hospitals ? payment disparities are unlikely to affect hospital resources and disparities in care in

> the short term. However, the magnitude of the incentives in HVBP will double from 1.0% of Medicare payments for DRGs in fiscal year 2013 to 2.0% by fiscal year 2017. During this time, the criteria for incentive payments will also shift toward performance on outcome measures, which may further hurt hospitals that care for more disadvantaged patients. Such hospitals are also more likely to face penalties from Medicare?s Hospital Readmissions Reduction Program. Over time, resource reductions from the additive effects of these programs may cause quality of care to deteriorate among hospitals caring for more disadvantaged patients.

The conclusion:

> However, a redistribution of resources away from hospitals serving high numbers of disadvantaged patients could increase disparities in care. Going forward, these programs must be carefully monitored and, if necessary, modified to avoid such unintended consequences.

Oh ha ha ha. Since when is fucking over the poor an "unintended consequence"? If you measure everything by the market, as neo-liberalism does, then people who have money *should* live, and people who have money *should* die.

The Dartmouth Study weasels have the same attitude. Hipparchia will correct me on this, but I would summarize the Dartmouth mentality this way: There is a box called a hospital, with inputs and outputs. The hospital boxes have outputs that vary greatly. Hence, they reason, the approach to take is to look inside the boxes with the best outputs, and then make all the boxes do what the "best" boxes do. Unfortunately for everybody but the people who extract profits and rents from the boxes, *the inputs to all boxes are not the same*, and so what they are really doing is optimizing the inputs, too; only the round pegs in round holes will get treatment, and the square pegs will be thrown away. And indeed, the measured outputs will improve, allowing the Dartmouth dudes to claim success!

To change metaphors, think of hospitals as meatgrinders. There are a variety of meatgrinders that make hamburg, some good for sirloin, others good for stew meat. The Dartmouth guy comes along, notes that the sirloin meatgrinder makes really great hamburg, and mandates that henceforth *all* meat be ground using the sirloin meatgrinder. So, forcing the the stew meat through the sirloin meatgrinder does indeed produce great hamburg -- Success!! -- but a lot the bones and tougher meat can't be force fit through the grinder at all, and so gets tossed on the floor (leading to a financial penalty, next quarter for waste....). Of course, in the real world, the meat and bone that gets tossed on the floor comprised human beings, but never mind that.

Sorry, gotta run, or this post would be more polished...

NOTE Thank for the study. You know who you are!

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