NATIONAL PERSPECTIVE: HEALTH CARE COSTS AND READMISSIONS

Cost Trends Hearing
Karen Joynt Maddox, MD MPH
October 2, 2017
Who is spending?

What is CMS doing about it?

How can MA do it better?
WHO IS SPENDING?

Patients: 90.0%
Spending: 51.2%
Potentially Preventable Spending: 26.2%

Joynt et al, Healthcare 2016
WHO ARE THESE HIGH-COST PATIENTS?

<table>
<thead>
<tr>
<th></th>
<th>High-Cost</th>
<th>Non-High-Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Age</td>
<td>73</td>
<td>72</td>
</tr>
<tr>
<td>Non-white</td>
<td>24%</td>
<td>19%</td>
</tr>
<tr>
<td>Dually eligible</td>
<td>37%</td>
<td>18%</td>
</tr>
<tr>
<td>Qualified based on disability</td>
<td>37%</td>
<td>24%</td>
</tr>
<tr>
<td>Mental health diagnosis</td>
<td>16%</td>
<td>6%</td>
</tr>
<tr>
<td>Number of chronic conditions</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>2 or more frailty indicators</td>
<td>40%</td>
<td>5%</td>
</tr>
</tbody>
</table>
NATIONAL EFFORTS TO REDUCE COSTS

- Clinical innovation
- Payment reform
- Price setting
- Consumerism
PAYMENT REFORM

Fee-for-Service Payment, no value assessment

Current payments for many encounters, some physician billing

Fee-for-Service Payment, with assessment of quality

Hospital Value-Based Purchasing, Physician Value-Based Payment Modifier

Alternative Payment Model with Fee-for-Service architecture

Medicare Shared Savings Program, Bundled Payments for Care Improvement

Alternative Payment Model with Global Payment architecture

Primary care innovation programs, Maryland hospitals
# Hospital Readmissions Reduction Program

<table>
<thead>
<tr>
<th>STATE</th>
<th>Hospitals Penalized</th>
<th>Hospitals Not Penalized</th>
<th>% Penalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delaware</td>
<td>6</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>West Virginia</td>
<td>29</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>42</td>
<td>2</td>
<td>95%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>61</td>
<td>3</td>
<td>95%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>28</td>
<td>2</td>
<td>93%</td>
</tr>
<tr>
<td>New York</td>
<td>139</td>
<td>11</td>
<td>93%</td>
</tr>
<tr>
<td>Florida</td>
<td>155</td>
<td>13</td>
<td>92%</td>
</tr>
<tr>
<td>Virginia</td>
<td>68</td>
<td>6</td>
<td>92%</td>
</tr>
<tr>
<td>Kentucky</td>
<td>59</td>
<td>6</td>
<td>91%</td>
</tr>
<tr>
<td><strong>Massachusetts</strong></td>
<td><strong>52</strong></td>
<td><strong>5</strong></td>
<td><strong>91%</strong></td>
</tr>
</tbody>
</table>
HOSPITAL READMISSIONS REDUCTION PROGRAM

Announcement

Implementation

Targeted conditions: slope, -0.017
slope, -0.103
slope, -0.005

Targeted conditions

Nontargeted conditions: slope, -0.008
slope, -0.061
slope, -0.004

Readmission Rate (%)
HOSPITAL VALUE-BASED PURCHASING

Preintervention period

Onset of HVBP

Post-intervention period

Risk adjusted 30 day mortality

Non-HVBP hospitals

HVBP hospitals

Year

2008 2009 2010 2011 2012 2013

Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4

0 4 8 12 16
POLICY EVALUATION: 2 PARTS

Prove efficacy
- Like the treatment effect in a clinical trial
  - Size and consistency of effect

Evaluate for unintended consequences
- Like the safety effect in a clinical trial
- What is “safety” in health policy?
  - Risk aversion
  - Gaming
  - Penalizing vulnerable hospitals
  - Exclusion of vulnerable populations
HOSPITAL-BASED PAYMENT REFORM: IMPACT ON THE SAFETY NET

<table>
<thead>
<tr>
<th>Program</th>
<th>Safety-Net</th>
<th>Non-Safety-Net</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Readmissions Reduction Program</td>
<td>89%</td>
<td>80%</td>
</tr>
<tr>
<td>Hospital Value-Based Purchasing Program</td>
<td>58%</td>
<td>41%</td>
</tr>
<tr>
<td>Hospital-Acquired Conditions Reduction Program</td>
<td>31%</td>
<td>20%</td>
</tr>
</tbody>
</table>

ASPE Office of Health Policy, 2016
## Social Risk and Readmissions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Dual Enrollment Alone</th>
<th>Dual Enrollment, Adjusting for Comorbidities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute MI</td>
<td>1.45</td>
<td>1.14</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>1.24</td>
<td>1.13</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>1.26</td>
<td>1.10</td>
</tr>
<tr>
<td>Hip/knee replacement</td>
<td>1.67</td>
<td>1.31</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>1.44</td>
<td>1.15</td>
</tr>
</tbody>
</table>
MEDICARE ADVANTAGE PAYMENT REFORM: IMPACT ON THE SAFETY NET

Proportion of Contracts ≥ 4 Stars

- Fewest Duals: 60.5%
- Few Duals: 61.6%
- Middle: 30.6%
- High-Dual: 23.3%
- Highest Duals: 12.9%

ASPE Office of Health Policy, 2016
### Social Risk and Quality Metrics

<table>
<thead>
<tr>
<th>Measure</th>
<th>Difference in Odds of Meeting Quality Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes—Blood Sugar Control</td>
<td>-0.32</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>-0.28</td>
</tr>
<tr>
<td>High-Risk Medication</td>
<td>-0.27</td>
</tr>
<tr>
<td>Annual Flu Vaccine</td>
<td>-0.22</td>
</tr>
<tr>
<td>Osteoporosis Management</td>
<td>-0.21</td>
</tr>
<tr>
<td>Improving Mental Health*</td>
<td>-0.19</td>
</tr>
<tr>
<td>Diabetes—Eye Exam</td>
<td>-0.18</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>-0.18</td>
</tr>
<tr>
<td>Medication Adherence, Hypertension</td>
<td>-0.17</td>
</tr>
<tr>
<td>Medication Adherence, Cholesterol</td>
<td>-0.12</td>
</tr>
<tr>
<td>Controlling Blood Pressure</td>
<td>-0.12</td>
</tr>
<tr>
<td>Rheumatoid Arthritis Management</td>
<td>-0.12</td>
</tr>
<tr>
<td>All-Cause Readmissions*</td>
<td>-0.12</td>
</tr>
<tr>
<td>Medication Adherence, Diabetes</td>
<td>-0.12</td>
</tr>
<tr>
<td>Improving Physical Health*</td>
<td>-0.12</td>
</tr>
<tr>
<td>Diabetes—Kidney Dz Monitoring</td>
<td>-0.07</td>
</tr>
<tr>
<td>Monitoring Physical Activity</td>
<td>-0.02</td>
</tr>
<tr>
<td>BMI Assessment</td>
<td>0.01</td>
</tr>
<tr>
<td>Reducing Risk of Falling</td>
<td>0.75</td>
</tr>
</tbody>
</table>

Dual enrollees had lower odds of meeting 16 measures, similar odds for two, and higher odds for one.
PHYSICIAN-FOCUSED PAYMENT REFORM: IMPACT ON THE SAFETY NET

Chen et al, JAMA 2017
SOCIAL RISK AND COSTS OF CARE

Overall Diabetes Coronary Artery Disease Chronic Obstructive Pulmonary Disease Heart Failure

Dually enrolled Not dually enrolled

ASPE Office of Health Policy, 2016
SO WHERE ARE WE WITH FEDERAL PAYMENT REFORM?

- Suboptimal efficacy
- High likelihood of unintended consequences

What can we learn?
STRATEGIES TO IMPROVE EFFICACY

❖ Match program design to goals
   ▪ Narrow or broad focus?
     • Readmissions program more efficacious than value-based purchasing
     • Data from the UK suggests erosion of gains over time, so rotation might be needed
   ▪ Penalties or bonuses?
     • Standard of care might respond to penalties
     • Innovation might better be driven by bonuses
       • Harness clinicians’ drive to do good and do well

❖ Ensure adequate incentives
   ▪ Unclear what this is for hospitals, clinics, etc.

❖ Focus on addressing the actual problems…
EVIDENCE FOR FINANCIAL INCENTIVES

Did the policy have a large impact on your institution’s efforts to reduce readmissions?

- Public Reporting of Discharge Planning: 15.3%, 25.4%, 28.1%
- Public Reporting of Readmission Rates: 25.1%, 39.0%, 41.9%
- Hospital Readmissions Reduction Program: 58.8%, 67.0%, 70.9%

Proportion Responding that Policy had a “Significant” or “Great” Impact

No penalty, Low Penalty, High Penalty

Joynt et al, AJMC 2016
EVIDENCE FOR FOCUSING ON SOCIAL RISK

- **Call patients 48 hrs after discharge**: 66.4%
- **Schedule follow-up appts**: 68.5%
- **Electronic tools to share D/C summary**: 72.5%
- **Discharge Planner/Coordinator**: 75.2%
- **Electronic tools to reconcile D/C meds**: 77.0%
- **Lack of transportation (to/from appointments)**: 44.6%
- **Lack sufficient staffing to implement programs**: 54.7%
- **Lack financial resources for new programs**: 61.4%
- **Patient mental health or substance abuse disorders**: 69.2%
- **Lack of mental health and substance abuse services**: 73.3%

Proportion Reporting they “Always” or “Usually” employ the strategy

Proportion Reporting Item as a “Great” Challenge

Figueroa et al, Med Care 2017
STRATEGIES TO REDUCE UNINTENDED CONSEQUENCES

- Account for social and medical risk in performance evaluation, where appropriate
  - Risk adjustment – including functional status

- Reward improvement
  - Helps baseline poor performers enter and succeed

- Consider targeted bonuses
  - Rewards only available to clinicians serving vulnerable populations
IMPACT OF MEDICAL AND SOCIAL RISK ADJUSTMENT

For an individual with serious mental illness:

- No risk adjustment
  - Paid: $6,000
  - Costs: $17,000

- Medical risk adjustment
  - Paid: $15,600
  - Costs: $17,000

- Medical and social risk adjustment
  - Paid: $16,500
  - Costs: $17,000

For a Department of Mental Health client:

- No risk adjustment
  - Paid: $6,000
  - Costs: $30,000

- Medical risk adjustment
  - Paid: $17,500
  - Costs: $30,000

- Medical and social risk adjustment
  - Paid: $30,000
  - Costs: $30,000
ACCOUNTABLE CARE COST TARGETS ARE AN IMPROVEMENT MEASURE

All ACOs | High-Dual ACOs | High-Disabled ACOs
---|---|---
No savings: 45.6% | No savings: 37.9% | No savings: 35.0%
Saved, but not enough to share in savings: 28.6% | Saved, but not enough to share in savings: 31.8% | Saved, but not enough to share in savings: 26.9%
Shared Savings: 25.8% | Shared Savings: 30.3% | Shared Savings: 38.1%

ASPE Office of Health Policy 2016
TARGETED BONUSES

- **Pros:** address both access and performance
- **Cons:** if patient factors are powerful enough, few may qualify

![Bar chart showing the proportion of practices under different risk categories and penalty scenarios.](chart)

- **Low Risk:** 76.2% (2.7% penalty, 20.8% bonus)
- **High Medical Risk Only:** 68.0% (1.6% penalty, 30.5% bonus)
- **High Social Risk Only:** 44.1% (2.0% penalty, 52.9% bonus)
- **Both High Social and Medical Risk:** 50.8% (3.3% penalty, 45.9% bonus)

0% performance-based bonus
SUMMARY AND CONCLUSIONS

- Healthcare spending is high, rising, and concentrated in complex, vulnerable patients.
- Payment reform has potential, but efficacy thus far has been modest.
- Must be done with caution, or could hurt the most vulnerable.
QUESTIONS / DISCUSSION