

Reforming Medicare to Better Manage Seniors' Health Care

Statement for the Record

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“Examining Bipartisan Medicare Policies that
Improve Care for Patients with Chronic Conditions”

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Chairman Hatch, Ranking Member Wyden, and committee members, thank you for the opportunity to submit comments about Medicare policies that improve care for patients with chronic conditions. I am Devon M. Herrick, Ph.D., a senior fellow at the National Center for Policy Analysis (NCPA). We are a nonprofit, nonpartisan public policy research organization headquartered in Dallas, Texas.

Not long after Medicare was established in 1965, expenditures began to skyrocket. Whereas spending per Medicare beneficiary was \$385 in 1970, spending per beneficiary increased to \$12,210 annually by 2013.¹

Nearly one-third of health care spending occurs in a hospital. An additional 20 percent is spent on physician services, while 10 percent is spent on drug therapies.² If one considers physician bills while patients are in the hospital, and other associated inpatient costs, a back-of-the-envelope calculation suggests nearly half of health spending occurs while patients are hospitalized, about to be hospitalized and while recuperating after an inpatient stay. It is increasingly clear that controlling costs means keeping chronically-ill seniors out of hospitals. To be effective, efforts to slow the growth in Medicare spending will have to focus on reducing hospital spending on beneficiaries in poor health by better managing their medical conditions.

To Reduce Costs, Focus on Big Spenders. It has long been known that a mere 20 percent of patients consume about 80 percent of health care resources. About 5 percent of patients spend half of health care dollars, while the sickest 1 percent consume nearly one-quarter (22 percent).³

If the sickest 5 percent of patients spend half of health care dollars that means that 95 percent of patients are responsible for the remaining half. Indeed, the healthiest 50 percent of the population only consumes 3 percent of health care dollars. Furthermore, one quarter of Medicare spending is on the 5 percent of beneficiaries who are in their last year of life. These figures suggest there are more opportunities to reduce health care spending by carefully managing the sickest 5 percent rather than wasting effort on the 95 percent who are relatively healthy. A significant portion of the big spenders are Medicare beneficiaries ages 65 to 79.⁴

¹ David Blumenthal, Karen Davis and Stuart Guteman, "Medicare at 50 — Origins and Evolution," *New England Journal of Medicine*, Vol. 372, No. 5, January 29, 2015, pages 479-486.

² "National Health Expenditures 2015 Highlights," Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, undated. Available at: <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads/highlights.pdf>.

³ "The High Concentration of U.S. Health Care Expenditures," Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, Research in Action No. 19, AHRQ Pub. No. 06-0060, June 2006.

⁴ Ibid.

The phrase “continuum of care” is used to describe the diverse settings where medical care is delivered at varying levels of intensity — each with a different expense level. For example, after self-care with over-the-counter drugs, the doctor is the first line of defense against illness in the continuum of care. A patient experiencing chest pains unable to get in to see his or her doctor on short notice may present at the hospital Emergency Department (ED). If the patient’s condition is very serious, they may then be admitted to a hospital intensive care unit (ICU). Once stabilized, the patient moves from the ICU to a standard patient room on an acute care floor of the hospital. As the patient’s condition improves, they may be transferred to a skilled nursing facility to convalesce or to a rehab facility for intensive therapy. Patients who are well enough to leave the hospital but too ill to convalesce at home may be transferred to a nursing home for a few days. Finally, when they are well enough, the patient will leave the nursing home and be sent home under the care of their primary care physician — and possibly provided with periodic home care by a visiting nurse. The continuum of care can involve numerous different settings, each providing a different level of care. The purpose for differing levels of care in the care continuum is to take advantage of efficiencies that exist in one environment compared to another. Care provided in the wrong setting (for example, a hospital stay when home care would have sufficed) is one way the health care system wastes money. However, a problem with having many different silos of care — each with different attending physicians — is that care coordination among providers is often neglected to the detriment of the patient. Coordinated care creates the opportunity to not only improve health status but also, if properly done saves money as well.

Problem: Poor Quality Care Transitions. When a patient’s care shifts from one setting to the next it is often referred to as “care transitions.” In a study of Medicare-age seniors, 22 percent of seniors observed made an average of one care transition per year — usually an admission to a hospital or a discharge from one.⁵ Poorly managed care transitions are very costly. Inadequate care coordination during the transition phase wastes an estimated \$25 billion to \$45 billion annually.⁶ Often, when seniors are discharged from the hospital they are not provided with appropriate post-discharge care. Without appropriate care after leaving the hospital, many get worse and have to be readmitted. This happens to be the case with many patients:⁷

- One-in-five seniors who are discharged from a hospital are readmitted within 30 days.
- More than one-third of Medicare hospital discharges are readmitted within 90 days, while more than half will return within a year.

⁵ Masayo Sato et al., “Residential and Health Care Transition Patterns Among Older Medicare Beneficiaries Over Time,” *The Gerontologist*, Vol. 55, No. 4, August 2015.

⁶ Rachel Burton et al., “Care Transitions,” *Health Affairs*, Health Policy Brief, September 13, 2012. Available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=76.

⁷ Steven F. Jencks, Mark V. Williams and Eric A. Coleman, “Rehospitalizations among Patients in the Medicare Fee-for-Service Program,” *New England Journal of Medicine*, No. 360, No. 14, April 2, 2009, pages 1418-1428.

- About one-in-seven seniors who are discharged from the hospital visit a hospital emergency room within 30 days of discharge; indeed, more than 10 percent of Medicare discharges are readmitted through the emergency department.⁸
- An estimated three-fourths of Medicare readmissions could be prevented with proper transitional care.

The exact cause of unnecessary Medicare hospital readmissions is the subject of much research and intensive debate. Increasingly, hospitals employ physicians trained as hospitalists. Some experts fear the growing use of hospitalists impedes the active participation of Medicare patients' own physicians in hospital rounds, and hampers continuity of care once a senior is discharged from the hospital.⁹ Physicians complain that communication between hospitalists and seniors' primary care providers is poor following hospital stays.¹⁰ During transitions from one care setting to another, seniors' physicians are often not notified and do not receive medical records necessary for follow-up care in a timely manner.¹¹ About half of seniors readmitted within one month did not even see their doctor between their discharge and readmission.¹²

If a Medicare inpatient's own physician was the attending physician, post-discharge care would potentially be more seamless. Yet, doctor-patient communication in general could also use improvement. In one study, three-fourths of physicians did not bother to inform patients when the results of diagnostic tests were normal.¹³ Nearly one-third did not contact patients when results were abnormal. Other studies found that patients did not understand the instructions given to them by their physicians about half the time.¹⁴ The blunt reality is that primary care physicians are generally not paid for their efforts to manage and coordinate the care their patients receive from other providers rendered in non-office settings.

⁸ Keith E. Kocher et al., "Emergency Department Visits After Surgery are Common For Medicare Patients, Suggesting Opportunities To Improve Care," *Health Affairs*, Vol. 32, No. 9, September 2013, pages. 1,600-1,607.

⁹ Hoangmai H. Pham et al., "Hospitalists and Care Transitions: The Divorce of Inpatient and Outpatient Care," *Health Affairs*, Vol. 27, No. 5, September 2008, pages 1,315-1,327.

¹⁰ Christine D. Jones, "A Failure to Communicate: A Qualitative Exploration of Care Coordination Between Hospitalists and Primary Care Providers Around Patient Hospitalizations," *Journal of General Internal Medicine*, Vol. 30, No. 4, April 2015, Volume 30, pages 417-424.

¹¹ Ibid.

¹² Stephen F. Jencks, Mark V. Williams and Eric A. Coleman, "Rehospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, Vol. 360, No. 14, April 2, 2009, pages 1,418-1,428.

¹³ Tejal K. Gandhi, "Fumbled Handoffs: One Dropped Ball after Another," *Annals of Internal Medicine*, Vol. 142, No. 5, March 2005, pages 352-358.

¹⁴ Debra L. Roter, Judith A. Hall, "Studies of Doctor-Patient Interaction," *Annual Review of Public Health*, Vol. 10, 1989, pages 163-180. Also see Dean Schillinger et al., "Closing the Loop: Physician Communication with Diabetic Patients Who Have Low Health Literacy," *Archives of Internal Medicine*, Vol. 163, No. 1, January 2003, pages 83-90.

Medical Homes and Care Coordinators. A medical home that coordinates care is an invaluable resource to seniors. For instance, a medical home coordinates care before, during and after the critical care transitions between a hospital and the follow up care post-discharge. A coordinator could advise seniors on lower-cost health care settings, evaluate the need for home care, and ensure seniors receive follow-up care and comply with drug therapy.

Consider the earlier example of a senior experiencing chest pains, but assume the symptoms are nausea that sometimes accompanies a heart attack. A call coordinator could advise the senior whether to immediately seek care at a hospital emergency department or a free-standing emergency room clinic. Depending on the symptoms, an urgent care clinic may be both more convenient and less expensive. If a condition does not warrant immediate care, a possible alternative to urgent care (or emergency care) is a retail clinic. A care coordinator might dispatch a nurse practitioner (or physician) in a van, or even assure a patient that waiting for an appointment with the affiliated primary care provider is more appropriate.

The setting where care is received matters. Hospital EDs are far more costly — and less convenient — than care received in other settings.¹⁵ Furthermore, about 15 percent of people who present to a hospital ED are admitted to the hospital.¹⁶ The corresponding admission rate for patients visiting free-standing ERs is only 4 percent or 5 percent.¹⁷ This may partly be due to self-selection; individuals who perceive their condition as extremely serious may purposefully choose a hospital ED rather than a free-standing ER. However, it could also be due to hospitals' desire to fill patient beds.

According to one study, nearly 60 percent of Medicare ED visits resulted in a hospital admission in 2010.¹⁸ ED visits account for approximately 2 percent of Medicare expenditures.¹⁹ Sometimes seniors are admitted unnecessarily or merely for observation. When seniors are put in the hospital under “observation care” but not officially “admitted,” their cost-sharing is often

¹⁵ Elayne J. Heisler and Nancy Leigh Tyler, “Hospital-Based Emergency Departments: Background and Policy Considerations,” Congressional Research Service, December 8, 2014.

¹⁶ Derek DeLia and Joel Cantor, *Emergency Department Utilization and Capacity* (Robert Wood Johnson Foundation, 2009).

¹⁷ Mike Williams and Michael Pfeffer, “Freestanding Emergency Departments: Do They Have a Role in California?” California HealthCare Foundation, Issue Brief, 2009.

¹⁸ Centers for Disease Control and Prevention, *Ambulatory Health Care Data: National Ambulatory Medicare Care Survey*, National Hospital Ambulatory Medicare Care Survey: 2010 Emergency Department Summary Tables, Hyattsville, MD, February 24, 2014, pages 6-7. Available at http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2010_ed_web_tables.pdf.

¹⁹ Jeffrey M. Gonzalez, *National Health Care Expenses in the U.S. Civilian Noninstitutionalized Population, 2011*, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Statistical Brief No 425, November 2013. Available at http://meps.ahrq.gov/mepsweb/data_files/publications/st425/stat425.pdf.

high.²⁰ In some cases, emergency room doctors have complained about being pressured by hospital executives to admit patients, or being given a quota and told that a fixed percentage of emergency room patients should be admitted.²¹ Inpatient admissions are where hospitals earn the bulk of their revenue. Thus, emergency room physicians are looking for criteria to justify admissions; they are not looking for solutions to avoid costly hospital stays.

Hospital prices are often many multiples of prices for procedures performed in other settings. A care coordinator could easily advise seniors needing an MRI or a CT scan which imaging centers offer high quality at lower prices. Diagnostic imaging procedures at free-standing radiology clinics are often only \$250 to \$300 (Medicare's price). The price at a hospital outpatient department would be much higher.

Physician Network Management. When Americans access the U.S. health care system, they typically seek the guidance of a gatekeeper — otherwise known as a licensed physician. The average Medicare beneficiary sees two primary care doctors and five specialists per year.²²

Seniors living with multiple chronic conditions may see more than a dozen different doctors.²³ About 90 percent of all seniors take a prescription drug in any given year.²⁴ Seniors with chronic ailments may take a dozen drugs or more on a daily basis. With the exception of over-the-counter drugs, patients must first consult with a doctor before beginning drug therapy, and often before refilling a prescription.

Just about everything that occurs within the continuum of care requires the authorization of a physician.²⁵ With few exceptions, health plans do not employ doctors directly. Insurers increasingly partner with physicians to provide the actual care and coordinate the care of other

²⁰ Susan Jaffe, "Medicare covers less when a hospital stay is an observation, not an admission," *Washington Post*, September 8, 2014.

²¹ "Hospitals: The cost of admission," 60 Minutes, CBS News, December 3, 2012 . Available at <http://www.cbsnews.com/news/hospitals-the-cost-of-admission-03-12-2012/>. Also see Bob Herman, "HMA: '60 Minutes Report Relied on Disgruntled Former Employees,'" *Becker's Hospital Review*, December 3, 2012

²² Thomas Bodenheimer, "Coordinating Care — A Perilous Journey through the Health Care System," *New England Journal of Medicine*, Vol. 358, No. 10, March 6, 2008.

²³ Hoangmai H. Pham et al., "Care Patterns in Medicare and Their Implications for Pay for Performance," *New England Journal of Medicine*, Vol. 356, No 11, 2007, pages 1,130-1,139

²⁴ Agency for Healthcare Research and Quality, "Prescription Medicines-Mean and Median Expenses per Person with Expense and Distribution of Expenses by Source of Payment: United States, 2010," Medical Expenditure Panel Survey Household Component Data. Available at <http://goo.gl/D0eNvT>.

²⁵ Nicholas Bonvicino and James Doulgeris, "High-performing Physician Networks: The Ideal ACO," *Physicians Practice*, blog, January 17, 2013. Available at <http://www.physicianspractice.com/blog/high-performing-physician-networks-ideal-aco>.

providers. Partnering with a well-managed physician network is the key to coordinating care, increasing quality of care and controlling costs.²⁶

Physician network managers are discovering physicians have value far beyond providing direct, primary care. Doctors can also be valuable in managing the cost and improving the health of Medicare populations. Physician networks can offer medical homes with a strong patient-provider relationship and a system of patient communication, significant training, support and care coordination.²⁷

Chronic Disease Management. To revisit a point made earlier, the sickest 5 percent of the population consumes nearly half of all medical care, while the sickest 1 percent accounts for nearly one-fourth of medical spending. Three chronic conditions account for 20 percent of total health expenditures: heart disease, pulmonary conditions and mental disorders. Spending is especially concentrated among chronically ill Medicare beneficiaries.²⁸ Successful efforts to improve health and reduce costs necessarily must focus on the big spenders — those with multiple chronic conditions.

There are also numerous other conditions that could be better managed to reduce costly interventions. According to CMS, more than half of beneficiaries in fee-for-service Medicare have high blood pressure, while nearly that many have high cholesterol. Nearly one-third have ischemic heart disease, while 6 percent are suffering from heart failure. More than one-fourth have diabetes, and a similar number have arthritis.²⁹

Many beneficiaries using traditional, fee-for-service Medicare have multiple chronic conditions:³⁰

- One-third of enrollees in fee-for-service Medicare have two or three chronic conditions.
- Nearly one-fourth have four or five chronic conditions.
- Fourteen percent have six or more.

As the number of chronic conditions rises, so does the likelihood of being admitted to a hospital during the year. Having multiple chronic conditions also boosts the likelihood of an ER

²⁶ Ibid.

²⁷ Ibid.

²⁸ “The High Concentration of U.S. Health Care Expenditures,” A gency for Healthcare Research and Quality, U.S. Department of Health and Human Services, Research in Action No. 19, AHRQ Pub. No. 06-0060, June 2006.

²⁹ “Chronic Conditions among Medicare Beneficiaries,” Chartbook: 2012 Edition, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, 2012

³⁰ Ibid.

visit, and a readmission.³¹ Medicare spending also rises as a function of the number of an enrollee's chronic conditions. Thus:

- More than one-third of beneficiaries in fee-for-service Medicare suffer from four or more chronic conditions. These individuals account for 90 percent of Medicare hospital readmissions, and three-quarters of total Medicare spending.
- Medicare fee-for-service enrollees with four to five chronic conditions spend 25 percent more than average.
- Those in fee-for-service Medicare with six or more conditions spend 235 percent more than average.³²

Conclusion

There are opportunities to reduce the growth in Medicare spending by carefully managing care for the sickest seniors. Increasingly, Medicare needs to use some of the other tools employed by private health plans. These include medical homes, care coordination and utilization management that rewards Medicare plans when they boost quality and lower costs.

Thank you for the opportunity to submit these written comments.

³¹ Ibid.

³² Ibid.