

Reforming Medicare to Better Manage Seniors' Health Care

Policy Report No. 374

by Devon M. Herrick

October 2015

Medicare reform requires empowering seniors to manage more of their own health care spending using Medicare Health Savings Accounts (HSAs) coupled with high-deductible Medicare plans. A criticism of HSAs is that hospitalized patients have long since exceeded their deductibles.



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Executive Summary

In addition, patients who are desperately ill are unlikely to forgo a potentially beneficial medical service merely because they bear a portion of the marginal cost. However, these arguments are easily addressed with better incentives and better plan design in the Medicare program.

About 5 percent of patients spend half of all health care dollars, while the sickest 1 percent consume nearly one-quarter (22 percent) of health care expenditures. These figures suggest there are more opportunities to reduce health care spending by carefully managing the sickest 5 percent instead of wasting effort on the 95 percent who are relatively healthy. 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 chronic conditions. Increasingly, controlling costs means keeping people out of hospitals, where nearly one-third of health care spending occurs.

Continuum of Care refers to the diverse settings where medical care is delivered at varying levels of intensity — each with a different cost structure. The purpose of the continuum of care is to exploit efficiencies in one care 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 not only creates opportunities to improve treatment outcomes, if done properly it also saves money.

Care Transitions refers to changes that occur when a patients' care shifts from one setting to the next. Poorly managed care transitions are very costly. 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 within days. Thus:

- 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.
- More than half of discharged seniors will return within a year; an estimated three-fourths of Medicare readmissions could be prevented with proper transition care.

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Integrated Health Plans, such as Medicare Advantage, have the infrastructure to share information across multiple care providers. Health plans that are financially at-risk for the cost of their enrollees' care also have incentives to track care more closely. Some of these health plans are choosing to become Accountable Care Organizations.

Accountable Care Organizations (ACOs) are voluntary partnerships of doctors, hospitals, health plans and other stakeholders that aim to better manage patient care. Although the concept was not new, the Affordable Care Act created pilot projects with incentives for stakeholders to establish Medicare ACOs. A complaint often voiced by ACO administrators is they do not know or exercise any control over who their members are. Nor do they control which providers their members see. The Centers for Medicare and Medicaid Services (CMS) assigns members retrospectively at year-end. This makes it difficult to develop outreach programs to identify at-risk members with chronic diseases. Retrospective assignment also discourages investment in chronic disease management, since the costs are borne by one ACO while the benefits may ultimately accrue to another ACO. This needs to change. Where ACOs are working well, they are partnering with physicians to coordinate care and manage high cost chronic conditions through a patient-centered medical home.

Medical Homes that coordinate Medicare patients' care are 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 followup care post-discharge. A coordinator could advise seniors on lower-cost health care settings, evaluate the need for home care and ensure seniors receive post-hospital followup care and comply with drug therapy instructions. The setting where care is received matters. Hospital prices are often many multiples of procedures performed in other settings. An ACO providing a medical home could also advise seniors on where to find cost-

effective services and whether they need a specialists and which specialists to see.

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. Doctors are a necessary partner to improving health and reducing spending. Partnering with a well-managed physician network is the key to coordinating care, increasing quality and controlling costs. Physician networks can provide medical homes with a strong patient-provider relationship and a system of patient communication, significant training, support and care coordination.

Utilization Management. The term “cookbook medicine” is sometimes used derisively to describe any system of checks and balances that constrains physicians' prerogatives when delivering care to their patients. Used correctly, case management is a way to bring together all members of the medical team to discuss specific care plans and treatment goals for each patient. Utilization management is designed to provide the “appropriate” care, not to limit or ration care.

Not long after Medicare was established in 1965, expenditures began to skyrocket. Whereas spending per Medicare beneficiary was \$385 in 1970, spending per beneficiary today is \$12,430 annually. This cost is not spread evenly among all beneficiaries. Spending is especially concentrated among chronically-ill Medicare beneficiaries. 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. Providers who reduce costs and increase quality should also be rewarded. Those who perform poorly need to suffer the consequences.

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Introduction

Medicare reform requires empowering seniors to manage more of their own health care spending using Medicare Health Savings Accounts (HSAs) coupled with high-deductible Medicare plans. A criticism of HSAs, high-deductible plans and other forms of cost-sharing is that they disproportionately affect those with the highest health costs. Another argument is that cost-sharing is not likely to be effective as a significant cost-control mechanism; people who are in the hospital exercise little control over their own care. Hospitalized patients have long since exceeded their deductibles. In addition, patients who are desperately ill are unlikely to forgo a potentially beneficial medical service merely because they bear a portion of the marginal costs. However, these arguments are easily addressed with better incentives and better Medicare plan design.

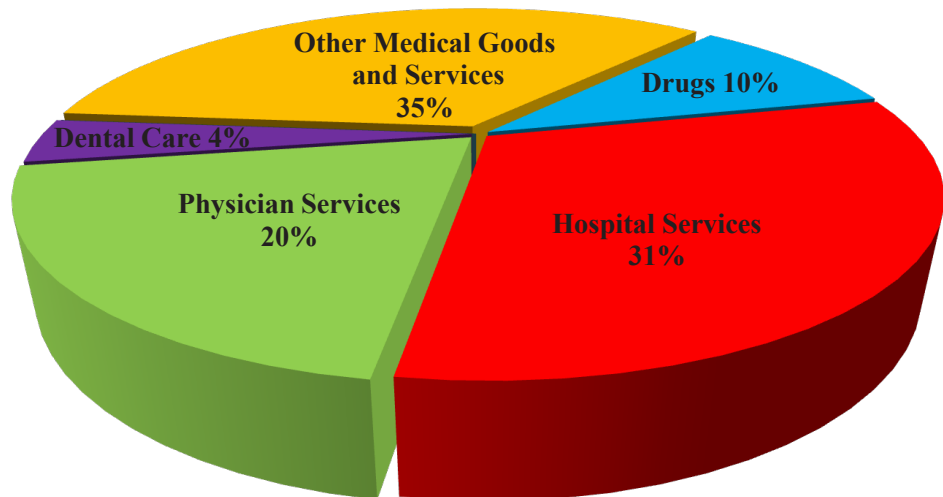
Nearly one-third of health care spending (31 percent) occurs in a hospital. An additional 20 percent is spent on physician services, while 10 percent is spent on drug therapies. [See Figure I.] If one considers physician bills while patients are in the hospital, and other associated inpatient costs, 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 people 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).¹ [See Figure II.]

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 79.²

Challenge: Health Care on Many Different Levels. The phrase “continuum of care” is used to describe the diverse settings where medical care is delivered at

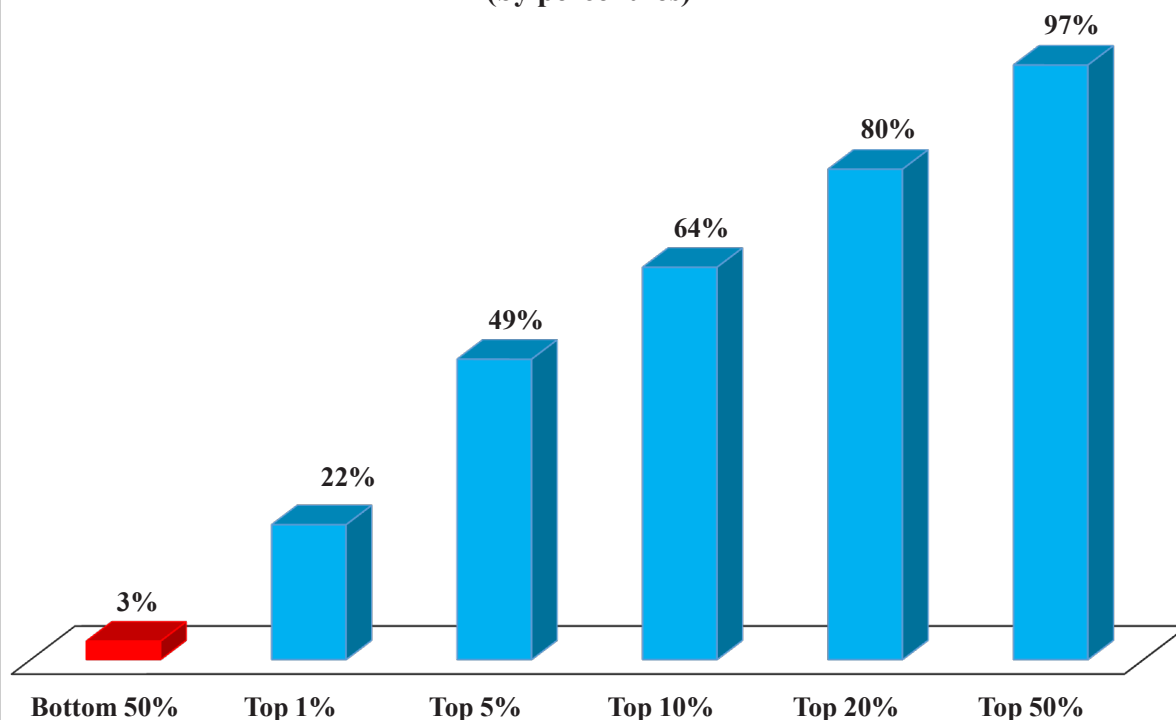
Figure I
Drug Spending as a Proportion of All Health Care Expenditure (2012)



Source: "National Health Expenditures by Type of Service and Source of Funds, CY 1960-2012," Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, page last modified January 7, 2013. Available at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE201.zip>.

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Figure II
Percent of Total U.S. Health Care Spending
(by percentiles)



“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.

In the example, the continuum of care involves seven 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

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. [See Figure III.]

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.

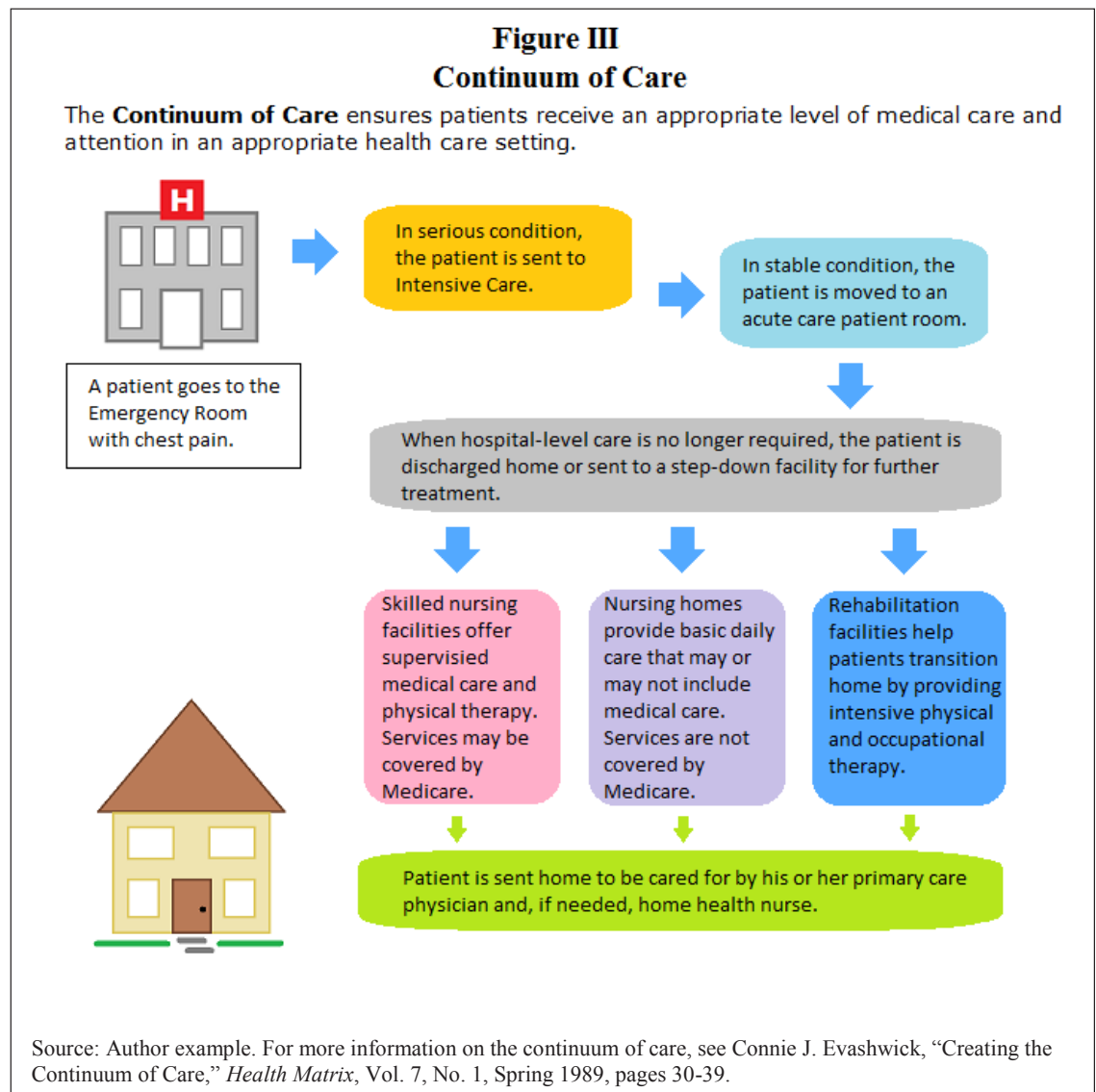
Problem: Poor Quality Care Transitions. When a patient’s care shifts from one setting to the next it is often referred to as “care transitions.” In a study of Medicare-age seniors, 22 percent of seniors observed made an average of one care transition per year — usually an admission to a hospital or a discharge from one.³ Poorly managed care transitions are very costly. Inadequate care coordination during the transition phase wastes an estimated \$25 billion to \$45 billion annually.⁴ 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 [see Figure IV]:

- 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.
- 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.⁵

- An estimated three-fourths of Medicare readmissions could be prevented with proper transitional care.

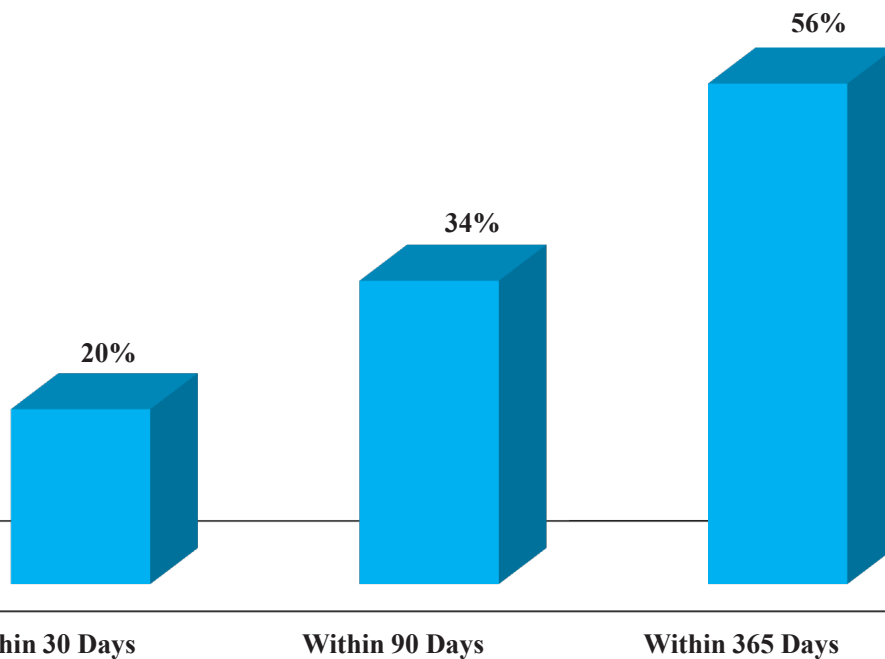
The exact cause of unnecessary Medicare hospital readmissions is the subject of much research and intensive debate. Increasingly, hospitals employ physicians trained as hospitalists. Some experts fear the growing use of hospitalists impedes the active participation of Medicare patients' own physicians in hospital rounds, and hampers continuity of care once a senior is discharged from the hospital.⁶ Physicians complain that communication between hospitalists and seniors' primary care providers is poor following hospital stays.⁷ 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.⁸ About half of seniors readmitted within one month did not even see their doctor between their discharge and readmission.⁹

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.¹⁰ 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.¹¹ The blunt reality is that primary care physicians are generally not

Figure IV
Readmission after Discharge from Hospital
(percent within number of days)



Source: 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*, Vol. 360, No. 14, April 2, 2009, pages 1418-1428.

paid for their efforts to manage and coordinate the care their patients receive from other providers rendered in non-office settings.

Integrated Medicare Plans. Integrated health plans, such as Medicare Advantage, already have the infrastructure necessary to share information across multiple care providers. Health plans that are financially at-risk for the cost of their enrollees' care also have an incentive to track care more closely. This incentive suggests integrated health systems should provide care that is both better coordinated and of higher quality than unintegrated networks of dispersed physician practices — as is often the case with fee-for-service Medicare.¹²

Lack of care coordination is the reason many public health experts hoped electronic medical records would solve the problems caused by poor care coordination. The idea is that diverse providers would have access to medical records of lab tests and diagnostic images performed at other institutions, reducing redundant and unnecessary medical services. As good as this concept sounds, hospitals and other providers who

earn revenue from medical services and diagnostic testing are unlikely to implement technology that does not help their bottom line.¹³ What some experts point to as resources wasted on redundant, unnecessary medical services is what the providers who perform those services refer to as revenue!

Pay for performance initiatives were created to reward doctors for working together to cut waste and improve outcomes. However, having multiple uncoordinated

physicians in fee-for-service settings limits the effectiveness of pay-for-performance initiatives.¹⁴

Providing Accountable Care. Accountable Care Organizations are the latest attempt to bridge the gap and reward doctors for taking the time to coordinate their patients' care. According to the Centers for Medicare and Medicaid Services:¹⁵

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

ACOs are voluntary partnerships of doctors, hospitals, health plans and other stakeholders. Although the concept was not new, the Affordable Care Act created pilot projects with incentives for stakeholders to establish Medicare ACOs. Some ACOs are sponsored by health plans, while others are sponsored by hospitals. Yet, ACOs don't recruit their members — they are assigned members. Furthermore, seniors don't explicitly join an ACO. Rather, they seek care at their provider of choice and are retrospectively assigned to an ACO based on which ACO-affiliated providers they received care from. There are two primary approaches to assigning members to ACOs. These are *prospective attribution* and *performance year attribution*. Both have advantages and disadvantages.

Prospective attribution is the term for when an ACO is provided with a list of members assigned to it that the ACO will be held responsible for in the coming year. Membership assignment is a function of where Medicare beneficiaries used care the previous year. Thus, seniors themselves reveal their preference for the ACO they wish to join by using that provider the prior year. ACO administrators overwhelmingly prefer this method of member assignment because it allows them to focus their efforts on better coordination of only their members' care.¹⁶

Performance year attribution is used to describe a system where members are assigned to an ACO retrospectively based on actual care received during the current year. Under this system, ACOs are not credited (or penalized) for patients who move away or voluntarily change providers and receive care elsewhere, possibly at a different ACO.¹⁷ Because members are not assigned prospectively, ACOs are not sure who to focus their efforts on. Moreover, a senior assigned to an ACO based on current use, but who also receives unnecessary services outside the ACO, will detract from the ACO's shared savings score.

A hybrid approach CMS elected to use preliminarily assigns members to an ACO based on where seniors received care the prior year. ACOs are notified about their presumed members. However, actual members are assigned retrospectively at the end of the year.¹⁸ Keep in mind, seniors can self-select where they seek care; they are also unaware of the actual ACO to which they are assigned. There are no limits on the care they receive, who they receive it from or incentives to cooperate

with their care coordinator at the ACO to which they will retrospectively be assigned. This method does not appear to be the “best of both worlds.”

How to Improve ACOs. A bone of contention often voiced by ACO administrators is they do not know or exercise any control over who their members are. Nor do they control which providers their members see. CMS assigns members retrospectively at year-end. This makes it difficult to develop outreach programs to identify at-risk members with chronic diseases.¹⁹ Retrospective assignment also discourages investment in chronic disease management, since the costs are borne by one ACO while the benefits may ultimately accrue to another ACO (or no ACO). ACOs are rewarded (and penalized) for how well (or poorly) they coordinate their members' care — even though a member has little incentive to cooperate with them.

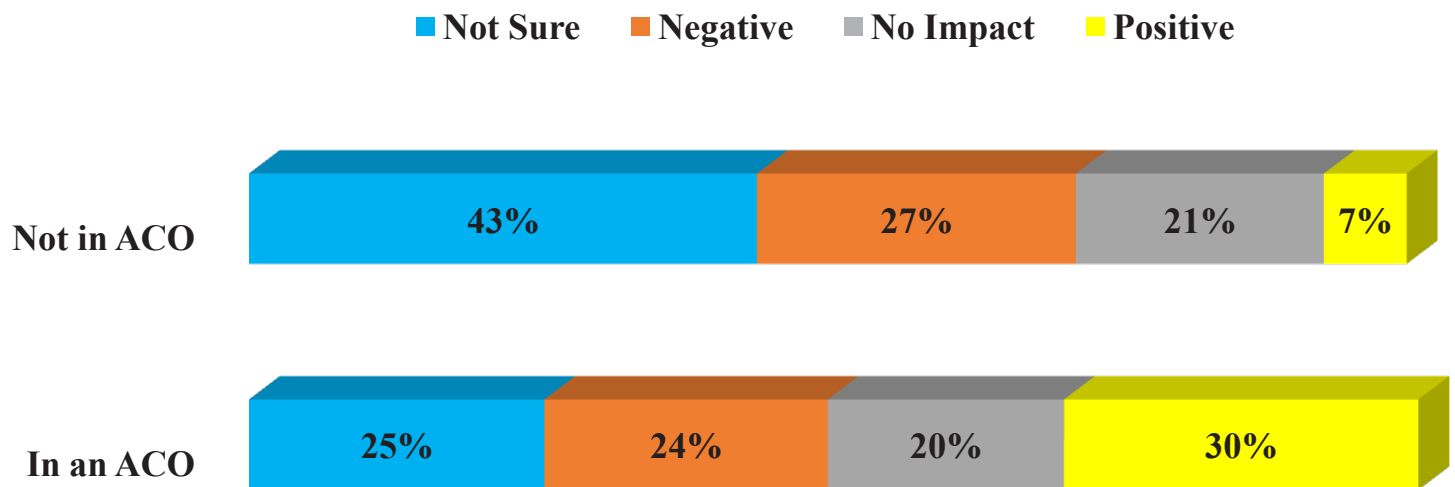
Physicians and hospitals have very diverse views of ACOs. In a survey of both ACO-affiliated and non-ACO physicians, 85 percent of physicians either expressed indifference, viewed ACOs negatively or thought ACOs had no impact on primary care providers' ability to deliver high quality care. Among physicians affiliated with an ACO, more than two-thirds (69 percent) shared that view. [See Figure V.]

Where ACOs are working well, they are partnering with physicians to coordinate care and manage high cost chronic conditions.

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 followup 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

Figure V
Physicians Attitudes Towards Accountable Care Organizations



Survey question: Do you think the increased use of accountable care organizations (ACOs) is having a positive, negative or no impact on primary care providers' ability to provide quality care to their patients?

Source: Commonwealth Fund/Kaiser Family Foundation 2015 National Survey of Primary Care Providers.

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.²⁰ Furthermore, about 15 percent of people who present to a hospital ED are admitted to the hospital.²¹ The corresponding admission rate for patients visiting free-standing ERs is only 4 percent or 5 percent.²² 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 2010.²³ ED visits account for approximately 2 percent of Medicare expenditures.²⁴ 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 high.²⁵ 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.²⁶ 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. An ACO providing

a medical home could also advise seniors on where to find cost-effective services and whether they need specialists and which specialists to see.

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.²⁷ Seniors living with multiple chronic conditions may see more than a dozen different doctors.²⁸ 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. More than 60 percent of Americans take a prescription drug in any given year, including 90 percent of all seniors.²⁹ Seniors with chronic ailments may take a dozen drugs or more on a daily basis. Depending on the state in which they reside, they may be required to have a doctor’s order to obtain routine tests of blood chemistry or laboratory tests to assess common metrics of their health status. Even in direct access states, such as Arizona, seniors are mostly powerless to act on any problems they find in laboratory test results without seeing a physician. In most states, a physician must order diagnostic images before a patient can obtain the service. Furthermore, only a licensed physician can admit patients to a hospital and generally must sign off and approve their discharge. Thus, doctors are a necessary partner to improving health and reducing spending.

Insurers attempt to create the appropriate incentives for enrollees to police their own spending using cost-sharing. Insurers should not neglect to give medical providers the appropriate incentives for high quality medical care at the lowest possible cost. Physicians don’t always have incentives that are aligned with insurers; physicians’ incentives are often at odds with those of the health plan reimbursing physicians’ fees. Yet, everything that occurs within the continuum of care requires the authorization of a physician.³⁰ With few exceptions, health plans do not employ doctors directly. Insurers must partner with physicians to provide the actual care and coordinate the care of other providers. Partnering with a well-managed physician network is the key to coordinating care, increasing quality of care and controlling costs.³¹

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.³²

Utilization Review and Case Management. The term “cookbook medicine” is sometimes used derisively to describe any system of checks and balances that constrains physicians’ prerogatives when delivering care to their patients. Used correctly, case management is a way to bring together all members of the medical team to discuss specific care plans and treatment goals for each patient. Utilization management is designed to provide “appropriate” care, not to limit or ration care.³³ Case management often includes decision-support software to assist the medical team and inform them on evidence-based protocols under specific conditions.³⁴

A recent analysis by Atul Gawande, a surgeon and professor at the Harvard School of Public Health, compared Medicare spending in two Texas cities, McAllen and El Paso. Medicare inpatient hospital spending and spending on Medicare Part B (professional services) were nearly two-thirds higher in McAllen than El Paso, while outpatient care spending was one-third higher in McAllen. Medicare spending on home care was nearly five times higher in McAllen.³⁵ This huge variation in two similar cities, both on the Texas border with Mexico, was hard to explain. In response to Gawande’s analysis, other researchers published a related analysis in the journal *Health Affairs*. Rather than Medicare spending, the *Health Affairs* article compared private health insurance plan spending on individuals under age 65 living in McAllen and El Paso. Their study found medical expenditures were very similar in both cities. What explains the difference? Medicare does not use utilization management to any degree, while private insurers do.³⁶ Better case management resulted in better cost control, without compromising quality.

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.³⁷ 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.³⁸

Many beneficiaries using traditional, fee-for-service Medicare have multiple chronic conditions:³⁹

- 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 visit, and a readmission.⁴⁰

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.⁴¹

Not long after Medicare was established in 1965, expenditures began to skyrocket. Whereas spending per Medicare beneficiary was \$385 in 1970, spending per beneficiary today is \$12,430 annually.

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. Accountable Care Organizations are Medicare's latest attempt to reward doctors for taking the time to coordinate patients' care. But ACOs could be far better. Providers who reduce costs and increase quality should be rewarded. Those who perform poorly need to suffer the consequences.

Notes

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