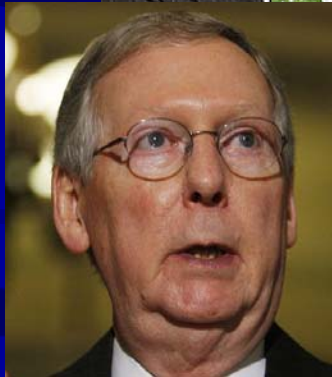


# Readmissions and the Politics of Health Reform



By Susan Dentzer  
Editor-in-Chief, *Health Affairs*  
The Third National Medicare Readmissions Summit  
June 14, 2011

# This presentation at a glance

- Readmissions and the politics of health reform – on different tracks
- Readmissions (rehospitalizations) as a legacy issue
- Emerging Innovation models
- The Politics of Reform -- briefly

# Once upon a time in America...

- We thought about admissions, not so much readmissions
- Much disease acute
- Long lengths of stay (LOS) were the norm
- President Eisenhower and his 1955 heart attack; was hospitalized for 7 weeks
- Cost-based “reimbursement”

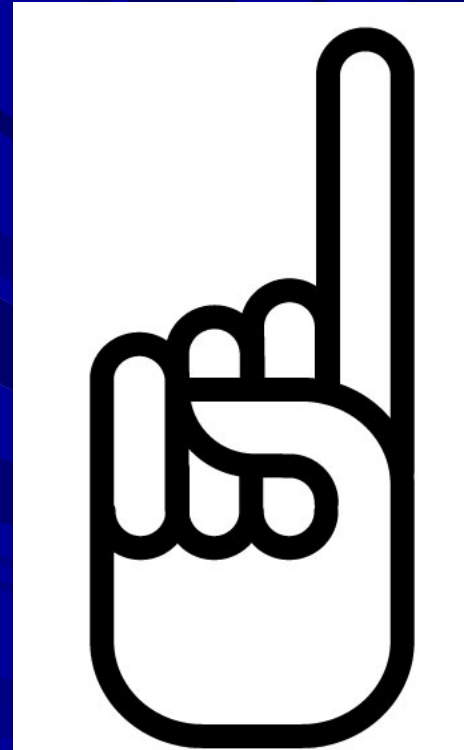


# Then, times changed....

- Medical technology improved, so interventions worked
- People survived acute illness and went on to develop chronic disease; chronic illness now accounts for 75% of US health spending
- System shifted from cost-based reimbursement for hospital care to prospective payment/DRGs
- LOS fell and relatively rapid discharges became the norm
- Health-care delivery system remained siloed and fragmented, so that there was little integration between hospital care and care in the community
- Other issues, including poor medication adherence
- “Readmissions” result

# Trends in Hospital Spending

- 1980: \$100.5 billion
- 1990: \$250.4 billion
- 2000: \$415.5 billion
- 2005: \$606.5 billion
- 2006: \$648.3 billion
- 2007: \$686.8 billion
- 2008: \$722.1 billion
- **2009: \$759.1 billion out of \$2.4683 trillion in total  
National Health Expenditures = 32.5%**



Source: "Recession Contributes To Slowest Annual Rate Of Increase In Health Spending In Five Decades." Anne Martin et al, National Health Expenditures Accounts Team, *Health Affairs*, Jan 2011, vol. 1, pp. 11-22.

**The readmissions “problem” is the legacy of these huge systemic changes and non-adaptations**

# Reducing avoidable readmissions

- In an analysis of 2003–2004 Medicare claims data, 20% of hospitalized patients were re-hospitalized within 30 days after discharge.
- 34% readmitted within 90 days
- Nearly half of the Medicare patients who are rehospitalized within 30 days did not have a physician visit between the time of discharge and readmission.

■ Source: Jencks S.F., Williams M.V., Coleman E.A.  
N Engl J Med 2009; 360:1418 - 1428



# The paradox and perverse incentives of readmissions

- Patients and their families would probably prefer not to undergo them
- Hospitals make money from them
- For society, they cost more and costs are probably underestimated



# “Still Crossing the Quality Chasm”

- April 2011 issue of *Health Affairs*
- Much progress; much remains to be done
- Success of some major initiatives – e.g., on bloodstream infections
- Adverse events in hospitals substantially more numerous than we thought



# ***Health Affairs Study Cited***

- **“Global Trigger Tool Shows That Adverse Events in Hospitals May Be Ten Times Greater Than Previously Measured,” by David C. Classen et al**
- **Exhaustive medical record review of 795 patient records at 3 unidentified tertiary care hospitals with advanced patient safety programs, during October 2004**
- **Showed adverse events occurred in 1 in 3 admissions**
- **Medication-related errors and events related to surgeries and procedures were those with greatest severity level**
- **Source: *Health Affairs* 30, No. 4 (2011): 581-589**

**Now, a fork in the road**



# Fork in the Road

## ■ Down one route:

- Stick largely with the current payment (FFS-PPS) and delivery (fragmented) systems
- Try to hammer preventable admissions out of them; figure out some way to compensate hospitals for lost revenue (e.g., “shared savings”)

## ■ Down the other route:

- Move to more integrated delivery systems and new payment (population-based, modified capitation)
- Put the reengineered systems in charge of weeding out preventable readmissions

# Fork #1 Tools

- Readmissions program
- Value-based purchasing
- Medical homes
- Community-based care transitions program
- Federal coordinated care office to better coordinate care of dual eligibles
- Medicare Shared Savings Program

# Medicare Shared Savings Program

- **Notice of Proposed Rulemaking (proposed regulations) published 3/31/11**
- **Two basic models or “on-ramps”**
- **“One-sided” option: ACOs not responsible for costs above expenditure target for the first two years; receive lower share of the savings compared to ACOs choosing two- sided option.**
- **Two-sided option: ACOs share in savings and risk liability for losses beginning in the first performance year. One-sided ACOs will be automatically converted to two-sided ACOs in the third year of the agreement.**

# Fork # 2 Tools

- **Accountable care organizations – Pioneer program version**
- **Fact that, if any pilots or tests (including ACO program) achieves stated goals of improving or not reducing quality and reducing spending, Secretary can expand across entire Medicare program**



# Community-based Care Transitions Program

- **Mandated by section 3026 of ACA; unveiled as Part of Partnership for Patients**
- **Goal: Improve transitions of beneficiaries from inpatient to other care settings; improve quality of care; reduce readmissions; document savings to Medicare**
- **Eligible entities = hospitals with high readmission rates (e.g., above 20% for AMI and above 27% for heart failure)**
- **Hospitals must partner with community-based organizations that provide care transition services**

# **Multi-Payer Advanced Primary Care Practice Demonstration**

- **8 states now participating**
- **Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota**
- **Demonstration will ultimately include up to approximately 1,200 medical homes serving up to one million Medicare beneficiaries**
- **Health professionals to receive “more coordinated” payment from Medicare, Medicaid and private health plans**

# Medicaid “Health Homes”

- **New State plan option allows patients enrolled in Medicaid with at least two chronic conditions to designate a provider as a “health home” to help coordinate treatments for the patient**
- **States that implement will receive enhanced financial resources from the federal government to support “health homes” in their Medicaid programs**
- **The Innovation Center to assist with learning, technical assistance and evaluation activities**

# Reducing avoidable readmissions

- Under Affordable Care Act, beginning in FY 2013, PPS hospitals with higher-than-expected readmissions rates will experience decreased Medicare payments
- In FY 2013, the reduction cannot be greater than 1 percent. In FY 2014, it cannot be larger than 2 percent, and in FY 2015 and beyond, it cannot be greater than 3 percent.
- Hospital performance will be evaluated based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay-for-reporting program and reported on Hospital Compare
- The ACA requires the Centers for Medicare & Medicaid Services to modify the measures to exclude planned readmissions, as well readmissions that are unrelated to the first admission
- CMS Office of the Actuary (OAct) projects that this provision, when fully implemented, will reduce Medicare costs by \$8.2 billion from implementation through 2019.
- CMS has not indicated when it will publish proposed rule

# Value-based Purchasing-Hospitals

- Required by Congress under Section 1886(o) of the Social Security Act
- Would apply beginning in FY 2013 to payments for discharges occurring on or after October 1, 2012
- Would make value-based incentive payments to acute care hospitals, based either on how well the hospitals perform on certain quality measures or how much the hospitals' performance improves on certain quality measures from their performance during a baseline period
- 70% of Total Performance Score based on Clinical Process of Care measures; 30% of Total Performance Score based on Patient Experience of Care measures
- CMS issued a notice of proposed rulemaking on January 13, 2011; accepted public comments on the proposed rule through March 8, 2011
- For more information, see [http://www.cms.gov/HospitalQualityInits/downloads/0210\\_Slides.pdf](http://www.cms.gov/HospitalQualityInits/downloads/0210_Slides.pdf)

# State Demonstrations to Integrate Care for Dual Eligible Individuals

- Dual eligibles = approximately 9 million; account for about \$300 billion annually in Medicare and Medicaid spending
- In Medicaid, duals = 15% of enrollment but account for 39% of costs
- 15 states awarded contracts of up to \$1 million to support development of new integrated care models that can be rapidly tested and, upon successful demonstration, replicated in other states.
- Aimed at improving care quality, care coordination, cost-effectiveness and overall experience of beneficiaries eligible for both Medicare and Medicaid and CHIP
- States selected: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, Wisconsin.

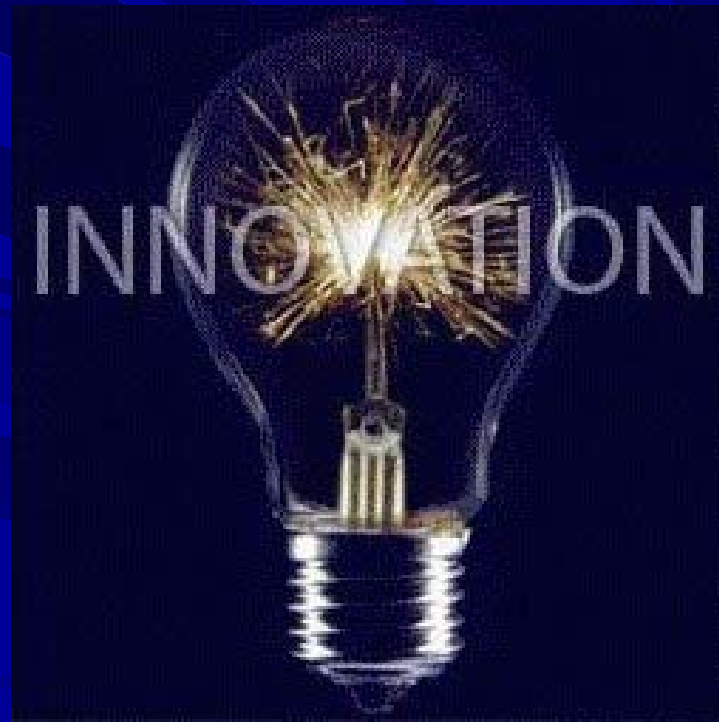


# Comparable Actions, Private Sector

- **WellPoint:** In recent years, has raised payments to hospitals in 14 states that serve its Blue Cross Blue Shield plans, which cover 34 million people, by an average 8%
- **Replacing with pay-for-value system**
- **Will pay increases only to hospitals that score high enough on 51 indicators**
- **Include whether hospital is working to prevent unnecessary readmissions, follows surgical safety checklist ; patients satisfaction (CAHPS)**



# Innovations Under Way



# What Participants Said

- **From government: Make Medicare claims data available in real time**
- **Give providers data on “attributable” patients**
- **Support expansion of infrastructure – e.g., HIT**
- **From themselves: Time for them to “get outside the building” and form relationships with others in community who promote health and deliver care**

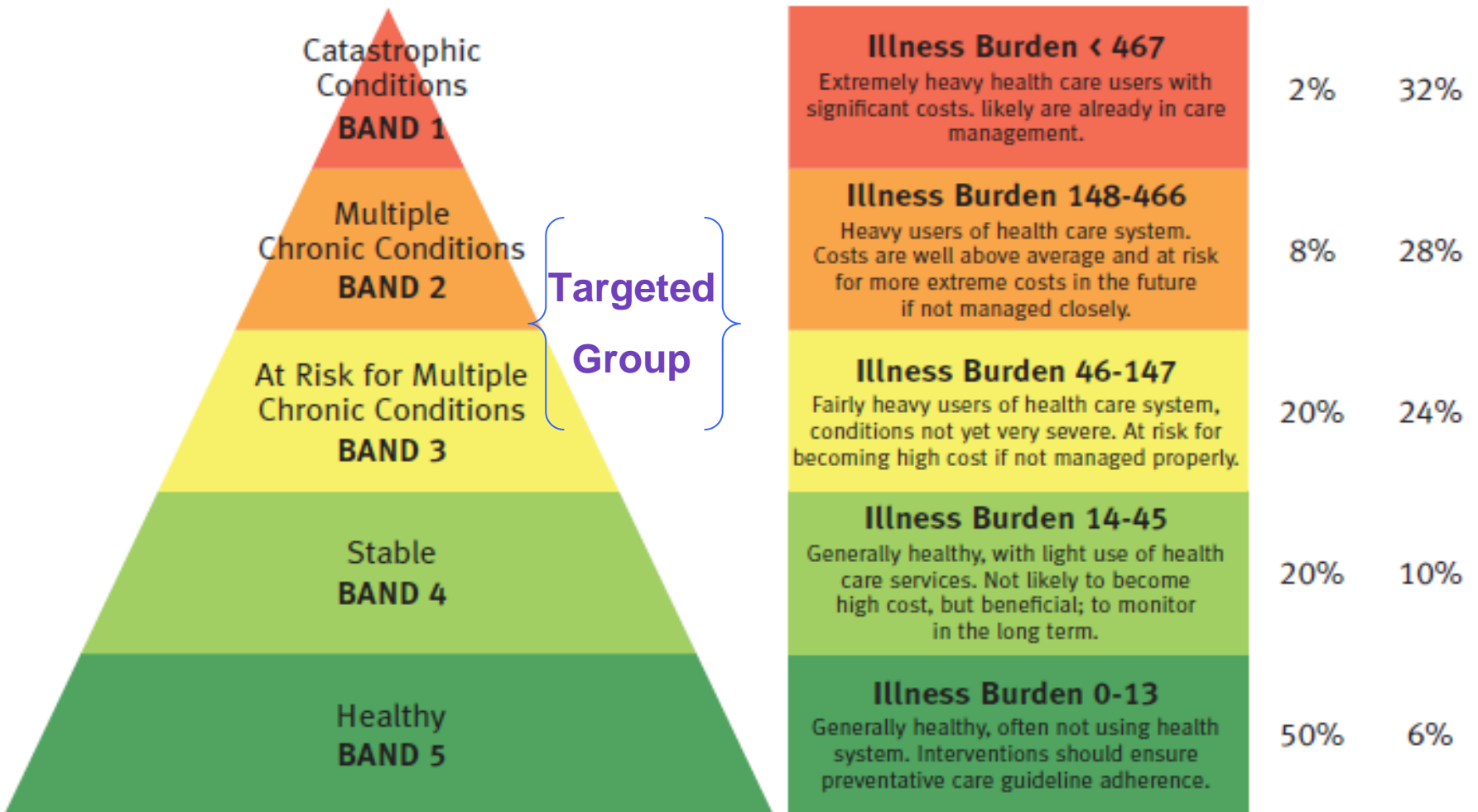
# **“A Model For Integrating Independent Physicians Into Accountable Care Organizations”**

- **Advocate Physician Partners, affiliated organization to Advocate Health System, largest hospital system in Illinois**
- **Author Mark C. Shields, vice president for medical management of Advocate Health Care and senior medical director of Advocate Physician Partners, in Mt. Prospect, Illinois; et al.**
- **Model for organizing independent physicians into partnerships with hospitals to improve care, cut costs, and be held accountable for the results.**
- **Signed its first commercial ACO contract effective January 1, 2011, with the largest insurer in Illinois, Blue Cross Blue Shield**
- **Other commercial contracts are expected to follow**

# CareFirst Blue Cross/Blue Shield: Focusing on High-Risk Patients

Wellness/Illness Burden Pyramid

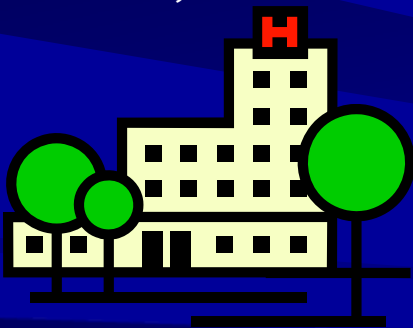
Percent of  
Population    Percent  
of Cost



# **Advanced Illness Management (AIM)**

Integrated Care for Patients With Late-  
Stage Chronic Illness

**Brad Stuart, M.D.**  
**Senior Medical Director**  
**Sutter VNA & Hospice**  
**Fairfield, CA**



**Hospitals**

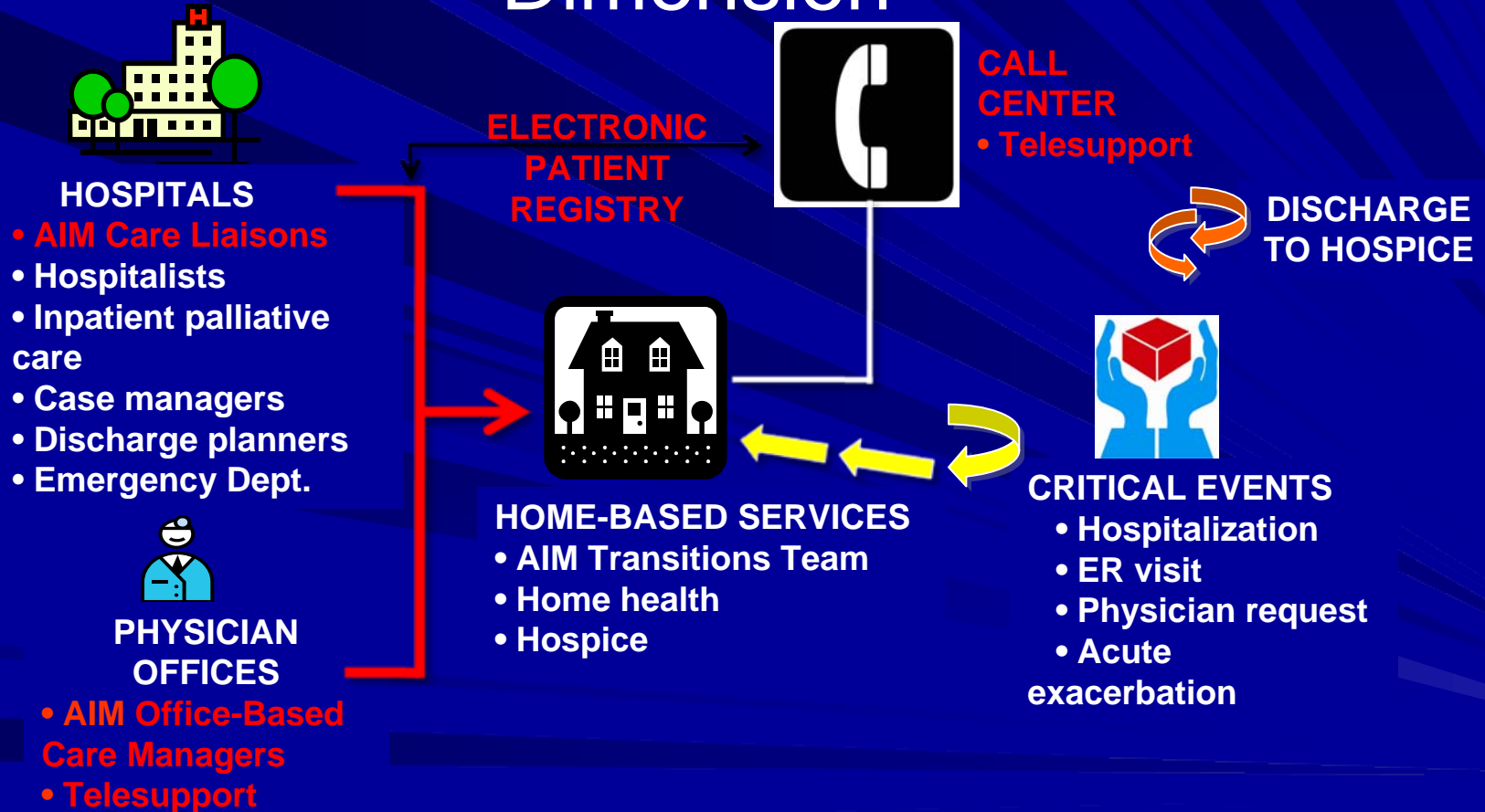


**Home-Based  
Services**



**Medical Foundations  
& Groups**

# Sutter VNA & Hospice: Care Coordination, Spatial Dimension



**Sutter VNA & Hospice:**  
**AIM 2.0 Preliminary Outcomes**  
**Sample period: 11/9/09-9/30/2010**

	<b>Days Pre/Post AIM Enrollment</b>		
	<b>30</b>	<b>60</b>	<b>90</b>
<b>N</b>	<b>185</b>	<b>121</b>	<b>96</b>
<b>Δ Hospitalizations</b>	<b>-68%</b>	<b>-59%</b>	<b>-63%</b>
<b>Total Direct Cost Savings*</b>	<b>\$394,326</b>	<b>\$475,305</b>	<b>\$573,581</b>
<b>Savings/Enrollee/Month*</b>	<b>\$2131</b>	<b>\$1964</b>	<b>\$1992</b>
<b>Excellent patient satisfaction</b>			
<b>Excellent physician satisfaction</b>			

**\*Includes savings from reduction in Emergency  
Department and hospital-based outpatient services**



By Glenn D. Steele, Jean A. Haynes, Duane E. Davis, Janet Tomcavage, Walter F. Stewart, Tom R. Graf, Ronald A. Paulus, Karena Weikel, and Janet Shikles

## ANALYSIS & COMMENTARY

# How Geisinger's Advanced Medical Home Model Argues The Case For Rapid-Cycle Innovation

**ABSTRACT** The Patient Protection and Affordable Care Act of 2010 provides for a number of major payment and delivery system initiatives. These potential changes need to be tested, scaled, and adapted with an urgency not evident in previous demonstration projects of the Centers for Medicare and Medicaid Services. We discuss lessons learned from our iterative tests of care reengineering at Geisinger—specifically, through our advanced medical home model, ProvenHealth Navigator<sup>SM</sup>, and the way we continuously modified the model to improve quality and value. We hypothesize that the most important ingredient in our model has been the embedding of nurse case managers into our community practices and the real-time feedback of data on the use of health services by the most complex patients.

**T**he Patient Protection and Affordable Care Act of 2010 contains a large portfolio of major payment and delivery system reengineering initiatives recently summarized by Stuart Guterman and colleagues at the Common-

care shared savings program or accountable care organization provisions of the Affordable Care Act in January 2012 (personal communication from Stuart Guterman to Glenn D. Steele, July 7, 2010).

The nation simply cannot afford another

DOI: 10.1377/hlthaff.2010.0840  
HEALTH AFFAIRS 29,  
NO. 11 (2010): 2047–2053  
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The People-to-People Health  
Foundation, Inc.

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**Tom R. Graf** is chairman of community practice for Geisinger Health System.

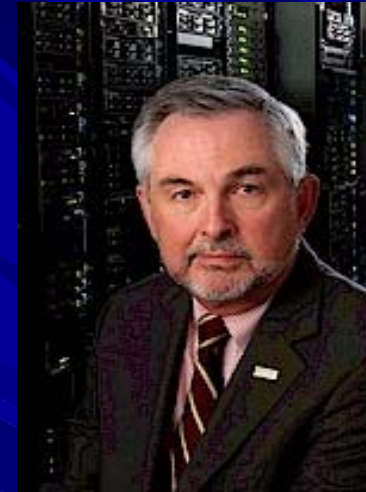
**Ronald A. Paulus** is president

**“We hypothesize that the most important ingredient in our model has been the embedding of nurse case managers into our community practices and the real-time feedback of data on the use of health services by the most complex patients.”**

**Source:**  
*Health Affairs*,  
2010 Nov; 29(11):2047-53.

# Geisinger's ProvenHealth Navigator

- Chronic care management, Medical Home, and Patient-Centered Primary Care
- 360-degree, 24/7 continuum of care
- **System-wide EHR**
- “Embedded” nurses in primary care practices
- Assured easy phone access
- Telephonic monitoring/case management
- Personalized tools (e.g., chronic disease report cards)



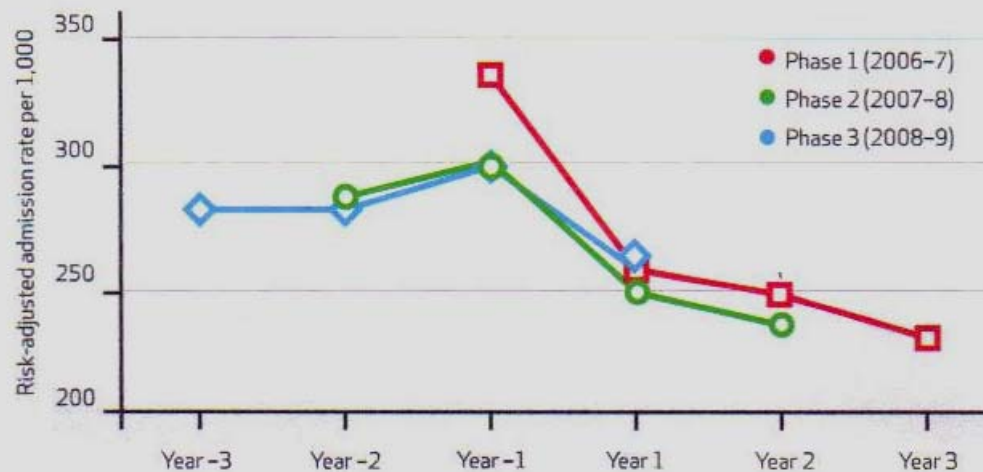
Glenn Steele,  
CEO  
Geisinger



## REENGINEERING THE DELIVERY SYSTEM

### EXHIBIT 2

**Risk-Adjusted Acute Hospital Admission Rates Per 1,000 For Primary Care Patients In Geisinger Health System Clinics That Launched ProvenHealth Navigator™ In Different Years, By Year Before Or After The Intervention, 2006-9**



SOURCE Geisinger Health System.

**Geisinger  
Health  
System:  
Hospital  
Admission  
Rates  
For  
Patients in  
Medical Home**

**Source:**  
*Health Affairs*,  
2010 Nov; 29(11):2047-53.



# Forthcoming in *Health Affairs*, July 2011

- State Action on Avoidable Rehospitalizations (STAAR) initiative
- Project of the Institute for Healthcare Improvement
- 148 hospitals and more than 500 “cross-continuum” team partners in four states (Massachusetts, Michigan, Washington, and Ohio)
- “Cross-continuum teams” =hospitals partnering with home health agencies, nursing facilities, office practices, community-based support services, and patients
- Multistakeholder state-level steering committees
- Source: Amy Boutwell et al, *Health Affairs*, forthcoming

# **The Politics, Briefly**

# 2010 Election Results

- Off-year elections

- House reverts to Republican control

- Senate remains in Democratic control despite slimmer margin

- Large # of Governorships captured by Republicans

House Speaker  
John Boehner



Sen. Majority  
Leader  
Harry Reid



# **“Repeal and Replace”**

- In January, House leadership sent instructions to five committees to begin drafting replacement language
- Effort appears to be going nowhere
- Rep. David Camp, chairman, House Ways & Means Committee, at *Health Affairs* breakfast on 5/6/11: “The Senate will not pass it ...I am not interested in laying down a marker, I’m interested in solutions.”



# Sequential Fights: Fiscal 2011 (current year) budget

- Budget deal finally struck on April 8, averting a government shutdown
- Although House voted to deny any ACA implementation funds, none of these proposed cuts survived final bill
- Lone exception: cut in loan funding for co-ops

# Where We Are Now: The “Known Unknowns”

- Outcome of congressional efforts to defund/repeal/replace individual provisions of ACA or entire law
- Outcome of President’s new proposal to allow states to set up own plan provided it can meet objectives of Affordable Care Act
- Outcome of federal lawsuits challenging individual mandate or entirety of law
- Outcome of fiscal 2012 House budget resolution, debt ceiling fight, and proposals to restructure Medicare and Medicaid

# Best Guess Scenario

- **ACA stays largely intact, at least until January 2013**
- **Delivery system/payment reform provisions have at least lukewarm support from Senate Republicans**
- **ACA remains key issue in November 2012 elections**

**Who will it be  
In 2012?**



# Health reform: The Next Wave?

- “Health care reform is part of deficit reform.”
- “We know that health care costs, including programs like Medicare and Medicaid, are the biggest contributors to our long-term deficit. Nobody disputes this.”
- Debt ceiling increase, negotiations with VP Biden may lead to plans for further Medicare and Medicaid reforms



President Obama at Families USA  
Conference, Washington, DC, Jan. 28, 2011

# Medicare Trustees' Report, May 2011

- “The Hospital Insurance trust fund is now estimated to be exhausted in 2024, 5 years earlier than was shown in last year's report, and the fund is not adequately financed over the next 10 years.
- Economy was slower in 2010 than projected so payroll taxes were lower
- Economic growth will be faster in from 2011-2019 than had been projected so hospital expenditures will also be higher than expected
- In 2010 Medicare ate into \$32 billion of trust fund assets to cover shortfall
- Asset balance to fall below trustees' recommended minimum level early this year
- For the 75-year projection period, the HI actuarial deficit has increased from 0.66 percent of taxable payroll, as shown in last year's report, to 0.79 percent of taxable payroll

# Medicare Trustees' Report, 2011

- "...underscores the importance of finding innovative new methods of delivering and paying for health care that achieve better cost efficiency without compromising the quality of outcomes.
- "The Affordable Care Act institutes a major new program of research and development, which could lead to such results.
- "Until specific methods have been designed, tested, and implemented, however, it is likely that the current-law projections for the HI trust fund (and SMI Part B as well) substantially understate the future cost of the program."





**“There has never been a better time to be an  
Innovator in health care.”**

**--Don Berwick, administrator, CMS  
Military Health System conference  
January 2011**





**“We always need to remember that behind almost every great moment in history, there are heroic people doing really boring and frustrating things for a prolonged period of time.”**

**– Gail Collins, *The New York Times*, August 13, 2010**

The End