



Insight

Paying to Keep At-Risk Patients Healthy

ROBERT BOOK | JULY 29, 2015

Executive Summary

One of the great dilemmas in health policy is that almost no one in the health care fields is actually paid to keep patients healthy. Health care providers are usually paid for performing specific services, while health plans are usually paid a specific amount per month for each beneficiary covered. As a result, providers have an incentive to perform more services and health plans have an incentive to cover fewer services. Most approaches to health policy focus on balancing these two interests, rather than incentivizing anyone to deliver the *right* services – both in terms of quantity and type. However, it is possible in at least some common situations to create incentives to do the job right, rather than simply to do “more” or “less.” It is long past time to begin paying to keep patients healthy rather than paying for specific treatments.

There are many common, chronic diseases which are progressive in nature, and whose progression can be slowed or stopped by appropriate disease-specific preventive care.^[1] Allowing a disease to progress is harmful to patients, as well as financially costly in the long run, because more intensive treatment is then required. Proper preventive care is also costly, but less (often much less) costly than allowing a disease to progress.

Health plans should be paid to keep patients healthy. That is, when some percentage of patients with a chronic progressive disease may be expected to progress to the next stage of that disease in the course of a year, health plans should be paid if they can keep the percentage of patients progressing significantly below the expected level. Depending on the level of success in preventing disease progression, and the payment required to achieve that level of success, preliminary estimates suggest that annual program savings could range from several hundred million to almost \$3 billion from chronic kidney disease alone. This is just the tip of the iceberg, since there are many other chronic progressive conditions that would be amenable to this sort of incentive system. Most important, because the payment for reducing disease progression can be calibrated to be lower than the payment for more severe stages of the diseases, it can be guaranteed that program costs will not increase. In other words, there is great potential benefit, but no downside risk to the taxpayer.

Risk Adjustment and Incentives

Medicare Advantage (MA), and several other government programs, currently pay health plans a monthly fee to provide health care to enrollees. The base monthly fee is determined according to a well-known formula, but there is also a process for adjusting the fees paid to plans based on the health history and status of the beneficiaries actually enrolled in each particular plan. This process, known as “risk adjustment,” is intended to increase payments for enrollees who will cost more to take care of, and decrease payments for healthier enrollees. This has two related benefits: first, it decreases the risk to each plan of attracting a disproportionate number of relatively unhealthy enrollees, and second, it decreases the incentive for plans to attempt to disproportionately attract healthier enrollees.

While risk adjustment is necessary to ensure that plans don't try to game the system by disproportionately attracting healthier enrollees, it does not necessarily create an incentive to keep patients healthy; if an enrollee gets sicker and therefore more expensive to care for, the enrollee will be given a higher risk score the following year, and the MA plan will be paid more to offset the increased care required.

Instead of just paying an additional amount for each enrollee with a particular disease stage, plans should also be paid for *reducing* the percentage of patients advancing to the next disease stage.

Suppose there is a chronic disease with stages A and B. Stage A is not all that severe and requires little treatment to maintain normal activities, but without any treatment, say 20 percent of patients progress to Stage B each year. Stage B is severe, and requires substantial amounts of treatment, very costly, to avoid becoming fatal. However, with appropriate preventive care, only 5 percent of patients progress to Stage B each year.

The current practice is to add a small amount, or no amount, to an enrollee's risk score (and therefore the MA payment) if that enrollee has the disease at Stage A, since little or no treatment is required, but to add a large amount if the enrollee has the disease at Stage B, since much treatment is required.

The American Action Forum (AAF) proposes providing an additional payment to MA plans if they are able to substantially reduce the rate of progression from Stage A to Stage B. For example, if the "usual" percentage progressing annually to Stage B is 20 percent, an additional payment should be provided for every percentage point reduction below (say) 16 percent. That amount should be multiplied by the number of Stage A patients, in excess of that percentage, not progressing in the given year. This amount should be calibrated so it is higher than the amount expected to be spent on appropriate preventive care, but lower than the amount that would be spent if those patients had progressed to stage B. This will make "keeping patients healthy" profitable for both the government and the insurer.

The payment should be made in year two based on the number of Stage A enrollees at the beginning of year one who have not progressed to Stage B (and are not deceased) by the beginning of year two. The payment should be made to the MA plan that covered the enrollee in year one, regardless of whether the enrollee is still enrolled in that plan in year two.

Example: Chronic Kidney Disease

A disease particularly suited for this type of incentive is chronic kidney disease (CKD). CKD is characterized by five well-defined stages objectively measurable in laboratory tests, defined primarily by the patient's glomerular filtration rate (GFR). Left untreated, a patient can progress from Stage 1, which is not all that serious, through Stage 5, and ultimately end stage renal disease (ESRD), requiring lifetime dialysis or a transplant. Table 1 displays the various stages of CKD and how they are defined. Early-stage diagnosis and appropriate treatment can reduce (though not eliminate) the probability of a patient progressing to more severe stages.

	Table 1.	
Stage of Kidney Disease	ICD-9 Code	Criteria*
Chronic Kidney Disease Stage 1	585.1	GFR ? 90 with any sign of kidney damage

Chronic Kidney Disease Stage 2	585.2	GFR range 60-89
Chronic Kidney Disease Stage 3**	585.3	GFR range 30-59
Chronic Kidney Disease Stage 4	585.4	GFR range 15-29
Chronic Kidney Disease Stage 5	585.5	GFR < 15
End Stage Renal Disease	586.6	Requires indefinite dialysis or transplant
<p>* "Clinical Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification, and Stratification," National Kidney Foundation, http://www2.kidney.org/professionals/KDOQI/guidelines_ckd/p4_class_g1.htm. GFR is glomerular filtration rate, measure in ml/min per 1.73 m².</p> <p>** Some clinicians and health systems distinguish between stage 3a (GFR between 45 and 59) and stage 3b (30-44), but Medicare Advantage does not.</p>		

In the current (2014 going forward) CMS-HCC risk model, there is no risk score or additional payment to MA plans associated with stages 1, 2, or 3. Stages 4 (HCC 137) and 5 (HCC 136) receive a risk factor of 0.230 for community beneficiaries. This corresponds to an average additional payment of approximately \$2,375 per year, based on the national average benchmark.[2] For institutionalized beneficiaries, stage 4 (HCC 137) is assigned a risk factor of 0.302, corresponding to an average additional payment of approximately \$3,119, and stage 5 (HCC 136) has a risk factor of 0.521, corresponding to an average additional payment of approximately \$5,380. An MA patient with ESRD is paid according to an entirely separate payment system, with an annual payment approximately \$57,225 higher than the average annual MA benchmark.[3]

Consequently, reducing the rate of disease progression would reduce MA program spending by those amounts for each patient whose disease was prevented from progressing.

Preliminary estimates imply that approximately a quarter of patients with stage 3 advance to stage 4, about a third advance from stage 4 to stage 5, and approximately a quarter advance from stage 5 to ESRD.[4] Table 2 displays the prevalence of each of the 5 stages in the Medicare population, and associated payments for treatment provided.

Table 2.

Stage	ICD-9	2014 HCC	Prevalence in	Risk Factor		Incremental Outlay Per Beneficiary	
			Medicare Population*	Community	Institutional	Community	Institutional
CKD Stage 1	585.1	None	0.232%				
CKD Stage 2	585.2	None	0.774%				

CKD Stage 3	585.3	None	4.589%				
CKD Stage 4	585.4	137	0.920%	0.230	0.302	\$566	\$743
CKD Stage 5	585.5	136	0.198%	0.230	0.521	\$889	\$2013
ESRD	586.6	N/A	0.013%	N/A	N/A	\$16,011	\$16,011
* U.S. Renal Data System Coordinating Center, 2014 USRDS Annual Data Report, http://www.usrds.org/adr.aspx							

Potential Savings

Clearly, reducing the percentages of beneficiaries reaching later stages of disease could reduce total MA payments. Based on current prevalence of each disease stage and current Medicare enrollment, a ten percentage point reduction in the rate of progression from one stage to the next could reduce MA program payments by approximately \$384 million annually. Paying a bonus to MA plans out of this savings would benefit all parties – patients would live longer, healthier lives, taxpayers would save money, and MA plans would benefit financially as well.

This of course represents only a small portion of the potential savings. Clinical experts indicate that reduction in CKD progression could substantially exceed this level, with a theoretical maximum savings of over \$3 billion annually at current disease prevalence rates and MA enrollment levels. With both CKD prevalence and MA enrollment increasing over time, the savings will also increase over time.

Most importantly, because the payment for reducing progression rates can be set to be less than the additional payment when the disease progresses, the potential for savings is *not* offset by any risk of spending increases. In the worst-case scenario, MA spending does not change at all. In other words, an incentive program tied to slowing disease progression has absolutely no downside risk to the taxpayer.

Additional Applications

Furthermore, CKD is only one of many chronic diseases whose progression can be mitigated by appropriate treatment and measured objectively. Another example is diabetes, whose management can be evaluated by a patient's HbA1C measurement. Insufficient diabetes management increases the probability of complications, and complications can result in severe consequences for patients. Complications also increase health care costs, and thus MA payments. A patient who progresses from uncomplicated diabetes to diabetes with complications generates an increased MA expenditure averaging about \$2,520 per year.

Conclusion

There are many common, chronic diseases which are progressive in nature, and whose progression can be slowed or stopped by appropriate disease-specific care. Allowing a disease to progress is harmful to patients, as well as financially costly in the long run, because more intensive treatment is then required. Proper preventive

care is also costly, but less (often much less) costly than allowing a disease to progress. While clinicians are surely not intentionally allowing the quick progression of disease stages, the payment structure is working against providers and health plans who are proactive about preventive care.

MA health plans can, and should, be paid to keep patients healthy. This can be accomplished by rewarding plans when they reduce the progression rates of their patients below the level that would normally be expected based on population data.

If the reward to keep patients healthy is lower than the additional risk adjustment payment that would be made in the event of disease progression, there is no downside risk to the taxpayer, and the prospect of significant financial benefits to both taxpayers and health plans. Plans would be paid for keeping patients healthy rather than simply treating them when they are sick. Most importantly, patients would live healthier and longer lives.

[1] Here the term “preventive care” is used in the linguistic sense of “health care intended to prevent otherwise likely adverse health outcomes” rather than in the regulatory sense of “services designated by the U.S. Preventive Services Task Force or the Secretary of Health and Human Services.” Unlike the latter, in the case of health care intended to prevent otherwise likely adverse health outcomes, there is no requirement in the Affordable Care Act to provide such services at all, let alone without cost-sharing.