Testimony of Howard S. Berliner
Joint Hearing of Assembly Health and Senate Health Committees
Sacramento, California
March 11, 2015

Committee Statement

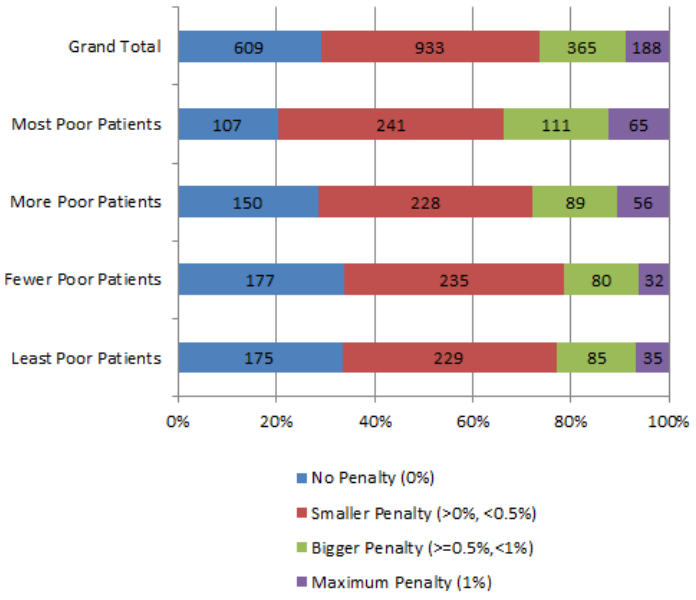
My name is Howard S. Berliner and I am pleased to be here today to talk about the lessons we've learned from Medicare's now multi-year payment reform programs as they relate to healthcare disparities.

I am Clinical Professor of Health Policy at the Weil Cornell School of Medicine and an Adjunct Professor at the New School University in New York. I was previously Professor and Chair of the Department of Health Policy and Management at the SUNY Downstate School of Public Health and Director of the Doctoral Program in Public Policy at the New School, and have been studying and writing on the issue of health disparities for over 30 years.

Today I want to focus on one case study - Medicare's hospital readmission within 30 days penalties - because I think it is the quickest and clearest way to illuminate the problems that occur when a disparities, or equity, framework is not built into payment reforms that aim to meet the goals of the NQS, or the Triple Aim.

Three years of data on hospital readmission penalties teaches us two lessons:

Lesson 1: Poor communities lose the most.



Rau, Jordan, Kaiser Health News, October 22, 2012, "Revised Medicare Penalties Hit Some States Hard", chart on p. 2 shows penalty rates from most poor to least poor patients
Safety net hospitals and academic medical centers serving poor, diverse urban communities are the most heavily penalized.

Comments on chart:

As the chart shows, in 2012, the first year penalties were assessed, 80% of the hospitals in the top quartile, serving the most poor patients, were hit by readmissions penalties, while less than 40% of hospitals in the lowest quartile, serving the least poor patients, incurred penalties.

The most recent penalties in 2014 have the same harmful effect, as Kaiser Health News states: "Safety net hospitals that treat large numbers of low-income patients have been more likely to receive penalties, in part because poor patients face financial and logistical challenges that make them more likely to get sicker after discharges than others...."

Thus if race and ethnicity, linguistic and cultural, and other SDS factors upstream from the hospital that play a significant role in its 30-day readmissions are not taken into account, hospitals that serve poor communities of color lose economically. The irony is that the old rationale that better quality results is being called into question by the evidence.

Lesson 2: It's not about quality.

EXHIBIT 2

Impacts Of Value-Based Purchasing (VBP), Hospital Readmissions Reduction Program (HRRP), And Electronic Health Record (EHR) Incentive Programs On Safety-Net And Non-Safety-Net Hospitals, 2013

Impact	Safety-net hospitals (*n*=60)	Other hospitals (*n*=182)	*p* value
Hospitals penalized under VBP	70.0%	58.2%	0.1051
VBP total performance score	45.0	52.2	0.0035
VBP process score	53.8	60.0	0.0615
VBP patient experience score	24.4	34.2	<0.0001
Hospitals penalized under the HRRP	88.3	68.1	0.0022
30-day readmission rate for acute myocardial infarction	19.9	19.2	0.0051
30-day readmission rate for heart failure	25.7	24.1	<0.0001
30-day readmission rate for pneumonia	18.9	18.2	0.0100
Hospitals receiving Medicare payment for demonstrating EHR meaningful use	38.3	55.0	0.0256

SOURCE Authors' analysis of data from the Medicare Impact File for 2013, Hospital Compare for 2011, and VBP performance scores for 2013 from Hospital Compare and the Centers for Medicare and Medicaid Services website. NOTES Readmission rates are risk-adjusted. Additional analytic details for the exhibit are included in the online Appendix (to access the Appendix, click on the Appendix link in the box to the right of the article online).

EXHIBIT 3

Thirty-Day Risk-Adjusted Mortality Rates For Acute Myocardial Infarction, Heart Failure, And Pneumonia, 2009–11

	Safety-net hospitals (*n*=60)	Other hospitals (*n*=182)	*p* value
Mortality rate for:			
Acute myocardial infarction	14.5%	15.0%	0.0950
Heart failure	9.5	11.2	<0.0001
Pneumonia	10.9	11.8	0.0036
Mortality rate index (actual over expected)	0.91	1.02	<0.0001
Hospitals with lower-than-expected mortality	66.7	41.2	0.0006

SOURCE Authors' analysis of data from Hospital Compare for 2011 and the Medicare Impact File for 2013. NOTE Additional analytic details for the exhibit are included in the online Appendix (to access the Appendix, click on the Appendix link in the box to the right of the article online).

1. (Gilman, HA, Exhibit 2 p 1319 compares penalty rates for safety net and all other hospitals in California showing 30% difference in safety net vs other hospitals for "Hospitals Penalized under the HRRP" (Readmissions penalties)
2. Gilman, Exhibit 3 p. 1320, compares mortality rate metrics for safety net vs other hospitals

Commentary:

A recent Health Affairs study of California hospitals found that Medicare DSH safety net hospitals had better patient outcomes, as measured by mortality rates for heart failure, AMI, and pneumonia, but suffered greater financial penalties both in the Readmissions and other Medicare VBP programs. As the Exhibit shows, safety net hospitals were 30% more likely than all other hospitals to incur readmissions penalties, (HRRP).

But analyzing these same groups of hospitals, it was the non-safety net group that had worse patient outcomes for all three conditions that result in readmissions penalties.

- 18% higher mortality rate for Heart Failure patients
- 10% higher mortality rate for AMI patients
- 3.5% higher mortality rate for pneumonia patients

Because Medicare's Hospital Readmissions program does not take health and healthcare status and disparities, of patients and communities, into account, its results to date are flawed:

- First: the penalties disproportionately hit hospitals serving poor, diverse communities compared to those in better off communities; even though
- These same safety net hospitals incurring the high readmissions penalties have better, not worse, patient outcomes than the less-penalized hospitals

My written testimony goes into some detail on how and why the federal system of quality measurement developed as it has. It then highlights the turning point federal policy currently faces:

- The National Quality Forum has broken its longstanding policy of excluding consideration of the socioeconomic and demographic factors that underlie health and healthcare disparities and is engaged in a 2-year trial period to study how they should be accounted for in quality measures.

- Congress is involved, and last year mandated studies on disparities and quality measures in the IMPACT Act.

- Meanwhile, CMS Secretary Burwell recently tripled down on extending Medicare's value-based purchasing programs, setting a goal of 85% VBP in 2016, and 90% in 2018.

It is not yet clear how all these forces will coalesce in D.C. One advantage states who are engaged in their own payment reforms have is learning from federal experience to date.

My recommendation to states is to make serious disparities analysis an integral part of payment reform, rather than have to play catch-up like NQF and CMS will. States should incorporate an Equity, or Disparities frame into the Triple Aim from the beginning.

I will be happy to answer any questions.

###

Written Testimony

15 Year History of US Quality Programs

The United States has accomplished much in recent years in bringing attention to the quality of care that is provided within the health care system. Much of the impetus for this quality initiative has come from the federal government through the Medicare program and more recently through the Affordable Care Act.

It was only in the 1999 report from the Institute of Medicine "To Err is Human" that the deficiencies in the quality of care rendered in U.S. hospitals reached the level of popular perception. It is not that quality was not recognized as an important factor in health care delivery prior to the report so much as attention to quality was crowded out by all the attention given to access and the cost of care. Also good mechanisms to recognize and evaluate quality were not yet available. The first payment reforms to incorporate this new concern with quality of care were pay for performance (P4P) strategies in which institutions would be financially rewarded for achieving certain quality metrics such as a reduction in the number of hospital-acquired infections. In many arenas a P4P model has proven effective in achieving well articulated goals although without serious controls can be easily manipulated to increase revenues without creating much change.

The use of P4P struck many as rewarding hospitals and other healthcare providers for doing a poor job and soon a more attractive name was coined—value based purchasing (VBP)—though the basic concept was the same. VBP and other programs have proliferated through internal policy decisions at CMS and the statutory authority of the ACA.[1]

The idea of value based purchasing was to use a budget neutral mechanism to pay hospitals more for certain outcomes if they did well and take that "bonus" from hospitals that did poorly to serve as a penalty. For FY 2015, more than 6% of a hospital's Medicare payments are contingent upon performance.[2]

In a recent paper in the New England Journal of Medicine, HHS Secretary Burwell said "Our goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018."[3] So clearly this movement to use payment to improve quality is moving forward rapidly.

There is something disconcerting in the rapid adoption of value based purchasing well before there is substantial evidence that it is actually working to solve the problem for which it was created.

The current VBP programs in place for Medicare rewards small hospitals in wealthy areas while penalizing safety net hospitals and academic medical centers in poor areas. While Secretary Burwell does not provide specifics of how and what will be achieved, it is not clear that simply "tying payment to quality" is an adequate answer.

---

[1] It is important to note that there is not a single Medicare quality program but actually several different programs, each with slightly different aims and different measures. These include: the Inpatient Quality Reporting Program, the Hospital Value Based Purchasing Program, the Hospital Readmission Reductions Program, the Hospital-Acquired Condition Reduction Program, the Hospital Outpatient Quality Reporting Program, the Ambulatory Surgery Center Quality Reporting Program, the Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals, the PPS-Exempt Cancer Hospital Quality Reporting Program, and the Inpatient Psychiatric Facility Quality Reporting Program. See: MAP 2015 Considerations for Selection of Measures for Federal Programs: Hospitals FINAL REPORT
FEBRUARY 2015, National Quality Forum.

[2] Jordan Rau, "1,700 Hospitals win quality bonuses from medicare, but most will never collect, KHN January 22, 2015.

[3] Burwell, Sylvia M "Setting Value-Based Payment Goals—HHS Efforts to Improve U.S. Health Care." NEJM January 26, 2015:p.1

The academic literature has long recognized the problem with excluding sociodemographic factors and disparities when tying payment to quality. As long ago as 2007, Casalino and colleagues in a paper in Health Affairs noted that P4P strategies could have negative consequences on reducing disparities unless they were designed specifically to address the issue of disparities.[4] As I will show below, for the most part this has not been done. People who devise new measures of quality seem to stick to the tried and true, even if it does not work effectively, which makes it most problematic to think about extending VBP to more services and procedures and other programs. The evidence shows that if these measures are continued without adjustment, we will see continued withdrawal of revenues from doctors and hospitals in poor communities, and a continuation of a false view of true community health.

Quality Programs Have Not Reduced Disparities

To make this quite clear, we need only look at the National Disparities Report from the Agency for Health Research and Quality (AHRQ) published in 2013.[5]
While "quality" was rated as fair overall and improving, the report noted that disparities were poor and had no change over time. This is not the direction in which we should be proceeding.

Overview	• Tracks >200 process outcome, and access measures • Analyzed national health care data from 2000-2011 • Goal: Create a baseline to track improvement over time
Quality	• **Rated as Fair** • Improving
Access	• **Rated as Fair** • *Getting worse*
Disparities	• **Rated as Poor** • *No change over time*

Case Study: Three Years of Hospital Readmissions Penalties and Disparities

CMS's attempts to improve the quality of care provided in hospitals and other settings is a good thing, but it will not meet National Quality Strategy goals, or the Triple Aim, if it fails to directly take equity, and disparities, into account. Up to now, the Readmissions program has not done so.

The readmissions program is one of the most aggressive quality improvement programs. Secretary Burwell provides a brief explanation of the program in her article: "There is now a national program to reduce hospital readmissions within 30 days after discharge, which encourages hospitals to improve transitional care and coordinate more effectively with ambulatory care providers."[6] Historically it has been noted that as many as 20% of hospital discharges for Medicare patients result in a readmission within 30 days at a great cost to the

[4] Casalino et al. "Will Pay-For-Performance And Quality Reporting Affect Health Care Disparities?" Health Affairs 26(3) 2007: W405-414
[5] 2013 National Healthcare Disparities Report AHRQ Washington DC
[6] Burwell. Op Cit. p.2

program in economic terms and a great cost to patients in the quality of care they are receiving. It is clear that one way to deal with this problem is to improve the coordination of care between hospitals and non-hospital providers and to make the transitions from one setting to another smoother and more seamless.[7]

Proponents of readmissions penalties argued that finding a mechanism to induce hospitals to reduce readmissions would save money, improve the health of the population at large, and improve the patient experience and quality—the so-called "Triple Aim" of health policy.[8] The case that readmissions penalties would meet these goals has yet to be proved.

The reasons why patients get readmitted to hospitals are reasonably clear and intuitive:

- Patients who lack an adequate primary care network or who have no direct relationship with a physician whom they can see in a reasonable amount of time may feel that they should return to the hospital emergency room if they have a problem or are not feeling well or do not understand what medications they should be taking following their hospital discharge.
- Primary care networks are far less robust in areas where poor people reside, in inner cities, and in rural areas.
- For people with low socioeconomic status, other social supports that might be available in other areas are generally lacking and there are fewer people and resources to aid them.
- Short-staffing: In the rush to discharge patients from the hospital, the many prescriptions that are received may not be well explained to the patient in some cases for linguistic or cultural reasons, in other cases because there is no one to coordinate the different medications and to explain to the patient how they should be taken. The patient may not be told how to understand how they should be expected to feel and what would indicate a problem requiring more medical attention rather than just the healing process.
- Where there is no electronic health record connection between the hospital and the primary care physician, the primary care doctor may find it easier and safer to refer the patient back to the hospital rather than attempt to deal with an unknown situation. (While many hospitals across the country have been purchasing physician practices to better coordinate care, this is far less likely to occur in poor communities.)

In order to reduce readmissions to hospitals, it is necessary to have an effective primary care system and social and other supports that are responsive to the patients and communities. Many poor communities and communities of color, as well as rural areas, do not have this. Thus Readmission rates penalize hospitals financially for things that are largely outside of their

[7] Ironically, it is likely that the readmissions problem was a consequence of the switch to DRG reimbursement in the 1980's which dramatically reduced length of stay and made it difficult for hospital staff to do effective discharge planning and health education with patients, stabilize their medications, and work with the caretakers of patients to deal with expected complications and questions.

[8] The Triple Aim is a framework developed by the Institute for Health Improvement (IHI) for optimizing health system performance. The framework has become the basis for the U.S. National Quality Strategy. See Steifel and Nolan, "A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost." Institute for Health Improvement White Paper, 2012

control. While it is right to have zero tolerance for hospital acquired infections for all hospitals, because that is something that is well within the purview of a hospital to control, this is a far more difficult task when outside world factors are independent variables.

Questionable Quality Assumptions Behind Readmissions Penalties

As codified in the ACA, Section 3025, a readmission is a an admission to an acute care hospital within 30 days of discharge from the same or another hospital for the following conditions- Acute Myocardial Infarction, Heart Failure, and Pneumonia. There is a complicated formula that compares a hospitals results to all hospitals across the nation and hospitals that have a higher than median rate are penalized up to 3% of the Medicare DRG base rate (FY 2015 and beyond).[9] Unlike the value-based purchasing program, hospitals can only break even or lose money- there is no bonus associated with a good rate.

The theory behind the strategy to penalize high readmissions is that the penalty will force hospitals to find ways to coordinate care for patients who are being discharged from the hospital and to further the impacts of other ACA-driven approaches including Accountable Care Organizations (ACO's) and Medical Homes. The reality, to date, has been somewhat less dramatic. While readmissions have fallen, a growing number of research studies have found that readmissions are not a great measure of quality or that we are not measuring them in the most appropriate way, that most hospitals have little control over what happens to patients once they are discharged, and perhaps most important, hospitals in areas with low socioeconomic status are the most heavily penalized.

Readmissions Penalties Hurt Poor Communities

The academic literature that links SES and SDS factors to higher readmission rates is consistent, from a study of four Massachusetts hospitals in 1994,[10] to a 2015 analysis, which found that 58% of the variation in hospital readmission rates was explained by the socioeconomic factors of the county in which the hospital was located.

Right at the beginning of the affordable care act in 2010, A Congressional Research Service paper warned of problems that will continue to cause increases in disparities and inequities even as overall quality may be said to improve, such as the high cost to preparing the

---

[9] CMS has the authority to add other diagnoses to the three explicitly noted in the ACA and also can change the penalty rate and the method of calculation. The National Quality Forum (NQF) is contracted by CMS to recommend new measures and approaches. In 2014 CMS added two new categories, and levied penalties for readmissions following elective hip or knee replacement and lung ailments such as chronic bronchitis.

[10] Weissman et al., "The Impact of Patient Socioeconomic Status and Other Factors on Readmission: A prospective study in four Massachusetts hospitals." Inquiry 31(Summer, 1994) 163-172; J. Herrin et al. "Community Factors and hospital Readmission Rates," Health Services Research Volume 50, Issue 1, February 2015, pages 20-39. See also Jencks, et al. "Rehospitalizations among Patients in the Medicare Fee-for-Service Program. NEJM. 360(14) April 2, 2009: 1418-1428.

infrastructure to reduce readmissions including community linked medical records with long term care and primary care providers.[11]

Poor communities are also hurt by Medicare's pay for performance program for physician groups. Groups practicing in lower socioeconomic status areas scored worse than those in higher socioeconomic status areas.[12]

Jordan Rau's articles in Kaiser Health News have documented not only the disparity between rich and poor communities in readmissions penalties, but also the greater difficulty poorer comunities have in improving their rates..[13]

Looking at California more specifically, Gilman and colleagues found that safety net hospitals provided better quality of care as measured by mortality rates but suffered greater financial penalties as a result of the Readmissions and VBP programs amongst others. Let me quote from the conclusion of their paper:

"Safety-net hospitals in California provide better health outcomes than other hospitals at a reasonable cost. This would suggest good performance on the part of safety-net hospitals. However, the value-based purchasing program, the Hospital Readmissions Reduction Program and the electronic health record meaningful use program are more likely to penalize these hospitals than non safety-net institutions… Medicare payments have already begun to affect revenues. Medicare and Medicaid DSH payment reductions are also on the horizon for these hospitals which will only compound the financial issue."[14]

These studies represent a small sample of the recent literature on readmissions and particularly on the need to adjust the readmissions program to account for SES, and there are more new developments at the federal level.

National Quality Forum Breaks Tradition on Disparities

Last year the National Quality Forum broke with its past practice of excluding socioeconomic or demographic factors from measure development. NQF's technical report, August, 2014, "Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors" recommends changes based on core principles, including

- Disparities in health and healthcare should be identified and reduced
- Performance measurement should not lead to increased disparities in health and healthcare

[11] Stone, J. Hoffman, GJ, "Medicare Hospital Readmissions: Issues, Policy Options and PPACA." Congressional Research Service September 21, 2010

[12] AT Chen, et al. "Do Physician Organizations Located in Lower Socioeconomic Status Areas Score Lower on Pay-for-Performance Measures?" JGIM (Online) December 13, 2011.

[13] Jordan Rau. "Cleveland Hospitals Grapple With Readmissions Fines." Kaiser Health News. January 26, 2015

[14] Gilman, et al. "California Safety-Net Hospitals Likely To Be Penalized by ACA Value, Readmission, And Meaningful Use Programs." Health Affairs 33(8) 2014:1314-1322

- Outcomes may be influenced by patient health status, clinical, and sociodemographic factors....[15]

NQF is currently engaged in a two-year trial period, in which measure developers must include stratification and sociodemographic adjustment in quality measures seeking NQF's endorsement.

NQF action was partly motivated by the real world experience with penalties to hospitals for readmissions and other quality related issues that are not adjusted for the population characteristics of the utilizers may so financially disadvantage those institutions that they provide even less care to communities in need. Those safety net hospitals that are already struggling with declining revenues can ill afford to lose more money and yet also have the least capacity to make the internal and community infrastructural changes necessary to reduce readmissions. Moreover, the concentration on this one facet of quality improvement may lead to significant backsliding in other areas that may have more profound impacts on patient health and safety.

Conclusion

The chief conclusion that emerges from reviewing the history and practice of federal healthcare reform efforts aimed at increasing quality while lowering costs is that if this country wants to achieve the triple aim, it must expand that aim to account for the fact that all populations are not the same, that all hospitals do not treat the same patients and neither do all health plans. As today's hearing has shown, significant health and healthcare disparities separate different social groups, races, ethnic groups, genders, and other social stratifications.

Expanding the bounds of the triple aim to include health equity will allow for health improvement to affect all parts of the population and will allow for the identification of problems affecting specific groups of people and specific communities. To do this requires the collection of data at a very granular level and most important, its analysis and dissemination with strategies to reduce intergroup disparities. It may be quixotic to think that we can achieve a zero-disparity state especially given a biodiverse population, genetic differences, and historical environmental, educational, nutritional, housing, and economic factors—but we can certainly get closer to such a state than where we are at present.

Thank you for the opportunity to talk with you today. I would be glad to answer any questions you might have.

[15] National Quality Forum, "Risk Adjustment for Socioeconomic Status or Other Sociodemographif Factors," August 2014, pp. vi-vii.