Session 1.1: Applying Alternative Payment Models to Manage Costs and Promote High-Quality Care

Summary of presentation by Center for Health Systems Effectiveness, OHSU

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Facing significant budgetary pressures, many states are pursuing care coordination programs as a means of reducing Medicaid costs. These programs target the small number of Medicaid patients that account for the bulk of spending. By directing high-quality primary care to these patients, states hope to prevent expensive acute care episodes, such as ED and hospital admissions, that make up the majority of Medicaid spending. The assumption underlying these programs is that a significant portion of high-cost acute care episodes can be prevented through better outpatient treatment.

Oregon's recent Medicaid overhaul is expected to realize significant savings through care coordination. While the entire Medicaid population will benefit from these policies, they are primarily aimed at high cost patients. Cutting preventable ED and inpatient hospitalizations, especially among super-utilizers, is a central priority.

However, the proportion of preventable hospitalizations within Oregon's high-cost Medicaid population is unknown. Previous research has shown that a majority of ED visits by Oregon Medicaid enrollees were preventable, and that high quality primary care could reduce hospitalizations and ED utilization for ambulatory care sensitive conditions (ACSC). Yet, it is unclear if these preventable admissions are the primary drivers of spending, especially in light of a growing body of evidence that suggests ACSCs comprise a small fraction of Medicare spending.

The most compelling piece of evidence, and the one our study is based on, is a paper by Karen Joynt, published in JAMA in June of this year. In it, she examined spending incurred by Medicare's high-cost population. She found that the top decile of spenders accounted for over 70% of inpatient and ED costs, but that only 10% of those costs were for conditions deemed primary care preventable. These results indicate that care coordination efforts, while laudable on their own merits, will not produce significant cost savings for Medicare.

Because Medicaid populations differ significantly from Medicare enrollees, we decided to replicate her study using Oregon Medicaid data from 2010-2011. We confined out study to acute care services utilized by adults within OHP. We excluded dual eligibles, decedents, and anyone not continuously enrolled for 180 days during both years. Comorbidities were assigned using HEDIS and CMS-HCC specifications. We assigned standard costs and imputed these onto MCO claims. We labeled the top 10% of spenders "high-cost" and then analyzed this population with AHRQ's PQIs to ascertain preventable admissions. Preliminary results are largely consistent with Joynt's findings.

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