ACCELERATOR2023
Advancing Value for Health Equity

Pre-Conference Research Report

Dr. Atul Gawande's 2009 article titled "The Cost Conundrum" sparked a pivotal discourse across the U.S. healthcare sector. Through a critical examination of McAllen, Texas—a region with the second-highest Medicare expenses in the country at the time—Dr. Gawande challenged the prevailing notion that higher costs are synonymous with better care. His insightful discussion on the inefficiencies and misaligned incentives in the U.S. healthcare system ignited nationwide conversations and spurred debates surrounding healthcare reform. These discussions underscored the need to explore alternatives to the prevalent fee-for-service (volume-based) payment model for healthcare providers, paving the way for significant policy transformations that have progressively influenced healthcare management across the U.S.

This leads us to our question: Has Dr. Gawande's article influenced the cost and quality of care for the Medicare fee-for-service population in the Rio Grande Valley? The first of two, this report uses data from CareJourney1 to examine the changes in the cost and quality of care for the Medicare population in the Rio Grande Valley (RGV) since Dr. Gawande's seminal paper. The second report will compare a select number of RGV well-being measures to the results captured in the first brief and highlight the care system improvements RGV residents and care providers believe are needed to establish a high-value, whole-person care system.

Together, the two reports will provide RGV residents and care providers with a common foundation for collectively advancing a care system that can reliably optimize health for all.

High-Value Care: What is it? Why is it important?

High-value care refers to the provision of medical services that strive to achieve the best possible outcomes for patients at the lowest possible cost. The goal is to maximize the benefit received per unit of healthcare cost through the delivery of safe, effective, patient-centered, timely, efficient, and equitable care.

Many regard the pursuit of high-value care as a fundamental imperative, pivotal not only for the stability of the U.S. economy but also for safeguarding the financial well-being of every American.2,3 This sense of urgency is fueled from the unsustainable pace of U.S. healthcare spending growth. The per capita cost of healthcare has risen 29% between 2013 and 2022 (from $9,048 to $13,413),4,5 with cost growth expected to continue for years to come. From 2022 to 2023 alone, the average annual healthcare costs for a family of four is expected to increase 5.6% to a total cost of $31,065.5 The financial strain caused by rising healthcare expenses disproportionately affects communities of color. For instance, the Hispanic community faces heightened barriers to healthcare access due to cost-related issues, which are likely to lead to increased instances of delayed or foregone medical care.7 Further, Black adults bear the brunt of medical debt more than any other racial or ethnic group in the U.S.8

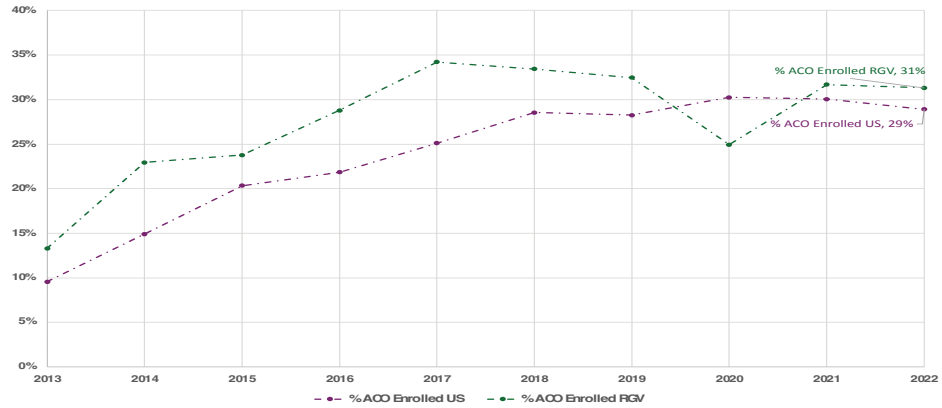
While escalating costs are problematic, potentially more alarming is the subpar health and well-being outcomes that those expenditures purchase. Despite a healthcare expenditure per capita that is more than double that of peer countries, the U.S. has the lowest life expectancy at birth, the highest death rates for avoidable or treatable conditions, the highest maternal and infant mortality, and the highest rate of people with multiple chronic conditions.9 Moreover, recent data (2019) shows the U.S. exhibits a rate of avoidable deaths per 100,000 people–which refers to deaths that are preventable and treatable–that is 71% higher than the country with the next highest rate.9 This gap in life expectancy is not just a national issue, it extends to RGV communities as well. For instance, people born in Starr County, TX have a shorter life expectancy than the citizens of over 80 different nations across the globe, including countries such as Chile, Bahrain, and Andorra.10,11 For these reasons and more, it is vital that we come together to find a path towards high-value care that serves every U.S. resident.

Moving Forward

A concerted attempt to incentivize high-value care for Medicare patients was instituted in the Affordable Care Act (2010) via a care delivery model called the Accountable Care Organization (ACO). ACOs, which are groups of doctors, hospitals, and other healthcare providers who come together voluntarily to deliver high-value care to patients attributed to the ACO, have the opportunity to share their cost savings with Medicare savings if they meet certain spending and quality metrics.

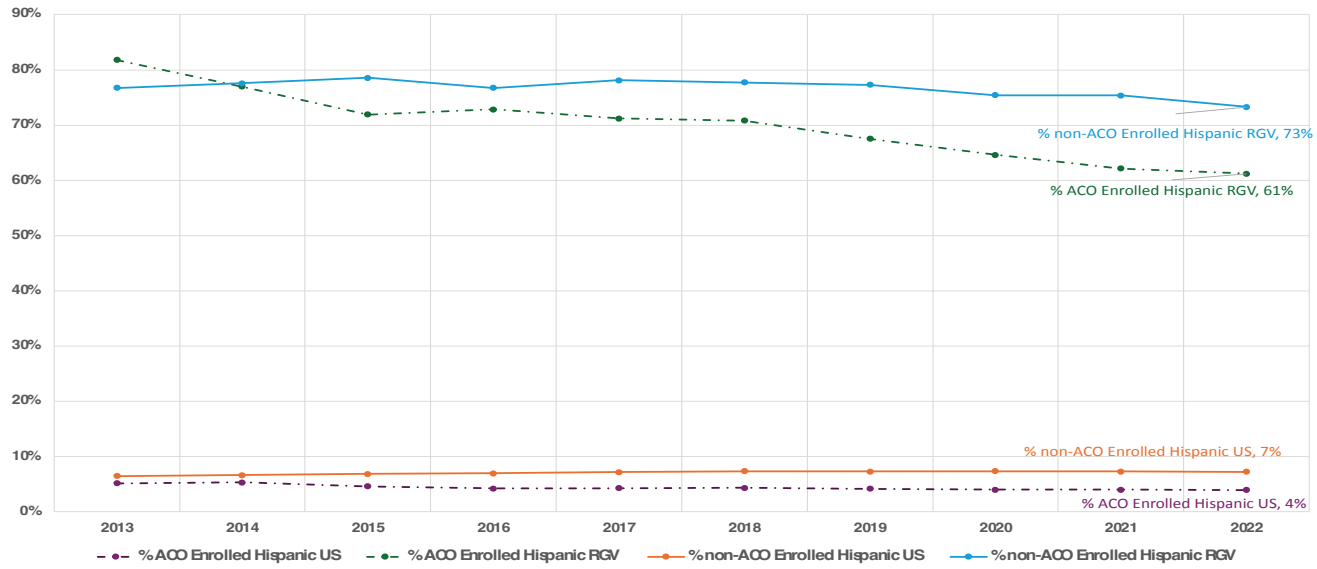
As illustrated in Figure 1, the percentage of the Medicare Fee-for-Service (FFS) population who were enrolled in an ACO across the U.S. measurably increased by nearly 20% between 2013 and 2022, from 9.6% to 28.9%. As of January 2022, the program nationally included over 525,000 participating physicians and non-physicians who provide care to more than 10 million people with Medicare.12 Similarly, the percentage of the RGV population served by an ACO has also measurably increased by nearly 20% (from 13.3% to 31.3%), with over 19,000 RGV residents now served by an ACO.1

Figure 1: Comparison of the ACO-Enrolled Medicare FFS populations in the U.S. to that in the RGV, 2013-2022



The characteristics of the ACO population at the national level and across the RGV have changed over time. A higher proportion of the ACO-enrolled RGV population and the RGV non-ACO-enrolled Medicare FFS populations are Hispanic compared to the US ACO and non-ACO populations (Figure 2); whereas the opposite is true when examining the Black population (figure not shown). While the proportion of the ACO- and non-ACO-enrolled populations in the RGV closely paralleled one another between 2013-2022, the proportion of Hispanics in the ACO-enrolled population declined relative to that in the non-ACO-enrolled population during the same time period. In the US, Blacks and Hispanics are relatively under-represented in the ACO-enrolled population.

Figure 2: Percentage of Medicare patients who identify as Hispanic, a comparison of ACO- and non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2013-2022



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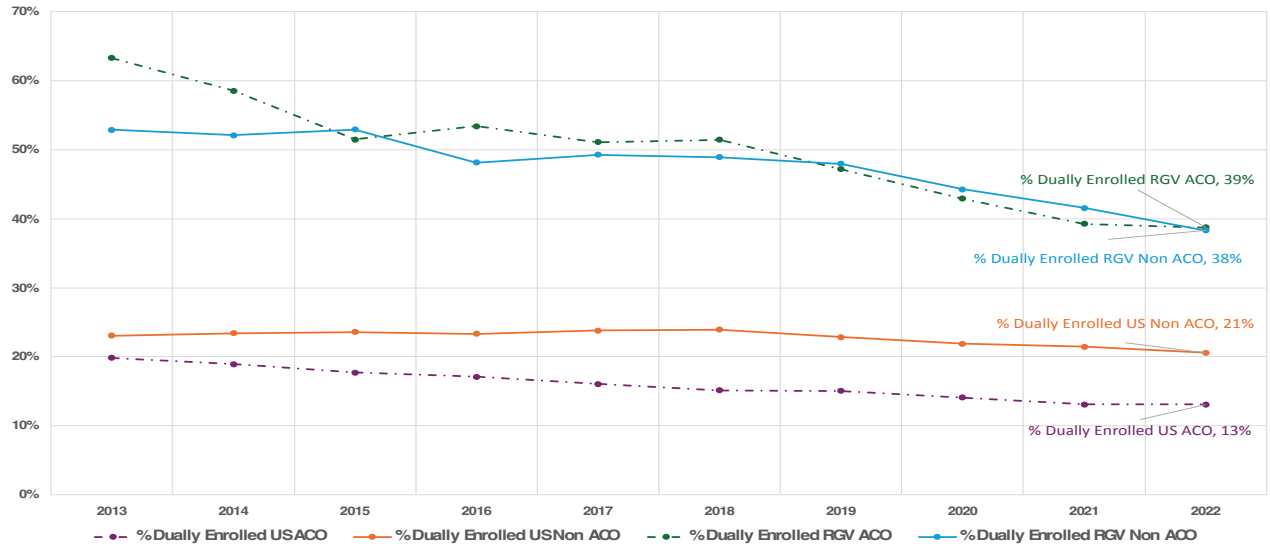
Dual-Eligible

A smaller proportion of the RGV population was "dual-eligible" in 2022 than 2013; however, that proportion is much higher in the RGV than in the US overall (Figure 3). In the RGV, the proportions of dual-eligible enrollees have been similar whether the individuals are enrolled in an ACO or not.

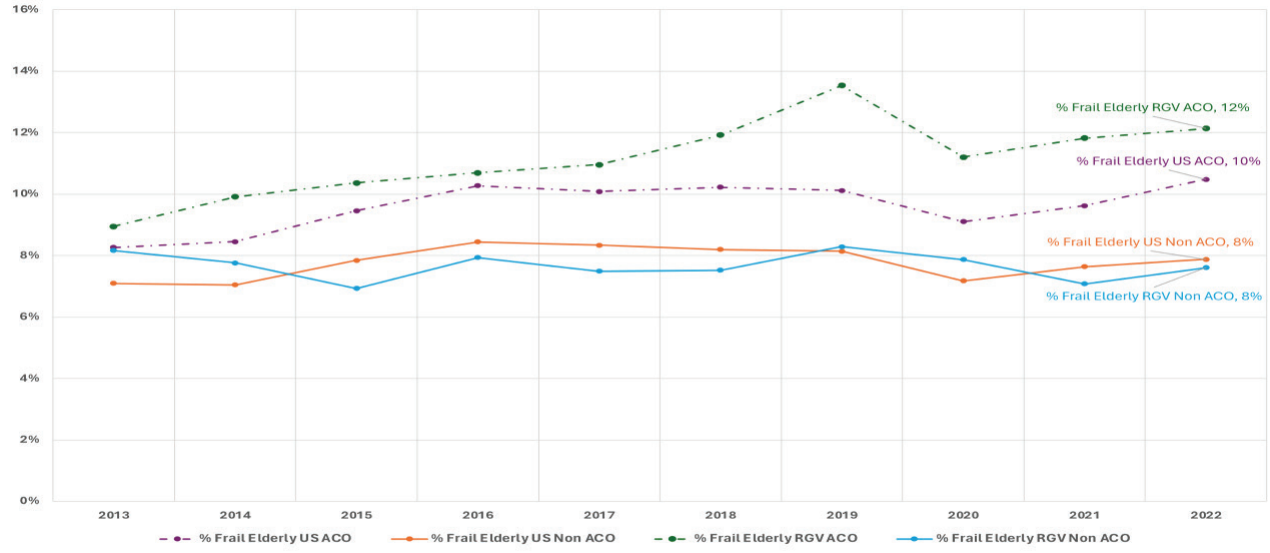
Figure 3: Percentage of Medicare patients identified as dual-eligible, a comparison of ACO- and non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2013-2022



Frail Elderly

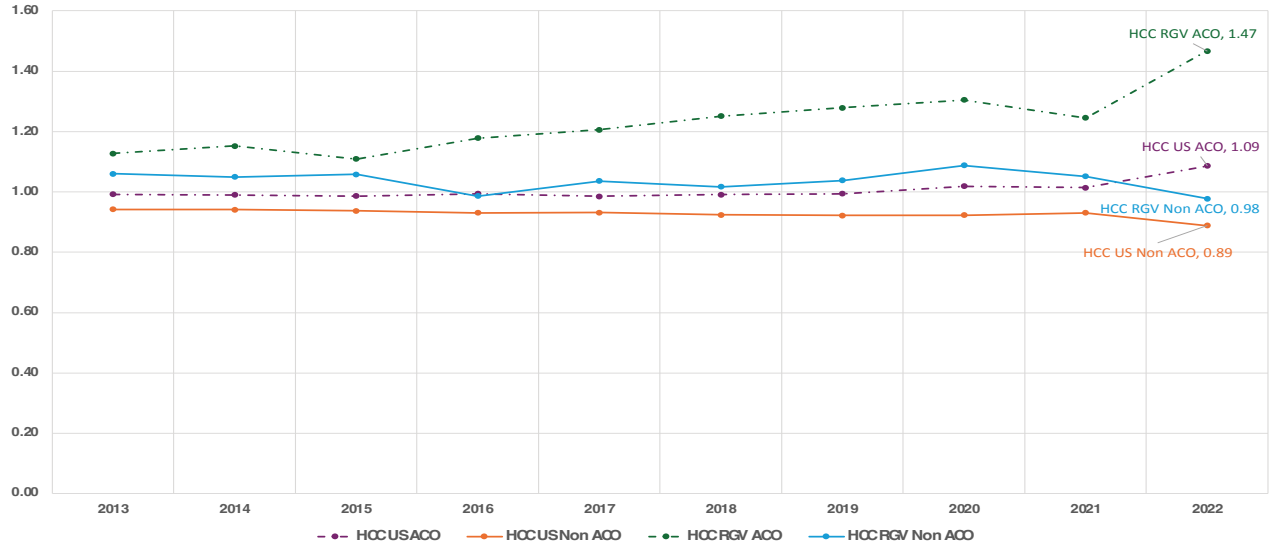
The proportion of the population that are frail elderly is higher in ACOs than non-ACOs, in both the US and the RGV, with the population proportion of the frail elderly in the RGV being higher than in the US (Figure 4).

Figure 4: Percentage of Medicare patients identified as frail elderly, a comparison of ACO- and Non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2013-2022



Hierarchical Condition Category (HCC)
Hierarchical condition category (HCC) scores show the predicted healthcare costs for the RGV ACO population in 2022 are 47% higher (a score of 1.47) than the average predicted costs for the population, a score much higher than in any other population in this study. The data also shows the mean HCC score for the ACO population across the RGV has increased consistently and rapidly over time (a 30% increase between 2013 and 2022).

Figure 5: Hierarchical Condition Scores (HCC), a comparison of ACO- and non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2013-2022

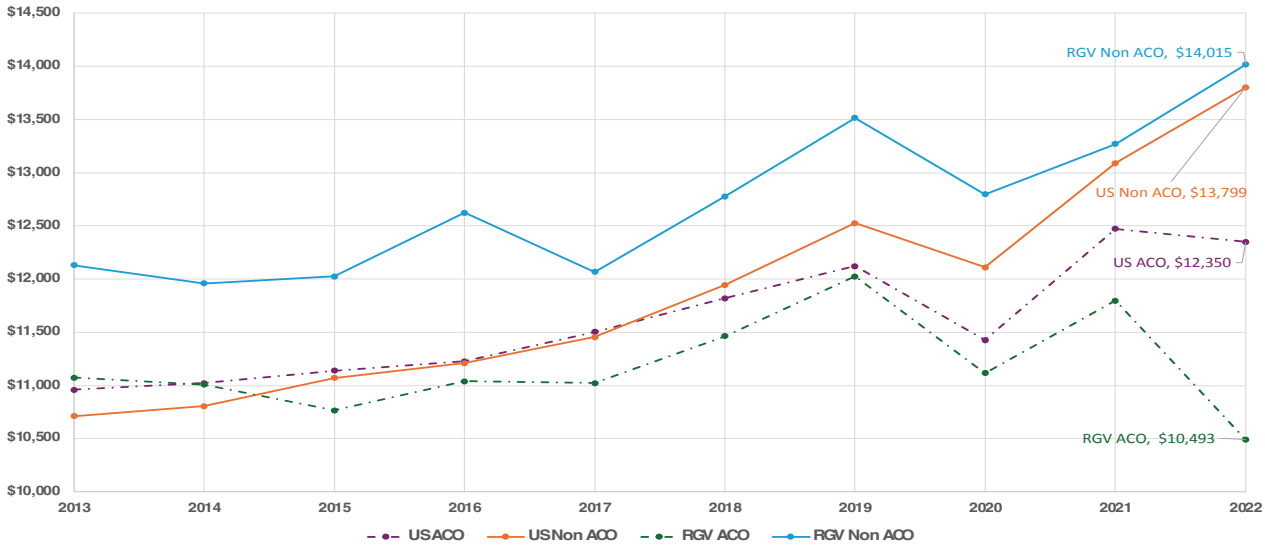


ACOs Impact on Cost

The shared savings payment model supporting ACOs is designed to reduce healthcare cost growth by motivating ACOs to proactively identify and manage the needs of each attributed patient. ACOs that are able to spend less than the projected cost of caring for their Medicare beneficiaries and simultaneously achieve quality of care thresholds are eligible to share in the savings.

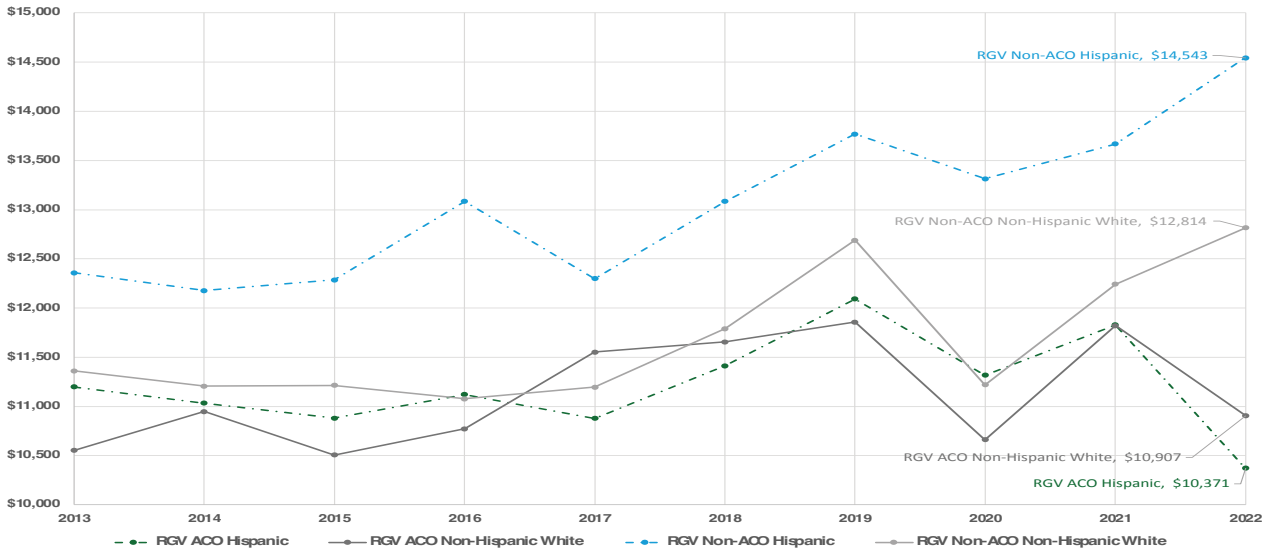
During the observed time period, data indicates ACOs at the national level and in the RGV reduced cost growth when compared to the non-ACO-enrolled population (Figure 6). When adjusting for the level of illness (by Hierarchical Condition Category) in each patient population, the total adjusted annual expenditures per member, per year (PMPY) are currently lower for ACO enrollees than for non-ACO enrollees, with divergence occurring about 2019. As of 2022, the total adjusted annual expenditures per-member-per-year (PMPY) for ACO enrollees in the RGV were $1,857 lower (15% less) than for ACO enrollees in the U.S. The adjusted PMPY has increased over time for all groups other than for ACO enrollees in the RGV. For the population served by ACOs in the RGV, the PMPY expenditures were lower in 2022 than any other time over the study period and were $3,522 less (25% lower) than the 2022 PMPY for the non-ACO-enrolled population in the RGV.

Figure 6: Adjusted total cost of care per Medicare member per year (PMPY) comparison of ACO- and non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2013-2022 (Lower is better)



It is important to note that the total adjusted PMPY in 2022 for the non-ACO Hispanic population in the RGV was 33% higher ($4,172 higher) than the PMPY for the ACO-enrolled Hispanic population (Figure 7).

Figure 7: Adjusted total cost of care per Medicare member per year (PMPY) comparison of ACO- and non-ACO-Enrolled Hispanic and non-Hispanic Medicare FFS populations in the U.S. to those in the RGV, 2013-2022 (Lower is better)



As highlighted in the figures in the appendix (Figures 17-22), the lower costs for 2022 (as displayed in Figure 6) in the ACO-enrolled population across the RGV compared to the non-ACO-enrolled population were driven by lower expenditures for Medicare Part A services ($1,313 lower, PMPY), Medicare Part B services ($540 PMPY), outpatient services ($664 PMPY), and services delivered in a Skilled Nursing Facility ($444 PMPY). While the PMPY expenditures for Home Health Agency (HHA) services were lower in the RGV population enrolled in an ACO than the RGV non-ACO-enrolled population ($678 vs. $1,094)

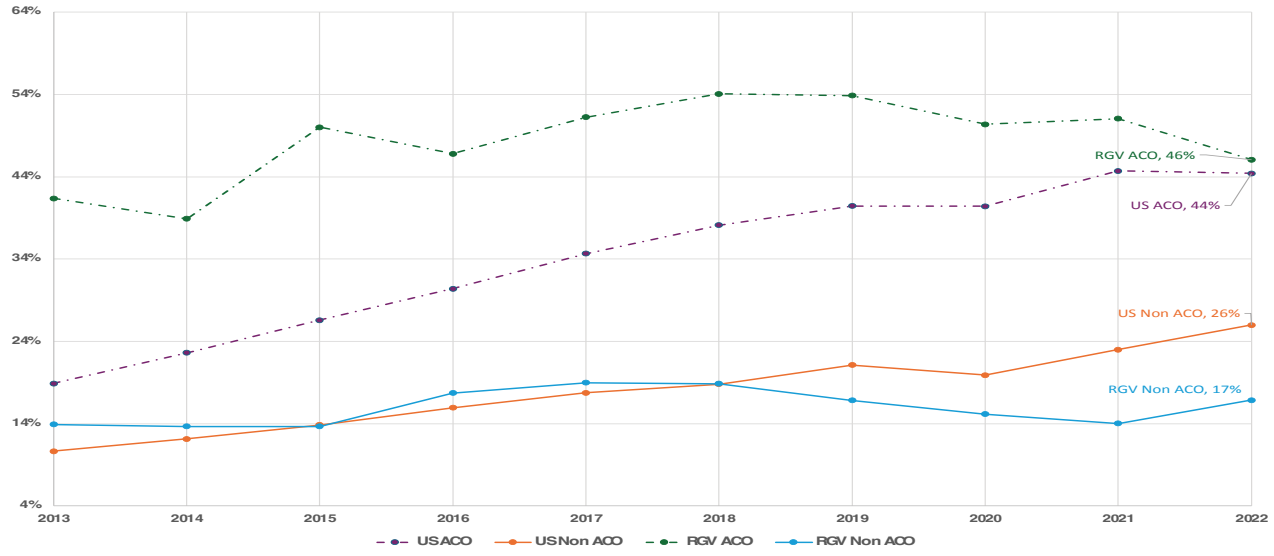
and for Hospice services ($442 vs. $584), the PMPY for the U.S. ACO-enrolled population were slightly lower than the ACO-enrolled population across the RGV for both services, $678 vs $514 and $442 vs. $359, respectively. The definition for each of the described services is listed in the appendix.

ACOs Impact on Quality

Quality measures play an important role in motivating ACOs to proactively improve the health of the population. This section highlights several quality measures that are broadly used to provide insights into the quality of proactive and equitable care provided to a population.

Annual Wellness Visit (AWV)
One strategy for optimizing care quality and population health is to engage patients at least once annually in an extended Annual Wellness Visit (AWV). Here, we found that ACO enrollees across the nation and within the RGV were much more likely than non-ACO enrollees to receive an AWV (Figure 8).

Figure 8: Percentage of patients who receive an Annual Wellness Visit (AWV), a comparison of ACO- and non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2013-2022 (Higher is better)



The US ACO population had the largest improvement between 2013 and 2022, with a 25% improvement (19% to 44%). Within the ACO population across the RGV, 46% of the Hispanic population and 47% non-Hispanic White populations received an AWV in 2022 (Figure not shown).

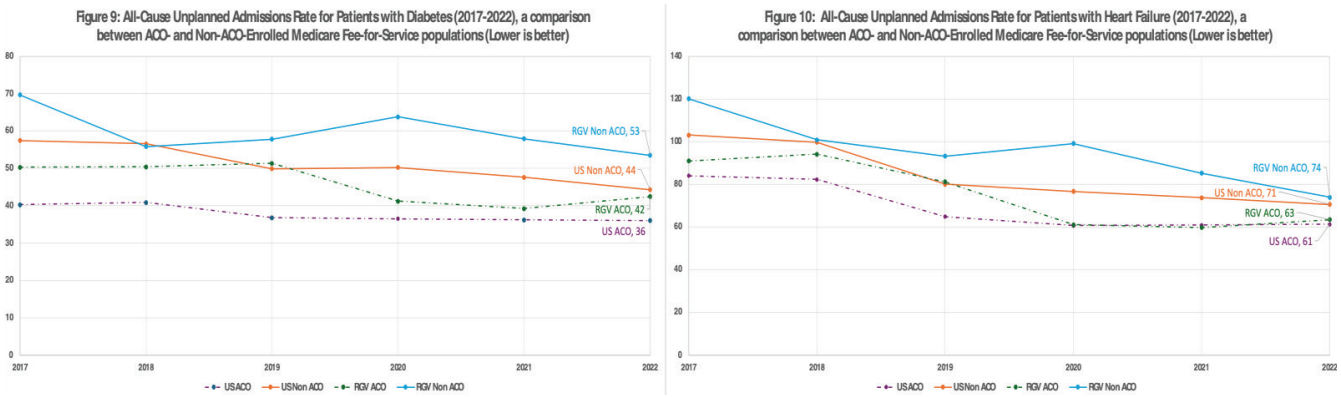
Given the proactive mindset ACOs bring to care, we also expect to see ACO patient populations having fewer unplanned inpatient (hospital) admissions and few avoidable visits to the Emergency Department (ED). The results for the time period studied show mixed results in these two measurement domains.

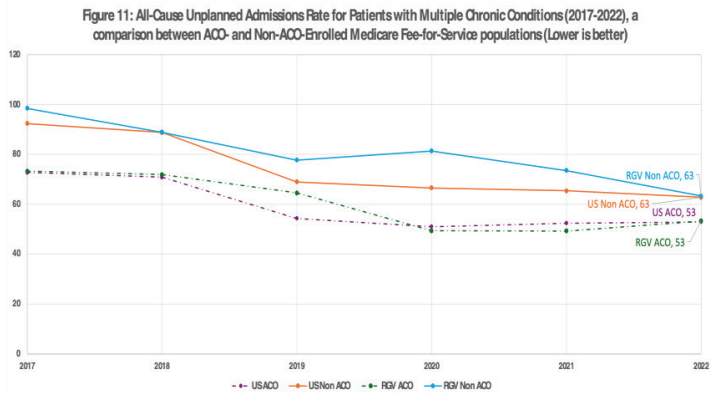
All-Cause Unplanned Admission Rate

Unplanned admissions are hospital admissions that are not scheduled in advance. These types of admissions are an important quality measure because they can help to identify health systems that are more likely to be providing care that is coordinated, preventive, and patient-centered.

When examining three measures covering unplanned admission rates for diabetes (Figure 9), heart failure (Figure 10), and patients with multiple chronic conditions (Figure 11), data show that ACOs outperform non-ACOs for all three measures at the national level and within the RGV. Between 2017 and 2022, the ACOs in the RGV showed reductions in the all-cause unplanned admissions rate for patients when compared to Medicare patients not attributed to ACOs in the RGV. However, non-ACOs serving the RGV showed a greater overall improvement (reduction) for all three measures across the examined time period when compared to ACOs in the RGV. For example, non-ACOs serving the RGV had a 24% drop in the all-cause unplanned admissions rate for patients with diabetes (Figure 9) between 2017 and 2022 compared to a 16% drop for the ACO population in the RGV. Additionally, when examining the all-cause unplanned admission rates for Medicare patients with heart failure and multiple chronic conditions, there was a larger overall reduction across the time period among non-ACOs serving the RGV than ACOs serving the RGV (38% vs. 31%, 36% vs. 27%).

Figures 9, 10, 11: All-Cause Unplanned Admissions Rate for Patients with Diabetes (Figure 9), Heart Failure (Figure 10), and Multiple Chronic Conditions (Figure 11), a comparison of ACO- and non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2017-2022 (Lower is better)

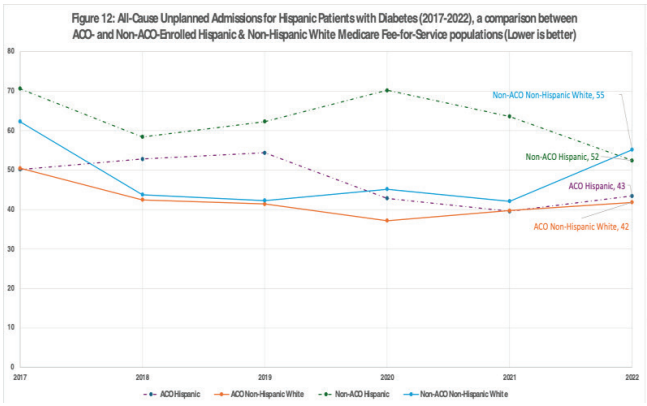


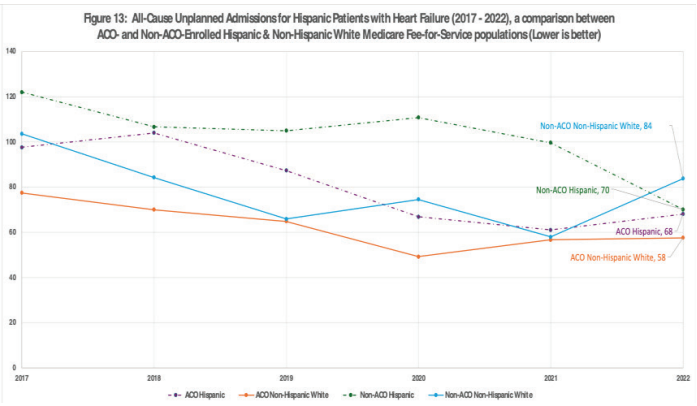


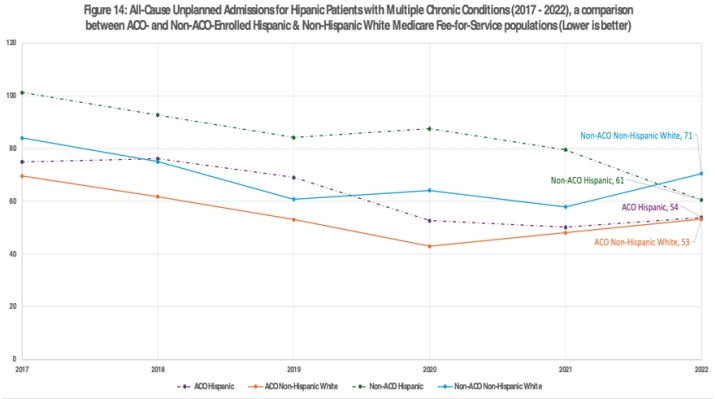
In 2022, the unplanned admission rate across all three conditions for the non-ACO non-Hispanic White population is higher for each of the conditions than for the ACO non-Hispanic White population and both the Hispanic ACO and non-ACO populations (Figures 12, 13, 14). We found the greatest percentage difference (36%) in the heart failure unplanned admission rate when comparing non-ACO non-Hispanic

White populations to ACO non-Hispanic White populations (84. vs. 58). While the Hispanic ACO population had rates similar to those for the ACO non-Hispanic population, the Hispanic ACO population has 17% higher rate than the ACO non-Hispanic population, potentially signaling underlying disparities in healthcare access, management of heart failure symptoms, or other socio-economic factors influencing health outcomes within the ACO delivery model.

Figures 12, 13, 14: All-Cause Unplanned Admissions Rate for Hispanic Patients with Diabetes (Figure 12), Heart Failure (Figure 13), and Multiple Chronic Conditions (Figure 14), a comparison between ACO- and non-ACO-Enrolled Hispanic & non-Hispanic White Medicare Fee-for-Service populations (Lower is better)





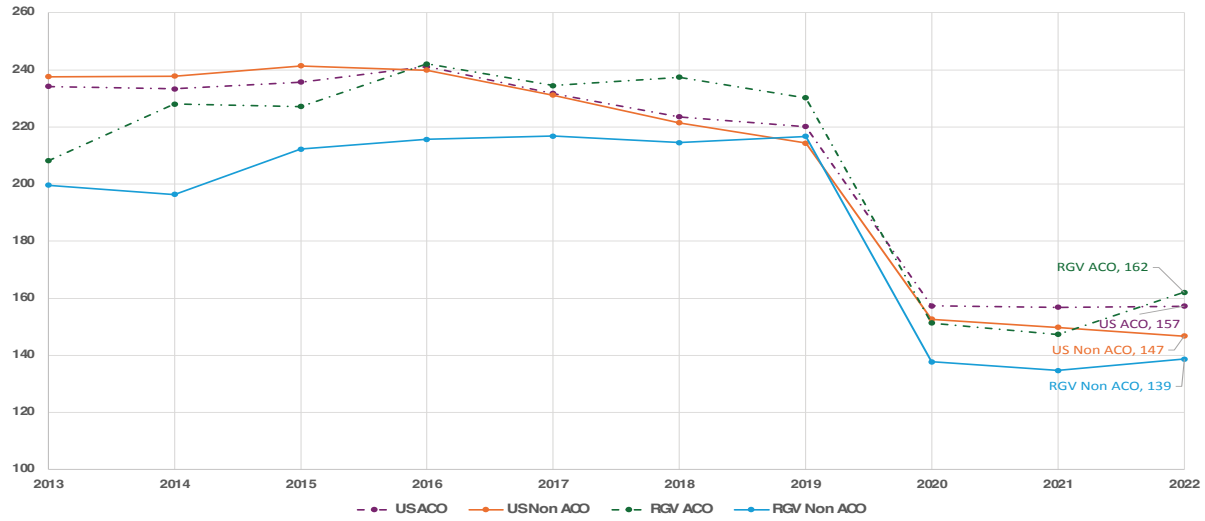


Avoidable Emergency Department Visits

Avoidable Emergency Department (ED) visits are also a measure of the quality and efficiency of care provided to patients. Avoidable ED visits suggest that these visits might have better served patients (at a lower cost) had they occurred in an outpatient or clinic setting, are generally not preferred by patients who would rather get care in a less acute setting such as a doctor's office, and often signal that patient are not receiving the proactive care they need from the local healthcare system.

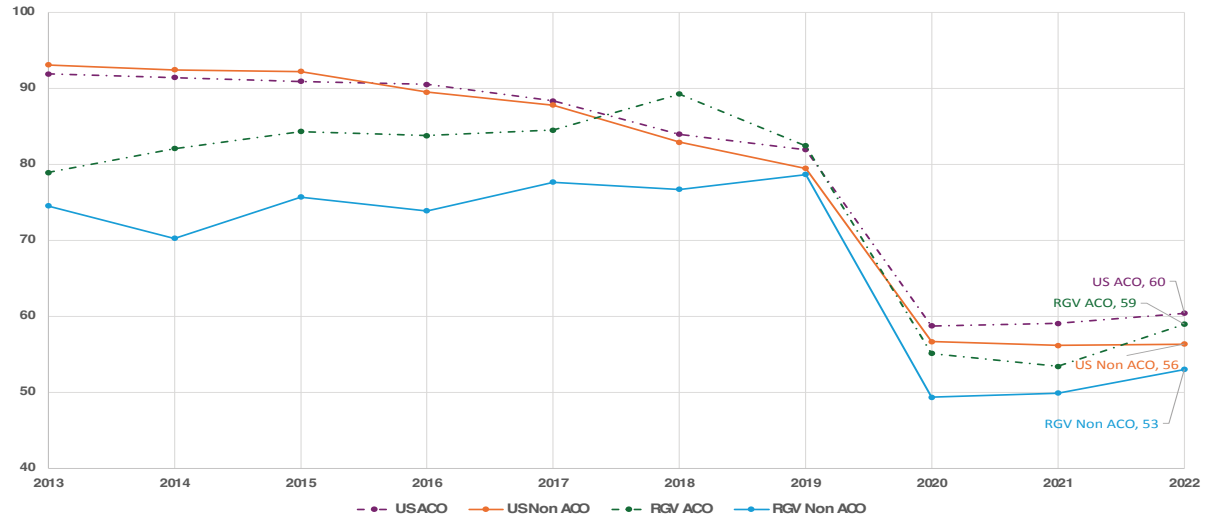
As of 2022, ACOs were performing worse than non-ACOs at the national level and across the RGV when examining two important indicators of high-value care: (1) avoidable Emergency Department (ED) visits per 1000 patients; and (2) ED visits among attributed patients for emergent, primary care treatable conditions. While the number of Avoidable ED Visits per 1000 patients has declined for all groups – particularly during the pandemic, when similar patterns were seen in all groups - ACO enrollees were experiencing higher avoidable ED visits than non-ACO enrollees (162 vs 139, a 15% difference). See Figure 15.

Figure 15: Avoidable Emergency Department (ED) Visits per 1000, a comparison of ACO- and non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2013-2022 (Lower is better)



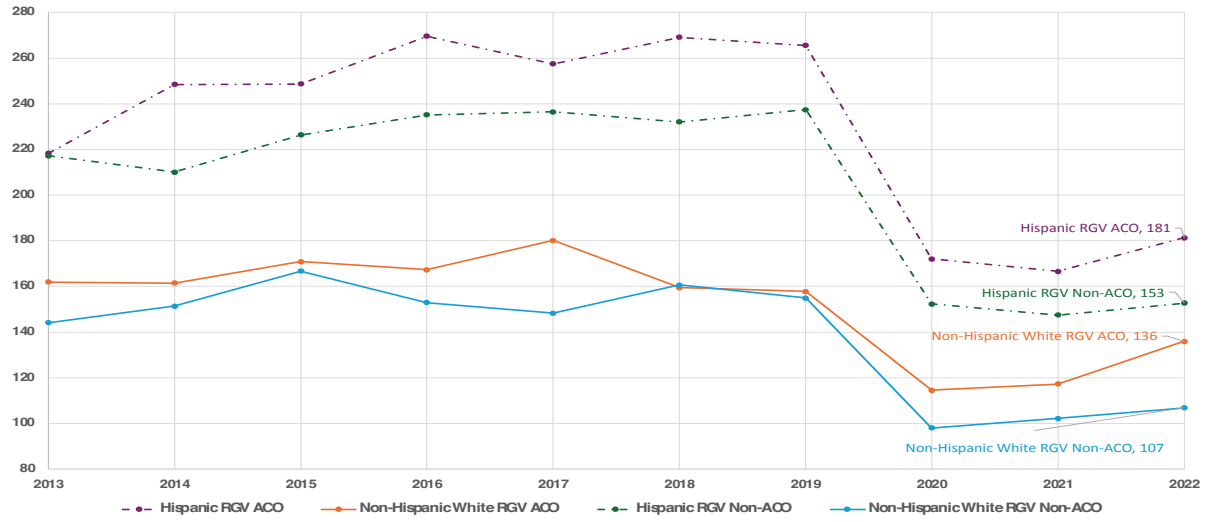
ED visits identified as primary care treatable show results similar to ED visits per 1000 (Figure 16). While the number of ED visits identified as primary care treatable has declined for all groups, ACO enrollees had higher avoidable ED visits than non-ACO enrollees (60 vs 53, a 12% difference).

Figure 16: Emergency Department Visits for emergent, primary care treatable conditions, a comparison of ACO- and non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2013-2022 (Lower is better)



As shown in Figure 17, 2022 results show a notable difference for avoidable Emergency Department (ED) visits per 1000 when comparing the ACO-enrolled Hispanic population in the RGV to the ACO-enrolled non-Hispanic White population in the RGV. Here, the ED visits per 1000 rate for the ACO-enrolled Hispanic population in the RGV (which has the highest score) is 52% higher than the ACO-enrolled non-Hispanic White population in the RGV (which has the lowest score). While ED visits per 1000 declined for all groups over the study period, the ACO-enrolled Hispanic population in the RGV declined by 17% vs. a 30% decline for the non-ACO-enrolled Hispanic population in the RGV.

Figure 17: Avoidable ED Visits per 1000, a comparison of Hispanic and non-Hispanic White ACO- and non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2013-2022 (Lower is better)

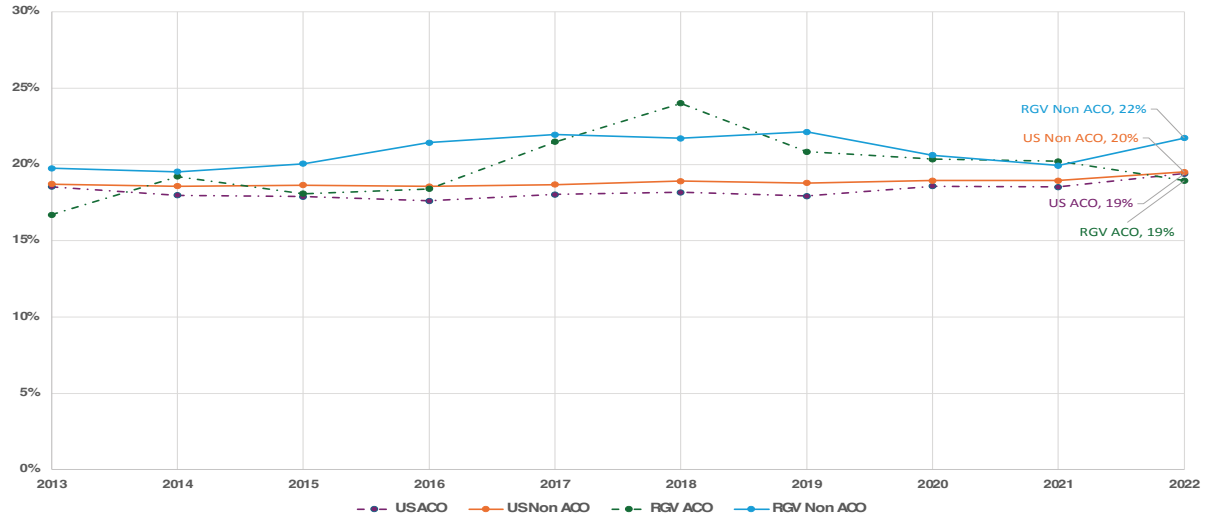


The same disparity in care is exhibited when examining ED visits among attributed patients for emergent, primary care treatable conditions. While ED visits per 1000 declined for all groups over the study period, the ACO-enrolled Hispanic population in the RGV declined the least among all groups (18% vs. the 30% observed for the non-ACO-enrolled Hispanic population in the RGV) and was 48% higher than the ACO-enrolled non-Hispanic White population in the RGV (67 vs. 41).

30-Day Readmission Rate

Another important indicator of care quality is the proportion of patients who have an unplanned inpatient (hospital) readmission within 30 days of discharge. This is because a readmission following hospitalization is a costly and often preventable event. Further, a hospital readmission, for any reason, is a major source of patient and family stress, costly to the healthcare system and patients, and can lead to the loss of functional ability, particularly among older patients. Using the 30-day all-cause readmission rate as a care quality indicator, we found that ACOs at the national level (19% vs. 20%) and across the RGV (19% vs. 22%) performed slightly better than non-ACOs as of 2022 (Figure 18).

Figure 18: 30-Day All-Cause Readmissions, a comparison of ACO- and non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2013-2022 (Lower is better)



Within the ACO population across the RGV, 30-day readmission rates in 2022 for the Hispanic and non-Hispanic White populations were similar (19% vs 20%).

Summary

Our study found several changes in the cost and quality of care for the Rio Grande Valley Medicare population since Dr. Gawande's 2009 article.

The Medicare population served by ACOs, a new value-focused care delivery model established after Dr. Gawande's article, increased in the RGV from 13% to 31% between 2013 and 2022. The population appears to have a higher illness burden compared to others, as evidenced by three commonly used illness burden indicators evaluated in this study.

Notably, in 2022, the per member, per year (PMPY) total adjusted annual expenditures – the noteworthy focus of Dr. Gawande's article – for the ACO-enrolled population across the RGV was at its lowest point since 2013 and $3,522 lower in 2022 than that for RGV residents who were not enrolled in an ACO. Of concern, however, is the finding that the total adjusted PMPY in 2022 for non-ACO Hispanic population in the RGV was 33% higher ($4,172 higher) than for the ACO-enrolled Hispanic population in the RGV.

Among the groups in our study, ACOs in the RGV were top performers when examining the percentage of the population with Annual Wellness Visits (AWVs), unplanned admission rates for patients with diabetes and multiple chronic conditions, and all-cause 30-day readmission rates (tied with the US ACOs). When examining the data for potential disparities in care among RGV residents, we found that the non-ACO non-Hispanic White population had the highest all-cause unplanned admission rates for patients for diabetes, multiple chronic conditions, and heart failure, with the ACO non-Hispanic White population having the lowest rates for all three conditions.

RGV and national ACOs were the worst performers when examining avoidable ED visits per 1000 and

ED visits for emergent, primary care treatable conditions. Here, while the ACOs in the RGV had a 22% decrease in avoidable ED visits per 1000 patients and a 25% decrease in the ED visits for emergent, primary care treatable conditions between 2013 and 2022, the ACOs in the RGV had the highest rate for avoidable ED visits per 1000 and the second highest rate for ED visits for emergent, primary care treatable conditions in 2022. The avoidable ED visits per 1000 rate for the ACO Hispanic population was 52% higher than the non-ACO non-Hispanic White population in the RGV and 48% higher for the ED visits for emergent, primary care treatable conditions measure.

Given care quality was generally the same, but patients were more complex and costs were lower in the ACO population across the RGV, it appears the value of care provided by ACOs in the RGV was relatively high compared to the US and to care obtained by the non-ACO population in the RGV.

Looking forward, it is important for the community to identify strategies that address three areas identified as low-value care for the ACO and non-ACO populations:

(1) high rates of avoidable ED visits per 1000 and ED visits for emergent, primary care treatable conditions for the ACO population across the RGV;

(2) high rates of avoidable ED visits per 1000 and ED visits for emergent primary care treatable conditions among the ACO Hispanic population in the RGV; and

(3) high rates of all-cause unplanned admissions for non-ACO non-Hispanic White patients in the RGV with diabetes, multiple chronic conditions, and heart failure.

By working collaboratively with all community stakeholders to address these three improvement opportunities – while simultaneously nurturing the positive trends in other care domains – the RGV community can make progress towards developing an inclusive and equitable high-value care system.

References

1. CareJourney's synthesis of publicly available Medicare Fee-for-Service (FFS) claims data. The CareJourney data was received for this report on August 29, 2023. The data was produced by CareJourney team members Nathan Smith, PhD and Joseph Patrick.

2. Institute of Medicine. For the Public's Health: Investing in a Healthier Future. Washington, DC: National Academies Press; 2012

3. McCullough JM, Speer M, Magnan S, Fielding JE, Kindig D, Teutsch SM. Reduction in US Health Care Spending Required to Meet the Institute of Medicine's 2030 Target. Am J Public Health. 2020 Dec;110(12):1735-1740. doi: 10.2105/AJPH.2020.305793. Epub 2020 Oct 15. PMID: 33058710; PMCID: PMC7661993.

4. National Health Expenditure Projections, 2022–31: Growth To Stabilize Once The COVID-19 Public Health Emergency Ends. Sean P. Keehan, Jacqueline A. Fiore, John A. Poisal, Gigi A. Cuckler, Andrea M. Sisko, Sheila D. Smith, Andrew J. Madison, and Kathryn E. Rennie. Health Affairs 2023 42:7, 886-898. https://doi.org/10.1377/hlthaff.2022.01397

5. "National Health Spending Explorer" Peterson-KFF Health System Tracker. Last accessed September 11, 2023, https://www.healthsystemtracker.org/health-spending-explorer/?outputType=%24pop&serviceType%5B0%5D=allTypes&sourceOfFunds%5B0%5D=allSources&tab=0&yearCompare%5B0%5D=%2A&yearCompare%5B1%5D=%2A&yearRange%5B0%5D=2013&yearRange%5B1%5D=%2A&yearSingle=%2A&yearType=range

6. 2023 Milliman Medical Index. Deana Bell, Mike Gaal, Paul R. Houchens, David M. Liner, Annie Man, Andrew L. Naugle, and Doug Norris. May 25, 2023. https://www.milliman.com/en/insight/2023-Milliman-Medical-Index/#1. Last accessed September 11, 2023

7. "Delay of needed care" Peterson-KFF Health System Tracker. Last accessed September 11, 2023, https://www.healthsystemtracker.org/indicator/access-affordability/delay-needed-care/#Percent%20of%20adults%20who%20reported%20delaying%20or%20going%20without%20medical%20care%20due%20to%20COVID-19,%202021

8. Lopes, Lunna, et al. "Health Care Debt In The U.S.: The Broad Consequences Of Medical And Dental Bills." Kaiser Family Foundation, 16 June 2022. Web. Accessed 18 Sept. 2023.

9. Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes (Commonwealth Fund, Jan. 2023). https://doi.org/10.26099/8ejy-yc74

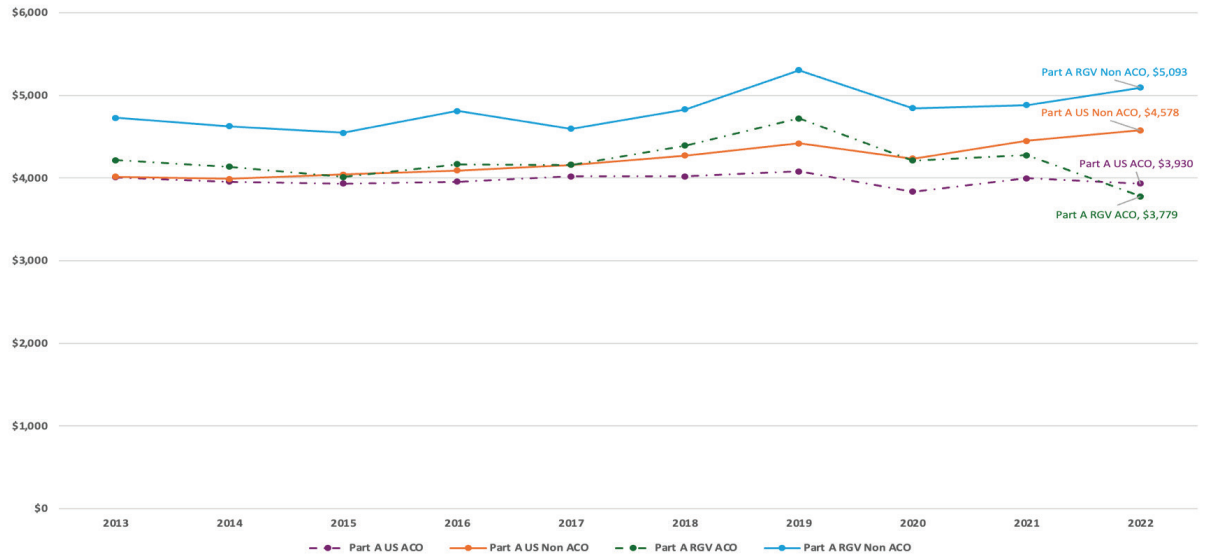
10. Our World in Data, "Differences in life expectancy across the world." 2023. Last accessed September 11, 2023.

11. University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps. 2023. Available from: https://www.countyhealthrankings.org/explore-health-rankings/texas/starr?year=2023. Last accessed September 11, 2023.

12. "January 2022 Performance Year Financial and Quality Results" Center for Medicare and Medicaid Services. Last accessed September 11, 2023, https://data.cms.gov/medicare-shared-savings-program/performance-year-financial-and-quality-results/data

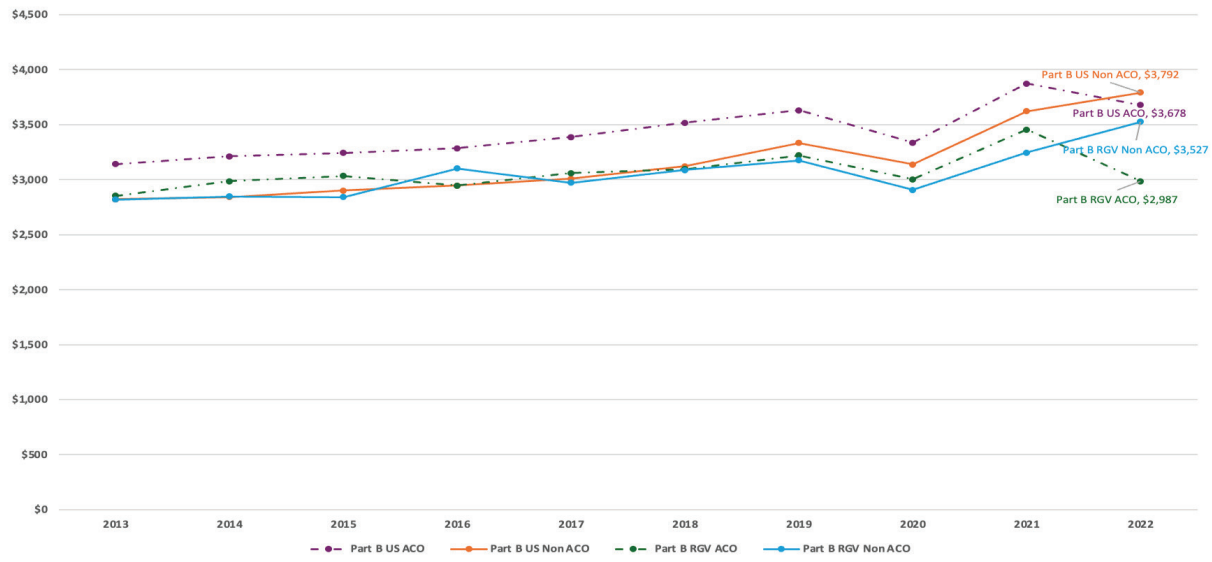
Appendix

Figure 19: Medicare Part A services* PMPY expenditures comparison for ACO- and non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2013-2022 (Lower is better)



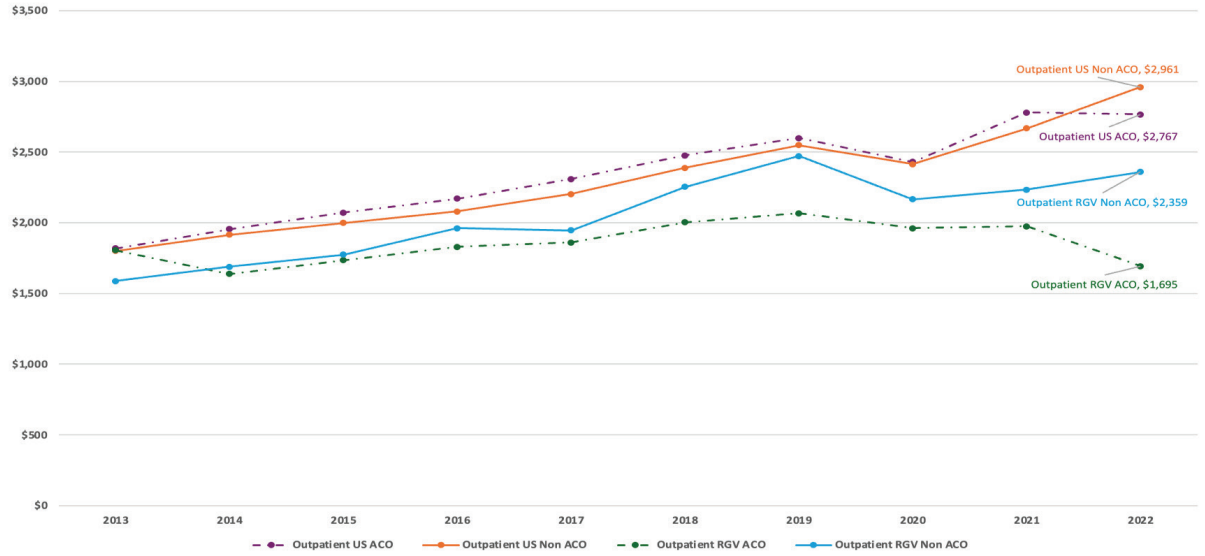
*Medicare payments for Medicare Part A primarily encompass the costs associated with hospital stays, including room and board, nursing services, and medications as part of the treatment.

Figure 20: Medicare Part B services* PMPY expenditures comparison for ACO- and non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2013-2022 (Lower is better)



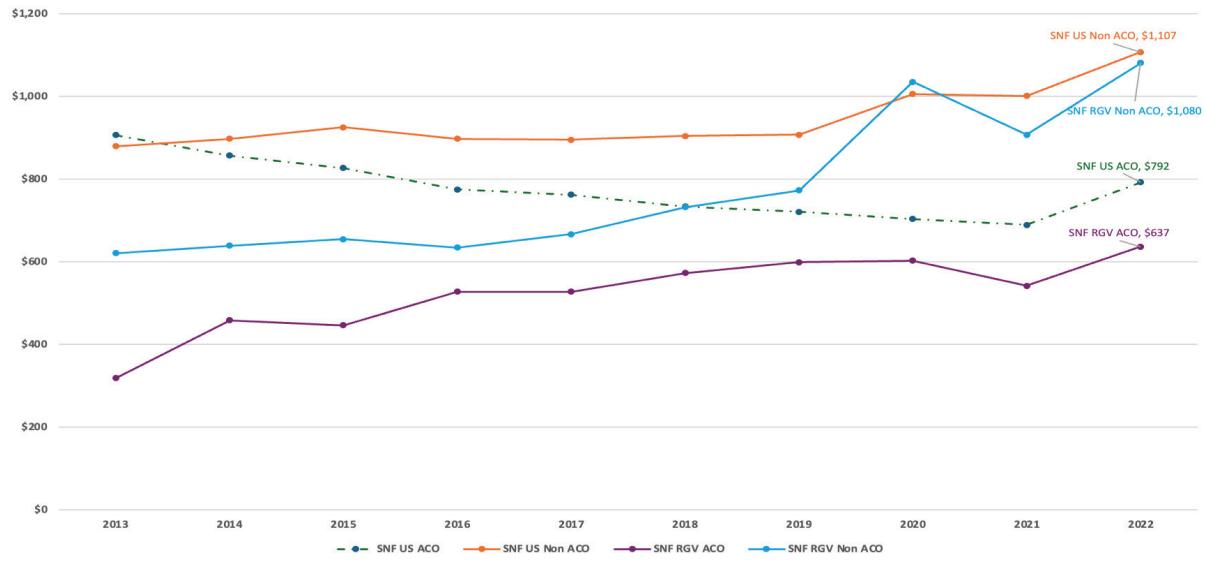
*Medicare Part B primarily covers outpatient services including doctor visits, preventive screenings, laboratory tests, and home health care.

Figure 21: Outpatient services PMPY expenditures comparison for ACO- and non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2013-2022 (Lower is better)



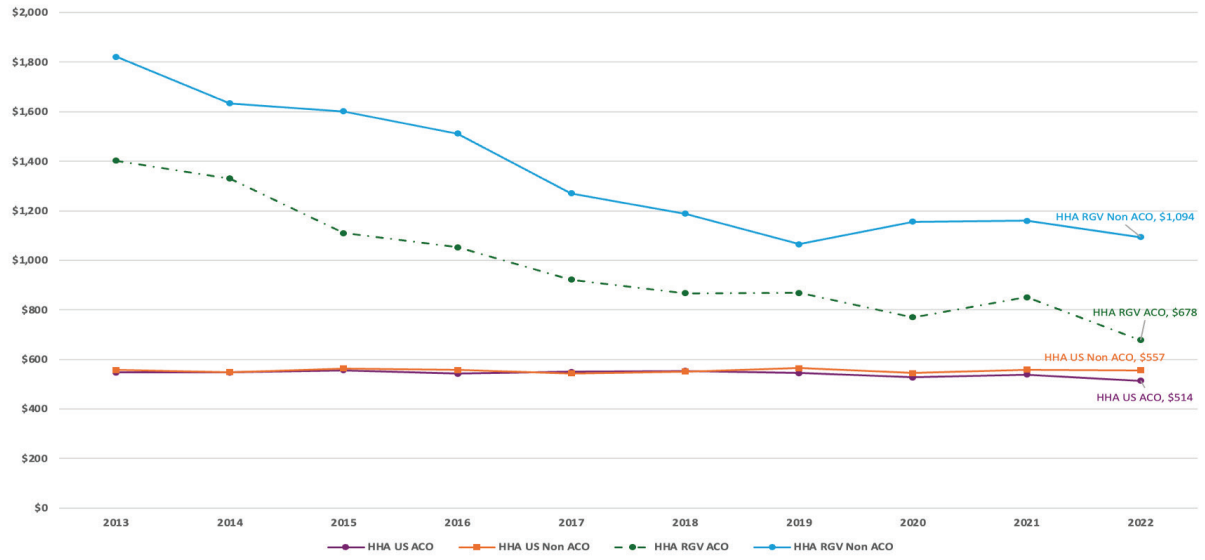
*Medicare payments for outpatient services encompass costs for medical procedures, tests, and services provided by hospitals or healthcare facilities that don't require an overnight stay.

Figure 22: Skilled Nursing Facility (SNF) services* PMPY expenditures comparison for ACO- and non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2013-2022 (Lower is better)



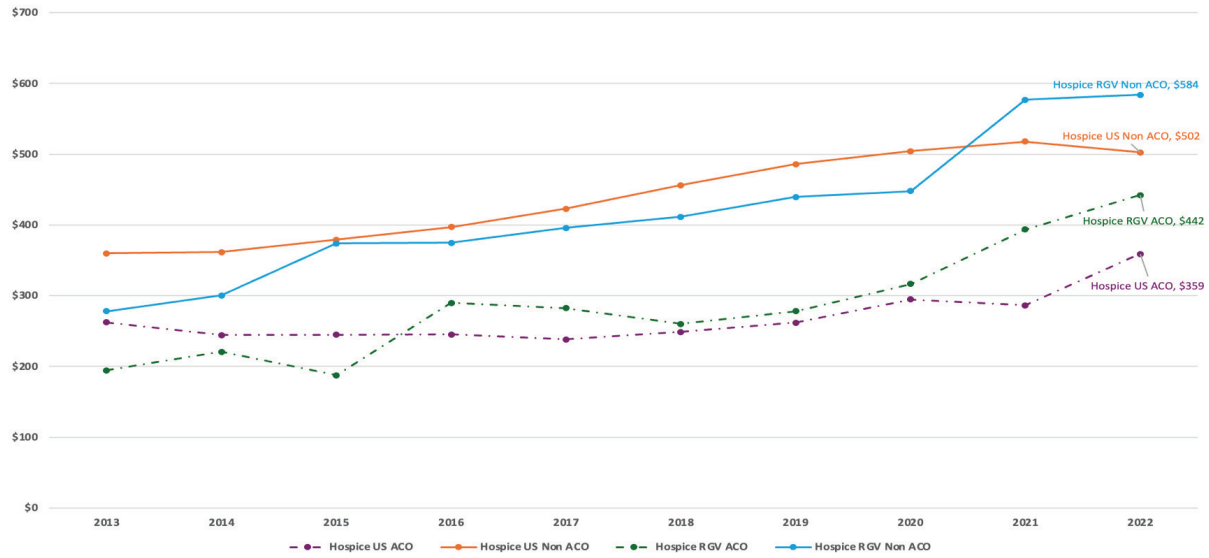
*Medicare payments for Skilled Nursing Facility (SNF) services are designed to cover short-term stays for patients who require skilled nursing care or rehabilitation services following a hospital stay.

Figure 23: Home Health Agency (HHA) services PMPY expenditures comparison for ACO- and non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2013-2022 (Lower is better)



*Medicare payments for Home Health Agency (HHA) services provide for a range of part-time, medically necessary home health services like skilled nursing care, physical therapy, and health aide services for beneficiaries who are homebound.

Figure 24: Hospice services PMPY expenditures comparison for ACO- and non-ACO-Enrolled Medicare FFS populations in the U.S. to those in the RGV, 2013-2022 (Lower is better)



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