MAYO CLINIC

A Foundation for Health Care Reform Legislation

MAYO CLINIC'S POINT OF VIEW

Mayo Clinic believes that U.S. health care urgently needs reform to ensure access to quality, affordable patient care. Each major stakeholder — doctors/hospitals, patients, payers and the government — plays a key role in reform. With reform now in the hands of lawmakers, it's important to outline the specific responsibilities that our elected officials have in helping to build a health care system that works for all Americans.

Goal

High-quality, affordable health care for all.

Government's Role in Achieving the Goal

- Reform the Medicare payment system to create incentives for caregivers to offer the highest quality care at the most reasonable cost.
- Coordinate basic, private insurance offerings and provide sliding-scale subsidies to enable all Americans to purchase health insurance.

Process

Legislation must address both issues — payment reform and insurance — simultaneously. This is the opportunity to begin a transformation toward a health care system that delivers and pays for what we really want — high quality, affordable care for patients.

Providing insurance without addressing underlying payment issues and care delivery will create significant unintended consequences — for example, restricted access for Medicare patients and early bankruptcy of this entitlement program. Historically, across-the-board payment cuts have not improved health care quality and have resulted in higher cost due to increased volumes of services provided to make up for lost revenues. We must identify novel approaches to accomplish these goals.

Detailed Recommendations — Payment Reform

Legislators must focus on creating new ways to provide fair payment to doctors and hospitals that offer high-quality, lower-cost care. The Medicare program is the lever that Congress can use to start us along this path.

We believe that Congress should set a three-year deadline for creating and implementing new Medicare payment methods. Congress must send the message to providers that they need to start now to re-engineer the care delivery models to create better value for patients, coordinate care and improve quality at a lower cost.

Some ideas to move toward paying for high-quality, affordable care include:

1. Medicare value indexing

Embed a "value index" into Medicare Parts A and B to reward those who provide safe, high-quality care with excellent service at a reasonable cost, and to provide the incentive for other providers to provide care that is of higher quality and lower cost.

For example, a value index could be defined by the equation Value equals Quality over Cost or V=Q/C.

1. Quality (Q) — the numerator — includes clinical outcomes, safety and patient-reported satisfaction.
    - Examples of outcome measures: hospital admissions, emergency department visits, readmission rates and mortality rates
    - Examples of safety measures: central line infection rates, medication errors and post-operative complications
    - Examples of patient satisfaction: National Research Corporation's *Healthcare Market Guide*

    Performance measurement information is currently available through a variety of respected sources, including the Agency for Healthcare Research and Quality, National Quality Foundation, Leap Frog, AQA, University HealthSystem Consortium, Medicare Provider Analysis and Review, and the Commonwealth Fund.

2. Cost (C) — the denominator — encompasses the cost of care *over time*. Regional Medicare spending data from Medicare itself or from the Dartmouth Atlas of Healthcare could provide the information necessary to round out the equation.

Providers would then experience payment repercussions based upon their value scores. Over time, we believe that providers would change their behaviors — sharing information, eliminating unnecessary tests — in order to increase quality and decrease costs because payment would be affected by it.

The value index can be constructed for many types of payment models, including hospital DRG payments, physician fees, payment updates and other payment formulas, including bundled payments.

2. Bundled payments for high-cost conditions, such as total knee replacement, heart attack and lumbar disc herniation

To realize cost savings quickly, Medicare should start with bundled payments for a limited number of high-cost hospital episodes. (Over time, bundled payments could be considered for some chronic conditions as well.) The goal is to reduce practice variation and focus on an outcome-based goal.

The bundled payment might include hospitalization (Part A), physician (Part B) and post-acute care (nursing home, home health care, etc.) services. The outcome would be defined as reasonably attainable improvement in health status in the safest, most cost-effective way and would cover the entire episode of care through the patient's return to function.

Such a reformed payment model would encourage improved coordination of care among physicians, hospitals and nursing homes, and it would encourage utilization of nursing

and other non-physician caregivers. It would be important to allow providers time to prepare for this method of reimbursement because many don't currently participate in organized delivery systems.

3. Value-based care demonstration project

A longer term recommendation is to develop and implement national value-based care demonstration projects. These pilots will help us determine which organizational structures and payment methods will drive quality, affordable care.

Detailed Recommendations – Insurance for All

The current private health insurance system must be reformed. We agree with the direction of the following proposal from Len Nichols and John Bertko of the New America Foundation:

- Require Americans to purchase health insurance
- Provide sliding-scale subsidies to help those in need to buy the insurance
- Prohibit pre-existing condition exclusions
- Define a minimum health benefit package or actuarial equivalent
- Adjust risk-levels among enrollees

Within the context of a reformed insurance system, we recommend that the government create a simple coordinating mechanism for individuals to select a basic private insurance plan from several options — perhaps modeled after the Federal Employees Health Benefit Plan (FEHBP). Let's give the American people the same insurance options that members of Congress enjoy. We do not support the creation of another government-run, government price-controlled, Medicare-like insurance plan. Medicare pays for volume, not value, causes significant cost-shifts to the private sector and is financially unsustainable.

Operational Framework

To carry out some of these functions, we may need to move them a step away from the direct influence of lobbyists and special interests. We recommend that Congress clearly delegate responsibility and authority to establish new methods of Medicare payment to either the Secretary for Health and Human Services (who could form an advisory board, if desired) or a quasi-independent commission. The idea is to create a longer-term, problem-solving function that is outside of yet reports progress to and is accountable for results to the U.S. government. Some functions of this body could include:

- Define, measure and create ways to pay for value, beginning with Medicare value indexing (see #1).
    - Consider starting with three to five conditions and three to five procedures that are most costly for Medicare.
- Within one to three years, link payment with these newly defined value measures.
- Require Medicare to truly negotiate with providers to find ways to reward various types of organized medical care (from virtual to bricks-and-mortar integrated practices). Examples include fee-for-service with variable updates, chronic disease coordinator payments and shared decision-making. (See addendum for more examples and explanations.)

In addition to payment reform, this board could serve as a trusted national data aggregator, making performance and pricing information publically available so that stakeholders can identify best practices and high performers. Administrative simplification might also fall under its purview.

Additional Elements

Some tools needed to achieve high-quality, low-cost care are already in place; some need to be created or expanded. These tools include the intelligent use of information technology, comparative effectiveness research, evidence-based medicine and the science of care delivery.

Summary

We believe that health care must be reformed and support reform efforts aimed at providing high-quality, affordable care for all Americans. Lawmakers must propose and pass bold, innovative legislation in order to accomplish this.

Addendum: Pay-for-Value Approaches

- ***Shared Savings***. For high-cost patients (such as patients hospitalized for diabetic-related complications), determine the annual cost per patient for each separate provider system. The payer would share this information with each provider system and offer to share savings in total cost per patient with each provider system that can deliver such savings while maintaining or improving patient outcomes.

- ***Chronic Condition(s) Coordination Payments***. Under this approach, patients with one or more chronic conditions would choose a "medical home" (place with resources and infrastructure to organize and coordinate care over time) for their care management, preventive care and minor care associated with those chronic conditions. The medical home would receive a periodic, prospectively-defined "care management payment" to cover those services. Acute patient care episodes would be paid separately under regular insurance coverage rules.

- ***Varied Provider Payment Updates***. This approach would expand the concept used by the CMS-Premier Hospital Quality Demonstration Project. For the hospital-based episodes of care (hospitalized patients account for the majority of health care expense), use risk-adjusted patient outcome measures (mortality, safety, patient satisfaction) and cost over a span of time (such as the Dartmouth Atlas cost in the last six months of life) to determine which care systems are delivering the best value. Providers delivering the best value would receive a larger payment update.

- ***Full Capitation***. Some large, integrated providers can accept full capitation for a defined benefit set for an enrolled population. This is an excellent way to encourage provider efficiency. Shared-risk agreements can be created for groups of various sizes, including smaller groups. It will be important, and possible, to develop capitation approaches that take into consideration the lessons learned from the failures of capitation in the 1990s.

- ***Shared Decision-Making***. Under this approach, all patient candidates with selected conditions that include preference-based elective surgery and other treatment choices (for example, spinal fusion, PSAs, etc.) would be offered an approved decision aid based on their disease/condition

and its treatment options. Medical centers would be compensated for offering the independent educational program. It may be appropriate to create incentives for payers to offer these programs and for patients to complete them.

- ***Accountable Care Organizations***. Under this approach, a group of physicians (and possibly a hospital) could be responsible for quality and overall annual Medicare spending for their patients. Different payment models could be tested. For example, physicians would be paid FFS rates, less a withhold, and then receive bonuses for meeting resources use and quality targets over the course of a year. Options might include creating virtual accountable care organizations based on physician-hospital referral relationships. Such an approach would create incentives for physicians and hospitals to work together to provide better value care.

- ***Episode-Based Payments for Hospitalized Patients***. This approach would provide a single bundled payment to hospitals and physicians managing the care for patients with major acute episodes. One lump payment for both hospital and physician services is different from the present Medicare DRG payment that only covers the hospital service. The new approach is intended to encourage the two groups (hospital and treating physicians) to effectively integrate patient care.

  The idea of "episode-based payments for hospitalized patients" is to concentrate efforts where the dollars are and not get bogged down trying to change payment approaches for all medical services. This is especially pertinent since 10-15% of patients will account for 80% of total costs.

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