

## Mayo Clinic Response to Senate Finance Committee

May 15, 2009

Mayo Clinic appreciates the opportunity to comment on your recent policy options paper *Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs*. We commend your efforts to face the enormous challenge of reforming our dysfunctional health care system, but we believe that most of the options attempt to merely build on past initiatives which have had limited success. Some of the ideas will likely be opposed as too bold by those who wish to defend the status quo, but we are concerned that they are not bold enough to address the serious deficiencies in the existing system.

Mayo is currently working with a number of premier health care organizations and other groups to develop a vision for the future of Medicare as a value-based model, and to lay out specific strategies and a time frame for achieving that vision. The deliberations of this group will conclude with a policy forum on May 27-28, and the output will be shared with you soon thereafter.

Today we are providing our reactions to your options outline, and suggestions for what we believe is a better approach to paying for value.

### **Overview – Pay for Value**

We believe that the health care delivery system must be realigned to provide better value, i.e., better clinical outcomes, safety and patient satisfaction at lower cost. This goal is similar for all health care professionals, hospitals, and other groups. In your review of policy options, you have identified problems and potential solutions for hospital care, physician care, use of imaging services and care coordination. As we considered the challenges you outlined, we identified an alternate approach that will reward value consistently, be easy to implement, and does not create a barrier to continuous innovation and quality improvement.

The concept we propose is the use of value indexing within the reimbursement system. Value is defined by an equation  $V=Q/C$  where Quality (Q) represents clinical outcomes, safety and patient-reported satisfaction and Cost (C) represents the cost of care over time. A value index can be constructed for many types of payment models, including hospital rates, physician fees, payment updates, and other payment formulas.

We have previously shared with Senate Finance Committee staff a specific application of a value index to the Medicare physician fee schedule. An updated version of that proposal is found in Appendix A.

The use of value indexing can be applied using current payment formulas and payment areas (as under the physician fee schedule), or using other existing areas such as hospital referral areas as under the analyses from the Dartmouth Atlas. Applying a value index to areas creates the incentive and catalyst for physicians, hospitals and other care providers to better coordinate patient care and integrate the delivery system.

This approach also eliminates the need to focus on line items or micromanagement of services such as imaging or lab utilization. This approach is simple, the data are already available and it is flexible enough to use over many years.

We believe this is a more effective approach to facilitate more rapid progress toward the transformation that is needed to achieve better value in the U.S. health care system. The approach utilizes to a great degree the Dartmouth Atlas data on regional variation that were mentioned multiple times at your May 12 Roundtable.

## **Comments on Specific Options**

### **Hospital Value Based Payment**

The current committee proposal will take too long to alter the Medicare payment system to reward value, as it waits until FY 2012 to collect data, and FY 2013 to initiate actual value-based payment. Our simpler approach would yield a faster, more effective mechanism of paying for quality and value.

There are some other limitations to the committee proposal for hospital value based payment. The proposed option suggests adding measures; we believe that we already have enough measures and that we need to refine them. The proposed option would base payments on 30-day mortality and on process measures for AMI, heart failure, pneumonia and other conditions. The statistical methods used to determine 30-day mortality ensure that virtually all hospitals in the U.S. are statistically similar in their performance. Our suggestion is to consider mortality on a regional/state basis, and to also include measures of patient satisfaction and regional cost, to better promote value.

The committee proposal for paying bonuses is limited in its ability to effectively pay for value. The base payment (less the reduction needed to fund the incentive pool) would be the same for all hospitals, including those with poor quality. If hospital revenues were distributed uniformly across the percentile ranks in quality, the actual incentive payment in 2013 would be a maximum of 4% of revenues. A hospital at the median value of quality could potentially only gain another 2% of revenue. A hospital at the 75<sup>th</sup> percentile would have absolutely no incentive for additional improvement. This would seem to create an incredible bureaucracy for detailed financial calculations, and insufficient incentive to make the necessary efforts that are required to improve quality.

Alternative Approach: We propose using a value index for hospital payment:

Value = Case-mix adjusted hospital mortality compared to expected+ Net Promoter Score

Per capita expenditures for last 12 months

One approach to moving toward value-based purchasing would then be to adjust provider payment based on a value score using the following structure.

<u>Hospital Value Score</u>	<u>Reimbursement Received</u>
Significantly above median (>84 <sup>th</sup> percentile)	+10%
Above median (67 <sup>th</sup> -84 <sup>th</sup> percentile)	+5%
Near median (33 <sup>rd</sup> -67 <sup>th</sup> percentile)	Normal
Below median (16 <sup>th</sup> -33 <sup>rd</sup> percentile)	-5%
Significantly below median (<16 <sup>th</sup> percentile)	-10%

The advantages of such an approach are:

- It could start now, as outcomes data are already available.
- More sizable payments affecting two-thirds of the hospitals would provide much greater incentive for medical centers to improve those factors impacting value – outcomes, service (net promoter score), and cost over time; the total scale of reimbursement adjustments (-10% to +10%, or 20%) is of sufficient magnitude to drive provider change.
- It would more favorably influence appropriate use of all resources, including advanced digital imaging, laboratory testing and all other resource use, as these costs would be reflected in the denominator of the equation.
- The reimbursement adjustments could be introduced over 2-3 years to facilitate ongoing adjustments, and then adjusted as better data became available.

As part of this approach, we suggest that payments be adjusted for all providers in the hospital service area or referral region (as is currently calculated in the Dartmouth Atlas) This would quickly influence multiple providers to develop better coordination of care to further improve clinical outcomes, reduce costly readmissions, enhance patient satisfaction and help reduce overall costs (by achieving better outcomes, fewer readmissions, and more rationale use of imaging, laboratory testing and other resources). It is more likely to achieve the overall objective of health reform in the United States by aligning payment reform to support physicians and providers working together in a hospital service area or referral region to create better value for patients.

### **Linking Physician Payment to Quality Outcomes: PQRI**

Completion of a MOC practice assessment is desirable, but will not likely lead to substantial reform. This is a process measure, rather than a measure of value. It will be already be required of virtually every physician in the U.S. by 2015(certainly all

who are board certified) for recertification. Many state licensing boards may shift to a similar requirement. Thus, virtually every physician would qualify for PQRI payments.

The PQRI program reporting would remain as difficult as it is now, and the administrative costs of compliance would likely outweigh even 5% penalties for failure to comply.

Alternative Approach: We propose adding a value multiplier to the physician work component for Medicare payment, as detailed in the separate proposal entitled “*A First Step Toward Paying for Value in Medicare*”:

Value = quality (state or regional measures of outcomes, service and safety)

Cost (by Medicare payment or referral region)

The advantages of this approach are:

- It is simpler and can be applied to all physicians within the current physician payment system, using the Medicare fee schedule. Current PQRI measures cannot be used by all physicians (especially sub-specialists).
- It would more favorably influence appropriate use of all resources, including advanced digital imaging, laboratory testing and all other resource use since the costs would be reflected in the denominator of the equation.

## **Evidence-Based Decision Making for Imaging Services**

### **Transparency in Self Referrals**

The proposed option to require physicians to inform patients in writing of alternate providers of imaging services would be an administrative nightmare. “A list of suppliers” in a major city like New York, Chicago, or Los Angeles would obviously pose an undue burden, and be of limited utility to the patient. For tertiary providers like Mayo, it would be very difficult to determine that services available in other practices would be truly equivalent to what we would provide, with respect to both the actual technology (comfort related to faster CT scans rather than older scanners) as well as the level of experience of our radiologists. There is no evidence that this approach would necessarily reduce the problem of overuse of complex imaging services.

### **Adherence to Appropriateness Criteria for Imaging Services**

The proposal to vary payment to ordering physicians and apply a reduction to the conversion factor for **all** services furnished by the physician (not just imaging

services) is too difficult to administer, and not evidence-based. Although the initial efforts of some professional groups to develop appropriateness criteria are well-intended, these criteria have major limitations:

1. The scientific evidence to support their development is limited. Most clinical practice guideline recommendations for imaging are based on “expert opinion”
2. There is no proven, generally accepted methodology for their development. One recent study found that appropriateness criteria varied substantially between different expert panels convened by the same professional organization.
3. There is scant (if any) evidence that their publication or application leads to a substantial reduction in imaging services. Published studies report modest (5-20%) rates of inappropriate studies, when there are reported regional differences of greater than 400-500%.
4. These criteria will potentially interfere with clinical judgment, as some patients will merit images that are generally “inappropriate” and others will not merit images that are generally “appropriate”
5. Such criteria will not reduce duplicate imaging services in different locations over a short period of time(as long as each image is “appropriate”)

The committee proposal would not alter physician payment until 2013.

Alternative Approach: The adoption of the previously proposed value index would immediately allow an adjustment for good or bad value on an ongoing basis. It could be refined each year from available data.

If the committee wished to specifically focus attention on imaging, it could add a separate value multiplier to the physician work component for Medicare payment, using overall imaging services in a region (compared to the national average), and thereby reduce payment to regions which are definite outliers (for example 50% or 75% above the national average) in their use of imaging services. Such a policy could be announced this year and implemented when 2010 data were available. It would promote value in the decisions made by ordering physicians, and reduce duplicate imaging services in a given region.

In addition, CMS should create incentives for rapid adoption of fully functional EMRs that can incorporate point of care decision support using the most recent appropriateness criteria for imaging, as well as for many other diagnostic and therapeutic choices. CMS should avoid “black-box” benefit managers and instead spend its money to put better clinical decision support systems in the hands of ordering physicians.

## **Hospital Readmissions and Bundling**

The major problem with the committee's readmission proposal is the withhold mechanism used for its financing. It also does not directly address the need to reward value in creation of care.

For both readmissions and bundling, published data show that a substantial minority of patient admissions under Medicare are not affiliated with a single primary and a single secondary hospital. How the hospital care received by these patients (presumably at tertiary hospitals) will be handled in such a system is highly problematic. In some cases, the patient may start out at a primary hospital but then be seen at a remote tertiary hospital (such as Mayo) within a few weeks. In other cases, the reverse will be true. This will create an enormous problem, particularly when patients cross state lines and enter different Medicare referral regions.

Alternative proposal: The proposed value index would account for the costs of readmission in the total cost of care represented in the denominator of the equation. Identification of readmissions with particular hospitals would not be necessary, as the decrease in patient satisfaction would be reflected in the numerator of the value index and the increase in costs would be reflected in the denominator

## **Accountable Care Organizations**

The major deficiency of this committee proposal is that the specific health systems that Congress wants the overall health care system to emulate (such as Geisinger, Mayo, Intermountain Health Care) would not be rewarded in any way by this system, as it measures only growth rates and does not take into account any "baseline" differences.

## **Summary**

A simple value index applied to payment for hospital and physician services would be easy to implement quickly, without additional measures development, and would more effectively help move the United States toward transformation of its health care system to more consistently deliver high value health care. Our alternative proposal would more effectively address the problems noted in the policy options.

We appreciate your consideration of our alternative approach and would welcome the opportunity to work with you to achieve the mutual goals of creating value in health care, coordinating care, developing new payment systems to reward value and achieving affordable health insurance coverage for every American.

As we stated earlier, we look forward to sharing with you with a broader vision and strategy for value-based Medicare at the conclusion of our current policy forum deliberations.

For information please contact:

Bruce Kelly  
Director of Government Relations  
Mayo Clinic

202-327-5424

[Kelly.bruce@mayo.edu](mailto:Kelly.bruce@mayo.edu)

## Appendix A

### A First Step toward Paying for Value in Medicare

Version 2.0

Medicare physician fee schedule currently indexes payment amounts for each of the 3 components of the fee schedule: physician work, practice expense, and malpractice.

These indices reflect differences in input costs for practice expense and malpractice insurance, and cost of living differences for physician work. All of these indices are based on external inputs, not on outputs. If we want better outputs (value) we should reward better outputs.

Physician work is the component of the fee schedule that produces value, and controls the outcomes of care. Physicians should be rewarded on the basis of outcomes, both high quality and efficient use of resources.

There is general consensus that Medicare should reward value. Value consists of both quality and efficiency. There are good ways to measure both quality and efficiency for populations within the payment localities that are currently used for the Medicare physician fee schedule, or for states (most states are a single payment area for Medicare purposes).

Linking rewards to the outcomes for the entire payment area creates the incentive for physicians and hospitals to work together to improve quality and use resources efficiently. Medical societies and hospital associations are state-based organizations and will be in a position to help bring together all the physicians and hospitals in the state to improve both quality and efficiency.

A major criticism of fee-for-service payment is the incentive to produce volume rather than value. This indexing will put a governor on volume because those who produce more volume will need to also improve care, or the increased volume will negatively impact fees.

This modest change will nudge Medicare fee-for-service payments in a positive manner. It will be disruptive enough to encourage the process of delivery system reform but will not be so disruptive that huge shifts in payment will result. The change can be phased in over several years if necessary to smooth out the transition. Over time this concept could be expanded to the entire fee schedule and/or to hospital payments.

The proposal is simple to understand and to execute. It involves only one change in the current Medicare physician fee schedule formula.

### **Examples:**

The goal is to reward both high quality and efficiency (lower total costs of care as measured over a period of time).

Value = quality divided by efficiency.

Higher quality raises the numerator; lower cost lowers the denominator

High quality and low cost: Quality is 5% above national average  
Cost is 5% below national average

$$\frac{1.05}{0.95} = 1.105$$

Low quality and high cost: Quality is 5% below national average  
Cost is 5% above national average

$$\frac{0.95}{1.05} = .905$$

High quality and high cost: 1.05 = 1.00  
1.05

Low quality and low cost: 0.95 = 1.00  
0.95

### **Measures**

There are very good measures for efficiency available from the Dartmouth Atlas and similar analyses. Efficiency can be measured using Medicare spending per beneficiary. We need to check whether this can be adjusted for age and severity, and whether it can be calculated with the effects of the GPCI indexing removed. Total Medicare payments in last 2 years of life may be another option which would reduce severity adjustment problems. Medicare spending should include both parts A and B.

There are many state measures of quality. Commonwealth Fund data for the State Report Card includes numerous quality measures. There are other sources such as AHRQ and NCQA. A composite index could be created easily from existing sources. Quality measures should include outcomes, safety, and service (patient satisfaction)

Most Medicare part B payment areas are whole states. Both quality and efficiency measures are available for states. For payment areas that are sub-state, cross walking efficiency data from the Dartmouth Atlas hospital service areas to the Medicare payment areas would be relatively easy. Quality data would likely need to be state –based.

Medicare should be given the authority to update the indexing mechanism as better data sources become available.

### **One Step**

This proposal does not solve the many problems associated with current fee-for-service reimbursement, but is a doable step in the right direction. It also works well within the context of other payment reform models, such as service bundling, coordinated care payments, chronic disease management, and medical home.

### **Addendum (3/23/09) -- Variations on the Theme**

Based on discussions with congressional staff, we are adding some thoughts and suggestions to the mix. There seems to be a favorable response to the concept of a geographic value index, but there are concerns about the political realities that will result from the payment redistribution.

#### Transition

There are many ways to smooth the transition over the short term, but for the long term we believe the full implementation will have a positive effect for all areas. Physicians and hospitals will have properly aligned incentives to increase the quality of care for the population and to make better use of resources. Over time, both quality and efficiency will move closer to the mean, while the mean will be constantly moving in a positive direction.

Examples of transition models include:

Geographic adjusters could be left in place, and the value index could be applied as an adjustment to the total fee schedule (not just the physician work component), with a gradual phase in of the value adjustment. For example, the value adjustment could apply to 25% of the overall fee in year one, 50% in year 2, 75% in year 3 and fully thereafter.

Floors and ceilings could be put in place that would limit the effect in early years. For example, a year one floor of 0.8 and a ceiling of 1.2.

The proposal as described could be phased in over several years, for example, by applying the value index to 50% of the work component and

applying the current GPCI to 50% of the work component in the initial year or two.

Transitions are commonly used when payment models are changed (DRGs for example), but they must be designed to phase out over time in order to achieve the goal of paying for value.

Examples that would not be as good as transition models would be

“Lumping” of geographic regions- the data will not be granular enough to identify meaningful groupings

Using rolling averages- will dampen any effect of change (and we want to link changes in reimbursement to changes in practice)

### Measures

Our discussions raised some questions about which measures to use for both quality and efficiency. We support quality measures that look at outcomes for the defined population. There are many good measures available on a state by state basis, and the Secretary can be directed to develop a composite measure using existing sources. Ideally, the measures should be broadly applicable to the population, relate to outcomes as opposed to utilization (as those will be covered in the denominator of the index) and be things that can change in the medium term (otherwise there would be no ability to affect the quality component of the index by changes in practice, which is, after all, the goal). The Secretary should have the flexibility to develop the index so that the best available measures can be used, and so that the most current data is used. There should also be flexibility to make changes as better data becomes available.

Likewise, the Secretary should have flexibility to create the efficiency measurement. We believe the best measure would be total Medicare spending per beneficiary (part A and B). But there may be other factors that could also be included in a composite measurement. It is important however that both part A and part B spending be reflected, given that one of the major ways to improve both quality and efficiency is to better manage patients with chronic conditions and thereby reduce unnecessary hospitalizations and readmissions. This may increase part B spending, but reduce part A spending.

Another question that will need to be addressed is whether there should be overall cost neutrality by readjusting the baseline (national average cost and quality) every year, or every few years, or not. The other option would be to at some point fix the baseline and reward everyone who improves value beyond that. In other words, will CMS continue to grade on a curve, so that there are always losers, or allow for the possibility that all can be winners? The latter would certainly be more palatable to providers.

### Simplicity and clarity

A positive aspect of the approach is simplicity of implementation. It makes one change in an existing formula that CMS has to re-calculate every year anyway.

It is also simple in that the incentives are clear – increasing quality and efficiency within the payment region will be rewarded. This in turn pushes physicians and hospitals to better coordinate care and work together within the region on behalf of the patient. The model is also transparent so the providers and patients alike can see where they stand in relation to the rest of the country.

This simplicity and clarity also reduce the need to over regulate and micromanage the providers and patients. They will have the flexibility to figure out the best way to reach the goals.