
A perspective on current health reform issues from Mayo Clinic

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Reform Bills: Points of Agreement and Divergence

As the House and Senate prepare to bring their final bills to their respective floors, Mayo Clinic would like to highlight the areas of agreement and divergence in the bills and our positions on health care reform. We are encouraged by much—including provisions to pay for value in health care, an insurance exchange, individual mandate, subsidies for people to achieve coverage, and pilot projects on accountable care organizations and bundling of payments.

At this juncture, Mayo Clinic will neither endorse nor oppose entire bills in the House or Senate, but will continue to point out provisions that we think move the country toward patient-centered health care and areas where we have concerns.

While many provisions in the bill are aligned with our recommendations, Mayo Clinic remains concerned about other areas including a public option that is based on Medicare rates, the long timeline for implementation of pay for value provisions and across the board cuts to providers.

It is critically important that we accelerate the timeline to adjust the Medicare payment system to pay for value in order to truly bend the cost curve—especially in light of the growing number of baby boomers reaching retirement age.

These **payment reform provisions should not lag behind expanding coverage to more Americans.** In any event, we must focus on ensuring the financial viability of health care for the long term to ensure that patients have access to quality care across the country.

Support House IOM Study of High Value Care and Geographic Variation

Mayo Clinic supports the provision that was added to the House bill that will charge the Institute of Medicine to study and design new payment methodologies to build value and address geographic variation into the Medicare payment system. The proposal is consistent with Mayo Clinic's focus on creating a mechanism to better define value, measure it, and create new payment methodologies that reward it.

Most of us, as patients or family members, don't stop to think that our doctors and hospitals are generally paid more for doing more tests and procedures—whether or not we need it. Take for example, the story of a patient eventually seen here at Mayo Clinic:

An older gentleman went to an emergency room because he fainted. A CT scan of the heart was done and showed calcification. Urgent heart catheterization was recommended and then bypass surgery was performed. Later, when a stress test was done, an abnormality was found and a second heart catheterization showed a complication—one bypass was blocked. Stents were placed in the heart artery where the

bypass was blocked. However, the fainting spells continued. With his issue unresolved, the patient came to Mayo Clinic, where we conducted a lengthy assessment by a team of physicians. It was determined that all he needed was an adjustment of his medications. In the end, the tests, stents, and surgery performed at the other facility were not needed, did nothing to help the patient, but were paid for by Medicare. On the other side, the additional office time spent at Mayo to fully assess patient's situation and ensure proper diagnosis and treatment was not covered by Medicare.

Doctors and hospitals are usually paid more for doing more tests, visits, hospital admissions, and surgeries rather than spending time with the patient and assessing their individual needs. What if instead, the system rewarded doctors and hospitals for spending time with patients, for doing a procedure successfully, for the fact that you leave the hospital without a fall or infection, and for providing excellent service to you while you were under their care.

Support Cantwell Amendment to Incentivize Value in Medicare

We support a similar provision in the Senate Finance Committee bill introduced by Sen. Cantwell that will help move Medicare in the direction of paying for value by creating a value modifier for physician payments that will create incentives around value in the Medicare physician payment formula.

Insurance Reform that Gives Access to All

We believe coverage can be achieved without creating or expanding a government-run, price-controlled, Medicare-like insurance model. A public option that employs a true negotiated rate process is better than a system based on Medicare rates. However, we are concerned that the exchange could be opened to large employers, which could result in a large shift from private to public insurance plans.

We support reforms to the current insurance system that eliminate pre-existing condition exclusions, and create an individual mandate where individuals can purchase private insurance in various ways:

- Through employers,
- On the individual market,
- Through co-operatives, or
- Through an exchange model like the Federal Employees Health Benefit Plan (FEHBP).

We also believe that the government should help people afford the insurance through sliding scale subsidies as needed.

Encouraged by Accountable Care Organization Pilot Project

Mayo Clinic is encouraged by provisions in the House and Senate bills that allow groups of providers who voluntarily meet certain statutory criteria, including quality measurements, to be recognized as Accountable Care Organizations (ACOs) and to be eligible to share in the cost-savings they achieve for the Medicare program. Both houses propose to start an ACO pilot program January 1, 2012.

Mayo Clinic believes that under this approach, a group of physicians would 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 should 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.

Bundling Payments Can Help Contain Costs

Both the House and Senate bills have provisions to test a system of bundling payments for Medicare Parts A & B. We are pleased with the pilot projects on Medicare payment bundling. However, we would like to see a more aggressive implementation timetable—not one that starts in 2014 or later, but finishes by 2014—so that we can see more immediate financial results for the Medicare system.

To realize cost savings quickly, Mayo Clinic believes Medicare should start bundled payments for high-cost hospital episodes such as total knee replacement, heart attack, and lumbar disc herniation. Over time, bundled payments could be considered for some chronic conditions as well. The bundled payment should 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.

The goal is to reduce practice variation and focus on an outcome-based goal. 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.

CMS Innovation Center to Enhance Quality, Improve Patient Safety

Mayo Clinic also supports the proposal in the Senate Finance Committee bill that calls for the HHS Secretary to create an Innovation Center within the CMS. The Innovation Center will be authorized to test, evaluate, and expand different payment structures and methodologies which aim to foster patient-centered care, improve quality, and slow the rate of Medicare cost growth. The provision calls for promoting improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions. The collaborative would develop best practices and proven care methods in improved quality and efficiency, as well as assist other health care institutions on how best to employ such best practices and proven care methods.

Independent Commission to Extend Medicare Solvency

The Senate Finance Committee proposal includes a provision to establish a 15-member Independent Medicare Commission to develop and submit proposals to Congress aimed at extending the Medicare program's solvency and improving its quality. Each year, beginning in 2013, the Medicare Actuary's Office would make projections about whether Medicare's per-capita spending growth rate in two years will exceed a targeted rate. In years when Medicare costs are projected to be unsustainable, the Commission's proposals will take effect unless Congress passes an alternative measure.

Mayo Clinic believes that this commission can insulate many health care decisions from direct political influence in Congress while still being accountable to Congress. We also

believe that the commission should have the authority to change the health care payment system with the goal to move away from fee-for-service medicine and toward paying for team-based, coordinated care.

In addition to payment reform, the commission 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.

This perspective is written by Jeffrey O. Korsmo, Executive Director, Mayo Clinic Health Policy Center; and Bruce Kelly, Director of Government Relations, Mayo Clinic.