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MAYO CLINIC Health Policy Center

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Creating Value-Based Payment Options within Medicare
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Executive Summary

The Mayo Clinic Health Policy Center in partnership with the Dartmouth Institute for Health Policy and Clinical Practice and HealthPartners brought together representatives from nearly 20 leading health care organizations to prioritize recommendations to introduce the concept of health care value into the Medicare payment structure.

Through a consensus-driven process, the group developed specific short-term and long-term priorities that add value as a component of the Medicare payment system. The short-term recommendations include infusing the current Medicare payment system with a new value element, combining existing health quality measures and measures of cost over time; bundling Medicare Part A and B payments for episodic and chronic care and addressing the regional variations in Medicare reimbursement. These recommendations, which can be implemented within the next fiscal year, will be presented to Congress as they draft health care reform legislation.

Background

The current Medicare payment system pays for volume, and does not consider either the safety and quality of the care provided or the relationship of safety and quality to cost, i.e., the concept of value. For more than 30 years, the Dartmouth Institute has been documenting regional variations in Medicare spending across the United States. Contrary to the notion that more is better, Dartmouth research has shown that quality of care is worse when spending and utilization of care (more visits, more tests, etc.) is greater. The research shows that if all U.S. regions would adopt the organizational structures and practice patterns of the lowest-spending, highest value regions, Medicare spending would decline by about 30 percent. Unfortunately, under the current Medicare payment system, physicians in low-spending areas who offer efficient, high-quality care are financially penalized for providing value. To raise the quality and effectiveness of health care throughout the nation, we advocate developing and testing new payment methods that reward value.

Principles of Agreement

- Make health care more affordable for consumers.
- Define and measure value starting with available metrics. Focus on outcomes instead of process measures. Health is the desired endpoint.
- Design flexibility and accountability within payment schemes in order to improve value.
- Tackle the supply-side costs of health care – hospitalization, utilization, etc.

Definition of roles within these principles

- The federal government should improve access for citizens and verify high-value outcomes – not regulate the care process.

- Providers will work with the government as a partner and payer; providers will not work for the government.
- Providers will engage with patients as partners in high-value care.

Key Assumptions of Participants

- Patients must be engaged in the discussion to improve the quality of health care. The group believes that transparency with the public about the disparities in quality will motivate patients to seek high quality care and push lower quality providers to improve care delivery.
- We need to create and deploy shared decision making practices that ensure patients are well informed about their health status, that their choices are respected, and that health outcomes are measured.
- Care plans must be effective in addressing chronic illness and focus on prevention and wellness and improved health outcomes.
- Paying for value can foster innovation so that providers better serve all populations.
- We must implement both positive and negative financial incentives for patients to manage chronic diseases. Even small amounts can change a person's behavior.
- A public dialogue must begin on the sensitive issue of end of life care. Nearly 30 percent of Medicare spending goes to recipients in their last year of life. End of life care should focus on patient preferences and pain control rather than performing extraordinary measures.

Specific Short-Term Recommendations

The group developed several key recommendations to introduce the concept of "value" as one factor in the Medicare fee-for-service reimbursement model.

Incorporate the Concept of Rewarding Value into the Reimbursement System

Introduce a "value index" into Medicare Parts A and B, to reward those who provide safe, high quality care with excellent service to Medicare patients at a reasonable cost. This value index would be defined by the equation Value equals Quality over Cost or V=Q/C. Quality (Q) would use existing data including clinical outcomes, safety and patient-reported satisfaction. Cost (C) would represent the cost of care over time. The value index can be constructed for many types of payment models, including hospital DRG payments, physician fees, payment updates, and other payment formulas.

Bundled Payments for Episodic and Chronic Care

Medicare should develop a bundled payment system for high cost episodic and chronic care conditions. The bundled payments should be designed so that any cost savings from integrated care are shared between payer and provider, to provide a reward for creating value. Such a reformed system would encourage improved coordination of care between hospitals, physicians, nursing homes and other providers of care, and it would encourage improved utilization of nursing and other non-physician caregivers.

Bundled payments for patients with high cost episodic conditions (such as myocardial infarction, spine surgery or joint replacement) would reduce 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.

Bundled payments should also be used for specific chronic illnesses with a health status measure for each. Begin with conditions that are high cost, have a high number of claimants, and are actionable such as diabetes and asthma management. For chronic illnesses, the bundling of payments could be focused on all non-hospitalization services provided to a patient over a year.

The Medicare system should base these bundled payment systems on current known and respected health care quality measures. This will jump-start the pay-for-value concept and incent providers to improve quality and lower costs in the short term. The current measurement data, which has been compiled and used by the Dartmouth Institute, and respected and cited widely by others, include specific measures for high cost conditions such as diabetes, total knee replacement, lumbar disc herniation, and heart attack.

Other short-term recommendations

- Use various payment tactics such as bundled payments, and Accountable Care Organizations (ACOs) to move to a Hospital Service Area (HSA) and Hospital Referral Region (HRR) conversion factor for Medicare Parts A and B over time.

Long-Term Value Based Care Demonstration Project

A longer term recommendation is to develop and implement a proposed national value based care demonstration project. This project would request funding from the American Recovery and Reinvestment Act of 2009, specifically provisions addressing health information technology and comparative effectiveness research. The goals of the project would be to partner with leading health systems to create a scalable infrastructure for common measurement for value-based care that can be widely replicated. The project would implement population-based payment models that will reduce spending growth by at least two percent below projections. The project can start with quality measures developed by the Dartmouth Institute along with other sources that emphasize managing chronic diseases. To ensure patients see the value of this project it was suggested that patients do not have an opt-in/opt-out option.

Other Long-Term Recommendations

- Expand programs and measurement research that successfully manage chronic diseases (such as those at Pitney Bowes, the City of Asheville, North Carolina and others).
- Incorporate the use of Advanced Registered Nurse Practitioners (ARNP) and Physician Assistants (PA) for common, uncomplicated, protocol appropriate conditions.
- Provide incentives for patients to follow treatment plans within episode of care payment plans (such as reducing or eliminating co-pays for medications).
- Encourage physicians to discuss living wills with Medicare recipients.

Participants

The following health care organizations participated in the meetings in which these recommendations were developed:

- Alliance of Community Health Plans
- American Hospital Association

- American Medical Association
- Association of American Medical Colleges
- Billings Clinic
- Dartmouth-Hitchcock
- The Dartmouth Institute for Health Policy and Clinical Practice
- Glaxo Smith Kline
- HealthPartners (Minnesota)
- Johns Hopkins University School of Medicine
- Marshfield Clinic
- Mayo Clinic
- The Permanente Foundation
- Virginia Mason Medical Center
- X-Prize Foundation