Improving Outcomes for Medicare Beneficiaries with Chronic Conditions

Senate Finance Committee
June 22, 2015

Population Health Department – Intermountain Healthcare

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Intermountain Healthcare appreciates the opportunity to discuss improving outcomes for Medicare beneficiaries with chronic conditions. Intermountain operates 23 hospitals in Utah and Idaho; more than 160 clinics; and an insurance plan, SelectHealth, which covers approximately 500,000 lives in Utah. Intermountain's Medical Group employs approximately 800 physicians, and about 2,300 other physicians affiliated with Intermountain.

Intermountain has developed a coordinated, evidence-based approach to managing patients with various chronic diseases, which has yielded positive results. However, under to the current pervasive payment system, Intermountain or any healthcare organization that strives to lower utilization and costs, does not have an incentive to do so. For this reason, we believe that healthcare payment should move rapidly toward a payment mechanism that rewards value rather than procedure volume. As the largest payer in the nation – by far – Medicare can catalyze this change. We believe bold movement toward comprehensive prepayment to provider groups has the potential to yield dramatic cost and quality benefits to the nation.

We suggest five principles to foster this change:

First, of course, is the development of a mechanism to pay providers for meeting the health needs of individuals in the most clinically and financially efficient way possible. Various permutations of prepayment, coupled with effective quality and patient satisfaction measures are, in our view, the most effective mechanism to do this.

Second, we believe that government should require results – high quality at affordable cost – rather than requiring a given organization structure. Intermountain is structured differently than Virginia Mason, which is different than the Mayo Clinic, which is different than Geisinger, which is different than the medical community of Grand Junction Colorado, and so on. And yet, all of these have achieved dramatically better quality at lower cost than the nation at large. It is often tempting to prescribe an approach – something that worked somewhere else, but it is much more effective to define and reward the desired outcome and unleash American creativity to achieve it. The best model may not have been tried yet.

Third, we believe that people using the healthcare system should have appropriate incentives to use the system wisely and to do their part in maintaining their own health. Individuals should have financial as well as literal skin in the game.

Fourth, the federal government generally, and CMS specifically, have huge amounts of information that can help providers of care to be more effective. One of Intermountain's keys to success has been a very robust data base of information that helps us to see what works and what doesn't. CMS could assist providers that lack our data capabilities to achieve similar benefits.

Fifth, and finally, there should be a substantial reward mechanism for providers making the major changes needed to provide high-value care. Specifically, organizations and localities that are currently high-cost should be given very strong incentives to do the hard work necessary to change paradigms from volume-based care to value-based care. This means less incentive and reward for organizations like Virginia Mason and Intermountain, but then, we don't have to make as many hard changes. We believe that the benefits of giving substantial incentives to higher cost places to make the needed but difficult changes will provide dividends to the nation for decades to come.

Shared Accountability

We call our proposed solution *Shared Accountability,* which requires partnerships and collaboration among all the important healthcare players: physicians, hospitals, other healthcare providers, and – critically – patients themselves. At the heart of the *Shared Accountability* concept is the alignment of incentives around the health of beneficiaries, rather than payment for the services they use. Shared Accountability payment models should move toward prepaid, outcomes-based arrangements as quickly as possible.

Shared Accountability: **Key Principles**

Through practical experience, Intermountain and other organizations have discovered and demonstrated a number of key principles that can deliver high quality healthcare at the lowest appropriate cost. We believe that if Medicare and Medicaid programs align incentives in such a way as to be consistent with these principles, organizations across the country would be able to move healthcare in the United States to a much more effective paradigm.

1. **Medicare (and other payers) should move from paying providers for volume to paying for what Americans really want: healthy beneficiaries. We suggest that the federal government should move to full prepaid, outcomes-based arrangements for Medicare beneficiaries as rapidly as possible.**

For decades, American health providers have been paid for the volume of care they provide to their patients. It is not surprising, therefore, that studies have shown substantial overutilization in many areas and that more intensive (and remunerative) procedures are frequently chosen over less intensive, but equally effective, alternatives.

If the fundamental Medicare payment mechanism were rebuilt around value – quality and cost measured at the beneficiary level – the beneficial impact would be enormous. And because Medicare, which is by far the largest healthcare purchaser in the country, tends to establish the payment mechanisms that others adopt, we can reasonably expect that these benefits would accrue to the rest of the population as well.

We believe this situation should be fundamentally changed. Accountability for Medicare beneficiaries should move toward prepayment in a deliberate but expeditious fashion. The following principles discuss some of the key components of such a course.

Congressional Action*: Congress should make it clear that the current Medicare payment trajectory will be significantly reduced and that providers will become accountable for the total cost of care for the population they serve.*

2. **The best results come about when healthcare providers behave in an organized, collaborative fashion. Whenever possible, make use of existing healthcare infrastructure and relationships, while encouraging growth in beneficial relationships over time.**

Repeated studies and analyses have shown that organized care delivery systems can be much more effective in providing high quality, efficient care than the more common fragmented amalgam of healthcare providers. A system can reduce duplication, coordinate the services of different specialties, provide the most effective diagnostics at the most effective time, reduce the likelihood of conflicting treatments, and identify and eliminate quality and cost problems and to take effective action to fix them.

Regulations must make it safe and feasible for physicians and other providers to work together in ways that improve value to the community through the provision of optimal care. They must be able to share information, coordinate incentives for quality and efficiency, and receive payment collectively from Medicare and other payers. Many of today's regulations are designed to protect purchasers (the federal government in particular) from inappropriate utilization; for instance, extensive regulation is designed to prevent kickbacks from facilities to physicians for providing (potentially unnecessary) care at their

institutions. If CMS (and potentially others) prepay for all of an individual's care, then the costs of the individual components become the concern and accountability of the coordinated system itself. Only at the system level can care be coordinated in a way that maximizes value to the purchasers and, ultimately, to the community.

Congressional Action*: For organizations that accept prepayment, provide relief from the regulations that are designed to prevent overutilization. If an organization accepts prepayment, overutilization harms the organization rather than CMS, rendering the regulations unnecessary (since the organization will be motivated to police itself). Relief from these regulations would save a great deal of money for both providers and the government and would be an attractive inducement to participate in prepayment.*

3. Flexibility should be allowed for organizations to develop new models of care that are not constrained by the walls of a hospital or clinic.

Government healthcare programs have, understandably, tended to regulate existing structures. The unintended consequence has been to entrench those structures, which often hinders trial and adoption of new and innovative care models. Historically, payment structures have reinforced traditional silos of care (e.g., physician care, inpatient care, outpatient acute care, hospice care, homecare, etc.), an approach that ultimately works against the patient's best interest. If organizations take on prepaid, outcomes-based arrangements with Medicare, they should be given the freedom to coordinate care in the way that best meets the needs of the beneficiaries they serve. For instance, innovative home-based and community-based models for advanced illness management and end-of-life care, including those that incorporate telemedicine and significant care management resources (which under current payment mechanisms are not compensated costs), are frequently just what the patient and family desire. Participating organizations should be given the flexibility to care for patients in the settings and with the approaches that best meet their individual patients' needs.

Congressional Action*: Legislation should direct CMS to allow organizations that accept prepayment and accountability for the health of Medicare beneficiaries to deliver care outside of traditional silos. Legislation should also direct CMS to view results (cost, quality, and service) as the key performance metrics, and process measures should be used only when an outcome measure (result) is unavailable/inadequate in a given area.*

4. The patient-provider relationship should be seen as a healthcare partnership. Both parties must be given the tools and incentives to work together to efficiently maintain and improve beneficiary health.

Willingness to engage in a partnership and active participation of both parties will be critical. In our experience with innovative care models, we have seen that the majority of both patients and providers are agreeable to participation in something new when they are given the choice to do so, when the incentives (financial and otherwise) are aligned, and when they have the knowledge, skills, and tools they need to be successful. All three of these elements will be critical in building a viable program.

All Medicare beneficiaries opting for the new model will need to select a *Shared Accountability Network* from which they will largely receive care, including a primary care provider(s) who will coordinate their care. This active and explicit selection process is necessary in order for *Shared Accountability Networks* to identify the patients for whom they are accountable. This selection could be made easier for seniors if Medicare were to provide personalized information to beneficiaries about which *Shared Accountability Networks* their existing providers participate in and allow Medicare beneficiaries to change their selection periodically if they are not pleased with the quality or service of the organization they have selected.

The governing and organizing body of the *Shared Accountability Network* will need to be required to build provider payments that incentivize high-value care, including maintaining beneficiary wellness and, when necessary, efficiently returning Medicare patients to health. While we don't believe the federal government should specify the details of these arrangements or the organizational structure, we believe it

should be clear that individual providers and/or provider organizations must have major participation in the quality and expense incentives.

Similarly, while we believe individual organizations should be free to implement tools for both physicians and beneficiaries that facilitate changing the conversations around care decisions. *Shared Decision-Making* is a good example – when patients are fully informed of the true risks and benefits of alternative courses of care, they can play an active role in selecting the best treatment options to meet their personal needs and values. Health literacy, price transparency, and other similar tools for both beneficiaries and providers will also likely be part of a comprehensive *Shared Accountability* model.

Congressional Action*: Medicare beneficiaries should be given an incentive to enroll with a prepaid organization. This incentive should be small initially, but increase over the next four years (e.g., those opting out should pay increasingly higher premiums over that time).*

5. **Accurate and timely data will need to be provided and used. Data are necessary for both managing the health of beneficiaries across the healthcare continuum and for holding *Shared Accountability Networks* responsible for beneficiary health.**

There is currently a great need for improved sharing of data and information in the healthcare industry. In order for this new program to be successful, CMS will need to provide comprehensive data to those providers agreeing to take on accountability for the totality of beneficiary health.

Meaningful, complete, and timely data must be provided to individual physicians and organizations that are willing to take on accountability for patient care and outcomes; without it, it is very difficult to identify whether best care is being provided, both from a quality and an efficiency perspective. If patients are not willing to have their data shared with their *Shared Accountability Networks*, it is impractical for these *Shared Accountability Networks* to be held responsible for managing the healthcare costs and quality of these beneficiaries.

Additionally, providers (physicians, hospitals, homecare agencies, etc.) working in collaboration in a *Shared Accountability Networks* will need to be able to share data with one another. Currently, there are many barriers to data-sharing that need to be addressed before any successful programs can be built.

Quality and performance metrics will be necessary to ensure *Shared Accountability Networks* are not reducing healthcare costs at the expense of long-term outcomes (one of the major criticisms of the managed care movement of the 80s and 90s). Performance metrics should be consistent with those of other programs and payers. Metrics need to be harmonized *both* in terms of what is measured *and* how success is achieved. We believe the greatest performance improvement will be achieved if a reasonable number of metrics (those validated as both actionable and important to individual and population health) are utilized across all government payers. The number of metrics required must be operationally feasible, which means a limited core measurement set. In order to motivate individuals and organizations, it is generally best to set goals upfront. Achievement thresholds, scientifically based on recent historical performance of organizations across the country, should be utilized for determining success within quality metrics. If goals are met, providers should logically be able to expect that rewards will follow. The consequences of achieving those goals should be clear.

Congressional Action*: Congress should designate one entity to develop a reasonable number of quality, service, and efficiency measures to reflect value provided to beneficiaries. These measures should be applied to all government programs (all forms of Medicare, Medicaid, FEHBP, CHAMPUS, etc.). This would not only reduce duplication and compliance costs but would also make improvement much more likely than in the current hodgepodge of different and occasionally conflicting measures.*

6. A successful program will give all participants the opportunity to succeed in the short-term, thereby cultivating trust and encouraging provider and public participation and acceptance.

We suggest that a single, affordable, nationwide, average per-beneficiary rate be defined (lower than the current average rate). That national target rate would then be adjusted to reflect legitimate differences in the underlying cost of providing care in different regions and organizations (which CMS does today for geographic variation in wages and teaching, for example). Prepayment amounts should appropriately reflect differences in underlying risk factors for the specific beneficiaries in each organization. Thus, each organization would have a specific target derived from the national target adjusted to reflect specific differences associated with the region, organization, and the beneficiaries they serve.

Then, over a period of years (five to seven seems reasonable), payment to an organization would move from their current per-beneficiary total payment to their organization's target. If an organization is able to improve more rapidly than this "glide slope," it can retain the entire difference in any given year. At the end of this period, the federal government would pay a consistent rate across the nation (with variation only for legitimate input cost differences), which would be significantly lower than the current trend. As discussed earlier, this new, lower rate (and lower growth rate) could dramatically improve the Medicare unfunded shortfall without the need for increased payroll taxes or cuts to benefits.

Congressional Action*: Congress should designate an entity to establish a reasonable nationwide per-beneficiary payment and to define specific cost-adjustment and risk-adjustment mechanisms to reflect legitimate differences among regions and organizations. Congress should enact a program that designates movement from current total pay to this target; the program should allow organizations that are able to accelerate savings beyond this pathway to retain the additional savings. (Savings to the government will be defined by the targets.)*

7. A transitional period will be necessary.

Some organizations are ready to accept accountability for Medicare beneficiaries today. However, some communities don't have any organization that is remotely prepared to undertake such a challenge. As we noted earlier, we believe that creating correct incentives will unleash tremendous creativity and development activity that, if supported by an appropriate regulatory environment, will lead to surprisingly rapid development of *Shared Accountability Networks*. If these organizations are then allowed to keep a portion of the savings they earn (as noted in the previous section) while on the path to affordable care, we believe success is very likely. And for every year during the transition, CMS will spend less than it otherwise would have under the traditional system.

This transitional period also can provide the motivation for providers to create the mechanisms necessary to accept shared accountability. Payment in a geographic area would move toward the target regardless of whether the providers in the area worked together to improve value, and CMS would withhold funds (from the fee-for-service payments to all providers) equivalent to this amount. For example, if a 2% reduction in spending is required during a year, then CMS would withhold 2% of all fee-for-service payments to providers. At the end of the year, if the providers had reduced unnecessary utilization by at least 2%, with resultant savings for CMS of at least 2% percent, then the per-use payment withhold would be returned. This would allow providers who reduce unnecessary utilization to avoid a reduction in payment for the services actually rendered. Of course, if utilization is not decreased by at least two percent, the withhold would be retained by CMS. *In either case, CMS saves at least 2% over what it would otherwise have spent, either through reductions in utilization or reductions in per-use payments.*

Under this approach, providers are incentivized to reduce unnecessary utilization – regardless of their level of formal organization. However, this approach would motivate providers to work together (and to create *Shared Accountability Organizations* of one form or another) so that they would have much better control of their joint performance. Either way, CMS is guaranteed to achieve targeted savings and over time would

move toward the target rate. Providers would either have to make improvements in care patterns or simply be paid decreasing amounts based on the old metric. In the short term, this approach would also allow rapid congressional action that would be more strategic and beneficial than simple across-the-board cuts to all Medicare providers (but with the same beneficial impact on the federal budget).

***Congressional Action**: For next year, implement a withhold of 2% of payments for all Medicare providers across the country. If the providers in a given geographic region are able to reduce overall utilization by at least 2% relative to target, the withhold would be returned to the providers at the end of the year. If not, then the withhold would be retained by the government. For future years, a targeted trajectory toward a national targeted per-beneficiary amount would be defined; this amount would be paid to organizations willing and able to accept prepayment. For those providers unwilling or unable to accept prepayment, this trajectory would be used to define a withhold percentage (which providers would receive if their utilization achieves equivalent savings).*

Concluding Thoughts

This is a pivotal moment in our nation's history and for the path we must build for a sustainable future. Many important items are up for discussion and debate in the effort to reduce the deficit, but none is more critical in size or scope than healthcare spending. We believe the nation needs a new approach that will incentivize spending in the right places and for the right things, with a promise of significant savings without harming beneficiaries for whom we have a mutual responsibility. We hope these recommendations serve to launch a new dialogue, an exchange of ideas that is perhaps different from what has come before, and a discussion in which there may be a winning option for the federal government, Medicare beneficiaries, and the country as a whole.

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