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June 22, 2015

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office

Washington, D.C. 20510

The Honorable Johnny Isakson
Committee on Finance
United States Senate
131 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Mark R. Warner
Committee on Finance
United States Senate
475 Russell Senate Office Building
Washington, D.C. 20510

Submitted electronically at chronic_care@finance.senate.gov

Dear Chairman Hatch and Senators Wyden, Isakson and Warner,

Thank you for the opportunity to comment on ways to improve care for Medicare beneficiaries with chronic conditions. As we are now witnessing in other healthcare programs across the country today, there are ways in which traditional Medicare can implement payment policies that will incentivize providers to improve disease management, streamline care coordination, improve quality, and reduce Medicare costs. Our proposal focuses on linking the outcomes of care and payment in a manner that will require providers to coordinate care and improve quality in order to be financially successful. Specifically, the proposed outcomes based payment reform would:

- Replace payment adjustments for quality based on adherence to processes with payment adjustments based on the outcomes of care
- Set a measureable and clinically meaningful national objective for improving the outcomes of care
- Make comprehensive information on the outcomes of care across all healthcare organizations available to Medicare beneficiaries

An outcomes based payment reform represents a proven alternative to existing attempts to link quality and payment. In order to improve the care for chronically ill patients, evidence has demonstrated that fundamental changes in how healthcare delivery organizations are paid will yield results.

Problems with existing attempts to link payment and quality

Historically, most of the methods used for measuring quality have been measures of adherence to specific clinical and administrative processes. Since there is no common metric for combining such process together, the use of care processes in a payment context inevitably results in arbitrary and complex rules for determining the overall measure of quality performance. The reliance on process measures has not only created the administrative burden of collecting and reporting adherence to the proscribed processes but its sheer complexity makes it difficult for healthcare delivery organizations to understand the actions needed to improve quality. *Thus, the attempt to pay for quality has gotten lost in an overly complex attempt to measure quality.*

There is an emerging consensus that payment adjustments that rely heavily on adherence to care processes have not been effective. In his June 2014 testimony before the Ways & Means Health Subcommittee the Executive Director of MedPAC, Mark Miller stated:

> "Current quality measures are overly process oriented and too numerous, they may not track well to health outcomes, and they create a significant burden for providers."

In a letter to CMS Administrator, the AMA stated that the current collection of payment adjustments for quality were "unnecessarily burdensome" with "incomprehensible, conflicting requirements and flawed implementation processes" (1). The AMA further stated that these programs were "causing tremendous confusion among physicians" and called on CMS to "synchronize and simplify" these programs. The Institute of Medicine observed that "thousands of measures are in use today to assess health and health care" but "their sheer number, as well as their lack of focus, consistency, and organization, limits their overall effectiveness in improving performance of the health system" (2). A Robert Wood Johnson Report on quality performance measures concluded that the focus of performance measures should "decisively move from measuring processes to outcomes" (3).

The failure of process based quality payment systems to effectively measure quality and control Medicare expenditures does not mean that process measures are not useful as internal management tools for individual providers. It means that adherence to processes dictated centrally by Medicare through payment adjustments is not an effective means of measuring quality and controlling expenditures.

Understanding the Lesson from the Success of the Medicare Hospital Inpatient Prospective Payment System (IPPS)

Arguably, IPPS is the most successful healthcare payment reform ever implemented (4). It is important to understand and replicate to the extent possible the key lessons that led to the success of IPPS. IPPS was an outcome-based system. The outcome was the cost of care for each type of patient (each DRG). A national standard rate of resource use (the price) for each DRG (the product) was established creating a "product with a price" payment system. If a hospital's production cost was lower than the price it made a profit but if its production cost was higher than the price it suffered a loss. Because the unit of payment (the DRG) was clinically meaningful, IPPS linked the clinical and financial aspects of care giving hospital management and medical staffs a common language to use in managing and controlling cost.

The IPPS financial incentive for efficiency was simple and easily understood and allowed hospitals to respond to in the way that worked best in their local community. IPPS did not attempt to dictate how medicine should be practiced by mandating adherence to a multitude of proscriptive process measures. Instead, IPPS recognized that *the role of the Federal government should be to create incentives to improve efficiency and quality but not to dictate how providers should deliver care in response to that incentive*.

The lessons of IPPS are clear: focus on outcomes, set national standards, be clinically meaningful, create the right incentives and keep it simple.

Focusing on Outcomes

The care of patients with extensive chronic disease is complex and requires coordination across the healthcare delivery system. The objective of payment reform should be to set outcomes standards that can only be met through better coordination of care and improved quality, thereby improving the care delivered to patients with extensive chronic disease. Several state Medicaid agencies are in the process of meeting this objective by implementing comprehensive outcomes payment reforms. Texas Senate Bill 7 was passed in 2011 and established an outcomes payment adjustment across all healthcare delivery organizations including managed care plans (5). Similarly, New York has issued regulations that establish an outcomes based payment reform (6). The key components of the Texas/New York models were contained in the "Incentivizing Health Care Quality Outcomes Act of 2014" (H.R. 5823). All these outcomes payment reforms would represent a significant departure from existing attempts to adjust Medicare payments for quality. They would replace the existing patchwork of process oriented quality measures used for Medicare payment adjustment with a uniform and comprehensive outcomes based quality measurement

system that would apply to all types of healthcare delivery organizations including hospitals, Medicare Advantage plans, health homes and accountable care organizations.

While some of the implementation details across the Texas and New York reforms may differ, they both focus on five types of outcomes related to potentially preventable complications, readmissions, admissions, emergency room visits and outpatient procedures and diagnostic tests (collectively referred to as potentially preventable events or PPEs). Since failures in quality typically result in a need for more interventions to correct the quality problem, PPEs represent an end manifestation (i.e., outcome) of an underlying quality problem. The only way a healthcare delivery organization can improve its PPE performance is to improve quality, efficiency and care coordination. For example, for a diabetic admitted for surgery, the hospital and physicians would be responsible for coordinating the post discharge chronic care to ensure that the patient does not have a preventable readmission or ER visit. Because a significant procedure can sometimes impact a diabetic's medications, a readmission or ER visit for diabetes would be considered preventable because better follow-up and medication monitoring would likely have prevented the readmission or ER visit. Fundamentally, an outcomes payment reform requires health delivery organizations to take a more holistic view of the patient in order to be successful in lowering PPE rates.

The 2012 Institute of Medicine (IOM) study *Best Care at Lower Cost* estimated that unneeded services, mistakes, delivery system ineffectiveness and missed prevention opportunities were leading to $395 billion in annual healthcare expenditures that could be avoided without worsening health outcomes (7). By focusing on potentially preventable events that are the end result of a quality failure, an outcomes payment reform provides comprehensive financial incentives to health delivery organizations aimed at eliminating the avoidable expenditures identified in the IOM report. The refocusing on a few well-defined outcomes is the kind of synchronization and simplification called for by the AMA and represents a shift in payment policy toward actually improving quality instead of an ever increasingly complex attempt to measure quality.

Focusing on Rates of Potentially Preventable Outcomes

The core objective of an outcomes payment reform is to motivate behavioral change that leads to improved outcomes, better quality and lower costs. By focusing in on outcomes that are potentially preventable, healthcare delivery organizations can direct their quality improvement efforts on problems where quality can actually be improved. A core assumption of an outcomes payment reform is that health delivery organizations with a consistently higher risk-adjusted rate of PPEs are more likely to have underlying quality problems that can be identified and corrected.

Because even the best performing healthcare delivery organizations will have a residual rate of PPEs even when care is optimal, payment adjustments in an outcomes payment reform need to be based on differences in PPE in rates compared to peer organizations. Healthcare delivery organizations with excess rates of PPEs would have a payment penalty imposed while healthcare delivery organizations with lower rates of PPEs would receive a payment bonus. As an inherent byproduct of existing payment systems, the financial impact of each of the PPEs is known (e.g., the MS-DRG payment for a readmission). This allows the net financial impact of higher or lower rates of PPEs to be quantified so that payment penalties and bonuses for a healthcare delivery organization can be proportional to the net financial impact of its overall PPE performance.

An outcomes payment reform meets the IPPS criteria for success

As being implemented in Texas and New York, an outcomes payment reform focuses on a few well-defined outcomes. A standard rate of occurrence for each outcome (analogous to the DRG price in IPPS) is set. Financial rewards and penalties for healthcare delivery organizations are based on their performance compared to the standard rate for each outcome (analogous to the DRG profit or loss compared to the DRG price). Because the outcomes are limited to those outcomes that are potentially preventable and the comparison of rates to the national standard is risk adjusted, outcomes performance is expressed in a clinically meaningful way. Thus, a clear financial incentive is created to lower the rates of potentially preventable events.

In addition, to the comprehensive outcomes payment reforms in Texas and New York, some states have implemented reforms based on a subset of the PPEs. In its first three years, a potentially preventable complication payment adjustment system in Maryland has resulted in a 32 percent reduction in inpatient complications (8). In its first three years, a potentially preventable readmissions project in Minnesota has resulted in a 20 percent reduction in readmissions (9).

Setting a national objective for improving outcomes

The focus on the rates of PPEs provides a clear basis for setting a national quality improvement objective that is measureable and achievable. The structure of the PPE based payment design described above directly translates lower PPE rates into savings for Medicare. A five-year target to reduce PPE rates nationally by at least 5 percent per year over the next 5 years is realistic and would have a far-reaching impact on care coordination, quality, and costs for chronically ill patients. Based on the success in states like Maryland and Minnesota such an objective is certainly achievable.

Engaging the patient

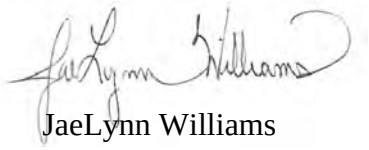
In addition, to creating an outcome based payment system, comparative PPE rates for each healthcare delivery organization should be made publicly available. As New York, Texas and other states are doing, policymakers should implement efforts to both measure and improve public engagement with the outcomes data. It is critical that this data be easily available to consumers because an active, engaged and confident consumer is the best guarantee of better outcomes and lower costs. All consumers of healthcare want quality care and good outcomes. Therefore, public availability of the PPE performance of each healthcare delivery organization is essential.

Conclusions

As an inherent byproduct of responding to the financial incentives in an outcomes payment reform, healthcare delivery organizations must find new and innovative ways to coordinate care and improve quality. Because there is a clear and unambiguous relationship between each PPE and its financial consequences, reductions in the rate of PPEs directly translate into lower cost of care. The only way to significantly improve outcomes performance is to provide better care coordination and improved quality. As a result, the care for patients with chronic diseases will improve as healthcare delivery organizations strive to improve their outcome performance. Instead of attempting to dictate how healthcare delivery organization should coordinate care for chronically ill patients, it is far more effective to create the outcomes based incentives that give healthcare delivery organizations the financial incentive to find new and innovative ways to coordinate care and improve quality.

We look forward to working with the Committee on this important effort to improve patient care, especially for those with chronic conditions. We would appreciate the opportunity to present additional findings from state initiatives as the workgroup continues its efforts and would welcome the opportunity to answer any questions. Please contact Megan Ivory Carr at mmivory@mmm.com or 202.414.3000 for any information.

Sincerely,



JaeLynn Williams
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