

Improving Quality, Lowering Costs: The Role of Health Care Delivery System Reform

Senate Health, Education, Labor and Pensions Committee
Thursday, November 10, 2011 - 2:30pm

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Intermountain Healthcare**

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Written Testimony – Greg Poulsen, Senior Vice President, Intermountain Healthcare

Intermountain Healthcare appreciates the opportunity to discuss improving quality and lowering the costs of health care from the delivery system perspective. My name is Greg Poulsen, and I am Senior Vice President and Chief Strategy Officer of Intermountain Healthcare in Salt Lake City, Utah. 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 affiliate with Intermountain.

Intermountain has become well-known nationally and internationally for identifying best clinical practices and applying them consistently. Dr. John E. Wennberg of Dartmouth summarized the results, saying, “Intermountain is the best model in the country of how you can actually change health care for the better.” Dartmouth estimated that if healthcare were practiced nationally in the way it is provided at Intermountain, “the nation could reduce healthcare spending for acute and chronic illnesses by more than 40%.”

Intermountain’s focus is on providing high-value healthcare. To that end, we:

- Have developed and structured physician-led clinical programs so that medicine at Intermountain is practiced by collaborative teams, and is based on the best available data.
- Establish specific clinical improvement goals, with accountability for accomplishing these goals reaching all the way to Intermountain’s governing board.
- Have developed information technology that allows us to track, compare, and improve outcomes—and eliminate inappropriate variation.
- View variation as an opportunity to improve, whether we find it in our clinical outcomes, or our supply chain.

However, we know there remains much room for improvement at Intermountain; the closer we look, the more we find areas where we can be better. The primary challenge for us, and the main reason that more organizations don’t adopt the high-value models discussed in this hearing, is the underlying fee-for-service payment system that predominates in the United States. Intermountain and other organizations have shown that improving quality is compatible with lowering costs – indeed, high quality care is generally less expensive than substandard care. Unfortunately, such high-quality, low-cost care generally leads to lower revenues and lower incomes for providers. Put bluntly, the current payment system rewards disorganized, inefficient and often unnecessary care.

Experience at Intermountain and elsewhere demonstrates that effective, coordinated clinical practice can improve outcomes dramatically while reducing costs significantly. One example relates to providing systematic, science-based treatment to patients coming to emergency rooms with sepsis (which is a deadly whole-body medical condition usually associated with blood infections). By applying a carefully-organized series of best practices EVERY TIME – consistency is the key – Intermountain’s mortality rates plunged to nearly one tenth of the national average (roughly 40% mortality nationally vs. under 5% at Intermountain),

and because of more rapid recoveries and fewer complications, costs were much lower than both national norms and our previous experience. The reward? A revenue loss of more than \$10 million per year to Intermountain physicians and hospitals as a direct result of improving quality. This is a dramatic illustration of the need to retool payment systems to incentivize value.

Similar results can occur with management of chronic diseases. Intermountain has developed a coordinated, evidence-based approach to managing patients with diabetes, and it is applied across our entire system. The results are much better health, many fewer complications like heart disease and amputations, and much lower cost; my friend, Dr. Denis Cortese, who recently retired as the CEO of the Mayo Clinic, told KARE TV in Minneapolis, “If I were ever diagnosed with diabetes, I would want to be treated by Intermountain Healthcare. They have the best outcomes in the country – and the lowest costs.” Again, unfortunately, the current payment system penalizes this success: our much lower rate of ER visits, amputations, heart disease and other hospital treatments costs Intermountain providers roughly \$5 million in revenue per year.

Sepsis care and diabetic care are just two examples of the dramatic improvement that can be made to both quality and cost. At Intermountain, we have seen this same dynamic play out in well over 100 other case types across the spectrum of care, from the timing of elective inductions of labor for pregnant women to the selection and administration of the most effective antibiotics. Intermountain develops these ‘best-practice’ protocols for those procedures and case types that we perform most often, that are the most expensive, or that have the widest variation in their performance – and we do it both through careful analysis of actual outcomes data available through our electronic medical records and through review of the latest and best scientific evidence. At Intermountain, our clinicians are not required to follow the protocols absolutely. Actual practices may vary somewhat because of patient preferences and values or because of clinicians’ best judgment. However, our clinicians have come to trust the data, and they rely on the decision support protocols as a valuable tool in the diagnosis and treatment of patients. And, it has been convincingly demonstrated that overall, both outcomes and costs improve.

The magnitude of the problem caused by the perverse incentives in the fee-for-service payment system – and the opportunity – can be seen in the expense data from across the country; even after adjusting for differences in input costs – like nursing salaries and building costs – similar populations of individuals with similar diseases cost Medicare much more than twice as much in some locations compared to other locations in the country. We even see huge variation within relatively small geographies (within Utah or Washington, for example). And this variation does not correlate to quality of care – indeed the reverse is frequently true. Generally speaking, people living in areas with low quality of care cost CMS and other payers more than those in areas where high-quality care is provided.

The perversity of our current payment system is also evident in the fact that we now have huge regulatory requirements built to prevent providers from succumbing to the enticements inherent in the fee-for-service payment system. Fraud and abuse, anti-kickback, RAC audits, readmission tracking and many other regulatory instruments – which are hugely expensive for both the government and providers – exist primarily to prevent providers from following the incentive to provide unnecessary care.

Improving care value is hard work, and takes time and resources. We believe that it is unrealistic to expect most providers to do these hard things when their reward is a financial *penalty*. 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.

We are including in this submittal a much more detailed white paper outlining our thinking on the key components that we believe would move healthcare in the United States to sustainably higher value. The document speaks directly to Medicare, because it is the country's largest payer for health services, because it is directly under the purview of the federal government, and because it tends to set the direction for commercial payers. The ideas could be adapted to Medicaid and to commercial plans.

Thank you for the opportunity to present on this important topic today. Questions may be directed to Intermountain's Director of Federal Relations, Bill Barnes at bill.barnes@imail.org or at 801-442-3240.

Recommendations to Congress for Building Sustainable Medicare Value Intermountain Healthcare November, 2011

Introduction

Projected expenditures in government healthcare programs are the largest federal deficit issue facing this country. The imbalance between the number of people paying into Medicare versus recipients, as well as the escalating cost of care for beneficiaries, is growing in ways not predicted – or even imagined – by the creators of Medicare. There is consensus that the Medicare spending trajectory is unsustainable and, unless checked, will be the leading contributor to the deficit in the future. Real deficit reduction is virtually impossible in the absence of healthcare improvement. It will require brave leaders to take on this divisive but critical issue.

Many Proposed Solutions Have Major Challenges

Many less-than-ideal, insufficient, or politically unattractive alternatives to balancing the Medicare books have been proposed from all directions. The easiest option at the present is to “kick the can down the road” once more, opting to leave this issue out of the discussion entirely for the time being, but this would leave an ever-growing problem for the next generation of American citizens and leaders. We firmly hope that the necessity to finally address this problem substantively will be acknowledged.

Of course, taxes could be raised to cover the predicted gap. However, a modest change in Medicare payroll taxes would have little impact. Eliminating the Medicare shortfall would require that the Medicare tax be raised several fold, and this would be disastrous economically, politically, and from a fairness perspective. Additionally, if healthcare costs continue to grow at their current rate, a tax increase today might only serve as another temporary solution. If either ignoring the issue or raising revenue to unprecedented levels is not palatable, the only alternative is to reduce the Medicare cost trajectory.

Medicare spending could be reduced through reducing benefits, rationing services based on patient criteria, or queuing patients. While each of these options is used in other countries, they would currently be politically challenging to implement here. Opponents to these options, including most Americans, will respond that beneficiaries and their physicians, not the federal government, should be making medical (often “life or death”) decisions for seniors. So, while we believe that evidence should impact how care is provided (and the federal government may well play a role in disseminating this evidence), we believe that more dramatic intrusions into care practice are likely to be very controversial. Spending could also be reduced by increasing the Medicare eligibility age to 67 or 70. Medicare benefits could be means-tested or tiered, with those who have higher incomes being made responsible for a larger percentage of their healthcare costs. All of these alternatives would likely result in public outcry, as Medicare was not initially constructed to be a safety-net program and those who have paid into it would feel they were not receiving what they have paid for.¹

¹ Actually, the average person pays far less into Medicare than s/he will receive (which is at the heart of the current problem). This is in large measure due to increases in both longevity and healthcare costs that were never anticipated by the creators of Medicare.

The most straightforward approach to reducing Medicare spending is to force across-the-board cuts to providers, such as the 2% reductions required if the Joint Select Committee and Congress cannot reach another solution. Although simple to impose and seemingly compatible with the need to reduce the overall cost of Medicare, this alternative would likely result in a cascade of negative consequences. Some providers that currently serve large Medicare patient populations and are unable to reduce their costs may be unable to survive on decreased margins and would eventually cease to exist. Other providers that have mixed practices may discontinue providing services to Medicare beneficiaries, resulting in access issues for America's most vulnerable seniors (we have already seen this in some parts of the country). Additionally, this may lead some providers to simply shift costs to other payer categories, increasing commercial insurance premiums at a time of economic vulnerability.

And perversely, the nation's most efficient, value-oriented providers would be disproportionately impacted by these cuts, since they simply have less "fat" to cut. Furthermore, since one way to be successful in a world of reduced per-use payments is to increase utilization of profitable but questionable services, some providers may simply attempt to "make it up on volume," which would make a major problem worse. Any system, good or bad, will ultimately produce exactly the results it incentivizes. A payment system that continues to pay providers on a per-use basis, albeit at a reduced rate, is likely to result in an increase of per-person utilization in order to spread significant fixed costs over a larger pool. For this reason, we do not believe these cuts will necessarily result in meaningful deficit reduction in the intermediate and long term.

A Better Opportunity

Intermountain believes there is another option, an alternative with a significant upside for the nation. This option addresses cost by improving clinical quality and avoiding waste. Implementation of this option can begin as early as 2013 through relatively simple changes to the current CMS payment model.

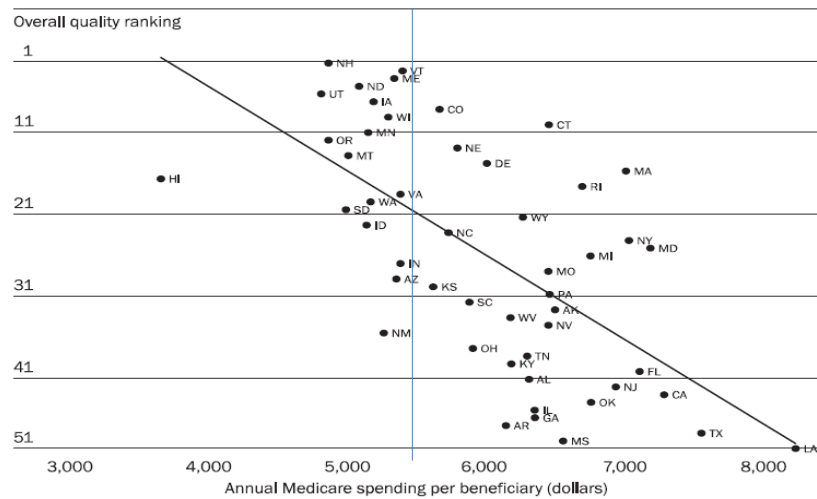
To understand the opportunity, it is important to recognize the massive variation in the way healthcare is provided within the United States – with per-capita cost differences of more than two-to-one among states for both Medicare beneficiaries and the rest of the population.² Additionally, for decades, research conducted by the Dartmouth Institute for Health Policy and many others has highlighted even greater variation in utilization and cost of healthcare services among smaller geographic regions within the United States³ Even after adjusting for age, sex, ethnicity, and local price variation, there is more than a three-fold difference in cost per beneficiary.⁴ Interestingly, the quality of medical care does not increase with the higher costs of healthcare. As shown in the following graph, states with higher costs of healthcare tend to have lower quality of care.

² Health Expenditure Data, Health Expenditures by State of Residence, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

³ Jonathan Skinner, Elliott Fisher, and John E. Wennberg, "The Efficiency of Medicare" in David Wise (ed.) *Analyses in the Economics of Aging*. Chicago: University of Chicago Press and NBER, 2005: 129-57.

⁴ Jonathan Skinner, et al., A New Series of Medicare Expenditure Measures by Hospital Referral Region: 2003-2008, 21 June 2011. The Dartmouth Institute for Health Policy & Clinical Practice, http://www.dartmouthatlas.org/downloads/reports/PA_Spending_Report_0611.pdf

Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001



SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
NOTE: For quality ranking, smaller values equal higher quality.

Those areas with higher quality yet lower costs have accomplished this through providing care with greater effectiveness and consistency. A good example is the Dartmouth study of care provided at the end of life; the overtreatment associated with fragmented care (unfortunately all too common in the United States) results in much higher costs and poorer outcomes for patients.⁵

Collectively, this enormous variation in virtually every type of care provided in the United States, and the overutilization it represents, has significant cost and quality implications – *and provides an enormous opportunity for improvement in both cost and quality*. For example, based on the most recent Medicare data available (2008), the average spending on the over-65 Medicare population was just over \$9,000 per person (price-adjusted by geography). If we could simply move the highest-cost states down to this national average, the country would save \$17 billion annually (and \$209 billion over 10 years);⁶ if overall spending approached the performance levels demonstrated by the most cost-effective states (\$7,000 per person), savings would be \$94 billion per year and \$1.13 trillion over 10 years. Of even greater note, if performance approached that demonstrated by high-performing organizations, including Intermountain Healthcare, savings would be \$160 billion per year, with 10-year savings of \$1.9 trillion.⁷ Furthermore, because these savings are modeled on organizations performing in the current environment of perverse incentives (providers largely being paid for volume, rather than value), we believe the opportunity estimated here is likely conservative.

⁵ John Wennberg et al., *Tracking the Care of Patients with Severe Chronic Illness*; The Dartmouth Atlas of Healthcare 2008.

⁶ Based on price-adjusted Medicare spending per person, with a 4% growth in the aged population.

⁷ John Wennberg et al., *An Agenda for Change: Improving Quality and Curbing Health Care Spending* (Lebanon N.H: Dartmouth Institute for Health Policy and Clinical Practice, 17 Dec 2008).

We call our proposed solution *Shared Accountability*. *Shared Accountability* 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.

We believe this solution can be practically realized, because history has repeatedly shown that healthcare providers are highly adaptable (e.g., the implementation of DRGs in 1983, the managed care revolution in the late 1980s, responses to even the possibility of reform in the first Clinton administration, alignment around EMR “meaningful use” requirements, etc.). The healthcare industry has great capacity to learn and evolve rapidly when incentivized to do so. Additionally, while many components of the *Patient Protection and Accountable Care Act* stirred controversy in the provider community, there was widespread concurrence across the country supporting the *concept* of “accountable care.” Many healthcare providers throughout the United States now agree that changes in the delivery system are inevitable and necessary; the status quo is no longer a viable option. We need to change the regulatory and payment system to incentivize our intended outcomes (lower per-person expenditures and higher quality of care), something that across-the-board reductions in per-use payments will not accomplish. Only by fundamentally changing the system can we truly solve the Medicare deficit problem for future generations of Americans.

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.**

The old cliché that “you get what you pay for” has proven true in healthcare, but not in a beneficial way. 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. In our experience, this impact is often subliminal: many providers don’t even recognize the incentive directly, but the very culture of care is impacted by it. We frequently adopted the mentality of “it probably won’t hurt; we might as well try it.”

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.

These general concepts have been proposed by both Democrats and Republicans, and there is much agreement that greater accountability, especially in the payment mechanism, is essential to making fundamental improvement in the way care is delivered. It makes sense from both a free-market and a social-conscience perspective. In spite of this, there has been little progress in this area.

Currently, Medicare Part C is the only full prepayment arrangement for managing the totality of health for Medicare beneficiaries, and less than a quarter of Medicare beneficiaries are enrolled in this program. Additionally, because Medicare Advantage is designed primarily as an insurance program, most plans are not highly integrated with healthcare providers; so while the insurer is paid in a way that discourages unnecessary utilization among their beneficiaries, delivery systems and providers are still generally paid on per-use arrangements with few value-oriented incentives.

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. Prepayment for the care of "traditional" Medicare beneficiaries should be made available to willing provider organizations beginning in 2013.*

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. The logic behind this is clear: A system can reduce duplication, coordinate the services of different specialties, provide the most effective diagnostics at the most effective time, and reduce the likelihood of conflicting treatments. It is also more able to identify and eliminate quality and cost problems and to take effective action to fix them. Systematic, coordinated care is more consistent, more efficient, and more attractive to patients.

But while the benefits of systematic care are widely recognized, the question of how to move from our current fragmented approach to a coordinated system is still hotly debated. Some advocate moving entirely to organized systems with employed, salaried providers, while others advocate approaches that use independent practitioners. The collective experience of many high-value organizations suggests that if correct incentives are provided (as discussed above), many different organizational approaches have the potential to achieve dramatically improved performance. In a widely hailed article, well-known physician-teacher-author Atul Gawande pointed out sterling performance in coordinated care by two diametrically different organizational approaches: first, the Mayo Clinic, an organization with more than a century of history, a deep culture, and a very cohesive corporate structure, and, second, the medical community in Grand Junction, Colorado, which is constituted largely of independent physicians and an independent hospital that got

together to create a virtually integrated system with a common electronic medical record, changed the payment structure, and put a coordinated focus on value improvement.⁸

High-value organizations across the nation have come from markedly different communities, history, and culture, and yet have achieved national recognition for both quality and cost-effectiveness. We are convinced that many other existing and potential organizational types can also achieve great improvements in value. Therefore, we believe that any “reform” program that is rigidly prescriptive about organizational structure will miss an opportunity to make effective use of organizations that already exist, many of which have the potential to significantly improve healthcare value if appropriately incentivized. Furthermore, American ingenuity may develop beneficial structures and approaches that have not yet been envisioned. An inflexible design would push many willing and engaged participants out of the race before they even get to the starting line. What matters most is that existing or future healthcare organizations, regardless of their configuration, be rewarded for delivering on the promise of improved quality and reduced costs.

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. Under a prepayment approach, however, this whole problem simply evaporates, since unnecessary utilization results in financial harm to the providers rather than to the payer (CMS in this case). Similarly, regulations should monitor competition among systems providing care, not among the individual providers within a system. Again, 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

⁸ Atul Gawande, “The Cost Conundrum,” *The New Yorker* (1 June 2009).

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 or 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.

If either providers or Medicare beneficiaries feel they are being forced into a new Medicare program, even if evidence has shown such a program will improve quality and reduce costs, there will inevitably be backlash from the outset. 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.

Both providers and Medicare beneficiaries will need to initially be given the option to participate in the new model. Traditional Medicare should still be an alternative for both providers and seniors, but the premiums and benefits to beneficiaries and the per-use payments to providers in the traditional program should reflect the fact that it will be a less-efficient paradigm than the new model. If no alternative model is offered, premium, benefit, and provider payment changes are inevitable as a means to rein in the federal debt; this new model provides an option to avoid those across-the-board changes.

All Medicare beneficiaries opting for the new model will need to select a *Shared Accountability Organization* from which they will largely receive care, including a primary care provider or group of providers who will coordinate their care. This active and explicit selection process is necessary in order for *Shared Accountability Organizations* 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 Organizations* their existing providers participate in. To make this selection requirement politically palatable and to encourage competition among providers in an area, Medicare beneficiaries should be allowed to change their selection periodically if they are not pleased with the quality or service of the organization they have selected.

All providers who opt for the new model will accept accountability for each beneficiary's health and expense. It is not enough for providers to just consent to participate in a *Shared Accountability Organization* and continue to receive per-use payments for health services provided. The governing and organizing body of the *Shared Accountability Organization* 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. This is critically important for the success of the program and to separate it from insurance-oriented programs that have not had the ability to motivate effective health-value improvement. So, 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 as they see fit, we believe tools for both physicians and beneficiaries that facilitate changing the conversations around care decisions will be important for successful programs. *Shared Decision-Making* is a good example. In Shared Decision-Making, patients are fully informed of the true risks and benefits of alternative courses of care, so they can play an active role in selecting the best treatment options to meet their personal needs and values. (It is important to note that Shared Decision-Making tools work best when provider incentives are aligned around the health of beneficiaries, rather than the number and type of healthcare services provided, which is why both elements in concert need to be a part of the model.) 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: *Beginning in 2014, 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 Organizations* 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. Without accurate information, it is very difficult to identify whether best care is being provided, both from a quality and an efficiency perspective. Timely feedback is also critical. Access to the information must be reasonably rapid to impact care patterns. 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. If patients are not willing to have their data shared with their *Shared Accountability Organization*, it is impractical for these *Shared Accountability Organizations* 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 Organization* 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. Providers will need to be given license to share information with one another when the purpose is to improve beneficiary health.

Quality and performance metrics will be necessary to ensure *Shared Accountability Organizations* 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. We are seeing a growing number of inconsistent (and sometimes incompatible) quality metrics being created by different oversight and purchaser organizations. 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.

There has been an historical standoff between providers (and geographic regions) that have had high historical per-beneficiary medical expense and those that have had low medical expense. There is more than a two-to-one variation between high-cost and low-cost providers (and regions), and much energy has been wasted in attempting to defend (or condemn) the performance of one by the other. Spokespersons for the low-cost organizations have argued that they deserve a bigger piece of the pie, while the high-cost organizations argue for defending the status quo. Of course, this leads to stalemate and, ultimately, continuation of traditional, unsustainable, cost increases.

We believe there is an approach that allows for a positive outcome for all participants who are willing (and able) to improve healthcare value, both for those who have had historically high cost and those with lower cost.

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). Of course, 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. Of course, high-cost organizations and geographic regions have far more opportunity to improve than do low-cost organizations, so they have far more opportunity to receive major payments. On the other hand, they must work harder and make more changes in order to achieve these, and if changes are not made, they have a potential for significant downside. Low-cost providers, on the other hand, have much less opportunity to achieve large savings but are rewarded by not having to make as many difficult changes. (Appendix 1 has a step-by-step description of the recommended process.)

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.)*⁹

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 Organizations*. 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

⁹ See Appendix 1 for a more detailed description of the recommended process.

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.*¹⁰

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.

¹⁰ Appendix 2 suggests a legislative approach using the methods discussed under this item that might be useful to achieve short-term cost saving while this more detailed plan is under discussion and development.

Appendix 1: A Step-by-Step Description of the Transition Described in Principles 6 & 7.

For the sake of clarity, we will examine the transition looking at two hypothetical, but representative communities: one is historically a high-utilizing community while the other is a low-utilizing community. Cost differences based on differences in input cost (e.g. wage differences) are adjusted. Exhibit 1 shows these communities and their cost to CMS on a per-beneficiary basis.

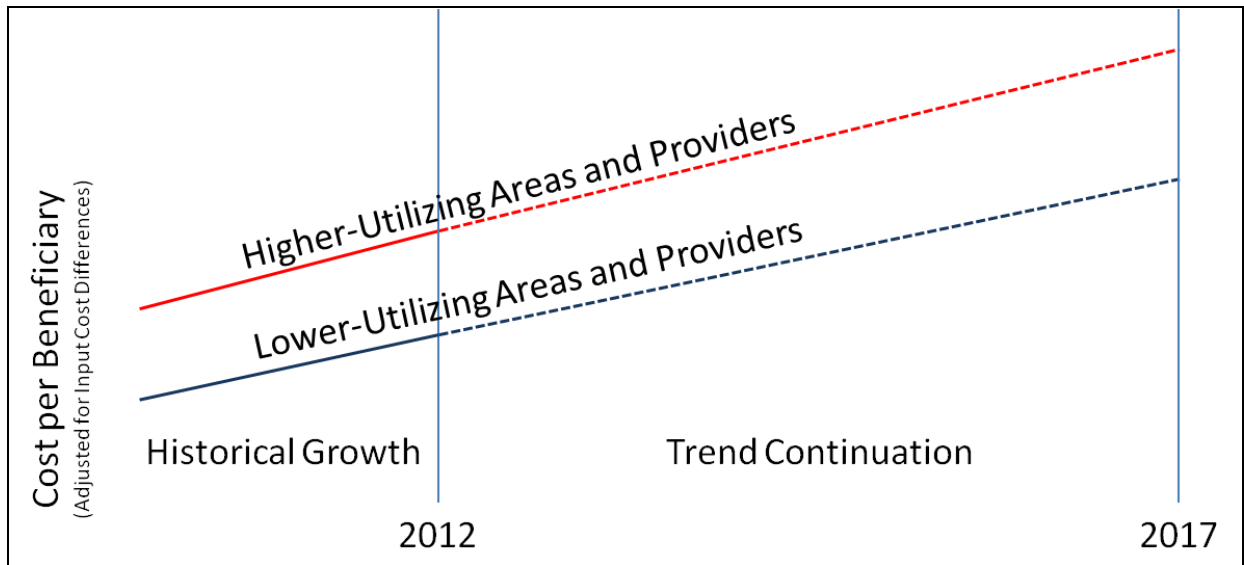


Figure 1

1. Define a target level for an average, national, per-beneficiary expense. This should be a level that would result in a sustainable expense for the federal government into the future.
2. Define adjustment factors that would accurately reflect legitimate differences in input costs of providing healthcare among geographic regions (similar to the adjusters to DRGs today).
3. Define adjustment factors for medical risk (Johns Hopkins ACGs are an example) to reflect differences in patient populations: illness, age, etc.
4. For a geographic region or a *Shared Accountability Organization*, apply the cost adjusters and the medical risk factors. This becomes the target for that region or organization. See Figure

2.

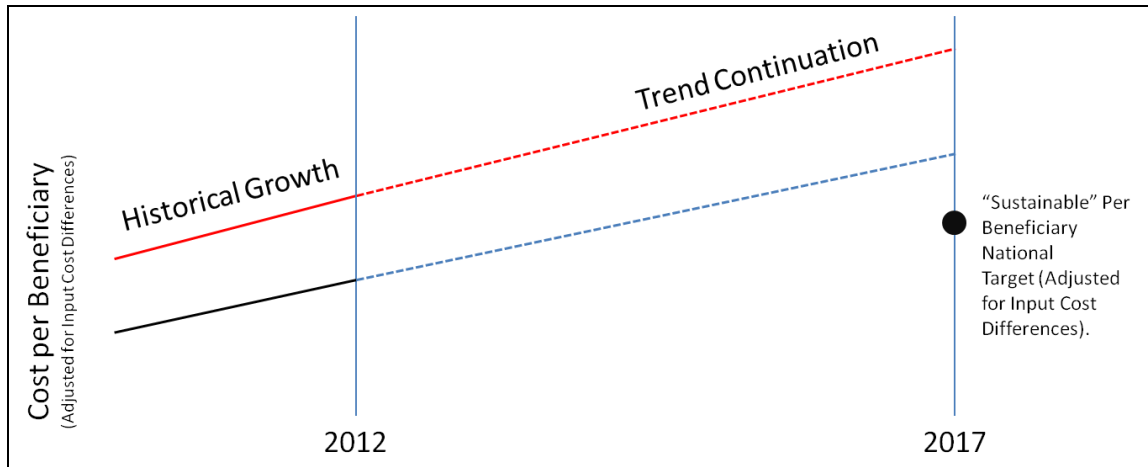


Figure 2

5. Over a defined period of time (we will use 2013 to 2017 as an example), the per-beneficiary paid amount would move from the current expense rate to the target. Figure 3 illustrates trajectories for both high and low utilizing communities (or organizations):

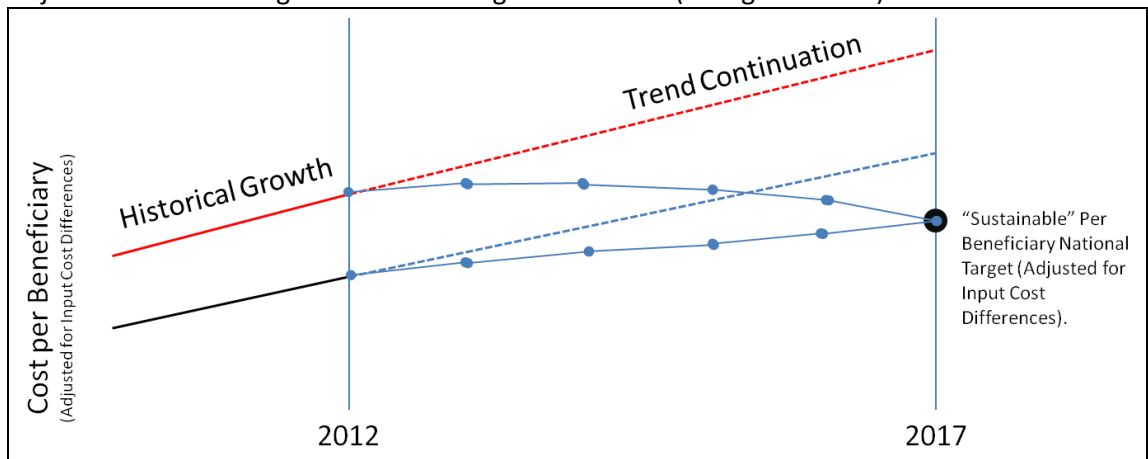


Figure 3

6. If the geographic region does not develop capabilities to accept prepayment, then these targets would be applied to fee-for-service payment (to bring spending into line with the national target). This could be done using a withhold approach. If at the end of the year, the providers had achieved savings in expenditures through utilization, then some or all of the withhold (and, potentially, additional funds) would be distributed (in the following year) to the providers. In this way, CMS could be reasonably assured of meeting the target level, but the providers could also have some control of their income by reducing utilization (which, in our example, would bring utilization closer to national norms).
7. This same example can be used to show how an organized provider group would be incentivized (as opposed to a non-organized geographic region as discussed in the previous step). An organized group could simply be (pre)paid the identified amount to care for those beneficiaries for whom they had accountability. If they are able to reduce expenses below that level, they

would retain all of the savings. If they were able, through improvements in utilization (avoiding overtreatment, helping patients manage chronic disease, improving patient safety, reducing readmissions, etc.), to achieve costs below the defined rate, the providers would retain the entire difference. This is a clear incentive to develop an organized mechanism to accept accountability for care of Medicare beneficiaries and to create mechanisms to provide care for those beneficiaries in an effective manner. *And, of course, the highest cost areas of the country have the greatest opportunity to generate savings (and, therefore, make the most money during the transition).* Figure 4 (which applies to both communities and organizations) shows the opportunity for providers in high-utilizing areas. The shaded area shows potential opportunity, and this opportunity amounts to tens of billions of dollars – which should get the attention of providers.

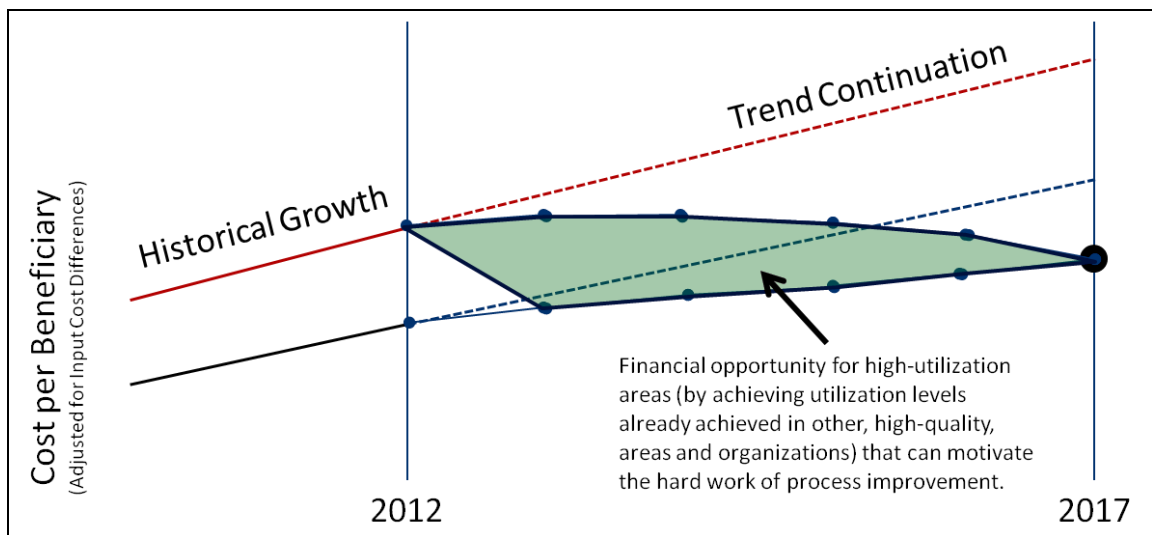


Figure 4

8. CMS would use consistent quality and satisfaction metrics to ensure that quality and efficiency were both being provided. These metrics would be used to generate either bonuses or penalties.

9. While there are potentially billions of dollars available to providers that work hard to manage ineffective or noncontributory utilization and reduce unnecessary costs, the real saver is CMS (and ultimately, the taxpayer). Figure 5 shows the savings as the shaded areas, generated from both low and high utilizing areas and organizations, compared to the historical trend. By simply moving toward practice patterns already demonstrated by high value localities and organizations, savings to the government can very realistically approach \$100 billion per year by 2017. Indeed, appropriately-set national targets would produce savings sufficient to place Medicare on a sound actuarial basis. And shared accountability – with beneficial incentives – could create a new (and sustainable) trend for the future.

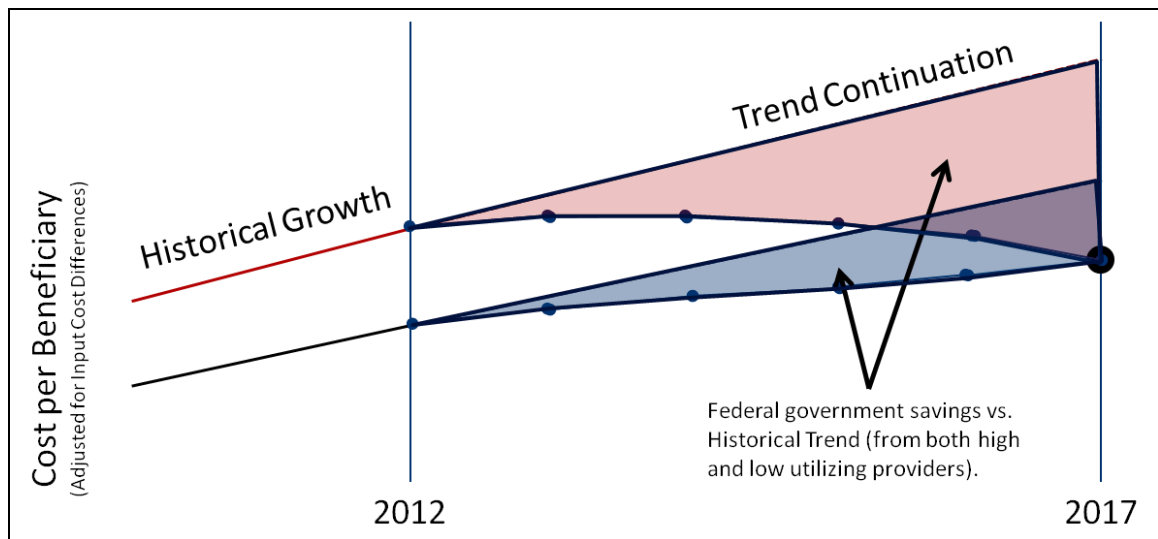


Figure 5

10. In our example, by 2017, all parts of the nation would have a consistent, fair, sustainable, and affordable rate for Medicare beneficiaries. And as a byproduct, this more effective care delivery would become the model for care provided to non-Medicare consumers as well.

Appendix 2: A Short-Term Approach to Cost Reduction for Medicare

We recognize that the approach discussed in this paper will require substantial analysis and discussion, and that creating both legislation and subsequent regulation is likely to take some time. With this in mind, we also suggest a short-term solution that could be rapidly adopted and that incorporates some of the components discussed in this paper.

If the target is a reduction in per-beneficiary expense, we believe the concepts described in Principle 7 will be more effective than a simple across-the-board cut in fee-for-service payment rates. The enormous and unwarranted variation in treatment volumes in the United States makes it clear that the most powerful way to create major cost savings is through elimination of ineffective and unnecessary utilization. Not only is overtreatment expensive; it is often risky to patients and frequently leads to poor medical outcomes.

Therefore, we suggest that a target rate for per-beneficiary spending be set in each geographic region (based on historical expenditures in that region). Rather than simply lowering the fee-for-service payment rate across the board, we instead propose that CMS withhold a fixed percentage of total fee-for-service payments to physicians, hospitals, and other Medicare providers.

Suppose that in 2012 the initial withhold rate is 2%. If the providers in the region keep overall *utilization* at least 2% under the target rate, then the withhold money is returned. If the target utilization is not met, CMS keeps the withhold money and returns it to the Treasury. *In either case, CMS saves at least 2% over what would otherwise have been spent.* This proposal can therefore be scored by CBO without tenuous assumptions about behavioral responses to financial incentives. Indeed, there could be even greater savings (and shared saving with providers or consumers) if the region kept utilization further below the 2% target saving. With a little additional complexity, this same approach could be applied to specific institutions that care for large numbers of Medicare patients (rather than just to geographic regions).

The key benefit to this approach is that it begins to incentivize providers of care to work together to reduce unnecessary utilization. This could effectively prepare them for the next step suggested in this paper: joining together to accept accountability for the health (and associated quality and cost) of a group of beneficiaries.

Useful Resources

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