Energy and Commerce Committee
Subcommittee on Health
Hearing on "Medicaid at 50: Strengthening and Sustaining the Program"
July 8, 2015

3M Company ("3M") appreciates the opportunity to submit this statement for the record before the Committee on Energy and Commerce, Subcommittee on Health Hearing on "Medicaid at 50: Strengthening and Sustaining the Program."

3M thanks the Committee for its continued efforts to improve all of the critical programs within the health care system to keep pace for the betterment of patients. As the Medicaid program expands and is responsible for more patient lives and health care expenditures, continued oversight of quality, outcomes and cost within the program is essential.

Background on 3M

3M is a large U.S.-based employer and manufacturer established over a century ago in Minnesota. Today, 3M is one of the largest and most diversified manufacturing companies in the world. We are a global company conducting the majority of our manufacturing and research activities in the United States.

3M, formerly known as Minnesota Mining and Manufacturing, is an American company currently headquartered in St Paul, Minnesota. The company, created in 1902 by a small group of entrepreneurs, initially began as a small sandpaper product manufacturer. Today, 3M is one of the largest and most diversified manufacturing companies in the world. 3M is home to such well-known brands as Scotch, Scotch-Brite, Post-it®, Nexcare®, Filtrete®, Command®, and Thinsulate® and is composed of five business sectors: Consumer; Electronics and Energy; Industrial; Health Care; and Safety and Graphics.

Ahead of their peers, 3M's founders insisted on a robust investment in R&D. Looking back, it is this early and consistent commitment to R&D that has been the main component of 3M's success. Today, 3M maintains 46 different technology platforms. These diverse platforms allow 3M scientists to share and combine technologies from one business to another, creating unique, innovative solutions for its customers. The financial commitment to R&D equated to $1.7 billion of R&D spending in 2013 and over $7.6 billion over the last 5 years. These investments produced high quality jobs for 4400 researchers in the United States. The results are equally impressive with 625 U.S. patents awarded in 2014 alone, and over 40,000 global patents and patent applications.

3M's worldwide sales in 2014 were $31 billion. 3M is one of the 30 companies on the Dow Jones Average and is a component of the Standard & Poor's 500 Index. This success is attributable to the people of 3M. Generations of imaginative and industrious employees in all of its business sectors throughout the world have built 3M into a successful global company.

3M: Health Information Systems

3M Health Information Systems works with providers, payers and government agencies to anticipate and navigate a changing healthcare landscape. 3M provides healthcare data aggregation, analysis, and strategic services that help clients move from volume to value-based health care, resulting improved provider performance and better patient outcomes. 3M HIS is one of the industry leaders in computer-assisted coding, clinical documentation improvement, performance monitoring, quality outcomes reporting and terminology management.

Targeting the Problem to Improve Quality and Reduce Costs

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.

If the health care system can focus on targeting these unneeded services, mistakes, inefficiencies and missed opportunities, we can improve patient care and save valuable health care resources.

We know that failures in quality typically result in a need for more interventions to correct the quality problem resulting in high rates of potentially preventable:

- Complications,
- Readmissions,
- Admissions,
- Emergency room visits, and
- Outpatient procedures and diagnostic tests.

These five potentially preventable events, or PPEs, identify an underlying quality of care problem. They also represent a large proportion of the unnecessary spending within our health care system and should be the target of state and federal efforts to make our system more efficient and effective for patients and tax payers. We can improve our health care system if we can reduce PPEs through better quality, efficiency, and care coordination.

State Efforts to Improve Outcomes and Reduce Costs in Their Medicaid Programs

For most states, expenditures for Medicaid are one of the largest or the largest item in the state budget. This has necessitated that states seek innovative ways to control Medicaid expenditures. **These successful payment system reforms are practical, transparent, and identify opportunities for improvement that are being realized today.**

Leading Medicaid programs have focused on payment system reforms that link the outcomes of care to payment. These state programs are boldly leading the way on healthcare system payment reform as they respond to their urgent state budget issues. States like Maryland, New York, and Texas have adopted payment systems that create clear financial incentives for providers to increase efficiency and improve quality outcomes.

The payment reforms implemented by state Medicaid programs have been more comprehensive than those implemented by Medicare. Examples include outcomes focused pay for performance programs that target a wider range of clinically-related readmissions and a more comprehensive set of healthcare acquired complications than is currently included in Medicare payment policies.

Several state Medicaid agencies are in the process of implementing comprehensive outcomes payment reforms. In Texas, Senate Bill 7 was passed in 2011 to establish an outcomes payment adjustment across all healthcare delivery organizations including managed care plans. Similarly, New York issued regulations that establish comprehensive outcomes based payment reform. In its first three years, a potentially preventable complication payment adjustment system in Maryland has resulted in a 32 percent reduction in inpatient complications. In Minnesota, the first three years of a potentially preventable readmissions project has resulted in a 20 percent reduction in readmissions. Key components of these state level reforms were contained in H.R. 5823, the "Incentivizing Health Care Quality Outcomes Act of 2014."

While some of the implementation details across these state Medicaid reforms may differ, they all have the following characteristics in common:

- Payment adjustments for quality are based on the outcomes of care
- Measureable and clinically meaningful objectives for improving the outcomes of care are established
- Comprehensive provider specific information on the outcomes of care are made publically available

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

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 will improve as healthcare delivery organizations strive to improve their outcome performance.

Conclusion: We Should Learn from What is Working

It is imperative that we learn from state Medicaid program efforts that are fully operational and producing real results. A more widespread adoption of these innovative payment system reforms across entire Medicaid program should encouraged. Payment system reforms that are practical, transparent, and identify opportunities for improvement can yield better outcomes at lower costs. We should apply such successful concepts not only across the Medicaid program but also to Medicare as well.

We would appreciate the opportunity to present additional findings 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.