Energy and Commerce Committee
Subcommittee on Health
Hearing on "Strengthening Medicaid and Prioritizing the Most Vulnerable"
February 1, 2017

3M Company ("3M") appreciates the opportunity to submit this statement for the record before the Energy and Commerce Subcommittee on Health Hearing on "Strengthening Medicaid and Prioritizing the Most Vulnerable.

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 Committee considers ways to strengthen the program and provide states with greater flexibility, we would recommend encouraging states to reduce costs by tying payment incentives to improved patient outcomes.

Background on 3M Health Information Systems

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 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 hospital and health system payment classification systems tied to quality,** 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 potentially preventable services, complications, 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 avoidable events represent the vast majority of avoidable adverse outcomes. The added benefit of this definition of avoidable outcomes is that each of these can be translated into dollars. As a consequence 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 these kinds of events through better collaboration, information, payment incentives 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 items in the state budget. This has necessitated that states seek innovative ways to control Medicaid expenditures. Many of **the successful state based 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 Texas, New York, Pennsylvania, Illinois, Maryland, Ohio, and Minnesota have adopted payment systems that create clear financial incentives for providers to increase efficiency and improve quality outcomes.

The payment reforms implemented by these and other 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.

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 publicly 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.

State Examples

Several state Medicaid agencies are in the process of implementing comprehensive outcomes payment reforms.

- **Texas** passed comprehensive Medicaid reform legislation in 2011 to establish quality outcomes based payment adjustment targeting managed care plans, hospitals and regional healthcare partnerships. As of 2016, Texas was generating annual savings of $90 million via plan and provider reductions of potentially avoidable events.

- **New York** has created a delivery system reform and value based payment program designed to reduce state-wide avoidable hospital use (readmissions, admissions and emergency department visits) by 25% over a five year period ending 2020.

- **Pennsylvania** has revamped its Medicaid managed care program, which will measure plans' quality outcomes, and will require plans to make 40% of their transactions with providers to be value based transactions within three years. Pennsylvania has also established a Hospital Quality Incentive Programs to reward hospitals showing year-to-year improvement in reducing avoidable readmissions.

- **Illinois** established a hospital inpatient rate adjustment program based on potentially preventable readmissions performance that generated $40 million in savings.

- **Maryland's** potentially preventable complication outcomes payment program has generated a state-wide 50% reduction in inpatient complications over a five year period.

- **Ohio** has established outcomes based payment programs to reduce hospital potentially preventable readmissions and nursing potentially preventable admissions.

- **Minnesota's** state hospital association sponsored "Reducing Avoidable Readmissions Effectively" Program reduced avoidable readmissions by 2% over three years, generating over $70 million in savings—and won the National Quality Forum Patient Safety Award in 2014.

Application for Medicaid Reform

As the Committee considers ways to strengthen the program and provide states with greater flexibility, we would recommend encouraging states to reduce costs by tying payment incentives to improved patient outcomes. The existing Federal Medical Assistance Percentage (FMAP) for Medicaid funding has resulted in a rising a Federal share along with increased complexity, cost and frustration experienced by states from CMS oversight. The existing Medicaid financing

relationship between CMS and the states should be transformed from a contractual arrangement to a simplified regulatory structure in which superior operational performance of a Medicaid agency and its bottom-line success are closely linked and do not require burdensome retrospective oversight measures.

Specifically, we would recommend replacing the current FMAP with a risk-adjusted, per capita matching payment system that ties payment incentives to efficiently delivered improved outcomes. This would permit states to have greater control over their program under a national rate not based on "covered costs" but instead based on spending adjusted for patient mix and achieved outcomes. This is an extension of the pricing approach used in the Medicare inpatient prospective payment system (IPPS) implemented in 1982. The IPPS had the effect of saving the Federal government billions of dollars while maintaining quality.

At the same time, we would recommend establishing quality outcomes targets for Medicaid programs to provide objective measurement of relative performance within the matched funding budget. Under such an approach, states could be allowed to earn a greater relative match by reducing their cost, thus driving reductions in overall costs but allowing states to share in their program efficiency improvements. Long term this would reduce federal share as average matching dollars will fall.

Conclusion: We Should Learn from and Respond to What is Working

Successful state Medicaid program efforts that are fully operational and producing improved outcomes should provide the basis for reforming and strengthening the Medicaid program going forward. A more widespread adoption of these innovative payment system reforms across entire Medicaid program should encouraged. Payment system reforms that are practical, transparent, clinically credible, and identify opportunities for improvement can yield better outcomes at lower costs.

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.