

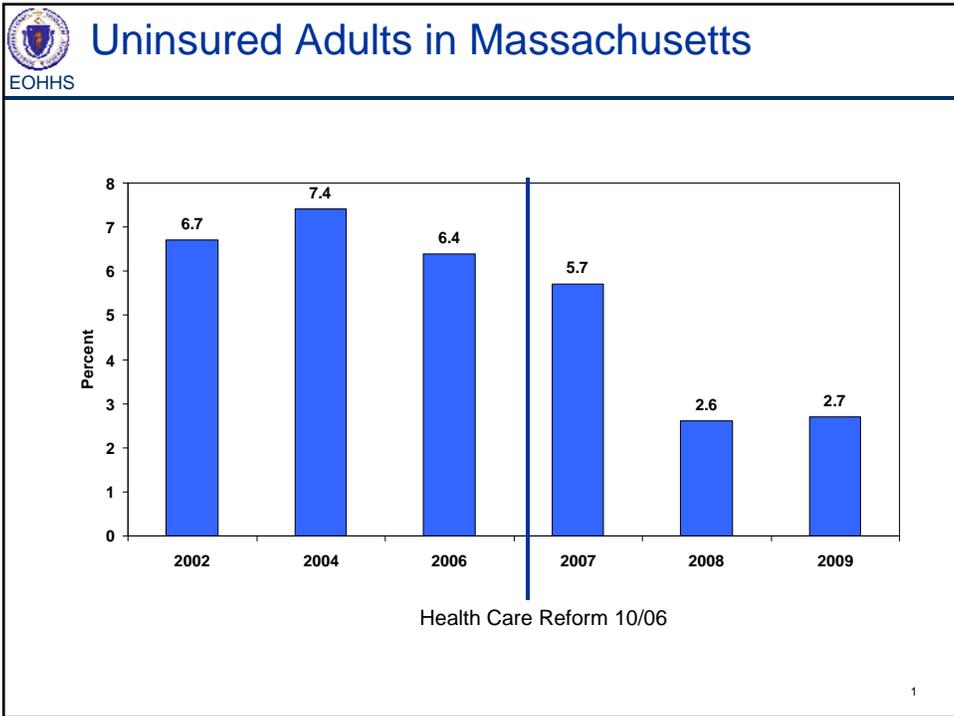
Commonwealth of Massachusetts
Executive Office of Health and Human Services



Toward a Shared Vision of Health Reform: Massachusetts Commission on Payment Reform and Next Steps

Massachusetts Medical Society October 2010

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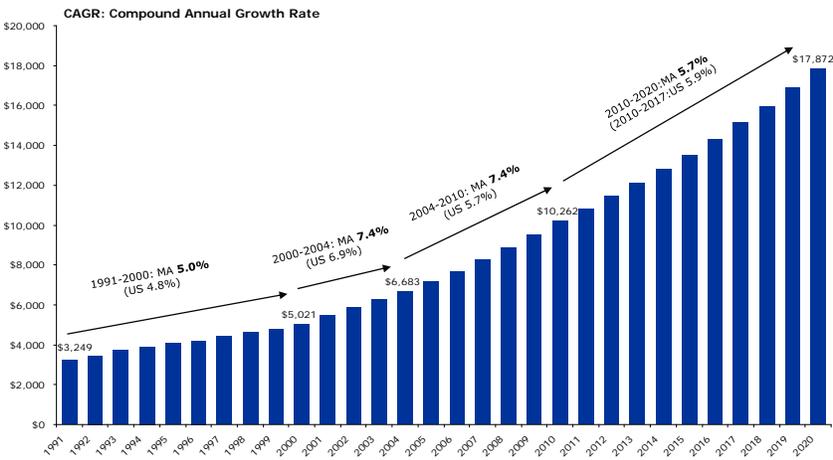
Impact on Access and Affordability

- Fewer people report having an “unmet need for health care
- More people, including racial and ethnic minorities, report having a usual source of care
- More people report seeing a doctor for preventive care
- Fewer people report having an unmet need for health care due to costs
- Fewer people report out of pocket health care costs \geq \$500
- 25-30% report have some barrier to care due to costs

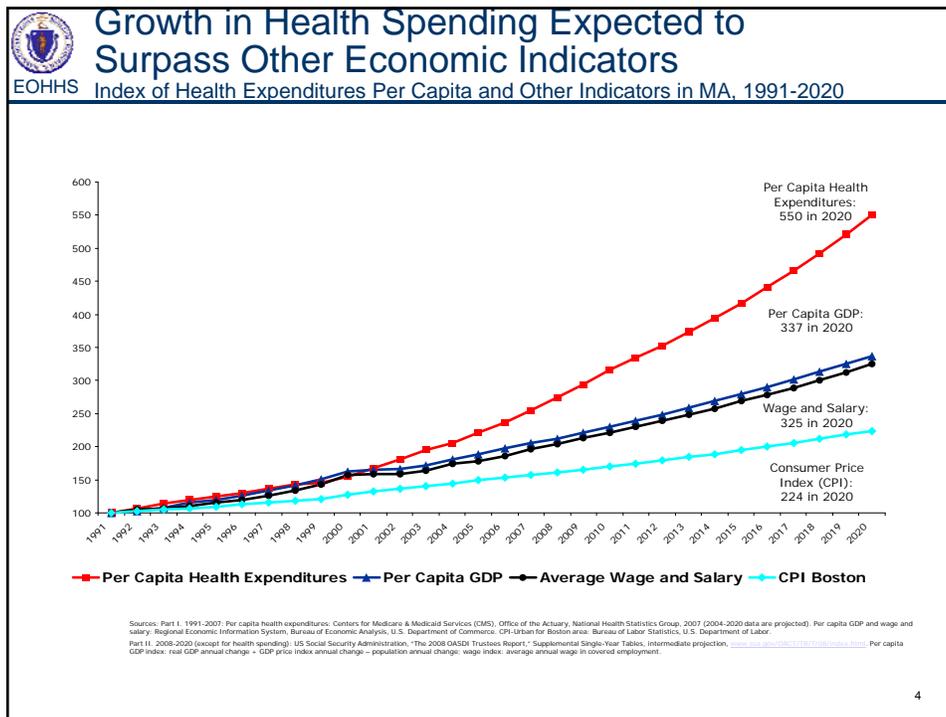


Per Capita Spending Is Projected to Nearly Double from 2009 to 2020 (Assumes No Cost Containment Intervention)

Massachusetts Per Capita Personal Health Care Expenditures, 1991-2020



Note: The health expenditures are defined by residence location and as personal health expenditures by CMS, which exclude expenditures on administration, public health, and construction. Data for 2005 – 2020 are projected.
 Source: Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group, 2007.



 **Creation of the Special Commission on Health Care payment**

- Recognizing the nexus between health care payment models and the quality and cost of health care, the Legislature enacted Section 44 of Chapter 305 of the Acts of 2008, **An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care.**
- Created the Special Commission on the Health Care Payment System to investigate reforming and restructuring the payment system in order to:
 - Provide incentives for efficient and effective patient-centered care.
 - Reduce variations in the quality and cost of care.

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A Vision of Higher Quality, More Cost-Effective Care

The Commission defined its vision for:

“fundamental reform of the Massachusetts health care payment system that will support safe, timely, efficient, effective, equitable, patient-centered care and both reduce per capita health care spending and significantly and sustainably slow future health care spending growth”

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Special Commission's Recommendation

Global payments with adjustments to reward provision of accessible and high quality care become the predominant form of payment to providers in Massachusetts within a period of five years

Government, payers and providers will be required to share responsibility for providing infrastructure, legal and technical support to providers in making this transition

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Key Components of Recommendations

- Participation by private and public payers
- Development of Accountable Care Organizations (ACOs)
- Patient-centered care and adoption of medical homes
- Patient choice
- Common core performance measures and cost and quality transparency
- Appropriately balanced sharing of financial risk between ACOs and carriers
- Strong and consistent risk-adjustment

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Transition Oversight

- Proposed Board to oversee transition:
 - Define parameters for a standard global payment *methodology*—but the *market* will determine global payment *amounts*.
 - Establish transition milestones and monitor progress, with a focus on the progress to global payments, progress to greater payment equity, and per capita health care costs.
 - Make decisions in an open and transparent manner and seek broad stakeholder input from providers, health plans, government, employers, and consumers.
- The oversight entity will have authority to assist and intervene, and make mid-course corrections if needed.

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 Commonwealth Fund Commission on a High Performance Health System

1. Extend affordable health insurance to all ✓
2. Align financial incentives to enhance value and achieve savings
3. Organize the health care system around the patient to ensure that care is accessible and coordinated
4. Meet and raise benchmarks for high-quality, efficient care
5. Ensure accountable national leadership and public/private collaboration

MA ranks 7th among states overall on the 2009 Commonwealth Fund *State Scorecard*, but ranks 33rd on measures related to avoidable hospital use and costs.

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 Comprehensive Health Care System Reform

| | | |
|--|---|--|
| <p><u>Access</u></p> <p>Uninsured</p> <p>Financial barriers to care</p> <p><u>Costs</u></p> <p>High and growing costs</p> <p>Volume driven</p> <p>Fee-for-service</p> <p><u>HIT</u></p> <p>Spotty implementation</p> <p>Lack of interoperability</p> <p>Potential not met</p> <p><u>Systems</u></p> <p>Inconsistent Quality</p> <p>Errors and adverse events</p> <p>Misuse, overuse, and duplication</p> <p>Inequities in care</p> <p>Disorganized, poorly coordinated</p> <p>Not always evidenced based</p> <p>Emphasis on specialty care</p> |  | <p>All insured</p> <p>Financial and structural barriers to access removed</p> <p>Value/Quality driven</p> <p>Wide adoption</p> <p>Interoperable</p> <p>Informs and transforms clinical practice</p> <p>Predictable outcomes</p> <p>Patient safety</p> <p>Appropriate use</p> <p>Disparities eliminated</p> <p>Coordinated, integrated care</p> <p>Evidenced based</p> <p>Patient centered primary care</p> |
|--|---|--|

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The HCQCC Roadmap to Cost Containment: System-wide Strategies

1. Adopt comprehensive payment reform
2. Adopt and use health information technology
3. Implement evidence-based coverage informed by comparative effectiveness information
4. Develop health resource planning
5. Support system redesign
6. Implement health plan design innovation to promote use of high-value care
7. Enact malpractice reform and peer review protections
8. Implement administrative simplification
9. Engage consumers
10. Encourage healthy behaviors
11. Further promote transparency

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Comprehensive Payment Reform

- State should encourage global payments as major model for health care payments. An independent Board should be established to guide and monitor implementation.
- Public and private payers should increase use of payment methodologies that will support health care delivery redesign during the transition to global payments, including:
 - Increased use of pay-for-performance and alignment of P4P across providers
 - Implementation of bundled or episode-based payments
 - Support for patient-centered medical homes – multi-payer initiative lead by MassHealth
 - Reduced payments for avoidable hospitalizations and preventable readmissions

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Comprehensive Payment Reform

- The Council should monitor cost growth and explore the potential impact of government rate regulation options if cost control targets not met.
- The state should continue efforts to work with CMS on system redesign initiatives, including implementation of medical homes and efforts to efficiently provide coverage to Massachusetts' residents that are dually eligible for Medicare and Medicaid. Further, the state should work with CMS to utilize its Center for Innovation to include Medicare's participation in payment reform efforts in Massachusetts.
 - Application to Advanced Primary Care demonstration through multipayer PCMH initiative
 - Medicare waiver, proposals to CMS Innovation Center

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Role of Government

- Balance between regulating conditions of change and promoting innovation and flexibility
- Ensure provider and consumers protections
- Monitor and report progress toward agreed upon outcomes
- Support for those on the margins vs letting the market determine all outcomes
 - Ensure essential services delivered
 - Ensure societal good
- Support early adopters and help to report their experiences

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Legislation is necessary

- To establish a mechanism to ensure desired outcomes related to
 - Ensuring and improving access to care
 - Ensuring and improving quality of care
 - Containing costs of care
- To promote transformation of the health care delivery system not just to introduce a new payment system
- Establishment of Oversight Board
 - Defining powers and duties of the Board
 - Establishment and regulation of ACO
 - Regulation of ACO risk assumption
 - Ensure services are delivered
- Allow data collection, analysis, and reporting
- Consumer protections
- Anti-trust, fraud and abuse, physician self-referral

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Responsibilities of Board

- Set parameters for ACO's while allowing flexibility and diversity
- ACOs are composed of hospitals, physicians and/or other clinician and non-clinician providers working as a team to manage provision and coordination of full range of services
 - Incorporated organizations or contracted networks of providers
 - Include primary care as patient centered medical homes
 - At least one physician on governing board
 - Possess or procure population management functions; care management; financial management; contract management; quality management; and patient and provider communication capabilities
- ACOs accept global payment for all or most care provided to an enrollee with a primary care physician within an ACO's network
- ACOs make adjustments based on performance against aggregate ACO global payments and performance, access, and quality incentives.

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Responsibilities of Board

- Methodologies utilized for global payments (base payment and incentive payment)
 - Establishes standard risk adjusters for use by all payers and account for past cost experience, clinical health status, socioeconomic status, geographic location but payments must be consistent with DOI risk reserve requirements
 - Establish safeguards against underutilization of services by ACO's, inappropriate selection of low-cost patients
 - Establish payments for teaching, disproportionate share status, sole community provider status, stand-by services and other factors
 - Certain classes of services may be exempt from global payment

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Key Concerns

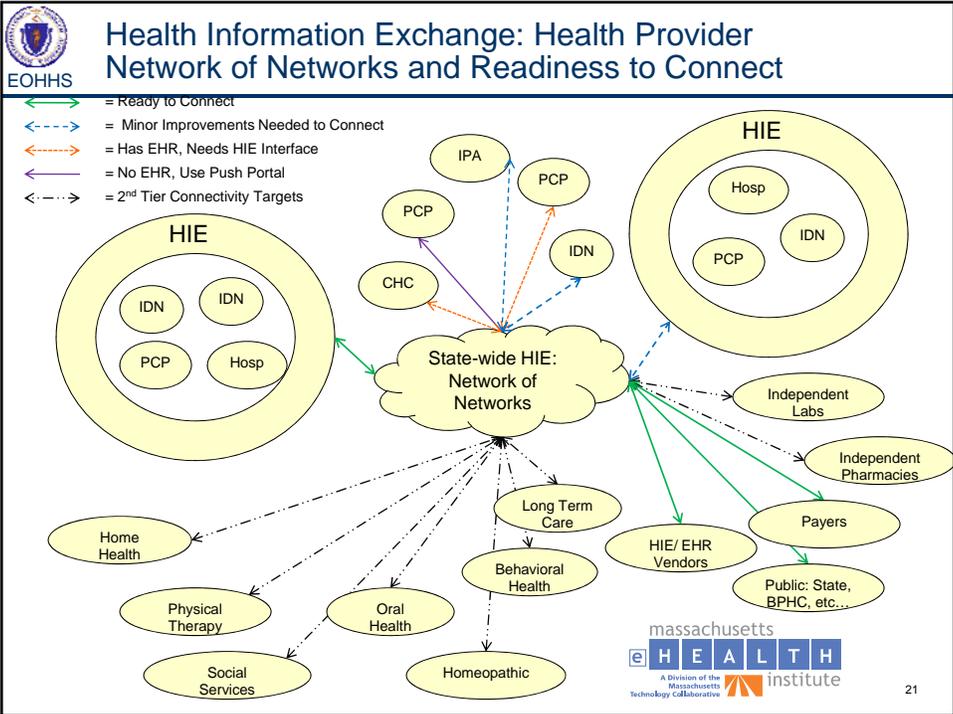
- Ability of the health care community to deal with global payments
 - Cost of and source of funding for reform
 - How to redirect existing resources
 - How can those who are not ready be brought along?
 - How will the shifting of risk from payers to providers be addressed? If risk is transferred, how to ensure that insurance products are consistent with provider risk? How can we ensure the transfer of risk is based on the provider's scope of control?
- Impact of global payments on consumer choice
 - Are consumers ready to accept limitations?
 - How will they be engaged in this transformation?
 - Will insurance products support this?
 - Will the business community support this?
- Mechanisms to fairly set payments, given the current limitations of risk adjustment methodologies
 - Current risk adjustment models only capture about two-thirds of cost variation due to patient acuity. How will the payment methodology account for this?
 - How do these models today correlate with performance on total medical expenditures?

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 **Opportunities**

- ACO development can lead to more integrated health care delivery systems but if we simply organize what exists we have not necessarily improved the system
 - Promoting a continuum of care across the life span should be an essential principle of the system

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Opportunities

- ACO development can lead to more integrated health care delivery systems but if we simply organize what exists we have not necessarily improved the system
 - Promoting a continuum of care across the life span should be an essential principle of the system
- To improve prevention strategies
- To improve care for vulnerable populations
- To improve chronic disease management
- To decrease gaps in transitions in care
- To improve palliative and end-of-life care
- Explicit statement about the social responsibility of all payers and providers
 - Behavioral health, medical education and training, essential community services (e.g. emergency departments), stand-by services, catastrophic cases

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Opportunities

- Provide incentives for institutions to transform to new business models to better support the needs of communities
- Promote partnerships among organizations to promote and improve population health
- Align with federal reform efforts
 - **2010**
 - Medicaid Global Payment System Demonstration
 - **2011**
 - HHS to develop national quality strategy
 - Center for Medicare and Medicaid Innovation - CMI
 - **2012**
 - Shared savings program to promote Accountable Care Organizations
 - Independence at Home Demonstration Project
 - **2013**
 - Pilot program for bundled payments

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Summary

- Economic Imperative to mitigate cost growth
 - Transition system to reward “value over volume”
 - Volume decreases due to avoidance of unnecessary interventions and improved outcomes
 - Costs decrease due to right care in the right place (primary care vs specialty care)
 - Price decreases due to transparent payment methodology for bundled services tied to outcome
- Reduction / conversion in capacity of over utilized resources
 - New business models for care delivery in communities are necessary
- Develop integrated care systems - “one stop shopping” that promotes wellness and maintenance of functional status across the continuum of care and across life cycle
 - Not simply rearranging the deck chairs
- Patient preference sought and respected
- Savings accrue to consumers, employers, and government