In the Health Care Financing Committee’s consideration of the above referenced legislation, the Massachusetts Medical Society (MMS) wishes to share the following policies from our House of Delegates. We hope these adopted policies will help inform legislators of the views of physicians on a broad range of relevant approaches and issues relating to access to health care, payment reform and quality assurance.

The following policies have been adopted, and in some cases renewed under our sunsetting rules, over the past decade or more. The MMS is proud of its role in supporting universal access to care, in becoming the first state medical society to state that health care is a basic human right, and in working to effectively implement these goals through our advocacy in a manner that is consistent with our policies.

Health Care as a Basic Human Right
1. That the MMS asserts that enjoyment of the highest attainable standard of health, in all its dimensions, including health care, is a basic human right.
2. That the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

Universal Access
The MMS supports comprehensive health coverage that provides universal access to equitable, high-quality, continuous, affordable health care, and is open to supporting any proposal that achieves this fundamental universal coverage goal. (HP)

Principles for Health Care Reform

- Physician leadership. Physician leadership is seen as essential for the implementation of new payment reform models. Strong leadership from primary care and specialty care physicians in both the administrative structure of accountable care organizations (ACOs) and other payment reform models, as well as in policy development, cost containment and clinical decision-making processes, is key.
- One size will not fit all. One single payment model will not be successful in all types of practice settings. Many physician groups will have a great deal of difficulty making a transition due to their geographic location, patient mix, specialty, technical and organizational readiness, and other factors.
- Deliberate and careful efforts must be undertaken to guard against the risk of unintended consequences in any introduction of a new payment system.
- Fee-for-service payments have a role. While a global payment model could encourage collaboration among providers, care coordination, and a more holistic approach to a patient's care, fee-for-service payments should be a component of any payment system.
- Infrastructure support. Sufficient resources for a comprehensive health information technology infrastructure and hiring an appropriate team of physician assistants, nurse practitioners, and other relevant staff are essential across all payment reform models.
- Proper risk adjustment. In order to take on a bundled, global payment or other related payment models, funding must be adequate, and adequate risk adjustment for patient panel sickness, socioeconomic status, and other factors is needed. Current risk adjustment tools have limitations, and payers must include physician input as tools evolve and provide enough flexibility regarding resources in order to ensure responsible approaches are implemented. In addition, ACOs and like entities must have the infrastructure in place and individuals with the skills to understand and manage risk.
- Transparency. There must be transparency across all aspects of administrative, legal, measurement, and payment policies across payers regarding ACO structures and new payment models. There must also be transparency in the financing of physicians across specialties. Trust is a necessary ingredient of a successful ACO or other payment reform model. The negotiations between specialists, primary care physicians, and payers will be a determining factor in establishing this trust.
- Proper measurements and good data. Comprehensive and actionable data from payers regarding the true risks of patients is key to any payment reform model. Without meaningful, comprehensive data, it becomes impractical to take on risk. Nationally accepted, reliable, and validated clinical measures must be used to both measure quality performance and efficiency and evaluate patient experience. Data must be accurate, timely, and made available to physicians for both trending and the ability to implement quality improvement and cost effective care. The ability to correct inaccurate data is also important.
- Patient expectations. Patient expectations need to be realigned to support the more realistic understanding of benefits and risks of tests and clinical services or procedures when considering new payment reform models. Physicians and payers must work together to provide a public health educational campaign, with an opportunity for patients to provide input as appropriate and engage in relevant processes.
- Patient incentives. Patient accountability coupled with physician accountability will be an effective element for success with payment reform. An important aspect of benefit design by payers is to exclude cost sharing for preventive care and other selected services.
- Benefit design. Benefit designs should be fluid and innovative. Any contemplation of regulation and legislation with regard to benefit design should balance mandating minimum benefits, administrative simplification, with sufficient freedom to create positive transparent incentives for both patients and physicians to maximize quality and value.
- Professional liability reform. Defensive medicine is not in the patient’s best interest and increases the cost of healthcare. In an environment where physicians have the incentive to do less, but patients request more, physicians view litigation as an inevitable outcome unless there is effective professional liability reform.
- Antitrust reform. As large provider entities, ACO definitions and behavior may collide with anti-trust laws. The state legislature may be the adjudicator of antitrust issues. Accountable care organizations and other relevant payment reform models should be adequately protected from existing antitrust, gain-sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.
- Administrative simplification. Physicians and others who participate in new payment models, including ACOs, should work with payers to reduce administrative processes and complexities and related burdens that interfere with delivering care. Primary care physicians
should be protected from undue administrative burdens or should be appropriately compensated for it.

- The incentives to transition. In order to transition to a new model, incentives must be predominantly positive.
- Planning must be flexible. Accommodations must be made to take into account the highly variable readiness of practices to move to a new system.
- Primary care physician. All patients should be encouraged to have a primary care physician with whom they can build a trusted relationship and from whom they can receive care coordination.
- Patient access. Health care reform must enable patient choice in access to physicians, hospitals and other services while recognizing economic realities.

**Ideal Payer System**

The MMS defines an ideal payer system and the definition encompasses goals that include:

- universal coverage of population;
- coverage of preexisting conditions;
- accessibility to everyone regardless of location or background;
- portability for all medically necessary services; and

The MMS definition of an ideal payer system encompasses comprehensive services, that include:

- acute and chronic illness care;
- prevention of disease and disability by risk assessment and education to change behaviors that may lead to disease or injury, early disease detection and treatment: to prevent, diminish, compress, and delay its disablements;
- rehabilitation of disabled persons: to improve their function for work and living;
- immunization;
- counseling;
- unimpeded access to appropriate specialty and subspecialty care; and

The MMS definition of an ideal payer system encompasses qualities, that include:

- efficiency/cost-effectiveness;
- equity/fairness, convenience and satisfying;
- maximal patient and physician involvement, choice, mutual decision-making, and respect;
- use of appropriate technologies, scientifically assessed for the needs of patients;
- continuous improvement efforts for better health care;
- outcomes through: practitioner education, at the undergraduate, graduate, and continuing medical education levels;
- research;
- reorganization of processes of care;
- professional self-management, internal to the practice;
- voluntary participation of physicians and patients;
- maintain freedom of physicians to contract directly with their patients;
- individuals retain right to establish medical saving accounts and to purchase catastrophic health insurance from insurer’s of their choice
- maintain freedom of entry into the health insurance market; and
The MMS definition of an ideal payer system encompasses characteristics for payment of services and insurance, that include:

- simplicity: uniform administrative criteria for eligibility and billing, single forms, and a single open formulary;
- accountability;
- consistency in benefit coverage limitations related to scientific evidence and expert opinion;
- timeliness;
- responsiveness: correction of defects; and
- appropriate funding

The MMS thanks the Committee on Health Care Financing for your consideration of these policies in its deliberations on single payor and Medicare for all legislation.