Recommendations of the Special Commission on the Health Care Payment System

July 16, 2009

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Executive Summary

Section 44 of Chapter 305 of the Acts of 2008 mandated the creation of a Special Commission on the Health Care Payment System to "investigate reforming and restructuring the system to provide incentives for efficient and effective patient-centered care and to reduce variations in the quality and cost of care." Section 44 established three responsibilities for the Special Commission: (1) to examine payment methodologies and purchasing strategies, (2) to recommend a common transparent methodology, and (3) to recommend a plan for the implementation of the common payment methodology across all public and private payers in the Commonwealth.

The legislation designated three categories of appointments to the Special Commission: three *ex officio* members, one member to be appointed by the Senate President, one member to be appointed by the Speaker of the House, and five members to be appointed by the Governor.

The Special Commission met on nine occasions between January and July 2009 to create a set of principles to guide the development of payment policy recommendations, elicit and consider input from key stakeholders, assess and debate alternative payment approaches, and arrive at recommendations for payment policy.

The Context for Payment Reform in Massachusetts

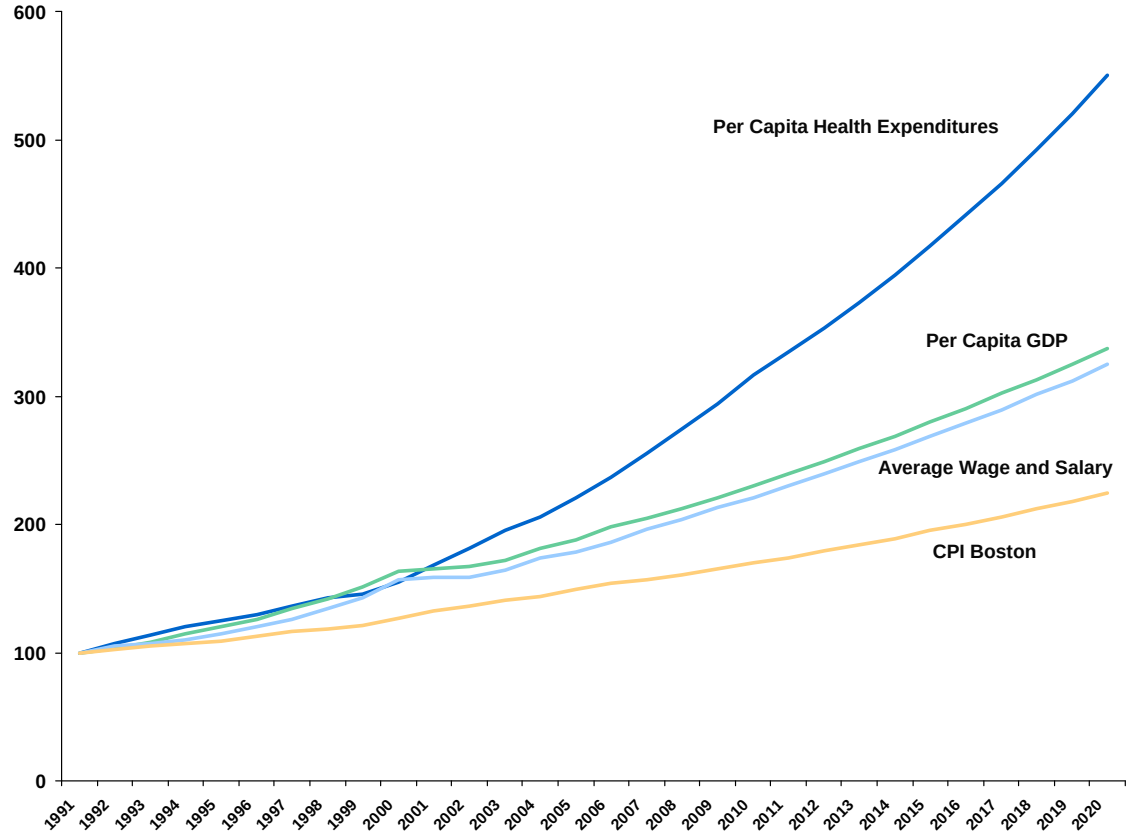
The Commonwealth of Massachusetts enjoys a number of signature achievements in health care—including highly skilled providers, excellent technology, generally good population health, and an extraordinarily high rate of health coverage under its historic health care reform initiative. However, important challenges remain—including high and fast-growing health care spending and significant opportunities to improve health care quality.

While the U.S. has the highest health care expenditures per capita among other industrialized countries, Massachusetts has among the highest health care costs in the U.S. In 2004, health care costs per capita in Massachusetts reached $6,683 (DHCFP, MA Health Care Spending 2009) and based on recent history, are projected to grow faster than for the U.S. as a whole (DHCFP, MA Health Care Cost Trends 2008).[1]

It is difficult to overstate the impact that high and fast-growing health care costs have on Massachusetts' citizens, businesses, cities, towns, and state government. Largely driven by these health cost increases, health insurance premiums have increased almost every year for the past two decades at a pace that well exceeds the annual increase in the cost of living.

[1] Data are unadjusted for wage area differences. In 2007, Massachusetts wages were 23.4 percent higher than the US average, while health care expenditures were 33.0 percent higher (Bureau of Economic Analysis, U.S. Department of Commerce). In 2000, both wages and health care expenditures were 24 percent higher in Massachusetts than the US average.

Figure A: Historic and Projected Index of Health Expenditures Per Capita and Other Indicators in MA, 1991-2020



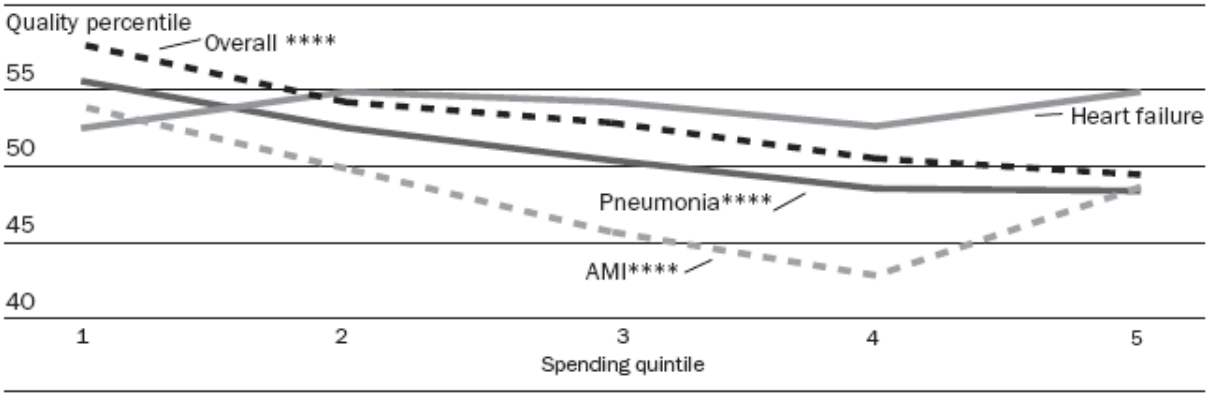
Source: Massachusetts Division of Health Care Finance and Policy (DHCFP). "Massachusetts Health Care Spending: Baseline Trends and Projections," February 4, 2009.

The impact of high and fast-growing health care costs is visible every day in the Commonwealth, depleting the resources of families, communities, businesses, and state government. Health care costs hurt individual citizens who are challenged to balance household budgets when wages are not increasing. Businesses struggle to compete when annual family health care premiums have begun to approach the wage level of a low-income employee, and displace wage growth for all. Health care cost impact is felt at the level of state government, with almost a third of the budget dedicated to the state's the Medicaid program (MassHealth). Finally, continued high cost growth threatens the viability of the Commonwealth's successful health reform initiative.

In Massachusetts, as elsewhere, high health care costs do not mean that patients are consistently receiving effective, evidence-driven, preventive care that produces the best outcomes for their health. A study conducted by the RAND Corporation concluded that adults nationwide receive just 55 percent of recommended care; few differences were found between Boston and eleven other metropolitan areas (Kerr et al. 2004). In addition, the Commonwealth Fund State Scorecard on Health System Performance in 2007 indicated that fewer than half of adult diabetics in Massachusetts received recommended preventive care, and fewer than half of all adults over age 50 received recommended screening and preventive care (Cantor et al. 2007).

With respect to hospital quality, national research indicates that hospitals' performance on quality of care is not associated with the intensity of their spending. For example, nationally, from 2004 to 2007, hospitals in which end-of-life expenditures per capita (for Medicare beneficiaries) were highest did not perform better on selected measures of quality than hospitals in which expenditures were lower (Exhibit 2).

EXHIBIT 2
Percentile Of Quality, By Quintile Of Spending, All Hospitals, 2004–2007



SOURCE: Authors' analysis (see text for complete details).
NOTES: Spending is measured as total end-of-life spending on chronically ill Medicare decedents in their last two years of life, adjusted for prices. AMI is acute myocardial infarction.
**** $p < 0.001$

Source: L. Yasaitis, E.S. Fisher, J.S. Skinner, and A. Chandra, A. "Hospital Quality and Intensity of Spending: Is There an Association?" *Health Affairs*, May 21, 2009; w566-s572.

Massachusetts also faces important challenges in maintaining important services, due to payments for health care that financially reward providers irrespective of value. For example, because primary care providers are paid relatively little compared with specialists, access to primary care is declining. From 2006 to 2008, the percentage of family medicine physicians who no longer accept new patients increased steadily from 25 percent to 35 percent (Massachusetts Medical Society 2008). Among internal medicine offices accepting new patients in 2008, the average wait time for an appointment was 50 days.

In addition, the gap between the financial performance of teaching and community hospitals is widening. This trend portends potential problems with access to care in some communities as well as escalating costs for hospital care.[2] In fiscal year 2008, teaching hospitals reported a median operating margin of 4.1 percent, compared with a median operating margin of 0.4 percent among community hospitals (Figure B). Among all acute care hospitals ranked by operating margin, hospitals at the 75th percentile made a 2.9 percent operating margin, but hospitals at the 25th percentile had a negative margin of -1.1 percent in fiscal year 2008 (Figure C). (Quarterly filings, which are less reliable than annual audited financials, suggest that the gap in performance between teaching and nonteaching hospitals may have narrowed in early fiscal year 2009, with operating performance apparently improving for the best-performing hospitals. However, performance at the 25th percentile remained flat.

[2] Hospital financial performance and performance on measures of health care quality are not necessarily correlated.

Figure B: Massachusetts Acute Hospital Median Operating Margin: Teaching vs. Community Hospitals, State Fiscal Years 2002-2009 (Quarter 2)

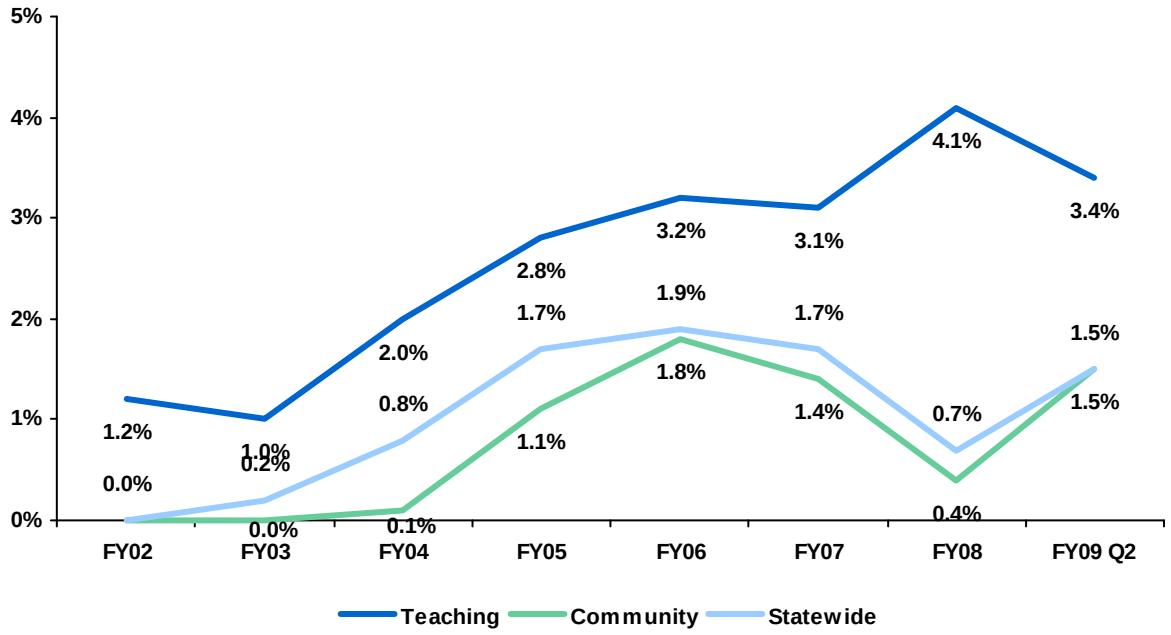
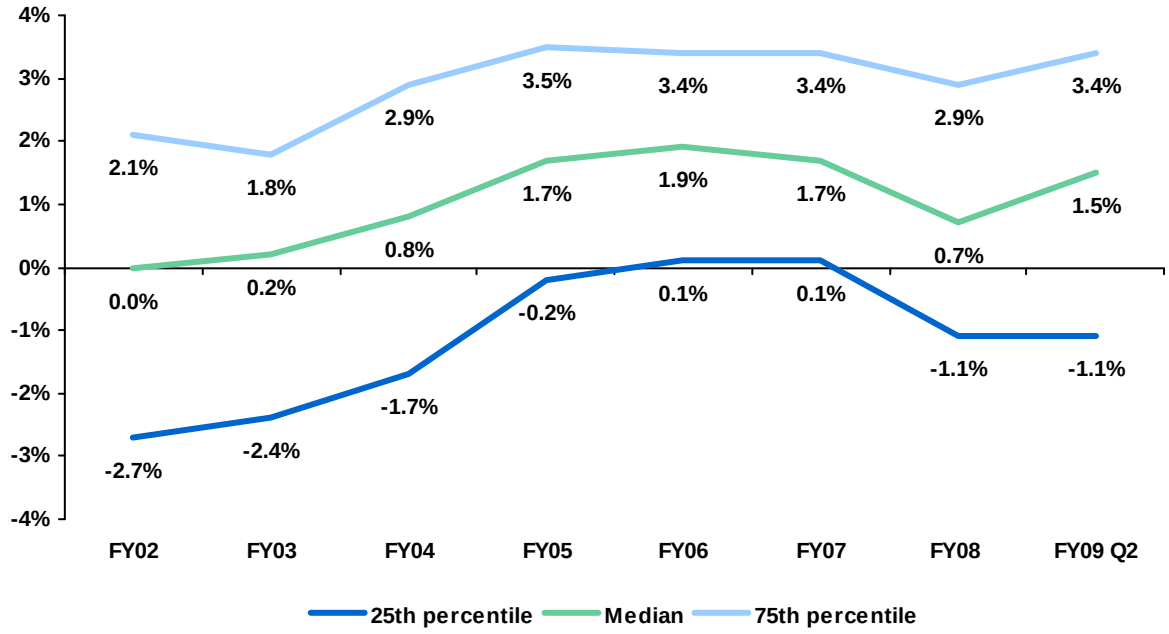


Figure C: Massachusetts Acute Hospital Operating Margins: Hospitals at the 25th, Median, and 75th Percentiles in State Fiscal Years 2002-2009 (Quarter 2)



Source: Massachusetts Division of Health Care Finance and Policy. "Massachusetts Acute Hospital Financial Performance: Fiscal Year 2009 through Quarter 2," pending publication.

It is widely recognized that the current fee-for-service health care payment system is a primary contributor to the problem of escalating costs and pervasive problems of uneven quality. In turn, the growing cost of health care is crowding out other expenditures for the public good that also affect health status, such as education, transportation, and housing. Recognizing the nexus between how care is paid for and the cost and quality of care that is delivered, the Legislature established the Special Commission on the Health Care Payment System to examine and recommend improvements to the current payment system in order to motivate and reward effective, efficient, and patient-centered care.

Principles for Payment Reform

The Special Commission seeks to develop recommendations 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. To support this vision, the Special Commission developed a set of principles that were subsequently adapted to reflect feedback from numerous stakeholder groups. These principles and many of which underlie its recommendations for fundamental reform of the Massachusetts health care payment system:

1. As currently implemented, fee-for-service payment rewards service volume rather than outcomes and efficiency, and therefore other models should be considered.
2. Health care payments should cover the cost of efficiently provided care, support investments in system infrastructure, and ensure timely access to high quality, patient-centered care. Additional payment should reward and promote the delivery of coordinated, patient-centered, high quality health care that aligns with evidence-based guidelines where available, and produces superior outcomes and improved health status. Performance measurement should rely on reliable information and utilize uniform, nationally accepted quality measures.
3. Provider payment systems should balance payments for cognitive, preventive, behavioral, chronic and interventional care; support the development and maintenance of an adequate supply of primary care practitioners; and respond to the cross-subsidization occurring within provider organizations as a result of the current lack of balance in payment levels by service.
4. Differences in health care payments should reflect measurable differences in value (cost and quality). Payments should be adjusted for clinical risk and socio-economic status wherever technically possible, and should promote greater equity of payments across payers and providers, to the extent that this is financially feasible.
    a. Differences in health care payments should be transparent, including across different payers.
    b. Costs associated with desired investments in teaching and research should be paid outside of base payments, and should require provider accountability for how such payments are spent.
    c. Costs associated with desired investment in special “stand by” capacity should be accounted for in the payment system.
5. The health care payment system should be structured in such a way as to minimize provider, payer and patient administrative costs that do not add value.

6. Payment reform must consider how:
    a. Some payment methods may require certain organization of the service delivery system, and
    b. Health benefit designs either support or limit payment reform.
7. Health care per capita costs and cost growth should be reduced, and providers, payers, private and public purchasers and patients should all share in the savings arising from payment reform.
8. The health care payment system should be transparent so that patients, providers and purchasers understand how providers are paid, and what incentives the payment system creates for providers.
9. It will be necessary to consider the diversity of populations, geography and providers across the Commonwealth when designing payment reform to ensure high quality, patient-centered care to all populations and geographic regions in the Commonwealth.
10. Implementation should be phased over time with:
    a. Clear and attainable deadlines;
    b. Planned evaluation for intended and unintended consequences; and
    c. Mid-course corrections.

Finally, the Special Commission recognizes the need to support the Commonwealth's infrastructure of community and disproportionate-share hospitals in the context of payment reform.

Special Commission Evaluation of Payment Models

Section 44 of Chapter 305 of the Acts of 2008 required the Special Commission to examine alternatives to the fee-for-service (FFS) payment model—including but not limited to blended capitation rates, episode-of-care payments, medical home models, global budgets, pay-for-performance (P4P) programs, tiering of providers, and evidence-based purchasing strategies. The Special Commission understood that that the models outlined in the legislation included basic payment models as well as complementary strategies relating to payments, benefits or care, which could be used with those basic payment models to improve health care quality and/or moderate cost growth. The Special Commission quickly acknowledged that its recommendations would likely combine a preferred basic payment model with one or more of these complementary strategies.

Fee-for-Service

Fee-for-service (FFS) is the dominant form of payment for health care services in Massachusetts and in other states. Under FFS, providers are paid for each service they produce. The Special Commission identified the following problems with the current Massachusetts health care system and with FFS in particular:

- FFS rewards overuse of services, does not encourage consideration of resource use, and thus cannot build in limitations on cost growth.
- FFS does not recognize differences in provider performance, quality, or efficiency, and thus does not align with evidence-based guidelines or outcomes.

- FFS focuses attention on prices, not costs, and fees do not relate to the actual cost of providing care.
- FFS is complex and difficult to administer given the wide array of individual health care services and changes in health care delivery and technology.
- Multiple payers negotiate different rates for a service, leading to different rates both within and among providers for the same service. These rates are more often based on relative market leverage, not health care value.
- Varied payment levels for services leads to variation in profit margins across services; variable margins incentivize volume in high profit services, not value.
- Some highly valued services are not currently recognized in the FFS system and thus not compensated.
- Caregiver incentives are not currently aligned among acute care hospitals, physicians, behavioral health providers, and other providers.

While changes built on the current FFS system might be easiest to achieve, the Special Commission concluded that complementary payment-related strategies (including P4P, which largely developed in response to the deficiencies of FFS) could not neutralize FFS incentives for greater volume and cost. Therefore, payment reform built on FFS was seen as not having enough potential for changing the way health care is delivered in Massachusetts. Moreover, the need to overlay multiple complementary payment strategies in an attempt to counter the pervasive incentives of FFS was viewed as a principal reason that the current FFS system is both administratively complex and difficult for both providers and patients to understand.

Alternative Payment Models

The Special Commission considered two other payment models—episode-based payment and global payment—that bundle services and payments in different ways. Compared with FFS (which pays for each service), episode-based payment bundles services as an episode of care; global payment bundles services at the patient-level over a defined period of time.

Compared with FFS, both episode-based payments and global payments place providers at financial risk for their clinical performance and coordination of care (that is, "performance risk") within, respectively, an episode of care and patient-level health care for a specified period of time. However, neither method, when properly implemented, should place providers at risk for the occurrence of health problems over which providers have no control (that is, insurance risk). In all cases, insurers should properly retain insurance risk, setting payments that transfer to providers performance risk but not insurance risk.

Episode-Based Payment

Episode-based payments reimburse providers for clinically defined episodes of care. In emerging episode-based payment models, the unit of payment is the full range of services that all or most providers deliver during a clinical episode for a specific procedure or condition—such as coronary artery bypass surgery and recovery. Payment is commonly designed to be made per-occurrence of an acute care episode to the provider or provider group identified as most responsible for the patient's care. As described above, episode-based payments place providers at financial risk for their clinical performance within an episode (performance risk), but at no risk

for the occurrence of an episode (insurance risk). Episode-based payments may be adjusted for severity of illness and also combined with complementary payment-related strategies such as P4P.

The Special Commission concluded that this model has many promising features, including incentives for efficient delivery of care and collaboration among providers within episodes of care. Federal policymakers currently are paying substantial attention to episode-based payments as a potential means for improving the efficiency of care provided to Medicare patients. However, this payment model would not fully address the volume incentive, as it would not improve incentives for providers to help patients avert the need for episodes of care. In addition, there is limited operational experience with episode-based payment, and for only a small number of episode types that have been designed to-date. Therefore, the Special Commission was concerned that episode-based payment methods would not be available to be implemented quickly enough, nor would episode-based payment as a basic payment model sufficiently curb incentives to increase the volume of care. However, the Special Commission recognized the strong potential of episode-based payment as a method for allocating global payments among providers as well as its potential as a possible transitional payment model.

Global Payment

Global payments prospectively compensate providers for all or most of the care that their patients may require over a contract period, such as a month or year. Usually estimated from past cost experience and an actuarial assessment of future risk related to patient demographics and known medical conditions, global payments reflect the expected costs of covered services. As with episode-based payments, providers hold performance risk in a global payment system. To protect providers from also holding insurance risk, global payments must be risk-adjusted so that they reflect the underlying health conditions and predictable probability of illness among each provider's patients. Carriers might also develop stop loss or risk corridor arrangements with providers to further protect them from insurance risk. Insurance carriers retain insurance risk for unpredictable illness and also adjust the level of global payments to reflect expected cost of consumer incentives (such as cost sharing for particular services or providers) in their benefit designs.

Global payments may be combined with complementary payment-related strategies (including P4P) to encourage improvements in quality, care coordination, and patient-centered care. Global payments, as envisioned, are very compatible with the concept of a medical home, which focuses on patient-centered care and on care coordination for patients who may have one or multiple chronic conditions.

The Special Commission viewed global payment models as having important advantages. They offer strong incentives for the efficient delivery of the full range of services that most patients need. They emphasize primary care and reinforce the goals of patient-centered medical homes. Moreover, some Massachusetts providers already have operational experience with some form of global payment. An estimated 20 percent of commercial physician payments are currently made in Massachusetts under some form of global payment (Bailit 2009). This experience suggests that broader adoption is feasible (since many providers already are managing under it successfully) and provides a base for wider progress towards global payment.

Finally, the Special Commission noted that global payment is compatible with P4P, which was viewed as important in protecting consumer access and encouraging the high-quality, evidence-based, patient-centered care that is central to the Special Commission's vision for payment reform. At the same time, the Special Commission recognized that there are challenges to replacing FFS with global payment—including adoption of appropriate risk adjustment methods and the widespread participation of providers, some of whom have little or no operational experience with global payments or integrated delivery systems.

Public and Stakeholder Input to the Special Commission

The Special Commission was committed to engaging stakeholders and the larger community during the process of evaluating the current health care payment system in Massachusetts, evaluating alternative payment models and purchasing strategies, and developing recommendations. Many meetings with stakeholders were held on behalf of the Special Commission, engaging a broad community of stakeholders throughout the Special Commission's deliberations. In addition, the Special Commission conducted a special meeting early in its discussions to elicit comments from the public.

The Special Commission used its second meeting on February 6, 2009 to hold a public input session to solicit comments. Various groups—including hospital organizations, physicians, insurers, patient advocates, health academicians, and other groups—presented at this meeting or provided written comments. The major themes that emerged from these statements included:

- The importance of expanding primary and preventive care, and transitioning Massachusetts' current health care system from a specialist-based system to a primary care-based system. Shortages of specific provider types were noted, including primary care providers, and the need to address workforce dynamics was emphasized.
- The weakness of the current fee-for-service payment model and the need to transition to a payment approach that would encourage better coordination of care.
- The need to encourage quality improvement through transparency and adoption of health information technology.
- The importance of accounting for individual special circumstances when reforming the payment system.

The statute specified that the Special Commission should consult with parties that its recommendations would likely affect. On behalf of the Special Commission, three meetings were convened with each of nine groups of stakeholders: physician specialty societies and large independent physician groups, physician groups affiliated with hospitals, community hospitals, large teaching hospitals and major safety-net hospitals, consumer advocates, organized labor groups, employers and employer organizations, health plans, and community health centers. Additional meetings and calls were conducted with the Health Care Quality and Cost Council, the Commonwealth Health Insurance Connector, and with the Office of Medicaid. Major themes that emerged from the stakeholder meetings included the following:

- The importance of moving away from FFS as the predominant form of payment.

- Better integration of care, whether real or virtual integration, to bring about improvements in efficiency, continuity of care, and patient outcomes.
- Transparent, deliberative, and consultative development of an alternative payment system.
- Building consistent provider incentives, including common performance metrics and measurement in pay-for-performance (P4P) programs and risk adjustments that appropriately recognize patients' clinical and socio-economic status (and therefore, systematic differences in levels of adherence to clinical instruction).
- Building appropriate consumer incentives for appropriate use of care, to manage their health, and to seek and use care efficiently.
- The need for provider infrastructure development to position providers to succeed under a new payment model.
- Protecting providers from the prospects of catastrophic financial loss under an alternative payment system.
- A careful transition with time and resources dedicated to evaluation, identification of unanticipated consequences, and opportunities for mid-course corrections.

Special Commission Recommendations for Payment Methods

To promote safe, timely, efficient, effective, equitable, patient-centered care, and thereby reduce growth and levels of per capita health care spending, the Special Commission recommends that global payments with adjustments to reward provision of accessible and high quality care become the predominant form of payment to providers in Massachusetts. The Special Commission notes that infrastructure, legal and technical support are needed for many providers to make this transition; and that government, payers and providers will be required to share responsibility for supporting providers in making this transition.

The Special Commission concludes that global payment models that provide appropriate incentives for efficiency in the delivery of services, while strongly encouraging improvements in quality and access to appropriate, coordinated care should serve as the direction for payment reform. In addition, the Special Commission concludes that global payments can be implemented over a period of five years on a statewide basis, with some providers participating in the near-term, while others will need more time and support to transition. All payers (including governmental payers) will need to transition to the new system within this timeframe.[3] The Special Commission recognizes that many providers will require infrastructure, legal and technical assistance and support, such as information technology adoption, training in use of registries, and managing risk before a transition to global payment can occur. The Special Commission also recognizes that certain narrow classifications of services or practitioners should continue to be paid outside of the global payment model for their services, such as very high cost drugs or providers of very limited and specialized services.

[3] The participation of Medicare will require a waiver to federal payment rules. Footnote 21 provides further explanation of the waiver process.

The Special Commission anticipates that, when fully implemented, global payment in Massachusetts will include the following key features:

- **The development of Accountable Care Organizations (ACOs)** (specifically as defined here) that accept responsibility for all or most of the care that enrollees need. ACOs will be composed of hospitals, physicians and/or other clinician and non-clinician providers working as a team to manage both the provision and coordination of care for the full range of services that patients are expected to need. ACOs could be real (incorporated) or virtual (contractually networked) organizations—potentially including, for example, a large physician organization that would contract with one or more hospitals and ancillary providers. The Special Commission envisions there will be a broad array of ACO models and encourages the development of a large number of ACOs.

- **Patient-centered care and a strong focus on primary care**. Consumers will play a pivotal role. The patient's selection of a primary care provider will direct insurer payments to the ACO with which the patient's primary care physician is affiliated. Thus, identification of a primary care provider by all patients is critical. Primary care practices associated with ACOs will receive technical support in order to become medical homes.

- **Patient choice.** Payments to ACOs will follow the enrollee's choice of a primary care physician. An enrollee will not be restricted (unless as a condition of his insurance contract) to providers in his primary care physician's ACO, although his insurance contract might require him to pay more if he obtains care from providers in another ACO.

- **Use of pay-for-performance (P4P) incentives** to ensure appropriate access to care, and to encourage quality improvement, evidence-based care, and coordination of care among providers and across sites of care. P4P will be based on consistent performance measures and measurement across all payers. The Special Commission anticipates that such measures will reflect available evidence about effective care, and that they will include measures of health care quality as experienced by the patient.

- **Participation by both private and public payers** to ensure alignment of financial incentives for providers treating patients covered by different payers. With respect to Medicare, this will entail obtaining an all-payer waiver of federal payment rules.

- **Sharing of financial risk between ACOs and carriers**. Carriers will retain their current role as holders of insurance risk for health insurance contracts written to groups and individuals. To ensure that ACOs are not subject to insurance risk, global payments will be risk adjusted (as described below). To further protect ACOs from insurance risk, carriers might develop stop loss or risk corridor arrangements with ACOs. However, ACOs will be held responsible appropriately for performance risk—including cost performance and meeting access and quality standards.

- **Strong and consistent risk adjustment**. Global payments will be adjusted to reflect providers' clinical and socioeconomic case mix, and, as appropriate, geography, so that no ACO will be financially harmed by accepting high-risk patients with complex or chronic health care needs. Clinical case mix adjusters will reflect both patients' health conditions and differences in consumer incentives associated with benefit design.

Socioeconomic adjustments will recognize differences in other patient characteristics such as income status to the extent they have been demonstrated to influence health. Appropriate socioeconomic risk adjustment will be made a priority for further research and development. All payers will use a standard risk adjustment methodology.

- **Cost and quality transparency**. ACOs will report performance against common metrics measuring health care quality and access to appropriate care. These measures will be made widely available to consumers, providers, and payers to support consumer choice, establish provider and insurer accountability, and encourage ongoing system improvement. Performance should be measured using reliable and tested metrics.

- **Widespread adoption of the medical home model**. In large part, the characteristics that will define an ACO—an emphasis on cost-effective primary care, clinical integration, and attention to quality as measured against common performance metrics—require medical home capacity. The Special Commission recommends that steps be taken to ensure that the primary care practices in each ACO undergo the necessary practice redesign to become effective patient-centered medical homes and that they are compensated in a manner that supports their operation. Such actions will provide ACOs with critical capacity for serving their patients. However, while the Special Commission endorses widespread adoption of medical homes, it concludes that medical homes overlaid on the current FFS system cannot achieve its vision for a high-value health care system.

Special Commission Recommendations for a Transition Strategy

The Special Commission anticipates that movement to global payment will promote significant changes in health care delivery and utilization in Massachusetts. During a transition to global payments, some relationships among health plans, providers, and patients/enrollees may change. The Special Commission recommends a careful and structured transition strategy, supporting both providers and consumers in the new payment model.

While some provider organizations (those with more experience and that already have the features of an ACO) may begin to accept global payment voluntarily in the near-term, others will shift more gradually as they build relationships and structure themselves as ACOs, develop necessary operational capabilities, and become accustomed to risk-sharing and performance-based payments. Provider organizations needing more time to transition would initially shift from fee-for-service to shared savings models—in which they would begin to participate in limited risk-sharing arrangements with uniform performance incentives—and then ultimately to full global payment. However, full global payment will not require accepting full financial risk (that is, both performance and insurance risk). The Special Commission recognizes that all ACOs will not be capable of assuming the same level of risk, and anticipates that carriers will share risk differently with ACOs in different circumstances. Moreover, the Special Commission recognizes that insurance risk (that is, risk associated with unpredictable health care costs) belongs with health insurers, not with provider organizations.

Shared Savings

The Special Commission recognizes that not all ACOs will be prepared immediately to accept any "downside" risk of financial losses associated with their clinical and cost performance under global payment. These ACOs—likely including providers who have not heretofore worked in a closely coordinated fashion—could receive payment in a shared savings model as an interim step in their transition to global payments.

Under the shared savings model, payers will negotiate spending targets with ACOs (consistent with the milestone targets discussed in the next section), reflecting predicted costs for their patients. At the end of the year, ACOs that meet uniform, system-wide access and quality standards and hold costs at or below the spending targets will receive bonus payments that reflect a portion of the savings they achieve. The Special Commission anticipates that payers, employers, and consumers also will share in these savings through lower premium payments.

The Special Commission recommends that the transition include financial incentives for provider organizations to move toward global payment. Such incentives might include allowing providers to keep a larger portion of savings they achieve under global payments for providing high-quality care (as they also gradually assume some down-side financial risk for their clinical and cost performance under global payment).

Technical Assistance and Consumer Education

While the Special Commission recognizes that a number of current provider organizations might easily meet the definition of ACO, it is likely that most providers will require technical assistance to transition successfully to global payment, including (1) training in best practices in key competencies such as governance and contracting, patient-centered care management, health information technology, data analysis, and medical home primary care practice redesign; and (2) ongoing, timely access to and analysis of claims data for their covered populations, to obtain information about member health, care management, expected cost outcomes, and performance against standard quality metrics.

Patients and employers also will require education regarding the new payment system and its implications for them. Patient-directed enrollment in an ACO and patient-centered care place patients and their families at the center of care planning and delivery; they will require more (and more useable) information and education to maximize the potential for coordinated care delivery to improve their health status and outcomes.

There are many organizations in Massachusetts that may be positioned to play a role in providing the needed technical assistance for providers and in supporting the envisioned education for patients and employers. These organizations include trade associations, not-for-profit quality improvement organizations, information technology support collaboratives, and others.

Employers will also continue to play a critical role as health plan sponsors. While global payment as envisioned by the Special Commission will not require employers to modify their health plan designs, employers can maximize the benefit of payment reform by aligning the consumer incentives that are implicit in their benefit designs—for example, reducing cost

sharing for use of appropriate primary and preventive care, other care that is known to be effective, or patient use of coordinated care within the ACO.

Transition Oversight

The Special Commission recommends that the Commonwealth assign the responsibility for guiding implementation of the new payment system to an entity with the expertise needed to perform this critical function.

The entity charged with steering implementation of the new payment system could be a new, independent Board consisting of members that are subject-matter experts. Areas of expertise may include (but may not be limited to) physician practice finance, hospital finance, provider organization and insurer operations, health care payment, clinical care, and consumer issues. This new, independent Board would be supported and staffed by existing state entities or agencies. Alternatively, responsibility for steering implementation of the new payment system could be assigned to an Executive Branch agency that would be advised by an independent Advisory Board with expertise in the previously mentioned areas.

In either case, the entity charged with guiding implementation of a new payment system would make decisions in an open and transparent manner and seek input from a broad array of stakeholders, including providers, health plans, government, employers, organized labor and consumers. The Special Commission also recommends that a permanent source of dedicated, adequate, additional funding be identified to support performance of its responsibilities.

Among its responsibilities, this entity will establish the methodology for global payments; establish the parameters that define an ACO; analyze health system data to support providers, patients, and employers; recommend the necessary infrastructure support for providers; and establish transition milestones and monitor progress. It will also have the authority to identify and implement mid-course adjustments as may be needed.

The key responsibilities of this entity—developing global payments, defining what constitutes an ACO, monitoring and analysis, ensuring infrastructure support, and establishing transition milestones—are discussed below.

- **Development of Parameters for Global Payments**. The oversight entity will develop parameters for a standard global payment methodology. Global payments will include adjustments for clinical risk, socio-economic status, geography (if appropriate), core access and quality incentive measures, and other factors. The Special Commission recommends that the *market determine global payment amounts* consistent with the methodology established by the oversight entity.

- **Defining Accountable Care Organizations.** The oversight entity will be responsible for determining the specific criteria that qualify provider organizations as ACOs. These criteria may include the scope of services that ACOs must provide and the minimum size of an ACO consistent with managing its performance risk.

- **Establishing Financial Risk Parameters for ACOs**. Under global payments, insurance carriers will continue to hold insurance risk for the contracts that they issue, but ACOs

will assume risk for their clinical and cost performance. The oversight entity will establish parameters for an ACO's assumption of financial risk for performance, taking into consideration the various circumstances that might affect an ACO's ability to assume financial risk. Also, the oversight entity will have the authority to establish requirements to accommodate ACOs that are capable of taking on only limited financial risk, such as requiring ACOs to reinsure or requiring adjustment of global payments for limited-risk ACOs.

- **Monitoring and Analysis.** In the first year, the oversight entity will collect and analyze data to inform policy-making and the establishment of payment system transition and performance milestones. It will adopt core common performance measures and monitor trends in performance. The oversight entity will conduct evaluations to monitor the impact of the transition to global payment, including assessments on changes in the workforce, trends in primary care physician capacity, and changes in health care provider practice operations, including progress toward shared responsibility for the needed infrastructure, legal, and technical support for providers. The oversight entity will have the authority to identify and implement mid-course adjustments as may be needed.

- **Infrastructure Support.** Providers will need significant support in building the infrastructure needed to integrate care successfully, meet performance metrics/targets, and manage financial risk for performance. The Special Commission sees an important role for state government in coordinating this effort, and sees a need for shared responsibility for infrastructure support for providers in this transition. The oversight entity will be responsible for identifying provider infrastructure needs and recommending policies to address those needs.

- **Establishing Milestones.** The oversight entity will establish milestones in three areas reflecting the goals of payment reform and the need for a phased and thoughtful transition. First, the oversight entity will set annual milestones for the market to advance to global payments and monitor progress using measures such as the percent of providers organized in an ACO and percentage of patient service revenue received through global payments or transition payment strategies. Second, the oversight entity will set milestones for achievement of greater value-based payment equity and monitor market progress to these targets, using metrics that might include variation in levels of risk-adjusted global payments to ACOs across payers, variation in levels of payments to different providers within ACOs, and/or payments for lines of service such as primary care and behavioral health relative to other services. Third, the oversight entity will analyze baseline per capita market cost trends to set target growth levels and monitor progress to these targets. The oversight entity will have the authority to intervene when milestones are not met or when unintended consequences occur; its authority will extend to both financial interventions and nonfinancial interventions. In determining progress toward each milestone, the oversight entity will consider whether providers have sufficient infrastructure support and suggest policy to address unmet needs for infrastructure or other support.

Complementary Strategies and Issues Requiring Further Consideration

The Special Commission recognizes the importance of a number of complementary strategies to achieve the goals of improved quality and value in Massachusetts' health care system, as suggested in meetings with stakeholders. While these issues were not fully explored during the Special Commission's discussions, it recommends that each be given careful consideration as the Commonwealth moves forward with payment reform:

- **Health plan design and coverage policy.** While payment reform would not necessarily require the redesign of health plan products, many stakeholders noted the importance of aligning patient and provider incentives under global payment. In addition, emerging evidence about the effectiveness of care for specific medical conditions suggests that a significant amount of care that is currently provided is ineffective and in fact may unnecessarily endanger patient health. Employers must be engaged to support the alignment of insurance benefit design and payment reform goals. The Special Commission recommends that a multi-stakeholder process be convened to review comparative effectiveness evidence, examine health plan design, and develop consensus coverage policies based on its findings to promote the use of high-value, efficient care.

- **Consumer engagement.** Many stakeholders emphasized the importance of engaging patients both in maintaining good health and in managing their own care, especially with respect to chronic conditions. The Special Commission recommends that existing efforts be coordinated and expanded to promote healthier lifestyles and support better self-management of chronic illness.

- **Review of existing statutory framework**. The Commonwealth's existing statutory framework for health care was developed in response to a health care system operating with fee-for-service as the predominant payment model. Thus, the Special Commission recommends a close review of statutory provisions (including state antitrust rules and insurance law) that could impact the realization of its recommendations and, to the extent there are barriers to achieving its vision, appropriate legislative action to address these issues.

- **Administrative simplification.** Many stakeholders expressed concern about current administrative burdens resulting from complying with widely divergent performance measures and payment structures. The Special Commission recognizes that important private and government efforts toward administrative simplification in Massachusetts are currently underway. The Special Commission recommends that these efforts should continue to fruition, and views monitoring and ongoing efforts to reduce administrative costs as critical activities under payment reform.

- **Medical malpractice reform.** The Special Commission recognizes physician views about medical malpractice reforms and recommends concerted efforts to resolve remaining issues and develop policy recommendations.

- **Primary care workforce development.** The Special Commission recommends that the Commonwealth develop implementable strategies for attracting and retaining primary

care physicians and other critical health professionals to meet increased demand under payment reform and ensure adequate access to primary care and medical homes. While support for the evolution of primary care practices to medical homes should help make primary care more attractive in time, it may not be sufficient to address current and anticipated future primary care shortages.

- **End-of-life care.** The Special Commission recommends that efforts addressing end-of-life care and decision-making, such as those of the End of Life Commission, be continued.

- **Payment for provider teaching and standby capacity.** In its guiding principles, the Special Commission recognized that costs associated with graduate medical education and necessary standby capacity should be paid for. Funding for these costs should be transparent and there should be accountability for how such payments are spent. The Special Commission recommends that these areas receive further attention.

Strength of the Special Commission's Recommended Approach

The Special Commission's recommendations address concerns rooted in experience with prior capitation models which have some methodological similarities to global payments. While some dispute these concerns, the Commission does envision a system of global payments that significantly improves on some capitation models of the past based on additional experience and progress over the past two decades:

- **Careful Transition and Provider Supports**. Over the five-year transition period, the Special Commission envisions that payers, provider organizations and the Commonwealth will join together to offer providers the significant support many will need to build infrastructure—helping them to integrate care successfully, measure their performance against standard metrics, and manage financial risk for performance. This is a more deliberative, transparent process than occurred under prior capitation models, with greater attention dedicated to helping providers succeed under global payment.

- **Robust Monitoring and Oversight**. The Special Commission recommends that the oversight entity be charged with extensive and ongoing monitoring of access, quality, and cost both at a population level and at the level of individual patients with specific conditions or characteristics. Such information—made available to policymakers, providers, insurers, employers, and consumers—will support both mid-course corrections as may be needed and ongoing system improvements. The Special Commission concludes that the ability to monitor and make mid-course corrections is essential to the success of global payments and that this would be a key area of improvement over prior experience with capitation.

- **Financial Incentives for Access and Quality.** To ensure access to care and continuously improve quality, global payments must reward providers systematically for excellent performance. The Special Commission views the ability to measure performance against comprehensive metrics of access and quality, including patient satisfaction, as an essential feature of an ACO and anticipates that global payments will

reward high performers as well as improvements in performance, as measured against the same core metrics for all payers. This will provide a safeguard against "stinting" on needed care for patients. Prior capitation arrangements did not systematically measure performance, use common core metrics across all payers, or necessarily link payment to improvements in performance.

- **Improved Risk Adjustment Models.** Over the last two decades, substantial progress has been made in the development of risk adjustment models that use both ambulatory and inpatient diagnoses, as well as models to estimate more appropriate outlier payments. While the Special Commission anticipates initial adoption of tested risk adjustment methods, the transition to global payment will expedite continued development of risk adjustment methods to maximize fairness as well as provider incentives to improve and maintain patient health. This improves on previous private-sector capitation models which did not risk-adjust adequately or at all.

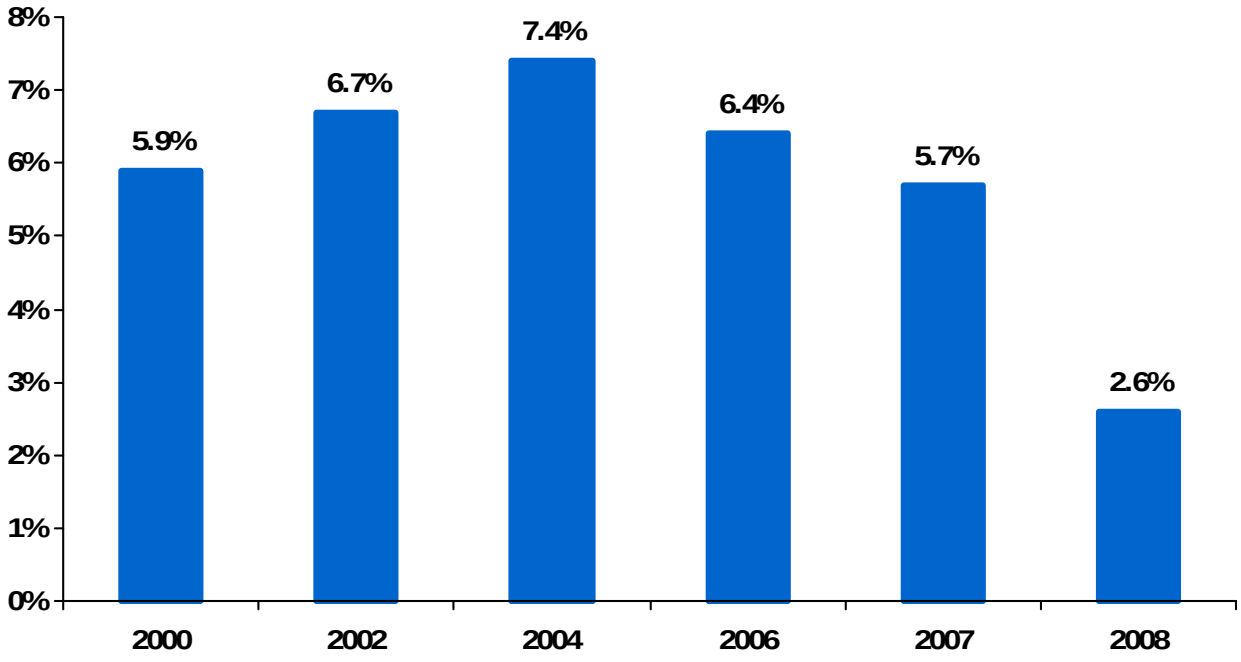
- **Health Information Technology Infrastructure and Support.** Prior capitation models were not developed in a strong health information technology (HIT) environment. In contrast, Massachusetts now has a number of important initiatives underway to disseminate health information technology and infrastructure throughout the state. The Special Commission envisions full use of these technologies and increased state support for infrastructure and training to help providers build the statewide, interoperable HIT network that a high-value health care system will require.

Chapter 1: The Rationale for Payment Reform

The Commonwealth of Massachusetts enjoys a number of signature achievements in health care. The highly skilled providers and technology available in the Commonwealth are among the very best in the world. Massachusetts residents are among the healthiest in the nation: rates of obesity, smoking, infant mortality, and premature death are all among the lowest of any state; and rates of preventive care (including childhood and adult immunizations, mammography, and colorectal cancer screening) are all well above the national average.

In addition, a larger proportion of the population is insured than in any other state. Following enactment of Massachusetts' landmark health reform legislation of 2006 requiring most residents to obtain health insurance, over 97 percent of the state's population had health insurance coverage in 2008 (Figure 1.1). In addition, the number of people without coverage decreased 53 percent from 355,000 in 2007 to 167,000 in 2008. Improvements in coverage have measurably enhanced access to health care for Massachusetts residents. For example, most children, non-elderly adults, and elderly adults in Massachusetts have a usual source of care in 2008, with non-elderly adults least likely (89 percent) and children most likely (97 percent) to have a usual source of care (DHCFP, MA Health Insurance Survey, 2009).

Figure 1.1 Percent of Massachusetts Residents Lacking Health Insurance: 2000-2008



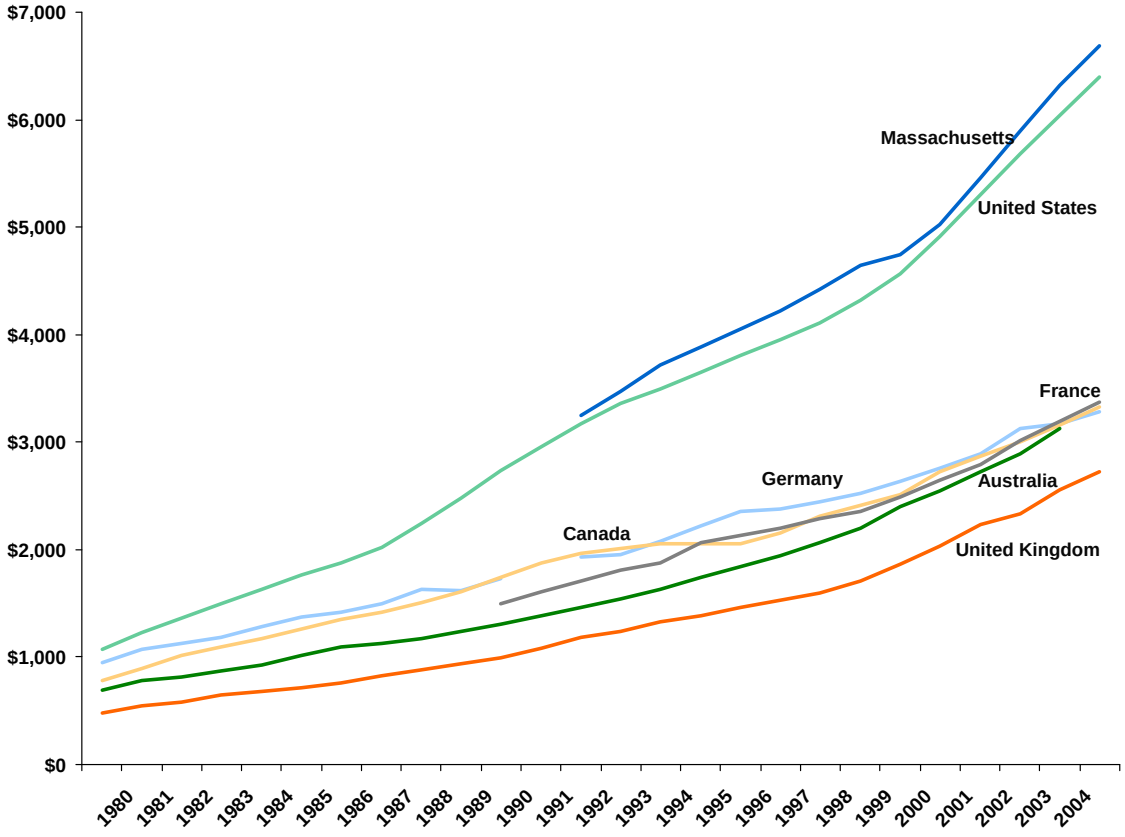
Source: Massachusetts Division of Health Care Finance and Policy, "Health Care in Massachusetts: Key Indicators," May 2009.

Notes: Estimates are based on DHCFP Household Surveys in each year. The 2008 survey had a number of methodological changes from surveys in prior years, which may affect comparability of the estimates.

However, important challenges remain. In designing this historic initiative, stakeholders explicitly recognized that the effort to provide affordable health insurance coverage to the state's uninsured would be followed by a focused effort to ensure its long-term sustainability. Continued rapid growth in health care costs in the state therefore threatens its achievements with respect to both coverage and access to care.

Health care expenditures in the U.S. are higher than any other industrialized country, with Canada and many European countries spending far less per capita than do residents in the U.S. or in Massachusetts (Figure 1.2). Despite their lower expenditures, these countries achieve measures of population health that are as good as or better than the U.S. (Davis et al. 2007). In Massachusetts, the growing cost of health care is crowding out other expenditures for the public good—including education, transportation, and housing—that also affect health status.

Figure 1.2 Average Health Care Expenditures per Capita, 1980-2004



Sources: Commonwealth Fund (2008), CMS (2007), U.S. Census (2009).

Note: U.S. dollars are current-year values. Other currencies are converted based on purchasing power parity.

In 2004, health care costs per capita in Massachusetts reached $6,683, among the highest in the nation and 26 percent higher than the U.S. average. Health care costs in Massachusetts are projected to grow faster than for the U.S. as a whole, and much faster than per-capita production

or wages and salaries.[4] Health insurance premiums, which are largely driven by these health cost increases, have increased almost every year for the past two decades at a pace that well exceeds the annual increase in the cost of living.

The impact of high and fast-growing health care costs is visible every day in the Commonwealth, depleting the resources of families, communities, businesses, and state government. Health care costs hurt individual citizens who are challenged to balance household budgets when wages are not increasing. Businesses struggle to compete when annual family health care premiums have begun to approach the wage level of a low-income employee, and displace wage growth for all. Health care cost impact is felt at the level of state government, with almost a third of the budget dedicated to the state's Medicaid program (MassHealth). Finally, continued high cost growth threatens the viability of the Commonwealth's successful health reform initiative.

In Massachusetts, as elsewhere, high health care costs do not mean that patients are consistently receiving effective, evidence-driven, preventive care that produces the best outcomes for their health. The quality of care provided to residents of the Commonwealth—while comparable to the U.S. average on many measures—can be improved. Nationally, researchers have shown significant variations in the quality of care delivered across medical conditions, with high quality care being delivered only an average of 50 percent of the time (McGlynn et al. 2003). In many cases, poor quality of care accounts for higher rates of complications and higher health care costs—as well as high personal, financial, and societal costs (IOM 1998). For example:

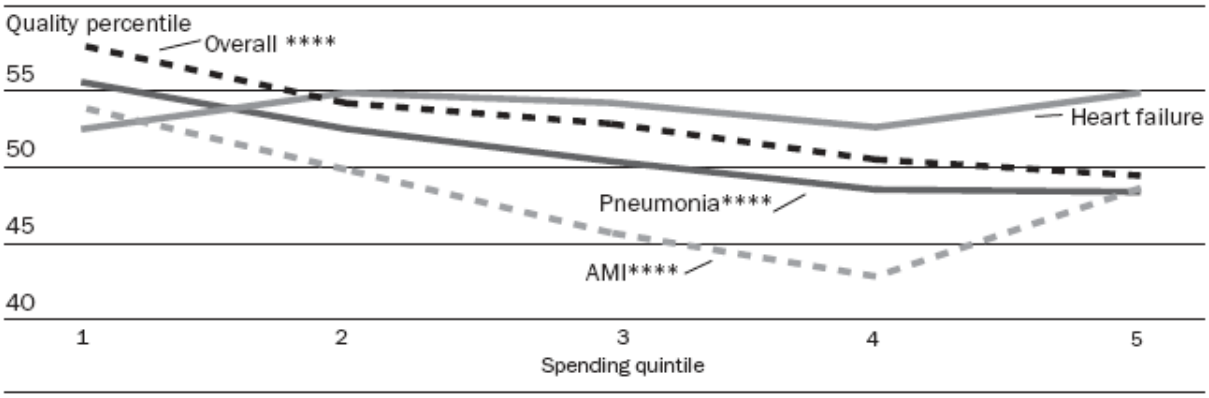
- Considering a group of 45 core measures that represent the most important and scientifically credible measures of quality, the 2008 National Healthcare Quality Report (NHQR) found that nationally the median level of necessary care received was just 59 percent (AHRQ 2008).[5]
- In multiple studies to examine regional cost variation and the underlying factors of the variation, researchers at Dartmouth Medical School concluded that a fragmented care management system has lead to high overall health services utilization without commensurate improvements in health outcomes (Wennberg et al. 2009).

Additional research indicates that hospitals' performance on quality of care is not associated with the intensity of their spending. For example, nationally, from 2004 to 2007, hospitals in which end-of-life expenditures per capita (for Medicare beneficiaries) were highest did not perform better on selected measures of quality than hospitals in which expenditures were lowest (Exhibit 2).

[4] Data are unadjusted for wage area differences. In 2007, Massachusetts wages were 23.4 percent higher than the US average, while health care expenditures were 33.0 percent higher (Bureau of Economic Analysis, U.S. Department of Commerce). In 2000, both wages and health care expenditures were 24 percent higher in Massachusetts than the US average.

[5] The NHQR is built on 220 measures categorized across four dimensions of quality: effectiveness, patient safety, timeliness, and patient centeredness. Each year since 2003, the Agency for Healthcare Research and Quality (AHRQ) has partnered with the Department of Health and Human Services to report on progress and opportunities for improving health care quality, as mandated by the U.S. Congress.

EXHIBIT 2
Percentile Of Quality, By Quintile Of Spending, All Hospitals, 2004–2007



SOURCE: Authors' analysis (see text for complete details).
NOTES: Spending is measured as total end-of-life spending on chronically ill Medicare decedents in their last two years of life, adjusted for prices. AMI is acute myocardial infarction.
**** $p < 0.001$

Source: L. Yasaitis, E.S. Fisher, J.S. Skinner, and A. Chandra, A. "Hospital Quality and Intensity of Spending: Is There an Association?" *Health Affairs*, May 21, 2009; w566-s572.

Evidence in Massachusetts likewise highlights the problems of quality, including insufficient emphasis on primary and preventive care that results in preventable illness. For example:

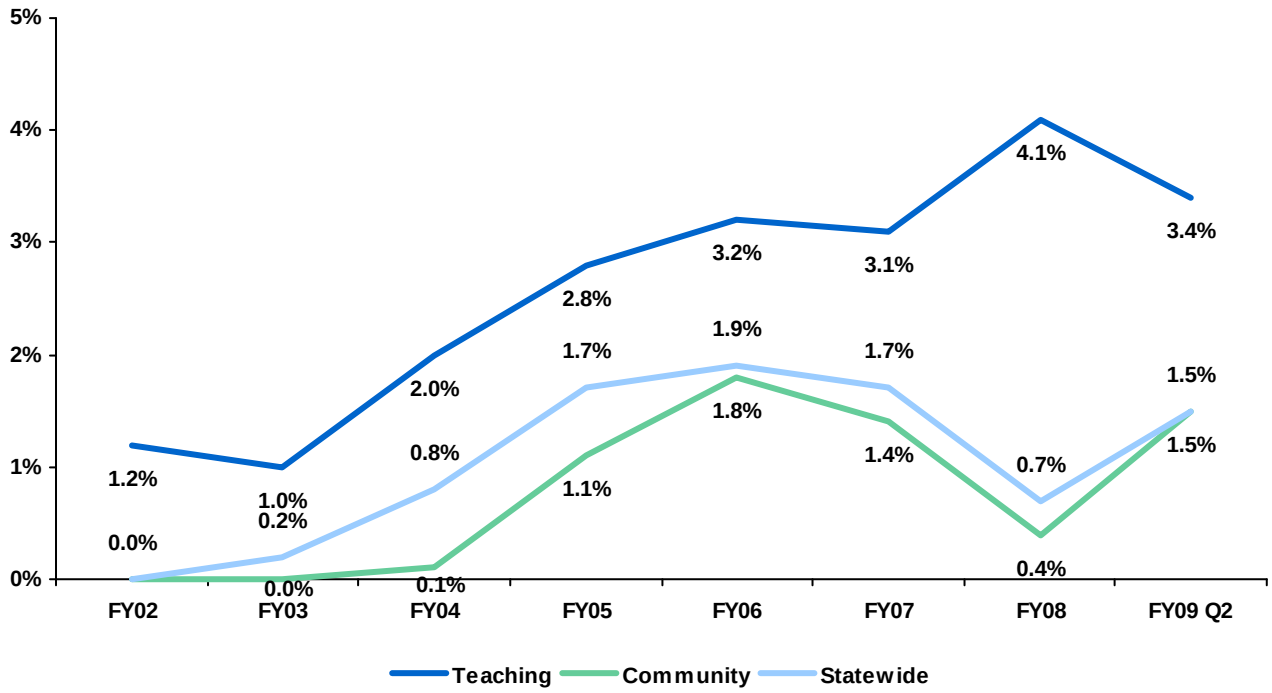
- A study conducted by the RAND Corporation concluded that adults nationwide receive just 55 percent of recommended care; few differences were found between Boston and eleven other metropolitan areas (Kerr et al. 2004).
- The Commonwealth Fund State Scorecard on Health System Performance in 2007 indicated that fewer than half of adult diabetics in Massachusetts received recommended preventive care, and fewer than half of all adults over age 50 received recommended screening and preventive care (Cantor et al. 2007).
- In 2006, an estimated 47.2 percent of emergency department visits were potentially preventable, representing an estimated potential cost savings of $398.5 million. (DHCFP, MA Health System Data Reference 2009)
- An analysis of 2006 hospital discharge data demonstrated that 8 percent of Massachusetts hospitalizations (totaling $582 million) were for ambulatory care sensitive conditions, for which effective outpatient care or early intervention might have prevented complications requiring hospitalization. The analysis went on to find that an estimated 7-10 percent of hospital readmissions were potentially avoidable, totaling between $380 and $576 million. (DHCFP, MA Health System Data Reference, 2009)

Massachusetts also faces important challenges in maintaining important services, due to payments for health care that financially reward providers irrespective of value. For example, because primary care providers are paid relatively little compared with specialists, access to primary care is declining. From 2006 to 2008, the percentage of family medicine physicians who no longer accept new patients increased steadily from 25 percent to 35 percent (Massachusetts

Medical Society 2008). Among internal medicine offices accepting new patients in 2008, the average wait time for an appointment was 50 days.

In addition, the gap between the financial performance of teaching and community hospitals is widening. This trend portends potential problems of access to care in some communities as well as escalating costs for hospital care.[6] In fiscal year 2008, teaching hospitals reported a median operating margin of 4.1 percent, compared with 0.4 percent among community hospitals (Figure 1.3). Among all acute care hospitals ranked by operating margin, hospitals at the 75th percentile made a 2.9 percent operating margin, but hospitals at the 25th percentile had a negative margin of -1.1 percent in fiscal year 2008 (Figure 1.4). (Quarterly filings, which are less reliable than annual audited financials, suggest that the gap in performance between teaching and nonteaching hospitals may have narrowed in early fiscal year 2009, with operating performance apparently improving for the best-performing hospitals. However, performance at the 25th percentile remained flat.)

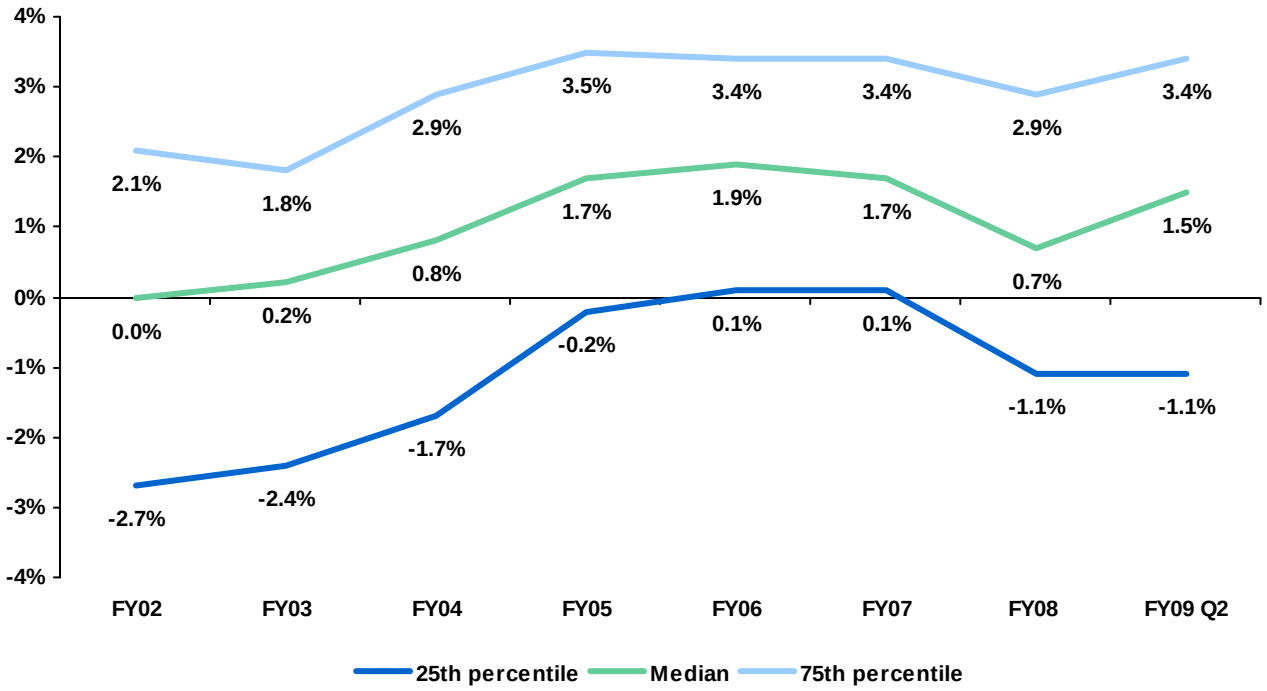
Figure 1.3: Massachusetts Acute Hospital Median Operating Margin: Teaching vs. Community Hospitals, State Fiscal Years 2002-2009 (Quarter 2)



Source: Massachusetts Division of Health Care Finance and Policy. "Massachusetts Acute Hospital Financial Performance: Fiscal Year 2009 through Quarter 2," pending publication.

[6] Hospital financial performance and performance on measures of health care quality are not necessarily correlated.

Figure 1.4: Massachusetts Acute Hospital Operating Margins: Hospitals at the 25th, Median, and 75th Percentiles in State Fiscal Years 2002-2009 (Quarter 2)



Source: Massachusetts Division of Health Care Finance and Policy. "Massachusetts Acute Hospital Financial Performance: Fiscal Year 2009 through Quarter 2," pending publication.

Over the past twenty years or more, many studies have pointed to opportunities for improving the quality of care and achieving better patient outcomes at lower cost. All major stakeholders now agree that significant cost savings could be gained by improving health care quality—including better management of chronic illness, avoidance of unnecessary treatments and duplications, and use of evidence-based treatment guidelines (Reuters 2009). What is lacking is a method of payment to providers that systematically and consistently rewards more effective, efficient, and patient-centered care.

Enhancing Efficiency in Health Care

The next stage of health care reform requires the Commonwealth to contain the growth of health care spending, to expand access to primary care and care coordination, and to improve quality of care. Most health care experts view fee-for-service payment as a primary reason for growing health care costs and fragmented, ineffective care. Fee-for-service payment gives providers financial incentives to favor high-cost procedures over low-cost procedures, increase the volume of tests and procedures, and deliver specialty care rather than primary care—all with no necessary improvement in health outcomes. A recent survey of health care opinion leaders conducted by the Commonwealth Fund found that just seven percent considered the fee-for-service payment approach to be effective or very effective in encouraging high quality care (Stremikis et al. 2008). Most recognized that some form of shared accountability for resource use would encourage more efficient provision of care.

The Massachusetts Special Commission on the Health Care Payment System

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 to create a Special Commission on the Health Care Payment System.[7] The Special Commission's charge was to "investigate reforming and restructuring the system to provide incentives for efficient and effective patient-centered care and to reduce variations in the quality and cost of care." In particular, Section 44 established three responsibilities for the Special Commission: (1) to examine payment methodologies and purchasing strategies, (2) to recommend a common transparent methodology, and (3) to recommend a plan for the implementation of the common payment methodology across all public and private payers in the Commonwealth.

The legislation designated three categories of appointments to the Special Commission: three *ex officio* members, one member to be appointed by the Senate President, one member to be appointed by the Speaker of the House, and five members to be appointed by the Governor. Members of the Special Commission are shown in Table 1.1.

The Special Commission met on nine occasions between January and July 2009 to create a set of principles to guide the development of payment policy, elicit and consider input from key stakeholders, assess and debate alternative payment approaches, and arrive at recommendations for payment policy. Agendas for all meetings of the Special Commission appear in Appendix B.

Table 1.1
Members of the Massachusetts Special Commission on the Health Care Payment System

Members	Title
***Ex Officio* Members**	
Leslie A. Kirwan	Secretary, Executive Office for Administration and Finance (co-chair)
Sarah Iselin	Commissioner, Division of Health Care Finance and Policy (co-chair)
Dolores Mitchell	Executive Director, Group Insurance Commission
Legislative Appointments	
Richard T. Moore	Senator, Massachusetts Senate, Senate Chair of Joint Legislative Committee on Health Care Financing
Harriett Stanley	Representative, Massachusetts House of Representatives, House Chair of Joint Legislative Committee on Health Care Financing
Gubernatorial Appointments	
Alice Coombs, M.D.	President-Elect, Massachusetts Medical Society
Andrew Dreyfus	Executive Vice President for Health Care Services, Blue Cross Blue Shield of Massachusetts
Deborah Enos	President and CEO, Neighborhood Health Plan
Nancy Kane, D.B.A.	Professor of Management and Associate Dean for Educational Programs, Harvard School of Public Health
Lynn Nicholas, FACHE	President and CEO, Massachusetts Hospital Association

[7] The text of Section 44 is provided in Appendix A.

Chapter 2: Principles for Reform and Consideration of Payment Models

The Special Commission developed a vision statement, drafted principles for payment reform, and considered various payment models and benefit design strategies as outlined in Section 44 of Chapter 305 of the Acts of 2008. This process, together with extensive stakeholder input (as described in Chapter 3), formed a foundation for the Special Commission's discussions about how to transform the Massachusetts's health care payment system.

Development of Principles for Payment Reform

The Special Commission seeks to develop recommendations 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. To support this vision, the Special Commission developed a set of principles which were subsequently adapted to reflect feedback from numerous stakeholder groups. These principles, underlie its recommendations for fundamental reform of the Massachusetts health care payment system:

1. As currently implemented, fee-for-service payment rewards service volume rather than outcomes and efficiency, and therefore other models should be considered.
2. Health care payments should cover the cost of efficiently provided care, support investments in system infrastructure, and ensure timely access to high quality, patient-centered care. Additional payment should reward and promote the delivery of coordinated, patient-centered, high quality health care that aligns with evidence-based guidelines where available, and produces superior outcomes and improved health status. Performance measurement should rely on reliable information and utilize uniform, nationally accepted quality measures.
3. Provider payment systems should balance payments for cognitive, preventive, behavioral, chronic and interventional care; support the development and maintenance of an adequate supply of primary care practitioners; and respond to the cross-subsidization occurring within provider organizations as a result of the current lack of balance in payment levels by service.
4. Differences in health care payments should reflect measurable differences in value (cost and quality). Payments should be adjusted for clinical risk and socio-economic status wherever technically possible, and should promote greater equity of payments across payers and providers, to the extent that this is financially feasible.
    a. Differences in health care payments should be transparent, including across different payers.
    b. Costs associated with desired investments in teaching and research should be paid outside of base payments, and should require provider accountability for how such payments are spent.
    c. Costs associated with desired investment in special "stand by" capacity should be accounted for in the payment system.

5. The health care payment system should be structured in such a way as to minimize provider, payer and patient administrative costs that do not add value.
6. Payment reform must consider how:
    a. Some payment methods may require certain organization of the service delivery system, and
    b. Health benefit designs either support or limit payment reform.
7. Health care per capita costs and cost growth should be reduced, and providers, payers, private and public purchasers and patients should all share in the savings arising from payment reform.
8. The health care payment system should be transparent so that patients, providers and purchasers understand how providers are paid, and what incentives the payment system creates for providers.
9. It will be necessary to consider the diversity of populations, geography and providers across the Commonwealth when designing payment reform to ensure high quality, patient-centered care to all populations and geographic regions in the Commonwealth.
10. Implementation should be phased over time with:
    a. Clear and attainable deadlines;
    b. Planned evaluation for intended and unintended consequences; and
    c. Mid-course corrections.

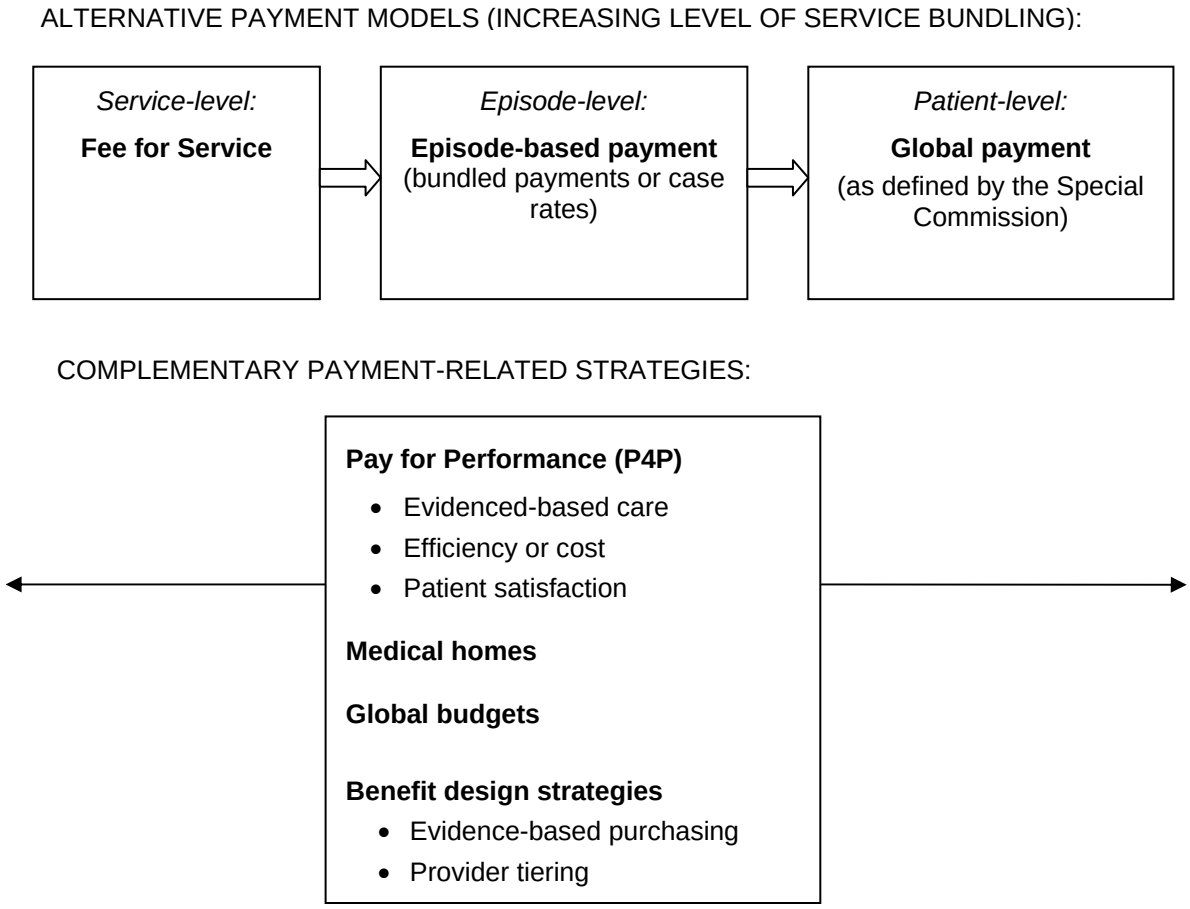
Finally, the Special Commission recognizes the need to support the Commonwealth's infrastructure of community and disproportionate-share hospitals in the context of payment reform.

Payment Models and Complementary Strategies

Section 44 of Chapter 305 of the Acts of 2008 required the Special Commission to examine alternatives to the fee-for-service (FFS) payment model, including but not limited to blended capitation rates, episode-of-care payments, medical home models, global budgets, pay-for-performance (P4P) programs, tiering of providers, and evidence-based purchasing strategies. The Special Commission understood that the models outlined in the legislation included basic payment models as well as complementary strategies relating to payment, benefits or care. The Special Commission quickly acknowledged that its recommendations would likely combine a preferred basic payment model with one or more of these complementary payment-related strategies to improve health care quality and moderate cost growth.

Figure 2.1 illustrates alternative basic payment models along a continuum of service-bundling, from payment per service to per-patient payments, and distinguishes these models from complementary strategies relating to payment, care and benefit design.

Figure 2.1: Thinking About Provider Payments



By paying for services at different levels of bundling, alternative basic payment models have different incentives for providers and payers and produce different results for patients. For example, FFS places on providers relatively little financial risk for either clinical or cost performance. As a result, FFS encourages providers to supply more services even when there is little chance they would be effective, increasing the cost for payers and producing inadequate health outcomes for consumers. Payers have developed a number of strategies intended to counter the effects of these incentives—including benefit design (provider tiering and evidence-based purchasing), P4P, medical home models, and (rarely) global budgets. In contrast, global payment models, which bundle services at the patient level, place financial accountability for clinical and cost performance ("performance risk") on providers and therefore offer the greatest incentive for providers to deliver effective and necessary care.

Past capitation models also bundled services at the patient level, but sometimes raised concerns about reduced patient access to care and inadequate attention to health care quality and quality improvement. In some cases, these concerns have triggered payer use of complementary payment-related strategies—including, P4P based on quality and patient satisfaction measures.

The Special Commission distinguished global payment from capitation models. Specifically, as envisioned by the Special Commission, global payment would focus strongly on primary and preventive care, be linked to quality improvement and the delivery of evidence-based care, and allow patient choice of providers. Moreover, it would carefully balance financial risk between insurers and providers, with insurers continuing to hold insurance risk.

Before proceeding with a review of alternative basic payment models and complementary strategies relating to payment, care and benefits, the Special Commission evaluated the current payment system in Massachusetts. During the Special Commission's first meeting on January 16, 2009, members discussed the shortcomings of the current payment system in Massachusetts, which is dominated by FFS.

Fee-for-Service

As the term implies, fee-for-service pays clinicians and institutions for each medical service they deliver such as an examination, administering a diagnostic test, or services delivered in the course of a hospital stay. Providers charge health plans or other payers after the service is delivered. In turn, payers generally do not pay the charged amount but instead establish fees, sometimes by negotiation and often in the form of a prospectively defined fee schedule.[8]

In general, prospectively defined FFS (versus charge-based FFS, which it has largely replaced) compensates providers for the expected costs of delivering individual services while helping to constrain price inflation (as providers are unable to increase their rates at will). However, prospective FFS retains four incentives of charge-based FFS that drive cost growth:

[8] Currently, many payers use prospective reimbursement formulas, which establish or negotiate a prices or fees before services are delivered. These formulas are commonly built on Medicare's resource-based relative value scale-based (RBRVS) system (for physicians) and diagnosis-related groups (for inpatient hospital care). Historically, most insurers have paid discounted charges for outpatient services. While Medicare implemented prospective payment for hospital outpatient services in 2000, other payers' use of prospective payment for outpatient services is generally not known.

- **Incentives for increased volume.** Providers have a financial incentive to increase the number of services they produce in order to increase their incomes (as long as the payment amount exceeds the cost of producing additional services).
- **Incentives to deliver more costly services.** Providers have a financial incentive to deliver more costly services over less costly services.
- **Little or no incentive for achieving positive results or for care coordination.** Because all providers bear no financial risk for either poor outcomes or higher costs, they have no financial incentive to deliver the most effective care or coordinate care for complex patients among multiple providers.
- **Little or no incentive to deliver preventive services or other services with low financial margins.** Providers have little incentive to provide services that represent low financial margins—including preventive care and behavioral health care.

The prevalence of fee-for-service payment and the complementary payment-related strategies that payers use with it vary by payer and by market. For example, in California and Minnesota, private insurers generally rely less heavily on traditional fee-for-service than do payers elsewhere in the U.S. Instead, many of the largest insurers use payment models that share financial risk with providers; by bundling payment at the patient level for some or all care, these models require providers to hold financial risk for their clinical and cost performance. Nevertheless, fee-for-service payments are still widely used in Massachusetts and across the U.S.

The Special Commission identified the following problems with the current Massachusetts health care system and with FFS payment in particular:

- FFS rewards overuse of services, does not encourage consideration of resource use, and thus cannot build in limitations on cost growth.
- FFS does not recognize differences in provider performance, quality, or efficiency, and thus does not align with evidence-based guidelines or outcomes.
- FFS focuses attention on prices, not costs, and fees do not relate to the actual cost of providing care.
- FFS is complex and difficult to administer given the wide range of individual health care services and changes in health care delivery and technology.
- Multiple payers negotiate different rates for a service, leading to different rates both within and among providers for the same service. These rates are more often based on relative market leverage, not health care value.
- Varied payment levels for services leads to variation in profit margins across services; variable margins incentivize volume in high profit services, not value.
- Some highly valued services—such as care coordination and support of patient self-management—are not currently recognized in the FFS system and thus not compensated.
- Caregiver incentives are not currently aligned among acute care hospitals, physicians, behavioral health providers, and other providers.

Alternative Payment Methods

The Special Commission invited various experts to make presentations about alternative payment models and benefit design strategies—including episode-based payment and global payment.[9] Each was reviewed in terms of its incentives for how providers deliver care, including especially incentives to constrain cost growth and improve health care quality and outcomes. In addition, the Special Commission reviewed examples and experiences of other states and organizations that have implemented each payment model and the lessons learned from their experiences.

Compared with FFS (which pays for each service), episode-based payment bundles services in an episode of care; global payment bundles services at the patient-level over a specified period of time. Both episode-based payments and global payments place providers at financial risk for their clinical performance and coordination of care (that is, performance risk) within, respectively, an episode of care and patient-level health care. However, neither method, when properly implemented, should place providers at risk for the occurrence of health problems over which providers have no control (that is, insurance risk). In all cases, insurers should properly retain insurance risk, setting payments that transfer to providers' performance risk, but not insurance risk.

Episode-Based Payment

Episode-based payments reimburse providers for clinically defined episodes of care (Christianson 2008; Gosfield 2008; Rosenthal 2008). In emerging episode-based payment models, the unit of payment is the full range of services that all or most providers deliver during a clinical episode for a specific condition—such as coronary artery bypass surgery and recovery.[10] Payment is made per-occurrence of an acute care episode to the provider or provider group identified as most responsible for the patient's care.[11] Episode-based payments may be adjusted for severity of illness and also combined with complementary payment-related strategies such as P4P, adjusting the base "case rate" to reflect performance on evidence-based standards.

Episode-based payments are intended to place providers at financial risk for their clinical and cost performance within an episode (performance risk)—therefore eliminating some of the incentives for cost growth that characterize FFS—but at no risk for the occurrence of an episode (insurance risk). Episode-based payments reward providers for delivering effective care,

[9] A more detailed discussion of each of these payment models and other purchasing strategies is provided in Appendix C. Appendix D provides copies of presentations provided to the Special Commission and information on implementation experience with some of these models and strategies. Appendix E provides minutes from the Special Commission meetings.

[10] Emerging episode-based payment models have some relationship to existing bundled payment approaches, including inpatient hospital Diagnosis-Related Groups (DRGs) and Medicare's hospital outpatient prospective payment system. However, these existing systems focus on care provided in single settings and are thus distinct from the emerging models which attempt to capture the full range of services delivered by all or most providers during clinical episodes.

[11] Typically, computer software is developed to identify and create episodes of care from claims and administrative data. Expected cost "case rates" are calculated from the claims data for particular types of episodes, or are based on expected costs of best practices in caring for episodes (Gosfield 2007; Thomas 2006). Payment is made to the provider deemed most responsible for the care of a patient, based on algorithms that attribute episodes to such providers.

coordinating care efficiently over the course of an episode, and reducing complications and readmissions (Mechanic and Altman 2009; MedPAC 2008). They offer providers no financial incentive to provide more services per episode. Moreover, episode-based payments are specific to the patient's condition and may be risk-adjusted—compensating providers for a sicker case mix and mitigating incentives for providers to avoid accepting sicker patients. However, because providers are not at risk for the development or number of episodes, episode-based payments may be less effective in controlling cost for patients with multiple chronic conditions than patient-based payments would be.

Experience with Implementation. Episode-based payments are in an early stage of development and use. During the 1990s and continuing to the present, Medicare has conducted a series of demonstrations of episode-based payment, but has not implemented such payments more broadly.[12]

Among private insurers, industry standards for episode-based payments are not established, nor are design approaches well developed. A number of private insurers and payers have used episode grouping software to establish network tiers and give providers performance feedback reports (Rattray, 2008), but it is unclear how widely, if at all, insurers are using fully operational episode-based payment models.

Recently, a payment model for clinical episodes associated with diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), heart attack, coronary artery disease (CAD), and orthopedic procedures such as knee and hip replacement was developed and (in January 2009) launched in three pilot sites (PROMETHEUS, Inc. 2008.)[13] A description of this payment model is provided in Table 2.1 (next page).

[12] In 1991, CMS implemented the Medicare Heart Bypass Center Demonstration; by 1993 (and through the second quarter of 1996) the demonstration included seven hospitals that were paid an established rate for each coronary artery bypass graft (CABG) surgery (Cromwell et al. 1998). This year, CMS is implementing the Medicare Acute Care Episode (ACE) payment demonstration, focusing payments for episodes of care related to cardiac and orthopedic inpatient procedures (CMS 2009).

[13] PROMETHEUS Payment, Inc.™ is an organization funded by the Robert Wood Johnson Foundation. The Massachusetts Quality Improvement Organization (Masspro) participated in the development of the PROMETHEUS model.

Table 2.1 Experience with the PROMETHEUS Payment® Model

Program Characteristic	Description
Description	• Payment amounts are based on historical costs and guidelines for evidence-based care. • Global fees, called Evidence-informed Case Rates (ECRs), cover full episodes of care and all providers related to acute and chronic conditions and inpatient and outpatient procedures. Supplemental payments are made to providers who meet quality measures and provide care for less than the ECR. • Participants "plug into" the PROMETHEUS Payment® model Engine, a claims tracking and financial accounting system. It produces a scorecard based on claims, medical records, and other data measuring the quality of care delivered to patients.
Program duration	Model was implemented in three pilot sites—Rockford, IL, Minneapolis, MN, and Philadelphia, PA—in January 2009.
Characteristics that favor program impact	• Targets a small, precisely defined list of conditions and procedures. • Accommodates both integrated and non-integrated providers by providing a default scheme for allocating payment.
Impacts	• No current findings related specifically to impacts of PROMETHEUS. Harvard School of Public Health and RAND will conduct an evaluation including some quantification of interim results, to inform recalibration and reconfiguration of the program as necessary.
Expert perspectives	*Harold Miller (Future Strategies, LLC), expert called upon to present by the Special Commission:* • Target the types of episodes with a large volume of cases and potentially large savings. • Develop common definitions of episodes across all payers. • Use severity adjustment. • Collaborate so all payers agree to use episode-base payment episodes defined in the same way. • Start by publicly reporting FFS payments on the basis of episodes. • Provide technical assistance to providers to reduce costs. • Implement software enhancements that distinguish which claims are to be paid on an episode basis and which are not. • Payments need not pay for full episodes to achieve some of the benefits of episode-based payment (for example, DRGs pay for just a portion of a full episode). • All providers need not be paid on an episode basis.

Sources: de Brantes and Camillus (2007); Miller (2009). See also: http://www.prometheuspayment.org/ index.html, accessed June 1, 2009.

Global Payment

Global payments compensate providers for all or most of the care that their patients may require over a contract period, such as a month or year. In general, global payments cover physician, ancillary, and hospital services as well as prescription drugs (Kongstevdt 2001; Hurley et al. 2002; Commonwealth Fund 2009).

Usually estimated from past cost experience and an actuarial assessment of future risk related to patient demographics and known medical conditions, global payments reflect the expected costs of covered services. As with episode-based payments, providers hold performance risk in a global payment system. In order to protect providers from also holding insurance risk, global

payments must be risk-adjusted to reflect the underlying health conditions and predictable probability of illness among patients. Insurance carriers retain insurance risk for unpredictable illness and also adjust the level of global payments to reflect the expected cost of consumer incentives (such as cost sharing for particular services or providers) in their benefit designs. Global payment approaches can be combined with complementary payment-related strategies, including P4P, to encourage improvements in quality and patient-centered care.

Because global payments place providers at financial risk for clinical and cost performance, providers have an incentive to deliver the most effective care possible (e.g., to provide lower-cost care when it is as effective as higher-cost alternatives) and integrate and coordinate services efficiently. Global payments may encourage improvements in the quality of care through specific incentives and/or because contracting providers expect quality improvements to reduce the costs of care.

Under a global payment system, payers retain insurance risk—that is, the risk of the occurrence of illness in an insured population associated with demographics or known medical conditions. Methods by which payers retain insurance risk may include stop-loss limits on provider liability, use of reinsurance or risk corridors, and/or a selective reduction of the scope of services for which providers are expected to be accountable (Kongstvedt 2001, Walker 2001).

Global payments may encourage providers to form larger (real or virtual) organizations in order to coordinate services cost-effectively across the multiple settings of care within the scope of covered services (Walker 2001). Medical homes, which focus on patient-centered care and on care coordination for patients who may have multiple chronic conditions, are wholly compatible with global payment models.

Experience with Implementation. Global payment approaches are most common in markets with a history of large medical groups or integrated delivery systems—including metropolitan areas in California, Minnesota, and Massachusetts.

Highly integrated group or staff model health plans (such as Kaiser Permanente) have used global payments for decades. In Massachusetts, Medicare Advantage plans have often used global payments to reimburse providers. In addition, Blue Cross Blue Shield of Massachusetts (BCBSMA) recently implemented Alternative Quality Contracts (described in Table 2.2) with organizations including the Mount Auburn Cambridge Independent Practice Association, Hampden County Physician Associates, and Tufts Medical Center and the affiliated New England Quality Care Alliance. BCBSMA's Alternative Quality Contracts combine features of global payment with incentives to improve health care quality and patient safety.

Table 2.2 Experience with BCBSMA's Alternative Quality Contract

Program Characteristic	Description
Description	• Payment is patient-based (and risk-adjusted), not procedure-based. Providers contract together as a system accountable for cost and quality across the full continuum of care. • Payment for the continuum of care and for costs associated with performing under the contract is intended to control cost growth and eliminate clinically wasteful care. • Budgets are set for five years based on historical costs, indexing price inflation in global payments to the Consumer Price Index (CPI). • Quality-based incentives, based in a robust set of measure for both ambulatory and inpatient care, comprise as much as10 percent of the overall budget.
Program duration	Five-year contracts began in 2008.
Characteristics that favor program impact	• Global payments are indexed for CPI price growth, not the historical growth in health care costs. • Recognizing that not all providers are immediately ready to accept full performance risk, providers are paid for infrastructure development and risk management costs. • High performance is defined in absolute terms, not relative to competitors. • Risk-adjusted payments offset provider's risk of treating sicker patients.
Expert Perspectives	*Patrick Gilligan (BCBSMA), expert called upon to present by the Special Commission:* • Providers have showed increasing interest and enthusiasm in new contract and payment structure.

Source: Gilligan (2009)

Complementary Payment and Care Strategies

In addition to the three basic payment models described above, the Special Commission reviewed three complementary payment and care strategies designed to constrain health care costs and improve quality and value: P4P, medical homes, and global budgeting. These complementary payment and care strategies can be combined with alternative basic payment models to enhance the efficiency and quality of care and limit the growth of health care costs. (In addition, the Special Commission considered two benefit design strategies—provider tiering and evidence-based purchasing—as described further below.)

Pay-for-Performance(P4P)

P4P is a complementary payment-related strategy that offers financial rewards to providers who achieve or exceed specified quality benchmarks (and sometimes also efficiency benchmarks). P4P is intended to increase the provision of quality care, decreasing health care costs due to patients remaining healthy for longer periods of time.

Many P4P programs have targeted care for patients with high-cost conditions, emphasizing the use of evidence-based guidelines. Typically, P4P programs focus on primary care physicians and

hospitals, but many also include medical specialists.[14] Some reward performance (such as patient access and outcomes), but they also may reward processes intended to improve the quality of care (such as the use of information technology).

Provider performance may be measured as absolute levels of performance, improvement over time, or rank among peers. P4P programs typically rely on claims analysis, but many now also include lab results and pharmacy data to support clinical quality measures. P4P payments may be made to individual providers or provider groups, institutions, and provider systems that include both. They can be made annually, semi-annually, or on a continuous basis; as a percentage of total provider fees for relevant care on a "per member" basis, as a percentage of cost savings relative to a benchmark, or by adjustments to providers' base rates.

Historically, P4P programs have usually been built on FFS payment or on capitation payment systems. However, P4P can be combined with any of the basic payment models (episode-based payments or global payment) as well as with other complementary care strategies (medical homes).

Experience with Implementation. Currently, there are more than 250 P4P programs across the country; almost half target hospital care (Felt-Lisk 2009). Private payers sponsor two-thirds of these programs; employers or employer coalitions sponsor 11 percent, Medicaid sponsors 18 percent, and Medicare sponsors the remaining five percent. Many examples of P4P programs exist in Massachusetts, as described in Table 2.3.

Table 2.3 Experience with Pay-for-Performance

Program Characteristic	Description
Description	P4P programs in general evaluate and reward physicians based on the Healthcare Effectiveness Data and Information Set (HEDIS) measures, utilization measures, use of information technology, and patient satisfaction surveys.
Program duration in Massachusetts	As early as 2004, 89 percent of Massachusetts physician groups had a P4P incentive in at least one commercial health plan contract.
Characteristics that favor program impact in Massachusetts	• Medium-sized and large practice groups able to pool incentives across practice sites are common in Massachusetts. • Other quality incentives exist in Massachusetts, including public reporting of quality measures and provider tiering. • There is energy around the development of electronic health records and interoperability in Massachusetts, as well as the infrastructure for aggregating and analyzing data.

[14] Many state Medicaid programs have implemented P4P programs, usually focusing on the delivery of primary care. As of mid-2006 more than half of states were operating one or more P4P programs, and 85 percent expected to do so within the next five years (Kuhmerker and Hartman 2007).

Expert Perspectives	*Suzanne Felt-Lisk (Mathematica Policy Research), expert called upon to present by the Special Commission. Her recommendations included:* • Match the terms of payment to desired outcomes. • Use a broad and balanced set of measures, and monitor patient access. • Physician engagement is critical: anticipate physician reaction and work for a trusting relationship. • The size of the incentive is important. Consider parallel rewards, such as additional payments for establishing a medical home with the same goals. • The infrastructure and resource of physician practices affect their ability to respond to incentives. • It takes time and resources to develop and implement P4P—including time for providers to build needed infrastructure.

Sources: Felt-Lisk (2009). See also: Christiansen et al. (2008), Felt-Lisk et al. (2007), Gold and Felt-Lisk (2008), Mehrotra (2007).

Medical Homes

The medical home model is intended to offer patients accessible, continuous, coordinated and comprehensive patient-centered care, managed centrally by a primary care team. While the Special Commission is not adopting one standard definition of a medical home, it notes that the National Committee for Quality Assurance (NCQA), in collaboration with four physician specialty societies, has jointly defined the medical home as:

> "…a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for providing all the patient's health care needs, and when appropriate, arranges for care with other qualified physicians" (NCQA 2008).

MedPAC further elaborates upon the essential capabilities of a medical home:

> "In addition to providing or coordinating appropriate preventive, maintenance, and acute health services, medical homes must: furnish primary care; use health information technology for active clinical decision support; conduct care management; maintain 24-hour patient communication and rapid access; keep up-to-date records of patients' advance directives; and be accredited/certified by an external accrediting body [such as NCQA]" (Boccutia et al. 2008).

It is hoped that such care will be cost-effective especially for children, adolescents, and adults with chronic conditions who require an array of services and sometimes frequent monitoring. It is also hoped that the development of medical homes will make primary care more professionally and financially rewarding and thereby encourage more medical students to choose primary care practice as a career.

The medical home model can be integrated into any of the basic payment models—FFS, episode-based payment, or global payment—ensuring that providers are compensated for providing continuous, coordinated services. Practices that receive payment as medical homes are

responsible for delivering and coordinating appropriate care for their patients. Some medical home models provide additional payments to enhance existing physician infrastructure consistent with improving care (for example, supporting integration of a care management function); others include P4P.

Experience with Implementation. Medical home pilots and demonstrations are under way or being planned in almost every state.[15] In Massachusetts, the Massachusetts Patient-Centered Medical Home Initiative recently began a broad-based planning process involving private and public payers, providers, consumer groups, employers, and others. In addition, a number of small pilots are underway at New England Quality Care Alliance, the Central Massachusetts Independent Physician Organization, the Fallon Clinic, and at the Brigham and Women's Hospital Foxboro practice site, among other provider entities. In addition, the Massachusetts League of Community Health Centers and the Executive Office of Health and Human Services recently received a grant from the Commonwealth Fund for a medical home initiative targeted at 14 community health centers.

Rhode Island recently adopted a multi-payer medical home initiative as part of its Chronic Care Sustainability Initiative (CSI-RI), intended to align quality improvement goals and financial incentives to develop and support a sustainable model for delivering chronic care in primary care settings. A description of Rhode Island's program is provided in Table 2.4.

Table 2.4 Experience with Medical Homes in Rhode Island

Program Characteristic	Description
Description	Program is initiative among payers that cover 67 percent of insured residents. It involves five medical practices and targets coronary artery disease, diabetes, and depression. Under the program: • Providers implement components of advanced Medical Home model using NCQA's Physician Practice Connections® standards (NCQA); participate in a local chronic care collaborative; conduct self measurement and participate in public reporting of measures (structural measures, outcome measures, and cost and utilization measures); and engage with patients and provide education. • Payers make a supplemental payment of $3 per member per month to participating physicians; pay the costs of nurse care managers that are allocated across provider sites; and provide shared data and common measures for utilization review and feedback to providers. • Self-insured employers pay for programs for their employees.

[15] Most programs piloting the medical home model rely on the National Committee for Quality Assurance (NCQA) guidelines. These include: (1) improved access and communication, (2) use of data systems to enhance safety and reliability, (3) care management, (4) patient self-management support, (5) electronic prescribing, (6) test tracking, (7) referral tracking, (8) performance reporting and improvement, and (9) advanced electronic communications (NCQA).

Program Characteristic	Description
Program duration	A two-year pilot began October 1, 2008, and will be expanded in 2010.
Characteristics that favor program impact	• All payers select the same core group of practice sites for their pilots, using a common set of practice qualifications. • All payers ask the pilot sites to implement the same set of new clinical services, drawn from the Patient-Centered Medical Home (PCMH) Principles.[16] • All payers evaluate practices using the same measures, drawn from national measurement sets. • The method and intent of incentive payments is consistent across all payers. • Plans and providers agree to a common member attribution methodology and standardized quality metrics.
Impacts	• No current findings related to impacts in RI. Harvard School of Public Health will conduct evaluation to examine adoption of the patient-centered medical home model; changes in care processes, outcomes, and experiences of care; changes in cost of care; and the experience of program adoption.
Expert Perspectives	*Christopher Koller, Rhode Island Commission of Health Insurance, expert called upon to present by the Special Commission. His recommendations included:* • Be transparent and share as much information as possible across stakeholders. Educate stakeholders on the need for delivery system reform, engage major purchasers and consumers as advocates, and develop physician leadership and collaboration. • Put objective assessment of costs on the table, but balance the need for a positive return on investment with the need to get the program going. • Focus on non-monetary benefits to providers (e.g., training and enhanced efficiency), understanding that persuading providers to do unreimbursed work is difficult. • Building an all-payer initiative is complex. Large national carriers have little incentive to participate in regional or state-level programs, fear losing competitive advantage, are unaccustomed to collaborating with other plans, and have little in common with Medicaid. Government can help overcome some of these issues by convening the plans and by helping to smooth anti-trust issues. However, without Medicare participation, it is impossible to target all patients. • Understand that planning and implementation take time. • Consider that there will be alignment in primary care physician contracting beyond the medical home demonstration program.

Source: Koller (2009)

Global Budgets

A global budget is a maximum level of expenditure for a defined set of health care services. It may reflect projected health needs or be determined relative to an independent metric (such as gross domestic product). A global budget is compatible with any basic payment model—such as FFS, episode-based payments, or global payments—but it implies an available enforcement mechanism—usually, regulation of provider payment amounts and/or premiums, and the ability of providers to manage patient queues (for example, by developing a triage system).

[16] The AAP, AAFP, ACP, and AOA have developed joint principles to describe the characteristics of the Patient Centered Medical Home (PCMH). See: http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home.

When used, a global budget is intended simply to limit total spending; it provides few direct incentives for providers to improve efficiency or quality. Institutional providers (such as hospitals) that receive a fixed budget with no assurance of rescue if they exceed it have a clear incentive to manage to that budget—in part by improving efficiency. Incentives for individual providers depend on the means used to enforce the limit.

Experience with Implementation. Examples of global budgets exist in most Western European countries, as well as in Canada and the U.S. In Canada, each provincial government acts as single payer that allocates annual budgets for hospitals and also sets private physician fees consistent with a global budget.

In the U.S, the Department of Veterans Affairs (VA) health care system is the largest single example of globally budgeted health care delivery. Each year, the VA budget is limited by its federal budget appropriation, and the Department in turn allocates budgets to local VA health systems, which are expected to operate within their budgets. In addition, in every state, the Medicaid program is globally budgeted.

At least two examples of private-sector example of global budgets in the U.S. can be found:

- In the 1980s, hospitals in Rochester, New York voluntarily agreed to operate under individual caps on hospital income from all payers—with favorable cost results. Rochester's program and lessons learned are summarized in Table 2.5.
- Developed on behalf of a consortium of large employers in Minnesota in 1997, Minnesota's Patient Choice model accepts bids from providers to deliver care within a global budget. This model is summarized in Table 2.6.

Table 2.5 Experience with Hospital Global Budgets in Rochester, New York

Program Characteristic	Description
Description	Using a Medicaid waiver, hospitals, BCBS of Rochester, the state, CMS and local employers implemented the Hospital Experimental Payments Program (HEP). This program: • Provided an annual global budget under which each hospital's revenues were limited to costs in a base year, plus annual inflation adjustments. • Required that planning decisions for major capital investments be made by hospitals as a group.
Program duration	Program existed between 1980 and 1987, and ended with the termination of the Medicare waiver in 1988.
Characteristics that favor program impact	• Rochester has a long history of community health planning directed by community leaders (not government), and local employers were heavily involved in health planning efforts. • The insurance market was stable. A large not-for-profit health insurer dominated, and health maintenance organizations (HMO's) had high levels of penetration. Community rating of health insurance was common.

Program Characteristic	Description
Impacts	• During the period of global budgeting, hospital cost inflation in Rochester was lower than inflation in the state and the nation. (Conversely, when global budgeting ended, hospitals experienced real annual growth rates higher than the state and nation as a whole.) • Rochester hospitals had positive operating margins for five of the eight years of the program, compared with positive operating margins in just two of the eight years among hospitals statewide.
Lessons learned	*United States Government Accountability Office's report to the Committee on Government Operations, House of Representatives*: • Global budgeting helped provide hospitals with predictable incomes. • Hospital global budgets did not address the growing share of health care costs incurred outside of hospitals. • Continuation of community-wide planning efforts was facilitated through the global budgeting process. • The initiative was not sustainable because the federal and state governments were moving in another direction with the implementation of case-based prospective payment. Hospitals no longer supported global budgets because they could make more money through the new payment system.

Source: U.S. Government Accountability Office (1993) and Griner (1994)

Table 2.6 Minnesota's Patient Choice Model

Program Characteristic	Description
Description	• Requires providers to organize into discrete care systems, but allows providers to define their referral and hospital network and brand and market position by focusing on specific population or region, setting their own price, and contracting externally for many services. • Allows providers to submit bids based on their expected total cost of care for populations with the same set of benefits (based on historic resource use), and allows them to add other amounts to cover non-paid services, such as care management. • Allows providers to bill as usual and be reimbursed for services rendered. Fee levels are adjusted quarterly based on how costs compare to claim target submitted in bid. • Classifies care system into different "bands" based on cost and quality indicators and provides information on indicators to consumers. • Varies consumer premiums and benefits based on which "band" chosen care system falls.
Program duration	Implemented in 1997 on behalf of the Buyers Health Care Action Group (BHCAG), spun off in 2001 into Patient Choice, and purchased by Medica, a large HMO, in 2004. Program continues to operate.
Characteristics that favor program impact	• Minnesota has several discrete primary care provider systems, with only some overlap of specialists, which facilitates organization into discrete care systems and consumer movement between systems based on performance. • Bid model was pre-set to reflect historic resource use, allowing for appropriate bids.

Program Characteristic	Description
Expert Perspectives	*Anne Robinow, co-founder of Patient Choice Healthcare, expert called upon to present by the Special Commission:* • Change is difficult, but possible, and requires strong administrative capabilities. Change creates winners and losers: losers will undermine the process while good performers will support it. • Providers can be differentiated and stratified accurately. • Lower prices do not necessarily mean lower costs. • Consumers will respond to cost and quality variation. • One can build on FFS using existing claim systems to drive appropriate resource use. • Smaller provider entities can participate if they are still accountable for total care of their patients. • Data integrity is crucial to the process and to get buy-in. • Patient Choice is harder to explain and sell than standard products. Employers are reluctant to hold employees accountable for their choices and to vary their programs across communities. • A critical mass of patients is needed to make change—especially when providers need to invest in infrastructure.

Source: Robinow (2009)

Benefit Design Strategies

A number of benefit design strategies have been developed, largely as attempts to counter FFS incentives for providers to deliver more care, and more costly care, regardless of its effectiveness. These strategies include evidence-based purchasing (EBP), which gives patients incentives to seek more effective care; and provider tiering, which gives patients incentives to use higher-quality and/or more cost-effective providers.

By definition, benefit design strategies are intended to affect consumer behavior: they are not payment models. As illustrated in Figure 2.1, both EBP and provider tiering can be used (individually or together) to complement alternative basic payment models—either FFS or episode-based payments, and potentially also some capitation or global payment models (not shown).

Evidence-Based Purchasing (EBP)

Evidence-based purchasing (EBP) may include value-based benefit design as well as evidence-based coverage. Value-based benefit design typically reduces insured consumers' cost sharing for use of care that clinical, cost-effectiveness, and comparative effectiveness research has shown to be effective. In contrast, evidence-based coverage uses effectiveness research to determine whether a service is covered at all—for example, use of a drug formulary that excludes less effective drugs of greater or similar cost, compared with a more effective drug—or under what conditions it should be covered based on a medical necessity determination.. By encouraging consumers to choose evidence-based services when obtaining care, EBP attempts to decrease cost by minimizing the misuse and overuse of health care. Because providers have strong financial incentives to deliver services that are covered, EBP encourages the delivery of care that is more cost-effective.

Experience with Implementation. In the U.S., experience with EBP is very limited—in part reflecting practices in Medicare, which accounts for a large share of health care services. Because Medicare is prohibited from taking cost into account when making decisions about covered treatments, the program has made very limited use of comparative effectiveness research in designing coverage.

States such as Oregon and Washington also have experience with EBP. For example, the Oregon Health Plan famously took on the task of expanding Medicaid eligibility, constraining costs by covering treatments based on clinical effectiveness and "net benefit." More recently, Washington State's Medicaid program has implemented an EBP program, as summarized in Table 2.7.[17]

Table 2.7 Experience with EBP in Washington State

Program Characteristic	Description
Description	• Medicaid program grades services based on the quality of the evidence supporting their effectiveness: o A = randomized controlled clinical trials o B = consistent and well-done observational studies o C = inconsistent studies o D = studies show no evidence, raise safety concerns, or no support by expert opinion • Medicaid program requires prior approval of services and generally approves services graded "A" or "B" for coverage. "C" and "D" services may be approved only after special, case-specific review.
Program duration	Program has been in effect since mid-2006.
Characteristics that favor program impact	• Washington State has experience with other evidence-based purchasing initiatives, including use of a preferred drug list and a State Health Technology Assessment Program. • The medical directors of all health-related state agencies coordinate policy via a core organization of evidence-based purchasing efforts. • State relies on expertise of an independent practice center (Oregon Health Sciences University's Evidence Practice Center)
Impacts	• Spending for bariatric surgery dropped 94 percent, from $970,000 in 2003 to $56,000 in 2006. • Spending for enternal nutrition spending dropped by $10 million. • After requiring a second-opinion, spending for drugs to treat attention deficit disorder in children dropped significantly, resulting in a 3:1 return on investment (ROI).

Source: Bailit (2009) and Porter (2006)

[17] A number of countries with single payer systems also use comparative effectiveness research to influence provider practice and/or support coverage decisions. For example, in the United Kingdom, the National Institute for Health and Clinical Excellence (NICE) performs research on the clinical effectiveness and cost-effectiveness of various procedures, pharmaceuticals, and technologies to help the National Health Service (NHS) make better purchasing decisions.

Provider Tiering

Provider tiering models give enrollees cost-sharing incentives to choose providers that score well on cost, quality measures, or both. Provider tiering is intended to shift enrollees to high-performing providers while both retaining consumer choice of providers and motivating providers to improve efficiency and quality in order to compete for patients (Draper et al. 2007; Fronstin 2003). Payers use claims data analysis to assign providers to tiers that reflect their relative efficiency (measured as costs per episode of care, unit prices, or average cost) and quality (Draper et al. 2007; Robinson 2003).

Experience with Implementation. In Massachusetts, there are several examples of provider tiering: the Group Insurance Commission (GIC) requires all contracted health plans to classify physicians in their networks into performance tiers; BCBSMA launched a two-tier product in 2001; and Tufts Health Plan introduced a product in 2002 that encourages use of community hospitals when possible.

The most recent development in tiered provider networks is the Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs developed by the Consumer-Purchaser Disclosure Project, described in Table 2.8.

Table 2.8 Patient Charter for Physician Performance Measurement, Reporting, and Tiering Programs

Program Characteristic	Description
Description	• The Consumer-Purchaser Disclosure Project is a coalition of consumer, employer, and labor organizations that work toward a common goal of ensuring that all Americans have access to publicly reported health performance information. • A national set of principles guides measuring and reporting physician performance, encouraging encourage insurers and physician groups to: o Allow for periodic independent review of physician reporting programs. o Use standard criteria for physician performance measurement, reporting, and tiering programs. o Provide full public disclosure of performance results against minimum standards and national benchmarks.
Program duration	The Patient Charter has been in effect since April 2008.
Characteristics that favor program impact	• Program is supported by large coalition of various stakeholders, including large health insurers and leading physician groups. • Program recommends use of standard criteria to reduce variation in performance measurement.
Findings	None to date.

Source: Chollet (2009) and Consumer-Purchaser Disclosure Project (2008)

Special Commission Evaluation of Payment Models

The Special Commission considered each of the basic payment models and complementary payment, care and benefit strategies described above and dismissed global budgeting from further consideration on its own. In general, the Special Commission members' lack of interest reflected their belief that it offered less potential to achieve their vision for payment reform in Massachusetts—specifically, strong incentives for efficient and effective patient-centered care with more uniform quality and cost.

The Special Commission considered the advantages and disadvantages of each model, including continued FFS. Each was reviewed in terms of its potential for comprehensive, substantial, and short- and long-term impact on:

- Efficiency
- Access to care and patient choice
- Improvement in the quality, effectiveness, and value of care
- Cost and cost trends, including unit cost and volume

With respect to these considerations, the advantages and disadvantages of each model are summarized in Table 2.9 and reported in somewhat greater detail below. The models are presented in the order in which the Special Commission considered them.
The Special Commission first considered the potential for achieving its vision for payment reform within the existing largely FFS system. In its deliberations, the Special Commission noted that changes built on the current FFS system might be easiest to achieve. However, the Special Commission concluded that complementary payment-related strategies (including P4P, which largely developed in response to the deficiencies of FFS) could not neutralize FFS incentives for greater volume and cost. That is, because FFS incentives for increasing service volume would remain, overlaying P4P might not sufficiently contain costs or improve care coordination and collaboration among providers. Moreover, the need to overlay multiple benefit design strategies and complementary payment-related strategies to counter the pervasive incentives of FFS was viewed as a principal reason that the current system is both administratively complex and difficult for both providers and patients to navigate. Nevertheless, the Special Commission strongly agreed that P4P offers substantial promise for improving the quality of care, if performance measurement is standardized and the basic payment model also encourages greater efficiency in the delivery of care.

The Special Commission next considered episode-based payment. The Special Commission recognized that this model has many promising features, including incentives for efficient delivery of care and collaboration among providers within episodes of care. Federal policymakers currently are paying substantial attention to episode-based payments as a potential means for improving the efficiency of care provided to Medicare patients. However, it was judged to be too early in development and too complex in design to be implemented quickly and comprehensively. Specifically, episodes can be challenging to define in terms of the diagnoses or procedures they are built around, when they begin and end, the range of services included, and which provider should be accountable. To date, there is limited operational experience with episode-based payment, and for only a small number of episode types. Moreover, the Special Commission concluded that while episode-based payment might in time result in the efficient

delivery of care during each episode, it offered no financial incentive for providers to help patients avoid the occurrence of episodes. However, the Special Commission did see a potentially strong role for episode-based payments as a means of allocating payments within ACOs in the long-term, as well as representing a potential transition payment strategy role.

The Special Commission next reviewed medical home strategies for care. Medical homes were thought to have promise for improving delivery and coordination of health care services, and given existing operational experience, could be developed relatively quickly. However, the Special Commission again recognized that no complementary payment or care strategy—neither P4P nor medical homes—can neutralize the volume and cost incentives of the basic FFS payment model. Therefore, the Special Commission concluded medical homes were best considered a complement to a new basic payment strategy that entailed fundamental change in our health care payment system (as opposed to a "solution" to the deficiencies of fee-for-service).

Finally, the Special Commission considered global payment models—which pay providers prospectively-set fees for all or most health care services that the enrolled population needs during a contract period. Global payment models were viewed as having important advantages: They offer strong incentives for the efficient delivery of the full range of services that most patients need. They emphasize primary care and are compatible with and reinforce the goals of patient-centered medical homes. Moreover, some Massachusetts providers already have operational experience with some form of global payment. An estimated 20 percent of commercial physician payments are currently made in the form of global payments. This experience suggests that broader adoption is feasible since providers are already managing under it successfully and provides a base for wider progress towards global payment. Finally, the Special Commission noted that global payment is compatible with P4P, which was viewed as important in protecting consumer access and encouraging the high-quality, evidence-based, patient-centered care that is central to the Special Commission's vision for payment reform.

At the same time, the Special Commission identified significant challenges to replacing FFS with global payment as the dominant payment model in Massachusetts. Specifically, a global payment model requires developing a statewide system of risk adjustment and the widespread participation of providers, some of whom have little to no operational experience with global payments or integrated delivery systems.

Table 2.9 Payment Reforms Considered by the Special Commission on the Health Care Payment System

Payment Model	Advantages	Disadvantages or Challenges
	Basic Payment Models	
FFS	• Can be readily adopted in reforms and may remain necessary for certain patients (e.g., from out of state) or specialized providers.	• Rewards delivery of more care without regard to resources or value. • Focuses attention on prices and not costs. • Cannot build in limits on cost growth. • Rewards intervention, not cognitive action. Some high-value services are not reimbursed. • Does not align incentives to encourage coordination of care among providers and across sites of care. • Does not recognize differences in performance, quality, or efficiency. • Multiple players determine the rates. Fees vary for the same service and often do not relate to actual costs. • Gives strong incentive to increase cost by providing more costly services over lower cost services that are equally effective. • Does not align with evidence-based guidelines, and does not reward quality or outcomes. • Requires overlay of benefit design strategies and/or complementary payment models to mitigate volume and cost incentives, encourage quality improvement and promote care coordination for both acute and chronic conditions. • Need to overlay multiple strategies and complementary models creates a "byzantine" system that is hard to administer and difficult for consumers and providers to navigate.
Episode-based payment	• Within episodes, eliminates incentives to increase the volume of services. • Within episodes, eliminates incentives to provide higher-cost services over lower-cost services that are equally effective. • Focuses attention on performance and coordination of care for important clinical conditions or procedures that correspond to acute care episodes.	• Some volume incentives remain—more payment for more episodes. • Operational experience is limited, and only currently exists for a small number of episode types. • Design and implementation are highly complex. • Requires providers to assume some financial risk for performance. • Strong risk adjustment methods are necessary to avoid selection of patients. • Requires a network of providers to develop systems and capabilities for integrated care management. • Incentives for consolidation could reduce market competition. • Requires overlay of benefit design strategies and/or complementary payment models to encourage quality improvement, ensure appropriate access to care within acute care episodes, and promote care coordination for chronic conditions. • Continued need to overlay benefit design strategies and complementary models would perpetuate payer systems that are hard to administer and difficult for consumers and providers to understand.

Global payments	• Eliminates incentives to increase volume, for all or most service types. • Eliminates incentives to provide higher-cost services over lower-cost services that are equally effective, for all or most clinical needs • Emphasizes the role of primary care providers. • Encourages integration and coordination of care, both within acute care episodes and for patients with chronic conditions. • Reinforces the goals of medical homes with respect to care coordination within and between acute care episodes • A significant number of physicians already have operational experience with some form of global payment.	• Require physicians to assume financial risk for performance. • Strong risk adjustment methods are necessary to avoid transfer of insurance risk to providers, and incentives for selection of patients. • Requires a network of providers to develop systems and capabilities for integrated care management. • Incentives for consolidation could reduce market competition. • Requires overlay of complementary payment model (P4P) to encourage quality improvement and ensure appropriate access—but it would not necessarily be complex, difficult to administer, or difficult to understand.
	Complementary Payment-Related Strategies	
P4P	• Can be combined with any basic payment model. • Can encourage improved clinical quality of care, evidence-based care, access and better patient outcomes and satisfaction. • Especially in combination with global payments, can be used to encourage improvements and coordination across the spectrum of services for acute and chronic conditions.	• Cannot neutralize volume and cost incentives of the basic payment model. • Low performance payments provide insufficient incentives for efficiency, care coordination, or integration of care. • Important gaps in performance measurement remain.
Medical homes	• Can be combined with any basic payment model. • Emphasizes patient-centered primary care, with particular potential quality and cost benefit for care of patients with chronic conditions. • By promoting access to primary care and care coordination, may avoid acute care episodes and reduce unnecessary use of services.	• Cannot neutralize volume and cost incentives of the basic payment model, particularly for care delivered outside of the primary care practice • In combination with FFS or episode-based payment, capacity to coordinate specialty care and integration of services—and therefore affect overall efficiency and cost—is limited. • Capacity to coordinate or rationalize use of all services (such as institutional care or highly specialized services) is limited.

Chapter 3: Public and Stakeholder Input

The Special Commission was committed to engaging stakeholders and the larger community during the entire process of evaluating the current health care payment system in Massachusetts, evaluating alternative payment models and purchasing strategies, and developing recommendations. A number of meetings with stakeholders were held on behalf of the Special Commission, engaging a broad community of stakeholders throughout the Special Commission's deliberations. In addition, the Special Commission conducted a special meeting early in its discussions to elicit comments from the public.

Statements Submitted to the Special Commission

The Special Commission used its second meeting on February 6, 2009 to hold a public input session to solicit comments. Various groups—including hospital organizations, insurers, patient advocates, health academicians, and provider groups—presented at this meeting or provided written comments.[18] The major themes that emerged from these statements included:

- The importance of expanding primary and preventive care, and transitioning Massachusetts's current health care system from a specialist-based system to a primary care-based system. Shortages of specific provider types were noted, including primary care providers, and the need to address workforce dynamics was emphasized.
- The weakness of the current fee-for-service payment model and the need to transition to a payment approach that would encourage better coordination of care.
- The need to encourage quality improvement through transparency and adoption of health information technology.
- The importance of accounting for individual special circumstances when reforming the payment system.

As presented to the Special Commission, major issues in each category are summarized below.

Increased Emphasis on Primary Care. Presenters attributed the high cost of health care to overuse of specialists, technologies, surgeries, and other services in the current system. While generally advocating movement to a system focused on preventive care and chronic disease management, some presenters expressed concern about access to primary care physicians (PCPs) currently, especially for low-income populations and persons with mental health needs or developmental disabilities. To improve access to primary care, some recommended increasing primary care physician reimbursement, expanding medical education loan forgiveness for physicians who choose primary care and transitioning graduate medical education funding from the inpatient hospital setting to outpatient and community-based settings where primary care providers are trained. Other presenters further recommended that all health plans be required to cover evidence-based primary and preventive care and treatment of chronic disease. Finally, some recommended that payment reform emphasize the role of physicians and PCPs in

[18] See Appendix F for the public input statements provided to the Special Commission.

particular—for example, requiring all patients to choose a PCP and empowering PCPs to direct patients to providers that provide the most appropriate and efficient care.

Weakness of the Current Fee-for-Service Payment Model. Many presenters viewed fee-for-service as an important reason for higher volume, duplication, and overuse and misuse of health care services. Presenters also indicated that fee-for-service payment encourages specialization of the medical profession (as fees paid to specialists are higher than those paid to PCPs), and that it fails to encourage care coordination or care management. To address these problems, some presenters recommended changing the payment system to encourage providers to work as a team across settings to promote care coordination by paying them as a group instead of as individuals—thereby rewarding quality and efficiency instead of volume. Some presenters recommended payment reforms such as global payment and episode-based payments, while others recommended reimbursement of care coordination services such as follow-up communication with patients and fellow providers. Other presenters advocated standard payment rates for the same services to prevent large providers with more market share from negotiating higher fees.

Increased Focus on Quality and Patient Safety. Presenters encouraged widespread adoption of quality initiatives and greater attention to patient safety. They encouraged transparency via collection and publication of provider efficiency and quality measures, but expressed concern about the large variety of quality measures and the resulting administrative burden on providers. Some presenters advocated that all payers adopt uniform efficiency and quality measurement methodologies. In addition, several presenters believed that payment reform could encourage health information technology (IT) adoption—such as computerized physician order entry and electronic medical records—that would improve patient safety. While many asserted that providers would need financial and technical assistance to adopt health IT (regardless of the payment model), many also indicated that a coordinated delivery system is a precondition to realizing the benefits of health IT.

Implementation Concerns. Finally, several presenters asked the Special Commission to consider the special circumstances of specific providers and patient groups. Believing that not all providers could accept risk-sharing arrangements immediately, they urged the Special Commission to recommend implementation of such reforms either in phases or through demonstration programs. Some presenters asked that the Special Commission give special consideration to certain providers and services (for example teaching hospitals and mental health services) when discussing any changes to the current payment system.

Further Feedback from Massachusetts Stakeholders

The statute specified that the Special Commission should consult with parties that its recommendations would likely affect—at minimum including "the office of Medicaid, the Division of Health Care Finance and Policy, the Commonwealth Health Insurance Connector, the Massachusetts Council of Community Hospitals, Inc., the Massachusetts League of Community Health Centers, Inc., 1 or more academic medical centers, 1 or more hospitals with a high proportion of public payors, 1 or more Taft-Hartley plans, 1 or more self-insured plans with

membership of more than 500, the Massachusetts Municipal Association, Inc. and organizations representing health care consumers."

On behalf of the Special Commission, Michael Bailit of Bailit Health Purchasing convened three meetings with each of nine groups of stakeholders:

- Physician specialty societies and large independent physician groups;
- Physician groups affiliated with hospitals;
- Community hospitals;
- Large teaching hospitals and major safety-net hospitals;
- Consumer advocates;
- Organized labor groups;
- Employers and employer organizations;
- Health plans, and
- Community health centers.

During the second and third rounds of engagement, Bailit shared the Commission's tentative recommendations with stakeholders.

Additional meetings and calls were conducted with the Health Care Quality and Cost Council, the Commonwealth Health Insurance Connector, and with the Office of Medicaid. For some meetings, Mr. Bailit was joined by staff from the Division of Health Care Finance and Policy and from the Executive Office for Administration and Finance. Mr. Bailit reported results of the meetings to the Special Commission at meeting number three, seven and eight. Summaries of these stakeholders meetings can be found in Appendix F, and the list of meetings is available in Appendix G.

All groups were eager to inform the Special Commission's deliberations and decision-making. Major themes of the stakeholder meetings included the following:

- **The importance of moving away from FFS as the predominant form of payment.** Stakeholders viewed the volume incentive in FFS as an essential feature of that payment model and a key driver of health care costs in the current system.

- **Integration of care.** All of the groups agreed that better integration of providers would improve the quality and value of health care, and that movement away from FFS payment was essential to achieving better integration. Some differed on whether real or virtual integration would be necessary to bring about improvements in efficiency, continuity of care, and patient outcomes.

- **Transparent, deliberative, and consultative development of an alternative payment system.** All of the groups appreciated the Special Commission's efforts to reach out to stakeholders, and emphasized the importance of engaging stakeholders similarly in any legislative and regulatory processes that might follow. In short, they appreciated the openness of the Special Commission's process and would like to see it continue.

- **Building consistent provider incentives.** All of the provider groups emphasized the importance of common performance metrics and measurement in pay-for-performance (P4P) programs. Providers emphasized the need to balance payment for cognitive, preventive chronic and interventional care better than in the current system, as well as the need to develop risk adjustments that appropriately recognize patients' clinical and socio-economic status (and therefore, systematic differences in levels of adherence to clinical instruction).
- **Building appropriate consumer incentives.** All of the groups—including providers, employers, and consumers—recognized the importance of health benefit design in making global payment both feasible for providers and ultimately successful in controlling overall health care costs. Incentives for appropriate use of care (such as no cost sharing for primary and preventive care) and incentives for consumers to manage their health and to seek and use care efficiently were cited as critical for the success of payment reform.
- **A careful transition.** All of the groups strongly recommended that particular care be taken in effecting the transition. They urged that implementation be phased in, with time and resources dedicated to evaluation, identification of unanticipated consequences, and opportunities for mid-course corrections.

Chapter 4: Recommendations for Payment Methods and Implementation

To promote safe, timely, efficient, effective, equitable, patient-centered care, and thereby reduce growth and levels of per capita health care spending, the Special Commission recommends that global payments with adjustments to reward provision of accessible and high quality care become the predominant form of payment to providers in Massachusetts. The Special Commission notes that infrastructure, legal and technical support are needed for many providers to make this transition; and that government, payers and providers will be required to share responsibility for supporting providers in making this transition.

The Special Commission concludes that global payment models that provide appropriate incentives for efficiency in the delivery of services, while strongly encouraging improvements in quality and access to appropriate, coordinated care should serve as the direction for payment reform. In addition, the Special Commission concludes that global payments can be implemented over a period of five years on a statewide basis, with some providers participating in the near-term, while others will need more time and support to transition. All payers (including governmental payers) will need to transition to the new system within this timeframe.[19] The Special Commission recognizes that many providers will require infrastructure, legal and technical assistance and support, such as information technology adoption, training in use of registries, and managing risk before a transition to global payment can occur. The Special Commission also recognizes that certain narrow classifications of services or practitioners should continue to be paid outside of the global payment model for their services, such as very high cost drugs or providers of very limited and specialized services.

The following sections present the Special Commission's recommendations with respect to the key components of global payment, as well as recommendations for transitioning to global payments, formation of an oversight authority, and the timeline for implementation.

Key Components of Global Payment

The Special Commission anticipates that, when fully implemented, global payment in Massachusetts will include the following key features:

- **The development of Accountable Care Organizations (ACOs)** that accept responsibility for all or most of the care that enrollees need.[20] ACOs will be composed of hospitals, physicians and/or other clinician and non-clinician providers working as a team

[19] Medicare participation will require a waiver to federal payment rules. Footnote 21 provides further explanation of the waiver process.

[20] The Special Commission termed these organizations 'Accountable Care Organizations' (ACOs) because certain members of the Special Commission were familiar and identified with this terminology. However, the Special Commission's definition of an ACO differs slightly from the original conception of the term, which defines an ACO as extended hospital medical staff (Fisher et al. 2007) and presumes that physicians practicing within an ACO are owned or directly contract with a provider entity such as a hospital. The Special Commission did not extend its definition of an ACO this far, allowing for other forms of provider organization.

to manage both the provision and coordination of care for the full range of services that patients are expected to need. ACOs could be real (incorporated) or virtual (contractually networked) organizations—potentially including, for example, a large physician organization that would contract with one or more hospitals and ancillary providers. Providers may decide to use established relationships to create an ACO, or they may enter into new relationships that they view as beneficial to their patients.

The Special Commission anticipates that a broad array of ACO models might emerge, and it encourages the development of a large number of ACOs. ACOs might have various central organizational forms—for example, physician-hospital organizations, consolidated medical groups, independent practice associations, or integrated delivery systems. In addition, they might form different legal relationships among the parties associated with the central organization—for example by contract or various forms of ownership. Finally, they might differ in the extent of exclusivity among different components of the organization. Differences in these aspects of organizations can correspond to differences in organizational culture and mission, differences in how financial risks and benefits are shared among different components of the organizations, and varying degrees of clinical integration.

- **Patient-centered care and a strong focus on primary care**. The Special Commission intends for global payment to accelerate movement toward a system of more patient-centered care in Massachusetts. Accordingly, patients will play a pivotal role, selecting a primary care provider of their choice to ensure care coordination. The patient's selection of a primary care provider will direct insurer payments to the ACO with which the patient's primary care physician is affiliated. Thus, identification of a primary care provider by all patients is critical. It may be necessary to modify some insurance product benefit designs to be consistent with this policy. The Special Commission recommends that all health plan products require the selection of a primary care physician. ACOs receiving global payments will then disburse those payments among participating providers, using methodologies—potentially including episode-based payment and medical home models—of their choice.

- **Patient choice.** While payments to ACOs will follow the enrollee's choice of a primary care physician, patients will not be restricted (unless as a condition of their insurance contract) to providers in their primary care physician's ACO. Carriers might continue to pay providers that patients might select from another ACO on a fee-for-service basis.

- **Use of P4P incentives** to ensure appropriate access to care, and to encourage quality improvement, evidence-based care, and coordination of care among providers and across sites of care. P4P will be based on consistent performance measures and measurement across all payers. The Special Commission anticipates that core P4P metrics will be uniform across all payers, and that they will reflect available research evidence about the relative effectiveness of alternative treatments (where such evidence exists) as well as the quality of care as experienced by the patient.

- **Participation by both private and public payers** to ensure alignment of financial incentives for providers treating patients covered by different payers. With respect to Medicare, this will entail obtaining an all-payer waiver of federal payment rules.[21]

- **Sharing of financial risk between ACOs and payers**. Payers—including private insurers and self-insured employers—will retain their current role as holders of insurance risk for health insurance contracts and employee health plans, respectively. To ensure that ACOs are not subject to insurance risk, global payments will be risk adjusted (as described below). To further protect ACOs from insurance risk, carriers might develop stop loss arrangements (which limit potential losses) or risk corridors (which limit the risk of financial loss as well as gain) with ACOs. However, ACOs will be held responsible appropriately for performance risk—including cost performance and meeting access and quality standards.

- **Strong and consistent risk adjustment**. Global payments will include adjustments for providers' clinical and socioeconomic case mix, and, as appropriate, geography, so that no ACO will be financially harmed by accepting high-risk patients with complex or chronic health care needs. Clinical case mix adjusters will reflect both patients' health conditions but also differences in consumer incentives associated with benefit design. Socioeconomic adjustments will recognize other patient characteristics such as income status, to the extent they have been demonstrated to influence health. Appropriate socioeconomic risk adjustment will be made a priority for further research and development.

- **Cost and quality transparency**. ACOs will report performance against common metrics measuring health care quality and access to appropriate care. These measures will be made widely available to consumers, providers, and payers to support consumer choice, establish provider and insurer accountability, and encourage ongoing system improvement. Performance should be measured using reliable and tested metrics.

- **Widespread adoption of medical home models of care**. In large part, the characteristics that will define an ACO—an emphasis on cost-effective primary care, clinical integration, and attention to quality as measured against common performance metrics—require medical home capacity. The Special Commission recommends that steps be taken to ensure that the primary care practices in each ACO undergo the necessary practice redesign to become effective patient-centered medical homes and that they are

[21] Federal law permits the Secretary of Health and Human Services to waive certain provisions of the Social Security Act to demonstrate new approaches to provider reimbursement. Such demonstrations may include: testing alternative payment methodologies; demonstrating new delivery systems; and coverage of additional services to improve the overall efficiency of Medicare. However, unlike Medicaid waivers, participation in a Medicare waiver is voluntary unless authorized by specific federal legislation. Moreover, implementation of global payment for Medicare beneficiaries is likely to require waivers of both Part A and Part B relating to conditions of and limitations on payment of services (Section 1814); payment to providers of services (Section 1815); payment of benefits (Section 1833); special payment rules for particular items and services (Section 1834); procedure for payment of claims of providers of services (Section 1835); and provisions relating to the administration of part A (Section 1816) and part B (Section 1842). Section 222 waivers only allow for payment methodology changes. If the state's ultimate design requires waivers of other provisions of the Medicare law, the state may need Congressional action to allow for a waiver of such provisions (Bailit and Waldman 2009).

compensated in a manner that supports their operation. Such actions will provide ACOs with critical capacity for serving their patients. However, it should be noted that while the Special Commission endorses widespread adoption of medical homes, it does not think medical homes alone can achieve its vision for a high-value health care system.

Recommendations for a Transition Strategy

The Special Commission anticipates that movement to global payment will promote significant changes in health care delivery and utilization in Massachusetts. The current organization of providers in Massachusetts includes sometimes complex and overlapping relationships among health plans, providers, and patients/enrollees. During a transition to global payments, some of these relationships may change—perhaps especially between payers and providers that currently accept primarily or exclusively fee-for-service payment.

Since some Massachusetts providers will face challenges moving away from fee-for-service, a careful transition must occur to ease system changes under the new arrangements and offer adequate infrastructure support for providers. The Special Commission recommends a careful and structured transition strategy, supporting both providers and consumers in the new payment model.

While some organizations (those with more experience and who already have the features of an ACO) may begin to voluntarily accept global payment in the near-term, others would shift more gradually as they build relationships and structure themselves as ACOs, develop necessary operational capabilities, and become accustomed to holding performance risk, including performance-based payments. Provider organizations needing more time to transition would initially shift from fee-for-service to shared savings models—in which they would begin to participate in limited risk-sharing arrangements with uniform performance incentives—and then ultimately to full global payment.

The Special Commission recognizes that full global payment does not mean accepting full financial risk (that is, both performance and insurance risk). All ACOs will not be capable of assuming the same level of risk, and the Special Commission anticipates that carriers will share risk differently with ACOs in different circumstances. However, while carriers will retain insurance risk, providers will become accountable for clinical and cost performance.

Shared Savings

The Special Commission recognizes that not all ACOs will be prepared to immediately accept the “downside” risk of financial losses under global payment. These ACOs—likely including providers who have not heretofore worked in a closely coordinated fashion—could receive payment in a shared savings model as an interim step in their transition to global payments.

Under the shared savings model, payers will negotiate spending targets with ACOs (consistent with the milestone targets discussed in the next section), reflecting predicted costs for their patients. Payers may continue to pay these organizations on a fee-for-service basis, or they may use alternative payment methods that bundle payment for some services (such as primary care for some chronic conditions). At the end of the year, the organization’s actual and target

spending will be compared. Organizations that meet uniform, system-wide quality standards and hold costs below the spending targets will receive bonus payments that reflect a portion of the savings they achieve. The Special Commission anticipates that payers, employers, and consumers will share in the savings generated through lower premium payments.

The Special Commission recommends that the transition include financial incentives for provider organizations to move toward global payment. Such incentives might include allowing providers to keep a larger portion of savings they achieve under global payments for providing high-quality care (as they also gradually assume some down-side financial risk for performance with the movement towards global payment).

Technical Assistance and Consumer Education

The Special Commission recognizes that a number of current provider organizations might already meet the criteria for an ACO. However, it is likely that most providers will require technical assistance to transition successfully to global payment. The Special Commission anticipates that such technical assistance would include:

> (1) Training in best practices in key competencies such as governance and contracting, patient-centered care management, health information technology, data analysis, and medical home primary care practice redesign; and
>
> (2) Ongoing, timely access to and analysis of claims data for their covered populations, to obtain information about member health, care management, expected cost outcomes, and performance against common quality metrics.

Patients and employers also will require education regarding the new payment system and its implications for them. Patient-directed enrollment in an ACO and patient-centered care place patients and their families at the center of care planning and delivery; they will require more (and more useable) information and education to maximize the potential for coordinated care delivery to improve their health status and outcomes.

There are an array of organizations in Massachusetts that may be positioned to play a role in providing the needed technical assistance for providers and in supporting the envisioned education for patients and employers. These organizations include trade associations, not-for-profit quality improvement organizations, information technology support collaboratives and others.

Employers will also continue to play a critical role as health plan sponsors. While global payment as envisioned by the Special Commission will not require employers to modify their health plan designs, employers should be engaged to maximize the benefit of payment reform by aligning the consumer incentives that are implicit in their benefit designs—for example, reducing cost sharing for use of appropriate primary and preventive care, and for care that is known to be effective, or by encouraging patient use of coordinated care within the ACO. To encourage use of care within the ACO, payers might adjust coinsurance levels for out-of-network care.

Transition Oversight

The Special Commission recommends that the Commonwealth assign the responsibility for guiding implementation of the new payment system to an entity with the expertise needed to perform this critical function.

The entity charged with steering implementation of the new payment system could be a new, independent Board consisting of members that are subject-matter experts. Areas of expertise may include (but may not be limited to) physician practice finance, hospital finance, provider organization and insurer operations, health care payment, clinical care, and consumer issues. This new, independent Board would be supported and staffed by existing state entities or agencies. Alternatively, responsibility for steering implementation of the new payment system could be assigned to an Executive Branch agency that would be advised by an independent Advisory Board with expertise in the previously mentioned areas.

In either case, the entity charged with guiding implementation of a new payment system would make decisions in an open and transparent manner and seek input from a broad array of stakeholders, including providers, health plans, government, employers, organized labor and consumers. The Special Commission also recommends that a permanent source of dedicated, adequate, additional funding be identified to support performance of its responsibilities.

Among its responsibilities, this entity will establish the methodology for global payments; establish the parameters that define an ACO; analyze health system data to support providers, patients, and employers; recommend the necessary infrastructure support for providers; and establish transition milestones and monitor progress. It will also have the authority to identify and implement mid-course adjustments as may be needed.

The key responsibilities of this entity—developing global payments, defining what constitutes an ACO, monitoring and analysis, ensuring infrastructure support, and establishing transition milestones—are discussed below.

Development of Global Payments

The oversight entity will develop parameters for a standard global payment methodology. Global payment rates will include adjustments for clinical risk, socio-economic status, geography (if appropriate), core access and quality incentive measures, and other factors. The Special Commission recommends that the *market* will determine global payment *amounts* consistent with the methodology established by the oversight entity. In certain unique circumstances, payers may need to continue fee-for-service payments to providers. Such circumstances might include specific health services that the oversight entity might exempt from the comprehensive care expected of an ACO, as well as care delivered to non-Massachusetts residents.

Defining Accountable Care Organizations

The Special Commission anticipates that ACOs will be responsible for all or most of the care that patients require—including primary and specialty care, hospital care, therapy services, home care, and prescription drugs. In addition, an ACO must be of sufficient size to accurately measure performance against uniform quality metrics.

The oversight entity will be responsible for determining the specific criteria that qualify provider organizations as ACOs. These criteria may include the scope of services that ACOs must provide and the minimum size of an ACO consistent with managing its performance risk.

Establishing Financial Risk Parameters for ACOs

Under global payments, payers will continue to hold insurance risk, but ACOs will assume some downside risk for both clinical and financial performance. The Special Commission recognizes that ACOs in different circumstances will have different capacities to bear financial risk.

The oversight entity will establish parameters for the assumption of financial risk by ACOs. These parameters will include risk floors consistent with effective financial incentives for cost management and risk ceilings consistent with financial stability. In establishing risk parameters, the oversight entity will consider the various circumstances that might affect an ACO's ability to assume financial risk—either insurance risk or performance risk. Such circumstances may include the size of the ACO and its experience with managing financial risk.

The oversight entity will have the authority to establish requirements to accommodate ACOs that are capable of taking on only limited financial risk. For example, the oversight entity might require such ACOs to purchase global stop loss insurance, which would limit their overall financial risk; or it might require adjustment of carriers' global payments to such ACOs to reflect specific stop loss limits, so that each carrier would retain greater risk for enrollees who choose a primary care provider in a limited-risk ACO.

Monitoring and Analysis

In the first year, the oversight entity will collect and analyze data to inform policy-making and the establishment of payment system transition milestones as well as to establish a benchmark upon which to measure the success of global payments on an ongoing basis. This analysis will measure the percentage of payments made under global payment arrangements; medical and administrative cost trends; payment rate variation among providers and health plans; the financial performance of ACOs, health plans, and sub-providers; and metrics on access to care, especially for underserved populations. In addition, the oversight entity will adopt core common performance measures—including measures of clinical quality (including both process and outcome measures), patient satisfaction, and access to care—and monitor trends in performance. The oversight entity will consider established measures of access and quality against which to measure progress.

The oversight entity will conduct evaluations to assess the impacts of the transition to global payment, included assessments on changes in the workforce, the trends in primary care physician capacity, and changes in health care provider practice operations, including progress toward shared responsibility for the needed infrastructure, legal, and technical support for providers. The oversight entity will have the authority to identify and implement mid-course adjustments as may be needed.

Infrastructure Support

Providers will need significant support in building the infrastructure needed to integrate care successfully, meet performance metrics/targets, and manage financial risk for performance. The

Special Commission sees a need for shared responsibility among state government, providers, insurers and others entities and individuals with capacity and expertise in providing infrastructure support for providers in organizations that might qualify as ACOs. The oversight entity will be responsible for identifying provider infrastructure needs and recommending policies to address those needs. Examples of shared responsibility for infrastructure support for providers currently exist in at least one other state (Pennsylvania).[22]

Establishing Milestones

The oversight entity will establish milestones in three areas reflecting the goals and implementation of payment reform: the pace of the thoughtful transition to global payment, improved payment equity, and slowing cost growth. It will have the authority to intervene when milestones are not met or when unintended consequences occur. The oversight entity's authority will extend to both non-financial interventions (including but not limited to technical assistance) and financial interventions (including, but not limited to fines and establishing payment rate parameters).

In determining progress toward each milestone, the oversight entity will consider whether providers have sufficient infrastructure support, identify barriers to implementation of infrastructure support, and suggest policy to remedy unmet needs. Specifically:

- **Transition to global payment.** The oversight entity will set annual milestones for the market to advance to global payments, and monitor progress. Such milestones might include (1) the percent of providers organized in an ACO; (2) the percent of payments made under a shared savings or global payment methodology; and (3) the percent of payments made under a global payment methodology. If the milestones are not achieved, the oversight entity may intervene by establishing payment rate parameters (for example, constraining fee-for-service rates).

- **Improved payment equity.** The oversight entity will set milestones for achievement of greater value-based payment equity and monitor market progress to these targets. Metrics for payment equity might include variation in levels of risk-adjusted global payments to ACOs across payers, variations in levels of payments to different providers within ACOs, and payments for lines of service such as primary care and behavioral health relative to other services. If targets are not met, the oversight entity will have the authority to

[22] Since May 2008, the state of Pennsylvania has provided support to primary care practices that are transitioning to Chronic Care Model-style medical homes. Insurer and state resources have been combined to provide primary care practices with technical assistance in the form of ongoing regional learning collaborative meetings involving participating practices and both in-state and national expert faculty, practice coaching, facilitation of monthly practice team calls, and maintenance of a learning collaborative listserv. In addition, practices lacking an electronic patient registry (which tracks their patient care against evidence-based protocols and other measures) are provided with one. Finally, practices receive supplemental payments to cover the costs of attending the learning collaborative sessions, incorporating care managers into their practices, and providing traditionally non-reimbursable primary care services. Through the Pennsylvania Chapter of the American Academy of Family Practice, carriers pay an intermediary for practice coaching and they pay the cost of implementing patient registries. Pennsylvania is making plans for additional support in the form of providing hospital and insurer data to practices to help them identify gaps in care, opportunities for managing transitions in care, and high-risk patients in need of care management support.

intervene (for example, by establishing payment rate standards that might constrain how providers bill the ACO).

- **Slowing cost growth.** The oversight entity will analyze baseline per capita cost trends to set target market growth levels and monitor market progress to these targets. Again, the oversight entity will have authority to intervene if targets are not met—for example, by establishing payment rate parameters modifying the trend factor used in the global payment methodology and restricting growth in allowed fee-for-service rates.

Complementary Strategies and Issues Requiring Further Consideration

In meetings with stakeholders, a number of strategies were suggested as important complements to payment reform. The Special Commission recognizes the importance of these strategies in achieving the goals of improved quality and value in Massachusetts' health care system. While these issues were not fully explored during the Special Commission's discussions, it recommends that each be given further consideration as the Commonwealth moves forward with payment reform:

- **Health plan design and coverage policy.** While payment reform would not necessarily require the redesign of health plan products, many stakeholders noted the importance of aligning patient and provider incentives under global payment. In addition, emerging evidence about the effectiveness of care for specific medical conditions suggests that a significant amount of care that is currently provided is ineffective and in fact may unnecessarily endanger patient health. Employers must also be engaged to support the alignment of insurance benefit design and payment reform goals. The Special Commission recommends that a multi-stakeholder process be convened to review comparative effectiveness evidence, examine health plan design, and develop consensus coverage policies based on its findings to promote the use of high-value, efficient care.[23]

- **Consumer engagement.** Many stakeholders emphasized the importance of engaging patients both in maintaining good health and in managing their own care, especially with respect to chronic conditions. The Special Commission recommends that existing community, employer, health plan and state efforts be coordinated and expanded to activate patients, promoting healthier lifestyles and improved self-management of chronic illness.

- **Review of existing statutory framework**. The Commonwealth's existing statutory framework for health care was developed in response to a health care system operating with fee-for-service as the predominant payment model. Thus, the Special Commission recommends a close review of statutory provisions (including state antitrust rules and insurance law) that could impact the realization of its recommendations, and to the extent

[23] For example, such a process might result in standardizing some benefit design incentives—such as eliminating cost sharing for preventive care, chronic care management visits and medications and adding incentives to encourage the use of care that comparative effectiveness research has shown to be effective.

there are barriers to achieving its vision, appropriate legislative action to address these issues.

- **Administrative simplification.** Many stakeholders expressed concern about current administrative burdens resulting from complying with divergent performance measures and payment structures. The Special Commission recognizes that important private and government efforts toward administrative simplification in Massachusetts are currently underway. The Special Commission recommends that these efforts should continue to fruition, and views monitoring and ongoing efforts to reduce administrative costs as critical activities under payment reform.

- **Medical malpractice reform.** Some stakeholders believe that "defensive medicine" is an important factor in the current level of health care costs. The Special Commission recognizes these views about medical malpractice reforms and recommends concerted efforts to resolve remaining issues and develop policy recommendations.

- **Primary care workforce development.** As recommended by the Special Commission, payment reform will further increase the demand for primary care and medical homes in Massachusetts. Therefore, the Special Commission recommends that the Commonwealth develop implementable strategies for attracting and retaining primary care physicians to meet this increased demand and ensure adequate access to primary care and medical homes.

- **End-of-life care.** In Massachusetts, the End of Life Commission makes information about end-of-life resources available online and in-print in communities throughout the Commonwealth, and works actively with a number of initiatives and organizations such as the Massachusetts Comprehensive Cancer Plan, the Massachusetts Pain Initiative, the Massachusetts Compassionate Care Coalition, the Veterans Administrations, and the Massachusetts Hospital Association. The Special Commission recommends that such efforts to address end-of-life care and decision-making be continued. In addition, graduate medical curricula should include geriatrics, pain management and end-of-life care.

- **Payment for provider teaching and standby capacity.** In its guiding principles, the Special Commission recognized that the costs associated with graduate medical education and necessary standby capacity should be paid for. Funding for these costs should be transparent and there should be accountability for how such payments are spent. The Special Commission recommends that these areas receive further attention.

Strength of the Special Commission's Recommended Approach

The Special Commission is aware of the concerns that have been raised regarding unintended negative effects of global payment on provider behavior and as a result, patient experience. Reflecting experience under the various capitation models that emerged in the 1990s, these allegations include impeded patient access to necessary and appropriate care, lack of incentives to improve care quality, and inequitable provider payments (Robinson 2001; Pauly and Nicholson 1999; Miller and Luft 1997).

Under prior models of capitation, problems of access to care sometimes resulted from incentives for providers to "stint" on necessary care and to avoid accepting high-cost patients.[24] Moreover, limited attention to measuring the quality of care, combined with the strong cost containment incentives of capitation had the tendency to dominate any independent effort to improve quality.[25] Arguably, at that time, provider incentives to reduce the amount of care provided and invest little in quality were magnified as insurance markets became more concentrated, placing providers at a disadvantage in negotiating capitation rates.

The Special Commission notes that these problems, while occurring in the past, were not universal. In fact, some prior models of capitation evolved and are widely viewed as having succeeded over time in managed care programs.

While there remains some debate over the experience with prior capitation models, the Commission does envision a system of global payments that significantly improves on capitation models of the past based on additional experience and progress over the past two decades:

Careful Transition and Provider Supports

The transition to global payments will occur over a five-year period. Over this period, the Special Commission envisions that insurers, provider organizations and the Commonwealth will join together to offer providers the significant support many will need to build infrastructure—helping them to integrate care successfully, measure their performance against standard metrics, and manage financial risk for performance. The Special Commission envisions an active role for the oversight entity: it will establish milestones that recognize progress toward global payment that include development of infrastructure, identify unmet infrastructure needs, and recommend policy to address those needs. This is a more deliberative, transparent process than occurred under prior capitation models, with greater attention dedicated to helping providers succeed under global payment.

[24] Many studies have shown that payment approaches involving risk-sharing with providers are associated with lower service use and cost, compared with fee-for-service arrangements. Such studies extend back to the RAND Health Insurance Experiment in the 1970s, continuing through the 1990s to the current decade. Most focus on the types of capitation arrangements common during the growth of managed care. The types of services studied varies, as do the data and methods used—controlling differently for patient characteristics and various features of the health care system that may affect use and cost of services. Not surprisingly, the estimated size of effects varies widely and their findings on how provider risk-sharing affects outcomes such as access to care, quality of care, and patient or provider satisfaction are mixed (Ross-Davies et al. 1986; Udvarhelyi et al. 1991; Kao et al. 1998; Flocke et al. 1998; Rubin et al. 1993). For example, some studies show *increased* delivery of primary care or preventive services when providers receive capitation; others show *reduced* access to care or reduced patient trust in their physicians. Like the research literature on use and cost effects, these studies are relatively old and vary widely in their methods as well as the populations and practice settings that are studied.

[25] Health services researchers have found little difference in the health care provided under risk-sharing arrangements and fee for service, even when patients may be vulnerable. When differences are detected, at least one study (conducted at the University of Massachusetts Medical Center) found improvements in care (HCFO 2002). Another study of Colorado Medicaid enrollees with severe mental illness found that receipt of care under a capitation arrangement had no effect on their outcomes, measured over a two-year period (Cuffel et al. 2002).

Robust Monitoring and Oversight

The Special Commission recommends putting in place monitoring systems to understand any barriers to the provision of care that have the potential to occur under the reformed payment system. Such monitoring may be most important for potentially vulnerable residents who live in areas that currently have few primary care providers or specialists relative to the population size.

As included in the Special Commission recommendations, the oversight entity is charged with extensive and ongoing monitoring responsibilities. The Special Commission anticipates that the oversight entity will monitor access, quality, and cost both at a population level and at the level of individual patients with specific conditions or characteristics. For this purpose, it may be necessary to conduct periodic consumer surveys to estimate the number and characteristics of people who may have impeded access to primary care providers or health care services. Also, the Commonwealth might require ACOs to submit data on standard measures of clinical quality of care, paralleling current Medicare program requirements for hospitals and Medicare Advantage plans. In turn, such information—made available to policymakers, providers, insurers, employers, and consumers—will support both mid-course corrections as may be needed and ongoing system improvements.[26]

Because prior capitation models did not systematically provide for such monitoring, evidence about unintended effects was slow to develop, relied on inconsistent measures and methods, and was largely unhelpful in developing public policy to correct problems even when documented. The Special Commission concludes that the ability to monitor and make mid-course corrections is essential to the success of global payments and that this would be a key area of improvement over prior experience with capitation.

Financial Incentives for Access and Quality

To ensure access to care and continuously improve quality, global payments must reward providers systematically for excellent performance—including, but not limited to, success in building and maintaining patient-centered medical homes. The ability to measure performance against comprehensive metrics of access, quality, and patient satisfaction is an essential feature of an ACO as envisioned by the Special Commission.

The Special Commission anticipates that global payments will be both appropriately risk-adjusted (as described below) and will reward high performers as well as improvements in performance, as measured against common core metrics for all payers. This will provide a safeguard against "stinting" on needed care for patients. Early capitation arrangements did not systematically measure performance, use common metrics across all payers, or necessarily link payment to improvements in performance.

[26] Such efforts might build on existing systems of performance measurement, such as the Healthcare Effectiveness Data and Information Set (HEDIS), the Massachusetts Health Quality Partners' patient surveys (which focus on clinician performance), the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys (which measure patients' experiences with ambulatory and facility-level care), Hospital Quality Alliance measures, and the Agency for Healthcare Research and Quality (AHRQ) Quality Indicators.

Improved Risk Adjustment Models

Risk adjustment deters "cherry picking" and helps to ensure fair payments to providers who care for patients with greater health care needs. The Special Commission anticipates initial adoption of tested risk adjustment methods—such as that which Medicare currently uses.[27] Ultimately, however, the transition to global payment in Massachusetts will offer an important opportunity and reason to expedite continued development and testing of better risk adjustment methods, to maximize fairness as well as provider incentives to improve and maintain patient health. This improves on previous private-sector capitation models which did not risk-adjust adequately or at all.

Health Information Technology Infrastructure and Support

Massachusetts has a number of important initiatives underway to disseminate health information technology (HIT) and infrastructure throughout the state. As part of Massachusetts' Chapter 305 cost containment legislation, state funds were allocated to accelerate implementation of Computerized Physician Order Entry (CPOE) at all community hospitals by 2010—an effort intended to reduce patient medication errors. Various private efforts, funded by nonprofit initiatives and foundations, are also underway—including efforts to introduce electronic medical records and exchange secure clinical information electronically.[28, 29]

The Special Commission envisions full use of these technologies and increased support for infrastructure and training to support ACO operations and help providers build the statewide, interoperable HIT network that a high-value system will require.

[27] CMS uses the DCG/HCC model for Medicare risk adjustment, chosen largely on the basis of transparency, ease of modification, and good clinical coherence (Pope et al. 2004). The DCG/HCC model was developed with CMS funding by researchers at RTI International and Boston University, with clinical input from physicians at Harvard Medical School.

[28] For example, the Massachusetts eHealth Collaborative recently implemented electronic health records in a diverse set of competitively selected communities, encompassing nearly 500 physicians serving over 500,000 patients (Goroll et al. 2009).

[29] MA-SHARE Push extends the efforts of the Massachusetts Health Data Consortium to develop secure and sustainable clinical data exchange. Push experiments with a new method for electronically transferring clinical documents related to patient care among organizations and individuals in the Massachusetts healthcare community. The initiative was developed and is funded by Beth Israel Deaconess Medical Center, Children's Hospital Boston, Northeast Health Systems, and Lahey Clinic to test the feasibility of reusing the NEHEN/MA SHARE technology infrastructure to simplify electronic exchange of clinical documents, improve the reliability of document delivery, and reduce associated costs. See: http://mycourses.med.harvard.edu/ec_res/nt/BEAA981F-0FFF-431A-9F77-2A51A42BA084/MA-SHARE_ Push_Pilot_Overview_2008-02-13.pdf, accessed June 2, 2009.

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