



## Special Commission on the Health Care Payment System

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May 8, 2009

11:00 a.m. – 2:00 p.m.

McCormack Building, 21<sup>st</sup> Floor

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## Agenda

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- Review Special Commission recommendations to date.
- Address remaining issues, considering:
  - The Special Commission's principles for payment reform; and
  - Feedback and recommendations from stakeholder groups.

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## Review of Recommendations

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- Movement from predominantly fee-for-service payment must occur to promote safe, timely, efficient, effective, equitable, patient-centered care and thereby reduce growth in per capita health care costs.
- Massachusetts will transition to a payment system where global payments to provider networks are the predominant form of reimbursement.
  - Global payments should be adjusted for risk and other factors and incorporate common performance measures.
  - Provider networks are “Accountable Care Organizations” (ACOs), which may include doctors, other community-based providers, and hospitals collectively capable of providing a full range of services to encourage the formation of medical homes. Relationships among providers can vary (ownership, virtual/contractual).

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## Review of Recommendations

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- Since some Massachusetts providers will face challenges moving away from fee-for-service, a careful transition must occur and offer adequate infrastructure support for providers.
- The transition will occur over a period not to exceed 5 years, though some providers may transition sooner.
  - The transition payment model, shared savings, should provide either no risk or limited downside risk for providers that are unable to assume full risk.
  - Transition will include financial incentives for more rapid movement (upside potential increases with movement toward global payment):

Fee-for-service → Shared savings → Global payment

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## How do we Transition to and Sustain a Global Payment Model?

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- o Shared Savings
- o Formation of Accountable Care Organizations (ACOs)
- o Support for ACOs
- o Oversight
- o Development of global payments
- o Transition milestones
- o Monitoring
- o Complementary strategies

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## Shared Savings Overview

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- o The principal features of a “shared savings” model include:
  - Payers and ACOs establish budget targets for the total health spending of ACO’s members.
  - Payers may continue to make payments on a fee-for-service basis.
  - At the end of the year, the actual and target spending are reconciled.
    - o If the actual spending is less than the target, and if the ACO has performed adequately on access and quality metrics, the ACO, payers, employers, and consumers share the difference (“shared savings”).

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## Formation of ACOs

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- **Provider role:** Providers will come together to form ACOs that will manage patient care, accept global payments, and allocate payments among its providers.
- **Payer role:** Health plans, MassHealth, Commonwealth Care, and Medicare (pending waiver) will contract directly or indirectly with ACOs in global payment arrangements.
- **Consumer role:** Patients will select a primary care provider of choice to ensure care coordination and support the creation of medical homes.

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## Support for ACOs

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Shared commitment and responsibility are needed among health plans, providers, government, employers, and others to support the formation of ACOs and the transition to global payments.

- 1) Technical assistance and training on 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.
- 2) Access to and analysis of claims data for an ACO's covered population to support analysis of member health, care management, predictive modeling, performance measurement and transparency, etc.
- 3) Education regarding the new payment system and its implications for patients.

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## Oversight

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- A new, independent Board will be charged with guiding implementation and monitoring of the new payment system.
  - Board members must be subject-matter experts.
- Responsibilities of the Board include:
  - Defining parameters for an Accountable Care Organization
  - Collecting and analyzing health system data
  - Establishing transition milestones and determining transition progress
  - Monitoring ongoing work
- The Board will be supported/staffed by existing state entities or agencies and make decisions in an open and transparent manner.
- The Board will seek broad stakeholder input from providers, health plans, government, employers, and consumers.

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## Development of Global Payments

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- The Board will develop parameters for a standard global payment methodology, including adjustments for:
  - Clinical risk;
  - Socio-economic status;
  - Geography, if appropriate;
  - Core access and quality incentive measures; and
  - Other adjustments, including for unique circumstances.
- The market, including both private and public entities, will determine global payment amounts consistent with the Board's methodology.
- Payers may need to utilize residual fee-for-service payments to providers in certain limited circumstances, such as
  - Out-of-ACO provider services, including care delivered to non-MA residents; and
  - A limited subset of health services that the Board may determine are inappropriate for ACO inclusion.

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## Defining an Accountable Care Organization

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- The Board will define the parameters of ACOs, such as:
  - Composition and participation (e.g. which scope of services must be available in/through ACOs, “rules” for participation)
  - Scale of ACO (e.g. market share)
  - Stop-loss and reinsurance protection (risk considerations)

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## Collecting and Analyzing Data

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- In the first year, the Board will collect and analyze data to inform policy-making and the establishment of transition milestones.
- Analysis may include:
  - Percentage of payments made under global payment arrangements;
  - Per capita health care cost trends, including medical vs. administrative cost trends;
  - Payment rate variation among providers and health plans;
  - Financial performance of ACOs, health plans, and sub-providers; and
  - Metrics on access to care, especially for underserved populations.
- The Board will also adopt core common performance measures, e.g. quality, patient satisfaction, and monitor trends.

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## Milestone: Progress to Global Payment

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- The Board will develop guidelines for shared savings and set annual targets for the market to advance to global payments.
  - Sample metric: Percent of payments made under shared savings and global payment arrangements.
- Board will continually monitor market progress to these targets.
- Board will have authority to intervene if targets are not met.
  - Interventions can be both non-financial and financial.
  - Non-financial interventions could include providing recommendations and technical assistance.
  - Financial interventions could include establishing payment rate parameters (e.g. constraining fee-for-service rates).

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## Milestone: Payment Equity

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- The Board will set targets for the market to promote greater payment equity.
  - Sample metric: Risk-adjusted global payments to ACOs
- Board will continually monitor market progress to these targets and monitor market conditions, such as:
  - Payments to providers within ACOs
  - Payments for lines of service (e.g. primary care, behavioral health, etc.)
- Board will have authority to intervene if targets are not met.
  - Interventions can be both non-financial and financial.
  - Non-financial interventions could include providing recommendations and technical assistance.
  - Financial interventions could include establishing payment rate parameters (e.g. constraining fee-for-service rates).

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## Milestone: Health Care Cost Growth

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- The Board will set targets for the market to contain health care cost growth.
  - Sample metrics:
    - Rate of per capita cost growth
    - Rate of growth in premium levels
- Board will continually monitor market progress to these targets.
- Board will have authority to intervene if targets are not met.
  - Interventions can be both non-financial and financial.
  - Non-financial interventions could include providing recommendations and technical assistance.
  - Financial interventions could include establishing payment rate parameters (e.g. constraining fee-for-service rates).

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## Monitoring

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- Board will closely monitor transition to global payment and have capacity to make mid-course corrections if needed.
  - Board will review and consider access, quality, and disparities measures.
- Board will consider implementation of infrastructure support for providers in previously discussed milestone targets.

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## Complementary Strategies

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- The following strategies have been identified as important complements to payment reform:
  - Health plan design: Coordinate and expand existing efforts to examine health plan design, promote the use of high-value care (e.g., no co-pays for chronic care management visits and medications) and discourage inappropriate care.
  - Evidence-based coverage: Coordinate and expand existing efforts to review comparative effectiveness evidence and develop consensus coverage policy based on findings.
  - Consumer engagement: Coordinate and expand existing community, employer, health plan and state efforts to activate patients and promote healthier lifestyles, and improved self-management of chronic illness.

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## Complementary Strategies

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- Administrative simplification: The important efforts underway (Chapter 305 task force, *HealthyMass* initiative, voluntary efforts involving MMS, MHA, MAHP and EACH) should continue through to fruition.
- Medical malpractice reform: Providers have cited the need to reform medical malpractice as an important goal to reduce costs in the health care system. Health care costs associated with “defensive medicine” have been cited as a concern.
- Primary care workforce development: With an increased emphasis on medical homes and primary care, efforts are needed to attract and retain primary care physicians.
- End-of-Life care: Many stakeholders have cited the need to address end-of-life care and decision-making. The efforts underway through the EOL Expert Panel should continue.

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## Difference from Prior Capitation Models

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- Careful transition period with extensive provider supports
- Robust monitoring activities to guard against unintended consequences
- Linked to performance measures with emphasis on patient-centered care
- Improved risk adjustment models
- Health information technology infrastructure support