



Massachusetts Health Care Payment System: Recommendations of the Special Commission

New York State Health Foundation Conference

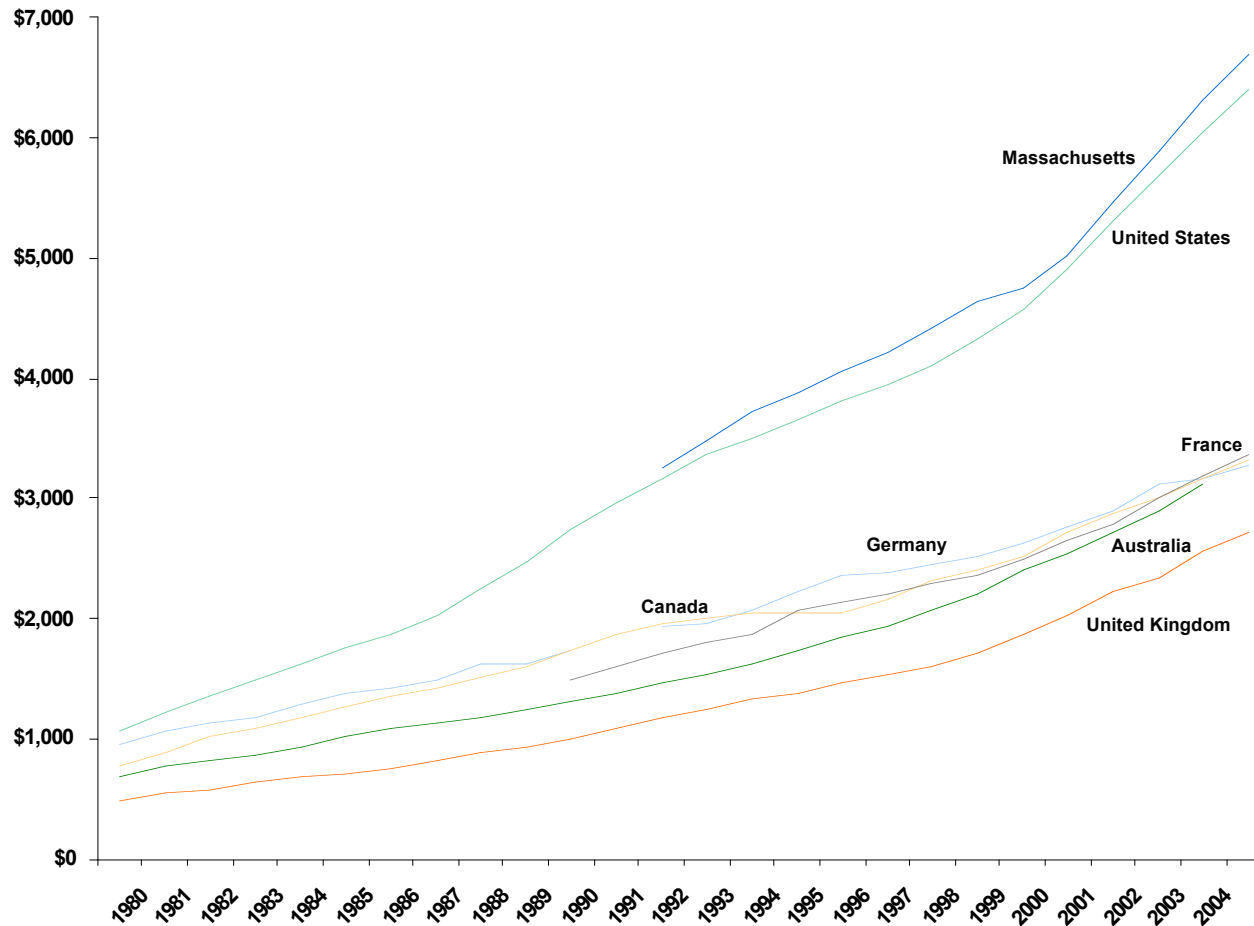
October 28, 2009

Health Care Reform: Phase 1

- On April 12, 2006, Massachusetts enacted landmark legislation (Chapter 58 of the Acts of 2006) that would provide nearly universal health care coverage to state residents
 - 406,000 newly insured
 - Only 2.7% of residents without health insurance in 2009
- With these successes, an important challenge remains...



While the U.S. has the highest health care expenditures per capita among other industrialized countries, MA has among the highest health care costs in the U.S.

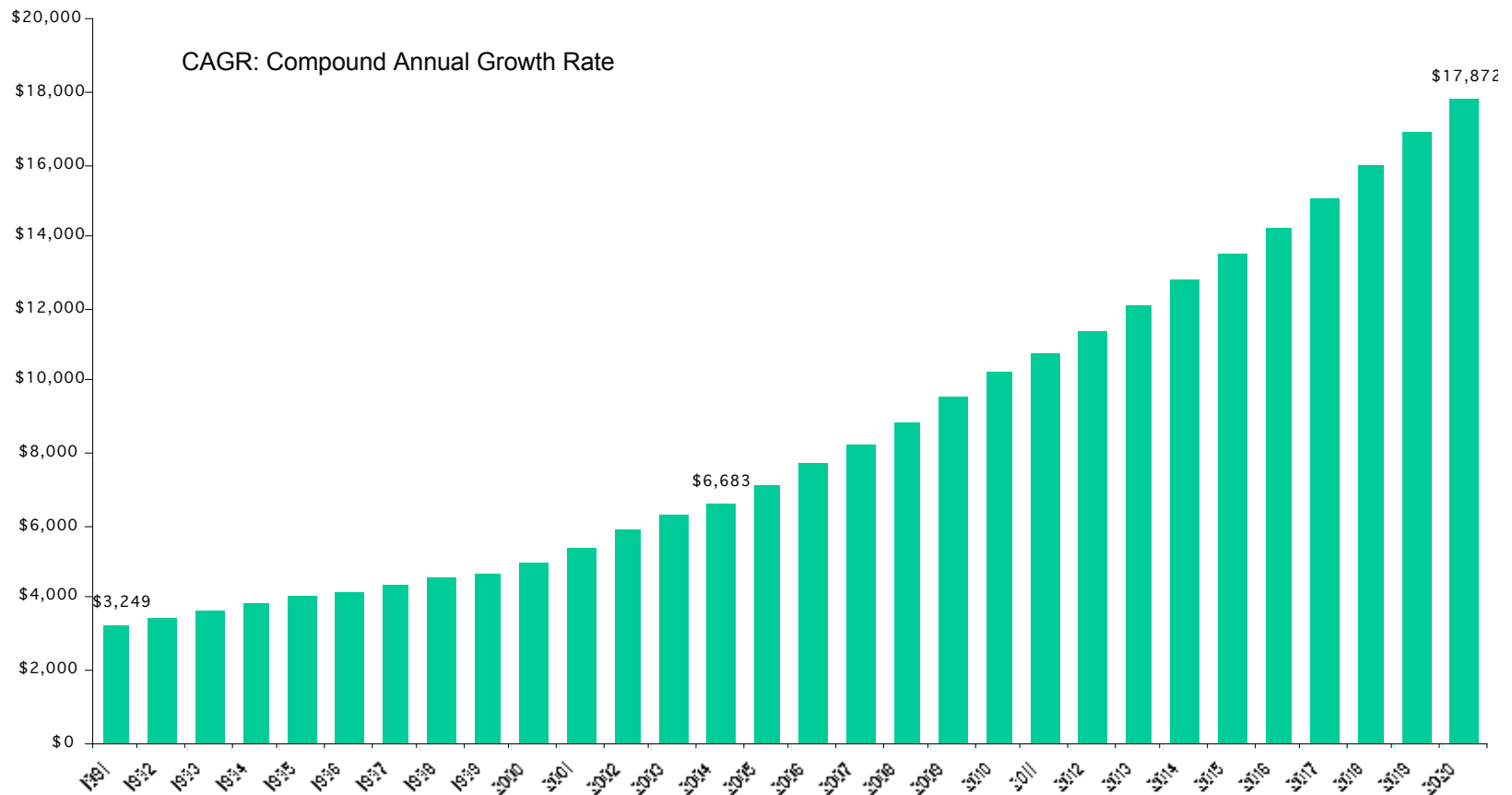


Sources: Commonwealth Fund (2008), CMS (2007), U.S. Census (2009).

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


With no intervention, per capita health care spending in Massachusetts is projected to nearly double by 2020

MA Per Capita Health Care Expenditures: 1991-2020



Note: The health expenditures are defined by residence location and as personal health expenditures by CMS, which exclude expenditures on administration, public health, and construction. Data for 2005 – 2020 are projected assuming 7.4% growth through 2010 and then 5.7% growth through 2020.

Source: Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group, 2007. Projections by the Division of Health Care Finance and Policy.



Though the quality of our health care is among the best in the U.S., even we can improve

Research on health care in Massachusetts highlights the problems of preventable illness and insufficient emphasis on primary and preventive care.

- Fewer than half of all adults over age 50 receive recommended preventive and screening care.*
- Fewer than half of adult diabetics receive recommended preventive care.*
- Nearly half of emergency department visits are potentially preventable.**
- 8 percent of hospitalizations and 7-10 percent of readmissions could have been avoidable with effective ambulatory care.**

* Cantor et al. 2007

** DHCFP, MA Health System Data Reference 2009



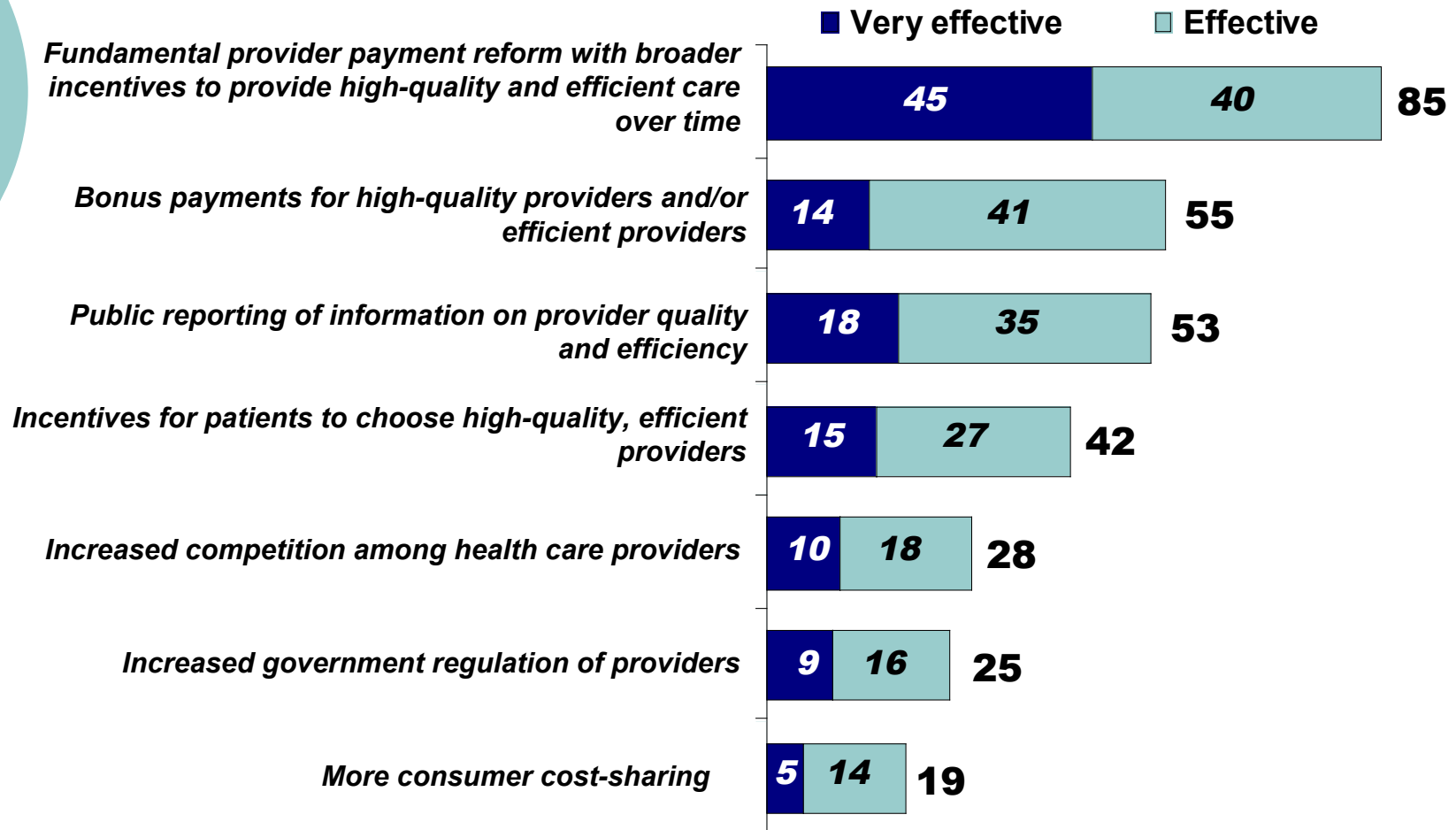
Specific potential savings opportunities in MA

| Opportunity | Estimated Costs |
|--------------------------------------|------------------------------------|
| Potentially Preventable ED Visits | \$398.5 million |
| Preventable Hospitalizations | \$582 million |
| Potentially Preventable Readmissions | \$380 - \$576 million ¹ |

Estimates of hospital costs incurred for conditions which may have been prevented or treated in a more cost effective setting. These costs represent opportunities for improved coordination of care throughout the health care system, rather than hospital-specific issues.

¹ The lower estimate assumes a 15-day window; the higher estimate assumes a 30-day window.

“How effective do you think each of the following policy strategies would be in improving U.S. health system performance (improving quality and/or reducing costs)?”





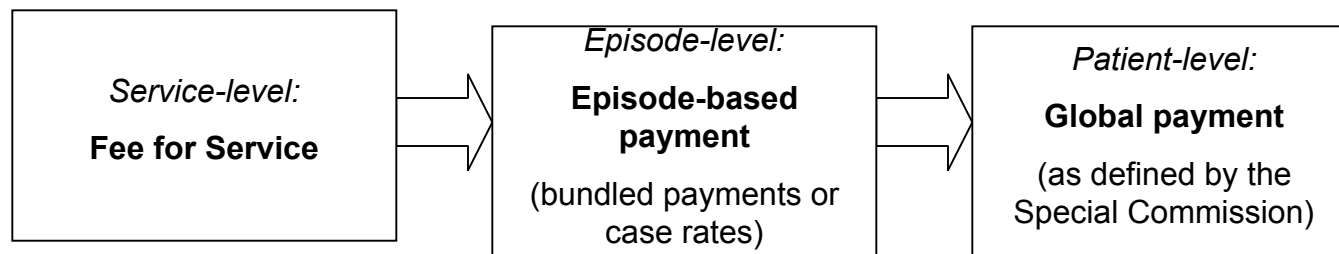
Health Care Reform: Phase 2

- Recognizing the nexus between health care payment models and the quality and cost of health care, the Legislature enacted Section 44 of Chapter 305 of the Acts of 2008, *An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care*, which created the Special Commission on the Health Care Payment System
- The Special Commission defined its vision for:
 - “fundamental reform of the Massachusetts health care payment system that will support safe, timely, efficient, effective, equitable, patient-centered care and both reduce per capita health care spending and significantly and sustainably slow future health care spending growth”

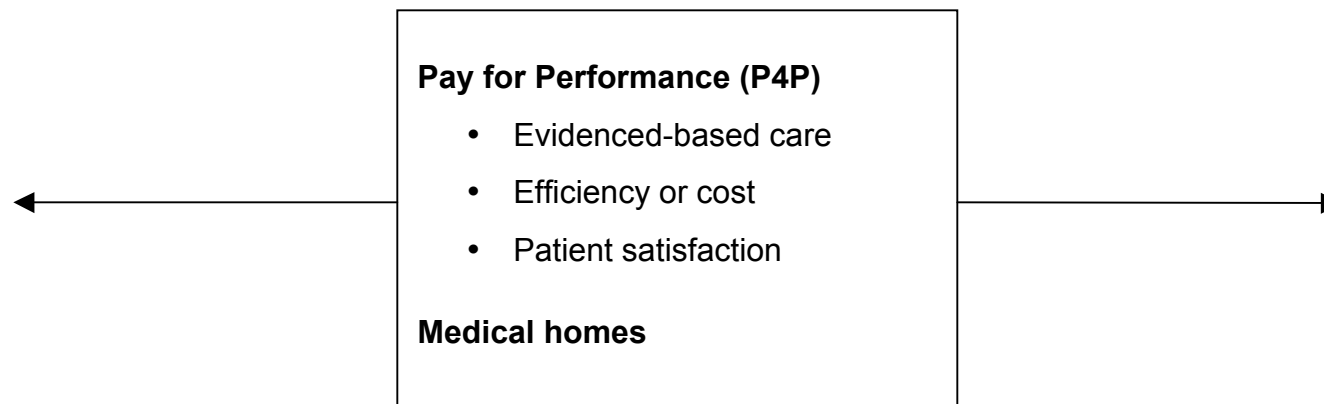


Thinking about Provider Payments

Alternative Payment Models (increasing level of service bundling):



Complementary Payment-related Strategies:





FFS payment drives health care cost growth and overuse of services

Providers are paid for each service they produce.

- **Incentives for increased volume.** Providers have a financial incentive to increase the number of services they produce.
- **Incentives to deliver more costly services.** Providers have a financial incentive to deliver services with higher financial margins — often more costly services.
- **Little or no incentive for achieving positive results or for care coordination.** Providers have no financial incentive to deliver the most effective care or to coordinate care.
- **Little or no incentive to deliver preventive services and or other services with low financial margins.** Providers have little incentive to provide services with low financial margins—including preventive care and behavioral health care.



Episode-Based Payment

Unit of payment is for full range of services that all or most providers deliver during a clinical episode for a specific procedure or condition.

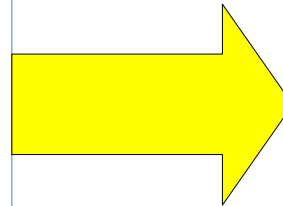
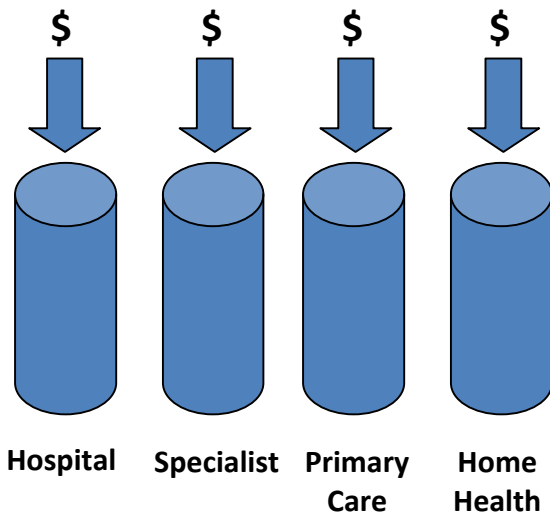
- **Provides incentives for efficient delivery of care and collaboration among providers within episodes of care.**
 - Federal policymakers currently are paying substantial attention to episode-based payments as a potential means for improving the efficiency of care provided to Medicare patients.
- **Does not fully address the volume incentive.** It would not improve incentives for providers to help patients avert the need for episodes of care.
- **Limited operational experience with model.** Only a small number of episode types have been designed to-date.

Special Commission's Recommendation

Current Fee-for-Service Payment System

The Problem

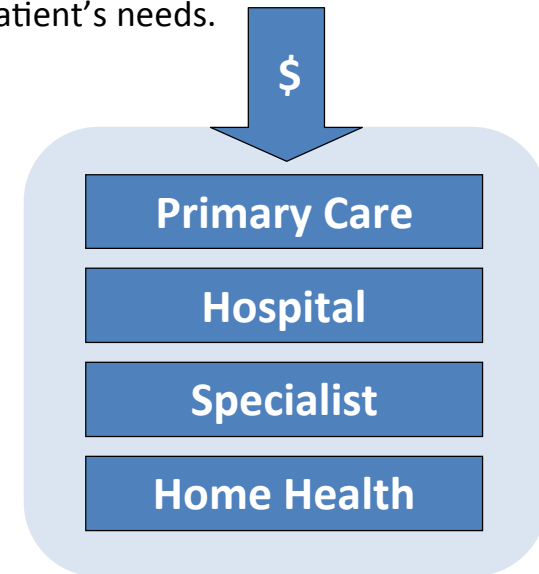
Care is fragmented instead of coordinated. Each provider is paid for doing work in isolation, and no one is responsible for coordinating care. Quality can suffer, costs rise and there is little accountability for either.



Patient-Centered Global Payment System

The Solution

Global payments made to a group of providers for all care. Providers are not rewarded for delivering *more* care, but for delivering the *right* care to meet patient's needs.



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



Key Components of Recommendations

1. Participation by all private and public payers
2. Development of integrated provider entities in various forms
3. Payment method will reward providers for performance using common measures, and promote cost and quality transparency
4. Adoption of medical homes with an emphasis on patient-centered care, primary care, and patient choice
5. Creation of an oversight entity that will:
 - Define parameters for a standard global payment methodology—but the *market* will determine global payment *amounts*
 - Establish transition milestones and monitor progress, with a focus on the progress to global payments, progress to greater payment equity, and per capita health care costs
 - Make decisions in an open and transparent manner and seek broad stakeholder input from providers, health plans, government, employers, and consumers
 - Assist, intervene, and make mid-course corrections if needed



Difference from Prior Payment Models

- 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 and consistent risk adjustment models
- Health information technology infrastructure support



Why Payment Reform, Why Now?

- The members of the Special Commission unanimously endorsed the recommendations.
 - Similar to the widespread commitment in Massachusetts that led to its expansion of health insurance coverage to virtually all residents, there is now a shared desire to promote high-quality, cost-effective care through payment reform.
- By showing leadership on payment reform, Massachusetts can improve how health care is delivered to over 6 million state residents and serve as a model for the nation.
- RAND analyzed the impact of various health care cost control strategies.
 - Five of the six most promising options involve changing payment approaches, with movement toward more bundled forms of payment producing the greatest savings.
- The Special Commission believes that a careful, thoughtful, and transparent transition to global payment is the best solution for Massachusetts.