

# Creating Accountable Care Organizations in Massachusetts

NOVEMBER 2009

*Prepared for MHA by Harold D. Miller*



**MHA** MASSACHUSETTS HOSPITAL ASSOCIATION

The leading voice for hospitals.



# Table of Contents

<b>EXECUTIVE SUMMARY</b> .....	<b>1</b>
<b>I. Introduction</b> .....	<b>4</b>
A. What Massachusetts Should Seek to Achieve in Creating ACOs .....	5
B. What Massachusetts Should Seek to Avoid in Creating ACOs .....	5
<b>II. Providing Adequate and Appropriate Payment for Services</b> .....	<b>6</b>
A. The Issues .....	6
1. The Importance of Appropriate Payment Levels .....	6
2. Problems With Current Payment Levels and Data on Spending .....	6
3. Challenges in Setting Global Payment Levels.....	7
4. Challenges in Risk Adjustment .....	8
5. Challenges in Allocating Global Payments.....	8
6. Length of Global Payment Contracts.....	9
B. What Massachusetts Needs to Do .....	9
<b>III. Aligning Payment Methods Across Payers</b> .....	<b>10</b>
A. The Issues.....	10
1. The Need for Multi-Payer Alignment.....	10
2. Challenges in Obtaining Participation by Medicare Patients .....	11
3. Challenges in Obtaining Participation by Employees of Self-Insured Employers .....	12
4. Challenges in Obtaining Participation by Individuals in National Health Insurance Plans .....	12
5. Challenges in Obtaining Participation by Individuals in All Insurance Products.....	13
B. What Massachusetts Needs to Do .....	13
<b>IV. Ensuring Appropriate and Efficient Quality Measurement</b> .....	<b>14</b>
A. The Issues.....	14
B. What Massachusetts Needs to Do .....	14
<b>V. Facilitating the Formation and Successful Operation of Accountable Care Organizations</b> .....	<b>15</b>
A. The Issues.....	15
1. Helping Willing Providers Explore the Development of an ACO .....	16
2. Helping Providers Develop the Capacity to Successfully Operate an ACO .....	16
3. Encouraging Appropriate, Affordable Choices of Services for Consumers .....	17
4. Encouraging Consumer Engagement and Accountability.....	18
5. Reducing Administrative Costs .....	18
6. Removing Regulatory Barriers .....	18
B. What Massachusetts Needs to Do .....	20
<b>VI. Addressing Key Transition Issues</b> .....	<b>21</b>
A. The Issues.....	21
1. Recruiting Sufficient Primary Care Practitioners .....	21
2. Creating Effective Healthcare Information Systems .....	22
3. Reconfiguring Hospital Capacity and Services .....	23
4. Creating Transitional Payment Systems.....	24
B. What Massachusetts Needs to Do .....	24

# Executive Summary

## GOALS

### What Massachusetts Should Seek to Achieve in Creating ACOs

- Give providers the maximum amount of flexibility to structure and deliver healthcare services to patients in the most efficient, effective way possible;
- Hold providers accountable for costs and outcomes that are within their control;
- Facilitate and encourage coordination among multiple providers and practitioners; Reward providers who keep their patients well and who deliver high quality, affordable healthcare services to patients, while reducing utilization of low-value services;
- Ensure transparency in the setting of payment rates, risk adjustment methodologies and reporting requirements.
- Reduce or eliminate unnecessary administrative costs imposed on providers; and
- Ensure that citizens in all parts of the Commonwealth have reasonable access to a full range of healthcare services and a choice of high-value providers.
- Eliminate the Medicaid underpayment gap, which threatens the sustainability of the first phase of health care reform in the state.

### What Massachusetts Should Seek to Avoid in Creating ACOs

- Paying providers less than the reasonably achievable costs of delivering necessary, high-quality services to patients based on their healthcare conditions and other needs; Encouraging unnecessary duplication of facilities and services;
- Expecting healthcare providers to reduce or deny services that patients have been promised under their health insurance benefits;
- Holding healthcare providers accountable for outcomes without adequate resources or incentives to ensure patient adherence;<sup>1</sup>
- Putting healthcare providers at risk for unpreventable variations in patient conditions and outcomes;<sup>2</sup>
- Expecting healthcare providers to perform functions currently delivered by health insurance plans without adequate resources to do so or sufficient time to develop those capabilities;

- Expecting healthcare providers to deliver services or perform functions for which an adequate workforce or effective technology is not available;
- Imposing unnecessary or excessive new administrative burdens that increase providers' operating costs without corresponding benefits in terms of the quality or costs of patient care; and
- Damaging Massachusetts's international leadership in healthcare teaching, research, and innovation.<sup>3</sup>

## STRATEGIES

### Providing Adequate and Appropriate Payment for Services

- Establish mechanisms to ensure that the amounts of global payments are adequate to cover the achievable costs of the services needed by patients whose care is to be covered by the global payments.
- Establish mechanisms to ensure fair allocations of global payments among those providers participating in an Accountable Care Organization who are not part of a single corporate structure.
- Establish mechanisms to ensure adequate and appropriate payment rates for services delivered by providers who are not part of an Accountable Care Organization, but whose services are used either because of patient choice (under a plan's benefit design) or necessity (e.g., because only one provider delivers that service).
- Establish protections to ensure that as people's health is improved and as services are reconfigured, Accountable Care Organizations appropriately, and in a transparent manner, reconfigure the distribution of global payments or shared savings to individual providers in ways that adequately cover their costs.
- Establish mechanisms to ensure that medical education, research, and other societal needs are adequately paid for in the context of Global Payments, either within such payments or through separate payments, and that the allocations of such payments to individual providers is fair and transparent. (A separate MHA briefing paper will address these societal needs in the context of a global payment system).
- Establish transparent mechanisms for ensuring that severity/ risk-adjustment systems, risk corridors, outlier payments,

reinsurance, etc. are adequately protecting ACOs from assuming insurance risk.

### Aligning Payment Methods Across Payers

- Require all regulated health plans in the state to participate in the Global Payment System and to use a consistent methodology for payment, severity/risk adjustment, pay-for-performance, etc.
- Work with Congress and the Obama Administration to obtain a legislative or regulatory waiver allowing Medicare to participate in the state's Global Payment system for ACOs.
- Work with self-insured employers to obtain voluntary agreements to participate in the Global Payment System.
- Work with all payers to develop agreement on a common transparent approach to the key elements of global payment systems.

### Ensuring Appropriate and Efficient Quality Measurement

- Establish mechanisms to ensure that quality measures used for public reporting or pay-for-performance are produced with input from physicians, hospitals, and other providers.
- Require all payers to use a transparent and consistent quality measurement system.
- Assess the costs of producing quality measures before requiring providers to collect and report them.

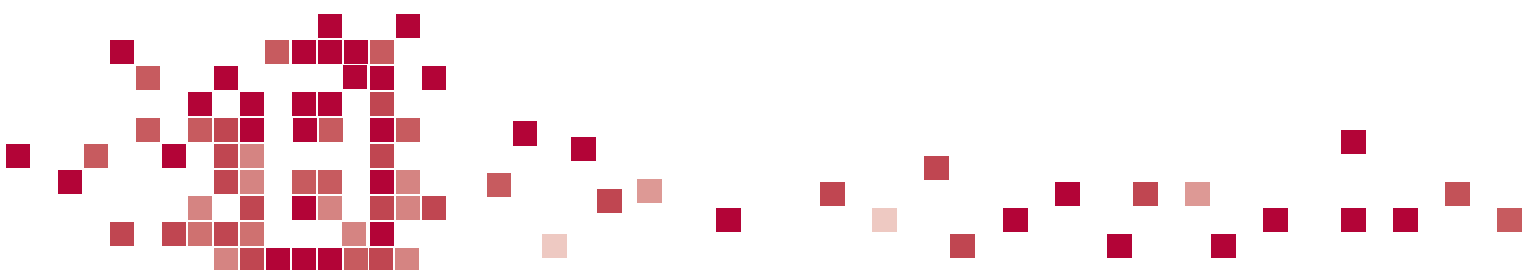
### Facilitating the Formation of Successful Accountable Care Organizations

- Facilitate discussions and agreements among providers, and between providers and payers, about the formation of Accountable Care Organizations.
- Help providers develop new capabilities and resources and enhance existing capabilities to successfully serve as Accountable Care Organizations and manage global payments.
- Encourage or require health insurance plans to use value-based benefit designs and other mechanisms to encourage consumers to select and use a consistent Accountable Care Organization, to adhere to treatment plans, and to select high-value providers and services.
- Require health insurance plans to reduce or eliminate unnecessary administrative costs.
- Review all existing state laws, regulations, and standards governing the structure and operations of healthcare providers to identify and modify any which (a) inappropriately impede the ability of providers to organize and deliver care in more coordinated, efficient ways, or (b) increase provider administration costs without corresponding benefits in terms of cost and quality.

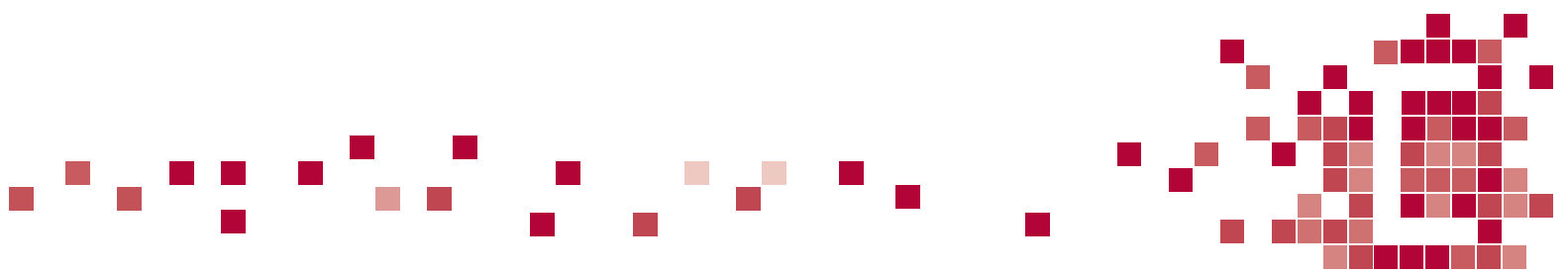
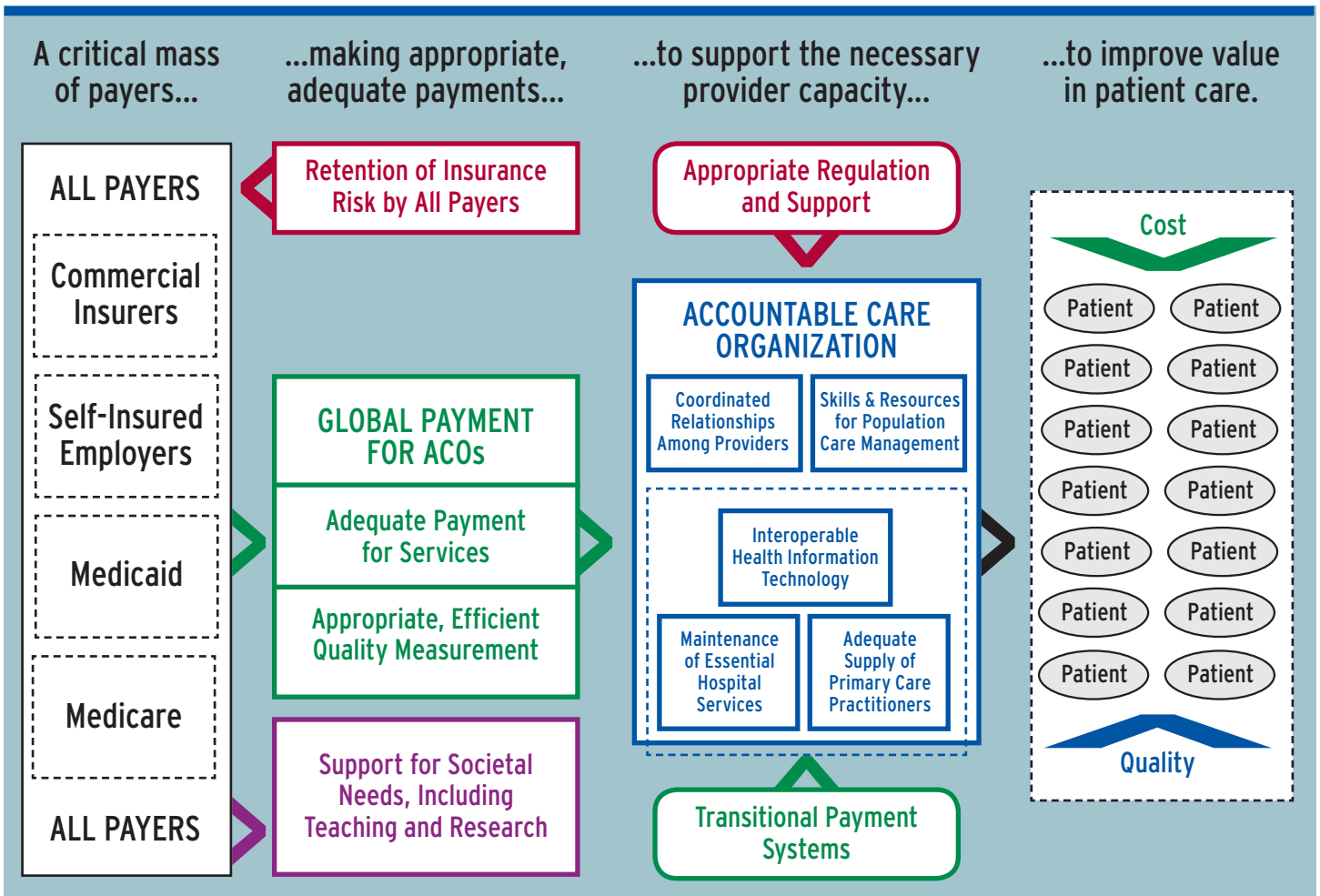
- Advocate for changes in federal laws and regulations and federally sponsored standards established by private organizations such as the Joint Commission that inappropriately impede the ability of providers to organize and deliver care in more coordinated, efficient ways, or increase administration costs without corresponding benefits in terms of cost and quality.
- Avoid establishing any new laws, regulations or standards that inappropriately limit the flexibility of Accountable Care Organizations to find innovative and efficient mechanisms for organizing and delivering services. Any new requirements or standards should only be established after adequate input from providers and clear evidence as to their necessity and cost-effectiveness.
- Review existing state laws, regulations, and standards governing insurance companies to ensure they do not unintentionally impede the formation of Accountable Care Organizations or impose unnecessary burdens on them.
- Establish regulations or other mechanisms to prevent Accountable Care Organizations from forming in ways that limit consumer access to essential services.

### Addressing Key Transition Issues

- Develop and implement a statewide strategy to recruit primary care physicians and expand primary care capacity in the state.
- Develop and implement a statewide strategy to help providers and Accountable Care Organizations develop effective information technology systems needed to coordinate patient care across multiple providers and settings and also to manage the quality and costs of care for populations of patients.
- Develop and implement a statewide strategy to help those hospitals that experience significant reductions in admissions (e.g., for ambulatory-care sensitive conditions) to restructure their capacity and services in order to remain financially viable.
- Develop and implement a statewide strategy for transitional payment systems to help providers build the capacity needed to function successfully as Accountable Care Organizations.



This graphic represents the goals and strategies for creating viable Accountable Care Organizations in Massachusetts.



# I. Introduction

As Massachusetts moves toward implementing “Global Payments” and “Accountable Care Organizations,” it is important to recognize that both new payment systems and new methods for organizing healthcare delivery are *means* to an end, not ends in themselves. The real goal is to control the level of per capita spending on healthcare in the Commonwealth while improving the health of the citizens and the quality of healthcare they receive. Massachusetts must take steps to ensure that Global Payment systems and Accountable Care Organizations (ACOs) do not reduce spending at the expense of quality, and that they improve value in ways that maintain the state’s recognized leadership in both access and innovation in healthcare.

Decisions about the design and implementation of both Global Payments and Accountable Care Organizations are inextricably interrelated. At its core, a Global Payment system is intended to accomplish three key things:

- *remove the barriers* that healthcare providers face under current fee-for-service systems in delivering efficient, coordinated care;
- *remove the disincentives* that healthcare providers face under current payment systems when they improve a patient’s health or avoid unnecessary services; and
- *reward* those healthcare providers who do the best job of efficiently and effectively achieving good health outcomes for their patients.

But even if a Global Payment system removes barriers and disincentives, and rewards high-value care, healthcare providers need to have the skills, resources, and motivation to respond and change the way they deliver care. At its core, an Accountable Care Organization should be a group of healthcare providers who:

- *share the goals* of controlling costs and improving quality for a population of patients;
- have, or are working to develop, the *skills and resources to achieve those goals*; and
- *have the ability to accept a Global Payment* and successfully use it to pay for the costs of delivering services to a population of patients.

Although most healthcare providers today likely share the goals of controlling costs and improving quality for a population of patients, most probably don’t have the resources

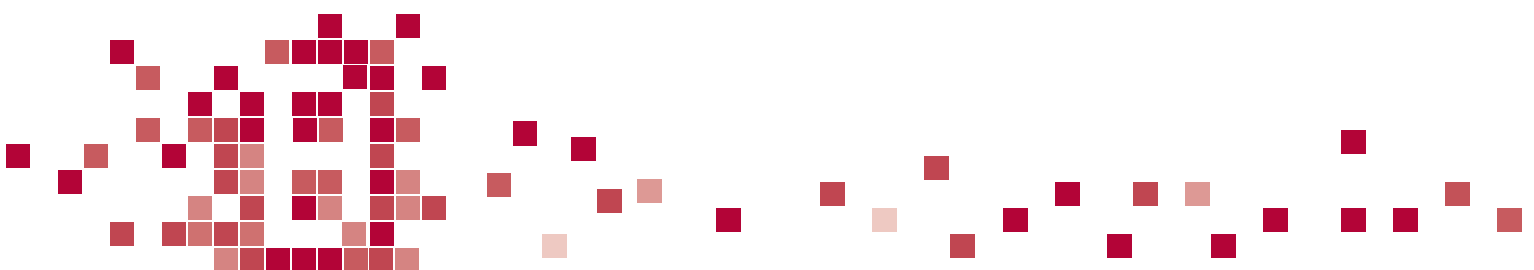
and capabilities to achieve those goals nor the ability to accept and successfully use a Global Payment to do so. The reason for this is simple: current payment systems haven’t supported or

**It is critically important that Massachusetts avoid designing or implementing payment systems that providers do not have the capacity to successfully manage, and it is vital that the Commonwealth support the ability of providers to develop that capacity so that the best possible payment systems can ultimately be implemented. This co-evolution process will take time, and if either payment reform or delivery system reform jumps too far ahead of the other, the ensuing problems could jeopardize the success of both.**

rewarded these capabilities; indeed, in many cases, current payment systems actually penalize providers who attempt to provide care in these ways.<sup>4</sup>

Consequently, payment reforms are as necessary to the creation of Accountable Care Organizations as ACOs are to the implementation of new payment systems. This means that both payment reforms and healthcare delivery changes in Massachusetts will need to *co-evolve*<sup>5</sup>. It is critically important that Massachusetts avoid designing or implementing payment systems that providers do not have the capacity to successfully manage, and it is vital that the Commonwealth support the ability of providers to develop that capacity so that the best possible payment systems can ultimately be implemented. This co-evolution process will take time, and if either payment reform or delivery system reform jumps too far ahead of the other, the ensuing problems could jeopardize the success of both.

As this co-evolution proceeds, it will need to be carefully monitored and supported to ensure that it is achieving the desired goals and avoiding undesirable and unintended consequences.



## A. What Massachusetts Should Seek to Achieve in Creating ACOs

- Give providers the maximum amount of flexibility to structure and deliver healthcare services to patients in the most efficient, effective way possible;
- Hold providers accountable for costs and outcomes that are within their control;
- Facilitate and encourage coordination among multiple providers and practitioners;
- Ensure transparency in the setting of payment rates, risk adjustment methodologies and reporting requirements.
- Reward providers who keep their patients well and who deliver the high quality, affordable healthcare services to patients, while reducing utilization of low-value services;
- Reduce or eliminate unnecessary administrative costs imposed on providers, and
- Ensure that citizens in all parts of the Commonwealth have reasonable access to a full range of healthcare services and a choice of high-value providers.

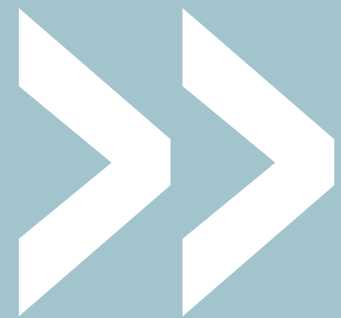
**Eliminate the Medicaid underpayment gap, which threatens the sustainability of the first phase of health care reform in the state.**

## B. What Massachusetts Should Seek to Avoid in Creating ACOs

- Paying providers less than the reasonably achievable costs of delivering necessary, high-quality services to patients based on their healthcare conditions and other needs;

- Encouraging unnecessary duplication of facilities and services;
- Expecting healthcare providers to reduce or deny services that patients have been promised under their health insurance benefits;
- Holding healthcare providers accountable for outcomes without adequate resources or incentives to ensure patient adherence;
- Putting healthcare providers at risk for unpreventable variations in patient conditions and outcomes;
- Expecting healthcare providers to perform functions currently delivered by health insurance plans without adequate resources to do so or sufficient time to develop those capabilities;
- Expecting healthcare providers to deliver services or perform functions for which an adequate workforce or effective technology is not available;
- Imposing unnecessary or excessive new administrative burdens that increase providers' operating costs without corresponding benefits in terms of the quality or costs of patient care; and
- Damaging Massachusetts's international leadership in healthcare teaching, research, and innovation.

The following sections describe in more detail a series of specific issues that must be addressed in the formation, management and payment of Accountable Care Organizations in order to achieve these positive outcomes and avoid the undesirable impacts.



# II. Providing Adequate and Appropriate Payment for Services

## A. The Issues

### 1. The Importance of Appropriate Payment Levels

Even though the Global Payment *method* has the potential for addressing many of the undesirable barriers and incentives in the current fee-for-service system, if the Global Payment *amount* is too low, the Accountable Care Organization receiving it may be forced to either under-provide care or to face bankruptcy due to costs exceeding revenues. Conversely, if the amount is set too high, the pressure to improve efficiency will be less and unnecessary services may continue to be provided.<sup>6</sup>

Moreover, the fact that a health insurance plan or other payer is making a Global Payment to an Accountable Care Organization does not automatically define the method or amount of payment to individual providers and practitioners who comprise the ACO; the ACO will need to have a method of allocating the Global Payment among them. If the amount of the allocation of the Global Payment given to an individual provider or practitioner is too low, that provider may be unable to deliver appropriate care, and if it is too high, it could lead to overutilization or overinvestment by that provider.

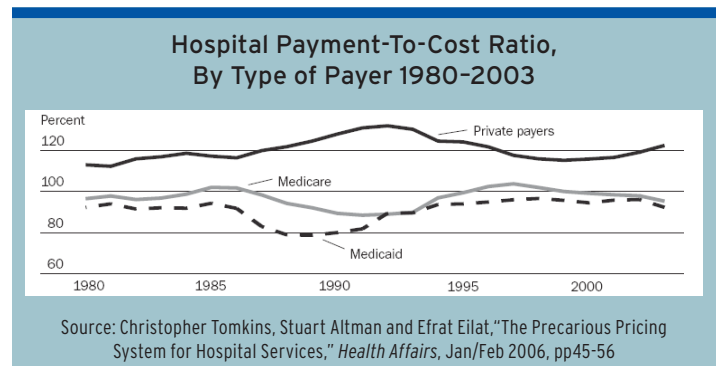
### 2. Problems With Current Payment Levels and Data on Spending

The amounts currently paid for services will not serve as a good basis for defining the amounts of Global Payments or the allocations of those payments to individual providers and practitioners for several reasons:

- **Mismatch Between Payments and Costs.** There is general agreement that the current payment levels for many individual providers and services are significantly different than the costs of those services. Despite having an extremely elaborate process for setting prices, Medicare is widely acknowledged to be overpaying for some services and underpaying for others<sup>7</sup>, and since many commercial payers base their payment levels on a percentage of the prices set by Medicare, the impacts of inappropriate Medicare pricing levels can be magnified across all payers. In addition, Medicare's Geographic Adjustment Factors (GAFs) for hospital payment and Geographic Practice Cost Indexes (GPCIs) for physician payment create further distortions in some regions<sup>8</sup>. The Massachusetts Medicaid program is also generally acknowledged to be paying well below the levels of other payers<sup>9</sup>, and likely well below the actual costs

of delivering care in many cases, but the ratio of payments to costs probably varies significantly from service to service, just as it does for other payers. Some providers have the ability to negotiate higher prices for some services, either because of the provider's size or because it is the exclusive provider of that service in a community or in the state. Finally, underpayments by some payers force other payers to overpay through cost-shifting<sup>10</sup>. All of these factors mean that prices and payments in healthcare rarely correspond to the actual costs of services.

- **Variations in Utilization Which Address Unpredictable Differences Among Patients.** There is wide variation in the utilization of individual services across providers and across regions<sup>11</sup>. Although variation in utilization is often referred to as "unwarranted," it is more accurate to describe it as "unexplained" variation, since some of the variation may be necessary and appropriate to deliver care to patients who differ in ways that are not captured by severity/risk-adjustment systems. In addition, differences in utilization rates can exacerbate the effects of the mismatches between payments and costs described earlier, since healthcare providers which deliver more of the services that produce high margins will fare better financially than those which deliver a large number of the services that are paid below the costs of delivering those services.
- **Introduction of New Technologies and Increases in Prices of Drugs and Devices.** A significant portion of the cost of hospital care is difficult to control because it is determined by the prices set by pharmaceutical companies and medical device manufacturers<sup>12</sup>. When new technologies are introduced that significantly improve patient outcomes, hospitals and other healthcare providers are expected to use them even if they increase costs.



■ **Costs of Teaching, Research, and Other Societal Needs.** Some providers charge more for services in order to cover the costs of socially desirable activities that are unrelated to the costs of caring for individual patients<sup>13</sup>. For example, academic medical centers and other teaching hospitals incur greater costs than community or non-teaching hospitals simply due to the additional personnel and time associated with teaching. Even if quality is the same, a teaching facility will be more expensive than a non-teaching facility, and if payments to teaching facilities are reduced, or if patients are encouraged to use lower-cost facilities without adjusting for this, it could jeopardize the ability of teaching hospitals to train new generations of physicians and other health care professionals. Medicare explicitly computes the portions of its hospital DRG payments that are attributable to medical education, but commercial payers generally do not. Similar issues arise with rural hospitals, disproportionate share providers, etc. that must incur higher costs for serving low patient volumes, providing greater security, caring for more uninsured and low-income patients, etc. (A separate MHA briefing paper will address these societal needs in the context of a global payment system).

### 3. Challenges in Setting Global Payment Levels

A Global Payment, by definition, is a single payment to cover all of the services that a patient receives from any provider involved in delivering those services. The problems cited above create a series of challenges in establishing the size of a Global Payment:

- A Global Payment provides the flexibility for an Accountable Care Organization to allocate funds among individual providers and services based on the actual costs of individual services, rather than being tied to current fee or payment levels. However, if the level of a Global Payment is based on current payment levels for services, those ACOs that currently deliver a high proportion of services that are overpaid today would receive a higher-than-necessary payment amount, while those ACOs that deliver primarily underpaid services might receive less than necessary to cover the costs of services. Moreover, as new technologies are introduced or as drug and device manufacturers change prices, payment levels based on historical data would increasingly diverge from actual costs.
- If a Global Payment to an ACO is based on the current levels of utilization of providers and services within that ACO, some ACOs would receive a higher Global Payment amount than others, even though their patients might not need more services. Conversely, if the same Global Payment amount were paid to all ACOs, some might receive considerably less or more than they currently feel they need to provide adequate

care to their patients, and ACOs that include teaching hospitals, research centers, etc. might no longer receive adequate revenues to support those other missions.

In addition to these challenges, most Accountable Care Organizations will need to incur additional costs in the short run to reconfigure their operations. For example ACOs will likely need to install or improve their health information systems, develop coordination agreements between primary care physicians and specialists, etc. These costs will disproportionately occur in the early years of operations of ACOs, and ACOs may not have sufficient reserves or margins to allow them to make these investments and recoup them over a long amortization period. This means that Global Payments may need to be higher in the earlier years of implementation than in later years in order to enable ACOs to cover these costs as well as in recognition of the fact that it may take time to realize savings from improved care.

**There will also likely be a strong desire by payers to estimate the expected savings from greater efficiencies, care coordination, etc. and capture those savings “up front” by reducing the amount of a Global Payment to an ACO below the sum of current payments to the ACO’s providers for the same patients, or to force slower rates of growth in spending by capping the annual increases on Global Payment levels. However, if the expected savings cannot be realized, ACOs and their member providers may be financially unable to provide quality care. In many capitation payment systems used in the 1990s, payments were arbitrarily set at levels below the average cost of care experienced prior to introduction of the capitation system, were not increased adequately over time to reflect inflation, or were even reduced from year to year as a way of increasing profits for health plans with no evidence that the lower payment amount could be justified by legitimate strategies to reduce utilization or cost, and this led to financial difficulties and bankruptcies for providers and to inappropriate reductions in care for patients.**

**There is no precise boundary between the “insurance risk” for which payers should retain responsibility and the “performance risk” for which providers should take more responsibility. Although a variety of severity/risk adjustment systems exist today to determine which patients have more severe conditions or are at greater risk of developing conditions,<sup>14</sup> most have been developed for research or quality reporting purposes, so they will likely need to be adapted for use in payment systems. In addition to adjustments for health conditions, it will also be important to consider socio-economic factors which have significant influences on costs and outcomes.<sup>15</sup>**

#### 4. Challenges in Risk Adjustment

Although a Global Payment system is intended to substitute a *single* payment for what is paid for today through multiple payments, there is no expectation that this single payment should be the *same amount* for all patients, as has been the case under many traditional capitation systems. The Special Commission on the Health Care Payment System recommended that Global Payment protect providers from insurance risk, which means that the amount of the payment would need to be higher for patients who have more diseases or conditions needing treatment and for patients who are at higher risk of developing such diseases or conditions in order to appropriately compensate health care providers for the additional treatment and preventive services they will need to deliver to those patients.

Moreover, no matter how good a severity/risk adjustment system is, it will be impossible for it to accurately identify all patients with unique needs or predict the appropriate cost of caring for them. Consequently, some system of outlier payments, risk corridors, stop-loss arrangements, and/or reinsurance will be needed to ensure that providers are not financially penalized for caring for these patients.<sup>16</sup> In other words, if the number of services needed to properly care for a group of patients significantly exceeds what reasonably can be covered by the payment amount for those patients (e.g., one or more of the patients are “outliers” compared to other patients with similar characteristics), providers should receive an additional payment in order to reduce or eliminate the financial

loss from delivering those additional services. (Obviously, providers would need to clearly document that the cases were truly outliers in terms of need or complexity.

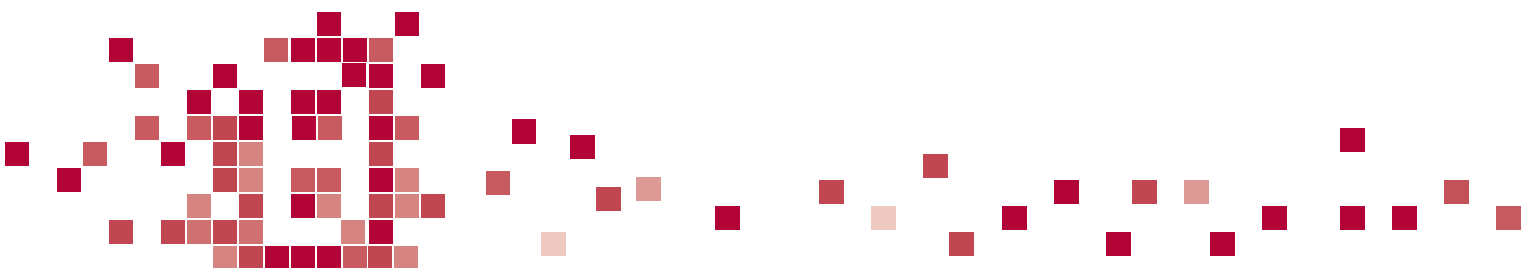
In short, the adequacy of the amount of a provider’s Global Payment will depend on the adequacy of the severity/risk-adjustment system, risk corridors, outlier payments, reinsurance, etc. that accompany the Global Payment.<sup>17</sup>

#### 5. Challenges in Allocating Global Payments

The challenges described in the previous sections also extend to the way the ACO allocates the Global Payment to individual providers. If it makes its initial allocation based on current payments for services or spending levels for each of its member providers, it will be perpetuating mispricing and rewarding overutilization just as a payer would be doing if it set the total payment for the ACO that way. If the ACO attempts to pay individual providers using bundled or partial global payment structures, there will be a need to use appropriate severity/risk-adjustment methods in doing so.

But the ACO will have the further challenge of *reallocating* payments to individual providers as the ACO successfully improves its patients’ health, reduces avoidable hospitalizations and readmissions, substitutes less intensive and higher value services for others, etc. Even if the “right” payment levels for individual services were known initially, they will likely change since the cost structures of many providers will change with higher or lower patient volumes. For example, as medical homes and care transitions programs are implemented and successfully reduce the number of chronic disease patients being admitted and readmitted to hospitals, the average costs of those hospitals will increase, particularly in the short run, since their significant fixed costs will now have to be spread over a smaller volume of patients. Although the ACO will still be able to spend less in total on hospital care than it did before these initiatives successfully reduced admissions, if it continues to pay the hospital the same amount for individual patients or services as it did before, it could push the hospital into financial distress. The ACO will need to adjust its payments to hospitals appropriately to preserve the ability of the hospital to continue offering high-quality services to the patients in its community.

An ACO may also face challenges in negotiating allocations of payments among providers with very different levels of bargaining power. A large provider, or the sole provider of a critical service, or even a provider with staff who are in short supply, may demand premium prices for its services, forcing the ACO to reduce payments to other providers which have less



negotiating leverage. This will be most likely in three situations:

- services that the ACO has to obtain from providers who are not formally part of the ACO, because the ACO does not have its own member providers who can deliver those services;
- services that the patient elects to obtain from a provider outside of the ACO, if the patient has the right to make that choice under the terms of their benefit plan but the ACO is still responsible for paying for the service from the Global Payment.

## 6. Length of Global Payment Contracts

As noted above, Accountable Care Organizations will need to incur significant startup costs. Although some of these could be recovered over a multi-year period with an appropriate amortization schedule, this would require that the ACO receive a multi-year contract to ensure an adequate, predictable revenue stream. Multi-year contracts would have the added benefit of enabling and encouraging ACOs to make appropriate investments in preventive care for patients, since they would have the potential to reap the financial benefits of lower cost care in the future. However, this also assumes an appropriate risk-adjustment structure (as discussed above) and a benefit design that enables and encourages consumers to stay with a consistent ACO over time (see Section V.A.4).

## B. What Massachusetts Needs to Do

In order for Global Payments and Accountable Care Organizations to be successful, the Commonwealth will need to establish effective mechanisms for avoiding or at least minimizing problems that arise in addressing all of these challenges. It is not realistic to expect payers, ACOs, and the providers within ACOs to work this out on their own; the work is complex and expensive, and the problems for both patients and providers that can result from errors are significant. Specifically, the Commonwealth should:

- Establish mechanisms to ensure that the amounts of global payments are adequate to cover the achievable costs of the services needed by patients whose care is to be covered by the global payments. For example, the Commonwealth could support analyses conducted in cooperation with hospitals and other providers to determine the true costs of delivering various services and to estimate the amount of savings that can reasonably be achieved through initiatives to improve the quality and coordination of care. Annual analyses could then be conducted to estimate the impact on costs of new technologies, price changes in drugs and devices, etc. In addition, the short-term costs that ACOs will need to incur to install new infrastructure (such as electronic health records, registries, etc.) and to reconfigure care processes could be

estimated and an appropriate amortization period could be defined so these costs can be factored into price-setting for Global Payments. Special attention will be needed to ensure that Global Payments under the state's Medicaid program are adequate to cover the costs of care. Analyzing the costs of delivering services will help to identify specific areas where Medicaid payments are particularly low and how much Global Payments made by the Medicaid program will need to be increased in order to compensate. In addition to increasing Medicaid payment levels to better match costs immediately, Medicaid payments could be brought into closer alignment with costs over time by maintaining or increasing Medicaid payment levels while allowing ACOs to find ways to reduce costs through delivering more efficient, effective care.

**Accountable Care Organizations should not feel compelled to duplicate services available elsewhere in the community merely to avoid paying premium prices to providers who are not part of the ACO, since this could contribute to higher overall costs. Neither should Accountable Care Organizations be expected to absorb the risk of higher costs for services delivered by other providers during emergencies or when the patient is traveling; these are really insurance risks, not performance risks.**

- Establish mechanisms to ensure fair allocations of global payments among those providers participating in an Accountable Care Organization who are not part of a single corporate structure. For example, a combination of objective data analysis and neutral facilitation by a third party could help independent providers in an ACO achieve win-win solutions.
- Establish mechanisms to ensure adequate and appropriate payment rates for services delivered by providers who are not part of an Accountable Care Organization, but whose services are used either because of patient choice (under a plan's benefit design) or necessity (e.g., because only one provider delivers that service, or because a patient receives the service while out of state or during an emergency). One approach would be to establish a "master contract" with these providers which sets payment rates for services delivered to all ACOs; another approach would be to have payers pay ACOs

beyond the Global Payment for all or part of the payments they make for these services (i.e., a form of “outlier payment”). (A separate MHA briefing paper will address these societal needs in the context of a global payment system).

- Establish protections to ensure that as people’s health is improved and as services are reconfigured, Accountable Care Organizations appropriately reconfigure the distribution of global payments or shared savings to individual providers in ways that adequately cover their costs. Again, a combination of objective data analysis and neutral facilitation by a third party could help ACOs develop win-win solutions for their member providers in these situations.
- Establish mechanisms to ensure that medical education, research, and other societal needs are adequately paid for in the context of Global Payments, either within such payments

or through separate payments, and that the allocations of such payments to individual providers is fair. (MHA will address these societal needs in the context of a global payment system in detail in a separate briefing paper to be released within the next few weeks).

- Establish mechanisms for ensuring that severity/risk-adjustment systems, risk corridors, outlier payments, reinsurance, etc. are adequately protecting ACOs from assuming insurance risk. For example, data on the differences in levels of services and costs of care among patients could be collected and compared to the differences predicted by severity/risk-adjustment systems used in Global Payment systems in order to assess the adequacy of such systems in protecting providers against unpredictable variations in cost.

### III. Aligning Payment Methods Across Payers

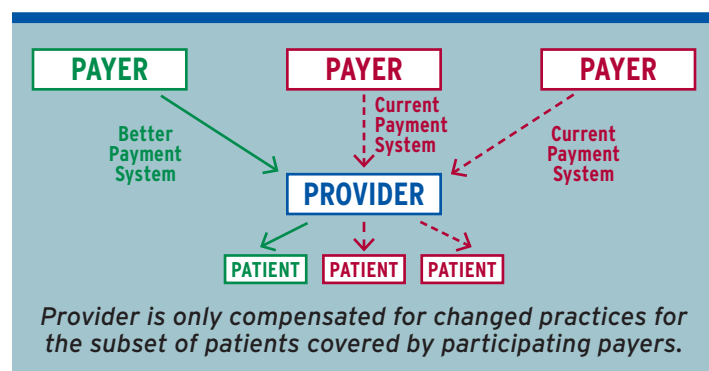
#### A. The Issues

##### 1. The Need for Multi-Payer Alignment

As noted in the Introduction, Global Payment is intended to remove the barriers and disincentives to efficient, effective care that exist in current payment systems so that Accountable Care Organizations can form, reorganize the way care is delivered, and improve both cost and quality outcomes. Ideally, Accountable Care Organizations should be “payer neutral” in the way they care for patients, but they can only do this if they do not suffer financially due to differences in the way different payers reimburse them for care.

It is particularly difficult for a provider to invest in new staff or infrastructure if only a portion of the provider’s patients are paid for under a new payment system<sup>20</sup>. For example, a key element of the medical home and chronic care models for patients with chronic diseases is to have a nonphysician care manager provide patient education and self-management support. A physician practice may have enough patients who can benefit from this type of care management to justify hiring a full-time care manager, but if only a subset of those patients are paid for under the Global Payment/Accountable Care Organization structure, the physician practice may not have enough revenues or flexibility to cover the cost of the care manager.

In addition, ACOs will have to develop and implement a variety of administrative systems to manage Global Payments, allocate them among providers and practitioners who are participating in the ACO, provide information to payers on the quality of care and the nature of patient needs in order to support quality reward and risk adjustment systems, etc. Even if two payers are each using a “Global Payment” system, if the technical details differ, it will require the Accountable Care Organization and potentially each of its participating providers to establish multiple administrative systems to accommodate those differences, which will increase the ACO’s administrative costs and burden and distract it and its member providers from what should be their primary focus, namely, restructuring and improving the way patient care is delivered.



Achieving alignment among multiple payers in the method of payment (as well as ensuring that payment amounts are appropriate, as discussed in Section II), has the potential for running afoul of federal anti-trust laws, so state oversight will be necessary to ensure that this is done appropriately. There are several examples of multi-payer payment reforms that have been developed and implemented in other states, including Minnesota<sup>21,22</sup>, Pennsylvania<sup>23</sup>, Rhode Island<sup>24</sup>, Vermont<sup>25</sup>, and Washington<sup>26</sup>. (See Sidebar to the left for more detail.)

## 2. Challenges in Obtaining Participation by Medicare Patients

Medicare represents about 1/3 of hospital revenues and about 1/5-1/6 of physician revenues in Massachusetts.<sup>27</sup> Consequently, if Global Payments are not used for patients covered by Medicare, it will create a significant gap for many providers, particularly for hospitals.

About 17% of Medicare recipients in Massachusetts participate in a Medicare Advantage plan rather than traditional fee-for-service Medicare. This is below the national average of 23%, but significantly higher than neighboring states other than Rhode Island.<sup>28</sup> Medicare Advantage plans do not have to pay providers in the same way as standard fee-for-service Medicare, so these plans could switch to a Global Payment structure if they wished.<sup>29</sup> However, state regulation of Medicare Advantage plans is pre-empted by federal regulation, so it is unlikely that Massachusetts would have any direct ability to force the plans to adopt Global Payment methods. Moreover, proposed cuts in payment levels to Medicare Advantage plans may result in reductions in the number of seniors participating in such plans.

As noted in the recommendations of the Special Commission on the Health Care Payment System, a Medicare waiver would be needed to change the way that providers are paid under the more common Medicare fee-for-service program. Although Medicare has a large number of demonstration programs ongoing, and most involve “waivers” of payment methods, the projects are defined by Medicare, not by states, and they are temporary projects, not permanent changes in payment methods. The only case today where a state has a “permanent” waiver of Medicare payment rules is Maryland, which has an all-payer rate setting commission that sets payment rates for Medicare that differ from those used in other states.<sup>30</sup> Massachusetts would need this type of permanent waiver, not a temporary demonstration program, to achieve the goals of Global Payment. There are provisions in the healthcare reform legislation currently being debated in Congress, particularly in

**Achieving a truly “all-payer” Global Payment system in Massachusetts would require participation by a wide range of different types of payers - Medicare, self-insured employers and Taft-Hartley plans, national health insurance plans, local health insurance plans, and Medicaid. Several of these are governed by federal laws, not state laws. Gaining participation of all of these diverse payers will present significant challenges that the Commonwealth will need to address.**

## Examples of Multi-Payer Payment Reform Initiatives in Other States

- The Institute for Clinical Systems Improvement in Minnesota developed a new payment method to support improved primary care for patients who have depression; it was adopted by all of the health plans in the state.
- In 2008, the state of Minnesota passed legislation permitting healthcare providers to establish prices for seven “baskets of care” (including diabetes, low back pain, obstetric care, and knee replacement) and requiring all commercial insurers using those services to pay the same prices.
- The Pennsylvania Governor’s Office organized and is currently implementing a demonstration program to implement the Chronic Care Model in dozens of physician practices across the state, with support of a common payment method by all of the commercial payers and Medicaid.
- The Rhode Island Chronic Care Sustainability Initiative is implementing the Patient-Centered Medical Home in 5 practice sites, with common payment support from both commercial payers and Medicaid.
- The Vermont Blueprint for Health is implementing a multi-payer initiative to support Community Care Teams to help primary care practices better manage patient care.
- In 2009, the State of Washington passed legislation to support the development of a multi-payer pilot project to support primary care medical homes.

the bill adopted by the Senate Finance Committee, that would facilitate the ability of states to get temporary or permanent waivers under Medicare.

A Medicare waiver should not only change the *method* for paying providers for caring for Medicare beneficiaries, but also ensure that the payment *amounts* are appropriate. In addition to adjusting Medicare payment levels to address the problems described in Section II, it will be important to ensure that the existing Medicare formula adjustments that help Massachusetts providers are maintained.

In addition to a Medicare waiver to change the structure and amount of payments to providers, Congress and CMS would also need to approve changes designed to encourage Medicare recipients to choose and consistently use an Accountable Care Organization. For example, in Medicare's Physician Group Practice Demonstration, which has been seen by many as a model for a Medicare Accountable Care Organization approach, not only are patients not encouraged or incented to use the participating physician groups as their medical home, the participating physicians do not even know which patients they are being held accountable for until up to 2 years after services are delivered.<sup>31</sup> Although there is no downside financial risk to the providers in that demonstration program, it would be difficult or impossible for providers to manage a true Global Payment, with both upside and downside risk, under this structure. Moreover, changes in Medicare cost-sharing requirements would be needed to enable and encourage Medicare beneficiaries to adhere to treatment plans if providers are to be held accountable for outcomes (see Section V.A.4. for more detail).

### 3. Challenges in Obtaining Participation by Employees of Self-Insured Employers

About 50% of the commercially insured patients in Massachusetts today are covered under self-insured plans (either individual self-insured employers or multi-employer Taft-Hartley plans).<sup>32</sup> The Federal Employee Retirement and Income Security Act (ERISA) pre-empts state regulation of these self-insured plans, which would preclude Massachusetts from requiring the plans to use Global Payments. Although one state (Hawaii) has a longstanding Congressional exemption that enables it to operate a state health care program, this was granted for unique reasons and private employers would likely mount significant opposition to any effort to override the state pre-emption under ERISA for Massachusetts.<sup>33</sup>

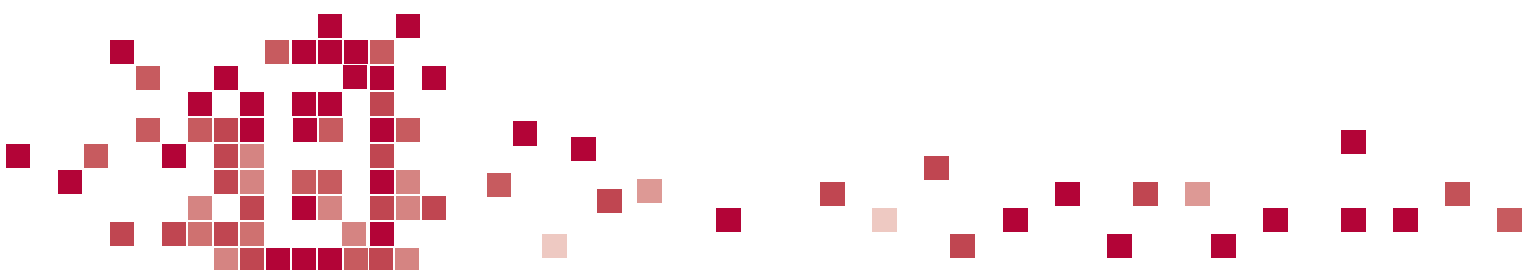
Even though self-insured employers could not be *required* to participate in a Global Payment structure, they could be *encouraged* to do so. The premise of Global Payments and Accountable Care Organizations is that they will reduce the costs of health care and control the growth in costs while improving employees' health and the quality of healthcare they receive, and this should be a particularly attractive proposition to self-insured employers. Participation would likely be easiest for employers whose employees are exclusively or primarily located in Massachusetts, since they would not have to manage two different payment systems in different states. Indeed, many of the largest employers in Massachusetts are healthcare providers, many of which are self-insured, so the creation of a voluntary effort by self-insured employers could begin with healthcare providers.

It should be noted, however, that many self-insured employers have established their own methods of managing and controlling costs, including direct delivery of care through on-site clinics. Consequently, some adjustments in payment levels and/or the structure of Accountable Care Organizations may be needed in order to capitalize on what these employers have put in place.

### 4. Challenges in Obtaining Participation by Individuals in National Health Insurance Plans

Although there would be no federal prohibition on the state's ability to require commercial health insurance plans to participate in a Global Payment system, national plans will likely be more resistant to changing their payment methods than local plans for the same reasons that national self-insured employers would, i.e., the costs associated with maintaining different payment systems for different states.

Fortunately, over <sup>2</sup>/<sub>3</sub> of commercially insured patients in Massachusetts are in three locally-based plans – Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan.<sup>34</sup> From an Accountable Care Organization's perspective, it will be better to have one large payer change its payment system than to have several very small payers do so if it means that more patients will be included. Also, if getting all payers to participate requires compromising excessively on the changes in the payment system, it may be better to move forward on a better payment system with fewer payers rather than to have more payers but fail to implement a truly flexible Global Payment structure.



## 5. Challenges in Obtaining Participation by Individuals in All Insurance Products

In addition to having as many payer *organizations* as possible participate in a Global Payment system, it will also be important to ensure that each payer participates through all of their separate insurance *products*. For example, the Alternative Quality Contract developed by Blue Cross Blue Shield of Massachusetts, which is a form of Global Payment, is currently only being used for patients in the health plan's HMO product, not its PPO plans. If specific types of insurance products do not participate in the Global Payment system, it will further erode the critical mass of patient participation that Accountable Care Organizations will need to succeed.

### B. What Massachusetts Needs to Do

To the maximum extent possible, all payers in Massachusetts need to adopt Global Payments with consistent technical methodologies in order to enable providers to make the changes in their operations needed to serve as Accountable Care Organizations. To help achieve this, the Commonwealth should:

- **Require all regulated health plans in the state to participate in the Global Payment System** through all of their insurance products and to use a consistent and transparent methodology for payment, severity/risk adjustment, pay-for-performance, etc.
- **Work with Congress and the Obama Administration to obtain a legislative or regulatory waiver allowing Medicare to participate in the state's Global Payment system for ACOs.** Ideally, the waiver would also include changes that encourage Medicare beneficiaries to choose and use a consistent medical home provider within an Accountable Care Organization, to adhere to treatment regimens, and to select high-value providers and services. It is important that Congress or the Center for Medicare and Medicaid Services (CMS) provide a long-term waiver, not a short-term demonstration program. In order to create a successful ACO, healthcare providers will have to make dramatic changes in the way they organize and deliver care, which will in turn require considerable investments of both time and money. Commercial payers will have to make dramatic changes in their payment systems and benefit designs, which will require major investments of both time and money. Neither payers nor providers are likely to be willing to make these kinds of investments for a short-term demonstration project with no assurance that it will continue.<sup>35</sup> "Pilot projects," which is the term Medicare uses for test projects that are specifically authorized to continue if they are successful, will probably be more attractive to

providers than demonstration projects. But the lack of a clear up-front commitment to continue the project for the long-term may discourage participation by other payers and discourage participation by all but the providers who are already well down the path toward implementation, thereby delaying cost and quality improvements. It will also be important to ensure that the terms of the waiver do not require reductions in Medicare spending levels in the state. Although it may be possible to achieve savings for Medicare after Accountable Care Organizations have been operating long enough to change the way care is delivered, the experience of the Physician Group Practice Demonstration program indicates that this will likely take several years at a minimum. If Congress or CMS attempts to capture savings immediately by reducing payment levels, it could jeopardize the ability of ACOs to be successful.

- **Work with self-insured employers to obtain voluntary agreements to participate in the Global Payment System.** This could begin with healthcare providers and other self-insured employers whose operations are exclusively or primarily located in Massachusetts, and then expand to multi-state and national employers. The goal should be to obtain as many patients as possible, not necessarily as many employers as possible.
- **Work with all payers to develop agreement on a common approach to the key elements of global payment systems,** e.g., severity adjustment methodologies, risk limits, quality rewards, etc. in order to minimize the need for ACOs and their member providers to establish multiple administrative systems for billing and reporting. In addition, efforts should be made to avoid inappropriate differences in the amounts of payment across different payers that are unrelated to volume, in order to avoid cost-shifting between payers.

# IV. Ensuring Appropriate and Efficient Quality Measurement

## A. The Issues

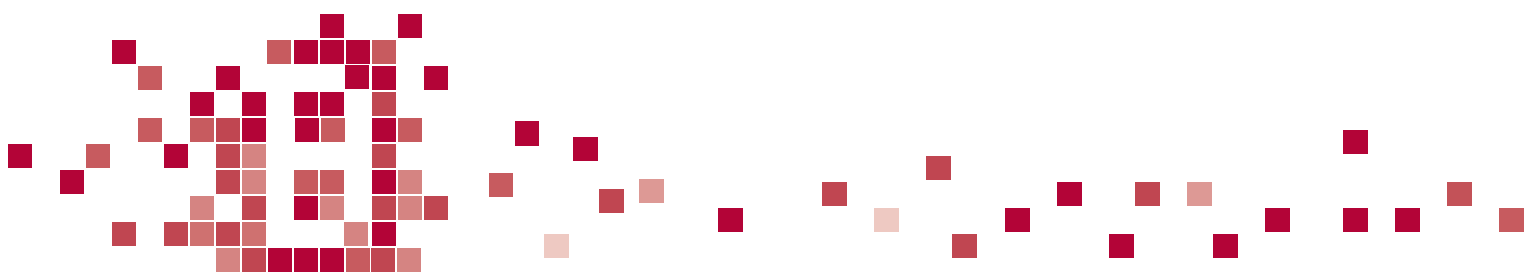
The previous section describes the importance of having a common approach across payers to the detailed methodology for making Global Payments. One element of the methodology that deserves particular attention is the methodology used for quality measurement.

A common concern about Global Payment systems is that they may encourage providers to skimp on care, particularly preventive services with longer-term outcomes, or to refuse to care for patients who appear likely to have poor outcomes (within a severity-adjusted payment category). It should be noted, however, that even fee-for-service payment is not immune to this problem, as evidenced by the widespread concerns about quality of care and the proliferation of pay-for-performance programs. Global Payments can help address the problems in fee-for-service payment by creating greater disincentives for providers to skimp on some kinds of care than exist today, since a provider which fails to provide high-quality services will be responsible for addressing some of the undesirable outcomes that result. Moreover, the incentive to skimp on services relates as much to the adequacy of the payment amount as to the structure of the payment system *per se*, which is why it is critical to ensure that Global Payment levels are adequate, as discussed in Section II.

Nonetheless, it is clearly appropriate and desirable to measure the quality of care provided by Accountable Care Organizations, and the Special Commission on the Health Care Payment System recommended that there be pay-for-performance incentives for ACOs 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.”<sup>36</sup> However, special attention is needed to ensure this is done efficiently and appropriately, for several reasons:

- Since there is no single measure of the “quality of care” for a group of patients or even for an individual episode of care, individual payers tend to use different quality measures. Even if all of the measures are technically valid, it is more difficult and expensive for an Accountable Care Organization to track and analyze multiple measures. Although the Special Commission on the Health Care Payment System said that it “anticipates that core P4P metrics will be uniform across payers,”<sup>37</sup> this does not preclude wide variation in additional measures used by individual payers.

- The ability to accurately measure a provider’s quality depends on having enough patients to create a statistically valid measure.<sup>38</sup> This problem is exacerbated when different measures are used by different payers, since it inherently reduces the number of patients for which any individual measure is calculated (particularly if individual payers only want to know about the quality of care for their own patients). Small ACOs could be unintentionally penalized if quality measures are reported for them without appropriate recognition of the potential for higher variation with smaller numbers of patients.
- Errors and incomplete records in data systems, particularly during the early stages of reporting processes, can inappropriately suggest problems in the quality of care a provider is delivering. (For example, it is no longer feasible to accurately determine whether patients have received an influenza vaccination because so many people obtain them through means other than their primary care physician.) Addressing this requires giving providers an opportunity to review and make corrections to measures before they are published or used as a basis for P4P systems.
- An overemphasis on process measures rather than outcome measures can unintentionally inhibit providers from innovating in the delivery of care. Even if a different process would improve outcomes, the provider could be penalized for failing to use the process that is measured in a quality measurement or P4P system.<sup>39</sup>
- Quality measurement systems can unintentionally create incentives for providers to avoid certain types of patients who are more difficult to care for and may have a higher probability of poor outcomes. Although severity/risk adjustment systems are intended to address this problem by controlling for differences in the types of patients that providers care for, these systems may not control for all relevant factors.
- Most current quality measurement systems rely on fee-for-service billings as a way of monitoring whether services are provided. Although a Global Payment system offers the potential for simplifying billing structures, the need to monitor quality (and to adjust payments for differences in patient severity) may force continuation of at least some aspects of current procedure-based billing systems in order to provide the data needed for quality monitoring. As electronic health records become more widely used, it should be possible



to obtain an even richer array of quality data than are available through billing records and enable discontinuation of complex billing systems.

- It will be important to not only have measures of the quality of individual providers, but also of the success of the overall delivery and payment system model, so that the best approaches to payment and delivery system structure can be identified.

The most successful systems for quality measurement and reporting across the country are those that are developed and managed with the active involvement of the providers themselves. For example, Massachusetts Health Quality Partners is a nationally-recognized leader in developing and reporting measures of the quality of physician services; it has extensive processes for ensuring the accuracy and appropriateness of the measures it reports using input from the physicians being measured.<sup>40</sup>

A separate issue that will need to be addressed when quality measurements are used in P4P systems is what levels of performance on quality measures should be used to determine whether and how ACOs and their member providers are rewarded or penalized. For example, a threshold of performance could be based on an absolute standard of performance (e.g., that 100% of patients should receive a certain test), or based on a provider's performance relative to other providers (e.g., that the percentage of patients receiving the test should be in the top quartile among providers

nationally), or based on the provider's improvement over time (e.g., that the percentage of patients receiving the test should have improved compared to the percentage for the same provider in the previous reporting period).<sup>41</sup>

## B. What Massachusetts Needs to Do

Careful planning and coordination is needed to ensure that quality measurements, and rewards based on those quality measurements, are developed and implemented in the most appropriate and efficient way possible. To accomplish this, the Commonwealth should:

- **Establish mechanisms to ensure that quality measures used for public reporting or pay-for-performance are produced with input from physicians, hospitals, and other providers** to ensure that they appropriately capture what each provider can and should be accountable for. These efforts should utilize existing expertise and systems such as those developed by Massachusetts Health Quality Partners.
- **Require all payers to use a consistent quality measurement system** so that hospitals and other providers are not forced to collect and submit data in multiple ways.
- **Assess the costs of producing quality measures before requiring providers to collect and report them**, particularly those measures dependent on data from current claims and billing systems which might otherwise be simplified or eliminated.

# V. Facilitating the Formation and Successful Operation of Accountable Care Organizations

## A. The Issues

Despite growing interest nationally in the concept of Accountable Care Organizations, there is little agreement on which types of providers could play this role or the organizational structure under which they should operate. This is not surprising, since there is very little evidence to prove that any particular type of provider or organizational structure cannot successfully manage total costs and quality for a defined population. Indeed, as noted in the introduction, the core of the concept of an Accountable Care Organization is not a structure, or even a process, but an outcome – reducing or controlling the costs of health care for a population of individuals while maintaining, or preferably improving, the quality of that care.

Ideally, designation as an Accountable Care Organization should ultimately be based solely or primarily on whether the provider organization actually achieves better cost and quality outcomes, not on the structure of the organization or even the processes it uses to improve outcomes.<sup>42</sup>

The Special Commission on the Health Care Payment System acknowledged that “a broad array of ACO models might emerge,” and it encouraged “the development of a large number of ACOs.” It wisely suggested that “ACOs might have various organizational forms – for example, physician-hospital organizations, consolidated medical groups, independent practice associations, or integrated delivery systems.”<sup>43</sup>

**It will be more likely that independent providers will join together in forming ACOs if there are mechanisms for facilitating discussions among them in ways that (a) are viewed as neutral by all participants, (b) serve as safe harbors against anti-trust violations, and (c) have access to accurate information on the opportunities and challenges associated with the ACO role.**

Achieving an appropriate number and diversity of ACOs, and ensuring that they can successfully deliver high-quality, efficient care will require both support and oversight from the Commonwealth. In many cases, independent providers could work together effectively as an ACO, but they will need support and encouragement to create the necessary organizational structure and processes to function in this new way. In other cases, however, providers might form or operate ACOs in ways that are deleterious to the overall goals of improving quality and controlling costs, and protections will be needed to prevent this.

### 1. Helping Willing Providers Explore the Development of an ACO

As noted in the Introduction, one of the keys to success for an Accountable Care Organization is having a commitment to improving quality and costs, and so the foundation for a successful ACO will be one or more providers who have that commitment and are willing to work together to achieve success. However, due in part to the problems created by current payment systems, independent providers are neither encouraged nor rewarded for working together to coordinate patient care, so even exploring the concept of an ACO will likely require discussions among providers who have not had a strong history of collaboration. Indeed, in some cases, the interests of these providers may have been at odds with each other in the past due to the nature of the incentives in current payment systems, and so it will be particularly challenging for them to begin discussions intended to form cooperative relationships.<sup>44</sup>

The challenges for independent providers in exploring the formation of an ACO are exacerbated by several factors:

- There need to be enough physicians involved in an ACO to generate statistically meaningful measures of the cost and

quality of care. Analyses by Elliott Fisher and colleagues at the Dartmouth Center for Health Policy Research have been used to recommend that if ACOs are to be supported through Medicare, they would need to serve a minimum of 5,000 Medicare patients in order for Medicare to measure their performance on cost with sufficient accuracy to support a payment system based on shared savings.<sup>45</sup> Since a typical primary care physician cares for 1,500–2,000 patients and usually fewer than half are Medicare patients, this implies that at least 10 primary care physicians would need to be in an Accountable Care Organization in order to meet this standard.<sup>46</sup> However, even a practice with 10 primary care physicians would be larger than 90% of the physician groups in Massachusetts today.<sup>47</sup> Consequently, multiple physician groups will need to participate in an ACO in order for it to successfully manage Global Payments. (A separate MHA briefing paper on Risk will address in detail some of the factors, including patient panel size, that could affect the ability of an ACO to manage global payments.)

- Legislative and regulatory prohibitions on collusion and gain-sharing by independent providers creates understandable fears that discussions about collaboration among providers will risk violating the law.
- Lack of detailed information about how Global Payments will ultimately be structured, about the nature of any obligations or restrictions that will be placed on ACOs, etc. will make it difficult for providers to understand and evaluate the advantages and disadvantages of forming an ACO.
- Most providers do not have access to comprehensive data on the nature of current services received by patients, current payment levels for those services, etc. This will make it difficult for them to assess the potential financial opportunities and risks associated with a Global Payment structure.

### 2. Helping Providers Develop the Capacity to Successfully Operate an ACO

Even if a group of providers is willing to work together as part of an ACO, that does not automatically translate into having the skills or resources needed for success. Since current payment systems primarily reward volume, not quality or efficiency, it's likely that skills in designing and managing care processes to improve quality and control costs for a population of patients will be in short supply until the incentives change. Moreover, without concurrent changes in payment structures, even providers with the right kinds of skills may not have the time or resources to reinvent all of the administrative systems and

processes of care that were designed to achieve different goals.

Although the most committed and entrepreneurial providers may overcome these barriers, more Accountable Care Organizations will be created more quickly, and they will be more likely to be successful, if external support is provided. Key elements of this support include:<sup>48</sup>

- **Coaching:** Providers may need training and technical assistance from experts to help them reinvent their operations to achieve higher quality and lower cost.
- **Information:** In order to define outcome targets and strategies for reaching them, providers need information about the *current* costs and outcomes associated with their patients. Because only payers generally have this type of information, and because the information about any particular provider's patients is fragmented across multiple payers, it is difficult for any provider or group of providers to know how they are doing today and where improvements may be possible without receiving more and better data from payers.
- **Shared Services:** Many small providers such as primary care practices may not be large enough to provide certain key services individually, but they could do so collectively. Providers would benefit from understanding different models for how these shared services might be delivered (e.g., a hospital or a home care agency in the ACO might provide an organizational home for nurse care managers who work for multiple primary care practices, or a community agency might offer the services for use by all ACOs) and they would benefit from receiving assistance in structuring or accessing such shared services.
- **Financial Modeling:** In addition to the need for data on their patients to better manage their care, many providers considering forming an ACO would need assistance in doing the financial modeling necessary to understand what a reasonable payment level might be and what they would need to do to be successful.
- **Seed Capital:** Many providers operating on tight financial margins will not have the resources needed to develop new legal agreements, retrain staff, purchase new equipment and software, etc. in order to design and implement the organizational structures and care processes needed to succeed as ACOs. Grants and loans will likely be needed to overcome these transitional costs.

### 3. Encouraging Appropriate, Affordable Choices of Services for Consumers

Many of the discussions about Accountable Care Organizations

nationally have implied that only certain types of organizational structures are desirable or feasible. For example, many have suggested that only large, integrated delivery systems can serve as ACOs. The problem with creating overly narrow definitions of the organizational structures eligible to serve as ACOs is that even if they are intended to foster coordination of care for patients and enhance efficiency of service delivery, they could also unintentionally serve to limit the choices of consumers and preclude some willing providers from participating.

For example, if the sole provider of a particular service in a community limits that service to consumers in a single ACO, it

**The designs of insurance benefit plans can have a major impact on consumers' ability to use cost-effective services and adhere to treatment plans. In particular, cost-sharing requirements for physician visits, purchase of medications, and use of preventive services can deter or prevent patients from seeking care early or taking necessary medications, and can potentially result in high costs of remedial care that more than offset any revenues generated through the cost-sharing contributions.<sup>50</sup>**

could preclude other providers from forming a separate ACO, since the second ACO would not be able to ensure consumers that they could receive the service if they need it, which in turn would limit competition and consumer choice. Even if the provider does not refuse to serve consumers from the second ACO, if it charges very high prices for doing so or increases its prices by prohibitive amounts, it could jeopardize the ability of the second ACO to successfully manage under a Global Payment System.

As noted earlier, the Special Commission on the Health Care Payment System wisely recommended that there should be a broad range of ACO structures and a large number of ACOs. To ensure that this occurs, mechanisms will be needed to ensure ACOs do not form in ways that limit consumer access to essential services or that preclude providers which offer quality services at competitive prices from forming or participating in an Accountable Care Organization.

At the same time, it will be important to ensure that efforts to create multiple ACOs do not inadvertently lead to undesirable outcomes, such as:

- unnecessary duplication of facilities and services, as multiple ACOs seek to develop their “own” services rather than contracting with providers which already offer them; and
- “cherry-picking” of higher margin services away from hospitals, leaving hospitals unable to generate the revenues needed to cover essential community services.

Preventing these problems will likely require proactive efforts to foster collaboration among providers and facilitation of shared-services agreements, as well as adjusting payment levels to better match the costs of services as described in Section II.

#### 4. Encouraging Consumer Engagement and Accountability

Even with appropriate severity/risk-adjustment for different patient conditions, the accountability of Accountable Care Organizations for cost and quality can only go so far, since

**Decisions about benefit structures will need to be made in coordination with Accountable Care Organizations, not independently by health plans.**

many outcomes depend as much on what consumers do (e.g., adherence to medication regimens, use of a consistent medical home, avoidance of unnecessary services) as what providers do. Clear definitions of the roles and responsibilities of consumers in management of their health will be needed, defined in ways that consumers believe is feasible and appropriate for them to carry out, and ideally, there should be measures of the extent to which consumers are carrying out those roles and responsibilities, to help determine the extent to which lack of progress on overall outcomes is attributable to consumers or providers.<sup>49</sup>

At the other end of the spectrum, Accountable Care Organizations cannot be expected to reduce the use of high-cost, unnecessary services if consumers feel they are entitled to those services under their insurance benefit plans. Although research has shown that more care and higher costs do *not* result in better patient outcomes, it's likely that most consumers still

believe that they *do*. Moreover, it is likely that consumers will need greater sensitivity to differences in the costs/prices of care in order for Accountable Care Organizations to encourage use of the highest-value providers and services.<sup>51</sup>

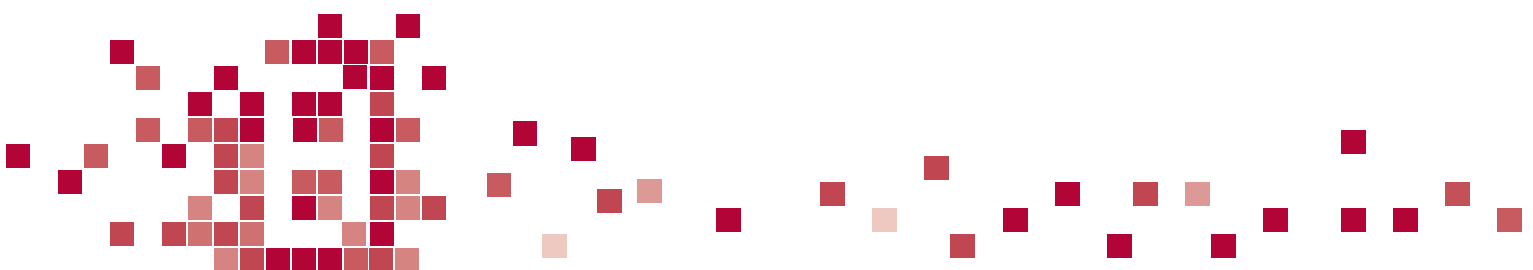
Moreover, consumers will need to be educated about the rationale for changes in benefits, about the importance of adhering to treatment regimens, and about the importance of choosing high-value providers and services. Although individual providers can certainly help to educate consumers about these issues and engage them in improved care processes, community-wide efforts will likely be necessary. If one provider is seen as requiring or expecting more of consumers than others, it could become a competitive disadvantage for that provider in attracting and retaining members or patients unless it is also promoted neutrally in the community as a positive thing.<sup>52</sup>

#### 5. Reducing Administrative Costs

A variety of significant administrative costs are incurred by providers to comply with billing, payment, quality reporting, and other procedures established by health insurance plans.<sup>53</sup> Accountable Care Organizations would be better able to reduce their costs of operation and focus attention on improving the quality of care if the requirements imposing these costs could be simplified or eliminated. In addition to the costs associated with quality reporting that are discussed in Section IV and the costs associated with complying with disparate requirements from multiple payers that are discussed in Section III, another area where providers incur significant administrative costs is collecting cost-sharing payments from consumers. In addition to aligning these cost-sharing payments with value, as described in the previous section, an assessment should be made of the administrative costs that providers incur in tracking detailed cost-sharing requirements and collecting payments from consumers. Administrative costs for providers could be reduced significantly if cost-sharing requirements were simplified or if payers took responsibility for collecting cost-sharing contributions from consumers rather than forcing providers to do so. In fact, the mechanisms for assessing consumer cost-sharing requirements will likely need to be completely re-examined, since global payments would allow providers the flexibility to restructure services in ways that may no longer match the categories for which cost-sharing requirements were established in health plans.

#### 6. Removing Regulatory Barriers

A wide variety of statutes and regulations governing healthcare providers and insurance companies have evolved over many



years. These laws and rules were developed based primarily on current organizational structures and processes for delivering care. However, Global Payment systems and Accountable Care Organizations are intended to allow a radical restructuring of the way healthcare is delivered in order to control costs and improve quality. As a result, many existing statutes and regulations may need to be modified so that they do not impede, and ideally that they facilitate, these transformations. For example:

- Federal laws restricting gain-sharing arrangements between hospitals and independent physicians could prevent Accountable Care Organizations from developing effective systems for allocating Global Payments among participating providers.
- State insurance laws and regulations could impose expensive reserve requirements on Accountable Care Organizations based on the fact that they are accepting performance risk for patient care. Although it may be appropriate to require ACOs to have reserves, if the reserve requirements are excessive or if they duplicate the reserve requirements placed on health plans, they could increase overall costs or preclude the ability of small ACOs to participate.<sup>54</sup>
- Practitioner and facility licensing standards and other requirements could potentially preclude or impede the implementation of more efficient and effective ways of delivering care to patients. For example, even though Chapter

305 of the Acts of 2008 made some modifications to state rules regarding the ability of nurse practitioners, physician assistants, and others to deliver certain kinds of primary care services, the continuing shortage of primary care physicians that Massachusetts is facing may warrant additional changes in these requirements.

**Administrative costs for providers could be reduced significantly if cost-sharing requirements were simplified or if payers took responsibility for collecting cost-sharing contributions from consumers rather than forcing providers to do so. In fact, the mechanisms for assessing consumer cost-sharing requirements will likely need to be completely re-examined, since global payments would allow providers the flexibility to restructure services in ways that may no longer match the categories for which cost-sharing requirements were established in health plans.**

## Areas of Legal Constraints

There are three areas of legal constraints on provider interrelationships that are relevant to the formation and operations of an ACO – antitrust, fraud and abuse and Stark. Ironically, these create larger obstacles during the formation stages than once an ACO has developed a sufficient level of clinical and administrative integration that it is accepting global payment.

Under antitrust law, a provider network that assumes substantial financial risk is judged under the more forgiving antitrust rule of reason standard and thereby not subject to the constraints on collective action that otherwise apply to non-integrated providers. But during the formative stage, prior to the substantial financial risk being actually assumed, the general antitrust constraints still do apply and could significantly inhibit the ability, for example, to share payer and pricing information among providers interested in forming an ACO. Although less than ideal, the providers would probably need to put mechanisms in place that could allow the use of this sensitive competitive information in constructing financial projections and global budgets, such as through use of an independent third party “black box” approach to review the data. An alternative approach might be to establish such a level of State oversight of and involvement in the formation process that the inter-provider activities could be protected under the State action exemption to the antitrust laws, but providers may have difficulty with the level of State intervention in their activities that would be required to achieve the exemption.

Similarly, where public program patients are involved, under the anti-kickback statute and Stark law generally there is protection for referrals taking place within provider networks that are sharing risk. However, these protections do not apply where the financial risk is not yet shared but where mechanisms are being created to begin to change referral patterns and where increasingly interconnected financial arrangements among the providers are being developed. From an anti-kickback perspective, enforcement agencies may be concerned that the underlying intent of the financial and referral arrangements is not the development of an ACO but rather creation of economic incentives specifically for the purpose of reorienting referral relationships, including for Medicare and Medicaid patients. This in turn might subject the transitional phase of ACO formation to greater regulatory scrutiny. While Stark does not rely on an intent analysis, where the services are designated health services under Stark (such as hospital services) and financial arrangements are put in place among the providers, those arrangements would need to comply very strictly with Stark without benefit of the risk-sharing exception.

In summary, while a fully functioning ACO taking global payments might be protected from enforcement in these three areas of law, the application of such laws will require providers to tread very carefully while moving toward, but not yet achieving, fully functional ACO status.

In addition, many existing requirements, while well-intended, can impose significant costs on providers, some of which do not achieve corresponding benefits in terms of patient protection or other goals. Since an overarching goal of payment and delivery system reforms is to control or reduce costs, eliminating or modifying such requirements could help the providers in ACOs reduce their costs and increase their likelihood of success in managing Global Payments.

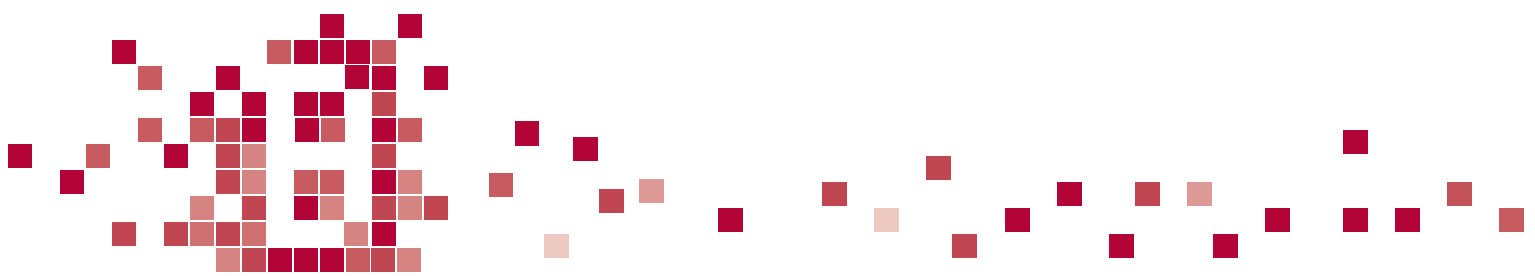
## B. What Massachusetts Needs to Do

In addition to requiring and regulating the structure of Global Payment systems as recommended in Sections II-IV, the Commonwealth will need to provide an appropriate balance of assistance and controls to foster a diverse range of Accountable Care Organizations in the state. In particular, Massachusetts should:

- **Facilitate discussions and agreements among providers, and between providers and payers, about the formation of Accountable Care Organizations**, the structure and magnitude of global payments, and the coordination of care, through mechanisms such as developing safe harbors against anti-trust prohibitions, removing restrictions on financial gainsharing among providers, providing mediation/dispute resolution services, and supporting multi-stakeholder collaboratives. Providers interested in forming Accountable Care Organizations should be given access to recent historical data on utilization of services and payment rates for services and should be provided assistance in financial modeling to help them develop or evaluate global payment rates.
- **Help providers develop new capabilities and resources and enhance existing capabilities to successfully serve as Accountable Care Organizations** and manage global payments. These include:
  - » Obtaining access to complete and timely information about patients and the services they are receiving across the entire continuum of care;
  - » Developing technology and skills and recruiting and training personnel to carry out population management and coordination of care;
  - » Developing or accessing community resources for patient education and self-management support; and
  - » Developing the infrastructure and skills for management of financial risk.

Training and financial assistance programs should be created to help providers, particularly smaller providers, develop these capabilities themselves or enter into partnerships with other organizations to do so.

- **Encourage or require health insurance plans to use value-based benefit designs and other mechanisms to encourage consumers to select and use a consistent Accountable Care Organization, to adhere to treatment plans, and to select high-value providers and services.**
- **Require health insurance plans to reduce or eliminate unnecessary administrative costs**, with a particular focus on collection of consumer cost-sharing requirements.
- **Review all existing state laws, regulations, and standards governing the structure and operations of healthcare providers** to identify and modify any which (a) inappropriately impede the ability of providers to organize and deliver care in more coordinated, efficient ways, or (b) increase provider administration costs without corresponding benefits in terms of cost and quality. It will be difficult to identify all potential problems with existing laws and regulations in advance, since the ways that ACOs will form and operate will likely evolve over time; consequently, an ongoing mechanism for identifying and quickly addressing regulatory barriers will be needed.
- **Advocate for changes in federal laws and regulations and federally sponsored standards** established by private organizations such as the Joint Commission that inappropriately impede the ability of providers to organize and deliver care in more coordinated, efficient ways, or increase administration costs without corresponding benefits in terms of cost and quality. In seeking waivers for Medicare participation as described in Section III, waivers of gain-sharing rules and other restrictions should also be sought.
- **Avoid establishing any new laws, regulations or standards that inappropriately limit the flexibility of Accountable Care Organizations** to find innovative and efficient mechanisms for organizing and delivering services. Any new requirements or standards should only be established after adequate input from providers and clear evidence as to their necessity and cost-effectiveness.
- **Review existing state laws, regulations, and standards governing insurance companies to ensure they do not unintentionally impede the formation of Accountable Care Organizations** or impose unnecessary burdens on them (e.g., reserve requirements that are not supported by global payment levels or which duplicate those required of insurance firms).
- **Establish regulations or other mechanisms to prevent Accountable Care Organizations from forming in ways that limit consumer access to essential services**, e.g., by preventing the sole provider of a service in a community from limiting that service to consumers in a single ACO if other ACOs want to form in the community and need access to the service.



# VI. Addressing Key Transition Issues

## A. The Issues

### 1. Recruiting Sufficient Primary Care Practitioners

A problem that all ACOs are likely to face is recruiting and retaining an adequate number of primary care practitioners. Many of the most important opportunities for controlling costs can and should be addressed through effective primary care, such as prevention, early diagnosis, and chronic disease management.<sup>55</sup> Consequently, it seems clear that, in order to be accountable for the health and healthcare of a broad population of patients, an Accountable Care Organization must have a sufficient number of primary care practitioners playing a central role.<sup>56</sup>

However, Massachusetts is already experiencing a shortage of primary care physicians, which will become even more critical as ACOs seek to enhance the responsibilities of primary care practitioners in improving the quality of care, reducing avoidable hospitalizations and emergency room visits, engaging with patients in shared decision-making processes about treatment, etc. National projections based on the career choices of current medical students suggest that the problem will get worse before it gets better.

The good news is that Global Payments provide the opportunity to address many of the problems that have led to the shortage of primary care physicians. Global Payments will provide the flexibility to increase payments for primary care physicians, to pay for primary care services delivered by non-physicians (such as nurse care managers), and to reward primary care practices for quality and value, rather than mere volume of services. The bad news is that even if these changes are made, it will likely take many years before the number of primary care physicians matches the number needed. As a result, ACOs and the state will likely have difficulty realizing the full benefits of Global Payment systems for quite some time.

This is a problem that ACOs will need help in solving. A variety of different strategies could be considered for addressing the issue, such as:

- A statewide campaign could be mounted to attract primary care physicians to the state, both from newly graduating medical school classes and for established physicians practicing in other parts of the country. The campaign could promote the greater flexibility, improved care coordination,

## Primary Care Provisions of Chapter 305 of the Acts of 2008.

An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Healthcare.

### Medical Home Demonstration (Section 30)

Authorized MassHealth to establish a "Medical Home" demonstration program to promote coordinated, comprehensive patient care and strengthen the role of primary care providers.

### Health Care Workforce Center (Section 8)

Established in DPH to:

- coordinate state and private primary care workforce development activities
- coordinate state and federal loan forgiveness programs
- outreach and marketing
- monitor trends in workforce capacity
- maximize all sources of funds for initiatives

Created a 16 member workforce advisory council to advise the center on trends, strategies/solutions and a loan repayment program for physicians and nurses for those who provide care in medically underserved areas for 2 years.

### Medical School Enrollment Expansions (Section 31)

UMass Medical School authorized to expand the entering class and increase residencies for graduates committed to entering the primary care field and to work in underserved areas of the state.

### UMass Medical School Enhanced Learning (Section 32)

UMass Medical School authorized to provide full waiver of fees and tuition for those who agree to at least 4 years of primary care, public or community service of underserved areas of the state.

### Housing Assistance Program for Health Professionals (Section 34)

Created an affordable housing model for health care professionals committed to providing care in underserved regions.

### Consumer Choice of Nurse Practitioners (Section 28)

Required health insurers to recognize and reimburse nurse practitioners as primary care providers.

### Physician Assistants (Section 16)

Expanded the number of physician assistants that a physician may supervise from 2 to 4.

### Nurse and Allied Health Healthcare Workforce

Trust Fund was established within the Department of Higher Education with the purpose of developing and supporting strategies to increase the number of faculty and students in programs that support nursing and allied health.

### Study of Medicaid Reimbursement Rates for Primary Care Providers (Section 40)

MassHealth Payment Policy Advisory Board required to study the need for an increase in Medicaid rates or bonus for primary care physicians, nurse practitioners and sub specialists who provide primary care services and report recommendations and estimate of financial impact.

and more outcome-driven payment system that Massachusetts is putting in place to support primary care.

- Incentives and assistance could be created to encourage more medical school students to enter primary care, such as loan forgiveness programs, to encourage primary care physicians in other parts of the country to relocate to Massachusetts, or even to encourage specialists to retrain and enter primary care.
- As noted in the previous section, scope of practice requirements for nurse practitioners, physician assistants, etc. could be changed to facilitate the delivery of primary care services where an adequate supply of physicians is not available.

## 2. Creating Effective Healthcare Information Systems

Although there is currently an extensive national program underway to expand the number of healthcare providers using Electronic Health Records (EHRs), and Massachusetts has put new state programs to encourage use of EHRs in place under provisions of Chapter 305 of the Acts of 2008, EHR systems are only as effective as the data contained in them. Most providers with EHRs only have data on the services they provide to the patients themselves, not on the services their patients are receiving from other providers. To successfully use EHR systems, ACOs will need to develop workable interconnections among the EHRs used by their member providers. Even if these systems are designed to be “interoperable,” actually making the

connections will likely be challenging and expensive. Moreover, in most ACOs, some patients will be receiving services from providers which are not formally part of the ACO; consequently, the ACOs will need assistance from payers or Health Information Exchanges in order to obtain complete information about all of their patients in order to successfully accept accountability for total costs as well as to improve the quality of care delivered.

Moreover, timeliness of data is critical – if data on services and costs are only available many months or years after the services are provided and the costs are incurred, it does little to help providers identify and intervene early in areas where costs are increasing or to identify and capitalize on opportunities for savings. For example, the providers participating in the Medicare Physician Group Practice Demonstration (which gives them incentives to function like ACOs) have had to wait 18-24 months to receive data on the costs of services for the patients they are responsible for,<sup>57</sup> which is much too slow to allow continuous improvement.

Perhaps most importantly of all, an ACO accepting accountability for the total costs and quality of care associated with a group of patients requires the skills for *population care management* and the technology to support it. For example, successful practices find that using clinical guidelines and

## Massachusetts State Mandates for Health Information Technology Development and Implementation

- Development of six-year Plan for statewide deployment of electronic health records and health information exchange.
- Creation of the Massachusetts e-Health Institute (MeHI) within the Massachusetts Technology Collaborative to develop and execute the plan.
- Creation of a Health Information Technology Council to approve this plan and all major contracts and oversee this process in partnership with private sector.
- State appropriated \$15 million for 2009: annual funding subject to appropriation through 2014.
- Use of “Implementing Organizations” (i.e., contractors) to assist in the execution of the plan through technology selection, project management, training etc.
- CPOE Adoption: mandates DPH to promulgate regulations by October 2012 that will require hospitals & community health centers to implement certified Computerized Physician Order Entry systems as licensure condition.
- EHR Adoption: mandates DPH to promulgate regulations by October 2015 that will require hospitals/CHCs to implement certified interoperable electronic health record systems.
- MD License Requirement: Requires MD licensure requirements to demonstrate that applicants are competent in electronic medical records/e-prescribing.

The federal American Recovery & Reinvestment Act (ARRA/HITECH Act) provides economic stimulus financing incentives for EHR adoption and use through Medicare and Medicaid that could total \$1.23 billion for Massachusetts hospitals (\$412 million), physicians (\$785 million), and health centers (\$30 million) through 2015.

ARRA/HITECH Act provisions include grant awards to states to develop and advance mechanisms for information sharing across the health care system (i.e., health information exchange networks). Total federal funding is \$564 million with grants in the \$4 million - \$40 million range over 4 years. MeHI has applied for such a grant to establish and implement appropriate governance, policies and network services within the broader national framework to rapidly build capacity for connectivity between and among health care providers. MeHI has also applied for designation and federal funding to serve as the Regional Extension Center for Massachusetts to assist targeted physicians, hospitals and health centers to plan, purchase, and successfully implement EHRs and thereby qualify for the Medicare and Medicaid incentives.

monitoring compliance with those guidelines (while allowing for exceptions when appropriate) improves overall outcomes for patients,<sup>58</sup> and that analyzing data on resource use can help reduce overuse and unnecessary spending.<sup>59</sup> Similarly, having a Patient Registry enables the practice to ensure that patients are receiving recommended care and to identify potential ways to improve outcomes, but the practice needs to redesign its internal processes so that it can use the information in the registry to change the way it delivers care.<sup>60</sup> (Having an EHR system does not automatically mean that a practice will have patient registry capabilities or know how to use them, and a practice can successfully maintain a Patient Registry without an Electronic Health Record (EHR) system.<sup>61</sup>) For more complex patients, successful coordination of care requires information systems that easily enable access at the point of care to complete information about the services delivered by different providers.

Developing, implementing, and refining these information technology capabilities will be time consuming and expensive. As noted in Section II, the size of Global Payments will likely need to be higher initially in order to cover both the upfront investments providers will need to make in these systems as well as the loss of productivity that is likely during the learning phases.

Indeed, because of the critical nature of these capabilities and the long lead times needed to successfully develop and implement them, it would be highly desirable to provide financial support to providers to begin the implementation process immediately, in order to increase the likelihood that the capabilities will be in place when Global Payments are to be implemented.

### 3. Reconfiguring Hospital Capacity and Services

As care is reorganized under a Global Payment System, some providers may lose revenues. Hospitals are particularly vulnerable to revenue reductions in light of the significant opportunities which exist for reducing or eliminating preventable adverse events and readmissions and reducing admissions for ambulatory sensitive conditions.<sup>62</sup> For example, the Geisinger Health System has reported that some of the community hospitals in central Pennsylvania have experienced large reductions in patient admissions as a result of the success of Geisinger's medical home initiatives in keeping chronic disease patients well.

The first response to reductions in revenues should obviously be for a hospital to try and find ways to deliver care more efficiently or to reduce its costs. For example, a number of initiatives based on the Toyota Production System and lean manufacturing

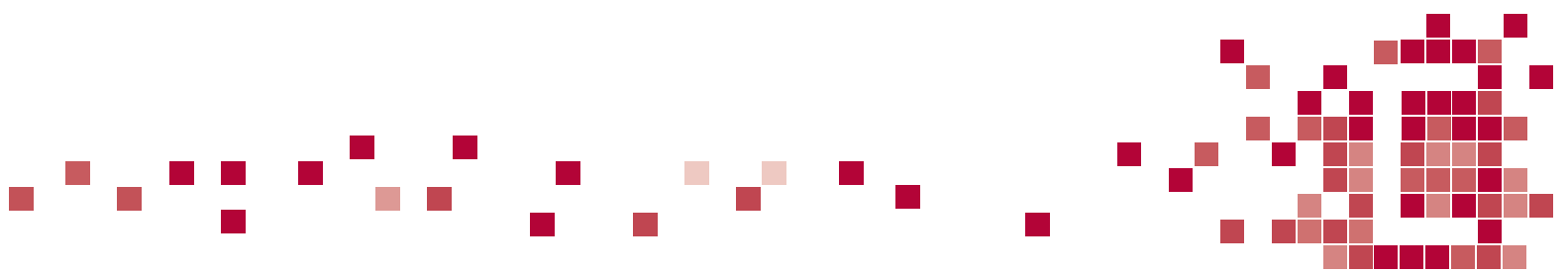
principles (e.g., the Pittsburgh Regional Health Initiative's Perfecting Patient Care<sup>SM</sup> techniques, in-house projects conducted by hospitals such as Virginia Mason in Seattle and ThedaCare in Wisconsin, etc.) have shown significant results in reducing costs as well as improving quality.<sup>63</sup>

**If these challenges are not properly addressed, many hospitals will face serious financial challenges, including the risk of closing or terminating essential community services. An ACO cannot ensure that its patients receive a full range of high-quality, efficient care without a high-quality, efficient hospital in the community, and if dramatic reductions in hospital admission rates caused by ACO initiatives make the hospital financially unviable, the ACO and the community as a whole could suffer.**

However, even using the best techniques for reducing costs, hospitals will face significant challenges in paying for needed equipment and facilities with smaller numbers of patients. For example, the "cost" of a day in a hospital bed is based in part on the capital cost of the hospital divided by the total number of patient days in the hospital. If fewer patients are admitted, the cost per patient will increase. Even some "variable" costs such as personnel are only variable with large changes in patient volume; for example, a small reduction in the number of patients on a hospital unit may not be sufficient to justify a reduction in nursing staff levels on the unit, thereby resulting in an increased cost per patient even though the total spending by the hospital has not changed. Over time, some hospital capital costs can be reduced, but this cannot happen immediately.

Several different strategies could be pursued to address these challenges:

- Help hospitals, particularly small community hospitals, obtain affordable access to training and consultants skilled in methods such as "lean" in order to identify and implement operating efficiencies wherever possible.
- Provide payment support (e.g., phased restructuring of payment rates) to hospitals that develop multi-year strategic plans for restructuring services in ways that will limit or reduce overall costs.



- Provide special financial assistance from payers or the state to enable hospitals (or groups of hospitals) to make the capital investments needed to reconfigure facilities, equipment, and services for more efficient operations.

#### 4. Creating Transitional Payment Systems

As noted in the Introduction, Global Payment systems and Accountable Care Organizations are highly interdependent, and each must co-evolve with the other if either is to be successful. Each of the issues described in this section – recruiting primary care practitioners, building information technology capacity, and restructuring hospital costs – require support from payment systems in order to be resolved. Yet each of them must be in place *before* a full Global Payment system can be successfully implemented.

This means that transitional payment systems will be needed to help providers and Accountable Care Systems develop the capabilities needed to accept a full Global Payment system.<sup>64</sup> For example:

- payers can help providers recruit and retain primary care practitioners and build the capacity to manage chronic disease patients by increasing primary care fees, paying for nurse care managers, etc.
- payers can help providers develop information technology capacity by entering into multi-year payment agreements to enable significant IT investments to be amortized and by supplying information on services delivered to their patients by other providers.
- payers can help hospitals transition by increasing payments to hospitals which reduce admissions for ambulatory care-sensitive conditions and/or reduce elective procedures in situations where conservative options offer equal potential benefits to patients, and adjusting payment rates to facilitate the hospitals' transition to lower admission rates.

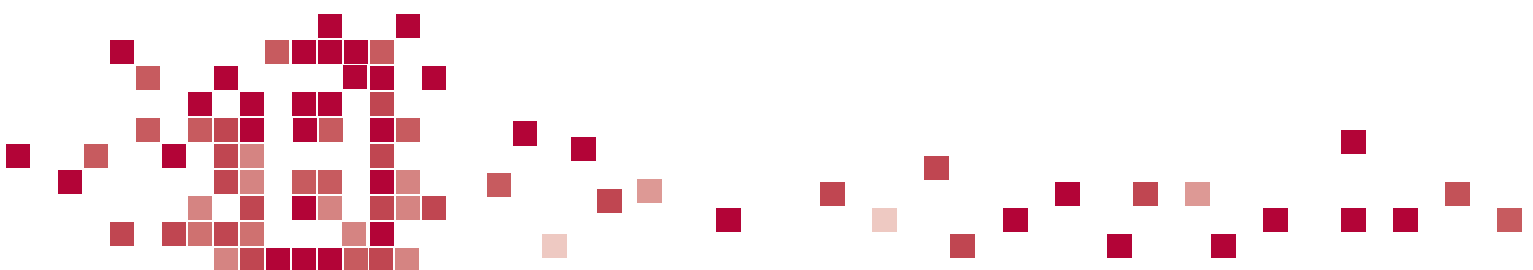
#### B. What Massachusetts Needs to Do

- Develop and implement a statewide strategy to recruit primary care physicians and expand primary care capacity in the state.
- Develop and implement a statewide strategy to help providers and Accountable Care Organizations develop effective information technology systems needed to coordinate patient care across multiple providers and settings and also to manage the quality and costs of care for populations of patients.
- Develop and implement a statewide strategy to help those hospitals that experience significant reductions in

- admissions (e.g., for ambulatory-care sensitive conditions) to restructure their capacity and services in order to remain financially viable.
- Develop and implement a statewide strategy for transitional payment systems to help providers build the capacity needed to function successfully as Accountable Care Organizations.

---

*Harold D. Miller is a consultant on policies and programs to improve the quality of healthcare services and to change the fundamental structure of healthcare payment and delivery systems in order to support improved value. He serves as the Executive Director of the Center for Healthcare Quality and Payment Reform and the President and CEO of the Network for Regional Healthcare Improvement, and he is Adjunct Professor of Public Policy and Management at Carnegie Mellon University.*



## NOTES

- <sup>1</sup> A separate MHA briefing paper will address benefit design in the context of a global payment system.
- <sup>2</sup> A separate MHA briefing paper will address risk in the context of a global payment system.
- <sup>3</sup> A separate MHA briefing paper will address societal needs in the context of a global payment system.
- <sup>4</sup> Miller, HD. From Volume to Value: Better Ways to Pay for Health Care. *Health Aff (Millwood)*. 2009 Sept-Oct;28(5):1418-28.
- <sup>5</sup> Kahn III CN. Payment Reform Alone Will Not Transform Health Care Delivery. *Health Aff*. 2009 January 27, 2009;hlthaff.28.2.w216; Shortell SM, Casalino LP. Health care reform requires accountable care systems. *JAMA*. 2008 Jul 2;300(1):95-7.
- <sup>6</sup> Miller, HD. How to Create Accountable Care Organizations. Center for Healthcare Quality and Payment Reform. September 2009. p. 28. Available at: [www.chqpr.org](http://www.chqpr.org)
- <sup>7</sup> Ginsburg PB, Grossman JM. When the price isn't right: how inadvertent payment incentives drive medical care. *Health Aff (Millwood)*. 2005 Jul-Dec;Suppl Web Exclusives:W5-376-84.
- <sup>8</sup> See, for example, *Reconsidering Geographic Adjustments to Medicare Physician Fees*, Urban Institute, September 2004, and "Chapter 6: An Alternative Method to Compute the Wage Index," in *Report to the Congress: Promoting Greater Efficiency in Medicare*, Medicare Payment Advisory Commission, June 2007.
- <sup>9</sup> A recent survey found that physician fees in the Massachusetts Medicaid program were 12% below Medicare fee levels and 22% below Medicare fee levels for primary care, although they were 30% above the national average for Medicaid programs. See Zuckerman S, Williams A, and Stockley K. Trends In Medicaid Physician Fees, 2003-2008. *Health Affairs Web Exclusive*, April 28, 2009. Most commercial payers pay fees above Medicare levels.
- <sup>10</sup> Tompkins CP, Altman SH, Eilat E. The precarious pricing system for hospital services. *Health Aff (Millwood)*. 2006 Jan-Feb;25(1):45-56.
- <sup>11</sup> See, for example, Wennberg JE, Fisher ES, Skinner JS. Geography And The Debate Over Medicare Reform. *Health Aff*. 2002 February 13, 2002;hlthaff.w2.96.
- <sup>12</sup> See, for example, Smith S, Newhouse JP, Freeland MS. Income, insurance, and technology: Why does health spending outpace economic growth? *Health Aff (Millwood)*. 2009 Sept-Oct;28(5):1276-84.
- <sup>13</sup> Tompkins, CP, Altman, SH, Eilat E. *op cit*.
- <sup>14</sup> See, for example, Society of Actuaries. *A Comparative Analysis of Claims-Based Tools for Health Risk Assessment*. 2009.
- <sup>15</sup> See, for example, Perelman J, Shmueli A, Closon M-C. Deriving a risk-adjustment formula for hospital financing: Integrating the impact of socio-economic status on length of stay. *Social Science and Medicine*. 2008; 66(1): 88-98.
- <sup>16</sup> Network for Regional Healthcare Improvement. From Volume to Value: Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs. November 2008. pp. 25-26.
- <sup>17</sup> A separate MHA briefing paper will address risk adjustment in the context of a global payment system.
- <sup>18</sup> A separate MHA briefing paper will address societal needs in the context of a global payment system.
- <sup>19</sup> A separate MHA briefing paper will address risk in the context of a global payment system.
- <sup>20</sup> Centers for Medicare & Medicaid Services. *Massachusetts Personal Health Care Expenditures 2004*.
- <sup>21</sup> Kaiser Family Foundation. *Medicare Advantage Plan Penetration, 2009*. [www.statehealthfacts.org](http://www.statehealthfacts.org).
- <sup>22</sup> A growing number of Medicare Advantage plans are structured as Private Fee-for-Service plans, rather than HMO or PPO models; however, it is not clear how this would affect the willingness or ability of the plans to participate in a Global Payment/ACO model, since the care management services would need to be developed by the ACO, not by the Medicare Advantage plan. A more important difference would be the lack of restrictions on the ability of a patient in a Private Fee-for-Service Medicare Advantage plan to choose services other than those offered or recommended by the ACO.
- <sup>23</sup> Murray, R. Setting hospital rates to control costs and boost quality: the Maryland experience. *Health Aff (Millwood)*. 2009;28(5):1395-1405.
- <sup>24</sup> Kautter, J, Pope G, et al. *Physician Group Practice Demonstration Bonus Methodology Specifications*. Waltham (MA): RTI International. 2004 December 20. Available at: [www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/PGP\\_Payment.pdf](http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/PGP_Payment.pdf).
- <sup>25</sup> Massachusetts Division of Health Care Finance and Policy. *Health Care in Massachusetts: Key Indicators*. August 2009.
- <sup>26</sup> Pierron W, Fronstin P. ERISA Pre-emption: Implications for Health Reform and Coverage. *Employee Benefit Research Institute*. February 2008.
- <sup>27</sup> Massachusetts Division of Health Care Finance and Policy. *op cit*.
- <sup>28</sup> Network for Regional Healthcare Improvement. *op cit*. p. 29.
- <sup>29</sup> Massachusetts Special Commission on the Health Care Payment System. *Recommendations of the Special Commission on the Health Care Payment System*. 2009. p. 54.
- <sup>30</sup> *Ibid*.
- <sup>31</sup> Miller, HD. How to Create Accountable Care Organizations. *op cit*. pp. 11-12.
- <sup>32</sup> See, for example, Network for Regional Healthcare Improvement. *Pay for Innovation or Pay for Standardization? How to Best Support the Patient-Centered Medical Home*. February 2009.
- <sup>33</sup> For more information, see the Massachusetts Health Quality Partners website, [www.mhqp.org](http://www.mhqp.org)
- <sup>34</sup> Tompkins CP, Higgins AR, Ritter GA. Measuring outcomes and efficiency in medicare value-based purchasing. *Health Aff (Millwood)*. 2009 Mar-Apr;28(2):w251-61.
- <sup>35</sup> Miller, HD. How to Create Accountable Care Organizations. *op cit*. p. 7.
- <sup>36</sup> Massachusetts Special Commission on the Health Care Payment System. *op cit*. p. 54.
- <sup>37</sup> Miller, HD. How to Create Accountable Care Organizations. *op cit*. pp. 13-16.
- <sup>38</sup> Because commercially insured patients have less intense needs than Medicare patients, the Dartmouth group has estimated that a practice would need approximately 15,000 commercially insured patients to provide statistically valid measures of cost and quality.
- <sup>39</sup> Fisher ES, McClellan MB, Bertko J, Lieberman SM, Lee JJ, Lewis JL, et al. *Fostering Accountable Health Care: Moving Forward In Medicare*. *Health Aff (Millwood)*. 2009 Jan 27.
- <sup>40</sup> Massachusetts Special Commission on the Health Care Payment System. *Massachusetts Health System Data Reference*. April 3, 2009.
- <sup>41</sup> Miller, HD. How to Create Accountable Care Organizations. *op cit*. pp. 34-35.
- <sup>42</sup> Miller, HD. How to Create Accountable Care Organizations. *op cit*. pp. 31-32.
- <sup>43</sup> See, for example, Kleinke JD. Access versus excess: Value-based cost sharing for prescription drugs. *Health Aff (Millwood)*. 2004 Jan-Feb;23(1):34-47.
- <sup>44</sup> Altman SH, Tompkins CP, Eilat E, Glavin MP. Escalating health care spending: is it desirable or inevitable? *Health Aff (Millwood)*. 2003 Jan-Jun;Suppl Web Exclusives:w3-1-14.
- <sup>45</sup> Miller, HD. How to Create Accountable Care Organizations. *op cit*. pp. 34-35.
- <sup>46</sup> See, for example, Casalino LP, Nicholson S, Gans DN, Hammons T, Morra D, Karrison T, Levinson W. What does it cost physician practices to interact with health plans? *Health Aff (Millwood)*. 2009;28(4):w533-543.
- <sup>47</sup> See, for example, Jost TS. Health care reform requires law reform. *Health Aff (Millwood)*. 2009 Sep-Oct;28(5):w761-9.
- <sup>48</sup> Sepulveda MJ, Bodenheimer T, Grundy P. Primary care: can it solve employers' health care dilemma? *Health Aff (Millwood)*. 2008 Jan-Feb;27(1):151-8.
- <sup>49</sup> Miller, HD. How to Create Accountable Care Organizations. *op cit*. pp. 7-8.
- <sup>50</sup> Kautter J, Pope G, et al. *op cit*.
- <sup>51</sup> Practices do not need to develop these guidelines themselves; for example, the Institute for Clinical Systems Improvement ([www.icsi.org](http://www.icsi.org)) has developed evidence-based guidelines for the appropriate treatment of many kinds of conditions, and it provides assistance to physicians in implementing them.
- <sup>52</sup> Greene RA, Beckman HB, Mahoney T. Beyond the efficiency index: finding a better way to reduce overuse and increase efficiency in physician care. *Health Aff (Millwood)*. 2008 Jul-Aug;27(4):w250-9.
- <sup>53</sup> Ortiz, DD. Using a Simple Patient Registry to Improve Your Chronic Disease Care. *Family Practice Management*. 2006 April, pp. 47-52.
- <sup>54</sup> Wright A, McGlinchey EA, Poon EG, Jenter CA, Bates DW, Simon SR. Ability to generate patient registries among practices with and without electronic health records. *J Med Internet Res*. 2009;11(3):e31.
- <sup>55</sup> Analyses conducted by the Massachusetts Division of Health Care Finance and Policy indicate that 8% of hospitalizations in Massachusetts are for ambulatory care sensitive conditions which might be prevented through effective outpatient care or early intervention. See Massachusetts Special Commission on the Health Care Payment System. *Massachusetts Health System Data Reference*. April 3, 2009
- <sup>56</sup> See, for example, Toussaint J. Writing the new playbook for U.S. health care: lessons from Wisconsin. *Health Aff (Millwood)*. 2009 Sept-Oct;28(5):1343-50.
- <sup>57</sup> Miller, HD. How to Create Accountable Care Organizations. *op cit*. p. 38.

**MHA** MASSACHUSETTS HOSPITAL ASSOCIATION

---

The leading voice for hospitals.

5 New England Executive Park  
Burlington, MA 01803-5096  
[www.mhalink.org](http://www.mhalink.org)

NOVEMBER 2009

