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REPORT

Is Massachusetts Poised to Leap Ahead of the Curve on Health Care Cost Containment?

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While the fate of national health care reform remains mired in the late-summer debate that rages in Washington and beyond, the Commonwealth of Massachusetts (the ''Commonwealth'') has stolen a march on national policymakers by proposing a paradigm shift in the way that health care is paid for. On July 16, the Massachusetts Special Commission on the Health Care Payment System (the ''Commission'') fulfilled its legislative mandate[1] by issuing a set of recommendations for implementing a ''common payment methodology'' – one that would apply state-wide and across all payers, both public and private—with the dual aims of slowing growth in per capita health care spending and ensuring safe, timely and effective ''patient-centered'' care. The Commission's recommendations are just that—recommendations, without the immediately or conditionally binding effect of directives from panels, like New York's 2006 Berger Commission[2], that other states have launched in an effort to curb their health care costs.

Notwithstanding the Commission's advisory nature, a number of factors make its report worthy of attention. These factors include:

- the unanimous endorsement of the report by a blue-ribbon panel of experts, high-level gubernatorial appointees and stakeholder representatives;
- its issuance in the state whose largely successful effort to achieve universal coverage has become the model for the bills now being debated in Congress; and
- its virtually unqualified— indeed, devastating—indictment of the reigning paradigm of fee-for-service payment.

Most of all, the Commission's report merits scrutiny for the solutions it proposes to the second half of the health care coverage/cost dilemma—namely, having attained the goal of insuring nearly all of its residents (97% of Massachusetts residents reportedly had coverage by the end of 2008)[3], how can the Commonwealth

[1] 2008 Mass. Acts ch. 305 § 44.

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[2] *See generally* NEW YORK STATE DEPARTMENT OF HEALTH, REPORT OF THE COMMISSION ON HEALTH CARE FACILITIES IN THE TWENTY-FIRST CENTURY (2006).

[3] MASSACHUSETTS SPECIAL COMMISSION ON HEALTH CARE PAYMENT REFORM, RECOMMENDATIONS OF THE SPECIAL COMMISSION ON THE HEALTH CARE PAYMENT SYSTEM at 19 (2009), http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/Final_Report/Final_Report.pdf.

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''preserve the viability of [its] successful health reform initiative''[4] by putting the growth in health care spending on a sustainable pace.

The Commission neither minced words nor shied from controversy in answering the central question posed by its legislative mandate:

> ''To promote, safe, timely, efficient, effective, equitable, patient-centered care, and thereby reduce growth and levels of per capita health care spending, the Special Commission recommends that ***global payments with adjustments to reward provision of accessible and high quality care*** become the predominant form of payment to providers in Massachusetts.''[5]

Condensed into this single clause is a sweeping vision not only of how to change and standardize health care payment but also how to remake the delivery system so that providers are suited to accept such payment and deliver better, more affordable and more coordinated care.

In the balance of this article, we address the Commission's rationale for endorsing global payment as a ''common, transparent'' and all-payer mechanism for reimbursing providers and the feasibility of its vision that this relatively untested, still emergent approach to payment be fully implemented in Massachusetts within five years. We start with the Commission's critique and resulting rejection of fee-for-service payment, with its ''pervasive incentives'' that ''financially reward providers irrespective of value.''[6] We then summarize the Commission's alternative proposal, including how global payments would be set, the role of risk adjustment and quality (or ''P4P'')[7] incentives in holding providers appropriately accountable for the cost and quality of their services without subjecting them to undue ''insurance risk,'' and the transition to integrated delivery systems (under the rubric of ''Accountable Care Organizations'' or ACOs) that the new payment approach would necessitate. Lastly, we address some of the daunting political and implementation challenges that the Commission's report faces, ranging from the nature and powers of the ''oversight entity'' that would be charged with implementing the new system to the requisite changes in state and federal law.

I. *The Commission's Critique of Fee-For-Service Payment*

After convening a series of public meetings over the first half of 2009 and being briefed by policy experts, the Commission found little to like in fee-for-service payment and much to condemn. According to the Commission, fee-for-service methodologies (i) reward providers for delivering ***more***, not ***better***, care; (ii) do not differentiate payment to account for superior performance (and, conversely, do not penalize care that yields poor outcomes); (iii) encourage providers to deliver more costly, higher-margin services without regard to the patient's need, comparative effectiveness research or evidence-based guidelines; (iv) under-value or wholly ignore preventive, care-coordination and other lower-margin services (like behavioral health); and (v) produce little or no incentive for hospitals, physicians and other care-givers to align their treatment strategies and avoid duplication of services. Summing up these deficiencies, the Commission embraced the view of experts that fee-for-service payment is a ''***primary reason*** for growing health care costs and fragmented, ineffective care.''[8]

In fact, so convinced was the Commission of its conclusion that fee-for-service carries ''pervasive incentives . . . for greater volume and cost''[9] that its report dispenses in short order with P4P as an adequate remedial strategy. The Commission concluded that, although P4P ''offers substantial promise for improving the quality of care,[10] ''it cannot suffice on its own, when layered as a ''complementary'' strategy on top of fee-for-service, to ''neutralize [the] volume and cost incentives of the basic payment model.''[11] The Commission's enabling statute obligated it to consider ''pay-for-performance programs'' among the mix of alternatives to fee-for-service models of payment; and in the course of doing so the Commission recognized that P4P strategies can play a valuable role in motivating providers to focus on coordinating care and achieving specific quality and efficiency benchmarks.[12] In light of the Commission's skepticism that P4P or other quality-based performance incentives could ever correct the fundamental misalignment in fee-for-service payment, the report embraces P4P not as a means of salvaging the current model, or improving it at the margins but, instead, as an important contributor to a new, fundamentally different global payment regime.

II. *Risk-Adjusted Global Payment as the New Payment Paradigm*

In lieu of fee-for-service, the Massachusetts Commission strongly endorsed the alternative of risk-adjusted global payments paid by carriers to ''Accountable Care Organizations'' on a per-patient basis. According to the Commission, global payments, appropriately risk-adjusted to account for patient demographics, medical condition and socio-economic factors that influence health, will shift ''performance risk'' to providers and thus make them accountable for the quality, cost and efficiency of care. Moreover, the Commission preferred the approach of bundling reimbursement through global payment, rather than episode-based ''case rates,''[13] on the ground that the latter methodology has not yet gained currency in the market, remains ''too complex in

[4] *Id.* at 2.
[5] *Id.* at 10 (emphasis added).
[6] *Id.* at 3.
[7] Pay-for-Performance (''P4P'') is ''a complementary payment-related strategy that offers financial rewards to providers who achieve or exceed specified quality benchmarks'' and potentially efficiency benchmarks as well. (*Id.* at 35). By emphasizing quality of care, P4P incentives aim to decrease overall costs as a result of improved patient health.
[8] *Id.* at 24 (emphasis added).
[9] *Id.* at 7.
[10] *Id.* at 45.
[11] *Id.* at 48.
[12] *Id.* at 35-36.
[13] In an episode-based payment system, providers are paid a fixed, all-inclusive rate for the full range of services consumed in a clinically defined episode of care, such as ''coronary artery bypass surgery and recovery.'' (*Id.* at 31). Like global payments, episode-based rates can be adjusted to reflect both severity of illness and quality of performance; however, unlike global payments, they are subject to difficult operational questions regarding the span of a given episode and the services, costs and providers to be covered by each payment.

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design,'' and in any case, offers ''no financial incentive for providers to help patients avoid the occurrence of episodes.''[14] The Commission concluded that mandating global payment as a uniform, state-wide payment mechanism, in combination with delivery system reforms that emphasize tight management of care by a primary care practice anchored within an ACO, offers the best hope of achieving its vision of a ''high-value health care system.''[15]

The key elements of the Commission's recommended approach are as follows:

Global Payments: As defined by the Commission, global payments ''prospectively compensate providers for all or most of the care that their patients may require over a contract period, such as a month or a year.''[16] Actuarially set, these payments are based on prior cost experience and designed to cover the expected future cost of delivering benefits to an enrolled population.

Risk Adjustment: On top of the core building block of global payment, the Commission calls for the uniform, state-wide adoption of risk adjusters that reflect the unique clinical, socio-economic and, to the extent appropriate, geographic case-mix of an ACO's patient panel. The report envisions that, for ease of adoption, the Massachusetts methodology will at first be modeled on the DCG/HCC system that the Centers for Medicare and Medicaid Services (''CMS'') uses to adjust Medicare Advantage premiums.[17] However, over time, these adjusters will be refined to account for Massachusetts-specific variations in health care spending and to ensure that ACOs serving disproportionate numbers of high-risk and chronically ill patients do not suffer financial harm. According to the Commission, development of a well-calibrated risk adjustment mechanism is essential both to keeping ''insurance risk'' with the patient's insurance carrier and to avoiding the tendency of prior, private-sector capitation experiments to encourage ''cherry-picking'' and stinting of care.

Accountable Care Organizations: To accept ''performance risk'' on a global basis, providers will need to group themselves into networks of care known as Accountable Care Organizations. These networks, composed of hospitals, physicians, other clinicians and ancillary suppliers, may incorporate as a single legal enterprise or form virtual organizations through contractual agreements. The Commission envisions a plethora of models, ranging from independent practice associations, integrated delivery systems and physician-hospital organizations to non-exclusive, contractual networks built around the hub of a strong, well-capitalized medical group. Irrespective of the model, the Commission expects that all ACOs will gravitate over time to delivering care through patient-centered medical homes – a care delivery strategy characterized by physician-led, multi-disciplinary care teams, active use of health information technology for decision support, preventive care and aggressive management of chronic disease.

The Centrality of Primary Care: Patients will be able to choose a primary care doctor from among those participating in their insurer's (or self-insured fund's) network, but once they do so, global payments will flow to the ACO with which that physician is associated. That ACO, in turn, will fund the cost of ancillary and institutional services from its global payment revenues. Depending on benefit design, the patient may be free to self-refer to providers outside that ACO. However, these out-of-network options are likely to be limited as a practical matter by the reluctance of payers and ACOs to pay for non-ACO services and their adoption of co-insurance and other differential cost-sharing obligations that effectively lock patients into their ACO network.

Use of P4P as a Complementary Payment Strategy: As a further improvement over prior, largely abortive attempts at global capitation, ACOs would be entitled to receive P4P incentive payments if they demonstrate either excellence or relative improvement in quality and patient satisfaction; adopt evidence-based practices; and coordinate care more effectively across multiple care settings. Notably, the Commission contemplates that performance metrics will be ''uniform across all payers''[18] and thus will need to be published and enforced on a state-wide basis.

State Oversight Entity: To bring this new health care system to fruition on the aggressive, five-year timetable set by the Commission, broad oversight powers would be lodged in an independent body consisting of subject-matter experts, including individuals proficient in physician and hospital finance, provider operations, payment and clinical care. This oversight body would be responsible for (i) defining the characteristics that qualify a network as an ACO; (ii) devising a state-wide methodology for global payment (leaving actual payment amounts to be determined by the market); (iii) setting annual milestones for the transition to global payment and monitoring progress against these milestones; (iv) considering mid-course corrections if it determines progress to date against these milestones, as well as defined cost, access and quality benchmarks, to be lagging; and (v) identifying for legislative action the infrastructure changes required to build and institutionalize ACOs and thus accomplish a successful transition from fee-for-service to global payment.

III. *Political and Implementation Difficulties Posed by the Commission's Report*

The Commission's vision of a new, state-mandated formula for health care payment is extraordinary in its sweep and, most of all, in its expectation that fundamental change can occur both in payment policy and in the way that care is organized and delivered on an accelerated timetable. For all the boldness and clarity of its vision, however, the Commission leaves a tremendous amount of programmatic detail to future development in the Commonwealth's policy and political arenas. Given the angry reception that has greeted the far more modest cost containment proposals now under consideration in Washington, it is a fair question

[14] *Id.* at 46.
[15] *Id.* at 12.
[16] *Id.* at 8.
[17] The requirement that MA premiums be subject to risk adjustment is set forth in 42 C.F.R. § 422.308. The current model is in manual guidance. *See generally* CENTERS FOR MEDICARE & MEDICAID SERVICES, MEDICARE MANAGED CARE MANUAL, Ch. 8 Payments to Medicare Advantage Organizations, 50 (2007).

[18] MASS. SPEC. COMM'N ON HEALTH CARE PAYMENT REFORM, RECOM'NS OF THE SPEC. COMM'N at 54 (2009).

whether the Commission has bitten off more than those charged with implementing its vision, starting with the administration of Governor Deval Patrick, will be able or willing to chew. The following are only some of the daunting challenges that full implementation faces.

Independence of the Oversight Entity: The Commission chose not to resolve whether the broad, discretionary powers that it envisions being exercised by an oversight body should be delegated to an independent, nonpolitical board of experts or, instead, should be vested in an Executive Branch agency, with advice to be furnished, as needed, by an independent board of experts. As the current debate over whether to empower the Medicare Payment Advisory Commission (''MedPAC'') to prescribe Medicare payment rates attests,[19] any proposal to take from politically accountable decisionmakers the ultimate authority to determine how global payments are to be set, risk-calibrated and quality-adjusted is bound to be controversial. Moreover, unlike MedPAC, which in the anticipated Senate Finance Committee proposal would at most be authorized to prescribe Medicare rates, methodologies and perhaps coverage policies, the Massachusetts entity would have far-ranging jurisdiction to determine the composition of ACOs, when ACOs are ready to assume full or limited ''performance risk,'' milestones for advancing the market to global payment, and, most significant of all, when to impose ''mid-course adjustments'' as required to achieve the Commission's vision – including even such ''financial interventions''[20] as fining recalcitrant payers and providers and setting parameters to constrain fee-for-service rates in order to check the growth of per capita health care costs. The more sweeping its powers, the more likely the oversight body will be subject to political check and thus unable to implement the Commission's vision without political entanglement.

''Insurance'' versus ''Performance'' Risk: The Commission draws a distinction between ''insurance risk,'' which is the cost of insuring against the fortuity that a particular disease or injury will occur in an enrolled population, and ''performance risk,'' which is the financial risk that a particular patient's medical needs will cost more if the providers responsible for that care fail to integrate their services, perform duplicate or unnecessary tests or opt for costly over equally effective, lower-cost treatments. Central to the Commission's embrace of global payments is that, in contrast to fee-for-service, this method puts providers at financial risk for the quality and efficiency of their performance.

The Commission recognizes that few, if any, ACOs will be positioned to accept the transfer of ''insurance risk'' from carriers and thereby be held accountable if the distribution of high-cost chronic disease or other unpredictable cost drivers exceeds actuarial benchmarks. To avoid such transfer, the Commission calls for ''strong risk adjustment methods''[21] so that global payments ''reflect the underlying health conditions and predictable probability of illness among each provider's patients.''[22] The report also provides that, although the oversight body will devise the risk adjustment methodology, actual global payment amounts will be set by the market, presumably in rate negotiations between ACOs and third-party payers. What happens if the state-set risk adjusters are imprecise, if providers accept inadequate rates or if an epidemic or other unforeseen event affects gross health care spending during a contract period for which global payments are already set, the Commission leaves unresolved, except to observe that certain ACOs may require a more gradual transition to full acceptance of performance risk and that others may require stop-loss or risk corridor arrangements to guard against ''insurance risk.''

Here, perhaps more than in any other aspect of the Commission's report, the success of its vision will depend on getting the details right, lest ACOs end up unable to fund the cost of care for which they have assumed responsibility.

Federal Law Obstacles to Full Integration: The Commission acknowledges that, to realign provider incentives with high-quality, efficient care, the Commonwealth would need a ''Section 222'' Medicare demonstration program waiver[23] to test global payment as an alternative to the fee-for-service methodologies that Congress has traditionally prescribed for Medicare Part A and Part B services.[24] Since Section 222 waivers allow only payment methodology changes,[25] the full sweep of the Commission's vision will likely require Congressional action to exempt the Commonwealth from other Medicare payment, coverage and program administration requirements. Yet, even beyond the changes enumerated in the report, the Commission's vision of fully aligned, clinically integrated networks of care may not be possible unless Congress overrides existing statutory impediments to care coordination and the sharing of cost savings among providers – both within and outside integrated systems.

For instance, both the Civil Monetary Penalties Law and the Stark physician self-referral statute prohibit certain kinds of payments between hospitals and their medical staff physicians, including bonus payments that are tied to reducing excess inpatient admissions and length of stay, and impose severe sanctions on those found to have violated their strictures. The reality of ACO integration is likely to fall short of the Commission's vision if these and other deterrents to paying incentive compensation within ACOs are not addressed through changes in federal law.

Antitrust Implications: Federal and state antitrust laws prevent both improper unilateral conduct, such as abuse of monopoly or market power, and collusion among independent economic actors, such as sharing pricing information and fixing prices. The development of ACOs will necessarily implicate these laws to the extent that collaborating hospitals and physicians are competitors who jointly negotiate payment rates, share pricing information and share payments.

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[19] *See* Bureau of National Affairs, Inc., *Reform Proposals: Congress, Not Independent Entity, Should Set Medicare Policy, 75 Members Say*, BNA's Health Care Daily Report, August 4, 2009. *See generally* Medicare Payment Advisory Commission (MedPAC) Reform Act, S. 1380, 111th Cong. (2009).

[20] Mass. Spec. Comm'n on Health Care Payment Reform, Recom'ns of the Spec. Comm'n at 17 (2009).

[21] *Id.* at 48.

[22] *Id.* at 8.

[23] *See* 42 U.S.C. § 1395b-1 (2006). *See also* Social Security Amendments of 1972, Pub. L. No. 92-603, § 222, 86 Stat. 1329, (1972).

[24] Mass. Spec. Comm'n on Health Care Payment Reform, Recom'ns of the Spec. Comm'n at 55 n. 21 (2009).

[25] *Id.*

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The Commission acknowledges that Massachusetts law has developed with fee-for-service as the prevailing paradigm, and that the state's antitrust statutes, among others, will need to be reconsidered and revised ''to the extent [these laws raise] barriers to achieving its vision.''[26] In undertaking this analysis, the Commonwealth's policymakers will need to be mindful of two fundamental principles of antitrust law: first, that joint negotiation of payment rates by competing providers may be *per se* illegal; and, second, that such joint negotiation and contracting by provider networks that have achieved significant clinical or economic integration are not *per se* illegal, but subject to a more permissive ''rule of reason'' analysis to determine whether the challenged activity is (i) reasonably necessary to achieve the purposes of the joint venture and (ii) not likely to have an anticompetitive effect in the relevant market.[27]

Much in the Commission's report suggests that ACOs will be structured to meet the tests of economic and/or clinical integration set forth by the federal antitrust regulators, making joint negotiation permissible under the antitrust laws. For instance, the Commission appears to expect that even virtually integrated ACOs will adopt common clinical practice guidelines, information technology and performance and reporting systems such that they can be deemed to satisfy clinical integration requirements.

Even so, given the importance to the Commission's vision of promptly forming large-scale ACOs on a statewide basis, a number of more nuanced, fact-specific antitrust questions will need to be addressed. These include: (i) whether joint negotiation of payment rates can be undertaken by ACOs that have accomplished a lesser degree of clinical or economic integration or are in transition to full integration; (ii) whether joint contracting by ACO participants may ever be permitted in a concentrated market where the ACO has monopoly or near-monopoly power; and (iii) the degree to which the Commonwealth must actively supervise the formation and conduct of ACOs in order to bring the collaboration of such ACOs within the ''state action'' doctrine and thereby shield their activity from antitrust scrutiny.[28]

IV. *Conclusion*

The report of the Massachusetts Special Commission on the Health Care Payment System represents a major leap forward in conceptualizing what a reformed health care system would look like, one in which the method of payment is closely aligned with the objective of delivering quality, affordable care. Compared with developments on the national stage, it may be that the leap is so far forward as to be utopian or, at a minimum, incapable of implementation on the scale and schedule proposed by the Commission.

But, whatever its practical effect, the Commission's report is to be commended not just for recognizing the inextricable link between how payment is made and the configuration of the health care system being funded, but also for sketching out its vision for both sides of that equation. In Massachusetts, at least, policymakers have given the clear answer that fee-for-service must be replaced with risk-adjusted global payment, and that providers must form closely integrated networks of care. Whether the political will exists to overcome the daunting obstacles and fully realize that vision remains to be seen.

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[26] *Id.* at 16.

[27] US Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care, Sec. 8(B)(1) (1996), http://www.usdoj.gov/atr/public/guidelines/0000.htm.

[28] *See California Retail Liquor Dealers Association v. Midcal Aluminum*, 445 U.S. 97 (1980). *See also Patrick v. Burget*, 486 U.S. 92 (1988).