



ISSUE BRIEF

The Massachusetts Health Policy Forum

Achieving Accountable Care in Massachusetts:

Payment Reform to Drive Delivery System Change

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Models and Policy Actions for Massachusetts*

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Introduction

Massachusetts led the nation on health reform, enacting comprehensive coverage legislation in 2006 and taking some additional steps to address cost containment in 2008 and 2010. Massachusetts hospitals and physicians currently deliver some of the most sophisticated care in the nation and in the world. Health plans provide comprehensive coverage and are consistently ranked among the best. With the lowest number of uninsured in the nation more people have access to comprehensive health care. However, in keeping with national trends, health care costs in the Commonwealth have risen significantly faster than wages, and current growth trends jeopardize the state's historic access reforms. The Commonwealth now faces a critical challenge in determining how to rein in costs and promote high quality care.

Restructuring the health care payment system is a widely discussed tool for reducing the rate of spending growth and better aligning the quality and cost of health services. The dominant form of payment for medical services, fee-for-service (FFS), rewards providers for supplying more health care, even when additional services may not be medically necessary. National and international studies suggest that higher costs are not necessarily correlated with higher quality, efficiency, access to care, equity or health status.^{1,2} In 2009, the Massachusetts Special Commission on the Health Care Payment System (Special Commission), relying on broad stakeholder consensus, recommended reforming and restructuring the payment system to promote efficient, effective patient-centered care and reducing variations in quality and cost.³ Concluding that FFS rewards volume instead of outcomes and efficiency, the Special Commission called for Massachusetts to begin the transition toward alternative payment models, such as global or bundled payments.⁵ Policymakers envision moving away from incentives to provide potentially excessive services that are embedded in FFS toward a system

promoting accountability for patients' health through quality metrics and alternative payment models. The goal is to encourage high quality, efficient and accountable health care through complementary payment reform and delivery system redesign strategies.

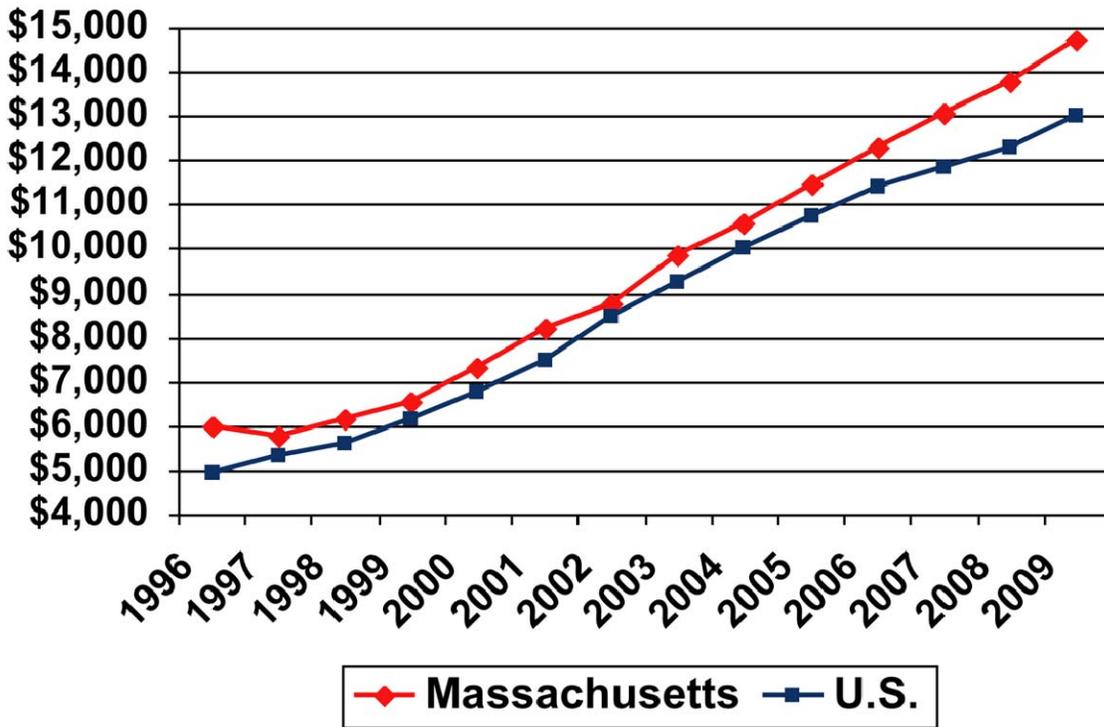
On November 30, 2010, the Massachusetts Health Policy Forum will convene a forum to examine models of accountable health care delivery. The forum will showcase organizations from Massachusetts and other states that have taken significant steps toward improving the efficiency and quality of health care delivery through vertically and virtually integrated systems. Local stakeholders representing government, payers, providers and consumers will discuss challenges and opportunities for the Commonwealth in promoting accountable care. This paper outlines the challenge of rising health care costs in Massachusetts and provides a brief summary of actions and reports by state officials to address quality and cost concerns. It then discusses the concept of accountable care delivery and related models of coordinated health care. Next, it provides a short overview of the five organizations invited to describe their delivery models. Finally, it identifies unresolved issues that may be addressed at the forum.

The Context for Delivery System Reform in Massachusetts

Massachusetts has some of the highest health care costs in the United States.^{4,5} The growth of health insurance costs has outpaced wage growth by three to four times.⁶ Average premiums for fully-insured members grew 12.2 percent from 2006 to 2008,⁶ and employer-based coverage for family premiums grew 47 percent from 2002 to 2008 while the comparable national rate nationwide was 38 percent.⁶ As health care costs rise, employers are shifting more of the costs to employees; in 2010, employees contributed 30 percent of

Figure 1: Annual Per Capita Spending in the United States and Massachusetts

Average Employer-Based Family Health Insurance Cost: Massachusetts vs. US



Source: Agency for Health Care Quality and Research Medical Expenditure Panel Survey.

premium costs for family coverage and 19 percent of costs for single coverage, up from 27 percent and 17 percent, respectively, in 2009.⁷ Rising costs threaten the coverage gains from 2006 reforms that expanded access to care. If more people are unable to purchase affordable insurance, fewer will be subject to the individual insurance mandate and coverage expansions could be eroded.

A comprehensive approach to providing more efficient care is the next target of reform efforts in Massachusetts. As noted,

the Massachusetts Special Commission on the Health Care Payment System issued recommendations in July 2009 to reform and restructure the payment system to promote efficient, effective patient-centered care and reduce quality and cost variations.⁵ The Special Commission evaluated several payment models and recommended 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 The final recommendations also called for the creation of “accountable care

organizations” (ACOs) to be the vehicle for aligning payment and delivery system reform.⁵ The Massachusetts Health Care Quality and Cost Council’s Roadmap to Cost Containment, issued in October 2009, echoed the Special Commission’s recommendations, calling for global payment with ACOs to become the dominant payment form in Massachusetts.¹² Finally, in April 2010, the Division of Health Care Finance and Policy (DHCFP) issued recommendations following the Division’s public hearings on cost trends in March 2010. Among the actions suggested for long term creation of an accountable health care delivery system was formation of “integrated care organizations”, or ICOs, to deliver integrated health services under globally capitated or shared savings payment models.⁶ The Massachusetts General Court has considered pursuing legislation to codify payment reform and delivery system redesign. However, lack of agreement on what such legislation would entail stalled comprehensive cost containment legislation in 2010, postponing legislative action.¹³ The Cost and Quality Council under the direction of Secretary Bigby is considering a range of possible actions.

The Role of Payment in Delivery System Reform

Health care payment models encourage particular behavior in the delivery of care. The dominant payment method remains fee-for-service, which rewards increased utilization of services and does little to explicitly encourage efficiency or quality. Under FFS, providers face incentives to order tests and interventions that may provide limited or ambiguous clinical benefit. The managed care movement in the

1990’s was an attempt to move away from FFS. Managed care took many forms and increased payment through capitation, or prospective payments to providers for patient care over a fixed time period. The idea was that this would realign the incentives towards prevention and efficiency. The major backlash against managed care was due in large part to restrictions placed on providers and patients regarding where and how care was provided. It was also hampered by an inability to risk adjust payments to accurately reflect patient severity and provider costs. Under capitation, if providers had a sicker population, or were adversely selected against, the capitation rate base on the average cost in the community was inadequate. Newer global or bundled payments have the opportunity to do a better job engaging providers in the process and using advances in health information technology to adjust provider payments so no one is disadvantaged by caring for “sicker” patients. Still under any per capita payment arrangement there may be incentive to under-provide care. These effects could be mitigated by using quality outcomes measures and making final payment contingent on achieving specified standards.

Bundled payments could be structured to package all the services for treating a particular condition into a fixed rate. The idea is to promote efficiency for specific episodes of care and in this way drive quality improvements in the health care delivery system. Bundled payments are expected to promote care coordination, improve quality, and reduce preventable complications, making them attractive to payers and providers.¹⁴ Detractors note the difficulty of bundling all services including such things as acute care episodes or outpatient hospital visits. Bundled

payments would also require sufficient risk adjustment to assure adequate reimbursement for complex cases and reduce the incentive to avoid sicker, more complex patients.¹⁴

As an alternative to FFS, per capita or global payment has its own challenges. A move towards global payments must overcome the perception and practice that eroded support for managed care organizations in the 1990s. During this period physicians experienced reduced autonomy through utilization review and came to be perceived as gate-keepers of services rather than trusted allies of patients.¹⁰ Patients also reacted against limits in the ability to choice of physicians, to see specialists without referral and to go to the hospital of their choice. Currently in Massachusetts, HMOs use capitation to pay just 16 percent of primary care providers and 5 percent of specialists, most commonly for Medicare and Medicaid managed care products.⁴ To be successful new global payment models will need to address issues of choice as well as make the case that the new incentives will not reduce access to care.

The Accountable Care Delivery Model

The concept of accountable care has emerged in recent years as a model for providing integrated care by aligning providers' financial incentives with patient care objectives and outcomes. Various definitions of accountable delivery systems exist, but the core principles involve achieving greater provider accountability for outcomes through global or bundled payment. Alternatively, "shared savings" models can encourage efficiency by allowing providers to keep a portion of

economic savings if they can deliver high quality care for a defined population at lower costs. To achieve these quality and cost goals, delivery systems would be encouraged to implement care coordination programs, electronic medical records, health information technology decision support programs, and timely data and feedback to providers regarding quality and outcomes of their patients.

Despite these commonalities, there has been an interest among policymakers and other stakeholders to preserve flexibility for provider organizations in precisely defining what constitutes an ACO. Accountable delivery systems in Massachusetts could vary based on degree of integration, extent of performance risk adopted by providers, and existing health care infrastructure in particular regions of the state. For example, should an ACO necessarily include hospitals, or could a set of primary and/or specialty physicians serve as an ACO and separately contract for inpatient services? An early conception of ACOs came from Elliott Fisher and colleagues at the Dartmouth Institute for Health Policy and Clinical Practice, who envisioned the creation of ACOs comprised of local hospitals and the physicians that worked with them through an extended hospital medical staff model.¹⁵ The Special Commission's recommendation to move toward ACOs includes hospitals as does the DHCFP recommendation to create ICOs. While such uniformity of organization and structure has many advantages, it may not be the best structure to meet variations in local needs and capacities. Thus, the precise organizational structure of an accountable care model, whether vertical or virtual, may vary according to the existing infrastructure and relationships among providers. Likewise, the specific payment methodology, such as global capitation,

bundled payment, shared savings, and the degree of risk-sharing by providers may differ across delivery systems and payers. DHCFP and the Special Commission have also encouraged flexibility to be permitted among providers and payers in forming accountable care delivery systems and developing payment contracts.

Nationally, the Patient Protection and Affordable Care Act (PPACA), which emphasized insurance reform, legislated Accountable Care Organizations (ACOs) as well. The federal legislation describes these as entities caring for at least 5,000 Medicare beneficiaries and emphasizing primary care, but capable of providing a broad range of services. The new law also suggests that these entities would operate under a shared savings model with a per capita target. PPACA did not specify what the structure of an ACO was, but directed CMS to establish them. The initial rules are expected to be made public in mid-December 2010. Many physician groups and hospitals throughout the country are preparing to become ACOs.

Models of Accountable Care: Lessons for Massachusetts

As stakeholders begin to consider changes to the health care delivery system that promote greater efficiency, successful models of integrated delivery may offer guidance. The Massachusetts Health Policy Forum's forum on accountable care delivery in Massachusetts will highlight five organizations seeking to deliver high quality, efficient care by shifting responsibility and risk to providers. Two organizations, Norton Healthcare and Tucson Medical Center, are part of the Dartmouth-Brookings ACO Learning

Network on developing and implementing ACOs. The other three are local examples of provider organizations that have undertaken efforts to deliver integrated, accountable care in Massachusetts: Mount Auburn Cambridge Independent Practice Association, Inc. (MACIPA), Hampden County Physicians Associates, and Atrius Health. The five organizations span a range of delivery models, from an integrated delivery system to a community hospital partnered with local physicians to physician organizations proactively collaborating with hospitals. Each has taken a distinct approach to improving the delivery of health care while limiting cost growth and offers different lessons for Massachusetts. Each is briefly described below.

Norton Healthcare, Louisville, Kentucky. Norton Healthcare is a Dartmouth-Brookings Collaborative pilot site. It is an integrated delivery system (5 hospitals, 11 immediate care centers, 80 practice locations, 400 employee providers). Norton has substantial critical information technology infrastructure in place. The pilot has focused on transparency and making 600 existing quality indicators useful to patients and providers. Partnering with payers has been very important to facilitate change by using claims data to generate information for providers. Norton is working closely with Humana on the pilot, which includes Norton and Humana employees. The pilot currently has about 10,000 patients, and Norton is looking to expand to other local employers and payers. The pilot started in December 2009 and has focused on building infrastructure, developing data, designing the attribution model for assignment of patients to PCPs, and

determining expense targets and how to reach them. Norton is working to include care coordination as part of pilot and looking at partnering for services not offered by the health care system. A key issue has been handling outliers and covering care management costs.^{16, 17}

Tucson Medical Center, Tucson, Arizona. Tucson Medical Center (TMC) is a Dartmouth-Brookings Collaborative pilot site. It is a standalone, not-for-profit 620-bed community hospital with about 14 employed physicians and about 800 affiliated independent physicians, approximately 400-500 of whom are active. TMC is in a competitive market with a 3-hospital health system with employed physicians, a for-profit hospital, and a university medical center/teaching hospital. Accountable care efforts developed due to financial trouble and efforts to reestablish relationships with physicians, which led to the creation of partnerships between physicians and hospitals. TMC started by partnering with an orthopedic group, creating a co-management/company to develop quality metrics and manage the service line. They used the same model with neurology/neurosurgery and cardiology/cardiovascular surgery. Subsequently, TMC engaged with primary care groups that were being rewarded by payers under shared savings models. As a pilot site, TMC is building a model based on a virtual network with independent physicians. TMC already had three years of experience working on quality metrics and service-lines, and is building on this expertise for the ACO pilot. TMC is working with UnitedHealthcare to develop an ACO model and hoping

Medicare will join it. The ACO has 30-35,000 patients, about half are Medicare patients, and slightly more than half are commercial enrollees. They are negotiating the payment model, which will likely to be mostly gain-sharing and/or shared savings, but probably not risk-sharing initially. Primary care specialists will include obstetrics/gynecology, pediatrics, and cardiology as well as traditional primary care specialties. TMC views the ACO as being driven by providers, not TMC.¹⁸

Mount Auburn Cambridge Independent Practice Association, Brighton, Massachusetts. MACIPA is an independent practice association with approximately 500 physicians on staff at Mount Auburn Hospital and Cambridge Health Alliance. It has been working under global payment for 20 years. There are about 114 primary care providers and 381 specialists working in small to large group practices, some of which are private and some are owned by Mount Auburn Hospital or Cambridge Health Alliance. The IPA provides services to physicians for case management, discharge planning, pharmacy management, data/reporting, contracting referral management, utilization review, and information services. Payment for the year is based on a negotiated budget determined by the age and sex of patients. Physicians are paid FFS during the year. A “health status adjuster” formula is used at the end of the year to adjust the budget according to health status of the patients, and expenses are counted against the global budget. Surpluses, if any, are distributed among the doctors and Mount Auburn Hospital according to a range of quality measures and

organizational participation. The IPA assumes up to 100% of the risk, excepting emergency care, and has benefited every year since the global payment model was introduced. Care management and coordination have been key to MACIPA's success with global payments.^{19, 20}

Hampden County Physician Associates, Springfield,

Massachusetts. Hampden County Physician Associates, LLC is a multispecialty group practice with 90 employed providers and is part of the newly formed Accountable Care Associates MSO and its network of 700 physicians in Western Massachusetts. Dr. Gaziano, a medical director in HCPA, and the president of ACA, has developed managed care infrastructure for these two organizations, including for case management, coding, data analytics, and dedicated hospital rounding. HCPA and ACA have provided managed care services in global capitation programs for more than 13 years, and was the first in the state to become delegated to do their own complex disease management for Medicare patients. Network quality, efficiency, and member satisfaction measures continue to improve. The ACA provider networks, which include both large provider practices and solo practitioners, now manage the care for 19,000 members in global capitation ACO-type programs, representing approximately 10 percent of the 200,000 members in the panels of the networks' 124 PCPs. While the majority of the providers still use paper charts, and fee for service care still accounts for the majority of the care delivered, the ACA and HCPA infrastructure has linked the

providers together which has led to best-in-state outcomes in the growing capitated ACO-type programs, and has given the providers improved overall practice satisfaction. Hampden County Physician Associates participates in the BCBSMA Alternative Quality Contract.^{21, 22}

Atrius Health, Boston Metropolitan Area, Massachusetts :

Five leading medical groups joined together as Atrius Health, a non-profit alliance in eastern Massachusetts. Dedham Medical Associates, Granite Medical, Harvard Vanguard Medical Associates, Southboro Medical Group and South Shore Medical Center are working together to create a new and proactive approach to patients' health, coordinated by the primary care doctor and medical team. Atrius Health serves more than 700,000 patients in over 2.4 million visits annually in 30 practice locations. The medical team includes more than 800 physicians and 1,300 other medical professionals, with a combined total of almost 5,500 employees. Atrius Health practices offer over 35 specialties, from obstetrics to pediatrics, including dental services, oncology, cardiology, ophthalmology, sports medicine, allergy, dermatology, surgery and behavioral health - as well as labs, imaging and pharmacies. Atrius Health also takes part in BCBSMA alternative quality contract. Further they are collaborating with Beth Israel Deaconess Medical Center (BIDMC) to establish a new model of health care delivery with the goal of improving quality and lowering costs. The goal is to gain efficiency through shared information technology, strong primary

care and a commitment to implementing best practices.²³

In addition to providing an overview of their organization and/or delivery system, the five representatives will be asked to comment on the following five dimensions of accountable care delivery:

1. **Organization design and stakeholder engagement.**
2. **Form of integration** (i.e. virtual or vertical).
3. **Payment structure**, including quality incentives, risk-adjustment, relationship with payers.
4. **Quality efforts**, including measurement, reporting and transparency.
5. **Government relations.**

Each of these pioneering systems have approached the core components of accountable care delivery in unique ways, while still providing high quality and efficient care. By framing the conversation around these organizational and strategic dimensions, the discussion will provide essential detail and facilitate comparison across the groups.

Policy Opportunities for Massachusetts

Restructuring health care delivery and payment to foster high quality, efficient and accountable care holds significant promise for Massachusetts. Much can be learned from existing models both locally and nationally. Transforming these lessons into policy action presents the crucial challenge for the Commonwealth in the coming years.

The forum will conclude with a panel of Massachusetts stakeholders representing government, payers, providers and consumers. Each group will be affected by a transition to accountable care and also has a role to play in achieving desired outcomes.

The panel will reflect on what was learned from Norton Healthcare, Tucson Medical Center, MACIPA and Hampden County Physician Associates and consider questions essential to successfully moving toward accountable care delivery. Specifically, the stakeholder panel will consider how policymakers can foster the development of accountable, integrated care, what providers can learn from other organizations about how to modify their work, how payers can facilitate change by physicians and encourage buy-in from consumers, and what responsibility consumers have as agents for their own health and health care. These and numerous related issues require critical public dialogue to ensure accountable care delivery promotes quality care and improves the health of Massachusetts citizens.

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