

# **Global Payments to Improve Quality and Efficiency in Medicaid:**

## **Concepts and Considerations**

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Prepared for the Massachusetts Medicaid Policy Institute  
by Mark Heit and Kip Piper  
Sellers Dorsey



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## Executive Summary

There is general consensus that public and private payers alike need to better align provider payments to encourage delivery of effective, efficient and high-quality care. Among the many solutions being considered at both federal and state levels is the use of global payments.

Fee-for-service (FFS) reimbursement is the primary form of provider reimbursement used by health care payers, including the Medicaid program (called MassHealth in Massachusetts). The FFS model, at best, discourages efficiency; at worst, it encourages poor quality and the overuse, underuse, and misuse of healthcare services. In simple terms, FFS creates an incentive for providers to increase volume rather than value, as it does not reward for the clinical efficacy and cost-effectiveness of the care that providers deliver. Under global payments, providers would be paid a set amount to provide all care for a person for a defined contract period (e.g. a year or a month). With payment to providers fixed under this model, there is a disincentive to provide costly and unnecessary care.

On July 16th 2009, the Massachusetts Special Commission on the Health Care Payment System (“The Payment Reform Commission”) recommended that the Commonwealth transition to a system of global payments for healthcare providers over the next three to five years. On October 21st, the Massachusetts Health Care Quality and Cost Council (the QCC) made a similar recommendation.

Payers are beginning to experiment with various new forms of reimbursement, including bundled payment and global payment approaches. Medicare, for example, is currently piloting bundled payments within the Acute Care Episode (ACE) program in New Mexico, Texas, Oklahoma, and Colorado. This initiative will combine physician and hospital payments for certain identified conditions, strengthening the financial incentive for physician-hospital coordination. In Massachusetts, Blue Cross Blue Shield has developed the *Alternative Quality Contract (AQC)*, which is paying hospitals or physician practices a global fee to reimburse for all care provided to members assigned to the contracted entity. The AQC also provides bonuses for high performance on certain quality measures.

Building on these initiatives, the fiscal year 2010 budget includes an outside section authorizing a pilot program that would test the concept of bundling MassHealth payments to one or more hospitals or hospital systems in the Commonwealth. Outside Section 117 authorizes the Secretary of Health and Human Services to “establish an aggregate prospective payment to cover the total cost of a defined set of health care services...creating incentives for such providers to integrate services, manage costs and utilization, and ensure high-quality care.”

As one of the largest payers in the marketplace, Medicaid should be a central part of the planning process for achieving successful and broad scale implementation of global payments. Medicaid provides coverage to more than 1.2 million Massachusetts residents, and provides critical support to both vulnerable populations and the providers who serve them. However, given the characteristics of the population and the unique nature of the federal-state partnership, special consideration should be given when contemplating the design, implementation, and operation of global payments in Medicaid.

### **Special Considerations for Implementing Global Payments in MassHealth**

Despite some experience with bundled payments in Medicare and with commercial populations, Medicaid's unique characteristics demand special consideration when contemplating similar initiatives within MassHealth. MassHealth provides coverage to a diverse set of populations with varied health care needs — some of them particularly vulnerable or with special needs not typically found in a commercial insurance population. In addition, some populations (such as children) are afforded special protections and services under federal law that must be guaranteed under global payments.

To ensure adequate access to MassHealth members within global payment model, MassHealth will need to appropriately assess the capacity and ability of providers to accept global payments. MassHealth members utilize a different mix of providers than individuals receiving care through Medicare or commercial insurance. Specifically, there is a greater reliance on community health centers (including Federally Qualified Health Centers), safety net hospitals, and children's hospitals. MassHealth frequently reimburses these providers using special methodologies to recognize their unique role, and these considerations could be maintained under global payments. As well, community health centers and safety net hospitals may have more limited access to capital financing markets, and MassHealth should assess how this impacts the ability to undertake modernization or infrastructure projects that may be necessary to implement global payments.

At the same time, payment reform efforts offer a unique opportunity to recognize and reinforce the particular specialties or expectations placed on Medicaid providers (e.g. cultural competency, interpreter services, patients involved in the child welfare system). The high proportion of Medicaid members within these providers' patient panels creates a greater opportunity for Medicaid payment reform to drive desired behavior and operational changes at those practices.

In addition, unlike most of the commercially insured population, Medicaid members may be eligible for a broader set of health care services, including acute care, behavioral health (BH), and long-term care (LTC). From a cost and quality perspective, there is a need for

better coordination within and across all three provider systems, which global payments can help to create. However, these additional sets of covered services require further analysis when determining the appropriate balance between alignment of financial incentives and an adequate and reasonable transfer of risk.

Lastly, in order to implement changes to reimbursement for Medicaid covered services, MassHealth must ensure that the approaches comply with the specific state and federal laws that govern Medicaid, and also comply with requirements for receiving federal matching funds.

Without special consideration, the Commonwealth may risk limiting access for members, and potentially undermining the policy objectives embedded in the current payment methods. At the same time, it may also miss the opportunity to significantly impact and improve the delivery of care within these critical provider networks.

## **Recommendations**

Based upon the analysis of the above considerations that are detailed in this paper, the following set of recommendations provides a possible roadmap for implementation of global payments across the MassHealth program.

- 1. Set a Goal and Outline Expectations.** Define the policy objectives related to payment reform (e.g. cost containment, quality improvement, enhanced care coordination). Then, set a target date by which all providers will be paid according to the new payment methodology. Develop and then communicate the transition plan to the provider community. Communication efforts should be continuous over the transition period, and should expand to include dissemination of best practices as that information is compiled, aggregated, and published.
- 2. Immediately Develop a Global Payment Pilot Program.** Develop a pilot program with a defined set of providers that includes high-volume Medicaid providers and providers currently participating in a global fee initiative with a commercial payer. Coordinate the pilot with a Medicaid MCO to also test the approach within a fully capitated delivery system. MassHealth has authority to develop this pilot pursuant to Outside Section 117 of the 2010 budget. The pilot program should provide for some transfer of risk to providers, but should also include risk corridors to limit the potential for undue, negative consequences while the approach is being tested and refined. MassHealth and the MCO can compare global fees to what would have been paid under FFS to determine whether risk corridors are exceeded.

**3. Implement Gradual Payment Reforms for Non-Pilot Providers.** MassHealth should begin implementing “shovel-ready” payment reforms across the program during the transition period, ideally beginning in year 1. Rather than simply flipping a switch on the implementation date, a gradual transition will limit the potential for restricted patient access and reduce incentives for providers to game the reimbursement system.

The intermediate reforms may include “virtual bundling” or payment adjustments for preventable readmissions in year 1. Building on these initial reforms, over the transition period, MassHealth should identify and implement opportunities to gradually expand the bundle of services that non-pilot providers will be accountable for. In doing so, this creates a glide path towards the implementation of full global payments. MassHealth should also build upon existing P4P initiatives to enhance provider response to key quality measures.

These intermediate reforms, many of which were recommended to Congress in the Medicare Payment Advisory Committee’s (MedPAC) March 2008 report, push hospitals and related providers to begin reallocating human and financial capital into new business practices that will evolve into broader system integration over the transition period.

**4. Allow for Voluntary Transition to the Global Fee System During the Transition.** Over the transition period, MassHealth should allow providers to move from the existing system (as modified under #3, above) to the new global fee system. MassHealth may create financial incentives to make this transition by targeting annual rate increases to the global fees while providing lesser or no increase to the traditional rates.

**5. Develop and Disseminate Performance Reports to All Providers.** MassHealth should publish public reports on rates of performance in certain key areas, including, but not limited to: preventable hospital readmissions, brand vs. generic drug utilization, and HEDIS scores. This information should be used to inform providers of their relative performance, set expectations for improvement, and create a feedback loop that will inform performance incentive rate setting and the refinement of a risk-adjustment methodology.

**6. Coordinate Payment Reform with HIT Planning Efforts.** The American Recovery and Reinvestment Act (ARRA) allocates unprecedented federal funding for both planning and implementation of statewide health information exchange (HIE) and provider adoption of *meaningful use* electronic health records — tools critical to the success of a global fee environment. The Commonwealth’s application for a *State HIE Cooperative Agreement Program* grant should focus on the relationship between payment reform, related delivery system reform, and the adoption and use of HIT. To the extent possible, applications for the *HIT Regional Extension Centers* should link the efforts around HIT education and



technical support to the role that HIT plays in redesigning workflows, enabling broader coordination, and providing real-time, actionable information.

7. **Examine opportunities for global payments to enhance coordination of physical, behavioral and long-term care.** As noted above, some Medicaid enrollees often have significant behavioral health and long-term care needs. Coordination across these settings offers tremendous opportunities for improving quality and coordination of care, and reducing costs. However, realizing those gains will require careful planning to avoid disruption in provider relationships in behavioral health and to coordinate with the federal government around long-term care (Medicare pays for most of the acute care services received by elderly Medicaid enrollees who are in nursing homes). The state should explore these opportunities to assure that coordination occurs over the long run.
8. **Stick to the Plan.** A continuing commitment to the plan will be critical to ensuring that payment reform efforts meet the intended objectives of lower cost and improved quality. Set timelines and milestones for accomplishing the stated goals, and follow through with those commitments. The experience of the transition should inform *how* the full-scale program is implemented, not *whether* the program is implemented.

This paper will explore the basis of these recommendations in greater detail, and will evaluate the opportunities for, and barriers to implementing the recommendations of the Payment Reform Commission and the QCC in the Massachusetts Medicaid program.

## Background

To address the inherent issues with both fee-for-service and sub-capitation, payers of healthcare services are beginning to experiment with various new forms of reimbursement, including performance-based and bundled payment approaches. Medicare, for example, is currently piloting bundled payments within the Acute Care Episode (ACE) program in New Mexico, Texas, Oklahoma, and Colorado. This initiative will combine physician and hospital payments for certain identified conditions, strengthening the financial incentive for physician-hospital coordination. In Massachusetts, specifically, Blue Cross Blue Shield has developed the *Alternative Quality Contract (AQC)*, which is paying hospitals or physician practices a global fee to reimburse for all care provided to members assigned to the contracted entity. The AQC also provides bonuses for high performance within certain measures.

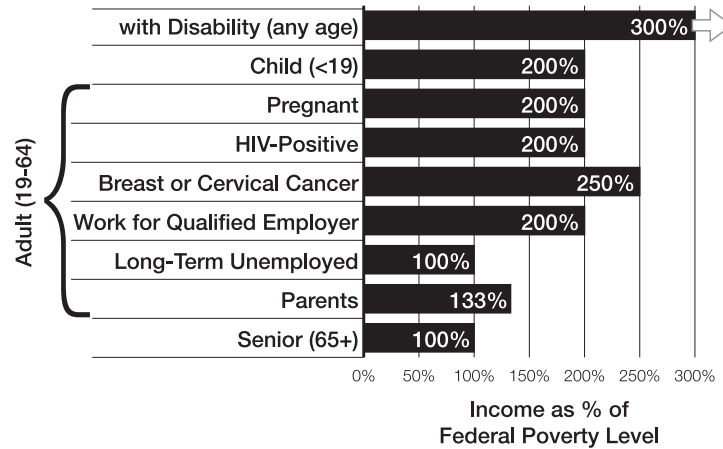
Building on these initiatives, the fiscal year 2010 budget includes an outside section authorizing a pilot program that would test the concept of bundling MassHealth payments to one or more hospitals or hospital systems in the Commonwealth. Specifically, Outside Section 117 authorizes the Secretary of the Executive Office of Health and Human Services to “establish an aggregate prospective payment to cover the total cost of a defined set of health care services...creating incentives for such providers to integrate services, manage costs and utilization, and ensure high-quality care.”

To provide support in pursuing payment reform within MassHealth, the following sections of this paper identify and evaluate the considerations for design, implementation and operation of an alternative payment system within a Medicaid context. While applicable to the authorized pilot, this assessment may also inform the development of broader payment reform beyond the pilot contemplated in Outside Section 117.

### **The MassHealth Population**

MassHealth provides health insurance coverage to over 1.2 million low- and middle-income Massachusetts residents. The program is operated under the Title XIX and Title XXI programs — Medicaid and the State Children’s Health Insurance Program (SCHIP), respectively. In state fiscal year 2009, the MassHealth budget totaled just over \$8.6 billion — over 25% of the state budget. As a federal-state partnership, MassHealth expenditures are eligible for federal matching funds. In general, the Commonwealth receives fifty cents on every dollar for Medicaid expenditures and sixty-five cents on every dollar for SCHIP. In other words, over fifty-percent of the program is paid for using federal dollars.

**Chart 1. MassHealth Eligibility**



MassHealth eligibility varies by categorical and financial eligibility standards, and the benefits provided to members vary between the different eligibility groups. MassHealth enrollees may be eligible for acute care services (including behavioral health), long-term care services, or both. In 2007, long-term care accounted for \$2.4 billion of the program budget.

Individuals enrolled in MassHealth may receive services through a managed care organization (MCO) under contract with the State, through the Commonwealth’s Primary Care Clinician Plan (PCCP), or through an unmanaged fee-for-service (FFS) benefit.

MassHealth eligibility is based upon certain federal categorical standards and additional criteria authorized through the Commonwealth’s Medicaid Section 1115 Waiver (“*MassHealth Waiver*”). From a statutory and regulatory perspective, MassHealth enrollees fall into 6 major categories:

1. Children under 19 years of age;
2. Parents and caretaker relatives living in a home with a child under 19 years of age;
3. Disabled adults;
4. Elderly persons 65 years of age or older;
5. Pregnant women;
6. Long-term unemployed, single adults.

While federal law requires minimum benefits and specific protections for each of these populations, MassHealth does not necessarily manage the program with regard to these groupings.

MassHealth members are ultimately enrolled in four distinct delivery systems — managed care organizations (MCO), senior care organizations (SCO), the Primary Care Clinician plan (PCC), and fee-for-service, which is generally wrap-around coverage for individuals with third party coverage (Medicare or from another source).

Table 1 provides a summary of the considerations for payment reform for these groups.

**Table 1. Key Considerations for Payment Reform by Group**

	Families	Disabled	Seniors	Long-Term Unemployed	
<b>Enrollees*</b>	<b>MCO</b>	352,195	33,141	10,895**	3,722
	<b>PCC</b>	161,270	68,833	N/A	68,053
	<b>FFS</b>	82,033	106,496	95,332	3,260
	<b>Total</b>	595,498	208,470	106,227	75,035
<b>Average Cost</b>	Low	High	High	Low	
<b>Medical Complexity</b>	Low	High	High	Low	
<b>Alignment with Current or Desired Models of Care</b>	PCP model is consistent with concepts of accountability and coordination	Episodic payments are well aligned with CCM and patient centered medical home pilots	The goals for acute and LTC coordination are consistent with bundled payment incentives. Also SCO.	PCP model is consistent with concepts of accountability and coordination	
<b>Other Considerations</b>	<ul style="list-style-type: none"> <li>• Lowest Risk</li> <li>• Largest Group</li> </ul>	<ul style="list-style-type: none"> <li>• 50% Dual Eligibles</li> <li>• Highly Vulnerable</li> </ul>	<ul style="list-style-type: none"> <li>• LTC Services</li> <li>• All Dual Eligibles</li> <li>• Medicare Waiver Required to Share Acute Care Savings</li> </ul>	<ul style="list-style-type: none"> <li>• Different Benefit Package</li> </ul>	

\* Excludes CommonHealth, Family Assistance, MassHealth Limited, Prenatal, Buy-in and Other enrollees

\*\* Senior MCO enrollees are enrolled in Senior Care Organizations (SCO)

Expanding on the information in Table 1, certain groups may warrant special consideration:

*Non-dual Disabled Adults and Children* frequently have complex healthcare needs, including chronic conditions and multiple co-morbidities. These groups comprise a disproportionate share of MassHealth expenditures. Overall, disabled populations make up 20% of MassHealth enrollment and 34% of expenditures. Research suggests that episodic and bundled payments align particularly well with incentivizing best practices for chronic disease management and the development of patient-centered medical homes. If implemented

appropriately, global payments for these vulnerable populations can reduce barriers to care and strengthen incentives for coordination, collaboration, and the use of health information technology. Global fees for this group could be implemented across the entire population, or could focus exclusively on diagnoses (e.g. Type II Diabetes).

*Dual Eligible beneficiaries (seniors and disabled adults)* pose significant issues for care management due to the fragmentation between the Medicaid and Medicare programs. Specifically, the financial incentives for hospital care within Medicare and long-term care (LTC) within Medicaid operate at cross-purposes to high-quality and coordinated care. Exemplifying MassHealth's history as an innovative payer, the Senior Care Options (SCO) program addresses some of these incentive issues through better service integration for senior care organization enrollees. In addition, MassHealth could explore global payments for SCO or non-SCO dual-eligibles to improve communication and coordination between hospital, nursing facility, and community LTC providers.

Separate from MassHealth, the Commonwealth helps to provide insurance to its residents through the Commonwealth Care Insurance Program. While Commonwealth Care is funded using Medicaid funds, it is separately administered from the MassHealth program. From a practical standpoint, Commonwealth Care is generally similar to the MassHealth MCO program. As such, the considerations for the MassHealth MCO program discussed herein could apply to Commonwealth Care. However, this analysis does not specifically address the Commonwealth Care program.

## **Payment Reform Concepts**

Before delving into the specific considerations for implementing a global payment system within the MassHealth program, it is important to understand the various bundled payment methodologies and pay-for-performance models that exist. While the Payment Reform Commission and the QCC recommended implementation of full global payments, the variations detailed below describe different payment reform models that may offer examples of transition initiatives that could be used to gradually move the system towards a full global payment model.

### **Bundled Payments**

Bundled payment comes in a variety of forms and continues to evolve in methodology, application, and nomenclature. The basic concept of bundled payments is simple. In lieu of traditional fee-for-service reimbursement, the projected costs of a patient case are bundled into a single payment or series of payments over time. The types of services, quantity, and duration of services covered within a bundled payment can vary. Therefore, in this paper

we use the terms “bundled” and “bundling” in their generic sense, which includes the entire continuum of bundled payments from limited methodologies (e.g. hospital DRGs), to episodic payments, and all the way to global payments, where the payment includes all services over an extended duration (e.g. one year).

While methodologies vary, bundling or consolidating reimbursement provides several advantages compared to traditional “pay for quantity” rates. For example:

1. Resources are provided directly to the accountable party — the health care provider. Clinicians are able to allocate the resources more quickly and tailor them to patient needs more effectively. Providers are also better able to invest in structural, staffing, and technological improvements.
2. The payer is able to focus on managing and supporting overall quality, safety, and access. Traditional medical management, including techniques many providers see as counterproductive micromanagement, is no longer necessary. The delivery system is thus about performance and empowering the clinicians, not about managing transactions and unit costs.
3. Bundling significantly reduces many of the central provider frustrations caused by traditional reimbursement, including the administrative burden of claims-based billing, payment delays, and uncertainty.
4. Bundling significantly increases the feasibility of implementing widely endorsed health care reforms, such as patient-centered medical homes.
5. Medical spending is far more predictable for purchasers and payers. Cost sharing may be more predictable for consumers.
6. Bundling creates the opportunity for major purchasers and payers in a given market to collaborate on system-wide or all-payer payment reforms.
7. Choice is maintained for patients and their families.

#### **Examples of Bundled Payments:**

The increasingly popular concept of bundling has evolved considerably to include several comprehensive, methodologically sophisticated approaches to consolidate reimbursement and focus resources on patient needs and provider performance.

#### **Hospital Bundled Payments:**

Traditionally, hospitals and surgeons are paid separately. The hospital is heavily reliant on the surgeon’s good will, since surgeons are critically important to driving patient volume.

Absent strong support from the physicians with hospital privileges, it is virtually impossible for a hospital to implement many of the organizational, procedural, staffing, scheduling, or technological changes needed to reduce preventable medical errors, reduce hospital acquired infections, increase patient survival rates, and improve operating efficiency. Many improvements require active participation by the physicians to succeed.

Traditional hospital reimbursement methodologies, most notably diagnosis-related group (DRG) payments, incentivize hospitals to minimize lengths of stay. Poor hospital performance increases the probability of costly readmissions and post-acute nursing and rehabilitation.

Under the bundled payment model, the hospital is paid for both the hospital and physician services associated with an inpatient stay. In effect, it expands upon the limited bundling provided by the DRG system to include physician services. It is a form of episode-based payment. This gives the hospital leverage with the physician and allows creation of performance incentives to reward the physicians for assisting with internal changes.

Among health finance experts and federal policy makers, there is growing support for the use of bundling in Medicare hospital reimbursement. The Medicare Payment Advisory Commission (MedPAC) has also advocated use of bundling. Medicare reform discussions in Congress and the Obama Administration include two possible uses of bundling:

- Bundling of hospital inpatient DRG-based payments and payments for inpatient-related physician services.
- Bundling of hospital inpatient DRG-based payments and cost of the first 30 days of post-acute care (e.g., home health, rehabilitation, skilled nursing facility care).

The Centers for Medicare and Medicaid Services (CMS) are implementing a demonstration to test the use of bundled payments for hospital and physician services associated with inpatient care.

**Episode-Based Payment:**

The provider is paid a specific, risk adjusted global fee to care for all or most of the health care needs of a patient during a pre-defined or reasonably predictable episode of care. An example is obstetrical care, where the patient's obstetrician care is based on a global fee to cover all the routine pregnancy related care, including office visits, lab tests, ultrasounds, and normal delivery.

Episode-based payments work best when the episode has a reasonably defined beginning and end and the patient has one primary acute diagnosis. Therefore, this approach works best for acute care conditions such as a maternity, stroke, heart attack, or hip fracture. While acute

conditions like a heart attack (i.e. acute myocardial infarction) may have a relationship to ongoing chronic conditions (e.g coronary artery disease), the initial acute episode typically has a defined beginning and end.

#### **Evidence-Informed Case Rates:**

An evidence-informed case rate (ECR) is a single, risk-adjusted payment to providers to care for a patient diagnosed with a specific acute or chronic condition. The case rates are based on the resources required to provide health care in accordance with nationally accepted, evidence-based clinical guidelines. The ECR model is under development by PROMETHEUS Payment, a non-profit organization working with large employers, employer coalitions, and leading health services researchers. The ECR model will be rolled out through employer-sponsored demonstrations.

#### **Condition-Specific Case Rate:**

A condition-specific case rate (CCR) is an approach to bundling for outpatient care of chronically ill patients. A group of providers is paid a global fee to care for a patient with a chronic condition(s). The case rate covers the services needed during a defined period, such as a year. To the extent feasible, the case rate is all inclusive, covering all of the primary and preventive care, care management, patient education, and minor acute care services associated with the patient's chronic condition(s). Major acute care services, such as inpatient admissions, are paid separately.

The condition-specific case rate may include performance incentives tied to specific outcomes or process-based measures most relevant to the chronic condition. The case rate is risk adjusted based on the patient's condition, mix of diagnoses (co-morbidities), and other factors likely to affect medical needs. In contrast to traditional capitation and sub-capitation, CCRs are designed to make the provider more directly accountable for their clinical performance.

#### **Global Payments**

Global payments are patient-specific, prospective payments intended to cover the costs of care for all covered services delivered over a defined period. Global payments are set based on an actuarial analysis, and should be risk-adjusted to recognize the variation in costs between patients with different healthcare conditions. While both ECRs and CCRs have elements of global payments, those methodologies are typically specific to certain populations, whereas global payments can be used for patients with no specific chronic or acute condition.



## **Pay for Performance**

Without proper safeguards, bundling payments has the potential for the same access and quality issues as sub-capitation. Pay for Performance (P4P) is one potential approach to mitigate some of these risks through the use of positive financial incentives to comply with clinical guidelines and best practices. MassHealth has implemented P4P initiatives for hospitals and nursing facilities serving Medicaid patients, and the Governor has proposed to expand these programs in his fiscal year 2010 budget.

P4P is an increasingly popular reimbursement reform. Building on the principles of value-based health care purchasing, P4P is intended to align provider payments (or at least a material portion of payments) with specific performance expectations. P4P may be used to incentivize providers (most commonly, physicians and hospitals) or health plans (through incentives from the purchaser, that is, employer, Medicaid, or Medicare). Most P4P programs apply to physicians or hospitals, although some purchasers, most notably state Medicaid programs, have P4P programs directed at health plans.

Therefore, P4P is layered on top of either traditional fee-for-service rate schedules or the bundled payment methodologies described above. The purchaser or payer establishes specific performance expectations, typically using a mix of process-based measures and outcomes-based measures. Specific incentives are tied to the provider's actual performance compared to the measures. P4P programs commonly select from among measures vetted through the National Quality Forum's consensus-based process for evaluating and endorsing quality measures.

Most incentives are monetary, typically a specific percentage add-on to fee-for-service rates. However, some P4P programs use other, non-financial incentives such as public recognition or higher market share for the best performers. Today, there are over 150 P4P programs across the U.S., ranging from small pilot projects to large-scale regional or national initiatives.

Evaluations of P4P programs consistently show improvement in one or more quality indicators. The extent of improvement varies from modest to significant. However, since P4P is ultimately about changing provider behavior and is built on top of traditional payment methods, it is often difficult for evaluators to separate the effect of financial incentives from other factors, such as other quality improvement efforts, staffing changes, patient behavior, and changes in patient case mix. Also, the magnitude of the performance incentive impacts the efficacy of the P4P program.

P4P programs are complex and time consuming to design, implement, and operate. The adequacy of risk adjustment and other safeguards, selection and vetting of measures, determining the right mix of process and outcomes based measures, whether to include

measures of cost efficiency, the size and frequency of incentive payments, data collection and verification, provider training and avoidance of gaming are just some of the issues P4P programs must address to be successful. Finally, P4P programs are typically additions to existing service-based fee schedules. Therefore, even in a robust P4P system, it is likely that only a relatively small portion of overall reimbursement is aligned with clinical objectives. However, coupling P4P with a bundled or episodic payment has the potential to both augment the strength of the financial incentives and decrease the risk of providers withholding necessary and appropriate services.

## Considerations for MassHealth

The Payment Reform Commission and QCC's ultimate goal of implementing broad scale global payments across the Commonwealth requires specific and careful consideration when making those changes to the MassHealth program. Executive Office of Health and Human Services and MassHealth leadership must undertake a range of planning and communication activities that ensure minimal disruption to the delivery system, and maximize the potential for improvements to cost and quality that the recommendations anticipate.

In large part, design, implementation, and operational considerations for MassHealth payment reform relate to transition planning efforts. The following discussion outlines the challenges and priorities for moving MassHealth reimbursement to global payments over the next several years.

### Design Considerations

Within a Medicaid program, there are four primary areas of consideration when designing a payment reform. Each of these topics is discussed in more detail in this section:

1. **Target Population:** The segments of the Medicaid population that will be included in a program change.
2. **Delivery Systems:** The clinical and administrative systems through which individuals within the target population receive care.
3. **Services:** The medical services that will be reimbursed through the new payment method.
4. **Reimbursement:** The basis and methodology upon which service providers will be paid.

### Target Population

Policymakers may choose to implement a global methodology for one, multiple, or all populations within the MassHealth program. For each group, it is important to consider a number of factors when sizing the opportunity and designing a program. These considerations include:

1. **Size of the Group:** The complexity of implementation, the likelihood of altering provider behavior, and potential cost savings are all affected by the size of the group that will be targeted for global payments. In the context of a pilot, the size of the group may also be limited by the number of participating providers (i.e. capacity) or by the administrative resources available to manage the initiative. Overall, the objective should be to maximize

the size of the group such that participating members make up a significant enough portion of a provider's panel to justify reorganizing the delivery of care.

This goal must be balanced, however, with the need to ensure appropriate access for members, limit the potential for gaming, and allow for proper monitoring and oversight. It is also important to acknowledge that a participating provider's behavior will be affected by the payment methodologies under which their other patients are reimbursed. As such, MassHealth should contemplate the extent to which participating providers are already serving commercial patients that are reimbursed under a global fee model.

2. **Cost of the Group:** The overuse, underuse, and misuse of care contributes to both low quality and high cost. By targeting population cohorts with high average cost or large variation in cost, MassHealth has the opportunity to derive significant savings from payment reform. If capacity or administrative resources limit the size of the pilot, MassHealth may want to focus on high cost groups to maximize the return on investment of the initiative.
3. **Medical Complexity:** The complexity of the target population's medical needs will frequently determine the number of providers involved in the delivery of care, the need for coordination of care, and the average cost of the patient. As well, complex cases — those involving chronic disease or co-morbid conditions — present a high risk-reward paradigm. The potential for positive impact on both cost and quality is balanced against the vulnerability of the population and the potential negative consequences resulting from limited access or other unintended consequences. Thus, the medical complexity of the target population affects the risk to members and providers, as well as the need for rigorous monitoring and oversight.
4. **Alignment with Current Models of Care:** As noted above, bundled payments, including global fees, align particularly well with integrated models of care, including patient-centered medical homes and the Chronic Care Model (CCM). Where MassHealth intends to or currently provides care to certain individuals through integrated models of care, it may be prudent to target this same population and overlay a global payment approach to the clinical care model.

## **Delivery Systems**

The discussion of delivery systems within the Medicaid program has two distinctions:

1. **MassHealth as Payer or Purchaser:** MassHealth enrollees who do not have third-party coverage (either through Medicare or another source) must choose between an MCO or the PCC Plan. Individuals with third-party coverage are generally enrolled in FFS, with

the exception of dual-eligible members enrolled in a Senior Care Organization (SCO). The distinction here is that in some instances, MassHealth's role is that of a payer (i.e. setting rates, enrolling providers, paying claims), as for the PCC plan and FFS programs, and in others is that of a purchaser (i.e. contracting with payer organizations), as it does in the MCO and SCO programs.

2. **Provider Network:** Regardless of purchaser vs. payer role, MassHealth enrollees are receiving care through certain provider delivery systems. These systems may be integrated or non-integrated health systems, and may include hospitals, physicians, other practitioners, and long-term care providers.

In the context of a transition plan, MassHealth must consider how payment reform will be staged within the various plan types, and also how and when provider networks will be selected for conversion from fee-for-service to a global payment method.

#### **MassHealth as a Payer vs. Purchaser**

The nature of MassHealth's role in administering the PCC plan and the FFS program versus that related to the MCO and SCO programs has significant implications for how a global payment program would be designed and administered. The Commonwealth has the option to utilize these different roles to test and stage implementation of global payments in a manner that best utilizes its resources. Ultimately, however, where broad payment reform is sought across the program, MassHealth should develop policies and procedures that ensure the global payment administration is consistent across both payer and purchaser programs.

1. **Primary Care Clinician Plan (PCC Plan):** The PCC Plan is a state-administered managed care option. With the exception of dual-eligibles, PCC enrollees include segments of nearly all eligibility groups within Medicaid. As of April 2009, approximately 70% of all non-dual disabled enrollees were enrolled in the PCC Plan. Services provided to PCC Plan enrollees are paid on a fee-for-service basis according to the MassHealth fee schedule. Behavioral health services for PCC Plan members are carved-out and provided through the Commonwealth's behavioral health contractor, the Massachusetts Behavioral Health Partnership (MBHP). Implementing global payments within the PCC plan would require MassHealth and the Division of Health Care Finance and Policy (DHCFP) to conduct all the necessary operational activities to administer the global payment model.
2. **Medicaid MCO:** Currently, there are four managed care plans serving the MassHealth population — Boston Medical Center's HealthNet, Neighborhood Health Plan, Cambridge Health Alliance's Network Health and Fallon Community Health. The MCOs are full-risk plans that include all acute services for enrolled members (including behavioral health and pharmacy). Like PCC Plan enrollment, MCO enrollees include segments from

all non-dual eligibility groups. MCOs are procured through an RFR process, and operate under annual contracts with MassHealth. Each MCO operates only in defined service areas as stipulated in contract. Typically, MCOs pay providers on a fee-for-service basis, though in some cases, sub-capitation or some form of global payment is being used. Implementing global payments more broadly within the MCOs would require MassHealth to work with the MCOs to design the program, and potentially make contract changes, but the MCOs would be responsible for the operation of the global payment program.

3. **Senior Care Organizations (SCO):** The SCO program is a nationally-recognized managed care program for seniors. Enrollment in the SCO program is voluntary. Currently, there are three plans (or senior care organizations) serving SCO enrollees: Senior Whole Health, Evercare, and Commonwealth Care Alliance. For dual-eligible enrollees, the senior care organization administers both Medicaid and Medicare benefits, providing a fully-integrated medical option for this vulnerable group. The SCO program includes seniors residing in institutions as well as those living in the community. The SCO is responsible for both long term care and acute services. In general, Medicare (or more specifically, the Medicare Special Needs Plan — SNP) is paying for the majority of acute services provided to SCO-enrolled seniors. Medicaid is typically paying only the co-insurance and deductible for these services. As such, implementation of global payments for the SCO population would require coordination with Medicare to address provider reimbursement restrictions and requirements within the regulations and laws governing Medicare SNPs.
4. **Fee for Service (FFS):** FFS could be considered the absence of a plan type, rather than a distinct delivery system. As the name implies, all services are paid on a FFS basis. Most FFS enrollees are dual-eligibles. For these individuals, Medicaid is paying a portion of acute services through third-party liability for Medicare cost-sharing requirements. Medicaid is also paying for long-term care services where the individual is eligible. Other FFS enrollees include individuals who have not yet selected the PCC Plan or an MCO, MassHealth eligible individuals with other sources of insurance coverage, and some other small groups. Considering the majority of FFS enrollees have either Medicare or commercial insurance coverage, implementation of global payments for this population would involve coordination with both Medicare and commercial payers. Regarding Medicare enrollees, as with SCO-enrollees, payment reform would require either waiver or demonstration authority. As for FFS-enrollees with commercial coverage, global payments would require the commercial insurance plan. Implementation within this group may be difficult because of the variation of services covered by the commercial insurance and the corresponding variation in “wrap-around” services that MassHealth provides to those individuals.

Each plan type offers different administrative and policy benefits related to the implementation of an alternative payment methodology. The pros and cons of these plan types are discussed in Table 2.

**Table 2. Pros and Cons of Global Payments by Plan Type**

Plan Type	Pros	Cons
<b>MCO</b>	<ul style="list-style-type: none"> <li>• Administrative infrastructure</li> <li>• No State Plan or Waiver Changes</li> <li>• May already have experience with sub-capitation and P4P</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of control over implementation</li> <li>• Requires contract amendment</li> <li>• May add administrative costs</li> <li>• Savings will not accrue immediately</li> </ul>
<b>PCC Plan</b>	<ul style="list-style-type: none"> <li>• Bundled payments complement primary care clinician model</li> <li>• Greater control over implementation</li> </ul>	<ul style="list-style-type: none"> <li>• Requires significant investment of MassHealth time and resources.</li> <li>• State Plan and Waiver Requirements</li> </ul>
<b>SCO</b>	<ul style="list-style-type: none"> <li>• Fully integrated delivery system</li> <li>• No waiver may be required</li> <li>• Complex enrollees by design</li> <li>• Diverse provider relationships</li> </ul>	<ul style="list-style-type: none"> <li>• Relatively small population (9,708)</li> <li>• Potential to disrupt carefully designed program</li> <li>• Coordination with SCO required, and potentially a Medicare waiver</li> </ul>
<b>Fee-for-Service</b>	<ul style="list-style-type: none"> <li>• Payment reform offers opportunity for improved outcomes from current unmanaged model</li> <li>• Greater control over implementation</li> </ul>	<ul style="list-style-type: none"> <li>• Requires significant investment of MassHealth time and resources.</li> <li>• State Plan and Waiver Requirements (including Medicare)</li> <li>• Majority of population are dual-eligible (Medicare coordination and financing)</li> </ul>

### Provider Networks

It will be critical that MassHealth appropriately assess the capacity and ability for provider networks to accept global payments. MassHealth members utilize a different mix of providers than individuals receiving care through Medicare or commercial insurance. Specifically, there is a greater reliance on community health centers (including Federally Qualified Health Centers), safety net hospitals, and children’s hospitals. MassHealth frequently reimburses these providers under different methodologies to recognize their unique role in the program. In addition, these entities may have more limited access to capital markets that could be used to fund modernization or infrastructure projects.

At the same time, payment reform efforts offer a unique opportunity to recognize the particular specialties or expectations placed on Medicaid providers (e.g. cultural competency, interpreter services, patients involved in the child welfare system). Furthermore, the high proportion of Medicaid patients at many of these providers creates a greater likelihood that

Medicaid payment reform can drive behavior and operational changes across other payer types as well — broadening the potential quality and cost improvement impact.

Without special consideration, the Commonwealth may risk limiting access for members, and potentially undermining the policy objectives embedded in the current payment methods. At the same time, it may also miss the opportunity to significantly impact and improve the delivery of care within these critical provider networks. Consideration must be given to:

1. **Integration:** The level of clinical, operational, and financial integration between primary, acute, and post-acute providers will determine the provider system's preparedness to effectively coordinate and manage the services (and thus costs) of the participating population.
2. **Presence of Technology:** Technology, both in the form of electronic medical records and other communication and collaboration tools, is assumed to be central to the administration and delivery of effective, timely and efficient care. A provider network accepting a global payment must possess necessary technologies (and protocols for the use of such technology) to ensure that information is being shared and utilized in the clinical decision making process.
3. **Medicaid Payer Mix:** Providers that are serving a disproportionate number of Medicaid patients present challenges and opportunities for global payment implementation due to their reliance on public funding, payment-to-cost ratios, and ability to cost-shift revenue shortfalls to other payer sources.
4. **Experience with Global Payments and Alignment with Other Payer Initiatives:** To the extent that providers are already accepting global payments, they are likely more prepared to accept such payments for MassHealth patients as well. Furthermore, evaluating instances where other payers are utilizing global payments, aligns MassHealth payment policy with those payers, thus strengthening desired incentives.

### **Integration**

Integration refers to both the organizational relationships (i.e. corporate structure, physical proximity, business affiliations, etc.) and the clinical integration of services delivered. Frequently, the term “integrated delivery system” is used explicitly to describe health care corporations that include hospitals, clinics, physician organizations, and other non-acute providers. While these models almost certainly meet the definitions of both organizational and clinical integration, the absence of a single corporate structure does not necessarily denote the absence of integration within a provider system. Regardless, any provider accepting global



payments will require an above average level of integration in both clinical and financial terms in order to ensure overall financial viability, and appropriate access to participating patients.

The integrated care models and experiments with global payments at Geisinger Health System in Pennsylvania and the Mayo Clinic in Minnesota have drawn national attention. These systems are highly integrated in both financial and clinical terms. Furthermore, these systems have dominant market share within their respective geographies. As a result, both of these systems possess closely aligned financial incentives for their hospitals, physician practices, and other non-hospital based providers. Not surprisingly, these financial incentives have also contributed to an organizational commitment to collaboration, coordination, and integration of clinical operations. These examples suggest that highly integrated systems may be better equipped to handle the transition to global payments. This is largely due to the organizational structures already in place that support the processes necessary to manage care within the financial boundaries of a fixed payment. Furthermore, these financially-integrated providers can more easily deal with the allocation of the fixed fee between different entities within their system.

Massachusetts does not necessarily have a provider system with the same characteristics as either Geisinger or Mayo. However, the level of integration achieved by hospitals and health systems in the Commonwealth does vary by provider and by region. These variations suggest that provider preparedness for a transition to global payments may also vary and should be considered when identifying providers to initially participate in the payment reform initiative.

To effectively manage global payments, a provider does not need to be a single, integrated health system, but it does need to be part of *a* system. That is to say, corporate integration may be a benefit, but its absence does not necessarily suggest ill-preparedness for payment reform, nor must it suggest an absence of coordination and communication between providers who lack a formal affiliation with each other. It is likely that informal relationships within the MassHealth provider network do exist, and that these offer efficient and high-quality options for care. Both with respect to implementation of payment reform and to the improved management of the PCC Plan, it is important that MassHealth evaluate the existence of these informal relationships and referral patterns. To the extent these networks exist, they may have significantly lower cost structures than many larger, fully-integrated institutions. By recognizing these informal networks and exploring global payments within them, MassHealth may be able to implement policies that replicate successful integration within efficient, high-quality, non-integrated health systems.

## Presence of Technology

Health information technology (HIT) can provide timely, decision-relevant information to providers that will allow for more effective management of an individual's care. However, under FFS reimbursement, there is only a limited business case, particularly for independent practitioners, to adopt the use of these tools. Global payments realign and improve the financial incentives for adoption by moving away from volume-based purchasing. Appropriately then, the financial model for bundled payment (and in particular, global payment) relies on the use of HIT to improve quality and reduce costs.

The American Recovery and Reinvestment Act created unprecedented funding to support the development of statewide health information exchange (HIE) networks and fully interoperable electronic medical record (EMR) technology across the Medicaid acute care provider community. These programs include funding to develop infrastructure, incentivize providers to purchase and *meaningful(ly) use* certified EMRs, and provide necessary training and education to providers as they incorporate these systems into their practices. The long-term value of these HIT investments (in terms of improved quality and reduced costs) is predicated on the same redesign of physician and hospital practices that a global payment approach presumes. In order to generate return on the HIT investment and to successfully operate within a global fee structure, participating providers and their community partners will need to adopt and *meaningful(ly) use* interoperable EMRs that connect to a statewide HIE.

It is important to note, however, that as of today MassHealth providers vary significantly in their use of EMRs and other HIT. Therefore, MassHealth should initially focus on pursuing global payments with provider networks (formal or informal) that are more advanced in the implementation process.

To address these issues, MassHealth should clearly define how its ARRA investments will further payment reform and ensure that it is incorporated in the HIE and EMR incentive payment planning processes. This integration can potentially provide additional federal funds to support global payment implementation. Specifically, MassHealth should explore the inclusion global payment implementation in its State Medicaid HIT Plan (as described in the September 1<sup>st</sup>, 2009 State Medicaid Director Letter) as well as the HIE strategic and operational plans required for the ARRA-related *State HIE Cooperative Agreement Program*. There may also be additional opportunities to align and coordinate the training and workflow redesign activities associated with global payment implementation with the activities the *Regional Extension Centers (RECs)* will be providing as it relates to EMR adoption and HIE.

These ARRA opportunities provide funding that significantly reduces the financial barriers to EMR adoption for high-volume Medicaid hospitals and non-hospital based providers<sup>1</sup>, and thus support successful implementation of global payments.

### **Medicaid Payer Mix**

The proportion of a provider's practice comprising Medicaid patients affects how that provider or group will respond to the financial incentives within a new Medicaid payment methodology — the higher the ratio of MassHealth patients, the stronger the response to the new methodology. MassHealth should consider each provider's payer mix when selecting providers for participation during the transition, and should closely monitor the impact of the new methodology on providers with relatively high proportion of Medicaid patients.

In terms of effecting change in the MassHealth program, reforming payment for large Medicaid providers presents the best opportunity to affect the care of the greatest number of members. Where Medicaid makes up a significant proportion of provider revenues, that provider has a stronger financial incentive to reorganize itself in a manner consistent with the incentives within the MassHealth methodology and thus change how care is delivered to those MassHealth patients. Furthermore, MassHealth should continue the practice of linking payment policy with overall policy objectives for Medicaid providers. As noted before, this may include ensuring that global payment design recognizes issues of importance to MassHealth such as cultural competency, interpreter services, and special considerations for populations like those in the child welfare system.

However, wholesale changes to Medicaid reimbursement also potentially pose greater risk for these providers. Whereas other providers can cross-subsidize Medicaid and Medicare business with operating margins from commercial payers, safety net, and other high-volume Medicaid providers frequently lack sufficient commercial revenues to operate in this fashion.

As such, MassHealth should make sure to design payment reform efforts in a manner consistent with its policy objectives and expectations for Medicaid providers, and should also closely monitor the impact of payment reform on the financial performance of large Medicaid providers, in particular.

### **Experience with Global Payments**

A simple determinant in assessing a provider system's ability to accept global payments is whether that system is currently accepting some form of them. While experience with other populations does not guarantee that the provider system will be prepared to manage similar

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<sup>1</sup> High-volume, non-hospital based provider is defined as a non-hospital provider having at least 30% MassHealth patients (or 20% for certain pediatric providers). Such providers are eligible for up to \$63,750 in federal funds through Medicaid payment incentives.

payments within MassHealth, it does give some indication of the ability of the system to organize itself around the patient and manage performance risk.

Furthermore, and perhaps more importantly, the financial incentive to restructure practices is strengthened where payers align payment methods. Where Medicaid is not the predominant payer, MassHealth can and should “piggyback” on commercial payer, global payment initiatives. In gross terms, Medicaid only comprises between ten and fifteen percent of total acute care volume.<sup>2</sup> Therefore, the success of global fees in changing provider behavior, in large part, relies on MassHealth coordinating and aligning payment reform with other payers (including both commercial, and ideally Medicare).

## Services

The scope of services included in a bundled payment determines the level of responsibility and the risk that providers will assume in the context of payment reform. Despite a global payment including *all* the covered services provided to a member, within Medicaid, there are still questions about what that global payment includes — acute care services, behavioral health services, and/or long-term care services. The goal when defining this package of services is to strike a balance between the strength of the incentives to coordinate care and what can be reasonably expected of those providers.

### Services Included in the Bundled Payment

MassHealth must identify the bundle of services that will be included in a global fee, and the array of services that may be gradually incorporated into the payment over the transition period. While there are no hard and fast rules, there are certain principles that policymakers should keep in mind.

1. **Bundling Changes Business.** As the services included in the rate expand across providers, the entity receiving the payment also becomes responsible for allocating those funds between the various entities delivering services. The ability for providers to manage these types of financial and contractual relationships will vary, and the process carries an administrative cost. Furthermore, this role represents a key element of market power and influence. For this is the reason, it *may* be easier for MassHealth to start with more formally integrated delivery systems.
2. **Virtual Bundles Work.** It is important to note that even though related providers may not be included in the global fee, changes to hospital reimbursement, for example, have the potential to affect the behavior of non-hospital providers. Take for instance the impact of prospective payments on non-hospital care in the 1980s and 90s. While not resulting in

<sup>2</sup> FY08 DHCFFP 403 Cost Report.

any changes in Medicare physician reimbursement, the implementation of the diagnostic-related groups (DRG) system for hospital payment resulted in vast and significant changes in physician care practices. This reinforces the concept that payment incentives for a single agent within a delivery system can change how that entity interacts with other agents, and thus how care is delivered overall. This all suggests that there are intermediate steps between the current fee-for-service system and full implementation of global payments that can ensure manageable risk during implementation, and still generate a level of desired results — progress.

3. **Bundles Can Expand Over Time.** As delivery systems respond to new financial incentives within intermediate payment bundling, these systems reorganize themselves in a manner that allows them to accept additional risk. As such, MassHealth can gradually expand the bundle of services for which a provider is financially responsible over the transition period. In most cases, hospital relationships with physicians and physician groups will be most mature at the outset. Within MassHealth, many of these relationships also include outpatient clinics and community health centers — either wholly-owned or independent. MassHealth should assess the strength of formal and informal hospital-clinic and hospital-physician relationships throughout the transition to identify opportunities to expand the bundle, ultimately reaching full global payments by the implementation date.
4. **Think Long Term (Care).** Unlike commercially insured individuals, a significant segment of the Medicaid population is eligible for long-term care services — nursing facility or home and community-based services. In some cases, these individuals are dually eligible for Medicare and Medicaid. In others, Medicaid is the primary payer for acute and long-term care services. In either case, the absence of coordination between the acute and long-term care providers results in lower quality care, and frequent and unnecessary movement between both settings. This lack of coordination also can lead to higher expenditures for both programs (i.e. payments for preventable hospitalizations, or higher rates for LTC services resulting from a premature decline in functional health status). While broad payment reform across the entire acute system does not necessarily need to contemplate how LTC services relate to global payments, MassHealth needs to consider this. This same logic applies to behavioral health services.

## **Reimbursement**

The reimbursement rates are the ultimate determinant of the risk transferred through bundled payments. The following are critical components of program design that MassHealth should consider when developing a reimbursement methodology for payment bundling:

1. **Appropriate Risk Adjustment.** Rates should be risk-adjusted to ensure that global fees appropriately reflect the risk of each individual. This will reduce the likelihood of “cream-skimming” and the incentive to withhold services for higher need patients.
2. **Actuarial Soundness.** Global fees need to be actuarially sound to ensure that the rate fairly reimburses for the risk transferred and the probable costs that the provider will incur. Actuarial analysis should be based upon a Medicaid population.
3. **Performance Incentives.** Performance incentives need to be based upon generally accepted measures that are specific to the MassHealth population.
4. **Risk-Sharing.** Risk sharing arrangements can be implemented as a short term or long term solution to issues of unaccounted for risk, adverse selection, or catastrophic events.

### **Appropriate Risk Adjustment**

Risk adjustment is an essential component of any payment reform, particularly global rates. The demographic and clinical diversity of the Medicaid population make proper risk adjustment even more critical. The risk associated with a young healthy child is different from a pregnant woman, which is different from an elderly person residing in a nursing facility. In addition to the variation within the population, MassHealth enrollees also differ from other groups more broadly, such as Medicare and commercial — potentially poorer, sicker, and with more intensive behavioral health needs.

The Payment Reform Commission recommends the use of risk adjustment to account for these factors. However, while a number of risk adjustment systems are currently used in the Medicaid managed care setting, these methodologies were not developed for purposes of setting rates for physician or hospital panels. The Payment Reform Commission suggests that risk adjustment should be used to separate performance risk from insurance risk, however the risk adjustment methodologies have not historically been used for that purpose. Rather, risk adjustment has been used to modify rates and reallocate funds between managed care organizations (MCOs) — entities that are also carrying insurance risk. Furthermore, enrollment in these MCOs is typically much larger than any physician practice, and thus defrays much of the risk associated with imperfections in the risk adjustment methodology.

While these risk adjustment tools have significantly improved in recent years, they were not developed for the purpose of drawing a clear distinction between insurance and performance risk. Additional study and improvement of risk adjustment methods is required before applying these same approaches to provider rate setting. However, despite additional research, risk adjustment methodologies will never be perfect. Therefore, providers, payers, and policymakers need to acknowledge that the absence of a perfect risk adjustment methodology

will not preclude the implementation of payment reform. These imperfections can and should be mitigated through appropriate risk sharing strategies, as described below.

### **Actuarial Soundness**

Case rates, whether for hospitals or clinics and whether for episodes of care or specific chronic conditions, must be actuarially sound. The data used in the actuarial model must be specific to the Medicaid population. MassHealth may be able to utilize an existing contractor to assist with rate development, or could identify a pre-approved vendor for an expedited procurement process.

Actuarial analysis does allow for some variability in the rate setting process — often referred to as the actuarially sound range. It is important to note that current Medicaid rates are generally lower than commercial rates. While this does not necessarily denote underpayment, the lower rates suggest that MassHealth may have a greater difficulty soliciting provider involvement than a commercial insurer might have when implementing global payments.

It is also important to distinguish between the need for actuarial soundness in the setting of global fees and the federal requirement for actuarial soundness for at-risk Medicaid health plans. In this case, actuarial soundness refers to the need to ensure that risk and expected costs are accurately reflected in the global fees, rather than compliance with the actuarial soundness provisions included in the Balanced Budget Act of 1997.

### **Performance Incentives**

The experience of pay for performance programs across the country provides many useful lessons in the structure of financial and other performance incentives. In particular, the incentives should be:

- Paid on a timely basis, preferably several times a year;
- Explicitly tied to the performance expectations; and,
- Sufficiently large, as a portion of total payments, to function as a genuine incentive.

The identification of performance expectations and associated measures requires careful consideration and consultation with stakeholders. The selection and vetting of measures, determining the right mix of process and outcomes based measures, whether to include measures of cost efficiency — all require thoughtful deliberation. Expectations and their measures should be limited in number, easy to understand and communicate, and directly relevant to the patient populations affected.

MassHealth currently administers P4P programs in hospitals and primary care clinician settings, both of which have applicability to the payment reform discussion. These programs are in various stages of maturity, and should be used as a baseline from which to improve and develop the more robust performance incentives envisioned under payment reform.

To the extent feasible, MassHealth should consider expanding P4P measures and select from among measures already endorsed through the National Quality Forum. The NQF's elaborate, highly deliberative, evidence-informed, and consensus-driven process helps ensure measures are scientifically defensible. Using NQF-endorsed measures also helps promote consistency among payers in the same marketplace. The selected measures should be appropriate to the Medicaid population at-large, or to the specific population targeted within the initiative — maternity measures for pregnant women; child-related measures for children; or diabetes measures for diabetics.

### **Risk Sharing**

The transfer of risk to providers can also be mitigated through contractual risk sharing arrangements. MassHealth and other Medicaid agencies frequently use such approaches to limit risk in managed care contracts. The primary examples of this type of risk-sharing are risk corridors and risk pools. These can be implemented through contract, and must be described in any state plan or waiver amendments required to modify provider payment.

1. **Risk corridors** limit the financial exposure of global payments to a provider within certain bands of cost. For example, a provider may be at risk for incurred costs up to 120% of the global rate, but the Commonwealth could share in some percentage of the risk for costs incurred above that level.
2. **Risk pools** are similar in that they provide funding for unexpected risk. Risk pools can be developed, however, to address the potential that risk adjustment may not sufficiently address risk associated with certain conditions. The pool allows the risk sharing arrangement to be limited to those specific populations.

### **Implementation Considerations**

Successful reform efforts require a smooth and transparent implementation. The discussion of implementation within MassHealth addresses five major issues.

1. **Federal Approvals.** The state plan and waiver amendments required for federal approval.
2. **Contracting Approaches and Rate Setting.** The contractual terms between providers and MassHealth or the MCOs and MassHealth.



3. **Member Assignment.** The process by which members will be assigned to a provider network.
4. **Provider Education and Involvement.** The means undertaken to ensure that the reimbursement principles and contractual terms are transparent to the providers.
5. **Transition Planning.** The approach to testing and scaling the initiative.
6. **Systems Modifications.** The changes to the Medicaid Management Information System (MMIS) and the eligibility verification system required to reimburse on a global fee basis.

### **Federal Approvals**

The federal approvals required to implement global payments vary based upon the different federal authorities under which the MassHealth program operates, and the structure of the ultimate payment reform initiative.

1. **Medicaid Section 1115 Waiver.** The waiver that authorizes fully capitated managed care, the PCC plan, and a range of provisions under which MassHealth administers the program.
2. **Medicaid State Plan.** The governing document for Medicaid that defines eligibility, payment methodologies, and other requirements defined in Section 1902 of the Social Security Act.
3. **Authority Related to Dual-eligibles and Medicare.** Additional authorities are required as it relates to changes to acute care payment for individuals enrolled in Medicare.

### **1115 Waiver**

Section 1115 of the federal Social Security Act permits state Medicaid agencies to request waivers of certain federal requirements in order to conduct multi-year demonstrations. The majority of MassHealth populations receive benefits under authority of the Commonwealth's 1115 MassHealth waiver. The current MassHealth 1115 Special Terms and Conditions include certain waivers that allow for the operation of managed care (MCO and PCC plan) that could be interpreted to allow for the implementation of global payments. However, it is likely that additional authority may be required for MassHealth to implement global payments in the PCC plan, and certain that CMS would want to review the 1115 waiver list to ensure that the payment methodologies are compliant with the terms of the MassHealth waiver. Nonetheless, it is very likely that CMS will look favorably upon an initiative to reform the MassHealth payment system to move to global fees.

### **State Plan Authority**

For changes to reimbursement where MassHealth is the payer (FFS or PCC Plan), MassHealth will be required to file a State Plan Amendment (SPA). The SPA will describe the providers eligible under the payment method, the amount of the payment or the method for calculating the amount, and any related restrictions to provider payment. While the SPA for global payment must be properly written and submitted, federal approval is likely. The State Plan process generally takes between 90 and 180 days for approval. Federal funds are not available until the SPA is approved by CMS. MassHealth is required to comply with all state and federal public notice requirements.

For MCO enrollees, there is no State Plan Amendment required. In general, MassHealth delegates physician and hospital payment policy to the MCO contractors. Federal permission is not required for health plans to negotiate alternative payments with providers. However, if the MCO is required to do so under new terms of its contract with the State, CMS will need to review the new contract.

Therefore, global payment for hospitals and/or physicians in MassHealth could be done:

- Through the PCC Plan, using a state plan amendment to implement rate changes along with potentially necessary changes to the 1115 waiver;
- On a voluntary basis by one or more participating health plans, perhaps initially on a demonstration basis and, or;
- Through a requirement in the Commonwealth's contract with the MassHealth managed care plans.

To the extent that payment is being changed for waiver populations, CMS may require assurances that the payment modifications will not affect the budget neutrality agreement. Given the objective to control long-term costs and provide greater budget certainty, providing these assurances should not pose any problems.

### **Authority Related to Dual Eligibles and Medicare**

Because Medicare pays for the majority of acute care for dual-eligibles, separate Medicare authority would be required to institute global payments for this population. Under separate statutory authority, states may request federal waivers to test new Medicare payment policies. While implementing global payments for the non-dual-eligible MassHealth population may not require additional federal waivers, Medicaid and/or Medicare demonstration waivers will be necessary to implement payment reforms as part of a larger, multi-payer initiative that includes Medicare beneficiaries.

In order to implement global payments for dual eligibles that would alter hospital or other Medicare reimbursement, the Commonwealth would require a Section 402/222 waiver<sup>3</sup>. The SCO program was initially implemented through such a waiver, but it was eventually phased out as Medicare evolved to include Special Needs Plans and risk-adjusted payment.

Implementing changes to the reimbursement for long-term care services for dual eligibles will require changes to the State Plan and likely also to the related Medicaid 1915(c) waiver.

### **Contracting Approaches and Rate Setting**

The contracting and rate setting approaches to implement global payments will vary based on whether MassHealth is operating as the payer (PCC Plan and FFS) or the purchaser (MCO and SCO). These modifications will be required in addition to the federal approval processes noted above. In the case of PCC Plan and FFS related changes, these modifications would be made in the contract with the participating hospital or through a separate agreement with the participating provider. In the case of MassHealth requiring an MCO to implement such a global payment program, MassHealth would need to amend the contract with one or all MCOs, and those MCOs, in turn, would modify their contracts with providers.

### **MassHealth as Payer (PCC Plan and FFS)**

MassHealth hospital rates for services provided to FFS or PCC plan enrollees are set annually through the RFA process. To implement a program for a limited set of providers, MassHealth would have to amend the RFA to include special reimbursement terms for the participating hospitals. Alternately, MassHealth could enter into a separate agreement, and stipulate in the RFA that any agreement entered into between a participating hospital and the Executive Office of Health and Human Services (EOHHS) supersedes the reimbursement terms of the RFA.

Physician rates are set through regulation by the Division of Healthcare Finance and Policy. Like the hospital scenario, any changes to physician reimbursement would require regulatory changes, a separate agreement with the participating physicians and EOHHS, or both. Similar language regarding superseding agreements would also be required. DHCFFP would also have to develop a new rate setting approach, which would be subject to the Commonwealth's and federal government's public notice and review processes.

### **MCO Enrollees**

In order to implement global payments through a requirement that the MCOs move to global payments for providers, MassHealth would have to amend the contracts with the

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<sup>3</sup> Sections 402/222 refer to section 402[a] of the Social Security Amendments of 1967, as amended by section 222[a] of the Social Security Amendments of 1972.

MCOs. The terms and time periods for amendments are stipulated in the current contracts. MassHealth could be specific in the requirements for the MCOs, or could provide general language and give the plans flexibility to determine how best to implement the bundled payments.

In the case of an MCO that voluntarily wants to pursue global payments with a hospital or other provider system, no contract amendment would be required. It is likely, however, that MassHealth would want to implement such a voluntary program through contract. Because the MCO will be performing functions such as education, rate setting, data collection, monitoring, etc., MassHealth may want to stipulate specific protocol for each of these elements. Alternately, they may want to at least require that the MCO develop written policies describing how they will conduct these functions, without necessarily prescribing a specific approach. As well, assuming that MassHealth will also be instituting global payments in the PCC Plan or FFS, it will be important to ensure that the MCO-administered plan is consistent with (if not identical to) the state-administered plan.

### **Member Assignment**

Member assignment is perhaps the most complicated component of payment reform, and includes design, implementation, and operational considerations. MassHealth and the MCOs must have a process for determining how to allocate members to a specific provider network, under what circumstances a member can switch networks, and how the reimbursement would be appropriated under those circumstances. Currently, both PCC Plan and MCO enrollees are required to select a primary care provider or primary care clinician. However, the nature of that relationship is vastly different from the nature of the relationship under a global fee arrangement. Nonetheless, the identified PCP/PCC for each member may be the best approach to begin the assignment process.

From the providers' perspective, there is not only the need to know which members are part of your patient panel, but there is also a need to understand the extent to which the member is "locked-in" to their assigned provider network. This, of course, is a complicated and potentially problematic issue. Nonetheless, the ability of a globally paid provider to financially manage the costs and care of their assigned patients depends on some level of management control.

To define these parameters and the related processes for member assignment, MassHealth will need to convene a stakeholder workgroup that includes hospitals, physicians, MCOs, patient advocates, quality organizations, and the agency. The group should consider how these policies affect access, financial viability, care management, and coordination. Additionally, the panel should specifically look at those populations on MassHealth that frequently cycle off the

program due to loss of eligibility (typically resulting from changes in income). Because this population may churn on and off MassHealth multiple times a year, they will pose particular problems as it relates to assignment, reimbursement, and thus a range of transactional and financial issues for MassHealth, the MCOs, and the providers.

### **Provider Education**

Successful implementation will require some degree of training and technical assistance for participating providers, as well as education for beneficiaries, beneficiary families, and patient advocates. MassHealth could also consider supporting formal collaboration among providers to facilitate sharing of best practices in quality improvement and care management. MassHealth will have to work with providers to confirm the assignment of members to particular physicians, clinics, or other accountable parties.

The American Recovery and Reinvestment Act authorized funding for grants to support *Regional Extension Centers* for Health Information Technology (HIT). These centers will primarily focus on activities related to selection, implementation, and adoption of electronic health records by providers. As the use of HIT is central to the models of care that a global payment method induces, these Regional Extension Centers should be viewed as a resource to support the implementation of payment and delivery system reforms in the Commonwealth. The Office of the National Coordinator of HIT issued guidance on August 20<sup>th</sup> detailing the grant program for these Centers. Entities will have three opportunities to apply for these grants, with the final deadline for applications on June 1, 2010.

### **Transition Planning**

While there is a pressing need to address payment reform across the program broadly, the design and implementation of global payments requires care and attention to detail to alleviate potential risks to both providers and members. Since the goal is broad scale implementation across the program, implementation should be phased in a manner that allows the global payment concepts to be tested, begins to immediately incentivize broader system coordination, and creates a feedback loop that can inform ongoing improvements to the reform effort.

To that end, MassHealth should consider administering targeted pilot programs with specific providers based on the provider selection criteria described above. Pilot programs could be administered both through the PCC Plan and through MCO contracts, and may also piggyback on commercial payer global payment initiatives where possible.

At the same time, it will be important to signal the end-state goal for payment reform and the target date for full-scale implementation. Communication of these objectives will be

critical to ensuring that providers begin in advance to restructure business practices, develop necessary relationships with other providers, and reorganize themselves into systems of care.

MassHealth can also begin implementing interim payment reforms on a system-wide basis. These transition reforms can create financial incentives for progress towards better coordination of care, but do not carry the same level of risk as full implementation of global payments.

It will also be critical that the transition includes robust performance reporting and dissemination. In order to successfully manage care within a global payment, providers (specifically primary care physicians) will require timely, meaningful, and actionable information regarding outcomes for their patients. The reports must be clinically relevant and based on a consistent methodology. The collection, analysis, and dissemination of data will allow providers to understand where better coordination is required, and will also provide important information for the continuous improvement of risk-adjustment.

In addition to reporting of established measures, the transition should include development and improvement of performance measures of specific concern to the Medicaid program. In particular, categorization and measurement tools for the LTC and behavioral health populations lack the sophistication of those for acute care. Measuring and reporting performance in these areas is particularly important to ensure that global payments for acute care are having the intended consequences on the overall cost and health status of Medicaid enrollees.

### **Systems Modifications**

To implement a new form of payment within the PCC Plan or FFS will require significant systems changes within both the eligibility and MMIS systems. MassHealth systems staff should be involved in the process early on, and should provide guidance on feasible and cost-effective approaches to implementation. Edits and new payment protocols should be tested prior to implementation and should be regularly verified during the early implementation period.

To the extent that system changes are necessary, MassHealth should evaluate modifications in the context of the Medicaid Information Technology Architecture (MITA) framework to ensure that the Commonwealth is securing maximum federal funding. Many of the goals related to global payment implementation are directly related to the objectives of MITA as it relates to patient-centeredness and enhanced use of technology to support better care coordination.

## Operational Considerations

### Safeguards and Oversight

Like any payment method, global reimbursement requires its own unique set of safeguards to ensure quality of care, access to care, protection of beneficiary rights, federal compliance, and program integrity. MassHealth will need to administer strong monitoring protocol that measure overall access to services (particularly for at-risk populations), the financial stability of critical Medicaid providers, and the overall changes in population health status at both provider and program levels.

### Ongoing Performance Measurement and Reporting

Leading up to and once global payments are implemented, physicians and other providers will require information about patient outcomes in order to effectively manage the care of the population for which they are financially responsible. While there are a multitude of reports that will be important to the care management process, MassHealth could prioritize reports that provide information in the following three critical areas:

1. **Emergency Room Utilization.** Physicians and other accountable providers must have timely information when patients present at the emergency room (“ER”). ER visits are a key indicator of gaps in patient care, and present a significant opportunity for cost savings. Furthermore, where an ER visit results in a hospital admission, there are a series of integrated activities that are required to limit the potential for adverse events while in the hospital, and to ensure that appropriate care is delivered post-discharge.
2. **Ancillary Services and Pharmaceuticals Ordered in the Physician Office.** From both cost management and care management perspectives, administrative and clinical data on ancillary services will be critical. This information will limit the duplication of orders (e.g. labs and tests), identify gaps in care, and also indicate where providers within a patient’s system of care are directing services outside of clinical guidelines.
3. **Patient Engagement.** As has been widely documented, consumer engagement is critical to effectively managing care, particularly for patients with complex or chronic conditions. To the extent that providers can receive information regarding both patient specific and overall rates of patient engagement among their panel, providers are better able to adjust their approach to improve communication approaches. Supplying this information to providers will be critical to ensuring continuous improvement in patient engagement and outreach, and will increase the likelihood that patients will take a more active role in condition self-management and implementation of necessary lifestyle changes.

4. **Children's Healthcare.** Due to the critical role MassHealth plays in providing coverage to children, the development and implementation of quality measures that relate directly to children's services will be paramount to assuring that quality is maintained or improved for this important population as payment methodologies are changed.



## Conclusion and Recommendations

The Payment Reform Commission's and QCC's recommendations highlight the perverse incentives within fee-for-service reimbursement, the need for broader alignment of payment methodologies across payers, and the potential for reduced costs and improved quality that can result from successful implementation of a global payment system. These system changes present a significant opportunity for overall improvement of the healthcare system, but also require careful planning to ensure the potentially detrimental risks are minimized.

Such planning is particularly critical within MassHealth due to the vulnerability of the Medicaid population, the scope of services that Medicaid covers, and the unique financial and operational characteristics of high-volume Medicaid providers. Furthermore, due to the administrative nature of the MassHealth program, administrative activities such as federal approvals and contract amendments will be required. In order to ensure that implementation of a global payment system does not repeat many of the same mistakes of the early days of managed care in the 1990s, MassHealth must:

- Undertake a detailed planning process; and,
- Administer a transition plan that:
  - Focuses on the gradual alignment of financial incentives for care coordination;
  - provides timely, clinically relevant, and actionable information on patient outcomes; and,
  - provides technical support and education to providers as they restructure business practices.

Finally, MassHealth must clearly communicate this transition plan, the timeline for implementation, and the expectations for providers that will be serving the MassHealth population.

The following set of recommendations provides a possible roadmap for implementation of global payments across the MassHealth program.

1. **Set a Goal and Outline Expectations.** Define the policy objectives related to payment reform (e.g. cost containment, quality improvement, enhanced care coordination). Then, set a target date by which all providers will be paid according to the new payment methodology. Develop and then communicate the transition plan to the provider community. Communications efforts should be continuous over the transition period, and should expand to include dissemination of best practices as that information is compiled, aggregated, and published.

**2. Immediately Develop a Global Payment Pilot Program.** Develop a pilot program with a defined set of providers that includes high-volume Medicaid providers and providers currently participating in a global fee initiative with a commercial payer. Coordinate the pilot with a Medicaid MCO to also test the approach within a fully capitated delivery system. MassHealth has authority to develop this pilot pursuant to Outside Section 117 of the 2010 budget. The pilot program should provide for some transfer of risk to providers, but should also include risk corridors to limit the potential for undue, negative consequences while the approach is being tested and refined. MassHealth and the MCO can compare global fees to what would have been paid under FFS to determine whether risk corridors are exceeded.

**3. Implement Gradual Payment Reforms for Non-Pilot Providers.** MassHealth should begin implementing “shovel-ready” payment reforms across the program during the transition period, ideally beginning in year 1. Rather than simply flipping a switch on the implementation date, a gradual transition will limit the potential for restricted patient access and reduce incentives for providers to game the reimbursement system.

The intermediate reforms may include “virtual bundling” or payment adjustments for preventable readmissions in year 1. Building on these initial reforms, over the transition period, MassHealth should identify and implement opportunities to gradually expand the bundle of services that non-pilot providers will be accountable for. In doing so, this creates a glide path towards the implementation of full global payments. MassHealth should also build upon existing P4P initiatives to enhance provider response to key quality measures.

These intermediate reforms, many of which were recommended to Congress in the Medicare Payment Advisory Committee’s (MedPAC) March 2008 report, push hospitals and related providers to begin reallocating human and financial capital into new business practices that will evolve into broader system integration over the transition period.

**4. Allow for Voluntary Transition to the Global Fee System During the Transition.** Over the transition period, MassHealth should allow providers to move from the existing system (as modified under #3, above) to the new global fee system. MassHealth may create financial incentives to make this transition by targeting annual rate increases to the global fees while providing lesser or no increase to the traditional rates.

**5. Develop and Disseminate Performance Reports to All Providers.** MassHealth should publish public reports on rates of performance in certain key areas, including, but not limited to: preventable hospital readmissions, brand vs. generic drug utilization, and HEDIS scores. This information should be used to inform providers of their relative

performance, set expectations for improvement, and create a feedback loop that will inform performance incentive rate setting and the refinement of a risk-adjustment methodology.

6. **Coordinate Payment Reform with HIT Planning Efforts.** The American Recovery and Reinvestment Act (ARRA) allocates unprecedented federal funding for both planning and implementation of statewide health information exchange (HIE) and provider adoption of *meaningful use* electronic health records — tools critical to the success of a global fee environment. The Commonwealth’s application for a *State HIE Cooperative Agreement Program* grant should focus on the relationship between payment reform, related delivery system reform, and the adoption and use of HIT. To the extent possible, applications for the *HIT Regional Extension Centers* should link the efforts around HIT education and technical support to the role that HIT plays in redesigning workflows, enabling broader coordination, and providing real-time, actionable information.
7. **Examine opportunities for global payments to enhance coordination of physical, behavioral and long-term care.** As noted above, some Medicaid enrollees often have significant behavioral health and long-term care needs. Coordination across these settings offers tremendous opportunities for improving quality and coordination of care, and reducing costs. However, realizing those gains will require careful planning to avoid disruption in provider relationships in behavioral health and to coordinate with the federal government around long-term care (Medicare pays for most of the acute care services received by elderly Medicaid enrollees who are in nursing homes). The state should explore these opportunities to assure that coordination occurs over the long run.
8. **Stick to the Plan.** A continuing commitment to the plan will be critical to ensuring that payment reform efforts meet the intended objectives of lower cost and improved quality. Set timelines and milestones for accomplishing the stated goals, and follow through with those commitments. The experience of the transition should inform *how* the full-scale program is implemented, not *whether* the program is implemented.

## Appendix A

### **Traditional Payment Methods in a Nutshell:**

Traditional approaches to health care provider reimbursement fall into two broad categories:

#### **1. Service-Specific Fees or Fee-for-Service Rates:**

The health care provider is paid a rate for each specific kind and level of service. This model is the cornerstone of fee-for-service health care. The provider's revenues are driven by the quantity, frequency, and mix of services provided and adequacy of the average fees received compared to costs.

#### **2. Capitation and Sub-Capitation:**

The health plan is paid a fixed amount per patient per month, regardless of the utilization of individual patients. Capitation rates are typically risk adjusted for age, sex, and health status. At its core, capitation is about the management of insurance risk, not management of care. In some cases, in lieu of a service-specific fee schedule, health plans sub-capitate providers, such as physician practice groups and hospitals. This serves to pass along insurance risk to the provider.

The research literature provides ample evidence on the adverse consequences, misaligned incentives, and limitations of traditional provider reimbursement, particularly fee-for-service payment:

- Service-specific fees reward volume and inefficiency.
- Since higher quality and lower medical error rates often reduce service utilization over time, particularly for the most profitable services, providers are economically penalized for improved patient care.
- Fee-based payments focus payers on narrow, short term issues such as coverage limits, patient cost sharing, utilization controls, and micromanagement of providers.
- Providers and payers miss opportunities to improve clinical value and cost effectiveness over the long term.

Capitation is an attempt to solve some of the problems of fee-for-service payment. For example, capitation rewards health plans (and sub-capitated providers) to control utilization of services, thereby reducing unnecessary services. To some extent, capitation also penalizes poor quality, since the holder of the risk must often pay for remedial costs.

However, capitation presents its own difficulties, according to the research. Most notably, in the absence of targeted safeguards, capitated health plans and sub-capitated providers have strong financial incentives to limit services in the aggregate, potentially including medically necessary care. Without proper safeguards and monitoring, capitation may also encourage plans to avoid chronically ill or otherwise high-risk patients. This is particularly true for health plans that specialize in managing risk instead of managing care. The capitated model also puts health plans and (sub-capitated) providers at substantial financial risk, requiring financial reserves.

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## **About the Authors**

**Mark Heit**, senior consultant at Sellers Dorsey, advises states and health care organizations on Medicaid financing, reimbursement strategy, and health care purchasing. Previously, he served as special assistant to the Massachusetts Medicaid director, where he advised state officials on health care reform and helped negotiate financing for Commonwealth’s \$1.34 billion federal waiver for MassHealth. [www.sellersdorsey.com](http://www.sellersdorsey.com)

**Kip Piper**, MA, FACHE, is a senior advisor to Sellers Dorsey and president of Health Results Group. With 27 years’ experience in senior federal, state, and private sector positions, he specializes in Medicare and Medicaid finance, policy, and business strategy. [www.kippiper.com](http://www.kippiper.com)

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Landmark Center • 401 Park Drive • Boston, MA 02215  
T 617.246.4022 F 617.246.3992 • [www.massmedicaid.org](http://www.massmedicaid.org)