Testimony of the Massachusetts Council of Community Hospitals
Before The Joint Committee on Health Care Financing
In response to the Special Commission on Health Care Payment System Report
October 8, 2009

My name is Donald Thieme. I am the Executive Director of the Massachusetts Council of Community Hospitals and I present this testimony of behalf of the Council.

The Massachusetts Council of Community Hospitals (MCCH) appreciates the value this report brings to the discussion of how to best improve the quality of life of our citizens, and address the ever rising cost of health care. We are enthusiastic that the Commonwealth has made such a diligent effort to responsibly deal with what seems such an intractable issue. Without payment reform, we believe that our collective ability to have sustainable insurance coverage, without crowding out the equally valuable priorities of education and support to cities and towns, will be further compromised. We made a bold move in enacting Chapter 58 and committing to an individual mandate and a public option alternative. We must continue to be bold in tackling cost containment despite the discomfort it causes us as providers. MCCH is grateful that we were included in the process and hope that you continue to include us as the process moves forward.

Our testimony focuses on those aspects of the report that are of the greatest concern to many community hospitals and, if dealt with, will greatly improve the chances of success. There are fundamental issues associated with the construct of ACOs and the ability of organizations to assume risk, which have a direct bearing on community hospitals. We believe the Payment Commission, and Cost and Quality Council, are fully aware of these concerns and we expect others to testify in greater detail concerning risk. We do encourage the Commonwealth to go forward in the general direction of the Report's suggestions, but request you give weight to our concerns, which will greatly improve the possibility of realizing the hoped for benefits of reform. Our concerns are:

1. **Establish a time frame for implementation that is more realistic than the 5 year proposal.**
   Five years are a blink of the eye when it comes to changing cultures and adjusting programs for the unintended consequences that occur in any massive undertaking. For example, we are badly deficient in having an optimally sized and rationally distributed primary care system. A precursor to success of payment reform is the establishment of a robust and reliable primary care system, which may be best addressed first outside a global payment system. The on-going recession, and its aftermath, greatly limits the availability of capital that could compromise many organizations ability to adapt to an efficient ACO model(s). Failure to adequately address the capital shortfalls of community hospitals may force inappropriate consolidations or service build outs. The national health reform initiative has yet to play itself out and will present obstacles that are yet unseen. One recent example is the discussion that ACOs, which assume risk, must be licensed as insurance companies. Should this view prevail it changes the landscape entirely. More focus on establishing a timeframe around the implementation of the first steps might prove more useful than a drop dead end date.

2. **Pressure test payment and organizational concepts through the use of demonstration or pilot programs**.
   We believe that the community hospital sector, as a central participant in the development of ACOs, is a desirable outcome. While not stated explicitly in the report, providing the right care, at the right time, in the right place, has been a hallmark of the community hospital sector. There is significant historical evidence that our community hospitals are efficient providers offering high quality services at reasonable cost. Yet, many are challenged financially and many were not rewarded in the marketplace for their effectiveness. Implementation mistakes due to policy decisions that can lead to failure of community hospitals can be avoided by the use of demonstration projects, especially those built around community hospitals that can create the pathways to success for all hospitals. We have many examples of best practice sharing among hospitals that is a strength of our healthcare culture. This strength can be exploited to allow for faster transfer of best practices and more rapid correction of models, but minimizing risk to the overall system. Models may already exist in the system that can be developed into demonstrations and thus accelerate the process. Build on what we may already know.

3. **Place achievement of a Medicare waiver on the critical path to health reform.**
   We believe the objectives of payment reform will not be achieved unless Medicare is a participant. Without Medicare's participation, a "global" payment scheme becomes nothing more than rearranging the deck chairs on the Titantic. Forty (40%) to fifty (50%) of hospital volume is Medicare. This will continue to rise disproportionately in the Commonwealth due to our aging population, a population that will require an ever increasing need for services. The Commonwealth should be able to make an argument that payment reform is in all our interests. We are aware the Administration is working diligently to secure such a waiver and applaud this effort.

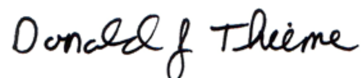
4. **Stabilize the community hospital sector immediately.**
   There is existing proposed legislation that contributes to either strengthen community hospitals and other providers, or otherwise tighten state controls over inappropriate building of possible redundant services and facilities. Specifically, pass a moral obligation bond program that increases the flexibility of HEFA to provide the lowest cost of capital to our hospitals; tighten the DoN program regarding ambulatory services; and require providers who currently escape supporting the Safety Net Trust Fund to participate in the funding.

5. **Establish a specific funding source and payment methodology to support the teaching and research mission of hospitals.**
   The valuable role that teaching and research institutions contribute to society, both clinically and economically, must be protected. However, the Commonwealth should avoid contaminating the goal of creating a very efficient clinical delivery model with organizational needs of providers that also must support the very inefficient missions associated with teaching and research. Transparency and oversight that would be required to administer such pools on an equitable basis may greatly contribute to making Massachusetts more competitive in teaching and research than it already is. Separate funding may also allow for such programs to provide more value to the Commonwealth by creating incentives to produce and otherwise retain primary care physicians and other scarce clinical resources.

6. **Commit to aligning benefits and incentives with payment reform.**
   The Report notes the importance of insurance redesign that supports the objectives of payment reform. Consumer incentives, which are supportive of the right care, at the right time, in the right place, must be in place. Transparency of information, as the only driver of consumer change, will not take us very far in achieving the expected goals. Transparency may improve confidence in the care provided, but preconceived perceptions of care run deep, and clearer and meaningful interventions are needed. The failure of current benefit designs, which include consumer-driven products, to take advantage of efficient providers warns us that this factor will require major investments in education, cooperation between payors, and political will to achieve a turnaround in behaviors.
7. **Commit to reform of the Malpractice system.**
   We would be foolish to expect to realize the high end of expected health care cost savings if we "bake" defensive medicine behaviors into health reform. This last legislative session produced many good ideas and best practices that have been implemented elsewhere. Integrating a plan for malpractice reform into the critical path of overall health reform and moving quickly to close with this issue must be a priority.

We stand with many others that believe that the status quo is not in the best interest of our citizens and believe there is a path forward that benefits all. We look forward to the challenges ahead and express our willingness to cooperate and contribute.

Respectfully submitted,



Donald Thieme
Executive Director