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A number of consumer groups, brought together by Health Care For All, have begun to coordinate their work around health care payment reform and reform of the health care delivery system. The growing network, which includes AARP, AIDS Action Committee, The American Heart/American Stroke Association, The American Cancer Society, Boston Health Care for the Homeless, The Boston Public Health Commission, Commonwealth Care Alliance, Community Catalyst, Community Partners, Greater Boston Interfaith Organization, Health Care For Artists, Health Law Advocates, The Massachusetts Public Health Association, NARAL Pro-Choice Massachusetts, and The Partnership for Health Care Excellence, support payment reform, as a means to improve the quality of care as well as reduce costs.

We believe an all-payer reform as recommended by the Special Commission can shift incentives to promote accessible, coordinated, patient-centered care that focuses on health and disease prevention. As payment reform legislation is advanced, a number of critical concerns must be addressed by the legislation and implementation of payment reform.

Improved quality of care must go hand in hand with cost growth reduction. Payment methodologies should simplify the process for individuals, promote primary and preventive care, encourage collaboration among providers and between providers and consumers, and include accountability for patient health. Payment systems must also take into account the role of public health and payment reform financing should not supplant public health programs and the state's commitment to financing the, We must be mindful of the particular requirements of those with special needs, such as the disabled, those who are chronically ill, immigrants, the homeless, low and moderate income people, seniors and children. MassHealth and Medicare should be included in an all-payer system.

Building on the success of chapter 305, we urge that the upcoming legislation takes a comprehensive approach to improving the quality of our health care and controlling costs. Since the most robust and reliable factor in cost containment is having healthy residents, payment reforms should be coordinated with broad steps to promote prevention and wellness, especially for the most medically and socially vulnerable residents.

**Our concerns include:**

**1. Transparency:** Measures of care and incentives built into the payment system must be open, transparent, and understandable by patients. The legislation should provide for an open process and full disclosure and explanation of all payment criteria



**2. Protect Vulnerable Consumers:** Risk should not be shifted entirely to providers. Payment policies should take into account the higher costs of patients whose needs are affected by socio-economic status, language and other social/cultural factors. Patients with high medical utilization should be protected by outlier payments. The unique role of safety-net and disproportionate-share institutions should be recognized by the payment system.

**3. Consumer Voice:** Consumers are the heart of the care system, and must have a strong voice in the governance of the payment reform structures. Consumers should be represented on any governmental implementation entity, as well as in the governance of ACOs or other payment intermediaries.

**4. Savings Shared With Consumers:** As cost growth is slowed, premium payers must share in the savings. The legislation should provide explicit methods to assure that savings created by payment reform get passed on to consumers.

**5. Patient Choice and Care Accessibility:** The payment system should preserve patient choice of primary care and other providers. Patients must have access to caregivers with linguistic and cultural capacity to provide effective care. Payment systems should promote patients' continuity of care with their providers. Patients should have access to clinical trials and medically necessary out-of-network care, including out-of-state providers.

**6. Evaluation and Monitoring:** The legislation should include independent, meaningful and frequent monitoring and evaluation of the payment system transition, focusing on quality of care, including patient satisfaction and quality of life. The evaluation should be public. The transition strategy should permit adjustments to be made as implementation proceeds.

**7. Patient Activation and Empowerment:** A number of patient activation and patient empowerment methods have been shown to lead to better health outcomes, reduced disparities, and better satisfaction with one's health care, as well as reduced costs. Models such as chronic disease self-management, ideal medical practice, shared decision-making, and others must be supported by the payment system. Practitioners, DPH, patients and community agencies have a role in developing a system that gives patients confidence and tools to navigate a new system. This is vital to enable patients to adapt to a global payment structure. Consumers should not be expected to bear additional financial risk without proper empowerment.



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**8. Consumer Protections:** Current protections of the Office of Patient Protection and other managed care regulations need to be maintained and extended to encompass ACOs, the patient-centered primary care home, and other payment reform entities.

**9. Promote Public and Community Health:** Payment reform must be accompanied by a renewed commitment in funding public and community health. DPH, local health boards, community groups and community health workers play an integral role in supporting a global payment system oriented towards wellness and prevention. New resources must be added to current public health spending for payment reform to be successful.

**10. Patient-Centered Primary Care:** Payment reform legislation should align incentives so that patient-centered primary care is the center of our health care system. The payment system should support teams that can deliver culturally-competent, coordinated preventive and primary care that focuses on the patient's physical and behavioral health. The system should encourage development of a robust adequate primary care workforce.