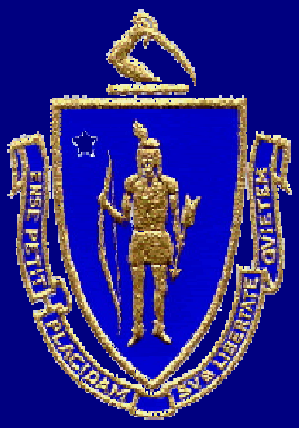

Office of the Inspector General

Commonwealth of Massachusetts

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Inspector General

Report Pursuant to Section 156 of Chapter 68 of the Acts of 2011:

Rates of Reimbursement to Providers in the MassHealth MCO Program

July 2012

Massachusetts Office of the Inspector General

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Report Pursuant to Section 156 of Chapter 68 of the Acts of 2011: Rates of Reimbursement to Providers in the MassHealth MCO Program

In Section 156 of Chapter 68 of the Acts of 2011, the Legislature directed the Office of the Inspector General for the Commonwealth of Massachusetts ("Office") to study and review MassHealth, the Massachusetts Medicaid Program. This report, which focuses on containing certain MassHealth costs, is part of the study and review that was mandated by the Legislature.

Lessons learned from the private health care market in Massachusetts are quite relevant to determining effective ways to contain MassHealth costs. In particular, the Patrick administration and Attorney General Martha Coakley have done important work ascertaining problems and solutions relating to cost containment in the private health care market. Both the Patrick administration and the Attorney General have issued a series of reports showing that provider market power has a significant effect on health care costs, and they have argued persuasively that regulation is a vital component of any effective system of health care cost containment in Massachusetts. And since 2010, Governor Patrick, through the Massachusetts Division of Insurance, has pursued the unprecedented step of regulating health insurance premiums in the small group market. In addition, for the past several years, the Office has consistently recommended that the Commonwealth implement measures to address undue provider market power and has recommended that the Division of Insurance use its existing authority to contain health care costs by regulating health insurance premiums.

In this context, the Office examines ways to save money for the Commonwealth by eliminating excessive MassHealth costs.

Introduction

MassHealth has two managed care programs operating side by side: the MassHealth Managed Care Organization ("MMCO") program and the Primary Care Clinician ("PCC") plan. As of June 2011, there were 1,307,106 MassHealth members, approximately 64% of which were in the two managed care programs – 489,873 in the MMCO program and 350,061 in the PCC plan. (MassHealth: The Basics – Facts, Trends and National Contest, Center for Health Law and Economics, University of Massachusetts Medical School, October 2011, p. 16.) At any time, MassHealth members in these managed care programs may switch between the two programs and, within the MMCO program, may switch among the various MMCOs.

The PCC plan is a fee-for-service managed care program with a "gatekeeper" physician, who is a primary care clinician chosen by the MassHealth member.[1] MassHealth reimburses providers directly under the PCC plan and does so at regulated rate levels. The three main regulated payment types are Standard Payment Amount Per Discharge ("SPAD") for inpatient services at acute care hospitals, Payment Amount Per Episode ("PAPE") for outpatient services at acute care hospitals, and a general Medicaid fee schedule for professional services. The regulated rates are considered by many providers to be low, at least relative to other provider reimbursements from public and private payers.

[1] The "gatekeeper" primary care clinician provides the member with checkups and other primary care services, and also manages the member's health care services. If the member wants to see a specialist or needs other services, the member must obtain a referral from the primary care clinician. The member can obtain physician services only from those doctors that accept MassHealth.

In contrast to the PCC plan, the MMCO program can fairly be characterized as a "capitated" managed care program. There are five MMCOs: Boston Medical Center HealthNet Plan, Fallon Community Health Plan, Inc., Health New England, Inc., Neighborhood Health Plan, Inc., and Network Health, Inc. ("Network Health"). The Commonwealth pays the MMCOs fixed capitation rates per member, and the MMCOs are responsible for all the health care expenses of their members. The MMCOs, in turn, contract with health care providers to provide health care services to MassHealth members. For the most part, the MMCOs do not pay hospitals and health care professionals at regulated reimbursement rates, but instead negotiate those reimbursement rates with the hospitals and with the health care professionals.

In general, in order to entice providers to participate in the MMCO program, the MMCOs pay higher reimbursement rates than they do under the PCC plan. And in those cases in which the provider has substantial market power, either because of a geographic monopoly or because of the reputation of the provider, the provider sometimes negotiates reimbursement rates far in excess of the PCC rates. In fact, there are instances in which providers have negotiated rates that are several times higher than the PCC rates.

The Office of the Inspector General first examined the issue of excessive MassHealth reimbursement rates in March 2010 after Network Health's President, Christina Severin, submitted testimony as part of the 2010 Health Care Cost Trend Hearings held by the Division of Health Care Finance and Policy ("DHCFP"). In particular, Ms. Severin testified as follows:

> It is, and always has been, an expectation in the Medicaid MCO market that contracted providers will be paid at a level above Medicaid and the relative "percentage of Medicaid" is the most common factor that is considered by

> payors and hospitals in determining contract rates. Hospitals insist that 100% Medicaid payment does not cover the costs of providing services to Medicaid enrollees and that therefore a percentage above Medicaid is expected. For Commonwealth Care members, the assumption is even greater since the Medicaid SPAD was developed incorporating a large pediatric experiential base. Nevertheless, it is assumed in the market that the base Medicaid payment level set by MassHealth provides a starting point for the relative cost variance of the contracted hospitals since this base Medicaid payment is calculated by MassHealth based upon case mix and cost factors of the respective hospitals. . . .
>
> In many geographic areas, hospitals enjoy geographic market dominance and use this advantage to selectively contract with the highest bidder or bidders. Network Health has been forced to pay higher rates in order to retain key service areas. Despite exhaustive efforts to reduce contracted rates, Network Health has, in certain markets, been forced to accept rates significantly above Medicaid in order to serve its members and provide sufficient choice and access.

(Testimony of Christina Severin, President of Network Health, 2010 Health Care Cost Trends Hearings, March 5, 2010, pp. 3-4.)

In discussions with the MMCOs, the Office learned that the problem of excessive reimbursements for providers in the MMCO program is widespread and not unique to Network Health. Moreover, the problem affects all three main areas of services – inpatient, outpatient, and professional.

In order to evaluate the magnitude of the problem, the Office collected reimbursement data from all five MMCOs and compared those data with analogous reimbursements calculated using the PCC methodology for determining reimbursement rates.[2] To produce an apples-to-apples comparison, adjustments were made to the inpatient data to account for

[2] These analogous reimbursements are referred to here as "Equivalent MassHealth PCC Reimbursements."

differences in case mix between the PCC plan and the MMCO program.[3] Ideally, similar adjustments would be made to the outpatient data, but the MMCOs do not currently collect and evaluate the data necessary to determine the outpatient case-mix differences between the PCC plan and the MMCO program.[4] For professional services, case mix is not a significant issue because most of these services are paid based on fee schedules, thereby implicitly adjusting for case mix.

Results and Analysis

1. Differences in Reimbursements between the MMCO Program and the PCC Plan

For claims in the most recently completed MMCO fiscal year (Fiscal Year 2011 -- from October 1, 2010 to September 30, 2011), the MMCO reimbursements were, on average, substantially higher than the Equivalent MassHealth PCC Reimbursements: 28% higher for inpatient services, 38% higher for outpatient services,[5] and 33% higher for professional services, with a weighted average of 33% higher overall. The corresponding dollar differences were approximately $113 million, $142 million, and $73 million, respectively, for a total of $328 million. (See Table 1 below)

[3] The inpatient case mix for MMCO members is more favorable than the inpatient case mix for PCC members, which reflects the tendency of MMCO members to be healthier on average than PCC members.

[4] Note that hospital-specific PCC PAPE rates were, however, used to determine the Equivalent MassHealth PCC Outpatient Reimbursements, so outpatient case-mix differences *among* the acute hospitals are implicitly taken into consideration. This is especially relevant when examining the variation in reimbursements to providers.

[5] If for outpatient services, as is true for inpatient services, the healthier MMCO member population causes the MMCO case mix to be more favorable than the PCC case mix, then the reported difference in outpatient reimbursements between the MMCO program and the PCC plan would be even larger.

TABLE 1
Comparison of FY2011 Reimbursements from MMCOs with Equivalent MassHealth PCC Reimbursements

Service Type	Amounts Paid to Providers	Equivalent MassHealth PCC Reimbursements	Percentage of Equivalent MassHealth PCC Reimbursements	$ Difference
INPATIENT SERVICES	$508,605,363	$395,851,873	128%	$112,753,490
OUTPATIENT SERVICES	$520,834,550	$378,652,608	138%	$142,181,941
PROFESSIONAL SERVICES	$293,373,205	$220,699,466	133%	$72,673,739
TOTAL	$1,322,813,117	$995,203,948	133%	$327,609,170

The differential between what providers would be reimbursed using the PCC methodology and what they are reimbursed under the MMCO program raises serious questions about the viability of the MMCO program as currently structured. While it is theoretically possible that the MMCO program produces enough savings in utilization to outweigh the large differentials in reimbursement rates, there is little evidence to support that possibility. In fact, studies of the private market have indicated that managed care savings come primarily from price reductions and not from decreases in utilization. (See, e.g., Cutler, D., McClellan, and Newhouse, J., "How does managed care do it?" RAND Journal of Economics, Vol. 31, No. 3, Autumn 2000, pp. 526-548.)

A recent national study of managed care in Medicaid suggested that in states where the regulated reimbursement rates for providers are low, managed care did not produce overall savings. (See Duggan, M., and Hayford, T., "Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from State and Local-Level Mandates," Working Paper 17236, National Bureau of Economic Research, July 2011.)[6] In Massachusetts, there have been conflicting

[6] Compare, The Lewin Group, "Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies," Prepared for America's Health Insurance Plans, 2009.

claims, by the MMCOs on the one hand and the Patrick administration on the other, about whether the MMCO program is more cost effective than the PCC plan.

Based on the results of the Office's investigation of reimbursement rates under the MMCO program and the PCC plan, it appears that currently the overall structure of the PCC plan is more cost effective than that of the MMCO program. The point of comparing the cost structures of the PCC plan and the MMCO program, however, is not to try to determine which one is more cost effective (and, presumably, then to argue for shifting members from one to the other). Instead, the comparison demonstrates that the Commonwealth should modify the MMCO program to merge the best aspects of both the MMCO program and the PCC plan. Specifically, the coordination-of-care and utilization-review benefits of the MMCO program should be preserved, but the mechanism for reimbursing providers should be modified to use the PCC methodology to establish limits on reimbursement rates in the MMCO program.

In recent years, the Patrick administration recognized the need to lower the provider reimbursement rates under the MMCO program and instituted new limits on the capitation rates for MMCOs. And for Fiscal Year 2012, the capitation rates were, for the first time, calculated based on the assumption that provider reimbursement rates would be 105% of the case-mix-adjusted SPAD rates for inpatient services, 105% of the PAPE rates for outpatient services, and 110% of the PCC medical fee schedule rates for professional services. MMCOs could pay providers in excess of those limits, but MMCOs received capitation rates that excluded any such excess payments.

The Office examined projected Fiscal Year 2012 data to determine the impact of this new rating policy.[7] The policy did produce some savings in MMCO reimbursements to providers. For projected Fiscal Year 2012, MMCO reimbursements were somewhat lower than for Fiscal Year 2011, but were still, on average, substantially higher than the Equivalent MassHealth PCC Reimbursements: 18% higher for inpatient services, 32% higher for outpatient services,[8] and 30% higher for professional services, with a weighted average of 26% higher overall. The corresponding dollar differences were approximately $71 million, $123 million, and $66 million, respectively, for a total of $260 million. (See Table 2)

TABLE 2
Comparison of Projected FY2012 Reimbursements from MMCOs with Equivalent MassHealth PCC Reimbursements

Service Type	Amounts Paid to Providers	Equivalent MassHealth PCC Reimbursements	Percentage of Equivalent MassHealth PCC Reimbursements	$ Difference
INPATIENT SERVICES	$464,799,919	$394,051,560	118%	$70,748,359
OUTPATIENT SERVICES	$506,552,019	$383,177,329	132%	$123,374,690
PROFESSIONAL SERVICES	$287,620,440	$221,688,663	130%	$65,931,777
TOTAL	$1,258,972,379	$998,917,553	126%	$260,054,825

The Office acknowledges that the Patrick administration has taken important steps to limit excessive reimbursements to providers under the MMCO program. Setting the target provider reimbursement rates implicit in the MMCO capitation rates was a good first step. As a direct result of the administration's revision of the provider reimbursement rates implicit in the MMCO capitation rates, reductions of about $67 million in reimbursement rates are projected to be realized in Fiscal Year 2012. That represents 21% of the $328 million difference between

[7] The MMCOs were asked to project FY2012 data by using the FY2011 data, revised to reflect any differences in provider contracts between the two fiscal years.

[8] Again, if for outpatient services, as is true for inpatient services, the healthier MMCO member population causes the MMCO case mix to be more favorable than the PCC case mix, then the reported difference in outpatient reimbursements between the MMCO program and the PCC plan would be even larger.

the MMCO reimbursements and the Equivalent MassHealth PCC Reimbursements for Fiscal Year 2011.

What the Office's study shows, however, is that lowering the capitation rates, by itself, does not have enough of an effect on the relative bargaining power of the MMCOs and the providers to address the issue of excessive reimbursements adequately. The MMCOs already have a strong financial incentive to negotiate the lowest possible provider reimbursement rates. Lowering the capitation rates paid to the MMCOs has not provided the MMCOs with sufficient leverage in negotiating with the providers. A more direct way of reducing provider reimbursement rates is therefore needed to augment the administration's efforts in this area.

2. Variation in Provider Reimbursement Rates

The Office examined the variation in provider reimbursement rates paid by the MMCOs. Reimbursement rates for all services provided in Fiscal Year 2011 varied widely. There were instances in which individual MMCOs paid reimbursement rates that varied by more than five to one. Even when the data for all the MMCOs were combined, variation in reimbursement rates was substantial, with some providers receiving average MMCO reimbursement rates that were five times higher than other providers received.

Below are tables that show the variation in outpatient and professional reimbursement rates using the Fiscal Year 2011 data for all MMCOs combined.[9]

[9] Similar data for inpatient services adjusted for case mix are not available because most of the MMCOs did not have easy access to case-mix-adjusted inpatient data by provider.

A. Data for Outpatient Services

Table 3 shows the variation in outpatient data for the top 15 acute hospital recipients of Fiscal Year 2011 outpatient reimbursements from all of the MMCOs. The variation ranged from 103% to 248% of what would have been paid under the MassHealth PCC plan.

TABLE 3
Top 15 Recipients of FY2011 Outpatient Reimbursements from MMCOs
(Amounts Received Ranged between $10 Million and $55 Million)

Acute Hospital	Percentage of Equivalent MassHealth PCC Reimbursements	Rank by Total Outpatient Reimbursements Received by Hospital from all MMCOs
HEALTHALLIANCE-BURBANK HOSPITAL	248%	13
BRIGHAM & WOMEN'S HOSPITAL	235%	9
TUFTS MEDICAL CENTER	210%	8
BERKSHIRE MEDICAL CENTER	178%	10
STEWARD ST. ANNE'S HOSPITAL	169%	12
NORTH SHORE MEDICAL CENTER	159%	14
MASSACHUSETTS GENERAL HOSPITAL	152%	6
SOUTHCOAST HOSPITAL GROUP	148%	7
BOSTON MEDICAL CENTER	144%	2
TOP 15 COMBINED	**143%**	
ALL HOSPITALS COMBINED	**138%**	
UMASS MEMORIAL MEDICAL CENTER	136%	3
LAWRENCE GENERAL HOSPITAL	135%	15
CHILDREN'S HOSPITAL MA	130%	4
BAYSTATE MEDICAL CENTER	125%	1
BETH ISRAEL DEACONESS MEDICAL CTR	122%	11
CAMBRIDGE HOSPITAL	103%	5

Table 4 below shows the variation in outpatient data for the remaining acute hospital recipients of Fiscal Year 2011 outpatient reimbursements from all of the MMCOs. The variation ranged from 78% to 412% of what would have been paid under the MassHealth PCC plan.

TABLE 4
Other Recipients of FY2011 Outpatient Reimbursements from MMCOs
(Ranked #16 to #65: Amounts Received Ranged Up to $10 Million)

Acute Hospital	Percentage of Equivalent MassHealth PCC Reimbursements	Rank by Total Outpatient Reimbursements Received by Hospital from all MMCOs
CLINTON HOSPITAL	412%	50
MARLBOROUGH HOSPITAL	411%	41
NEWTON-WELLESLEY HOSPITAL	252%	44
NEW ENGLAND BAPTIST HOSPITAL	218%	63
MILTON HOSPITAL	211%	58
NANTUCKET COTTAGE HOSPITAL	205%	64
FAULKNER HOSPITAL	203%	43
MARTHA'S VINEYARD HOSPITAL	176%	62
SOUTH SHORE HOSPITAL	174%	22
NORTH ADAMS REGIONAL HOSPITAL	169%	39
METROWEST	166%	30
MOUNT AUBURN HOSPITAL	165%	47
ATHOL MEMORIAL HOSPITAL	164%	59
WING MEMORIAL HOSPITAL	162%	33
STEWARD CARNEY HOSPITAL	158%	37
COOLEY DICKINSON HOSPITAL	156%	38
STEWARD NORWOOD HOSPITAL	154%	52
BAYSTATE MARY LANE HOSPITAL	152%	57
STEWARD NASHOBA VALLEY MEDICAL CENTER	151%	60
BAYSTATE FRANKLIN MEDICAL CENTER	148%	34
FAIRVIEW HOSPITAL	147%	54
HALLMARK HEALTH SYSTEM	142%	23
ST. VINCENT HOSPITAL	141%	24
ALL HOSPITALS COMBINED	**138%**	
JORDAN HOSPITAL	135%	48
LOWELL GENERAL HOSPITAL	132%	19
BEVERLY HOSPITAL	130%	26
HARRINGTON MEMORIAL HOSPITAL	129%	20
HOSPITALS RANKED #16 to #65 COMBINED	**129%**	
QUINCY MEDICAL CENTER	127%	53
STEWARD HOLY FAMILY HOSPITAL	127%	25
BROCKTON HOSPITAL	126%	18
MILFORD REGIONAL MEDICAL CENTER	126%	42
HENRY HEYWOOD MEMORIAL HOSPITAL	125%	35
STEWARD MERRIMACK VALLEY HOSPITAL	123%	55
MORTON HOSPITAL	120%	36
SAINTS MEMORIAL MEDICAL CENTER	119%	27
STEWARD GOOD SAMARITAN MEDICAL CENTER	117%	31
WINCHESTER HOSPITAL	114%	46
STEWARD ST. ELIZABETH'S MEDICAL CENTER	109%	45
THE TRUSTEES OF NOBLE HOSPITAL	108%	51
HOLYOKE MEDICAL CENTER, INC.	108%	17
BETH ISRAEL DEACONESS -- NEEDHAM	107%	65
ANNA JAQUES HOSPITAL	107%	56
MASS. EYE & EAR INFIRMARY	106%	32
STURDY MEMORIAL HOSPITAL	106%	40
MERCY MEDICAL CENTER (MA)	104%	21
CAPE COD HOSPITAL	103%	29
EMERSON HOSPITAL	103%	61
DANA-FARBER CANCER INSTITUTE	103%	16
FALMOUTH HOSPITAL	100%	49
LAHEY CLINIC HOSPITAL	78%	28

B. Data for Professional Services

Table 5 shows the variation in professional services data for the top 10 physician group recipients of Fiscal Year 2011 professional reimbursements from all of the MMCOs. The variation ranged from 107% to 262% of what would have been paid under the MassHealth PCC plan.

TABLE 5
Top 10 Recipients[10] of FY2011 Professional Reimbursements from MMCOs
(Amounts Received Ranged Up to $50 Million)

Physician Groups	Percentage of Equivalent MassHealth PCC Reimbursements	Rank by Total Professional Reimbursements Received from all MMCOs
CHILDREN'S AFFILIATED	262%	1
PARTNERS AFFILIATED	152%	3
TOP 10 COMBINED	**144%**	
UMASS AFFILIATED	138%	4
ALL PHYSICIAN GROUPS COMBINED	**133%**	
BAYCARE HEALTH PARTNERS	120%	2
BOSTON MEDICAL CENTER AFFILIATED	117%	5
BETH ISRAEL DEACONESS	114%	6
COOLEY DICKINSON	111%	9
LOWELL COMMUNITY HEALTH CENTER	111%	10
CAMBRIDGE HEALTH ALLIANCE	109%	8
GREATER LAWRENCE FAMILY HEALTH CENTER	107%	7

Of particular interest is the comparison of those physician groups receiving more than $10 million each in professional reimbursements with those receiving less than $10 million each in professional reimbursements. (See Table 6 below)

[10] The list of the top 10 recipients of professional reimbursements includes only those physician groups receiving significant reimbursements from multiple MCOs.

TABLE 6
Comparison of Groups Receiving More Than $10 Million in Reimbursements with Groups Receiving Less Than $10 Million in Reimbursement

Physician Groups	Total Professional Reimbursements Received from all MMCOs	Equivalent MassHealth PCC Reimbursements	Percentage of Equivalent MassHealth PCC Reimbursements
GROUPS RECEIVING MORE THAN $10 MILLION[11]	$167,184,855	$106,201,150	157%
GROUPS RECEIVING LESS THAN $10 MILLION	$126,188,350	$114,498,051	110%

The groups receiving less than $10 million each in reimbursements were paid on average 110% of the Equivalent MassHealth PCC Reimbursements. That amount matches the allowance for professional services in the MMCO capitation rates. The six groups receiving more than $10 million each received much higher reimbursement rates – 157% of the Equivalent MassHealth PCC Reimbursements on average. A substantial differential in reimbursements still remains even if the groups affiliated with Children's Hospital are excluded from the analysis; specifically, the other five groups that each received more than $10 million were paid 135% of the Equivalent MassHealth PCC Reimbursements on average.

Recommendation

The above information is consistent with the findings of Attorney General Martha Coakley, who has shown that variation in prices in the private health care market in Massachusetts cannot be explained by differences in quality of care. (See, generally, 2010 Report for Annual Public Hearing on Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 118G, § 6 1/2(b), hereafter "2010 AG Report," Office of Attorney General Martha Coakley, March 16, 2010; 2011 Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 118G,

[11] These groups are the top five groups listed in Table 5 and one other group not listed in that table because the group received significant reimbursements from only one MMCO.

§ 6 1/2(b), Office of Attorney General Martha Coakley, August 3, 2011.) Attorney General Coakley also demonstrated that these variations are correlated with market leverage, such as provider size, geographic location, brand name, and niche or specialty service line offered. (See 2010 AG Report, supra, at 28-33.) Similar findings about price variation and market leverage were reported by DHCFP. (See Massachusetts Health Care Cost Trends: Price Variation in Health Care Services, DHCFP, May 2011, revised June 3, 2011.)

The data underlying the Office's study indicate that the same types of market leverage problems as those identified by the Attorney General and DHCFP with respect to the private market also affect the MMCO program, where many providers with market clout have negotiated reimbursement rates well in excess of those produced by the PCC plan reimbursement methodology. In this type of dysfunctional market, a PCC-like mechanism for counteracting the effects of market leverage would produce substantial savings for the MMCO program.

There are likely several ways to bring the MMCO provider reimbursement rates more in line with those that would be produced using the PCC method of determining reimbursement rates. Any reasonable proposal that would achieve that goal deserves serious consideration. The Office offers the following such proposal, which would modify the MMCO program:

1. Out-of-network providers that have a contract with MassHealth should be required to accept, from any MMCO, case-mix-adjusted MassHealth SPAD rates

for inpatient services,[12] MassHealth PAPE rates for outpatient services, and the MassHealth fee schedule for professional services. Currently, the MassHealth contract with providers requires them – when out of an MMCO's network – to accept MassHealth reimbursement rate levels from the MMCO for all emergency and post-stabilization services. Establishing limits on all services would lower payments to out-of-network providers, but more important, would provide leverage to the MMCOs in negotiating reasonable in-network reimbursement rates.

2. Reimbursements to in-network providers should be limited to no more than 105% of the applicable MassHealth case-mix-adjusted SPAD rates for inpatient services,[13] 105% of the applicable MassHealth PAPE rates for outpatient services, and 110% of the applicable MassHealth fee schedule rates for professional services. The 105%, 105%, and 110% caps, respectively, (as opposed to a uniform cap of 100%) would be permitted as compensation to providers for participating in the network of an MMCO. Larger payments, which are prevalent today, are primarily the result of undue provider market power. These excessive payments have driven up costs for the Commonwealth and should be eliminated from MassHealth.

[12] MassHealth would calculate these rates by applying the methodology for determining the SPAD rates currently to the MMCO-specific inpatient data for each hospital.

[13] Again, MassHealth would calculate these rates by applying the methodology for determining the SPAD rates currently to the MMCO-specific inpatient data for each hospital.

The Office estimates savings of more than $200 million annually resulting from this proposal. Any reductions in provider reimbursements by MMCOs would be passed along to the Commonwealth in the form of lower capitation rates included in the MassHealth contracts with the MMCOs.[14] The Office recommends that the above approach be implemented administratively through the MassHealth RFA process. No new legislation would be needed.

The Office is aware that some providers will claim that this proposal should not be adopted because they believe it will result in reimbursement rates at levels lower than the current cost of providing those services. In response, the Office makes the following observations:

1. Claiming that reimbursement rates do not cover provider costs begs the question as to what costs are reasonable for the providers to incur. A thorough examination of the underlying provider costs would be very illuminating and is, in the Office's view, necessary in order for the Commonwealth ever to control the amounts paid for health care in both the public and private markets.

2. How is the cost of providing services defined by providers? For example, in instances where provider costs include compensation paid to health care professionals and staff, are all increases in such compensation defined by providers as "costs" that should be reimbursed?

[14] Since the Office's recommendations limit provider reimbursements to levels similar to those underlying the current MMCO capitation rates, one might be tempted to conclude that adopting the recommendations would produce no savings. But dramatically reducing the payments by MMCOs would clearly enable the MMCOs to accept much lower capitation rates, and the Office's discussions with MMCO staff members confirmed this point. As for the related issue of how any MMCOs have made profits while paying providers much more than the amounts allowed in the capitation rates, one possible explanation is that other components underlying the calculation of the capitation rates are overly generous.

3. Accepting actual provider costs as the basis for determining reimbursement rates is tantamount to establishing a cost-plus reimbursement system, which eliminates the incentive for providers to control their own costs. The Patrick administration and previous administrations have rightly rejected the notion that MassHealth should reimburse all provider costs.

4. While the state and federal public payers been able to prevent providers from being reimbursed on a cost-plus basis, payers in the private health care market have generally been unable to prevent providers from being reimbursed on that basis. Due to the cost-plus nature of the private health care market, price increases in that market over the past decade have vastly exceeded price increases to buyers in virtually every non-health-care private market in Massachusetts and in the nation.

5. The MMCO program was put in place, in part, as a cost-effective alternative to the PCC plan. The MMCO program was certainly not supposed to be a mechanism for providers to circumvent state regulation and receive reimbursement rates substantially higher than those established for the MassHealth PCC plan.

6. The Office's proposal allows MMCOs to pay reimbursement rates that are higher than those in the PCC plan and that are consistent with the reimbursement rate assumptions underlying the current MMCO capitation rates.

The Office is mindful that the Legislature is currently working on a health care cost control bill, which contains many provisions that could affect the efficacy of the Office's proposal. The Office is also aware that the Patrick administration is considering transitioning to global payment structures in the MassHealth program. The Office recommends that, as the Legislature and the Patrick administration examine reform proposals affecting MassHealth reimbursements, due consideration be given to the concerns raised in this study. In particular, it is recommended that a specific PCC-like reimbursement mechanism should be implemented to counter the effects of provider market leverage. Otherwise, the results of the Office's study, as well as the work of the Attorney General and of DHCFP, indicate that the Commonwealth will likely pay excessive provider reimbursement rates, regardless of whether MassHealth moves to a global payment structure.

Conclusion

Due to provider market power issues similar to those identified by Attorney General Coakley and DHCFP for the private health care market, providers in the MassHealth MMCO program are reimbursed at much higher rates than they are in the MassHealth PCC plan. (Also, variation in MMCO reimbursement rates is substantial, with some providers receiving average rates five times higher than other providers receive.) In Fiscal Year 2011, rates were about 33% higher in the MMCO program than in the PCC plan on average, costing the Commonwealth an estimated $328 million in excessive reimbursements. The Patrick administration implemented new rating

rules for Fiscal Year 2012, and, as a result, excessive provider reimbursements were reduced by an estimated $67 million (or 21%), lowering the $328 million amount to $260 million.

In order for the Commonwealth to achieve additional savings for the MMCO program, the Office of the Inspector General recommends that the administration use its existing regulatory authority to establish a PCC-like mechanism to control excessive reimbursements. The Office proposes that, in the adoption of a PCC-like mechanism, the administration use the very same benchmarks underlying the Fiscal Year 2012 MMCO capitation rates. This would help the MMCOs negotiate lower reimbursement rates for those providers that possess undue market power, resulting in more than $200 million in annual savings for the Commonwealth.