

ALTERNATIVE PAYMENT MODELS AND THE CASE OF SAFETY-NET PROVIDERS IN MASSACHUSETTS

Executive Summary

MARCH 2015



FOUNDATION
MASSACHUSETTS

Prepared for the Blue Cross Blue Shield of Massachusetts Foundation by

Megan Burns and Michael Bailit
Bailit Health Purchasing, LLC

EXECUTIVE SUMMARY

Much national attention has been placed on the rising costs of health care and the influence that moving away from fee-for-service payment toward alternative payment models (APMs) can have on improving the efficiency and quality of health care. Massachusetts has been a leader in APM adoption in the commercial market. Now, aided by the enactment of Chapter 224 of the Acts of 2012, which required MassHealth, the Commonwealth's Medicaid program, to adopt APMs, Massachusetts is one of a few leading states in APM adoption in the Medicaid market too.

While the expansion of global payment adoption in recent years has mainly affected large providers in relatively stable financial condition, MassHealth's entry into global payment is encouraging smaller and less financially robust providers serving the safety net to begin or expand their implementation of this model. Some safety-net providers are for the first time entering into global payment arrangements with little experience upon which to draw. In some instances, these providers are not yet prepared to manage total population risk. Safety-net providers are especially vulnerable when they begin to take financial accountability for the total cost of care of a patient population. Doing so requires significant financial assets and sophisticated data systems—both of which many safety-net providers lack.

Safety-net providers, both hospitals and community health centers (CHCs), play a vital role in serving vulnerable populations in the state. Most provide essential services to predominantly low-income patients, many of whom belong to racial and ethnic minorities.

This report provides a comprehensive review of the landscape of payment reform in Massachusetts and, in particular, of how the changing landscape is affecting safety-net providers in the state. The analysis builds off state-collected data that details the adoption of APMs by payers over the course of 2012 and 2013 and adds qualitative findings gathered from a sample of payers and providers in mid-2014 about variation in the characteristics of Massachusetts global payment arrangements and the impact the contracts are having on safety-net providers.

THE STATUS OF ALTERNATIVE PAYMENT MODELS IN MASSACHUSETTS

The use of APMs has a long history in Massachusetts and has exceeded the use of APMs nationally. In Massachusetts in 2013, about a third of all payments in the commercial market were being made using APMs,¹ the overwhelming majority of which were global payments within health maintenance organization (HMO)-type insurance arrangements. Our interviews revealed that considerable changes occurred in 2014 across the commercial market.

Based on our interviews for this report, we estimate that today the leading commercial plans pay for between 23% and 50% of their members under a global payment reimbursement method,

¹ See *Performance of the Massachusetts Health Care System Series: Adoption of Alternative Payment Methods in Massachusetts, 2012-2013*, January 2015.

and in excess of 80% of network providers are participating in such arrangements. In addition, those commercial plans whose representatives we interviewed indicated that they would be moving their local PPO business to APMs during 2015 and 2016. This is especially critical because HMO membership has declined in both Massachusetts and the nation in favor of PPO products.²

While the use of global payments has garnered the most attention in the commercial insurance market, the Medicaid managed-care market has followed in its adoption of this approach. For Medicaid the trend has been accelerated by state legislative action in the form of Chapter 224 of the Acts of 2012, which requires MassHealth to pursue alternative payment methodologies for beneficiaries. As of 2013, 8% of MassHealth managed-care members³ were covered under global payment arrangements.⁴ In 2014, however, MassHealth newly contracted with 28 primary care centers across 47 practice locations, representing slightly more than 20% of the Primary Care Clinician (PCC) Plan covered lives, using a global payment arrangement that includes capitation for primary care and a shared savings opportunity for non-primary care as part of its three-year Primary Care Payment Reform (PCPR) Program.

THE USE OF GLOBAL PAYMENTS AMONG SAFETY-NET PROVIDERS IN MASSACHUSETTS

In Massachusetts, safety-net providers have been newly entering global payment arrangements,⁵ many for the first time in 2014 as part of the PCC Plan's PCPR. The depth of experience with global payments varied across our interviewees, with most having very limited experience.

Even without much experience, safety-net providers are pouring millions of dollars into preparing their clinical and business operations to effectively manage them under global payments. The majority of our interviewees were using internal funds, while a minority were tapping into dollars offered by the Health Policy Commission and under MassHealth's 1115 waiver.

Operating in a non-fee-for-service environment is a significant shift for most providers—a shift that needs and is deserving of technical support. Whether support was available from payers, the state, foundations, or other organizations varied by provider, with the majority of our safety-net provider interviewees indicating they had received little to no technical support from contracted payers. These providers said they were seeking guidance on the financial models in use, how to capture quality measures, and how to analyze data on clinical and cost outcomes that are useful and integrated across payers. In contrast, payers indicated that they were offering a wide variety of support, including individual assistance to providers for translating data to action and tools to query plan databases. This inconsistency between the payers and providers may result from ei-

² See *Performance of the Massachusetts Health Care System Series: Managed Care Membership in the Massachusetts Market*, February 2015.

³ MassHealth MCO members reported here include members in the MassHealth-administered Primary Care Clinician (PCC) Plan but do not include the dually eligible beneficiaries enrolled in One Care or Senior Care Options, nor do they include those covered under MassHealth fee-for-service programs. For more information on MassHealth and its offerings, see [MassHealth: The Basics, Facts, Trends and National Context](#).

⁴ In 2013, nearly 30% of APM use for MassHealth MCOs and the PCC Plan was for a non-global-payment pilot program that supported patient-centered medical homes.

⁵ Hacker, K., Mechanic, R., and Santos, P., "Accountable Care in the Safety Net: A Case Study of the Cambridge Health Alliance," *The Commonwealth Fund*, publication 1756, volume 13, June 2014.

ther payers furnishing technical support that is not useful or providers not having the awareness, resources, or experience to use the support, but in any event it should be addressed.

As a result of global payment arrangements, some strategic market maneuvering is happening among safety-net providers. First, a number of safety-net providers have entered APMs through contracts with formally affiliated and non-affiliated provider-based organizations. Second, safety-net hospitals, in particular, desire to employ more primary care physicians to gain greater control over the management of care delivery.

CHALLENGES FACING SAFETY-NET PROVIDERS ENGAGED IN GLOBAL PAYMENTS

For most providers, participating in a global payment contract is a challenge, because it requires the ability to coordinate care across multiple sites. It also requires a significant amount of data about a population to stratify patients based on risk, identify variation in treatment patterns, and create new clinical pathways to care for patients. There were a few key difficulties that stymied safety-net providers, in particular.

First, we observed a wide difference in self-reported readiness to enter into global payment arrangements between safety-net providers and non-safety-net providers, especially with regard to arrangements under which providers are at financial risk for spending above contracted targets (i.e., are accepting “downside risk”). Some payers reported that CHCs, in particular, lack management and actuarial expertise for managing downside risk as well as experience in how to interpret data and apply it for population health management activities.

Second, there is little to no consistency in the design of global payment contracts, especially in terms of quality measures. This is challenging for all providers and can be especially challenging for safety-net providers. Tracking and improving upon quality measures is reported to be one of the most significant burdens of participating in a global payment contract, because of the time and intensive resources that are required to be compliant and achieve performance targets.

Last, and with one notable exception, most of the Medicaid global payment arrangements in the state do not include behavioral health services in the total-cost-of-care calculations. A carve-out vendor manages mental health and substance use disorder services for its members. The exception is the MassHealth PCPR model, in which some providers are responsible for behavioral health services in their spending targets and the carve-out vendor is providing a sub-capitated payment to the primary care practice for some behavioral health services. In general, this lack of integration further fragments connections between primary medical care and behavioral health care; this is particularly challenging for primary care providers because most behavioral health treatment for adults is provided in the primary care setting.⁶

6 Wang, P.S., et al., “Twelve-Month Use of Mental Health Service in the United States: Results From the National Comorbidity Survey Replication,” *Archives of General Psychiatry* 62(6): 629–40, June 2005; and Wang, P.S., et al., “Changing Profile of Service Sectors Used for Mental Health Care in the U.S.,” *American Journal of Psychiatry* 163(7): 1187–1198, 2006.

In addition to the above challenges, we also noted that CHC participation in global payments is challenging in light of the volume of patients the centers serve and the distribution of their revenue across multiple Medicaid payers.

RECOMMENDATIONS TO SUPPORT SAFETY-NET PROVIDER ADOPTION OF ALTERNATIVE PAYMENT MODELS

Given the critical importance of safety-net providers, it is essential to protect the ability of these institutions and providers to carry out their mission. Failure to support these providers in their efforts to operate in a system characterized by increasing reliance on APMs could have an adverse impact on the populations who typically depend on them for care.

This report makes several recommendations pertaining to activities that payers, the state, or foundations could provide to aid safety-net providers in their preparation for payment reform. These recommendations include:

- Establishing a learning community specific to safety-net providers to enable them to learn about and share best practices for successfully operating under APMs;
- Developing an educational seminar series on APMs specific to safety-net provider chief financial officers (CFOs);
- Supporting evaluation of existing data infrastructure and analytics capacity and providing capital support for safety-net providers to access and use high-quality data; and
- Offering “light touch” technical assistance (TA) on those unique situations or challenges identified by particular safety-net hospitals or CHCs.

CONCLUSION

It is clear that Massachusetts payers will continue to increase their use of APMs over the next several years and that more providers will be paid using global payments. Safety-net providers will be among the providers that are affected by alternative payment contracts. To successfully operate under these risk-based contracts, safety-net providers, and in particular CHCs, will need additional infrastructure development focused on financial management, data management, clinical management, and quality measurement and improvement.