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

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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, and in excess of 80% of network providers are participating in such arrangements. In addition,

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

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 members[3] 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.

I. INTRODUCTION

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. While many plans, providers, payers, and states are working toward wider adoption of APMs, few states have adopted APMs more broadly than Massachusetts. Massachusetts was first known as a leader in APM adoption for its use of global payments in the commercial marketplace. Now, aided by the enactment of Chapter 224 of the Acts of 2012, which requires MassHealth to adopt APMs, Massachusetts is also one of a few leading states in APM adoption in the Medicaid market.

With little exception, global payment is the APM of choice in Massachusetts. All major Massachusetts-based health plans in the commercial, Medicaid, and Medicare markets use this model to some extent. "Global payment" is a model that establishes 12-month spending targets for the costs of the vast majority of covered health care services for a specific population. It requires providers to share with plans any savings generated as a result of provider interventions and, in some cases, to share with plans the risk of losses due to costs above an established spending target. Global payment in the Massachusetts commercial insurance market has been in existence for decades, although its current widespread application has existed for only a few years.

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. Safety-net providers—those providers who are characterized by serving a high percentage of Medicaid beneficiaries and uninsured individuals—are in some cases, for the first time, entering into global payment arrangements with little experience upon which to draw and may not yet be 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, since doing so requires significant financial assets and sophisticated data systems—both of which many safety-net providers lack. Failing to offer these providers support to address challenges associated with global payments could have detrimental implications on the people who most depend on them for their care.

This report provides a comprehensive review of the landscape of payment reform in Massachusetts and, in particular, of how the changing landscape is affecting the safety-net providers in the state. It builds off state-collected data that details the adoption of APMs by payers over the course of 2012 and 2013 and adds qualitative findings we gathered in mid-2014.[7] These find-

7 For the purposes of this report, we analyzed publicly available APM data that payers are required to provide to the Massachusetts Center for Health Information and Analysis (CHIA). We did not independently verify the accuracy of the data reported to CHIA. In addition, this report focuses on the payer data related to the commercial HMO and PPO lines of business, Medicare Advantage, the MassHealth PCC Plan, and the Medicaid MCOs. We do not report on CommonwealthCare because the program was discontinued in 2014, nor do we report on products for persons dually eligible for Medicaid and Medicare, including Senior Care Options and One Care.

ings focus on the variation in the characteristics of Massachusetts global payment arrangements and the impact the contracts are having on safety-net providers. The rapid change in global payment adoption in the state is reflected in the differences between the 2012 and 2013 state-collected data and our 2014 qualitative findings.

This report also documents key challenges and barriers that providers, and in particular safety-net providers, confront in adopting global payments.

II. METHODOLOGY

Information for this report was collected primarily through a series of hour-long telephone and in-person interviews with Massachusetts-based payers, providers, and organizations representing the interests of providers.

We used a convenience sample of interviewees that we believe is representative of the safety-net providers in the state. We interviewed representatives of 10 primary care provider organizations, nine of which can be categorized as community health centers (CHCs). We also interviewed five hospital-based organizations, some of which deliver primary care, and two provider networks that contract on behalf of owned and non-owned practices and hospitals that delivery primary and specialty care. Of these 17 distinct provider organizations, the majority were characterized by a high percentage of MassHealth beneficiaries or uninsured individuals in their patient populations. We refer to these organizations as "safety-net providers." We specifically chose to oversample safety-net providers that were engaged in an APM with MassHealth, with a commercial insurer, or with both.

We also interviewed representatives of five Massachusetts payers representing the majority of the commercial and Medicaid markets, including the Executive Office of Health and Human Services (EOHHS). Finally, we interviewed representatives of the Massachusetts League of Community Health Centers. Descriptive information about our interviewees is presented in Table 1.

TABLE 1. DESCRIPTIVE INFORMATION ABOUT INTERVIEWEES

INTERVIEWEE TYPE	SAFETY-NET PROVIDER	COUNT
Community health centers	Yes	9
Hospital-based organizations	Yes	5
Provider networks	No	2
Primary care providers	No	1
Health plans	No	5
Other	No	1
TOTAL		**23**

In order to make this report as robust as possible, we asked our interviewees to discuss confidential information about their financial arrangements with payers or providers. Because of the sensitive nature of the information obtained and described herein, payers and providers are not identified by name in the report. Where payer names are mentioned, the information was obtained through publicly available sources.

In addition to these first-person interviews, this report draws upon publicly available information that has been published by the Massachusetts Center for Health Information and Analysis (CHIA)[8], a state agency devoted to collecting and analyzing data on health care performance in Massachusetts; the written testimony for the 2014 Annual Cost Trend Hearings[9] hosted by the Health Policy Commission (HPC) in collaboration with CHIA and the Office of the Attorney General (AGO); and other sources of information on key APMs in current use.

III. THE STATUS OF ALTERNATIVE PAYMENT MODELS IN MASSACHUSETTS

KEY FINDINGS IN THIS SECTION

- **Use of global payments in Massachusetts is expanding, especially in the Medicaid market.**
- **In 2014, global payments are estimated to be the financing approach for between 23% and 50% of each of the leading commercial and Medicaid insurers' covered lives and 80% of providers who contract with commercial insurers.**

The use of APMs in Massachusetts has a long history and has exceeded the use of APMs nationally.[10] Global payment, which is a model that establishes 12-month spending targets for the costs of the vast majority of covered health care services for a specific population, is the dominant APM. As is discussed later in this report, across the Commonwealth payers, there is great variability in the detailed application of global payments. Because 95% of members in an APM were covered under global payment in 2013—the most recent year for which we have publicly

8 Massachusetts laws M.G.L.c 12C § 10 and M.G.L.c 12C § 16 tasked the Center for Health Information and Analysis (CHIA) with collecting and reporting annually on the use of APMs among payers in Massachusetts.

9 See www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/annual-cost-trends-hearing/2014/testimony-and-presentations/.

10 The Catalyst for Payment Reform (CPR) is the only organization known to collect data on the use of APMs nationally. We do not use its data in this report because its survey is a non-scientific, voluntary survey that can describe trends but cannot portray with certainty the state of payment reform in the country. Furthermore, the definitions of APMs used by CPR are significantly different from those often used in Massachusetts. Nonetheless, our experience working in other states allows us to confidently assert that Massachusetts is one of only a handful of states in which APMs are in common use.

reported data—we focus specifically on that model in this report.[11] This section describes the use of global payments by commercial insurers, Medicaid Managed Care Organizations (MCOs), the MassHealth-administered Primary Care Clinician (PCC) Plan, and Medicare Advantage plans in 2013 as reported by CHIA.[12]

1. COMMERCIAL MARKET

While the use of global payments waned in Massachusetts in the 1990s, Blue Cross Blue Shield of Massachusetts (BCBSMA) introduced the "Alternative Quality Contract" in 2009 and thereby changed the market. This market disruption, coupled with the recommendations of the Special Commission on the Health Care Payment System (created by Section 44 of the Acts of 2008[13]) and Chapter 224 of the Acts of 2012,[14] has led to resurgent use of global payment arrangements. Table 2 outlines the percentage of plan-covered lives under global payment arrangements for each of the commercial carriers for 2013.

TABLE 2. PERCENT OF COMMERCIAL MEMBERS IN GLOBAL PAYMENT ARRANGEMENTS BY CARRIER, 2013

PAYER	% COMMERCIAL MEMBERS*	% COMMERCIAL MEMBERS COVERED BY GLOBAL PAYMENTS*
Blue Cross Blue Shield of MA	40%	48%
Harvard Pilgrim Health Care	17%	26%
Tufts	10%	40%
United	9%	0%
WellPoint	7%	NDA**
Cigna	5%	0%
Aetna	4%	0%
Fallon Health	3%	21%
Health New England	3%	64%
UniCare	NDA**	0%
Neighborhood Health Plan	NDA**	13%
TOTAL MARKET	**98%**	**33%**

*See Performance of the Massachusetts Health Care System Series: Adoption of Alternative Payment Methods in Massachusetts, 2012-2013, January 2015, and the APM Policy Brief Data Book.
**No data available.

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

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

13 For the Commission's recommendations, see www.mass.gov/chia/gov/commissions-and-initiatives/health-care-payment-system/recommendations-of-the-special-commission-on.html.

14 "An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation," at https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224.

As indicated in the CHIA Annual Report and validated in our interviews, APMs are primarily used today within health maintenance organization (HMO)–type[15] insurance arrangements. APMs tend to be easier to administer in HMOs because patients can be more easily attributed to a primary care provider for the purposes of identifying which provider is responsible for the total costs of care of a member. In a preferred provider organization (PPO) model, a complicated formula involving a retrospective review of claims must be employed to determine which provider (if any) is considered responsible for the total costs of care of a member. Despite this extra complexity, 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.[16]

Providers expressed mixed feelings about this transition, however, primarily owing to concern about the implications of serving populations that have not explicitly chosen a practice's primary care clinicians. It is of note that global payment use for PPO business is more common in other states where PPO products have historically dominated the market to a greater degree than they have in Massachusetts.[17]

Our interviews revealed that considerable changes have occurred in 2014 across the commercial market. Based on these interviews, we estimate that today global payments affect between 23% and 50% of each of the leading commercial plans' lives, and that in excess of 80% of network providers are affected by such arrangements. We expect the percentage of commercial lives under global payment arrangements to jump dramatically during 2015 and 2016 as PPO lives move into these contracts.

15 A health maintenance organization (HMO) product is one in which the patient must choose a primary care physician who is responsible for the care of a patient and for referring the patient to specialists as necessary. A preferred provider organization (PPO) product is one in which the patient may choose to use any provider and will have lower copays when using physicians contracted as in-network for the health plan.

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

17 See http://kff.org/other/state-indicator/hmo-penetration-rate/.

2. MEDICAID MARKET

While the use of global payments has garnered the most attention in the commercial insurance market, its application has followed in the Medicaid managed-care market. For Medicaid this 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. The use of APMs in the Medicaid program is proceeding more quickly in Massachusetts than it is in most states. Arkansas, Minnesota, Ohio, Oregon, Tennessee, and Vermont, along with Massachusetts, are among the states where Medicaid is most rapidly shifting away from fee-for-service. As of 2013, 8% of MassHealth MCO members[18] were covered under global payment arrangements. Table 3 outlines the percentage of MassHealth managed-care program members covered under global payment arrangements for each of the MassHealth MCOs and the MassHealth-administered PCC Plan in 2013.

TABLE 3. PERCENTAGE OF MASSHEALTH MANAGED-CARE PROGRAM MEMBERS IN GLOBAL PAYMENT ARRANGEMENTS, 2013[19]

PAYER	MARKET DISTRIBUTION OF MASSHEALTH MANAGED-CARE MEMBERS	% MASSHEALTH MANAGED-CARE MEMBERS COVERED BY GLOBAL PAYMENTS
PCC Plan	40%	0%
BMC HealthNet Plan	22%	5%
Neighborhood Health Plan	18%	13%
Network Health	16%	13%
Fallon Health	2%	81%
Health New England	1%	72%
TOTAL MARKET	**100%**	**8%**

While global payment arrangements are the predominant APM in the commercial and Medicare markets, they did not predominate in the Medicaid market in 2013. The only APM used by the PCC Plan, and the predominant APM used by two other Medicaid MCOs, in 2013 was supplemental payment and shared savings for practices participating in the Massachusetts Patient-Centered Medical Home Initiative (PCMHI).

However, there were two notable changes in 2014 that occurred within the MassHealth-administered PCC Plan, which will likely shift the balance of APM usage to a majority global

18 MassHealth MCO members reported here include members in the MassHealth-administered 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.

19 This table includes data on beneficiaries enrolled in MassHealth MCOs and the PCC Plan. It does not include any beneficiary who was dually eligible for Medicare and Medicaid, such as beneficiaries in the Senior Care Options or One Care programs. Data sources: Performance of the Massachusetts Health Care System Series: Adoption of Alternative Payment Methods in Massachusetts, 2012-2013, January 2015, and the APM Policy Brief Data Book.

payment. In March 2014, MassHealth ended its Patient-Centered Medical Home Initiative, thereby ending the APMs associated with the program. Almost simultaneously, MassHealth newly contracted with 28 primary care centers across 47 practice locations, representing slightly more than 20% of the PCC Plan covered lives, using a global payment arrangement that includes capitation for a set of primary care services (and optionally, behavioral health services) and a shared savings opportunity for non-primary care spending as part of its three-year Primary Care Payment Reform Program (PCPR). (See sidebar for more detail.)

3. MEDICARE MARKET

For Medicare, the adoption of global payments has been accelerated by the broad authority the Centers for Medicare and Medicaid Innovation (CMMI) has to test different APMs. CMMI has established three global payment programs that providers in Massachusetts have joined: the Medicare Shared Savings Program, the Pioneer ACO, and the Advance Payment ACO model. Approximately 22% of Medicare beneficiaries not in Medicare Advantage plans are reported to be receiving care at one of the five Pioneer ACOs established in the state.[20] In addition, CMMI launched a bundled payment program that has attracted many hospitals in the state, although the number of beneficiaries affected by this payment model is unknown.

About 17% of Commonwealth residents are eligible for Medicare, and 20% of those are enrolled in Medicare Advantage plans in Massachusetts—a proportion that is lower than the national average.[21] Of those 20% enrolled in Medicare Advantage plans, about 60% are covered under a global payment arrangement, which results in some of the Medicare Advantage plans having the highest proportion of global payment use in the state. Table 4 outlines the percentage of members covered under global payment arrangements for each of the Medicare MCOs in 2013.

MASSHEALTH'S PRIMARY CARE PAYMENT REFORM PROGRAM (PCPR)

PCPR is a three-year APM contract, launched in March 2014, that pays primary care providers a global payment to provide primary care services to a defined population. Providers can share in any savings generated through reduced spending on non-primary care services.

Primary care providers can choose one of three risk tracks that vary the amount of risk (from 0% to 6%) and the amount of savings (up to 6%). While all participants started in a shared-savings-only model, in the second and third years of PCPR most participants will be required to take on some downside risk.

Participants also choose one of three clinical models that vary the amount of behavioral health services included in the global payment. In the first contract year, most chose the least integrated option.

20 Donnelly, J., "Mass. Has Winners and Losers in Medicare ACO Project," *Boston Business Journal*, July 16, 2013.

21 See http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population/.

TABLE 4. PERCENTAGE OF MEMBERS IN GLOBAL PAYMENT ARRANGEMENTS BY MEDICARE ADVANTAGE PLAN, 2013[22]

PAYER	% MEDICARE ADVANTAGE MEMBERS	% MEDICARE ADVANTAGE MEMBERS COVERED BY GLOBAL PAYMENTS
Tufts	46%	98%
United	16%	0%
Fallon Health	14%	57%
Blue Cross Blue Shield MA	14%	9%
Aetna	6%	0%
Health New England	4%	83%
TOTAL MARKET	**100%**	**61%**

A notable exception to the trend of global payments across plans, in all market sectors, is the lack of national-plan participation in global payments in the state. While the leading national plans have APMs in other markets, only two plans indicated offering anything other than fee-for-service in Massachusetts. This is not surprising given that five plans share 17% of the commercial market and two plans share 22% of the (already small) Medicare market. National plans are typically limiting their payment reform activity to geographic areas where they have significant market share.

IV. CHARACTERISTICS OF GLOBAL PAYMENT ARRANGEMENTS

KEY FINDINGS IN THIS SECTION

- **Global payment methodologies vary, at times significantly, from plan to plan.**
- **As of 2014, the greatest point of divergence is the amount of risk borne by providers. Commercial plans typically have 50/50 risk share, while Medicaid plans most often utilize shared-savings arrangements.**
- **Generally speaking, providers are responsible for spending on behavioral health in commercial contracts but not in Medicaid-based contracts.**

22 *Annual Report on the Performance of the Massachusetts Health Care System*, Center for Health Information Analysis, 2014.

In practice, global payments in Massachusetts operate on a fee-for-service "chassis," meaning that billing, coding, and claims adjudication are done in the traditional way, with a reconciliation at the end of the year (or conclusion of a performance period) to compare performance against budget for a defined population, at which point it is determined whether the payer owes the provider or vice versa. The methodology of a global payment contract, however, is more complicated, and no one methodology looks exactly like the next. This section details the variation in global payment methodologies across the payers we interviewed, including what services are included within the budget, how provider performance is determined, and the level of financial risk providers assume.

1. SERVICES INCLUDED WITHIN GLOBAL PAYMENT ARRANGEMENTS

Global payment arrangements across commercial and Medicaid contracts are generally inclusive of all preventive, chronic illness and acute care services, including pharmacy. The most notable exception is behavioral health. Behavioral health carve-outs are a common practice among the Medicaid payers we interviewed. Since those payers are holding another entity at risk for behavioral health services, those services are not included in risk-based contracts with providers. A counterexample is the MassHealth PCPR model, in which providers in the more integrated clinical models (see sidebar on page 11) are responsible for behavioral health services in their spending targets and the carve-out vendor is providing a sub-capitated payment to primary care practices for some behavioral health services.

On occasion, emergency out-of-area services and transplants are excluded from some arrangements. For Medicaid, long-term services and supports are included only in Programs for All-inclusive Care for the Elderly (PACE) contracts and in the total-cost-of-care calculation for shared savings, by provider choice, in PCC Plan PCPR contracts.

2. PROVIDER RISK ASSUMPTION

As a general business practice, commercial and Medicaid payers utilize a mix of shared savings ("upside" risk only for the provider) and shared risk ("downside" as well as "upside" risk for the provider) in global payment arrangements. Shared-savings arrangements are much more commonly used by Medicaid payers than by commercial payers, the latter using shared risk for most, if not all, of their global payment arrangements. All interviewed payers, however, expressed a desire to move toward more shared risk in the future.

Representatives of Medicaid managed-care plans said that the extent to which they share risk depends on provider financial and operational readiness to effectively manage downside risk, and that when risk is shared, it is sometimes within very narrow corridors (risk caps). (For a more complete discussion of provider readiness, see section VII.)

Payers and providers are for the most part content with sharing risk. Payers did not express any desire to move toward full-risk contracts whereby providers are paid a percentage of premium. Some said they would be open to full-risk contracts, while one payer said it opposed the concept as it believed shared risk better aligned payer and provider incentives. Payers reported that a few providers are requesting full-risk arrangements, and this interest was confirmed in a couple of provider interviews.

For those sharing risk, it is typically split on a 50/50 basis, with a cap (limit) set on both provider downside risk exposure and on provider upside gain opportunity. For example, in PCPR's transitional risk model,[23] participants are eligible for 60% of savings up to 10% of the total budgeted cost of care. Information from Massachusetts payers revealed that most of these caps were set at less than 10% of the total budgeted cost of care, but a few arrangements had no caps.[24] Those providers bearing risk with no caps on exposure were typically larger provider organizations with more experience in risk arrangements.

3. SETTING GLOBAL PAYMENT BUDGET TARGETS

There is variation in practice regarding how to set the global payment budget target against which provider performance is assessed. In our experience, this variation mirrors variation in practice in other states. Some insurers revealed that they had been modifying their approach over time trying to find the optimal method.

There are currently two primary methods in use. The first is to prospectively set a per-member-per-month medical expense budget target, which takes into account historical spending and, implicitly, population health status. Under this approach, the payer and provider agree upon a forecast of future spending based on this past spending and forecasted spending growth ("trend"). The principal benefit of this approach is that the provider knows in advance the target toward which it must manage. This method is vulnerable to unanticipated market and other environmental trends. For example, the introduction of costly pharmaceuticals, like those recently released to the market to manage hepatitis C, can make a difference in whether a provider falls below or exceeds its budget target.

The second method in use is a comparison of provider performance to market trend. Under this approach, a provider has to constrain health care spending growth for its attributed population so that it is less than that observed in the general market. The strength of this approach is that it controls for broad-based market and environmental trends. Its shortcomings include that the contracted provider doesn't know what medical expense growth rate it needs to achieve to generate savings. In addition, this approach may not provide sufficient incentives for higher cost providers in comparison with an approach that encourages and incentivizes provider improvement relative to its own past performance. In addition, while macro-market and environmental factors are controlled, there is no adjustment for more local market factors (e.g., a large rate increase for a specific hospital to which the provider admits a significant percentage of its patients).

Regardless of the approach employed, shared savings calculations are always risk-adjusted. However, just as there is variability in alternative payment methodologies, there is also meaningful variability in risk adjustment approaches across payers.

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23 PCPR has three "risk tracks." Track 1 is a shared-risk model with risk corridors and stop-loss provisions. Track 2, the "transitional risk model," is a shared-risk arrangement with risk corridors and greater stop-loss provisions. Track 3 is a shared-savings arrangement.

24 Preliminary information from members of a technical advisory group on Health Care Payment Arrangements hosted by the Massachusetts Division of Health Care Finance and Policy, 2012.

4. REQUIRED PATIENT POPULATION SIZE

A significant challenge in global payment arrangements is attaining statistical confidence that any observed savings—or spending in excess of a budget or target—reflect actual performance. Health care utilization and cost are subject to considerable random variation. Random variation plays a more significant role in populations with good health status and relatively low utilization than in populations with a higher burden of illness.

The impact of random variation is also greater on smaller populations and at smaller degrees of variance from budget or target. For example, 2012 modeling of MassHealth PCC Plan and MCO data revealed that for a population of 5,000 beneficiaries (including women and children as well as persons with disabilities), with savings of 1%, there is a 27% chance that those savings are due to random factors. For savings of 2%, the likelihood that the savings are due to random factors drops to 18%.[25]

We found that all payers defined a minimum population size for shared-savings and shared-risk arrangements. The minimum population size employed by payers when contracting with providers under global payment arrangements was generally low. Payers were willing to set a lower minimum population for shared-savings arrangements than for shared risk—a practice that benefits providers at payer expense.

Payers informed us that minimum population size was defined as as small as 2,000 to 3,000 for shared savings and between 5,000 and 10,000 for shared risk, although one payer said it would set the minimum population size at 3,000 for shared risk.[26] Medicaid managed-care plans shared the challenge they are experiencing to expand global payment arrangements to more providers to help meet the state's goal of moving 80% of MassHealth Medicaid-only beneficiaries into APMs by July 1, 2015. MassHealth beneficiaries are spread across five Medicaid MCOs and the PCC Plan, with no one Medicaid MCO serving more than 25% of the population. Plans explained that the numbers of members they have with a given provider often falls below what the plan considers to be a reasonable population threshold, making the continued spread of global payment arrangements difficult. Creating a shared-savings population-based payment arrangement for a small population places the payer at significant risk for sharing savings that are not "real"— i.e., that result from random variation and not specific action on the part of the contracting provider. While the providers and MassHealth would like the Medicaid MCOs to be aligned with the PCPR model, the Medicaid MCOs are hoping for some flexibility in design to find models that are appropriate for smaller populations.

25 Weismann, J.S., Bailit, M., D'Andrea, G., and Rosenthal, M.B., "The Design and Application of Shared Savings Programs: Lessons From Early Adopters," *Health Affairs* 31(9), September 2012.

26 PACE programs assume risk for much smaller populations than those cited here. The covered populations have a much higher risk profile, and spending is less subject to random variation than it is for the average Medicaid beneficiary served by the PCC Plan or a Medicaid MCO.

5. FINANCIAL INCENTIVES FOR QUALITY IN GLOBAL PAYMENT ARRANGEMENTS

Financial incentives for quality performance are handled in two ways by Massachusetts payers. Our prior research demonstrates that these two general approaches are consistent with practice elsewhere in the country.[27]

In most cases, payers have created a quality performance methodology that is independent from the financial arrangement of the global payment. Payers use payer-specific measure sets that include quality measures and also sometimes utilization measures. The size of these incentive pools relative to the total global payment budget target can be 4% to 10%. For a primary care–based provider, however, this can equate to 25% to 50% of revenue, according to one Medicaid managed care plan.

The other method in use incorporates quality performance into the global payment methodology. Any provider financial gains or losses are modified by quality performance, creating an integrated incentive model. This means that a shared-savings distribution can be enhanced or diminished by quality performance, and possibly any financial losses can also be enhanced or diminished by quality performance.

V. RESULTS OF GLOBAL PAYMENT ARRANGEMENTS

KEY FINDINGS IN THIS SECTION

- **Providers are generally sharing in savings as a result of their performance in global payment arrangements, but many safety-net providers are still uncertain of their prospects.**
- **Performance on quality measures varies and some hospital-based organizations and provider networks find it difficult to perform well on primary care-specific measures.**

This section describes provider performance on financial and quality metrics in global payments, as reported to us by both payers and providers.

27 Bailit, M.H. and Hughes, C., "Key Design Elements of Shared-Savings Payment Arrangements," The Commonwealth Fund, New York, NY, August 2011.

1. PERFORMANCE ON FINANCIAL METRICS

Most providers we interviewed generally stated that they had been financially successful under APMs. BCBSMA reported modest savings achieved by providers participating in the first two years of the Alternative Quality Contract (AQC) program.[28] However, for both safety-net and non-safety-net providers, the extent to which they were successful varied year to year and by payer. The two provider networks we interviewed noted variability in their success from year to year, but in one case, success in 2012 balanced out losses in 2013. One safety-net hospital-based organization noted that its PACE program was not on track to generate savings, but its Medicare Advantage contract was generating some savings. Another safety-net hospital-based organization noted that it had "done well with not a lot of effort" on certain commercial APM contracts, but another commercial APM contract put it in a deficit situation almost immediately.

> "We hope we'll be financially successful, but it is really unclear."
>
> — *Community Health Center*

Among many of the CHCs we interviewed, there was hope that they will be more financially successful under the PCPR model than under the traditional fee-for-service model, but they recognized that there is uncertainty because the model is still new and no performance results had been released as of the writing of this report. Providers reported that the modeling provided by MassHealth prior to the start of the contract indicated that PCPR was to be a generous financial model compared with traditional fee-for-service. Early reported financial experience with the primary care capitation element of PCPR was quite favorable, although some providers expressed concern that the data MassHealth relied upon to make its assumptions were faulty. Since our interviews, MassHealth has informed providers that it would be lowering the comprehensive primary care payment rate.

2. PERFORMANCE ON QUALITY METRICS

Overall financial success in global payment arrangements is affected by performance on contractually specified quality measures. Payers reported that providers earn about 75% of the eligible quality dollars. BCBSMA's AQC program reported improvements in quality in the first four years.[29] Despite these successes, some providers perform quite poorly. One payer attributed such poor performance to lack of provider attention, stating that quality bonuses are treated "like Christmas presents" by some providers—i.e., they are expected but don't require any work to be earned. On the other hand, hospital-based organizations and the provider networks noted that quality measures were too focused on the primary care population and were not in line with their core business. Some of these organizations did not focus their efforts on meeting those measures and in at least one case performed poorly on Healthcare Data and Information Set (HEDIS) measures as a result.

28 Song, Z., et al., "The 'Alternative Quality Contract,' Based on a Global Budget, Lowered Medical Spending and Improved Quality," *Health Affairs*, July 2012.

29 Song, Z., et al., "Changes in Health Care Spending and Quality 4 Years Into Global Payment," *New England Journal of Medicine* 371: 1704–1714, October 30, 2014.

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

KEY FINDINGS IN THIS SECTION

- **The proportion of total net patient service revenue coming from global payments ranged from less than 5% to 50%, with a median of about 30%.**
- **Most of the interviewed safety-net providers in global payment arrangements are in a shared-savings arrangement.**
- **Significant investments have been made in clinical and business operations to prepare for and operate under global payments.**
- **Smaller providers are affiliating with large systems or third-party contracting entities in order to obtain favorable APM contracts.**
- **Provider consolidation has been an ongoing trend in Massachusetts that may negatively impact the cost-savings effect of global payments as a result of increased provider market power that drives up prices.**

Nationally, risk-based contracting with safety-net providers is relatively new, with the literature only beginning to cite examples.[30] In Massachusetts, safety-net providers have been newly entering global payment arrangements,[31] many for the first time in 2014 as part of the PCC Plan's PCPR. For the most part, the safety-net providers we interviewed were trying to "get ahead of the curve" with respect to participating in global payments, because many of them view the proliferation of global payments adoption as "the writing on the wall." They expressed a desire to practice operating under global payments before the stakes get any higher and while adoption is still voluntary.

> "Global payment is really hard, but we figured this was the time to figure it out."
>
> — *Community Health Center*

This section describes global payment participation among interviewed safety-net providers, the financial considerations for safety-net providers engaged in global payments, and some of the key internal and external changes they are making to adapt to this new form of payment.

30 Schoenherr, K.E., et al., "Establishing a Coalition to Pursue Accountable Care in the Safety Net: A Case Study of the FQHC Urban Health Network," The Commonwealth Fund, publication 1710, volume 28, October 2013; and Maxwell, J., Bailit, M., Tobey, R., and Barron, C., "Early Observations Show Safety Net ACOs Hold Promise to Achieve the Triple Aim and Promote Health Equity," *Health Affairs* blog, September 15, 2014.

31 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.

1. GLOBAL PAYMENT PARTICIPATION RATES AMONG SAFETY-NET PROVIDERS

There are several global payment arrangements in which safety-net providers are participating, with the two most commonly observed being MassHealth's PCPR and the BCBSMA Alternative Quality Contract. Some interviewees were also participating in shared-savings or shared-risk arrangements with commercial MCOs other than BCBSMA, with Medicaid MCOs, and as part of the PACE program. In addition, some interviewees cited global payment experience with a Medicare Advantage product and with the Medicare Shared Savings Program (MSSP). The percentage of total net patient service revenue in global payments ranged from less than 5% to 50%, with a median of about 30%. Only three providers, however, reported that 40% or more of their revenue came from global payments. The primary care provider organizations were on the lower end of spectrum, at 5% to 15%, while the hospitals ranged across the full spectrum, at 5% to 50%. Most of these arrangements are for shared savings and not shared risk. For those providers with shared risk, the percentage of dollars that are actually at risk for any given organization was reported to be very small.

The depth of experience with global payments varied across our interviewees, with most having quite limited experience. The arrangements with commercial payers tended to be longer-standing than the Medicaid payer global payment arrangements, by a few years. However, for most safety-net providers, commercial insurers represent a small percentage of total revenue. One provider noted that 70% of its patients are enrolled with Medicaid. Medicaid payers, with a few provider- and payer-specific exceptions, entered into global payment contracts with safety-net providers for the first time over the past couple of years. Five of the providers we interviewed were participating only in PCPR and consequently had only a few months' worth of experience participating in a global payment.

Not all providers we interviewed found the global payment arrangements available to them to be worthwhile. One CHC that had chosen not to participate in any APM had philosophical differences with the models and specifically worried that global payments would encourage its providers to see their patients fewer times over the course of a year. The model as presented to this CHC would net it the same revenue as fee-for-service and therefore it felt it unnecessary to take financial risk for no gain. The same provider also expressed concerns with the quality of the data MassHealth was using to financially model PCPR and was uncomfortable with the "fluidity" of attributed patients from one report to the next.

> "Why would we want to be paid in such a way that would have us see our patients less?"
>
> — *Community Health Center not in PCPR*

2. FINANCIAL CONSIDERATIONS FOR SAFETY-NET PROVIDERS

A. Financial Readiness

When entering into a global payment arrangement, most providers seek to understand what impact the model will have on their bottom line, as well as on cash flow and reserves. These last two are especially important for safety-net providers as their reserves may not cover any significant swings in cash flow or losses that may occur under alternative payment arrangements,

despite the protections that payers put in place in many global payment arrangements, including caps on risk exposure. Half of the Massachusetts safety-net hospitals with the highest proportion of "disproportionate share hospital" (DSH) payments have negative operating margins.[32]

We asked interviewees how they have assessed their financial readiness to participate in global payments. Some safety-net providers reported hiring actuarial consultants, but the majority relied on internal or health plan analyses to determine whether they had a chance to be successful under the arrangement. We found that many safety-net providers, particularly CHCs, have not done extensive analysis to assess their financial readiness to take on downside risk, likely due to the very little downside risk currently being borne by most safety-net providers.

In addition to payer methodological protections (e.g., risk caps or PCPR's "good clause" exemption[33]), there are two general protections that are afforded safety-net providers with respect to APMs and risk. First, federal law requires that any APM agreed to by a federally qualified community health center (FQHC)[34] and Medicaid must result in a payment that is at least equal to the amount otherwise required to be paid for services typically provided (e.g., preventive care and chronic disease management).[35] This protection is implemented in PCPR through its hold-harmless provision, which prevents any of the participants (CHC and non-CHCs alike) from losing money on services for which they would normally bill. At regular intervals, each PCPR participant's billing is compared with its comprehensive primary care payment under the program, and if the former exceeds the latter the participant may receive a supplemental payment. Second, insurance regulations that have been recently promulgated by the state Division of Insurance require providers to obtain an annual actuarial certification that the risk-based APMs in which they are engaged with payers will not threaten their financial solvency.[36]

Despite the provisions of the federal law and the PCPR model, CHCs are not prevented from taking on downside risk on the total cost of care, so while they may be made whole for services they provide, they may be at risk for owing the payer money if they exceed a negotiated budget target for services that others provide (e.g., hospitalizations and specialist visits). With safety-net providers lacking "deep pockets" and in many cases operating in the red, being involved in shared risk contracts could be detrimental to certain providers.

B. Prospective Payment

Currently, the only prospective payment arrangements in the state that we identified are the capitated primary care payment in the PCPR contract and the contracts employed by at least

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32 A disproportionate share hospital (DSH) is defined in state law as "any acute hospital that exhibits a payer mix where a minimum of 63% of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the Federal Social Security Act, other government payers, and free care." MassHealth categorizes certain hospitals as DSH and provides a supplemental payment to them. Hospital operating margins were provided by CHIA through its Hospital Financial Performance Factsheets. See www.mass.gov/chia/researcher/hcf-data-resources/hospital-financial-performance/historical-financial-performance.html#FY12Sheets.

33 PCPR includes an additional protection through its own "good clause" exemption: a process that allows participants who feel unprepared to take on downside risk to remain in shared-savings arrangements for year two of the program if they meet basic financial criteria.

34 Most community health centers in Massachusetts are FQHCs.

35 42 U.S.C. 1396a, payment for services provided by federally qualified health centers and rural health clinics.

36 211 CMR 155.00: Risk Bearing Provider Organizations, at www.mass.gov/ocabr/docs/doi/legal-hearings/211-155.pdf.

one Medicare Advantage plan.[37] Prospective payments are important because they allow providers to use the upfront cash flow to provide care to their patients in ways that are not traditionally reimbursed under fee-for-service payment. For example, a prospective payment could allow providers to pay for nurse care managers to provide telephone support to patients or for providers to arrange transportation to and from medical office visits. In other cases, and as reported by some interviewees engaged in PCPR, prospective payments help to increase staff and build the infrastructure required to be successful under global payments. Prospective payments may be especially valued by safety-net providers, in particular, because these providers tend to be more cash-strapped than non-safety-net providers.

The majority of interviewed providers preferred this method of payment for their services, although a minority were indifferent. Importantly, though, providers interviewed were not interested in accepting a prospective payment for all services (i.e., the services they provide plus those they do not) because it would require them to administer payments to other providers. Also, as one provider noted, the current fee-for-system "chassis" is what they are used to operating under, and a prospective payment for all services would require too much retooling of their systems. What was clear among most providers is that the existing prospectively paid arrangements don't represent a high enough percentage of total revenue for the prospective payment to make an appreciable difference in their ability to provide health care in new ways. Only two providers noted that the prospective payments were enough to cause significant change within their practices.

One CHC we interviewed reported being in such dire straits that despite the hold-harmless clause in PCPR, it opted out of the model because if it was paid prospectively and it provided more services than were covered under the prospective payment, the health center would not have the cash reserves to cover those expenses until the hold-harmless reconciliation was performed at the end of the performance period.

3. INVESTMENTS AND OPERATIONAL CHANGES

Massachusetts safety-net providers reported significant investments and operational changes in preparation for an increase in alternative payment arrangements. While not all providers have tracked the dollar investments devoted to preparation for and participation in global payments, the investments appear to have been sizable, and those that have tracked spending have reported spending millions of dollars. These investments have been used to support change to clinical and business operations.

The majority of interviewees reported using their own internal funds to support delivery system transformation and infrastructure development. One provider that was part of a larger health care system reported some level of investment being made by the parent organization. Hospitals we interviewed referred to two state grant programs that provided support to safety-net hospitals. The Health Policy Commission offered up to $10 million for community hospitals across the state

37 PCPR prospectively pays only for primary care (and behavioral health if the provider chooses to deliver those services) but holds the providers responsible for total cost of care. Most of the providers contracted with the identified Medicare Advantage plan receive prospective payment for primary care, but some receive prospective payment for all services, and others receive prospective payment for only hospital or specialists' costs in addition to primary care.

for delivery system transformation through Community Hospital Acceleration, Revitalization, and Transformation (CHART) grants. Another $60 million is currently available for Phase 2 CHART grants, and $50 million will become available over the next four years. Under MassHealth's 1115 Medicaid waiver, since 2012 the state and federal government have offered up to $209 million annually in a performance-based incentive program—the Delivery System Transformation Initiative (DSTI)—to support seven safety-net hospitals' investments in delivery system transformation efforts, including preparation to accept APMs. In October of 2014, the federal government agreed to increase funding for this program to $230 million annually for three more years (through state fiscal year 2017). In addition, the 1115 waiver authorizes $30 million annually through infrastructure and capacity-building grants to other providers (who are not eligible for DSTI), including CHCs, hospitals, primary care practices, and physicians, for enhancing health care quality and cost-containment goals.

A. Clinical Changes in Response to Global Payments

One of the linchpins of the case for moving away from fee-for-service payment is that the care of patients will improve as a result of payment incentives being aligned with activities that support high quality care. Among the safety-net providers we interviewed, most, but not all, were working on some manner of change to their clinical operations. The most notable clinical change reported by providers was an increase in community health workers and nurse care-management staff to help manage the patients with the highest risks. Much of this was started when many of the providers we interviewed participated in the Massachusetts Patient-Centered Medical Home Initiative[38] and is continuing today as some of those providers move into PCPR or other global payment arrangements.

> "This is really hard. We have to transform every aspect of the organization … clinical, care coordination, quality and finance."
>
> — *Community Health Center*

Very few providers stated that they were not making any clinical changes. Of those that did say participation in global payments did not change their clinical care, one CHC reported that it contracted only with plans offering global payments that fit its preexisting clinical practice. On the other hand, other providers that have yet to make significant clinical change recognize the need to do so but thus far have not because the amount of upside potential is too small to motivate any significant change.

B. Business Changes in Response to Global Payments

The most significant investment made by safety-net providers in business operations has been in data management. Many of the CHCs recognized that one of the most significant changes they need to make to be successful in a global payment, or any APM, is to improve data analytics to better manage populations of patients. Both the primary care providers and hospitals we interviewed reported making significant operational changes regarding collection, analysis, and application of data. Activities categorized as data management include investments in:

38 The Massachusetts Patient-Centered Medical Home Initiative was a three-year, state-led, multi-payer initiative involving 44 mostly safety-net primary care practices between 2011 and 2014.

- Staff with expertise in information technology (IT), finance, and analysis to provide quality business and technical support;
- IT systems, including data warehousing and electronic health records; and
- Resources to educate and train clinical staff to use electronic health records in order to properly capture quality data.

The level of change varied from one provider to the next, with one provider restructuring its finance department to be more responsive to fiscal modeling and analytics, and another provider installing a new electronic health record. These business changes in response to global payments were also confirmed by some providers in their written testimony for Massachusetts' 2014 Annual Cost Trends Hearing.

In addition, safety-net hospitals were looking internally to make strategic changes, including right-sizing the number of inpatient beds and restructuring staff, without hiring additional staff, to accomplish the new tasks associated with managing under global payments.

4. AVAILABLE TECHNICAL SUPPORT

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. We asked providers whether technical support has been offered by any outside organization, including payers, the state, or foundations, and found that the type and level of technical support has varied significantly among providers. We also asked payers what support they offer providers. We found inconsistency between what technical support the payers reported supplying to safety-net providers and what safety-net providers reported receiving.

In terms of payer support, among the hospital-based organizations, three reported receiving support and one did not. One hospital-based organization that received support described its largest payer as having provided a considerable amount of assistance educating the hospital about bundled payments. This hospital and payer have yet to engage in a bundled payment arrangement, but the payer is reportedly paying for consulting services to assist the hospital in understanding and preparing for bundled payments. Another hospital-based organization remarked that some payers had very good reports that provide trend and benchmark measures on quality, utilization, and referral provider cost, including internal resources to assist providers with reports that are presented, whereas other payers supplied this provider with little technical support.

> "If we're going to be at risk for patients, we need to know who the patients are. We don't know who the patients are and we're not getting the data we need to manage."
>
> — *Hospital-based safety-net provider*

Among the primary care practices, most reported receiving little to no technical support from contracted payers. A few mentioned that MassHealth and the Massachusetts League of Community Health Centers had provided several useful learning opportunities about PCPR and APMs generally. One CHC engaged in PCPR hired a consultant to help manage the transition to the new payment model.

In contrast, payers indicated that they were offering a wide variety of supports, including individual assistance to providers for translating data to action and tools to query plan databases. This inconsistency between the payers and providers may be the result of payers furnishing technical support that is not useful or the providers not having the awareness, resources, or knowledge to use the support.

The two provider networks we interviewed were in the position of providing support to safety-net practices with which they were affiliated. Those organizations reported creating and developing resources to assist their practices in managing risk and providing data. One organization was working to create a "virtual" medical home where care managers shared across multiple providers would be deployed to assist primary care practices in managing their highest-risk patients. However, the safety-net providers we interviewed that were affiliated with these larger organizations did not indicate having received any of this support, which again led us to conclude that either the support was not valuable or the practices were having trouble taking advantage of the support.

5. STRATEGIC CHANGES IN RESPONSE TO MARKET SHIFT

Across the country and especially in Massachusetts, the market has been shifting in response to global payments. Health systems have been consolidating, and providers and health plans continue to be in merger and/or affiliation discussions. Safety-net providers are not immune from these forces or trends.

A. Provider Affiliation

With the exception of CHCs, there are few independent medical groups that are contracting with commercial or Medicaid payers. Medical groups and hospitals that are not affiliated with a larger system are increasingly entering global payments via a third-party contracting entity that offers favorable reimbursement rates and support services, including data analytics. We found this to also be the case with a number of safety-net providers that have entered global payments through contracts with formally affiliated and non-affiliated provider-based organizations. While affiliating via third-party contracting entities may appear sensible given the small size of many CHCs, the relayed experiences of a few CHC interviewees suggests that their small size limits the support they receive from the larger organization.

In addition to collaboration via third-party contracting entities, smaller providers participating in PCPR are being organized in pools so that they may participate despite an attributed population size that alone would be considered too small by most payers. Providers were given the opportunity to pool together in the PCPR model, and there were mixed feelings among our interviewees about whether this was going to be successful for them. One CHC that did not join PCPR stayed away because it was unclear to the CHC how partnering entities were going to divide up any losses or gains at the end of the year. It felt that the uncertainty in the pooling arrangement with its potential partners might put the organization at unnecessary financial risk for the poor performance of the other providers, even if the CHC's own performance was positive. In contrast, another safety-net provider that did join PCPR via a pool expressed more comfort around the arrangement because it joined a trusted partner in the pool, despite the fact that the details of the pooling arrangement with its partner had not been solidified at the time of our interview.

Pooling is a mechanism to get small providers "into the game," but it may also make it hard for those providers to see the impact of their own actions.

B. Provider Consolidation

Provider consolidation has captured headlines in Massachusetts for the past few years, and it is a continuing trend that caused some of our interviewees to voice concern. One payer reported that while the state's 2013 trend target was 3.6%,[39] it was currently negotiating contracts with providers that were seeking increases far in excess of that level. In fact, one forecast for 2015 commercial premium growth is 7%.[40] Many national observers have worried for the past few years that provider consolidation may undercut the desired impact of global payments, because large providers have considerable leverage to negotiate higher rates, which could outweigh the potential cost-reduction opportunities of global payments.[41]

Safety-net providers are also thinking about provider consolidation but in sometimes different ways. Safety-net hospitals, in particular, appear to be thinking strategically. One safety-net hospital shared its desire is to employ more primary care physicians and have greater control over care delivery. This may be because primary care providers are a key leverage point to manage chronic conditions and direct referrals and help avoid preventable and unnecessary hospital admissions. CHCs, in contrast, described the adverse impact of hospitals (including safety-net hospitals) employing primary care providers at higher wages than CHCs can afford.

Observing the effects of provider consolidation, one CHC noted that a large regional health center with strong market power in its area was refusing to negotiate with a certain payer. This CHC worried that the payer will leave its geographic market and lamented that "today's payers might not be tomorrow's payers."

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39 Chapter 224 requires the Health Policy Commission to set a benchmark for health care cost growth, and if market expenditures are above the benchmark, the Health Policy Commission may require those health care entities that are above the benchmark to enact performance improvement plans. The targeted cost growth for years 2013-2017 is set at the growth rate of potential gross state product, which was +3.6% in 2013. For more information, see CHIA's *Annual Report on the Performance of the Massachusetts Health Care System*, at www.mass.gov/chia/docs/r/pubs/14/chia-annual-report-2014.pdf.

40 Fernandes, D., "Massachusetts Insurers Say Healthcare Costs Are Forecast to Rise 7%," *The Boston Globe*, February 5, 2015.

41 Ginsburg, P.B. and Pawlson, L.G., "Seeking Lower Prices Where Providers Are Consolidated: An Examination of Market and Policy Strategies," *Health Affairs* 33(6): 1067–1075, June 2014; and Yin, B., "ACO Conundrum: Market Consolidation Could Push Prices Up," *Fierce Healthcare*, February 3, 2011.

VII. CHALLENGES FACING SAFETY-NET PROVIDERS ENGAGED IN GLOBAL PAYMENTS

KEY FINDINGS IN THIS SECTION

- **Readiness to accept downside risk varies greatly between safety-net providers and non-safety-net providers.**
- **The lack of consistency in quality measures across global payment arrangements challenges providers because of the resulting broad demands of measurement and quality improvement.**
- **Most global payments involving safety-net providers do not facilitate true behavioral health integration, thus further fragmenting connections between primary care and mental health care and substance use treatment. This is particularly challenging for safety-net providers because they provide care and services to a disproportionate share of those with behavioral health needs.**

For most providers, participating in global payments 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. This section describes some of the key challenges specifically facing safety-net providers engaged in global payments.

1. READINESS

We observed a wide difference in reported readiness to accept global payments, in particular those with downside risk, between safety-net providers and non-safety-net-providers. Most payers we interviewed reported conducting readiness assessments with all providers prior to the start of a global payment contract. Readiness assessments were reported to include an assessment of infrastructure, financial statements, and commitment from senior leadership. Some payers reported that CHCs, in particular, lack management and actuarial expertise for managing downside risk, as well as an understanding of how to interpret data and apply it for population health-management activities. One payer said, "We have a lot of providers very early in the process. They are getting used to viewing panels and conducting patient-level care management." Another payer stated, "As a general class, CHCs aren't anywhere near ready for downside risk." As mentioned, the safety-net providers we interviewed reported having expended significant resources on data management. Nonetheless,

> "The biggest weakness for community health centers is their ability to take information and translate it into a medical management strategy."
>
> — *Payer*

many reported that clinical and financial data management are among the most significant areas in which their organizations need to evolve to be successful under global payment arrangements.

Additionally, we observed in our interviews that there is a lack of clarity about the contracted global payments themselves and what impact those payments could have on an organization. It was apparent that in some cases safety-net providers were not aware of key provisions described by payers as contained within their global payment contracts, in particular regarding the quality and financial targets for which providers are responsible.

In stark contrast, the non-safety-net providers we interviewed were both more understanding of their global payment arrangements and more sophisticated in their approaches to managing for success. These non-safety-net providers—and some of the safety-net providers with significant commercial business—had spent several years investing time and resources to be able to better manage care using clinical data. Additionally, non-safety-net providers tended to have greater financial stability as a result of having a higher proportion of commercially insured patients.

2. CONSISTENCY AND RELEVANCY OF QUALITY MEASURES

We found that across the different health plans, there is little to no consistency in the design of the global payments, and this can be generally challenging for all providers but especially challenging for safety-net providers. Most interviewees reported the most challenging point of divergence among the global payment contracts to be the quality measures for which providers are held accountable.[42] One provider reported that one plan had three times as many quality measures as other plans. Tracking and improving upon quality measures is reported to be one of the most significant burdens of participating in a global payment because of the time and intensive resources that are required. Interviewees discussed the time and education that go into ensuring that clinical staff are entering the appropriate data into the appropriate fields of an electronic medical record so that the quality analytics staff can create or interpret reports that are unique for each payer and that in some cases include metrics focused on the same clinical area but measured using different definitions. In addition, staff are following up on any discrepancies between information collected through clinical data captured at the provider level and claims data from the payer.

Approximately half of all CHCs in the state are using a centralized data warehouse to create common reports required of CHCs by law. We were not able to ascertain what value that warehouse can offer to those health centers as it relates to reporting requirements for global payment contracts.

Some hospital-based and multispecialty providers noted that global payment contracts' primary care quality measures were not relevant to their core business and therefore were not worth the effort that it would take to improve performance relative to the quality measures. In Massachu-

42 This issue is not specific to Massachusetts. Measures sets in other states and nationally tend to be poorly aligned. See Bazinsky, K. and Bailit, M., "The Significant Lack of Alignment Across State and Regional Health Measure Sets," Buying Value, Washington, DC, September 15, 2013.

setts and across the nation, plans and providers are struggling with how to measure the quality of specialty care. Additionally, one provider suggested that one plan's quality measures were not up to date with current clinical guidelines, so the provider opted not to focus on those particular quality measures until they could be updated in subsequent contract years. It appears possible that the provider resources invested in measurement of quality performance may currently exceed the resources dedicated to quality improvement.

Finally, one payer representative offered that he saw no competitive advantage to how global payment deals are structured and further said he would be willing to use quality measurements that were multi-payer.

3. INCORPORATING BEHAVIORAL HEALTH

Behavioral health conditions drive a significant portion of primary care spending. Over the course of a year, nearly 30% of the adult population in the U.S. suffers from a behavioral health disorder,[43] and over half of all Medicaid beneficiaries with disabilities are diagnosed with one.[44] Yet most of the Medicaid global payment models in the state do not include behavioral health services in the total-cost-of-care calculations because most of the Medicaid MCOs use a carve-out behavioral health vendor to manage the mental health and substance use needs of their members. This is problematic because most behavioral health treatment for adults is provided in primary care settings;[45] behavioral health conditions are more prevalent among patients with chronic conditions[46] that are commonly treated in primary care settings; and left untreated, behavioral health disorders can lead to complications with medical issues and result in higher total health care costs.[47] This separation of medical care into global payments and behavioral health care into fee-for-service can contribute to fragmented services for Medicaid beneficiaries—especially those with mental health and substance use disorder needs.

The exception is MassHealth's PCPR program. The PCPR program incorporates behavioral health into many different facets of the model. First, all providers that have joined PCPR are expected to incorporate behavioral health into their clinical model of care in ways that best fit the practice outlined in the contract. Second, there are three tiers of payment that vary depending on the extent to which the primary care provider wishes to incorporate behavioral health services into the global payment. The first tier includes no extra dollars for behavioral health; the second includes basic integrated care services like brief interventions, screening, assessments, and triage in the

43 Kessler, R.C., Chiu, W.T., Demler, O., Merikangas, K.R., and Walters, E.E., "Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry* 62(6): 617–627, 2005.

44 Kronick, R.G., Bella, M., and Gilmer, T.P., "The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions," Center for Health Care Strategies, Inc., October 2009.

45 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.

46 Katon, W.J., "Clinical and Health Services Relationships Between Major Depression, Depressive Symptoms, and General Medical Illness," *Society of Biological Psychiatry* 54: 216–226, 2003; and Katon, W.J., Lin, E.H., and Kroenke, K., "The Association of Depression and Anxiety With Medical Symptom Burden in Patients With Chronic Medical Illness," *General Hospital Psychiatry* 29: 147–155, 2007.

47 Kessler, R.C., Chiu, W.T., Demler, O., Merikangas, K.R., and Walters, E.E., "Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry* 62(6): 617–627, 2005.

prospective payment; and the third includes more advanced behavioral health services, including medication management. However, only a small proportion of PCPR-participating providers chose either of the integrated behavioral health models in the first year of the program. Last, in the shared-savings calculations of the PCPR model, practices are responsible for the cost of behavioral health services in total-cost-of-care calculations.

4. SMALL NUMBERS

As noted previously, CHC participation in global payments is challenging in light of CHCs' small size and the fragmentation of their revenue sources across multiple payers. This is a challenge for Medicaid payers as well, one of whose representatives said, "The problem is what to do with a CHC with which we have 500 members … What's the APM that makes the most sense for a small population?"

In response, a couple of Medicaid payers spoke of the need for a range of alternative approaches for providers. One Medicaid payer shared that it was contemplating making its entire provider network a risk contract. MassHealth may need to collaborate with providers and payers to identify approaches that make sense for all parties.

5. UPSIDE POTENTIAL

In order to participate in a shared-risk arrangement, providers have noted that there needs to be enough of a reward, or enough upside potential, to make engagement in the model worthwhile. With many operating with very low or negative margins, risking further losses for little potential gain was not appealing to most.

6. LEADERSHIP

Organizational change requires strong leadership, and moving to a global payment arrangement certainly qualifies as organizational change. Some payers observed variation in leadership commitment to the changes APMs require of safety-net provider executives, with one noting that its most committed safety-net providers have "blown everyone out of the water on quality." Another stated, "Some providers take these programs much more to heart than others."

VIII. 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 missions. 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.

Informed by the interviews completed as part of this report and other concurrent work we have conducted on safety-net provider readiness for payment and delivery system reform across the

country, we recommend several 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.* A facilitated learning community would give safety-net providers the opportunity to learn how their peers are operating under APMs. Through the learning community, providers would be able to share best practices for successfully operating under APMs and offer strategies for addressing common challenges. Making this forum available to safety-net providers is important because they face challenges that are different from those confronting non-safety-net providers and therefore individual success strategies may differ.
- *Developing an **educational seminar series on APMs specific to safety-net provider chief financial officers (CFOs)**.* We found that safety-net providers in Massachusetts have done little to assess their financial readiness to participate in an APM. Many CFOs are consumed with the managing of day-to-day cash flow operations and could benefit from education on strategies for success in financial management of an APM.
- *Supporting evaluation of **existing data infrastructure and analytics capacity and providing capital support** for safety-net providers to access and use high quality data.* As previously described, many safety-net providers appear to lack the data infrastructure and analytics capacity necessary for successful participation in an APM. One CHC interviewee said, "We need funding for people to get out of their day-to-day work to do infrastructure development." A first step to aid most safety-net providers would include a gap analysis, identifying the data resources that currently exist compared with those that are lacking but are critical to support participation in an APM. Based on the findings of such an analysis, certain capital investments should be identified and prioritized.
- *Offering **"light touch" technical assistance (TA)** on those unique situations or challenges identified by particular safety-net hospitals or CHCs.* In addition to the learning community idea described above, there may be unique needs or interests of safety-net providers, based on the particular populations they serve. To that end, providing TA in the form of access to expert consultation on topics such as care coordination models or behavioral health integration approaches would be greatly beneficial to a number of safety-net providers. While some CHCs have hired consultants to provide them with individual technical assistance, not all safety-net providers have the resources to afford their own.

IX. 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 a global payment. Most of the payers we interviewed reported concrete intentions to engage more providers or add more plan products into global payment arrangements, including one payer reporting its intention to move its entire network to risk-based contracting. MassHealth has also stated its intention to contract with ACOs in the near future and is currently seeking stakeholder input into the formation of its ACO initiative.

Safety-net providers will undoubtedly 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.

APPENDIX: DEFINITIONS OF ALTERNATIVE PAYMENT MODELS

Many different terms are used to describe APMs. We have chosen to use the terms already defined by CHIA, in order to remain consistent with how APMs are described in the state. However, CHIA does not define all of the possible terms that are used to describe the models in this report; therefore, we have created this glossary of terms.

Alternative payment model: a payment model that is other than fee-for-service. When we refer to APMs, we are not considering whether they are retrospectively or prospectively administered. Most APMs are administered by paying providers on a fee-for-service basis and, at the conclusion of the performance period, retrospectively reconciling payments with a negotiated budgeted amount.

Bundled payment: a model that pays multiple providers across multiple settings for health care services associated with a defined "episode of care" under a single payment rate.[48] Bundled payment is sometimes called "episode-based payment."

Fee-for-service: a model in which providers are reimbursed by payers at negotiated rates for individual services delivered to patients without financial responsibility for the total cost for specified episodes of care or for a population of patients. This category also includes pay-for-performance incentives that accompany fee-for-service payments.[49]

Global payment: a model that establishes spending targets to cover all of the expected costs for health care services to be delivered to a specified population during a stated time period.[50] Global payment is called by other names, including "total-cost-of-care payment" and "population-based payment,"in other states.

Shared risk: a model that holds the provider financially responsible for a negotiated portion of costs that exceed a predetermined budget, in exchange for provider eligibility for a portion of any savings generated below the predetermined budget. Shared-risk arrangements can be applied to global or bundled payments.

Shared savings: a model that allows the provider to share in a portion of any savings generated below a predetermined budget. Shared-savings arrangements can be applied to global or bundled payments.

48 Alternative Payment Methods in the Massachusetts Commercial Market: Baseline Report (2012 data), Center for Health Information and Analysis, 2014.

49 Alternative Payment Methods in the Massachusetts Commercial Market: Baseline Report (2012 data), Center for Health Information and Analysis, 2014, with added clarifying language.

50 Alternative Payment Methods in the Massachusetts Commercial Market: Baseline Report (2012 data), Center for Health Information and Analysis, 2014.