Commonwealth of Massachusetts

Center for Health Information and Analysis

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Executive Director

Alternative Payment Methods in the Massachusetts Commercial Market: Baseline Report (2012 Data)

December 2013

Center for Health Information and Analysis

Glossary of Terms

Alternative Payment Methods: Payment methods used by a payer to reimburse heath care providers that are not solely based on the fee-for-service (FFS) basis.

Global Payment: Global payments are a type of payment arrangement between payers and providers that establishes a spending target for a comprehensive set of health care services to be delivered to a specified population during a defined time period. Global payment arrangements may shift some financial risk from payers to providers. In these cases, if costs exceed the budgeted amounts, providers must absorb those costs, subject to negotiated risk sharing agreements.[1] On the other hand, providers may share in, or retain, the savings if costs are lower than the budgeted amounts and health care quality performance targets are met.

It is important to note that within the framework of a global payment arrangement with a managing physician group, payments to service providers are generally made on a FFS basis. Also, global payments as defined here do not consider the extent of risk, if any, borne by the managing physician group. It is difficult to capture levels of risk, as there is currently no standardized approach to risk classification or reporting.[2]

Limited Budget: Limited budgets, like global budgets, represent a move away from FFS-based payments. Limited budgets are payment arrangements whereby payers and providers, either prospectively or retrospectively, agree to pay for a specific set of services to be delivered by a single provider. This could include, for instance, capitated primary care or oncology services. Limited budgets also shift some financial risk from payers to providers.

Bundled Payment: Bundled payments are a method of reimbursing providers, or a group of providers, for providing multiple health care services associated with defined "episodes of care" (e.g. knee surgery, pregnancy and delivery, and etc.) for a patient or set of patients. These payments may include services developed based upon clinical guidelines, severity adjustments to account for the general health status of a patient and comorbidities (other related ailments), and even designated "profit" margins and allowances for potential complications.[3]

Other, non-FFS-based: This category includes all other payment arrangements that are not based on a FFS model, but that also do not easily fit into any of the other categories. This category includes supplemental payments for the Patient Center Medical Home Initiative (PCHMI), for instance.

Fee-for-service (FFS): Under this model, health care providers are reimbursed by payers at negotiated rates for individual services delivered to patients. A variety of FFS payment arrangements exist, including, but not limited to, Diagnosis Related Groups (DRGs), per-diem payments, claims-based payments adjusted by performance measures, and discounted charge-based payments. This category also includes pay-for-performance incentives that accompany FFS payments.

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1 Payers and providers may negotiate risk corridors or other types of risk limitation mechanisms.

2 Risk sharing arrangements can vary significantly, complicating classification of risk parameters. For more detailed information on risk sharing arrangements, please see the 2013 report from the Massachusetts Office of Attorney General: *Examination of Health Care Cost Trends and Cost Drivers*. Available at http://www.mass.gov/ago/docs/healthcare/2013-hcctd.pdf (accessed December 2, 2013)

3 For more information, please see the 2011 report from the Division of Health Care Finance and Policy: *DHCFP Report on Bundled Payments, Volume 1*. Available at http://www.mass.gov/chia/docs/r/pubs/11/bundled-payments-report-02-2011.pdf (accessed December 2, 2013)

Executive Summary

Chapter 224 of the Acts of 2012 encourages the adoption and use of alternative payment methods (APMs) to improve the efficiency and quality of health care delivery. This baseline report on APMs in the Massachusetts commercial market examines the extent to which APMs were being used to pay for the care of members enrolled in commercial health insurance in 2012. The Center for Health Information and Analysis will collect and report annually on information regarding changes in type of payment methods implemented by payers and the number of members covered by APMs.

In 2012, fee-for-service (FFS) continued to be the most prevalent payment method in Massachusetts, used to pay for the care of 65% of commercially insured members. APMs were used to pay for the care of the remaining 35% of members. The predominant APM was the global payment method.

Commercial payers used APMs only in a subset of HMO-type contracts: 57% of HMO-enrolled members, representing 35% of all commercially insured members. Non-HMO products such as PPO and Indemnity-type products utilized FFS exclusively.

Payer Analysis

All Massachusetts-based payers have implemented some APMs. In contrast, only one nationally-based payer reported use of these arrangements in Massachusetts, while the remaining nationally-based payers relied on the traditional FFS payment method.

Comparing health status and spending between members associated with APMs and members associated with FFS yielded no consistent patterns across all payers. Among the HMO population, health status adjusted medical spending was higher under the global payment method at the three largest payers, but was lower at other payers.

Provider Analysis

APMs were most prevalent among larger physician groups while smaller physician groups tended to be paid more frequently using FFS.

The ten largest physician groups in Massachusetts had a significant proportion of HMO members' care paid using APMs, with the exception of UMass Memorial Health Care,[4] which was paid using FFS exclusively by all commercial payers examined.

Regional Analysis

APMs were in use for the care of residents in all fourteen Massachusetts counties. However, in Berkshire County, APMs were used to pay for the care of less than three percent of the commercially insured population.

4 UMass Memorial has informed CHIA that it entered into APM arrangements with four commercial payers in 2013.

Introduction

Chapter 224 of the Acts of 2012 (Chapter 224) focuses on lowering health care costs while maintaining or increasing the quality of care delivered in Massachusetts. Certain initiatives under Chapter 224 stemmed from the work of the 2009 Special Commission on the Health Care Payment System. This Special Commission recommended that the health care payment system move away from the traditional fee-for-service (FFS) payment method in favor of alternative payment methods (APMs), particularly the global payment method.[5] A number of Chapter 224 initiatives encourage the adoption and use of APMs to improve the efficiency and quality of health care delivery.

This baseline report on APMs examines the extent of their use in the Massachusetts commercial market. This report also discusses the prevalence of APMs among the various insurance products, between Massachusetts regions, and within physician groups in Massachusetts that manage the members' care. The Center for Health Information and Analysis (CHIA) will continue to monitor and report on the use of APMs in Massachusetts in future reports.

5 See *Recommendations of the Special Commission on the Health Care Payment System* (July 2009). Report available at: http://www.mass.gov/chia/docs/pc/final-report/final-report.pdf (accessed December 2, 2013).

Statewide Analysis

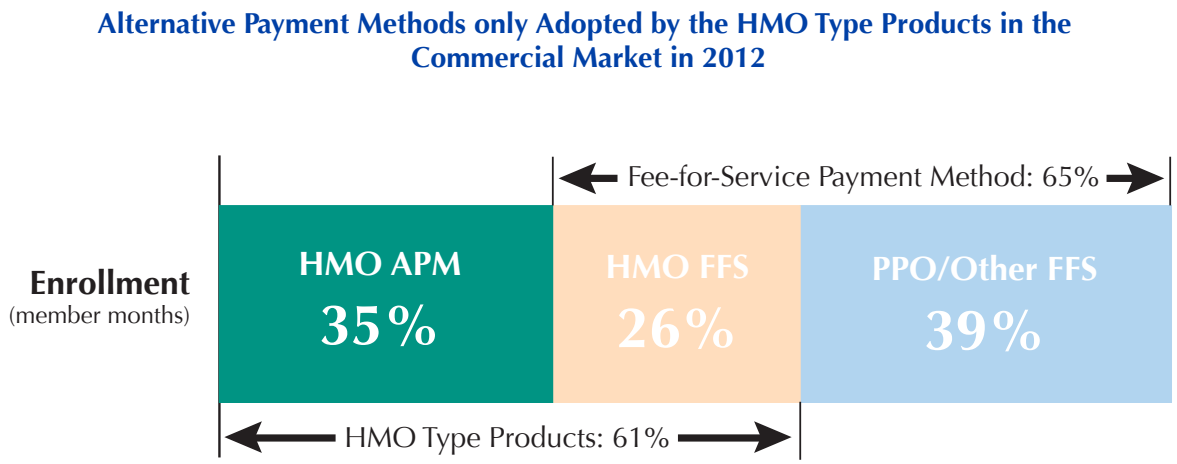

Figure 1. 2012 Statewide enrollment and spending by product type and payment method in the Massachusetts commercial market.

In 2012, FFS remained the most prevalent payment method in Massachusetts and was used to pay for the care of 65% of commercially insured members, while APMs were used to pay for the care of the remaining 35% of members (Figure 1).

FFS was used by virtually all non-HMO-type products such as PPO and Indemnity products (categorized as PPO/Other throughout this report), accounting for 39% of all members.[6] FFS was also used to pay for the care of more than two out of five members enrolled in HMO-type products (26% of all members).

In constrast to the broad utilization of FFS across all product types, the adoption of APMs was exclusive to HMO-type products. In the Massachusetts commercial market, about 61% of members were enrolled in HMO-type products. Among these HMO members, APMs were used to pay for the care of 57% (35% of all members).

6 Harvard Pilgrim Health Care and Aetna both had a very small number of commercially insured members (22 and 669 member months, respectively) whose care was paid using APMs enrolled in PPO-type products.

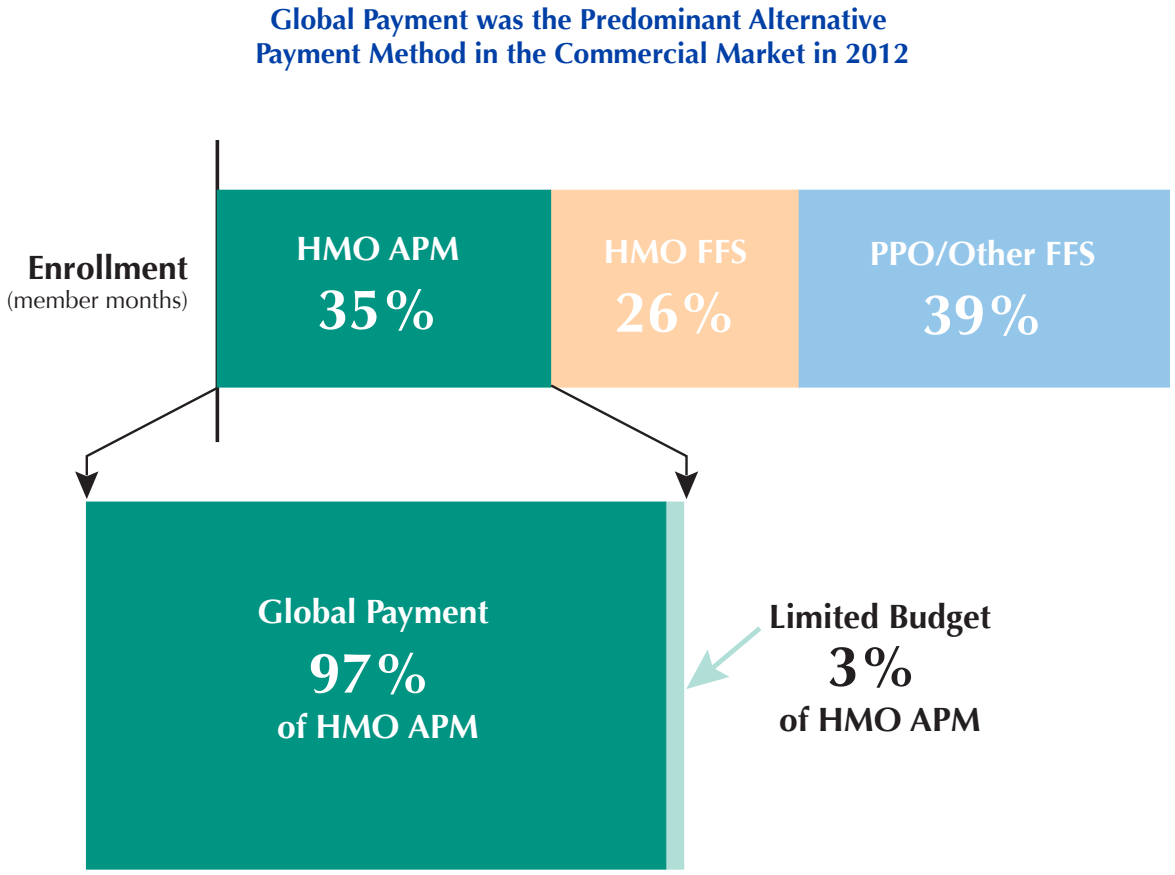

Figure 2. 2012 Enrollment by payment method in the commercial market.

Global payments were the predominant type of APM, accounting for 97 % of members whose care was paid using APMs. Limited budgets accounted for the remaining three percent (Figure 2).[7] Payers did not report the use of bundled payments and other non-FFS payments in the Massachusetts commerical market in 2012.

7 Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, Aetna, and Health New England used the limited budget payment method for their commercially insured populations in 2012. Please see Data Appendix 1 for more information.

Payer Analysis

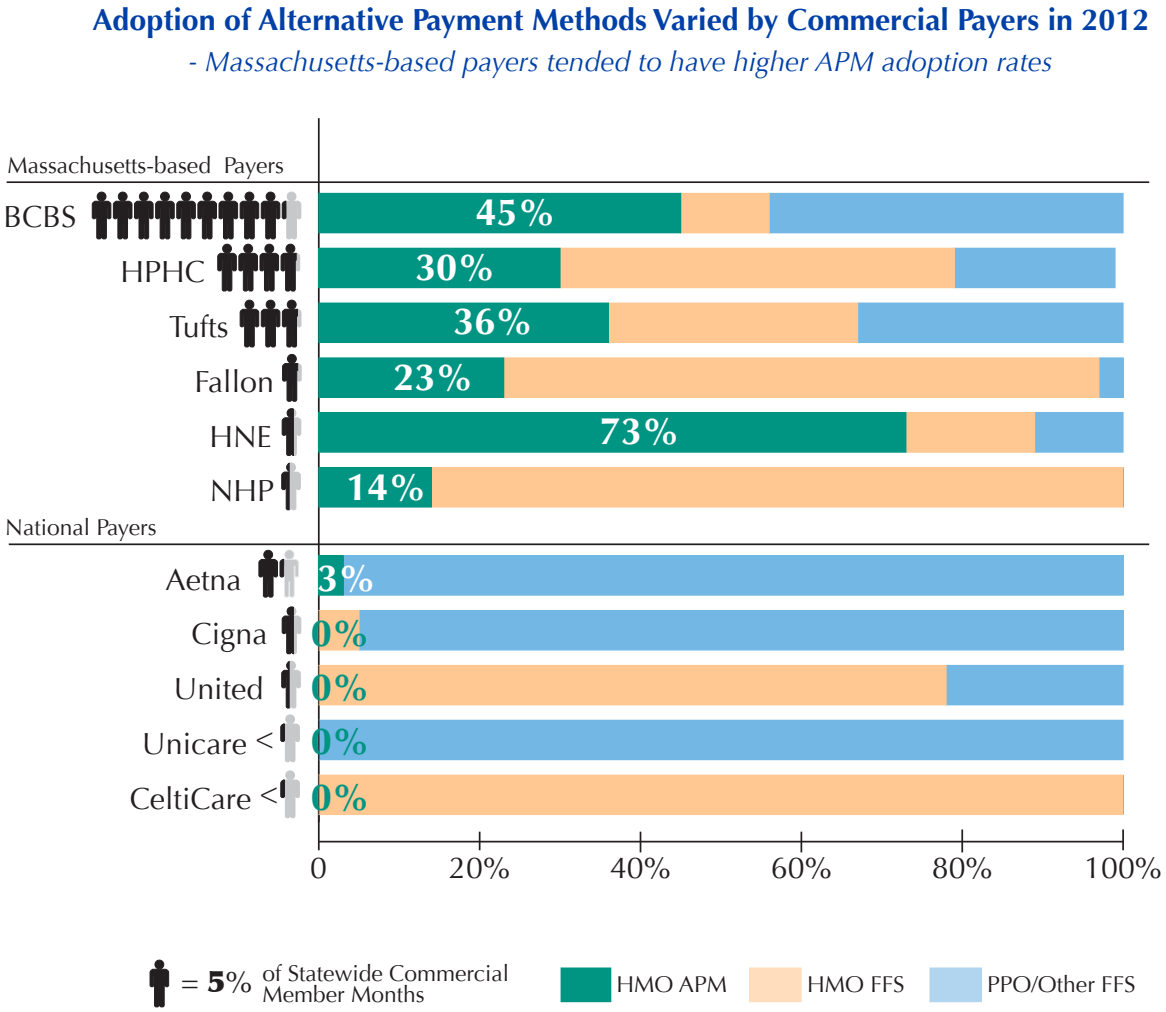

Figure 3. 2012 Commercial insurance payer-specific enrollments and spending by product type and payment method.

The adoption of APMs varied widely among the largest commercial payers in Massachusetts (Figure 3). Payers based in Massachusetts had a substantially higher rate of APM adoption than national payers offering health insurance in Massachusetts.

Among Massachusetts-based payers, Health New England (HNE) had the highest proportion of its members whose care was paid using APMs (72%). Three provider organizations serve approximately 75% of HNE members; HNE's high proportion of APMs is attributable to the global payment contracts it secured with those three groups. All other Massachusetts-based payers used APMs for at least some of their HMO contracts.

Most national payers that were licensed to sell insurance in Massachusetts paid providers exclusively on a FFS basis. The exception, Aetna, used APMs to pay for the care of only 3% of members. Across all payers, FFS was used exclusively to pay for the care of members under PPO/Other products.

Table 1. 2012 Top Five Commercial Payers' Member Relative Health Status Score by Product Type and Payment Method

Payer		HMO Global Payment	HMO FFS	PPO/Other FFS
BCBS	Relative Health Status Score	1.00	0.93	1.12
	Enrollment Distribution	45%	11%	44%
HPHC	Relative Health Status Score	1.00	1.04	1.17
	Enrollment Distribution	30%	49%	20%
Tufts	Relative Health Status Score	1.00	1.01	1.05
	Enrollment Distribution	36%	31%	33%
Fallon	Relative Health Status Score	1.00	0.91	0.80
	Enrollment Distribution	23%	74%	3%
HNE	Relative Health Status Score	1.00	0.85	0.87
	Enrollment Distribution	73%	16%	11%

Note: HMO members under global payments served as the reference group (1.0) for each payer. Values above 1.0 reflect higher health risks than the reference group. Scores can only be compared within each payer's network. See the Technical Appendix for a full description of the methodology.

There is no evidence that members managed under global payment arrangements were consistently healthier or less healthy than other members (Table 1). For Blue Cross Blue Shield of Massachusetts (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (Tufts), members enrolled in PPO/Other products (whose care was paid using FFS) tended to have higher health risks than members enrolled in HMO products. However, Fallon Community Health Plan (Fallon) and HNE did not follow this pattern.

Within the HMO products, BCBS, Fallon, and HNE members whose care was paid using FFS tended to have lower health risk than members whose care was paid using APMs; however this relationship was reversed for HPHC and Tufts.

Table 2. 2012 Relative Health Status Adjusted Medical Spending by Payment Method among the HMO Member Populations in the Commercial Market

Payer		HMO Global Payments	HMO FFS
BCBS	Relative HSA Spending PMPM	1.00	0.90
	HMO Enrollment Distribution	80%	20%
HPHC	Relative HSA Spending PMPM	1.00	0.92
	HMO Enrollment Distribution	38%	62%
Tufts	Relative HSA Spending PMPM	1.00	0.83
	HMO Enrollment Distribution	54%	31%
Fallon	Relative HSA Spending PMPM	1.00	1.07
	HMO Enrollment Distribution	24%	76%
HNE	Relative HSA Spending PMPM	1.00	1.18
	HMO Enrollment Distribution	82%	18%

Note: HMO members under global payments served as the reference group (1.0). The higher the value, the higher HSA medical spending per member per month was for the population. Values can only be compared within each payer's network. See the Technical Appendix for a full description of the methodology.

As with health status, there is no evidence that care managed under global payment arrangements was consistently more or less expensive than under FFS contracts (Table 2). Within the member populations of HMO products, health status adjusted (HSA) medical spending per member per month (PMPM) varied by payment method across the top five payers.

For BCBS, HPHC, and Tufts, HMO members whose care was paid using global payments tended to have higher HSA medical spending PMPM than HMO members whose care was paid using the traditional FFS payment method. On the contrary, for Fallon and HNE, HMO members whose care was paid using FFS tended to have higher HSA medical spending PMPM than HMO members whose care was paid using global payments.

There are a variety of reasons that may explain why the three largest payers report higher spending associated with global payment contracts. Health status adjustment methods may not fully capture the health differences among these patient populations. Moreover, larger physician groups were more likely to participate in global payment arrangements (see discussion below). In general, these physician groups tend to have higher negotiated price levels and also tend to be affiliated with higher priced health systems (see CHIA's 2013 Annual Report[8]). Thus, spending differences between APM and non-APM contracts may simply reflect the kinds of providers participating, rather than a characteristic of APM contracts themselves. It is also possible that payers are offering richer terms in their APM contracts than in their FFS contracts for other reasons.

HNE's lower HSA medical spending for its HMO members whose care was paid using global payments may have been due to its ability to negotiate global budgets with a small number of provider organizations who manage most of their members' care.

8 *Annual Report on the Massachusetts Health Care Market* (August 2013). Available at http://www.mass.gov/chia/docs/r/pubs/13/ar-ma-health-care-market-2013.pdf (accessed December 2, 2013)

Regional Analysis

Table 3. 2012 Commercial Member Months by Product Type and Payment Method by County

County *(Population Proportion)*	HMO APM	HMO FFS	PPO/Other FFS
Middlesex *(26%)*	36%	23%	42%
Worcester *(13%)*	22%	51%	27%
Norfolk *(12%)*	37%	21%	42%
Essex *(11%)*	41%	19%	40%
Suffolk *(9%)*	32%	23%	45%
Plymouth *(8%)*	44%	19%	37%
Bristol *(7%)*	36%	27%	38%
Hampden *(6%)*	44%	18%	38%
Barnstable *(3%)*	40%	21%	40%
Hampshire *(3%)*	38%	26%	35%
Berkshire *(2%)*	3%	68%	29%
Franklin *(1%)*	43%	22%	35%
Dukes *(<1%)*	25%	21%	54%
Nantucket *(<1%)*	17%	18%	65%
Statewide *(100%)*	**35%**	**26%**	**39%**

Note: Numbers may not sum to 100% due to rounding.

APMs were in use for the care of commercial members living in all fourteen Massachusetts counties (Table 3). In Plymouth County and Hampden County, APMs were used to pay for the care of 44% of commercial members in each of these two counties, which were the highest proportions among all counties. In Berkshire County, APMs were used to pay for the care of only 3% of resident members, the lowest among all counties, even though 71% of Berkshire County members were enrolled in HMO products, the second highest among all counties.

The proportions of commercial members under APMs in less populous regions of Massachusetts tended to be below the statewide average. This may be due to the smaller size and number of physician groups practicing in these regions as well as their ability or willingness to take on the financial risks associated with APMs. The larger proportions of commercial members under APMs in more populous regions of Massachusetts may indicate that the larger physician groups that practice in these areas may have a higher degree of integration and infrastructure to support closer patient care coordination and manage financial risk. Of note, Worcester is a region with a higher proportion of commercial members, yet adoption of APMs is below the statewide average. Contributing to this is lower proportion of APM use is the fact that Worcester County's largest physician group did not hold any global payment contracts with commercial payers in 2012 (see Figure 4).

Provider Analysis

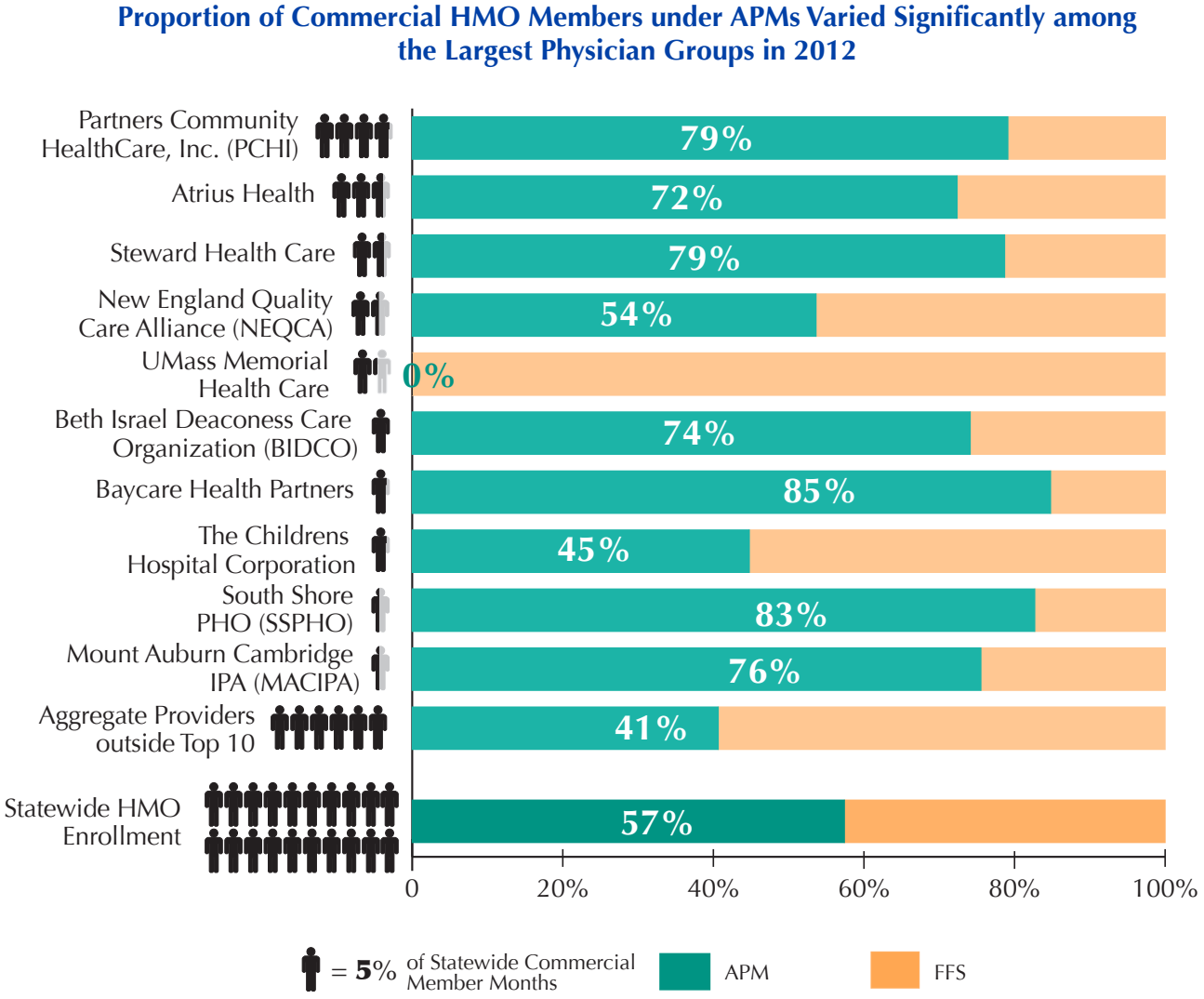

Figure 4. 2012 Commercial HMO member months by payment method among the top 10 managing physician groups.

The members of the top ten physician groups in this report represented 70% of all members whose HMO-type products required them to select a primary care physician. Most of these physician groups had a significant proportion of their HMO members whose care was paid using APMs, with the exception of UMass Memorial,[9] which was paid using FFS exclusively by all commercial payers examined (Figure 4). Seven of the top ten physician groups had more than 70% of their HMO members under APMs.

Physicians and physician groups that were not in the top ten managed approximately 30% of HMO members in Massachusetts. Among these smaller physician groups, 41% of their HMO members received care that was paid using APMs.

9 UMass Memorial has informed CHIA that it entered into APM arrangements with four commercial payers in 2013.

Table 4. 2012 Commercial HMO Member Months by Payment Method and Payer among the Top 10 Managing Physician Groups

Contracting Entity	Payer	APM	FFS
Partners Community HealthCare, Inc. (PCHI) (19%)	BCBS	100%	0%
	HPHC	60%	40%
	Tufts	76%	24%
Atrius Health (13%)	BCBS	100%	0%
	HPHC	48%	52%
	Tufts	79%	21%
	Fallon	71%	29%
Steward Health Care (8%)	BCBS	100%	0%
	HPHC	60%	40%
	Tufts	59%	41%
New England Quality Care Alliance (NEQCA) (7%)	BCBS	100%	0%
	HPHC	0%	100%
	Tufts	8%	92%
UMass Memorial Health Care (6%)	BCBS	0%	100%
	HPHC	0%	100%
	Tufts	0%	100%
	Fallon	0%	100%
Beth Israel Deaconess Care Organization (BIDCO) (5%)	BCBS	100%	0%
	HPHC	53%	47%
	Tufts	78%	22%
Baycare Health Partners (4%)	BCBS	100%	0%
	HPHC	0%	100%
	Tufts	88%	12%
	Fallon	0%	100%
	HNE	100%	0%
The Children's Hospital Corporation (4%)	BCBS	100%	0%
	HPHC	0%	100%
	Tufts	0%	100%
South Shore PHO (2%)	BCBS	100%	0%
	HPHC	59%	41%
	Tufts	79%	21%
Mount Auburn Cambridge IPA (MACIPA) (2%)	BCBS	100%	0%
	HPHC	55%	45%
	Tufts	59%	41%

Note: Only the top five payers are presented.

With the exception of UMass Memorial, BCBS used global payments exclusively to pay for the care of its HMO members managed by the largest physician groups (Table 4). HPHC and Tufts used both global payments and FFS to pay for the care of their HMO members. HPHC's HMO members that were managed by certain large physician groups, such as New England Quality Care Alliance (NEQCA) and Baycare Health Partners, were exclusively under FFS payment arrangements. Ultimately, these variations indicate the extent to which the adoption of APMs is dependent on complex negotiations between payers and providers. There appear to be opportunities to expand the use of APMs in HMO contracting with the top ten physician groups.

Conclusion

This initial report on APMs establishes a baseline from which to measure the adoption of APMs over time. In 2012, APMs were used to pay for the care of 35% of members enrolled in commercial insurance products, while FFS was the most prevalent payment method in Massachusetts, used to pay for the care of 65% of commercial members. APM adoption was concentrated in Massachusetts-based payer contracts. Although APMs were only used in HMO-type insurance products, more than one-third of overall care for Massachusetts' commercial members was paid using APMs. This is well above national benchmarks for "value-oriented care."[10] Furthermore, APMs were used to pay for the care of residents in all regions of the Commonwealth, and nearly all of the largest physician groups in Massachusetts had contractual agreements with major commercial payers that included APMs.

Adoption of alternative payment methodologies is a clear goal of the Commonwealth's 2012 cost containment law. This baseline report indicates that Massachusetts commercial payers have taken significant steps to implement this approach. In future reports, CHIA will monitor changes in APM use relative to these baselines. However, APMs are only a means of achieving the ultimate goals of reduced cost and increased quality. In the future, CHIA plans to collaborate with the Health Policy Commission to evaluate the impact of APM adoption on the cost and quality of health care in the Commonwealth.

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10 Catalyst for Payment Reform (2013). *National Scorecard on Payment Reform*. Available at: http://www.catalyzepaymentreform.org/how-we-catalyze/national-scorecard (accessed December 2, 2013)

Technical Appendix

CHIA collected calendar year (CY) 2012 data on payment methods from the ten largest commercial payers in the Massachusetts commercial health insurance market, and commercial payers that offered Medicare Advantage plans, Medicaid Managed Care Organization (MCO) plans, and Commonwealth Care plans.[11] Data from eleven commercial payers was used in this report, representing 98.5% of the commercial market in Massachusetts.[12] This report focuses on the commercial market; additional analysis on the other insurance categories may be found in the Data Appendices.

Alternative Payment Method (APM) data is collected by insurance category,[13] by product type,[14] and by payment method for reporting according to member zip code and managing physician group. APM data is only collected for Massachusetts residents as determined by the member's residence on the last day of the reporting year. For payment method assignment, payers classified payment methods for physician groups and members based on the payment method allocation hierarchy:[15] (1) global payment; (2) limited budget; (3) bundled payment; (4) other, non-FFS based; and (5) FFS.

Although most APMs are layered on a FFS structure, the type of APM that the physician group and the member should be attributed to is determined by the comprehensiveness of the covered services under the spending target. For example, if a member whose managing physician group is under global payment contracts, the dollar amount associated with this member should be classified as global payments even though the payer utilizes a FFS payment mechanism to reimburse providers at the transactional level and then conducts a financial settlement against the spending target at the end of the year. The same logic applies to limited budget or bundled payment arrangements.

For zip code-level reporting, payers reported total spending and member months associated with each payment method by insurance category and by product type for each Massachusetts zip code. For physician-level reporting, payers reported total spending and member months associated with each payment method by insurance category at the contracting physician group-level for their managed members. Thus, the contracting physician group-level information reported by the payer only contained members of HMO-type products who were required to select a primary care physician (PCP) to manage their care. The data reported for each physician group included spending for all covered health services for these members, even when care was provided outside of the physician group. For the physician-level data, payers only reported physician groups that met the threshold of 36,000 member months per year.[16]

11 The ten largest commercial payers (in alphabetical order) are Aetna, Blue Cross Blue Shield of Massachusetts, CIGNA, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan, Tufts Health Plan, UniCare, United Insurance Company. CeltiCare was also included, as it offers both Commonwealth Care and commercial insurance products in Massachusetts.

12 Commercial payer market share is based on the number of covered lives (member months) in Massachusetts reported to the Division of Health Care Finance and Policy for calendar year 2010 Total Medical Expenses and on the number of Massachusetts residents enrolled in commercial insurance as reported to the Division of Health Care Finance and Policy for calendar year 2010 Key Indicators.

13 Insurance categories include: Commercial, Commonwealth Care, Medicaid and Medicaid MCOs, Medicare Advantage, and Other.

14 Product types include: HMO and POS, PPO, Indemnity, and Other.

15 Please see the payment method allocation logic on Page 9 of Alternative Payment Methods Data Specification Manual. Available at http://www.mass.gov/chia/docs/p/tme-rp/alternative-payment-methods-dsm-040513.pdf (accessed December 2, 2013)

16 Reporting thresholds are established in 957 CMR 2.00.

Members are assigned to each type of APM based on the contractual arrangement between the payer and the managing physician group. Members cannot choose to be a part of an APM. Although APMs normally incorporate a spending target/budget, most provider payment transactions continue to be paid using FFS. Generally, under a global payment arrangement, spending for a population of patients is compared to the budgeted amount at the end of an established period. The reconciliation may result in amounts due between the physician group and the payer, which may include risk-sharing pursuant to the terms of their contract. CHIA does not collect information on the level of shared risks/shavings and whether the spending target is set prospectively or retrospectively for APMs.

In order to compare member health status and payment methods across different product types and within each payer's network, a relative health status score was calculated. Since global payments are the predominant type of APM, only members whose care was paid using global payments were included in the comparision to members whose care was paid using FFS. The health status score of the HMO members whose care was paid using global payments served as the reference population; thus this group's relative health status score was a 1.0 value.[17] The health status scores of the HMO and PPO members whose care was paid using FFS were calculated and were then compared to the health status score of the reference population to derive relative health status scores.

Similarly, to compare health status adjusted (HSA) medical spending per member per month (PMPM) between global payments and FFS among the HMO members, a relative HSA medical spending PMPM was calculated. The HSA medical spending PMPM of the HMO members whose care was paid using global payments served as the reference; thus this group's relative HSA medical spending PMPM was a 1.0 value. If the relative HSA spending PMPM of the HMO members whose care was paid using FFS was higher than 1.0, it indicates that this population had higher average spending than the population under global payments after adjusting for health status differences between the two populations.

[17] The value of relative health status score below 1.0 means that a payer's member population of a given product type and payment method combination has less health risk, and hence is predicted to have less health spending based on its collective health status than the HMO members whose care was paid using global payments. Conversely, a value above 1.0 means that a payer's member population of a given product type and payment method combination has higher health risks, and is predicted to have higher health spending based on its collective health status than the HMO members whose care was paid using global payments. Please note that health status scores may only be compared within a payer's network because of different health status adjustment tools used by payers.

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