



Commonwealth of Massachusetts  
Office of the State Auditor  
Suzanne M. Bump

*Making government work better*

Official Audit Report – Issued February 18, 2016

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## Office of Medicaid (MassHealth)—Review of MassHealth’s Progress to Implement Alternative Payment Methodologies

For the period August 6, 2012 through June 30, 2015





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Office of the State Auditor  
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February 18, 2016

Ms. Marylou Sudders, Secretary  
Executive Office of Health and Human Services  
Office of Medicaid  
1 Ashburton Place, 11th Floor  
Boston, MA 02108

Dear Ms. Sudders:

I am pleased to provide this performance audit of the Office of Medicaid's (MassHealth's) progress in implementing alternative payment methodologies. This report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, August 6, 2012 through June 30, 2015. My audit staff discussed the contents of this report with management of the agency, whose comments are reflected in this report.

I would also like to express my appreciation to MassHealth for the cooperation and assistance provided to my staff during the audit.

Sincerely,

A handwritten signature in blue ink, appearing to read "SMB", written over a light blue circular watermark.

Suzanne M. Bump  
Auditor of the Commonwealth

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## LIST OF ABBREVIATIONS

APM	alternative payment methodology
CHC	community health center
CHIA	Center for Health Information and Analysis
CMS	Centers for Medicare and Medicaid Services
EOHHS	Executive Office of Health and Human Services
FFS	fee-for-service
HLHC	hospital licensed health center
HPC	Health Policy Commission
IDS	integrated delivery system
MCO	managed-care organization
MMIS	Medicaid Management Information System
OSA	Office of the State Auditor
PAPE	payment amount per episode
PCC	primary-care clinician
PCCP	Primary Care Clinician Plan
PCMH	Patient-Centered Medical Home
PCMHI	Patient-Centered Medical Home Initiative
PCPRI	Primary Care Payment Reform Initiative
SPAD	standard payment amount per discharge

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## EXECUTIVE SUMMARY

The Office of the State Auditor (OSA) is required by Chapter 224 of the Acts of 2012 (An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation) to review financial and programmatic effects of this legislation and present findings and recommendations to the Legislature by March 31, 2017. The Legislature enacted this law in order to align the state's healthcare-delivery system with the federal Affordable Care Act of 2010,<sup>1</sup> improve the quality of healthcare, and reduce rising healthcare costs. In addition to assessing the aforesaid effects of this legislation, OSA is conducting a series of audits related to different initiatives established by Chapter 224. Among these is the requirement that the Office of Medicaid (MassHealth) transition from paying for healthcare services for its eligible members using the traditional fee-for-service<sup>2</sup> approach to using other payment methods, referred to in Chapter 224 and in this report as alternative payment methodologies (APMs).

As part of this effort, and in accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, OSA has conducted a performance audit of MassHealth covering the period August 6, 2012<sup>3</sup> through June 30, 2015. The purpose of this audit was to assess MassHealth's progress in reaching the benchmarks established by Chapter 224 for transitioning to APMs.

Section 261 of Chapter 224 includes the following benchmarks, which MassHealth must meet to the maximum extent feasible:

- No later than July 1, 2013, MassHealth shall pay for healthcare using APMs for no fewer than 25% of eligible members.
- No later than July 1, 2014, MassHealth shall pay for healthcare using APMs for no fewer than 50% of eligible members.
- No later than July 1, 2015, MassHealth shall pay for healthcare using APMs for no fewer than 80% of eligible members.

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1. On March 23, 2010 and March 30, 2010, President Obama signed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, respectively. These two separate pieces of legislation are referred to as the Affordable Care Act. The purposes of the Affordable Care Act are to expand medical coverage to millions of Americans who would not or could not buy health insurance or who are underinsured and to improve the quality of healthcare services.

2. Under this payment model, payers reimburse healthcare providers at negotiated rates for individual services delivered to patients.

3. August 6, 2012 is the date Chapter 224 was enacted.

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Below is a summary of our finding and our recommendations, with links to each page listed.

<b>Finding 1</b> <b>Page <a href="#">10</a></b>	Although MassHealth has made progress, it has not reached the APM adoption rate required by Chapter 224.
<b>Recommendations</b> <b>Page <a href="#">13</a></b>	<ol style="list-style-type: none"><li>1. MassHealth, in collaboration with its contractors, should continue its efforts to achieve the APM benchmarks established by Chapter 224.</li><li>2. MassHealth should develop a method for accurately calculating its APM adoption rate from year to year.</li><li>3. MassHealth should verify the accuracy of data from managed-care organizations that it plans to use to measure its APM adoption rates.</li></ol>

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## OVERVIEW OF AUDITED ENTITY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services (EOHHS) is responsible for the administration of the state's Medicaid program, known as MassHealth. MassHealth provides access to healthcare services to approximately 1.9 million eligible low- and moderate-income individuals, couples, and families annually. In fiscal year 2015, MassHealth paid healthcare providers \$13.6 billion, of which approximately 50%<sup>4</sup> was funded by the Commonwealth. Medicaid expenditures represent approximately 38% of the Commonwealth's total annual budget.

Medicaid is a joint federal-state program created by Congress in 1965 as Title XIX of the Social Security Act. At the federal level, the Centers for Medicare and Medicaid Services (CMS), within the federal Department of Health and Human Services, administer the Medicare program and work with state governments to administer their Medicaid programs. Each state administers its Medicaid program in accordance with its CMS-approved state plan. States have considerable flexibility in designing and operating their Medicaid programs, but must comply with applicable federal requirements established by Section 1902 of Title XIX of the Social Security Act.

### Alternative Payment Methodologies

Alternative payment methodologies (APMs) are alternatives to the more common method of paying for healthcare, the fee-for-service (FFS) method. With the FFS method, healthcare providers are paid for each specific service they perform, each time they perform it. In contrast, APMs include options such as paying a healthcare provider a set amount for all the services that s/he will provide to a particular member, rather than paying for each service as it occurs.

The Commonwealth passed Chapter 224 of the Acts of 2012 to encourage movement toward APMs in the healthcare industry in an effort to contain costs and improve quality and availability of service. One of the effects of Chapter 224 was to add Chapter 6D to the General Laws. Section 1 of Chapter 6D defines APMs as follows:

*methods of payment that are not solely based on fee-for-service reimbursements; provided that, "alternative payment methodologies" may include, but shall not be limited to, shared savings arrangement, bundled payments and global payments; provided further, that "alternative payment*

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4. The Federal Medical Assistance Percentage (federal matching funds) for the state's Medicaid expenditures is 50%.

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*methodologies” may include fee-for-service payments, which are settled or reconciled with a bundled or global payment.*

In its August 2015 paper “Alternative Payment Methodologies,” the Center for Health Information and Analysis (CHIA)<sup>5</sup> identified and defined four APMs available to provider groups. MassHealth and its managed-care organizations (MCOs) negotiate with provider groups to accept these new payment methods for managing member healthcare services while taking on financial risk. Below are the four APMs in order of comprehensiveness of coverage and risk accepted by the provider.

- **Global Budget:** This payment arrangement between payers and providers establishes a spending target based on a comprehensive set of healthcare services to be delivered to a specified population during a defined period.
- **Limited Budget:** This payment arrangement between payers and providers establishes payment for a specific set of services, such as primary care or oncology, delivered by a single provider.
- **Bundled Payment:** This payment arrangement reimburses providers for multiple healthcare services associated with defined episodes of care (such as knee surgery, or pregnancy and delivery).
- **Other, Non-FFS-Based:** This refers to any payment arrangement that is not based on an FFS model and does not fit into any of the other APM models.

## **MassHealth APM Initiatives**

In June 2009, EOHHS convened a group of interested stakeholders, including insurers, physicians, hospitals, and state agencies, and formed the Council of the Massachusetts Patient-Centered Medical Home Initiative to develop the framework for the initiative, define roles and responsibilities, and support primary-care practices in implementing APMs.

According to EOHHS’s Section 1115 Demonstration Project Extension Request<sup>6</sup> submitted June 30, 2010, the objectives of the council were as follows:

- 1. To implement and evaluate the [Patient-Centered Medical Home, or PCMH] model as a means to achieve accessible, high-quality primary care;*

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5. CHIA is an independent agency with oversight from the state’s Executive Office for Administration and Finance and other agencies established with the passage of Chapter 224. CHIA is the Commonwealth’s primary hub for healthcare data and a primary source of healthcare analytics that support policy development. Further, it promulgates regulations to ensure uniform reporting of revenue, charges, costs, prices, and use of healthcare services by institutional providers and provider organizations.

6. State agencies (in Massachusetts, EOHHS) submit this request form to CMS periodically to request federal matching funds for state-specific programs.

2. *To attract and retain primary care clinicians into practice in Massachusetts by increasing resources available to practices and improving their quality of work life; and*
3. *To demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model.*

The first phase of implementation, which became operational in April 2011, was a three-year, multi-payer initiative known as the Patient-Centered Medical Home Initiative (PCMHI). EOHHS's website describes this initiative as follows:

*The Patient-Centered Medical Home (PCMH) model is designed to promote comprehensive, coordinated, patient-centered care delivered by teams of primary care providers, including physicians and nurses. In a patient-centered medical home, a primary care provider and members of his or her team coordinates all of a patient's health needs, including management of chronic conditions, visits to specialists, hospital admissions, and reminding patients when they need check-ups and tests. . . . The Massachusetts PCMH Initiative (PCMHI) is intended to address a series of challenges, including:*

- *fragmented, discontinuous care that harms patient health status and increases costs;*
- *increasing prevalence of chronic disease, and suboptimal management of chronic disease among patients with such illness; and*
- *a growing shortage of primary care providers.*

The PCMHI began in April 2011 and concluded in March 2014.

Beginning in 2013, EOHHS began accepting provider applications for its second PCMH model, the Primary Care Payment Reform Initiative. This new model requires providers to accept more responsibilities, including additional reporting based on medical measures and metrics, more profit and loss risk, and integration of behavioral-health services with a member's total care.

## **MassHealth's Future APM Plans**

On June 1, 2015, MassHealth gave the Office of the State Auditor its initiatives, plans, and timetable for developing and implementing additional APMs. (An updated version of the document containing that information is appended to this report.) With the assistance of a healthcare consulting firm, MassHealth is preparing to design and adopt new APMs in order to meet the ultimate 80% APM adoption rate goal outlined in Chapter 224.<sup>7</sup>

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7. This 80% goal was to be achieved by July 1, 2015, which was outside our audit period. Therefore, for this audit, we did not review whether MassHealth had reached an 80% adoption rate.

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## APM Calculations

MassHealth members enrolled in MassHealth-contracted MCOs and MassHealth's Primary Care Clinician Plan (PCCP) are eligible to have their healthcare paid for using APMs, and therefore we considered them in our APM adoption rate calculations.

According to Section 508.004(A) of Title 130 of the Code of Massachusetts Regulations, the following members are not eligible to participate in MCOs and therefore are excluded from APM adoption rate calculations:

- members enrolled in Medicare or other insurance plans
- members living in nursing facilities, chronic disease or rehabilitation hospitals, intermediate care facilities for individuals with intellectual disabilities, or state psychiatric hospitals for reasons other than short-term rehabilitative stays
- members enrolled in the MassHealth Limited program
- members enrolled in the Emergency Aid to the Elderly, Disabled and Children program
- members enrolled in the Children's Medical Security Plan program
- members in hospice with less than six months to live

Finally, Section 261 of Chapter 224 excludes dual-eligible members (members who have MassHealth coverage as well as other health insurance, such as Medicare, employer-sponsored insurance, or privately purchased insurance) from the calculations.

## MCOs

MCOs are healthcare-delivery systems organized to manage member healthcare and improve the quality of care while containing costs. MassHealth pays the MCO a fixed monthly fee, or capitated premium, for each member enrolled in the MCO. During the audit period, MassHealth had contracts with six commercial MCOs. The MCOs recruit and oversee networks of third-party direct-care providers who assume responsibility for providing a range of covered healthcare services. The following were MassHealth's six commercial MCOs during the audit period:

- Boston Medical Center HealthNet Plan (BMC HealthNet)
- Celticare Health Plan (Celticare)

- Fallon Community Health Plan (Fallon)
- Health New England (Health NE)
- Neighborhood Health Plan (Neighborhood Health)
- Tufts Health Plan—Network Health (Tufts Network Health)

Additionally, MassHealth operates its own managed-care program, the PCCP. Upon enrollment in the PCCP, members can select a primary-care clinician (PCC) from among participating PCCP providers. The member's PCC is responsible for providing and/or coordinating most of the member's medical care and, as necessary, referring the member to other MassHealth providers for non-primary-care services.

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## AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor has conducted a performance audit of certain activities of the Office of Medicaid (MassHealth) for the period August 6, 2012 through June 30, 2015.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our finding and conclusion based on our audit objective.

Below is our audit objective, indicating the question we intended our audit to answer; the conclusion we reached regarding that objective; and where it is discussed in this report.

Objective	Conclusion
1. Did MassHealth meet the benchmarks established by Section 261 of Chapter 224 of the Acts of 2012 for transitioning its members into alternative payment methodologies (APMs)?	<b>No; see Finding 1</b>

To achieve our objective, we reviewed applicable state and federal laws, rules, and regulations; the Health Policy Commission (HPC)<sup>8</sup> and Center for Health Information and Analysis (CHIA)<sup>9</sup> annual APM performance reports; and healthcare industry APM reports. We attended the Massachusetts Association of Health Plans' 2015 legislative briefing, "MassHealth and Medicaid MCOs." We met with HPC and CHIA officials to define APMs and payment methods.

We requested from MassHealth the policies and procedures it uses to develop and implement APMs. We obtained MassHealth's APM project team organization chart; list of APM programs; total numbers of MassHealth members, APM-eligible members, and APM member enrollments; and procedures used to calculate APM adoption. In addition, we met with MassHealth officials to discuss APM initiatives and

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8. Section 8(g) of Chapter 6D of the General Laws requires HPC to publish an annual report including spending trends, underlying factors, and recommendations to increase the efficiency of the healthcare system.

9. Section 16(a) of Chapter 12C of the General Laws requires CHIA to publish an annual report including costs and cost trend comparisons to healthcare cost growth benchmarks; the proportion of healthcare expenditures reimbursed by fee for service and by APMs; and price variations among healthcare providers.

programs, member populations, obstacles encountered with APM implementation, and future initiatives aimed at reaching the ultimate Chapter 224 APM adoption rate of 80%.

We met with officials from all six of MassHealth's contracted managed-care organizations (MCOs) to gain an understanding of their APM contracts, member populations, APM reporting requirements, and obstacles to implementing APMs. Additionally, for MassHealth's own MCO, the Primary Care Clinician Plan, MassHealth gave us its lists of APM-contracted providers, eligible-member data, and a summary of the obstacles it had encountered in APM implementation.

We assessed the reliability of the MassHealth data in the Medicaid Management Information System (MMIS), which is maintained by the Executive Office of Health and Human Services. As part of this assessment, we reviewed existing information, tested selected system controls, and interviewed knowledgeable agency officials about the data. Additionally, we performed other procedures to identify missing data elements and verify values within designated periods. To assess the reliability of MassHealth's APM adoption-rate calculations, we verified eligible member populations within the Patient-Centered Medical Home Initiative and the Primary Care Payment Reform Initiative through MMIS queries for July 1, 2013 and July 1, 2014, respectively. We also compared MCOs' APM adoption-rate calculations to data in CHIA's annual performance report and researched any significant differences. Based on the results of this work, we determined that the data obtained were sufficiently reliable for the purpose of this report.

At the conclusion of our audit fieldwork, we gave MassHealth and the MCOs a draft of this report. We requested that they review, and comment on, the accuracy and completeness of the audit finding and recommendations. We considered their responses when preparing this final report.

## DETAILED AUDIT FINDINGS WITH AUDITEE’S RESPONSE

### 1. Although MassHealth has made progress, it has not fully reached the required adoption rate for alternative payment methodologies.

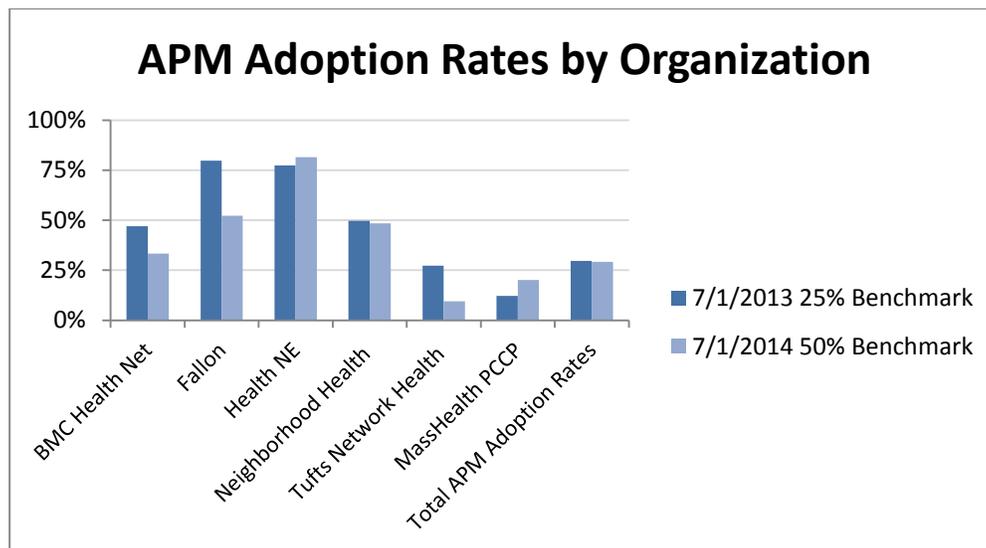
MassHealth’s reported alternative payment methodology (APM) adoption rate as of July 1, 2013 was 30%, which exceeded the 25% benchmark established by Chapter 224. However, this rate had dropped to 29% as of July 1, 2014. Chapter 224 of the Acts of 2012 required MassHealth to achieve a 50% adoption rate by this date. The table below provides a summary of MassHealth’s reported APM adoption rates for these benchmark dates.

**MassHealth APM Adoption Rates for Eligible Members**

Benchmark Date	Total Eligible Members	Total Eligible Members in APMs	APM Adoption Rate	Benchmark
July 1, 2013	928,004	275,684	30%	25%
July 1, 2014	1,084,492	317,300	29%	50%

By missing the mandated July 1, 2014 APM benchmark, MassHealth is not achieving its mandate from the Legislature to improve the quality of healthcare services and effectively rein in the program’s costs.

The chart below further details MassHealth’s overall APM adoption. (The figures in this table differ from those published by the Center for Health Information and Analysis [CHIA] in its 2015 annual report because we calculated the adoption rate as of a specific date, whereas CHIA used a yearly average.)



As illustrated in the chart above, several managed-care organizations (MCOs) made significant progress in adopting APMs. However, MassHealth overall has lagged in developing and implementing APMs.

During the audit period, the MassHealth Primary Care Clinician Plan (PCCP) and its MCOs negotiated APM contracts with a number of participating provider groups. These APM contracts included incentives for providers who met performance thresholds and/or a variety of risk-based payment models based on an estimated budget of expected costs to treat a particular condition or patient population. Under these contracts, a provider may share in savings if the cost of care is lower than anticipated (upside risk) or be responsible for a percentage of the losses if the cost is higher than anticipated (downside risk).

Six of the seven<sup>10</sup> MCOs (i.e., the six commercial MCOs plus the PCCP) paid for member healthcare costs through APM agreements with affiliated provider groups and networks. Each MCO developed and implemented unique payment agreements with its provider groups, which included physician groups, community health centers (CHCs), hospital licensed health centers (HLHCs), and an integrated delivery system (IDS). The terms of these APM agreements included provisions for sharing of risks, such as upside risk, downside risk, and a combination of the two. The table below details these agreements.

### APM Providers, Types, and Risk Arrangements by MCO

MCO	Total Member Enrollments (July 1, 2013)	Total Member Enrollments (July 1, 2014)	APM Provider Types	Payment Methods	APM Contract Risk
<b>BMC HealthNet</b>	192,769	265,794	CHCs, hospital, physician groups	Global, other non-fee-for-service (FFS)	Upside, non-financial incentives*
<b>Fallon</b>	14,141	28,563	Physician group	Global	Downside, non-financial incentives*
<b>Health NE</b>	12,799	17,357	CHCs, physician groups	Global, other non-FFS	Upside, upside/downside <sup>†</sup>
<b>Neighborhood Health</b>	151,178	231,216	CHCs, IDS, physician group	Global, other non-FFS	Upside, upside/downside <sup>†</sup>
<b>Tufts Network Health</b>	138,445	200,451	Physician groups	Global, other non-FFS	Upside, upside/downside <sup>†</sup>
<b>MassHealth PCCP</b>	418,672	341,111	CHCs, HLHCs, group practice organizations, outpatient (acute) hospital	Global, other non-FFS	Upside, non-financial incentives*
<b>Total</b>	<u>928,004</u>	<u>1,084,492</u>			

\* This term represents APM contracts with incentives for providers that meet APM quality and efficiency thresholds.

† In 2013, these contracts had incentives or upside risk only. In 2014, they began incorporating some downside risk.

10. Celticare did not participate in the MassHealth program until January 1, 2014. Celticare’s officials told us it worked with MassHealth in 2014 to implement the Primary Care Payment Reform Initiative but, as a new provider, did not have enough time to implement it before the July 2014 benchmark date.

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## Authoritative Guidance

Section 261 of Chapter 224 states,

*The office of Medicaid shall develop alternative payment methodologies including, but not limited to, bundled payments, global payments, shared savings and other innovative methods of paying for health care services. . . .*

*In making the transition to alternative payment methodologies, the office of Medicaid shall achieve the following benchmarks, to the maximum extent feasible:*

- (i) Not later than July 1, 2013, the office of Medicaid shall pay for health care utilizing alternative payment methodologies for no fewer than 25 per cent of its enrollees that are not also covered by other health insurance coverage, including Medicare and employer-sponsored or privately purchased insurance.*
- (ii) Not later than July 1, 2014, the office of Medicaid shall pay for health care utilizing alternative payment methodologies for no fewer than 50 per cent of its enrollees that are not also covered by other health insurance coverage, including Medicare and employer-sponsored or privately purchased insurance.*

## Obstacles to APM Implementation

MassHealth officials whom we interviewed before March 2015 did not pursue APMs sufficiently to meet the Chapter 224 benchmark because, as they told us, most members had received at least one service that might qualify as an APM bundled payment. Specifically, these officials believed that the majority of its members had received or would receive at least one service that that was paid for using one of the following payment methods: standard payment amount per discharge (SPAD) or payment amount per episode (PAPE). An example of a SPAD payment is a single set payment a hospital receives for a member's inpatient stay of up to 20 days. An example of a PAPE payment is a single fee a clinical laboratory receives for processing a battery of drug tests for one member. These officials believed that such payments qualified as APMs and could be used to measure APM adoption rates.

However, since that time, MassHealth and CHIA each have told us that because the SPAD and PAPE payment methods were already used before Chapter 224 was adopted, and since they are very similar to the fixed or negotiated FFS payment rates that Chapter 224 is intended to move the Commonwealth away from, they believe MassHealth should not have included them in calculating its APM adoption rates. According to MassHealth, in order for a payment method to be considered an APM, it must address not only cost but also quality of care.

We also found other issues with MassHealth's original calculation of APM adoption rates. Specifically, MCOs are required to report their APM adoption rates to CHIA. When calculating overall APM adoption rates, MassHealth relied on this reported information for 2013 and 2014, rather than independently verifying it.

In addition to the issues presented above, contracted MCOs reported the following obstacles:

**Provider readiness:** Many provider groups lack the infrastructure, including actuarial experience, technical skill, and strategic planning (management), to track, measure, and report information to MassHealth on member healthcare services, to perform under an APM contract.

**Member population:** Some provider groups are reluctant to participate in APMs because of MassHealth's ever-changing member population and the challenges they face in serving this population, including the following:

- members who are permitted to transfer to or from MCOs on a daily basis
- members who have complex preexisting health conditions
- members who lack medical histories
- a disproportionately high share of members who have multiple high-risk diagnoses

**APM contract scope:** Many provider groups are concerned about the rigid nature of MassHealth's Primary Care Payment Reform Initiative (PCPRI) contract. Providers emphasized that a single contract does not fit every case because of differences in enrollments, services, and technical and financial resources.

**Lack of guidance:** Some provider groups are reluctant to participate in APMs because they have not received sufficient guidance from MassHealth on payment models, key contract provisions, capturing of quality measures, and data analysis regarding clinical outcomes and costs.

## **Recommendations**

1. MassHealth, in collaboration with its contractors, should continue its efforts to achieve the APM benchmarks established by Chapter 224.
2. MassHealth should develop a method for accurately calculating its APM adoption rate from year to year.

3. MassHealth should verify the accuracy of MCO-solicited data that it plans to use to measure its APM adoption rates.

### MassHealth's Response

*MassHealth is committed to achieving the ultimate APM benchmark in Chapter 224 of covering 80% of the eligible MassHealth population, and MassHealth's current administration has made APM development and implementation a central strategic priority as part of a broader effort to improve the sustainability of the MassHealth program.*

*Over the past several months, MassHealth has undertaken a massive effort to develop the design of an at-scale payment reform. During that time, MassHealth has held public listening sessions all over the Commonwealth; identified common principles, goals, and objectives for at-scale payment and delivery system reform; established eight stakeholder work groups and held dozens of meetings to work through collaborative design of a payment reform strategy; formed and staffed a new Payment and Care Delivery Innovation unit at MassHealth headed at the executive level; discussed ongoing design work collaboratively with federal partners at the Center for Medicare and Medicaid Services (CMS) and the Center for Medicare and Medicaid Innovation (CMMI); and used funding from Massachusetts' State Innovation Model (SIM) grant to contract with several vendors to help with various design and implementation functions.*

*In Finding 1, [OSA] states that, while MassHealth has made progress towards Chapter 224's goals of APM adoption, it has not reached the APM adoption rate required by Chapter 224. This finding is consistent with MassHealth's own evaluation. [OSA's] first Recommendation recognizes the significant work MassHealth has already undertaken in response (as described above), and states that MassHealth should continue these efforts—MassHealth remains committed to doing so.*

*[OSA's] second Recommendation states that MassHealth should develop a method for accurately calculating its APM adoption rate from year to year. MassHealth appreciates the difficulty to-date in performing this calculation for MCO-enrolled MassHealth lives, given the limited data currently collected on the nature of MCO contracts and APM enrollment. MassHealth has developed a calculation of APM adoption for the lives in the MassHealth-administered Primary Care Clinician (PCC) Plan, and going forward, we will develop a consistent methodology across MassHealth to track APM adoption year to year. MassHealth plans to implement APMs in an aligned manner across its managed care programs. This approach will enable a more accurate calculation of APM adoption, consistent with [OSA's] recommendation.*

*With that Recommendation in mind, MassHealth appreciates [OSA's] third Recommendation that MassHealth should verify the accuracy of data from the MCOs on APM adoption rates. MassHealth has already begun work with its MCOs to set clear expectations for aligned APM implementation and improved data integration, and has recently incorporated requirements for the latter into MCO contracts.*

*Finally, [OSA's] report contains a section titled "Obstacles to APM Implementation," to which MassHealth would like to add some clarification and context. The section discusses MassHealth's Primary Care Payment Reform (PCPR) initiative and some of the obstacles to its increased adoption, and mentions the "rigid nature" of the contract. PCPR's contract allows a number of different*

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*options for participating providers, including three different shared savings risk tiers (including an upside-only tier) and three different tiers of behavioral health integration; further, to accommodate the different starting points for provider readiness, PCPR provides a significant ramp-up period for participating practices, with the clinical expectations phasing in as contractual milestones over the course of 18–24 months. The primary obstacle to further adoption of PCPR was the lack of aligned MCO implementation of the model; MassHealth is addressing this learning in its current payment reform implementation. In the same section, the report notes "lack of guidance" as a barrier to broader adoption of APMs such as PCPR at MassHealth. MassHealth is not currently enrolling new providers in APMs, but is instead actively developing new APMs for at-scale implementation in the near future. MassHealth has been pursuing the development of new APMs with significant public transparency and stakeholder input, and plans for significant provider engagement and education in the lead-up to implementation and throughout the operation of the new payment models.*

## **MCOs' Responses**

In their responses, the six MCOs agreed with our finding and recommendations and our description of the obstacles to implementing APMs. Two MCOs provided additional comments regarding obstacles and challenges encountered in implementing the PCPRI. One stated,

*Regarding the obstacles to implementation of APMs reported by the MCOs, [the MCO] agrees with the summary of obstacles and notes that the complexity of the PCPRI initiative is prohibitive and unnecessary and should not be considered a model for successful APMs.*

Another stated,

*Funding for the program was also a barrier as it was insufficient to effectively implement a sustainable program. For example, the PCPR initiative [funding] turned out to be insufficient for providers to agree to this initiative with us, despite exhaustive attempts.*

## **Auditor's Reply**

In its response, MassHealth states that it agrees with our audit finding and recommendations but is concerned about our discussion of obstacles to APM implementation. Specifically, MassHealth did not agree that the PCPRI was rigid; the agency gave us information to support its view of the PCPRI's flexibility, including the various risk and behavioral-health tiers available to providers. However, the opinion of the MCOs, as we reported, was that the PCPRI was rigid, meaning that providers could not meet its contract requirements, including data reporting, time commitments, and taking on risk. The need for MassHealth to develop more viable APMs as alternatives to the PCPRI is discussed in detail in the appendix of this report.

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## APPENDIX

### MassHealth's Plan to Reach 80% Adoption for Alternative Payment Methodologies

In response to the draft report, MassHealth gave us detailed information on its present and future actions on this matter, excerpted below.

***Overview of MassHealth policies, procedures, and human resources capacity to help ensure that the 80% will be met:***

- *Moving to alternative payment methods is a major priority for the current administration as a critical strategy to make MassHealth sustainable over the long term.*
- *MassHealth is in the process of intensive policy development and stakeholder engagement to shape its APM strategy. We currently envision that MassHealth's comprehensive approach to APMs will be centered on a payment model for Accountable Care Organizations (ACOs). Under this planned payment reform, ACOs will be partnerships of providers and community entities that will come together to take accountability for populations of attributed members. This payment model will require and incentivize collaboration among entities across the care continuum, including physical health, behavioral health, and long term services and supports (LTSS) providers. We are also exploring a Health Homes model to provide additional support for community-based care management for high-risk populations. We plan to support this strategy through infrastructure investments and technical assistance, along with transparency and data support to providers to accelerate transformation.*
- *MassHealth has recently established a new Payment and Care Delivery Innovation unit, led by a newly appointed member of the MassHealth Executive Team. This group is responsible for the development and implementation of an at-scale APM program for MassHealth.*
- *MassHealth has also contracted with several vendors to help MassHealth design and implement at-scale APMs, funded by Massachusetts' State Innovation Model (SIM) Test Award, which is a federal grant to help accelerate care delivery and payment innovation efforts at the state level. These vendors are assisting MassHealth with analytic and technical design, provider reporting, strategic and business process design, and various aspects of pre-implementation and organizational readiness.*
- *MassHealth has begun to articulate our vision in the context of our State Innovation Model grant, including several discussions and collaborative working sessions with the Centers for Medicare and Medicaid Services (CMS), including leadership from the Center for Medicare and Medicaid Innovation (CMMI). Over the next several months, we will be refining the design of our planned APMs, and we will continue discussions with CMS in parallel.*
- *MassHealth is very committed to reaching its 80% APM goals and has reiterated this benchmark as a performance target for the MA SIM Test Award. In doing so, we have aligned our goals and processes with CMS; the quarterly reporting requirements of the SIM grant will support our efforts to regularly assess our progress towards the 80% goal,*

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*identify risk factors that may affect that progress, and develop and implement risk mitigation strategies.*

- *MassHealth is planning to integrate this payment reform agenda into our [state Medicaid plan] through a proposal for investment funding to support the transformation of the health care delivery system, known as a Delivery System Incentive Reform Payment Program (DSRIP). We have been in dialogue with CMS about submitting such a proposal and will continue these discussions in order to maximize the chances of CMS approval for this new investment. We aim to structure the proposed DSRIP program to support providers in care improvement and population management.*
- *Finally, MassHealth has also set clear expectations with its MCO partners for aligned implementation of at-scale payment reform, and has already begun incorporating those expectations into MCO contracts, starting with increased data integration.*

***Overview of MassHealth's approach for transitioning to alternative payment methods and timelines going forward:***

- *We will continue to iterate on our thinking for our payment reform initiatives through extensive stakeholder engagement, public transparency, and collaborative design. Our timelines and approach outlined in this and other documents are subject to further refinement based on feedback from our stakeholder community, including members, providers, plans, other state agencies, and CMS/CMMI.*
- *We have significantly increased the amount of stakeholder engagement from our initial plans and have made tremendous progress over the last four months through our eight stakeholder Work Groups. We have been releasing our latest thinking on an ongoing basis through public meetings and materials posted on our website. We are planning to release a formal 1115 Waiver proposal for public comment in the early part of Calendar Year 2016.*
- *We plan to continue working through the technical design, pricing and implementation of our new APM model(s) over the course of Calendar Year 2016.*