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Massachusetts health care reform 'Part Two'

What providers should know about future managed care contracting

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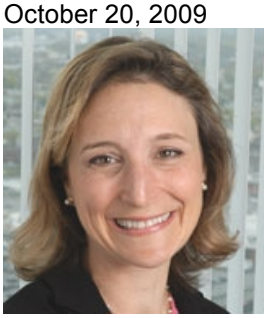

Health care reform "Part Two" is coming soon to Massachusetts, as a result of recent state initiatives focusing on payment reform.

On July 16, 2009, the state Special Commission on the Health Care Payment System unanimously endorsed recommendations intended to improve the quality of patient care by fundamentally changing the way health care is reimbursed.

The Special Commission was established to examine alternatives to the fee-for-service payment model. The details would need to be more fully fleshed out by legislation and likely regulation as well. The Special Commission recommends that global payments completely replace fee-for-service reimbursement, over a five-year period.

Under a global payment system, a physician, physician group or other provider organization would be paid prospectively a set amount for all or most of the care that their patients may require over a set time period, such as monthly or annually.

Global payments would be made to highly integrated accountable care organizations (ACOs), which would be comprised of primary and specialty care physicians, as well as hospitals and other institutional providers.

The recommendations apply to both public and private payers.

The Special Commission also proposes using agreements such as the Alternative Quality (AQ) Contract recently introduced by Blue Cross Blue Shield of Massachusetts as a payment model.

The AQ Contract is an innovative managed care agreement that may eventually be used as a model throughout the state if the recommendations are implemented.

For health care providers, these changes mean that a well-negotiated contract with payers will be even more critical. Providers will need to form alliances and negotiate collective agreements with managed care entities.

In this new, more highly managed world, all health care providers will need to negotiate the details of such agreements more carefully, focusing on the practical and financial ramifications.

Here is a look at what would change under the main recommendations from the Special Commission:

- Physicians would receive global payments for all or most of the care provided to patients.
- Consistent pay-for-performance (P4P) incentives would be applied across all payers. These programs would continue to focus on primary care physicians and hospitals, but might also include specialists.
- ACOs would be composed of hospitals, physicians and/or other providers. They would work as a team to manage both the provision and coordination of care for the full range of patient services.

Under the recommendations, the models for these organizations would be broad and could include incorporated or "virtual" organizations. For example, "a large physician organization that would contract with one or more hospitals and ancillary providers" would qualify.

- Global payments would be risk-adjusted, with providers responsible for performance risk, including cost performance and meeting access and quality standards.
- Tiering would be used to rank providers.

Health plans may be required to classify physicians in their networks into performance tiers. National guidelines may be used for measuring and reporting physician performance.

The AQ Contract

The AQ Contract provides a model for global payment with quality-based performance incentives. This new model of contract has recently been negotiated with several providers, including a physician group. It combines two forms of payment: a global payment per patient, and a second payment if the provider achieves certain nationally accepted measures of quality, effectiveness and patient care.

Under the AQ Contract, a physician would receive a fixed global payment per patient, adjusted for health status, as well as separate performance incentive payments for achieving certain quality measures.

The AQ Contract does not contain the larger yearly increases common in more standard managed care contracts, since it provides for the possibility of receiving fairly substantial performance incentive payments. The global payment amount is not reset annually; instead there is an inflationary increase. The AQ Contract term is generally five years.

Under the AQ contract, there would be many quality measures. Providers are at relatively low risk in the first two years and at greater risk in the subsequent years of the agreement, if they cannot meet the quality measures.

The determination as to whether a provider has achieved the quality measures would be made on a

quarterly basis. Each measure would be evaluated individually. Providers would receive an add-on to their rate at the end of each year based upon the extent to which they have accomplished each quality measure, with a potential for increasing the total payment by up to 10 percent of the fixed rate.

Tips for negotiating agreements

Here are some important provisions that providers should negotiate in their managed care agreements going forward:

- Quality measures, and the method for evaluating whether each measure has been achieved, should be based on standards set by a third party. For example, the Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by most of the nation's health plans to measure provider performance. Quality measures may be proposed by the provider, and then negotiated with the payer.
- Explicit upper and lower limits of financial risk for failing to reach each quality goal should be instituted for each quality measure.
- A slow phase-in of the quality measures over the contract term during the first year(s) of the contract should be included.
- Any changes to quality measures (or other contract terms) should be by mutual written agreement. A payer should not have the ability to eliminate and replace quality measures in its sole discretion.
- Provisions that limit potential losses should be included to protect against excess risk and catastrophic loss.
- A global payment model for primary care providers is advisable, with a separate model for specialists. A "carve out" for certain service categories, such as behavioral health, should be included in the contract, meaning that those services might be paid on a fee-for-service basis, and not subject to the global fixed rate.
- The ability to enter into global fixed rate (sub-capitated) service contracts with specialty providers, service vendors and/or community hospitals should be included for services the provider does not provide directly or through its affiliated integrated system.
- A risk "floor" – which is a minimum level beneath which the provider is protected from loss or liability – should be included.
- The contract should revert to a straight "rate lift" contract (a low or non-risk-based contract with annual rate increases) in the event that quality measures are not met, or if there are losses on the global rate.

Providers need to educate and prepare themselves for a completely new type of managed care environment. Fortunately, some strong contract models already exist, so all will not be new territory in this brave new world of managed care. Following these tips will go a long way toward protecting providers facing a new reimbursement model.

For the full text on the Special Commission's report and Recommendations, please see: http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/Final_Report/Final_Report.pdf.

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