# MassHealth 1115 Demonstration Attachment O

**-Pricing methodology for ACOs and MCOs**

*The Commonwealth may modify this Attachment with the approval of CMS without amending the STCs.*

# Unified approach to setting TCOC Benchmarks for Primary Care ACOs and MCO- Administered ACOs, and setting prospective Capitation Rates for MCOs and Partnership Plans

Massachusetts will set total cost of care (TCOC) Benchmarks using a uniform methodology that aligns with the methodology for setting prospective Capitation Rates for MCOs and Accountable Care Partnership Plans. As described in STC 41, Accountable Care Partnership Plans will be paid prospectively rated capitation payments, which are subject to annual rate certification.

Primary Care ACOs will share savings and losses with the Commonwealth based on comparison between their TCOC Performance and TCOC Benchmark (i.e., their performance on managing the costs of their attributed or enrolled population). Primary Care ACOs may also be paid under a prospective pre-payment methodology as described in STC 41. Similarly, MCO-administered ACOs will share savings and losses with their contracting MCOs based on the same comparison. EOHHS intends to establish an aligned methodology for setting TCOC benchmarks for Primary Care ACOs and MCO-Administered ACOs, as further described below; EOHHS will require MCOs to share savings and losses with their contracted MCO-Administered ACOs using this methodology and based on the risk-tracks and schedule set by the state. Such requirement is broadly consistent with 42 CFR 438.6.

The TCOC benchmark (for Primary Care ACOs or MCO-Administered ACOs) or prospective Capitation Rate (for MCOs or Accountable Care Partnership Plans) will be developed as follows:

* 1. A benchmark or rate will be developed for each individual rate cell, where a rate cell is defined as a specific region and rating category (e.g., Rating Category I – Adults in Greater Boston Region).
  2. All such benchmarks and rates will be based on a unified base dataset, which will be constructed as follows:
     1. Claims and encounter experience for all Managed Care-eligible lives, including members enrolled in the MCO, PCC, and ACO programs, will be aggregated for a baseline period established annually by the Commonwealth (e.g., one to three years of the most recent available history).
     2. Only services covered under the list of MCO Covered Services, the list of ACO Covered Services, or the list of TCOC Included Services will be included in the base data. These three lists of services will align, as ACOs will be financially accountable for the same services as MCOs. EOHHS will finalize and publish these lists in advance of finalizing the benchmarks/rates.
     3. Actual prices paid for covered services during the baseline period will be re-priced to reflect average market prices paid for those services. The methodology used to

re-price services delivered during the base period will be developed by the Commonwealth and shared with CMS for approval before the Operational Start Date of the ACO and MCO programs.

* 1. For each rate cell, actuarial methods will be applied to the base dataset to estimate the average per-member per-month total cost of care (“market-rate TCOC”). Actuarial adjustments could account for factors such as, but not limited to, the following:
     1. Changes in member risk and enrollment
     2. Completion for incurred but not reported encounters in the base data
     3. Anticipated program changes between the base period and the performance period
     4. Cost and utilization trends from the base period to the performance period
     5. Other adjustments as appropriate
  2. This market-rate TCOC will be consistent across all ACOs and MCOs within each rate cell, and will be incorporated into the final benchmarks and rates, along with the Network Efficiency factor as described in the following section.

# Development and incorporation of the Network Efficiency Factor in TCOC Benchmarks and prospective Capitation Rates

The Commonwealth will incorporate an ACO-specific Network Efficiency Factor into the TCOC Benchmarks for Primary Care ACOs and MCO-Administered ACOs, and into the prospective Capitation Rates for Partnership Plans.

The Commonwealth will calculate and apply the Network Efficiency Factor for each ACO, for each Performance Year, as follows:

* 1. The Network Efficiency Factor will equal the ACO’s Historic TCOC divided by the ACO’s market-rate TCOC, after applying adjustments for each ACO’s member mix across rate cells and member acuity.
     1. For each ACO, using a similar methodology and adjustments to those used to calculate the market-rate TCOC, the Commonwealth will develop for each rate cell an ACO’s Historic TCOC based on the cost experience in the base period for the Managed Care eligible members attributed to primary care providers participating in the ACO.
     2. The Network Efficiency Factor represents the variance between an ACO’s Historic TCOC and the ACO’s market-rate TCOC that cannot be explained by variation in price or member risk
  2. The Commonwealth will multiply each ACO’s market-rate TCOC (after applying adjustments for each ACO’s member mix across rate cells and member acuity) by the ACO’s Network Efficiency Factor. The Commonwealth will calculate and apply the Network Efficiency Factor each year, but intends to place a decreasing weight on the Network Efficiency Factor over time. For example, in the first rating period under the demonstration, a 90 percent weight may be placed on the Network Efficiency Factor; that is, an ACO with a Network Efficiency Factor of 1.10 would have a TCOC benchmark that is 9.0% higher than its market-rate TCOC, while an ACO with a Network Efficiency Factor of 0.95 would have a TCOC benchmark that is 4.5% below its market-rate TCOC.

# Additional detail on TCOC reconciliation

The Commonwealth may incorporate a number of further policies into the TCOC benchmark- setting methodology described above, subject to CMS approval. Such decisions may include, but are not limited to:

1. Excluding certain high-cost services (e.g., therapies for treating Hepatitis C) from the list of covered services, and therefore the base dataset
2. Applying stop-loss thresholds in the base period and performance period TCOC benchmark
3. Setting TCOC Benchmarks on a preliminary basis, and refining them during reconciliation to produce final TCOC Benchmarks that incorporate certain retrospective adjustments for unforeseen effects, to ensure ACOs are appropriately held accountable for their performance rather than exogenous factors

The Commonwealth may decide to apply such policies for some types of ACOs but not others, subject to CMS approval. For instance, the Commonwealth may decide to exclude certain high- cost drugs from the benchmark for Primary Care ACOs and MCO-administered ACOs, but not Accountable Care Partnership Plans. Should such a policy be applied differently between ACO model types, the benchmark-setting methodology for each model type would fully reflect the difference.

For each Primary Care ACO and MCO-Administered ACO, total savings or losses will be calculated as the difference between actual TCOC performance during the performance period and the ACO’s TCOC benchmark, in aggregate across all rate cells in which the ACO participates. The portion of savings and losses shared, as well as the mechanism by which savings and losses are shared, will differ by ACO model type. The share of savings and losses may be symmetric or asymmetric, and may include shares of savings and losses up to 100%. ACO risk sharing arrangements will include requirements for financial stability (e.g., including reinsurance requirements) and in some cases will include maximum caps on gains and losses. The Commonwealth intends to generally increase the share of savings and losses over time in ACO risk tracks, and to move towards symmetric rather than asymmetric arrangements; however, the Commonwealth will continue to evaluate ACOs’ performance and ability to bear risk in setting risk track policy. The Commonwealth will submit details of these risk arrangements to CMS for approval prior to the Operational Start Date of the ACO and MCO programs.

For each ACO model type, the final calculation of shared savings and losses is subject to the ACO’s quality performance. In the event that an ACO is determined to have earned savings, poor quality performance can reduce the share of savings retained by Accountable Care Partnership Plans or paid to Primary Care ACOs and MCO-administered ACOs. In the event that an ACO is determined to have incurred losses, strong quality performance can reduce the share of losses retained by Accountable Care Partnership Plans or the share of losses owed by Primary Care ACOs and MCO-administered ACOs.