# MassHealth 1115 Demonstration Attachment Q:

**Medicaid Managed Care Entity/ACO Performance-Based Incentive Payment Mechanisms**

1. **Overview**

As delivery system reforms are implemented, the Commonwealth and CMS seek to shift payments to risk-based alternative payment models focused on accountability for quality, integration and total cost of care. Consistent with this goal, within the five-year demonstration term, the Commonwealth will direct Medicaid Managed Care Entities/Accountable Care organizations (MMCE/ACO), to administer performance-based quality incentive programs for hospitals as described below (“MMCE/ACO payment mechanism”). In addition to being critical to the delivery system reform goals shared by the Commonwealth and CMS, these performance- based quality incentive programs are integral to the Commonwealth’s overall financing of activities authorized under the demonstration, and are considered payments that are broadly compliant with requirements for payments made under 42 CFR 438.6(c)(1)(ii).

# General Requirements

The four MMCE/ACO payment mechanisms described below, which the Commonwealth agrees to establish, shall be implemented through MMCE/ACO contracts consistent with this Attachment in order to meet the requirements of 42 CFR 438.6.

# Description of the Payment Mechanisms

The Commonwealth intends to direct MMCE/ACOs to administer the following four MMCE/ACO performance-based quality incentive programs:

* 1. **Disability Access Incentive (DY21/SFY2018 – DY25/SFY2022):** The Commonwealth will direct MMCE/ACOs to make payments to all contracted acute hospitals based on reporting and performance related to disabled members’ access to medical and diagnostic equipment.
  2. **Hospital Quality Incentive (DY21/SFY2018 – DY25/SFY2022):** The Commonwealth will direct MMCE/ACOs to make payments to Essential MassHealth hospitals (Cambridge Health Alliance and UMass Memorial Health Care, Inc. Hospitals) based on hospital quality performance.
  3. **Integrated Care Incentive (DY22/SFY 2019 – DY25/SFY 2022):** In the event that primary care providers employed by or affiliated with Cambridge Health Alliance participate in the Commonwealth’s Accountable Care Partnership Plan model, the Commonwealth will direct that MMCE/ACO to make payments to non-federal, non-state, public hospitals based on the accountable care performance of such hospitals’ owned or affiliated primary care providers.
  4. **Behavioral Health Quality Incentive (DY23/SFY 2020 – DY25/SFY 2022):** The Commonwealth will direct the Commonwealth’s single Prepaid Inpatient Health Plan (PIHP) to make payments to non-federal, non-state, public hospitals in its network based on behavioral health quality performance.

# General Methodology Linking Payment Mechanisms to Utilization/Delivery of Services

The Commonwealth shall include in its MMCE/ACO contracts payment mechanisms consistent with the following approach:

* 1. The Commonwealth will specify the maximum allowable payment amount that it will direct each MMCE/ACO to pay to one or more designated classes of hospitals during the MMCE/ACO contract year.
  2. The maximum payment amount earned by a specific hospital (i.e., the amount earned if a hospital attains a quality score of 100 percent) will be equal to the total amount directed to the designated class multiplied by the proportion of the class’s total managed and non- managed Medicaid Gross Patient Service Revenue (“Medicaid GPSR”) or other measure of utilization and delivered of services, for which the specific hospital’s Medicaid GPSR, or other measure of delivered services, accounts during the MMCE/ACO contract year.
  3. The Commonwealth will calculate periodic lump sum payments that MMCE/ACOs will be directed to pay to specific hospitals. The periodic lump sum payments will be calculated based on:
     1. The Commonwealth’s projection of each hospital’s Medicaid GPSR, or other measure of utilization and delivered services, during the MMCE/ACO contract year;
     2. Each hospital’s expected performance (based on prior year or other data);
     3. A target for the MMCE/ACO to pay 90% of each hospital’s expected earned payments in advance of a final reconciliation after the MMCE/ACO contract year.
  4. Within seven days prior to each scheduled lump sum payment described above, the Commonwealth shall make a payment to each MMCE/ACO that is directed to make an incentive payment to hospitals. The Commonwealth’s payment to each MMCE/ACO shall be equal to the sum of all payments that the MMCE/ACO is directed to make. The Commonwealth may use any permissible source, including intergovernmental transfers, as the source of the non-federal share for MMCE/ACO payments.
  5. Following the MMCE/ACO contract year, actual Medicaid GPSR, or other measure of utilization and delivered services, for each hospital and performance under each contract will be determined and the actual payment amount earned by hospitals will be calculated.
  6. Final reconciliation: Based on the difference between the periodic lump sum amounts paid to hospitals during the MMCE/ACO contract year and the actual amount earned, MMCE/ACOs will be directed to make a final reconciliation payment to hospitals. In the event that the lump sum payments made by the MMCE/ACO to a hospital during the MMCE/ACO contract year exceeded the total actual amount earned, the hospital will remit the excess payment to the MMCE/ACO as part of the final reconciliation. Any amount remitted by a hospital to a MMCE/ACO as part of the reconciliation shall in turn be remitted by the MMCE/ACO to the Commonwealth.

# Performance Measures and Evaluation Plan

As required under 42 CFR 438.6(c)(2)(i)(D), the Commonwealth shall have a plan to evaluate the extent to which the payment mechanisms and performance measure incentives achieve the goals and objectives identified in the managed care quality strategy. The Commonwealth may use performance measures based upon the following domains, or other domains not listed below, for the incentive programs. The Commonwealth may include process, improvement, outcomes, system transformation, and innovative measures and indicators that are consistent with the Commonwealth’s delivery system reforms and quality strategy. For the Hospital Quality, Integrated Care, and Behavioral Health Quality Incentives, the Commonwealth will designate two types of performance measure domains. Type I domains will have 80% or more of the measures drawn from nationally vetted and endorsed measure sets (e.g. National Quality Forum, National Committee for Quality Assurance, the Joint Commission, etc.) or measures in wide use across Medicare and Medicaid quality initiatives (e.g. the Medicaid Child and Adult Core Set Measures, CMS Core Quality Measures Collaborative measure sets, Health Home measure sets, Behavioral Health Clinic measure sets, and Merit-based Incentive Payment System and Alternative Payment Model measures, etc.). Type II domains will not have a lower limit on the percentage of measures drawn from nationally validated measure sets. As a matter of general principle, where practicable, specific performance measures for each incentive payment mechanism will be drawn from the nationally recognized measure sets.

The Commonwealth will submit the evaluation plan and performance measures to CMS for approval, consistent with the process set forth at 438.6.

Any changes made to the specific domains listed below would not require an amendment to the Demonstration:

* 1. **Disability Access Incentive Payment** - Hospital performance expectations shall increase every year from the beginning of the incentive program, beginning with two years of reporting and three years of performance as measured by disability access to MDE:
     1. Year 1 of incentive program (October 1, 2016 to September 30, 2017): Hospitals required to report:
        1. The Provider’s capacity to provide accessible MDE to individuals with disabilities
        2. A detailed list of the Provider’s accessible MDE
        3. The Provider’s plan to improve its provision of accessible medical and diagnostic equipment
        4. The name and contact information for the Provider’s single point of contact for those seeking or having questions about access for individuals with disabilities (i.e. a Disability Access Key Contact)
     2. Year 2: Hospitals shall be required to report:
        1. Year 1 metrics
        2. Measures related to patient experience. The measures may include, and are not limited to:
           + Average wait times for disabled patients for specified MDE
           + Ratio of accessible MDE to the number of local disabled individuals
           + Results of disabled patient experience surveys regarding access to MDE
     3. Years 3-5

1. Continued reporting requirements as in Years 1 and 2
2. Hospital performance will be measured on the basis of how a disabled member’s experience of accessing MDE compares to the experience of a non- disabled member. The metrics upon which the two populations’ experience would be compared may include, and are not limited to:
   * Average wait times for disabled patients for specified MDE
   * Ratio of accessible MDE to the number of local disabled individuals
   * Results of disabled patient experience surveys regarding access to MDE
3. **Hospital Quality Incentive Payment -** Performance for this payment mechanism will be based on the following:
   1. Type I domains include measures related to:
      1. Inpatient care and other hospital system quality (e.g., appropriate care for key conditions)
      2. Transitions of care (e.g., follow-up after discharge, reconciled medication list at discharge)
      3. Avoidable utilization and patient safety (e.g., rates of hospital- acquired infections)
   2. Type II domains include measures related to:
      1. System transformation
   3. EOHHS may include other domains beyond those listed here
4. **Integrated Care Incentive Payment -** Performance for this payment mechanism will be based on the following:
   1. Type I domains include measures related to:
      1. Care coordination – transitions of care
      2. Avoidable / appropriate utilization (e.g., admission from emergency department to inpatient setting and readmissions rates)
      3. Patient quality scores
   2. Type II domains include measures related to:
5. Care coordination measures aside from transitions of care
6. Member engagement
7. Care integration, system transformation, multi-disciplinary team- based care
   1. EOHHS may include other domains beyond those listed here
8. **Behavioral Health Quality Incentive Payment -** Performance for this payment will be based on the following:
   1. Type I domains include measures related to:
      1. Behavioral health-specific quality of care
   2. Type II domains include measures related to:
      1. Behavioral health-specific care coordination
      2. System transformation
   3. EOHHS may include other domains beyond those listed here
   4. Many of the proposed measures will be the same measures for which non- federal, non-state, public hospitals are accountable in the PHTII program under this demonstration.

Each participating hospital’s performance, under each performance-based incentive payment mechanism, shall be measured against approved benchmarks and a score for each measure or group of measures will be calculated according to a methodology to be defined by EOHHS and approved by CMS. Benchmarks for any individual performance measure may be set either on the basis of absolute performance standards or improvement targets for individual hospitals. Scores will be summed, with or without weighting, across all measures or groups of measures in order to calculate an overall performance score between 0 and 100 percent. Under the MMCE/ACO payment mechanism, each hospital’s performance score shall be multiplied by that hospital’s maximum incentive payment amount in order to calculate the actual payment earned by the hospital.

To the extent practicable and feasible, the specific performance measures for each incentive payment mechanisms should be aligned with comparable national standards and other process, improvement, outcomes, system transformation, and innovative metrics that are consistent with the Commonwealth’s delivery system reforms and quality strategy.

# Funding Sources and Anticipated Incentive Program Amounts

The scheduled maximum dollar amounts directed to designated classes of providers under each of the four MMCE/ACO incentive payments mechanisms are:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| # | Incentive Title | MMCE/ACO  vehicle | Hospital class | Maximum MCO incentive payment to designated hospital class, by SFY ($ millions) | | | | |
| SFY 2018 | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 |
| 1 | Disability access incentive | MMCOs | All in- network acute hospitals | 265 | 265 | 265 | 265 | 265 |
| 2 | Hospital Quality incentive | MMCOs | Essential MassHealth hospitals in network | 157 | 315 | 316 | 315 | 315 |
| 3 | Integrated care incentive | Accountable care partnership plans affiliated with Cambridge Health Alliance | Non-federal, non-state, public hospitals in network | 0 | 28 | 39 | 39 | 39 |
| 4 | Behavioral health quality incentive | Commonwealth’s single Prepaid Inpatient Health Plan (PIHP) | Non-federal, non-state, public hospitals in network | 0 | 0 | 141 | 138 | 135 |

The Commonwealth may propose an increase or decrease of 20 percent of the maximum payment amounts listed in the Table. The incentive payments will be incorporated as a component of the MMCE/ACO capitation amounts, and are therefore subject to CMS approval under the review and approval process described in the next section.

Because of the expectation that these payments will transition out of the demonstration, these amounts are not reflected in Attachment E for the respective years noted above.

# CMS Review and Approval

No later than November 15, 2016, as part of the template described below, the Commonwealth shall submit to CMS a detailed framework for measuring and scoring performance under the Hospital Quality, Integrated Care, and Behavioral Health Quality incentive payments described in this attachment. The Commonwealth and CMS shall work toward applicable approvals by January 15, 2017.

The Commonwealth shall submit to CMS for approval any payment mechanisms that direct payments as described in 42 CFR 438.6(c) at least 120 days prior to implementation, in a format and template to be specified by CMS. Such submission shall include the incentive payment amounts and the performance measures and scoring benchmarks. In addition, the Commonwealth shall clearly identify the specific goals and objectives described in the Commonwealth’s managed care quality strategy that the incentive payment mechanism is designed to achieve. Materials submitted for approval shall be consistent with this Attachment in order to meet the requirements of 42 CFR 438.6 and may be submitted for approval prior to the contract and rate certification submission under 42 CFR 438.3 and 42 CFR 438.7. CMS will

provide initial written feedback within 45 calendar days of the Commonwealth’s submission, and shall render a final decision on the proposal no more than 90 days after the Commonwealth’s initial submission. Pursuant to 42 CFR 438.6(c)(2)(1), the Commonwealth must obtain annual prior written approval from CMS for each performance-based quality incentive program.

This Attachment is intended to describe a common understanding between the Commonwealth and CMS on a framework for implementing incentive payments. The attachment does not prohibit the Commonwealth from modifying the payment amounts or the performance measures to best meet its needs and submitting such revisions through the CMS review and approval process; such changes shall not require an amendment to the demonstration.

CMS and the State recognize that this performance framework is a new, significant shift toward a performance-based structure for hospital supplemental payments. Therefore, at the end of the second year of this demonstration, CMS and the State shall jointly evaluate and review the performance measures described in Section 5 of this Attachment.