# MassHealth 1115 Demonstration

# Attachment L: Pilot Accountable Care Organization (ACO) Payment Methodology

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[Other sources of information are reviewed, as needed, such as regional and national economic indicators that can provide broad perspectives of industry trends in the United States and in the Northeast. 5](#_Toc459979307)

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*Note:* *The methodology described in this attachment is wholly distinct from the methodology used for the full implementaiton of MassHealth’s ACO program rolling out late 2017.*

*Overview: MassHealth providers will be paid on a fee-for-service basis for care provided to members attributed to Pilot AOCs. For each ACO, MassHealth will track the total costs of care (TCOC) for the ACO’s attributed members during the performance periods, and will retrospectively compare these costs against an ACO-specific target. Based on the difference between an ACO’s TCOC performance and its TCOC target, EOHHS may share savings with the ACO or require the ACO to pay a share of losses. This attachment describes the methodology MassHealth will use to calculate these payments.*

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

## Section 1. Eligible and Enrolled Population

### 1.1. Performance Period

For ACOs that do not choose to extend, the ACO Pilot performance period will begin December 1, 2016 and end November 30, 2017. ACOs that extend to February 28, 2017 will have two performance periods. Performance Period A will match the original pilot performance period of December 1, 2016 through November 30, 2017. Performance Period B will begin on December 1, 2016 and extend through February 28, 2018.

1.2. Member eligibility

MassHealth members must be enrolled in the MassHealth PCC Plan during either performance period in order to be attributed to a Pilot ACO. The eligible population is therefore the same population eligible for the PCC Plan, which includes disabled and non-disabled children and adults under age 65 (i.e., RC I, II, IX, and X). Similarly, MassHealth members who are not eligible for the PCC Plan will not be eligible for the Pilot ACO program, including members who are Medicare dually eligible, limited standard eligible, family planning waiver, women eligible due to pregnancy, Health Safety Net members, and third party liability members.

In developing the Pilot ACO TCOC targets, MassHealth is using data for PCC Plan members during the base period.

| Rating Category | Description |
| --- | --- |
| RC I Child | Temporary Assistance to Needy Families (TANF) less than 21 years of age. |
| RC I Adult | Temporary Assistance to Needy Families (TANF), ages 21 through 64. |
| RC II Child | Disabled members, including Supplemental Security Income (SSI) and SSI-related less than 21 years of age. |
| RC II Adult | Disabled members, including Supplemental Security Income (SSI) and SSI-related, ages 21 through 64. |
| RC IX | Individuals ages 21 through 64 with incomes up to 133% federal poverty level (FPL), who are not pregnant, disabled, or a parent or caretaker relative of a child under age 19, or eligible for other MassHealth coverage. |
| RC X | Individuals ages 21 through 64 with incomes up to 133% FPL, who are not pregnant, disabled, or a parent or caretaker relative of a child under age 19, or eligible for other MassHealth coverage, who are also receiving EAEDC through the Massachusetts Department of Transitional Assistance |

### 1.3. Member attribution to ACO

Members in the PCC Plan are each enrolled with a PCC. Each Pilot ACO has a unique, exclusive group of PCCs who have contracted to participate with that ACO; PCC Plan members enrolled with a Pilot ACO’s PCCs are considered attributed members for that Pilot ACO.

## Section 2. Services included in Total Cost of Care (TCOC)

The services included in TCOC will be broadly consistent with services included in the base capitation for MassHealth’s managed care organizations, with some differences. In particular, there are select services (e.g., Hepatitis C drugs) that MassHealth will exclude from the TCOC calculation in order to prevent unpredictable, rare, high-cost events from driving substantial losses for an individual ACO. Additionally, Home Health and LTC services are also excluded from the TCOC, but will be tracked and reported to providers.

### 2.1. List of services included in Total Cost of Care (TCOC)

Below is a list of service categories included in the TCOC under the ACO Pilot program:

| Category | Definition |
| --- | --- |
| Inpatient PH — Non‑maternity | Inpatient services that have not been identified as maternity, behavioral health or LTC. Includes services provided in acute and chronic hospital settings; includes both room and board data and ancillary data billed by the facility during the stay. |
| Inpatient PH — Maternity | Inpatient PH — Maternity Acute hospital inpatient services related to maternity care and deliveries. |
| Emergency Room | Emergency room services provided in acute hospital settings; does not include ancillary data associated with the visit if not coded "emergency room" on the claim. Emergency room discharges that result in an admission are not included in this category. |
| Lab and Radiology — Facility | Laboratory and radiology services provided as outpatient services by acute or chronic care hospitals and freestanding facilities. |
| Other Outpatient Hospital | Outpatient services provided by acute care hospitals, chronic care hospitals, and ambulatory surgical centers, except those meeting categorization criteria for behavioral health, emergency room, and laboratory and radiology. |
| Clinics (CHC) | Services provided by Community Health Centers. |
| Professional Services | PH services provided by medical professionals; including physicians, nurse practitioners, podiatrists, chiropractors, and physical therapists. This category includes professional laboratory services, as well as physician inpatient services billed separately. |
| DME & Supplies | DME and medical supplies; including hearing aids, orthotics, prosthetics, and oxygen/respiratory care equipment. |
| Emergency Transportation | Transportation services provided by emergency transportation providers. |
| Pharmacy | Retail pharmacy. |
| Other Medical Services | Speech and hearing services, renal dialysis, dental care, hospice care, and other miscellaneous services. |
| Inpatient Behavioral Health | Inpatient services related to behavioral health care, provided in acute care hospitals, chronic care hospitals, behavioral health hospitals, or other specialty behavioral health residential facilities. |
| Outpatient Behavioral Health | Outpatient behavioral health services provided by behavioral health hospitals, mental health clinics, acute care hospitals, physicians, and other appropriate behavioral health service providers. Does not include CBHI services. |
| Diversionary Behavioral Health | Diversionary behavioral health services are home and community-based mental health and substance use disorder services furnished as clinically appropriate alternatives to and diversions from inpatient mental health and substance use disorder services in more community- based, less structured environments. Diversionary services are also provided to support an individual’s return to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. |

### 2.2. Excluded services

MassHealth’s current MCO capitation rates include certain high-cost services that are relatively new to the MassHealth program, which may result in a large and unpredictable impact on ACOs’ TCOC. Some such services, specifically Hepatitis C drugs, Cystic Fibrosis drugs, and Applied Behavioral Analysis, will therefore be excluded from TCOC calculations.

TCOC will also exclude services that are currently excluded from MCO capitation rates. Long Term Supports & Services (LTSS) will be excluded, as will services rendered by state agencies outside of MassHealth or the health safety net.

## Section 3. Calculation of TCOC target

Prior to the start of the performance year, MassHealth will establish a preliminary TCOC target for each Pilot ACO. This section describes how that target will be calculated.

### 3.1. Base data

The TCOC target will be based on a one-year historical base period of October 1, 2014 through September 30, 2015. MassHealth selected this base period after reviewing the most recent three years of available and reliable data for the ACO-eligible population.

All base data for PCC Plan members and included services will be utilized to inform adjustments such as trend. The base data will consist of MassHealth eligibility records, Primary Care Clinician (PCC) Plan claims and Massachusetts Behavioral Health Partnership (BHP) contractor encounter data for PCC and BHP covered services. Each Pilot ACO’s TCOC target will be based on the data for members attributed to that ACO’s participating PCCs, specifically, during the base period. For Performance Period B, additional trend and seasonality adjustments will be made to reflect the 15 month performance period.

### 3.2. Risk/acuity adjustment

For each ACO, MassHealth will adjust for any observed changes in acuity between the members attributed during the base period (October 1, 2014 - September 30, 2015) and the ACO performance periods (December 1, 2016 to November 30, 2017 or December 1, 2016 to February 28, 2018). Specifically, MassHealth will normalize each ACO’s risk score to the overall PCC program during the base period, and again for each performance period.

MassHealth will use a statistically developed risk adjustment tool and standard DxCG grouper to develop individual member-level risk scores; this tool also incorporates independent variables related to social determinants of health.

### 3.3. Stop-loss adjustment

Consistent with the stop-loss approach described in Section 4.1, MassHealth will adjust the base data in order to mitigate the risk to providers from claims incurred for individual members beyond the stop-loss thresholds ($50,000 for RC I, $110,000 for RC II). Expenditures beyond these thresholds will be reduced by 90% in the base data; ACOs are therefore “at risk” for only 10% of these outlier costs.

### 3.4. Trend

Trend is an estimate of the change in the overall cost of medical services over a finite period of time. A trend factor is necessary to estimate the expenses of providing health care services in a future time period. As part of the TCOC development process, unit cost and utilization trend factors by RC, region, and service category will be developed.

The primary data sources used in trend development will consist of ACO-eligible members’ eligibility records, PCC Plan claims, and BHP encounter data for PCC and BHP covered services. The data reflects a variety of influences, including potential changes in medical management practices, network construction, and population risk. Some of these influences may be accounted for in other aspects of rate setting, such as program changes, and, as such, the data must be considered within the broader context of other assumptions. Any services excluded from TCOC will also be excluded from the trend development.

### 3.5. Program changes

MassHealth will account for program changes occurring between the base and performance periods that are expected to affect the TCOC. Data will be adjusted for any known programmatic, benefit, fee, population changes occurring between the base period and the performance periods.

Section 4. Calculation of shared savings and losses

### 4.1. Retrospective calculation of TCOC performance and savings / losses

Within one year from the end of each performance period, MassHealth will calculate each ACO’s TCOC performance for the list of covered services described in Section 2.1. Several potential adjustments may be made at that time to account for additional changes between the base and performance periods:

* Shifts in risk: MassHealth will calculate each ACO’s benchmark to reflect the actual risk scores of the ACO’s covered population, as well as reflect the ACO’s final enrollment mix by rating category (i.e., rating category and age group). .
* Program changes: To the degree that MassHealth introduces substantial shifts in policy during the performance periods that has an effect on TCOC, calculations of performance may be adjusted to reflect the impact of those policy changes
* Stop-loss: In order to appropriately incent ACOs to manage costs, it is important to insulate those ACOs’ performance from the impact of unmanageable catastrophic costs incurred by a small number of members. Therefore, MassHealth will count only 10% of claims beyond $50,000 for individual members in Rating Category I and $110,000 for individual members in Rating Category II in the calculation of TCOC performance. This approach is consistent with the discounting of those claims from the base data, as described in Section 3. The threshold amounts for each rating category were determined based on Monte Carlo simulations using the distribution in member-level spending and the expected number of attributed lives in the expected Pilot ACOs. By testing the financial impact of different stop-loss thresholds on each ACO’s TCOC performance under the assumption that members are randomly assigned to ACOs, MassHealth determined an appropriate threshold that protected ACOs from suffering significant losses due to random variation alone while maintaining a meaningful incentive to manage utilization for high-cost members.

After the adjustments described above, the difference in each ACO’s TCOC performance and its target (each expressed as a PMPM) will be calculated on a PMPM basis.

For ACOs that have signed a contract extension, MassHealth will calculate TCOC performance for both the original 12 month performance period (Performance Period A) and the extended 15 month performance period (Performance Period B), against corresponding PMPM targets. ACOs will be accountable to whichever performance period leads to the larger total shared savings or smaller total shared losses payment.

### 4.2. Determination of shared portion of savings / losses

Once the total savings or losses have been calculated, MassHealth will follow a series of steps that determine the portion of savings or losses retained by the ACO:

* Savings / losses cap: MassHealth will recognize savings or losses for each individual ACO up to a cap of 15% of the ACO’s TCOC target. For example, if an ACO’s target TCOC is $500 PMPM, then its cap on recognized savings or losses is $500 \* 15% = $75 PMPM. If the ACO achieves TCOC performance of $400 PMPM, MassHealth would only recognize $75 PMPM of the savings. Similarly, if the ACO has a TCOC performance of $580 PMPM, only $75 PMPM of losses would be recognized. For the ACO, 100% of savings or losses would be recognized if the ACO performed between $425 and $575 PMPM.
* Share of savings: After the determination of savings and losses, MassHealth will pay 50% of recognized savings to ACOs with TCOC performance below target. In the example where an ACO performs at $400 PMPM on a $500 PMPM target, MassHealth would therefore pay the ACO $75\*50% = $37.50 PMPM. Therefore, the maximum financial upside in the ACO Pilot is 7.5% of target.
* Share of losses: MassHealth will recoup 10% of the recognized losses from ACOs with TCOC performance above target. In the example where ACO A performs at $580 PMPM on a $500 PMPM target, MassHealth would therefore recoup from ACO A $75\*10% = $7.50 PMPM. Therefore, the maximum financial upside beyond target TCOC is 1.5% of target.
* Minimum savings / loss ratio: If total savings or losses are less than 2% of the TCOC target, MassHealth will not pay shared savings or recoup shared losses. This approach prevents payments or recoupments from being incurred due to random variation. For example, if an ACO’s target TCOC is $500 PMPM, and its performance is between $490.01 and $509.99 PMPM, no savings or losses will be shared. If performance was $490.00 and below or $510.00 and above, then the full difference between performance and target would be recognized (per the prior three bullets)

### 4.3. Impact of quality reporting on shared savings / losses

Pilot ACOs will be required to report on certain clinical quality measures. ACOs that fail to satisfy quality reporting requirements will not be eligible to share in savings.