MassHealth Technical ACO/MCO Pricing meeting

Executive Office of Health & Human Services

Discussion document

April 28, 2017

Material in this PowerPoint is presented for informational purposes only

Topics

- Upcoming touchpoints on ACO / MCO pricing
- Pricing and programmatic updates
  1. Cap on payments to acute hospitals form MCOs and ACPPs
  2. Special assignment
  3. Provider ID mapping and movement
- Q&A

Key pricing touchpoints in coming months (anticipated)

Late April / May

- ACO/MCO Databook: to be released week of May 1
  - Price-normalized RY16 base data, with category of service-level view
  - Public meeting on Wednesday, May 3 to review
- Detailed pricing methodology discussion
  - Technical pricing details (e.g., risk adjustment methodology, price normalization by category of service)
  - Public meeting in mid-May to review technical pricing details
  - To be followed by written Q&A

June

- Entity-specific capitation rates (for Accountable Care Partnership Plans and Managed Care Organizations) and TCOC benchmarks (for Primary Care ACOs and MCO-Administered ACOs), reflecting Network Variance Factor
  - Full entity-specific detail on how base TCOC was developed
- Information sharing package
  - Further in-depth explanation of how TCOC rates and benchmarks were developed
  - To be followed by written Q&A

EOHHS, with its actuaries, will continue to hold regular public meetings, ACO bidders' conferences, and MCO bidders' conferences in order to explain its pricing methodology and give stakeholders an opportunity to ask questions and raise concerns

① Cap on payments to acute hospitals by MCOs, ACPPs as described in model contracts

Broad contract provision (Section 2.7.D.3 in MCO and ACPP model contracts):

EOHHS may, in its discretion direct the Contractor to establish payment rates[1] that are no greater than a certain percentage of the MassHealth Fee-For-Service (FFS) rate or another payment rate specified by EOHHS. Such maximum payment rate shall not be less than 100% of the MassHealth FFS rate. EOHHS may approve an exemption from any such requirement upon the Contractor's written request, which shall include the reason(s) why it is necessary for the Contractor to pay a higher rate, such as in order for the Contractor to implement value-based payment arrangements.

Contract provisions specific to <u>acute hospitals</u> (Section 2.7.D.6 in MCO and ACPP model contracts):

*The Contractor shall not enter into provider agreements with hospitals that provide for payment exceeding 100%[2] of MassHealth-equivalent rates under Sections 5.B.1 through 5.B.3, 5.B.6, 5.B.7, 5.C.1, and 5.D.7 of the MassHealth Acute Hospital RFA (subject to Sections 8.1. through 8.3 of said RFA, as applicable) and with the exception of Emergency and Post-Stabilization Services (which are governed by **Section 2.6.G** of this Contract) and Behavioral Health services, unless a higher rate is necessary for the Contractor to retain its ability to reasonably manage risk or necessary to accomplish the goals of this Contract (e.g., meet access and availability standards). The Contractor shall report any such provider agreements to EOHHS and explain the reason(s) such payments are necessary.*

[1] EOHHS anticipates updating "provider agreements" to clarify that this provision applies to in-network and out-of-network provider agreements.

[2] The RFR for MCOs states "100%"; the RFR for ACOs states "105%"; the Accountable Care Partnership Plan contract will be amended to state "100%".

① MassHealth benchmark for Managed Care Rate Year 2018

In Managed Care Rate Year 2018, the benchmark referenced in the model contracts above for both MCOs and ACPPs will be set at 100% of MassHealth equivalent rates. This is consistent with the development of capitation rates for MCOs and ACPPs, which will be set assuming that the MCOs and ACPPs contract with acute hospital providers at 100% of MassHealth-equivalent rates.

EOHHS anticipates that an increase of at least 2.5% will be applied to the MassHealth fee-for-service (FFS) acute hospital rates beginning in Managed Care Rate Year 2018.

① When MCOs and ACPPs may pay above the MassHealth benchmark

There are circumstances in which MCOs and ACPPs may pay rates greater than the MassHealth benchmark. In accordance with the model contracts, MCOs and ACPPs may pay *a higher rate if necessary for the MCO or ACPP to retain its ability to reasonably manage risk or necessary to accomplish the goals of the Contract*.* Examples of when EOHHS believes a higher rate may be necessary in accordance with the above include the following:

- In order to meet **access and availability standards** for members. This scenario is currently cited as an example in the model contracts.
  - Higher acute hospital payment rates may be paid if such rates are necessary for the MCO or ACPP to provide medically necessary services covered under the contract in accordance with access and availability requirements set forth in the contract.

- In order to implement **value-based payment arrangements**. This scenario will be added as an example in the model contracts prior to execution.
  - Higher acute hospital payment rates may be paid as part of a payment arrangement that features:
    - Material financial downside risk for the hospital, and
    - Meaningful Total-Cost-of-Care, quality, and/or other performance metrics related to MCO or ACPP-covered services delivered by the acute hospital

*This provision does not apply in the case of non-network hospital emergency and post-stabilization services, for which the maximum amount that can be paid to hospitals is governed by federal law.

1 Freestanding pediatric and specialty cancer hospitals payment provisions

EOHHS will update the MCO and ACPP model contracts to reflect the following provisions for freestanding pediatric and specialty cancer acute hospitals:

Freestanding pediatric acute hospitals

- For inpatient discharges with a MassHealth DRG weight[1] of 3.5 or greater, MCOs and ACPPs will be required to pay the equivalent of 100% of the MassHealth Inpatient acute hospital FFS rate.
  - It is anticipated that beginning in Managed Care Rate Year 2018, the MassHealth FFS payment methodology applicable to discharges from freestanding pediatric acute hospitals with a MassHealth DRG Weight of 3.5 or greater, will incorporate an APAD base rate that includes a 45% increase from the normal APAD base rate.[2] MassHealth will continue to apply its cost-based outlier methodology for these and other discharges in setting its FFS rate.
- For all other inpatient and outpatient services, payments to these hospitals will not be subject to the requirements set forth in Section 2.7.D.6.

Specialty cancer acute hospitals

- Payments to specialty acute cancer hospitals will not be subject to the requirements set forth in Section 2.7.D.6.

[1] "MassHealth DRG weight" is the MassHealth relative weight developed by EOHHS for each unique combination of APR-DRG and severity of illness (SOI); it relies on the 3M grouper used to set the MassHealth fee-for-service (FFS) payments.

[2] The APAD base rate refers generally to the sum of the wage-adjusted operating standard per discharge and the statewide capital standard per discharge.

2 What supports are available to members?

In order to educate members on these restructuring efforts and answer their questions appropriately, the following supports will be available to members:

Global Awareness & Education	• Staff Training: MassHealth Enrollment Center (MEC) • MassHealth Training Forum (MTF) Presentations • EOHHS Website Updates • Sister Agency & Advocacy Training • Certified Application Counselor (CAC) & Navigator training • Materials Feedback Sessions • Targeted Advertising
Support Material	• Enrollment Guide presenting all available MCO, ACO, and PCC Plan options • Member-specific letters with information about Special Assignment, PSP and FEP • Choice Counseling Tool • Updated Member Booklet • Video/Animation “How to Enroll”
Member Engagement	• Community Health Worker (CHW) Training • Ombudsman • Community Enrollment Events throughout the Commonwealth
Customer Service Center	• Searchable Provider Directory • Enhanced Call Center Staff

2 Current and Future Choices for Managed Care Members

- Currently, managed care members can choose:
  - **PCC Plan:**
    - BH is managed by a vendor; capitated payment
    - All other services (medical and LTSS) are provided directly by MassHealth, paid FFS
  - **An MCO** in their region:
    - Manages medical and BH services; capitated payment
    - LTSS is provided directly by MassHealth, paid FFS

- When new ACO and MCO contracts begin in December 18, 2017, these MassHealth members will have the following choices:
  - **Accountable Care Partnership Plans** in their service area *(new choices)*
  - **MCOs** in their region; may also receive primary care through an **MCO-Administered ACO** (*new choices*)
  - **Primary Care ACOs** with a PCP in their area *(new choices)*
  - **PCC Plan** with a PCP in their area

2 Key Dates

Managed Care Eligible Members

Date	Message
October 2, 2017	First day of mailing for managed care eligible members*
October 13, 2017	Last day of mailing for managed care eligible members*
December 18, 2017	Start date of new health plans
December 18, 2017 – March 18, 2018	Plan Selection Period for all managed care eligible members
March 19, 2018	Start of the Fixed Enrollment Period for all members enrolled in an MCO or an ACO

2 Member Enrollment in New MCOs and ACOs

- In order to ensure that the applicable set eligible members are enrolled in MCOs and ACOs (or PCC Plan) by December 18, 2017, certain members will have a **"Special Assignment"** to plans

- Special Assignment will be based on keeping members with their PCP to the extent possible. Members may be specially assigned if their PCP is joining an ACO. Members are "following" their PCPs into new health plan choices
    - Members whose PCPs are joining an Accountable Care Partnership Plan or a Primary Care ACO will be special assigned to the ACPP or Primary Care ACO that the member's PCP joined
    - Members whose PCPs are joining an MCO-administered ACO will be special assigned to an MCO in their region, unless they are already in an MCO that is continuing after December 18th

- If a member's MCO will no longer be available as of 12/18/17, and the member's PCP is not joining an ACO, the member will be auto assigned to a health plan in their region on December 18, 2017
- If a member does not fall into either of the above categories, the member will remain enrolled with the member's current health plan, unless the member chooses a new health plan
- For continuity of care purposes, during Fall 2017, health plan choices for new and auto-reenrolled members may be limited to health plans that are anticipated to be available to members after December 18, 2017.

2 Special Assignment

Communications:

1. In October, all managed care eligible members will receive a letter from MassHealth. If a member is a HOH they will also be sent a new enrollment guide that will contain all the health plan choices available
    - Members who are being specially assigned will receive a letter informing them of their new health plan assignment, Plan Selection Period and Fixed Enrollment Period.
    - Members whose MCOs are not re-procured will receive a letter informing them that they will be auto-assigned on Dec 18th unless they make a choice of health plan. They will also be informed of their Plan Selection Period and Fixed Enrollment Period
    - All other members will be sent a notice letting them know of their Plan Selection Period and Fixed Enrollment Period.
2. Members who are specially assigned or auto assigned will be enrolled into their new plans on December 18, 2017 if they do not make another choice
3. On December 18, 2017, Plan Selection Period will begin for all managed care eligible members, including those who were newly assigned to plans
4. On March 19, 2017, Fixed Enrollment Period will begin for all members enrolled in an MCO or ACO.

3 Recap of PCP participation and exclusivity

- Each ACO's list of participating primary care providers will drive that ACO's **rates/TCOC benchmarks and initial member assignments**
  - ACO rates/TCOC benchmarks blend a market-based standard with a **historic TCOC value**
    - The historic TCOC value is based on the TCOC experience of the members who were **primary care-assigned to the ACO's primary care providers** during the base year
    - In Contract Year 1, the historic TCOC value will make up **90%** of the ACO's blended rate/TCOC benchmark
  - This fall, MassHealth will **"special assign"** to each ACO the members who have primary care assignments to that ACO's primary care providers. This will be these members' **default enrollments**, effective on the Operational Start Date of the program, unless they choose to change enrollment options (all members will have choice)

- Because PCP lists drive rates and assignment, **it is important that they are stable.** MassHealth will have limited operational ability to update ACOs' composition mid-year
  - **Each ACO is responsible** for maintaining its list of PCPs for Contract Year 1
  - MassHealth will establish a process to handle **minor, unavoidable changes** (e.g., a doctor moves out of state) mid-year
  - MassHealth will establish an **annual process with fixed deadlines** to handle more general change requests

- Primary care participation must also be **exclusive**. This exclusivity is enforced at the **practice or entity level** rather than at the individual doctor level

③ Backup: Introduction to MassHealth PCP enrollment

Broadly, a primary care provider may have one of **three enrollment statuses**[1] with MassHealth

Enrolled as a "Primary Care Clinician" PCC	**Enrolled as a FFS provider only**	**Not enrolled with MassHealth**
▪ Each PCC may have one or several sites ▪ Each site has a Provider ID/ Service Location (PID/SL, or "Site ID"). The PCC also has a PID/SL ("PCC ID"), which is typically used by the sites for billing ▪ PCC Plan members' assignments are at the site level (rather than the doctor level) ▪ This is the **building block for enrolling ACOs** in MassHealth and driving their member assignments for Y1	▪ Many providers are not PCCs or PCC sites, but have PID/SLs with MassHealth that they use to bill for services or to indicate on claims that they are the ordering or referring provider ▪ Many individual doctors have such "FFS-only" enrollments with MassHealth, and also participate as part of a practice or site that has a separate PID/SL as a PCC or site ▪ Members are not assigned to FFS-only PID/SLs	▪ Certain providers are not enrolled with MassHealth at all. This includes providers who participate with MassHealth MCOs but do not take MassHealth FFS or PCC Plan members

[1]Further nuance exists (e.g., provider enrollments can be "active"/ "inactive," etc.)

③ Backup: Overview of provider identification and matching process

Major steps	Process/ validation
▪ MassHealth will identify each ACO as: – PCC PID/SLs (PCCs and their affiliated sites) – Additional providers that do not have corresponding PCC/site enrollments	Established and directly validated with each ACO through this process (RFC #1)
▪ MassHealth will match these practices and providers to MCO provider data using National Provider Identifier (NPI) and tax ID number (TIN) information to identify the corresponding MCO enrollees for rate-/ benchmark-setting and special assignment purposes	MassHealth will provide the resulting list of matched MCO practices to ACOs
▪ MassHealth will set rates and special assign members based on these affiliations	MassHealth will release rates with accompanying information in late June
▪ MassHealth will enroll each ACO in MMIS, create PCC/site enrollments for any ACO providers that do not have them, change the “contract type” of each ACO’s sites to indicate that they are participating exclusively with an ACO (rather than, e.g., the PCC Plan), and affiliate each ACO’s enrolled PCC providers exclusively to that ACO	MassHealth will operationalize enrollments over the course of the summer