MassHealth Technical ACO/MCO Pricing meeting

Executive Office of Health & Human Services

Discussion document

March 31, 2017

Material in this PowerPoint is presented for informational purposes only

Topics

- Upcoming touchpoints on ACO / MCO pricing
- Pricing design – updates
  1. ACO quality metrics
  2. DSRIP Safety Net Category PMPM Increase
  3. Pricing parity for hospital and professional services
  4. NVF weighting factors in Rate Year 2018 and Rate Year 2019
  5. Aggregate risk corridor settlements for MCOs and Partnership Plans
  6. Risk corridor for HCV pharmacy costs
- Q&A

Key pricing touchpoints in coming months (anticipated)

Late April / May

- ACO/MCO Databook
  - Price-normalized RY16 base data, with category of service-level view
- Detailed pricing methodology discussion
  - Technical pricing details (e.g., risk adjustment methodology, price normalization by category of service)

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 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 ACO quality metrics (1 of 3)

Each ACO's quality performance will be measured for a contract year

- Quality score between 0 and 1
- Calculated after the end of each year, allowing for claims run-out
- Preliminary slate of quality measures on next page

Performance on quality metrics financially impacts ACOs in two ways:

- DSRIP: Increasing portion of DSRIP funds at risk for quality performance over five years (~5% in 2018, ~10% total across the DSRIP period)
- Shared savings / losses:
  - Savings: 100% of ACO's share of savings (after risk corridor calculations) are subject to quality performance
  - Losses: up to 20% of ACO's share of losses (after risk corridor calculations) can be offset based on quality performance
  - Examples:

	Quality score: 0.6	**Quality score: 0.9**
Post-risk corridor savings: $10M	Effective savings = **$6M** *($10M x 0.6)*	Effective savings = **$9M** *($10M x 0.9)*
Post-risk corridor losses: $10M	Effective losses = **$8.8M** *($10M – [$10M x 20% x 0.6])*	Effective losses = **$8.2M** *($10M – [$10M x 20% x 0.9])*

See Section 4.5.G and Appendix Q of Accountable Care Partnership Plan model contract
See Section 4.3.C and Appendix B of Primary Care ACO model contract
See Section 2.7.D and Appendix B of MCO-Administered ACO model contract

① ACO quality metrics (2 of 3) - *PRELIMINARY*

Measure
Prevention & Wellness *(10 measures)*
Pediatrics
Well child visits in first 15 months of life
Well child visits 3-6 yrs
Adolescent
Adolescent well-care visit
Weight assessment and counseling for nutrition and physical activity for children/adolescents
Immunization for adolescents
Maternity
Prenatal care
Postpartum care
Oral
Oral evaluation, dental services
Adult (emphasis on SDH)
Tobacco use screening and cessation intervention
Adult BMI assessment

Measure
Chronic Disease Management *(5 measures)*
Controlling high blood pressure
COPD or asthma admission rate in older adults (obs to exp)
Asthma medication ratio
Comprehensive diabetes care: A1c poor control
Diabetes short-term complications admission rate
Behavioral Health / Substance Abuse *(9 measures)*
Developmental screening for behavioral health needs: Under age 21
Screening for clinical depression and follow-up plan: Age 12+
Depression remission at 12 months
Initiation/Engagement of alcohol & other drugs (AOD) treatment
Opioid addiction counseling
Follow-up after hospitalization for mental illness (7-day)
Follow-up care for children prescribed ADHD medication (Initiation/Continuation)
Long Term Services and Supports *(1 measure)*
Patients received age-appropriate LTSS assessment

① ACO quality metrics (3 of 3) - *PRELIMINARY*

Measure
Integration *(11 measures)*
Utilization of BH community partner care coordination services
Utilization of outpatient BH services
Hospital admissions for SMI/SUD populations
ED utilization for SMI/SUD populations (obs to exp)
ED care coordination of ED boarding population
Utilization of LTSS community partners
All cause readmission among LTSS CP eligible
Social service screening
Utilization of flexible services
Care plan collaboration across: PC, BH, LTSS, and SS providers
Community Tenure

Measure
Avoidable Utilization *(3 measures)*
Potentially preventable admissions (obs to exp)
All condition readmission (obs to exp)
Potentially preventable ED visits (obs to exp)
Member Experience
Measures from three Patient Experience Surveys: • Primary Care survey • BH survey • LTSS survey

② Startup and Ongoing DSRIP Safety Net Category PMPM increase

- ACOs' Startup and Ongoing DSRIP payments will be based in part on payer revenue mix. ACOs with higher Medicaid/uninsured payer revenue mix would receive higher DSRIP PMPMs
  - Based on its Safety Net Category, an ACO would be eligible for a 0-40% increase to its DSRIP Startup and Ongoing base PMPM

- **Beginning in Performance Year 2 (CY 2019), MassHealth intends to apply the maximum Safety Net Category PMPM increase (40%) to all ACO members whose Primary Care Provider (PCP) is affiliated with a community health center (CHC), as to be further specified by EOHHS**
  - The Safety Net Category PMPM increase for all other members will based on the ACO's overall payer revenue mix

③ Pricing parity

- Recall: EOHHS will now use 100% of the EOHHS fee-for-service (FFS) fee schedule equivalent in setting capitation rates for Accountable Care Partnership Plans and Managed Care Organizations rather then the former 105% for acute hospitals and 110% for professionals

- EOHHS intends to rebalance MassHealth FFS Payment rates for acute inpatient and outpatient hospital services by **at least 2.5%**
  - Applies to APAD and APEC payments
  - Accountable Care Partnership Plans and MCOs will be expected to pay at or below 100% of the MassHealth benchmark for hospital services

- EOHHS intends to rebalance MassHealth FFS payment rates for selected professional services by **at least 5%**
  - Applies to services covered under the Medicine (101 CMR 317), Surgery and Anesthesia (114.3 CMR 16.00), and radiology (114.3 CMR 18.00) fee schedules

- Rebalancing is **budget neutral** for acute hospitals, professionals, and the Commonwealth

- Final rebalancing to be announced in late April / Early May

- Rate rebalancing will take effect **December 18, 2017**

④ NVF weighting factors in Rate Year 2018 and Rate Year 2019

- Recall:
  - To calculate the entity-specific TCOC that will inform MCOs' and Partnership Plans' medical component of the capitation rate and Primary Care ACOs' and MCO-administered ACOs' TCOC benchmarks, EOHHS will apply a Network Variance Factor (NVF)
    - *Capitation or benchmark =*
      *(Market-based TCOC) * [(NVF * NVF weight) + (1.0 – NVF weight)] * (Risk adj.)*
  - The NVF is the ratio of an ACO or the MCO class's historical Total Cost of Care (TCOC) to the common market-based standard TCOC after normalizing for historical differences in unit prices paid and members' risk scores
  - Beginning in Rate Year 2018 and moving forward, EOHHS will apply a declining weight to the NVF in calculating ACOs' and the MCO class's TCOC

In Rate Year 2018, EOHHS intends to apply a **90%** weight to the NVF

- Examples:
  - ACO with a historical price-normalized, risk-adjusted TCOC of $550 PMPM and a common market-based standard of $500 PMPM would have a capitation / benchmark of $545 PMPM prior to risk adjustment
  - An ACO with a historical TCOC of $380 PMPM and a common market-based standard of $400 PMPM would have a capitation / benchmark of $382 PMPM prior to risk adjustment

In Rate Year 2019, EOHHS intends to apply a **70% to 80%** weight to the NVF

⑤ Aggregate risk corridor settlements for MCOs and Partnership Plans

Language in MCO (4.5.C.5) and Accountable Care Partnership Plan (4.5.B.2) Model Contracts

- *If the Contractor incurs a loss that would require EOHHS to make a risk sharing payment to the Contractor, and the Contractor has paid an amount in aggregate for MCO Covered Services that exceeds the amount that EOHHS would have paid in aggregate for the same services on a Fee-For-Service basis, then EOHHS may reprice the Contractor's paid Claims to reflect EOHHS's fee schedule for the purposes of calculating the risk-sharing payment.*

<u>Illustrative examples ($ PMPM)</u>:

	(A)	(B)	(C)	(D)	(E)	(F)
	Capitation	Actual cost	Losses in excess of 3%	Recalculated cost after repricing to MassHealth FFS equivalent	Losses in excess of 3% after repricing	EOHHS risk sharing payment
			*B – A*103%*		*D – A*103%*	*E*50%*
MCE 1	500	540	25	535	20	10
MCE 2	400	425	13	405	-	-
MCE 3	600	610	-	*Not repriced*	-	-
MCE 4	500	490	-	*Not repriced*	-	-

6 Risk corridor for HCV pharmacy costs (1 of 2)

Risk mitigation:

- EOHHS will develop an HCV component of the capitation rate for MCOs and Model A ACOs, and an HCV component of the TCOC benchmark for Primary Care ACOs and MCO-administered ACOs
- MCOs and ACOs will be financially at-risk for:
  - 100% of any gains or losses that are less than or equal to 5% of the HCV component of the capitation / TCOC benchmark
  - 5% of any further gains or losses
- Accordingly, EOHHS is at-risk for 0% of gains or losses within the first 5% of the HCV component of the capitation / TCOC benchmark, and 95% of any further gains or losses

Payment mechanics:

		How payments flow after contract period:	
Model type	How HCV target is incorporated	Entity incurs less HCV cost than target	Entity incurs more HCV cost than target
MCO / ACPP	Standalone component of prospective capitation rate	MCO/ACPP pays EOHHS the state's share of the savings	EOHHS pays MCO/ACPP the state's share of losses
Primary Care ACO / MCO-Administered ACO	Standalone component of retrospective TCOC benchmark	ACO receives more total savings (lower total losses) in final TCOC reconciliation	ACO receives lower total savings (more total losses) in final TCOC reconciliation

See Section 4.5 and Exhibit 3 of MCO Model contract
See Section 4.2.B.3 and 4.5.F of Accountable Care Partnership Plan model contract

6 Risk corridor for HCV pharmacy costs (2 of 2) - *Example*

Example calculation of gains / losses (ACOs with 100K member months):

	HCV capitation / benchmark		Actual HCV cost		Gain / (loss) on HCV				
	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)
	PMPM ($)	Total ($K)	PMPM ($)	Total ($K)	Total gain / (loss) ($K)	First 5% ($K)	Remaining ($K)	ACO share ($K)	MassHealth share ($K)
					B - D	5% * B	E - F	100%*F + 5%*G	E - H
ACO 1	20.00	2,000	15.00	1,500	500	100	400	120	380
ACO 2	30.00	3,000	40.00	4,000	(1,000)	(150)	(850)	(193)	(807)
ACO 3	25.00	2,500	25.00	2,500	-	-	-	-	-

Payment mechanics:

	Accountable Care Partnership Plan / Managed Care Organization	Primary Care ACO / MCO-administered ACO	
		ACO has savings on non-HCV TCOC benchmark	ACO has losses on non-HCV TCOC benchmark
ACO 1	ACO pays MassHealth $380,000 after end of contract year	Total TCOC savings increased by $120,000	Total TCOC losses decreased by $120,000
ACO 2	MassHealth pays ACO $807,000 after end of contract year	Total TCOC savings decreased by $193,000	Total TCOC losses increased by $193,000
ACO 3	No payment at end of contract year	No impact on overall TCOC savings	