MassHealth Delivery System Restructuring: Overview

Executive Office of Health & Human Services

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FOR POLICY DEVELOPMENT PURPOSES ONLY

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MassHealth restructuring update

- We are committed to a sustainable, robust MassHealth program for our 1.8M members
  - Unsustainable growth, now almost 40% ($15B+) of the Commonwealth’s budget
  - The current fee-for-service model for providers results in fragmented, siloed care
  - The fundamental structure of the MassHealth program has not changed in 20 years

- We are transitioning from fee-for-service, siloed care and into integrated, accountable care models
  - Accountable Care Organizations (ACOs) are provider-led organizations that coordinate care, have an enhanced role for primary care, and are rewarded for value – better cost and outcomes – not volume
  - Managed Care Organizations (MCOs) remain the insurer, pay claims and work with ACO providers to improve care delivery
  - We have a major and unique focus on better integrating our members’ physical, behavioral health (BH) and long term services and supports (LTSS) needs, as well as building linkages to social services

- We are negotiating a new 5-year 1115 waiver with the federal government that includes ~$1.5Bn of upfront investment over 5 years to support this effort
  - Financing for current waiver expires June 30, 2017 with $1Bn/ year at risk
  - Proposing 5-year Delivery System Reform Investment Program (DSRIP) investment
  - Unique investment approach, including:
    - Support for providers who sign on for ACO models
    - Funding for BH and LTSS community organizations
    - Services not traditionally reimbursed as medical care to address health-related social needs
    - Statewide investments in health care workforce development, improved accommodations for people with disabilities, other state priorities
  - Also proposing expansion of treatment continuum for Substance Use Disorder/ Opioids
MassHealth growth trajectory

**MassHealth Program Spending***

$ billions

- **Gross Program Spend**
- **Net State Cost**

Forecasted, prior to proposed FY17 budget initiatives

- **MassHealth has significantly outpaced revenue growth for the Commonwealth**
- **We have brought down growth** for FY16 and FY17 through **near-term** program integrity, operational and other efforts
- **We must ensure long-term sustainability** of the program

*Includes Hutchinson settlement; excludes MATF (supplemental payments)*
ACOs are provider-led organizations that coordinate care, have an enhanced role for primary care, and are rewarded for value – improving total cost of care and outcomes – not volume.

ACOs incented to partner with community-based expertise for behavioral health BH, LTSS and build linkages to social services.

ACOs will have access to DSRIP funding designated explicitly for addressing social determinants.

-- “Flexible services” not traditionally reimbursed but likely to improve health outcomes (e.g., air conditioner for kids with asthma, housing supports).

The state expects Managed Care Organizations (MCOs) to work with ACO providers to improve care delivery and population health management.

DSRIP funding encourages providers to enter into ACO models.

It serves as a bridge – supports a transition into a sustainable model; it is not a rate increase.

DSRIP investments are used to support development of scalable new capabilities and capacity.
Materially improve member experience—ACOs expected to innovate and engage members differently (e.g., better transitions of care, improved coordination between a member’s various providers)

Strengthen the relationship between members and Primary Care Providers (PCPs) by attributing members to an ACO through their selection of a PCP

Encourage ACOs to develop high value, clinically integrated provider partnerships by expecting and allowing ACOs to define coordinated care teams and, for some ACOs, to establish preferred networks

Partner with MCOs, with expectations for MCOs to help administer the ACO program and work with providers in strengthening provider-based care management

Increase BH/LTSS integration and linkages to social services in ACO models through explicit requirements for partnering with BH and LTSS Community Partners
**What is an ACO and what does it provide**
- An ACO is a provider-led entity (e.g., a group of providers or a health system)
- ACOs are expected to build explicit coordinated care teams with providers across the care continuum
- ACOs are expected to deliver a coordinated and improved member experience and have flexibility to engage members differently (e.g., enhanced services, care coordination)
- Unless it is integrated with a health plan, an ACO does not set fee schedules or process claims from other providers – that remains the responsibility of MassHealth and our MCOs

**Which providers can be an ACO**
- At minimum, an ACO must include primary care providers (PCPs)
- Hospitals, specialists, BH, LTSS and social service providers may join or partner with ACOs
- ACOs must have partnerships with certified community based BH and LTSS providers
- ACOs must meet other criteria (e.g., minimum number of members, risk bearing capability)

**How do ACOs and Managed Care Organizations (MCOs) fit together**
- MCOs have an important role in implementing ACO models
- MCOs remain the insurer, pay claims, and work with ACOs to improve care delivery and support integration of care
- MCOs also support providers to build provider capacity, including providing analytics for population health management
Who is eligible

- Members for whom MassHealth is the primary payer
- Does not include members where Medicare or a private insurer is the primary payer
- At this time, non-dual HCBS\(^1\) waiver populations are eligible to enroll in an ACO, but HCBS waiver services will continue to be provided outside of ACO scope and budgets
- Includes adults, youth/children, members with BH and/or LTSS needs

There are three ACO models (not a one size fits all model)

- Model A: Integrated entity that includes both the ACO provider and health plan (MCO)
- Model B: ACO providers who contract directly with MassHealth, which remains the insurer
- Model C: ACO providers who contract directly with health plans (MCOs)

Members choose an ACO based on PCP selection

- Members directly enroll in Model A and Model B ACOs based on their selection of PCP
- For Model C, members enroll in an MCO and choose an ACO based on their selection of PCP
- For members whose PCP is not in an ACO, members will still have MCO and PCCP options

ACO models have the same set of benefits as the broader MCO program; ACOs and MCOs may invest in additional care coordination or services to engage members

In addition, we want to ensure quality access to care for individuals with disabilities

- ACO and MCO contracts will focus more directly on accommodations for MassHealth members with disabilities, including provision of accessible medical and diagnostic equipment
- DSRIP funding may be available to support related enhancements

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\(^1\) Home and Community Based Services
MassHealth ACO models: how does the payment model work?

- **ACOs have total cost of care accountability for the following areas:**
  - All managed care eligible spend (physical health + behavioral health)
  - LTSS: Year 1 reporting only; Year 2 and on some accountability phases in
  - At this time, HCBS waiver services continue to be provided outside of ACO scope and budgets
  - Total cost of care is risk-adjusted (UMass Medical School is developing a risk adjustment model that incorporates some of the social determinants of health)
  - Separate “rating category” or adjustor for Serious Mental Illness (SMI)

- **Who is paying claims**
  - Model A: the MCO that is part of the integrated ACO/MCO entity
  - Model B: MassHealth and MBHP pay claims to providers in the MassHealth and MBHP network
  - Model C: MCOs pay claims to providers in their networks
  - ACOs are not responsible for paying claims and authorizing LTSS services (exceptions in future years, if the ACO is integrated with an MCO qualified to cover LTSS)

- **Payments for ACOs are linked to performance on quality metrics across multiple domains**
  - We will also measure quality and access of care specifically for members with disabilities (e.g., for ID/DD members, individuals with physical disabilities)

- **In addition, we will increase member protections to ensure right care from the right providers**
  - Members in ACO models will have access to an ombudsman and advocacy resource
  - Members with LTSS needs in ACO models will be able to access an LTSS Community Partner (CP – see later in document for detail) as an independent advocate and resource counselor
MassHealth ACO models: 3 types of ACO models

**Model A: Integrated ACO/MCO model**
- Fully integrated: an ACO joins with an MCO to provide full range of services
- Risk-adjusted, prospective capitation rate
- ACO/MCO entity takes on full insurance risk

**Model B: Direct to ACO model**
- ACO provider contracts directly with MassHealth for overall cost/quality
- Based on MassHealth/MBHP provider network
- ACO may have provider partnerships for referrals and care coordination
- Advanced model with two-sided performance (not insurance) risk

**Model C: MCO-administered ACO model**
- ACOs contract and work with MCOs
- MCOs play larger role to support population health management
- Various levels of risk; all include two-sided performance (not insurance) risk

*Increasing levels of sophistication, care coordination, and DSRIP $s*
Community Partners (CPs) and linkages to social services

Goals:
- Encourage ACOs to “buy” BH/ LTSS care management expertise from existing community-based organizations vs. “build”
- Invest in infrastructure and capacity to overcome fragmentation amongst community-based organizations

Who can be a BH or LTSS Community Partners
- The State certifies BH and LTSS CPs
- Criteria include expertise in care coordination and assessments and infrastructure/ capacity
- CPs can be providers but self-referrals monitored
- LTSS CPs must demonstrate expertise across multiple populations with disabilities

How it works
- Certified CPs and ACOs both get direct DSRIP funding
  - Funding for both is contingent on ACOs and CPs formalizing arrangements for how they work together
- Portion of ACO funding designated for “flexible services” to address social determinants
- MCOs may provide support to Model A and Model C ACOs for integrating with BH and LTSS CPs

DSRIP $ Given to the ACO but designated for flexible services to address social determinants of health

DSRIP $ Contingent on the ACO and CP formalizing a partnership

DSRIP $ Certified BH Community Partner (SMI, SED, SUD)

DSRIP $ Certified LTSS Community Partner

DSRIP $ Other BH providers

DSRIP $ Other LTSS providers

Social service providers – (ranging from housing stabilization/ supports, nutrition and utility assistance to child care)

SMI = Serious Mental Illness, SED= Serious Emotional Disturbance, SUD = Substance Use Disorder
Partnering with Managed Care Organizations (MCOs) for delivery system reform

- MCOs have a significant role in administering the ACO program
  - In most cases when a member enrolls in an ACO, MCOs remain the insurer
  - MCOs may integrate with ACOs for Model A (may also support ACOs in Model B)

- For Models A and C, MCOs will be explicitly responsible for working with ACO providers (or integrating as an entity) to improve care delivery

- We are partnering with MCOs to support ACO providers in improving care
  - Upcoming repProcurement will include expectations for MCOs to contract with ACOs
  - MCOs help determine which care management functions best done at the provider vs. at the MCO level
  - MCOs also support providers in making the shift to accountable care (including analytics for population management)
  - MCOs may also help ACOs determine how best to integrate BH and LTSS CPs into care teams

- In addition, we will expand a One Care-like model into the non-Duals MCO program in future years (One Care is an integrated care demonstration for Duals)
  - Improves integration of LTSS and other services, like DME and transportation, into the physical and BH managed care benefit
DSRIP: summary of investments

- **$1.5B of upfront investments** (as part of the 1115 waiver renewal) to support delivery system restructuring
  - State commits to annual targets for performance improvement over 5 years (reduction in total cost of care trend, reduction in avoidable utilization, improvement in quality metrics)
  - Access to new funding contingent on providers partnering to better integrate care

- ACO transition + social determinants
  - Contingent on ACO adoption
  - Funding based on lives covered
  - Must meet annual milestones or metrics
  - Funding to invest in certain defined, currently non-reimbursed “flexible services” to address social determinants

- Certified BH and LTSS Community Partners
  - State certifies BH and LTSS Community Partners to develop scaled infrastructure and capacity
  - ACOs incented to partner with existing community resources (i.e. buy not build)
  - Direct funding available to CPs under a performance accountability framework

- Statewide investments*
  - Health care workforce development and training
  - Targeted technical assistance for providers
  - Improved accommodations for people with disabilities
  - Other state priorities, including Emergency Department (ED) boarding

*Subject to final 1115 waiver approval
DSRIP: in order to receive DSRIP from CMS, MA must commit to targets for quality and bending the cost curve

- State accountability to CMS for DSRIP funds also dependent on reduction in avoidable utilization and quality
- Quality domains include chronic disease management, BH/LTSS, and patient experience
We are also working to expand Substance Use Disorder (SUD) treatment

Context
- 1,099 people died from opioid overdoses in Massachusetts in 2014 (65% increase over 2012)
- ~75% were enrolled in MassHealth at the time of death
- Our current SUD treatment system spans the American Society of Addiction Medicine (ASAM) continuum of services
- However, many gaps remain for MassHealth members, especially for step-down and residential – results in members cycle repeatedly through detoxification programs.

1115 waiver: what we have proposed to CMS
- Proposal: expand access to SUD treatment, particularly for members who require residential treatment services, recovery coaching and care coordination
  - Federal Financial Participation generated on current Bureau of Substance Abuse Services (BSAS) services for MassHealth members funds a significant expansion for SUD treatment across the continuum of care
- For all Medicaid eligible members:
  - Expand SUD benefit to include Transitional Support Services (TSS) and Residential Rehabilitation Services (RRS)
  - Cover up to 90 days of medically necessary residential treatment (based on ASAM assessment)
- For Members with FFS coverage:
  - Expand SUD benefit to include enhanced acute treatment services for dually-diagnosed members and Structured Outpatient Addiction Programs
  - These services are currently available only to members enrolled in managed care plans
- Expand access to care coordination, supportive case management and recovery support services throughout the system, and extend availability of services into recovery
- Negotiations with CMS are ongoing and positive
In addition, we have a number of other important initiatives underway

**Strengthen program integrity in LTSS**
- We have strengthened LTSS program integrity – home health example:
  - Home health spending grew last year by $170M, or 41%
  - Over 80% of growth driven by providers new to the Commonwealth since 2013
  - We have referred 12 providers to the Attorney General’s office for fraud
  - Actions: moratorium on new home health providers; clinical prior authorizations in place for home health services

**We will be implementing independent, conflict-free clinical assessments**
- Ensure members receive a conflict-free assessment of their full set of needs and that individuals have access to a full range of services, not just a service from the agency that assessed the individual

**Encourage enrollment in managed and accountable care**
- We will present members with options and incentives to choose to enroll in high quality, integrated MCO and ACO programs (effective October 2017)
  - All benefits available to all members under MCO and ACO programs
  - PCC plan will have fewer optional benefits (e.g., physical therapy, chiropractor)
- We will be encouraging enrollment in Senior Care Options, One Care and PACE programs to better integrate care
  - Active member outreach and engagement efforts about the benefits of these plans
  - Passive enrollment for SCO (late FY2017) and One Care with opt-out
- We will move to annual open enrollment windows for the MCO program (Oct. 2016)
  - Similar to commercial/ Connector plans (90 day opt-out, provisions to switch plans)

**Improve customer service and operations**
- Made significant improvements to the eligibility system and completed 1.2 million outstanding eligibility redeterminations as required by the federal government
- Improved website/ consumer functionality and member satisfaction (+8%)
- Reduced call center wait times and improved support for health centers and providers
- Developing comprehensive enrollment materials/ trainings to support choice
Timelines

Public listening session
- April 20th, 9-11a (1 Ashburton Place, 21st Floor, Boston)
- Written comments may be submitted through the end of April at MassHealth.Innovations@State.MA.US
- Comments beyond the end of April can be provided through the formal public comment process (see below)

1115 waiver proposal timelines
- May: **1115 waiver proposal posted** for 30 day public comment period, including 2 public hearings (dates and locations TBD)
- June: **1115 waiver proposal submitted** to CMS
- The waiver proposal for CMS will focus on:
  - Authorities required for ACO models
  - DSRIP uses and financing
  - Safety Net Care Pool structure and financing
  - Expansion of treatment continuum for Substance Use Disorder
- The waiver proposal does not include operational details for ACO and Community Partner models

Implementation timelines
- Advanced ACO pilot: solicitation spring 2016, launch December 2016
- DSRIP funding begins FY18
- Community Partners launch early FY18
- Full ACO models: solicitation summer 2016, roll-out October 2017
- MCO reprocurement effective October 2017 (sequenced after ACO procurement)