MassHealth 1115 Waiver Hearing

Executive Office of Health & Human Services

June 24, 2016

Agenda

- **Presentation on 1115 Waiver Proposal** — **EOHHS/MassHealth**

- Comments and Discussion — Medical Care Advisory Committee
  Payment Policy Advisory Board

- Comments — General Public

MassHealth 1115 waiver demonstration and restructuring summary

- **We must renegotiate the federal 1115 MassHealth waiver including $1B of safety net care pool funding that expires on June 30, 2017**

- **We are committed to a sustainable, robust MassHealth program for 1.8M members**
  - Unsustainable growth, now almost 40% ($15B+) of the Commonwealth's budget
  - Opportunity to bring in significant federal investment to support health care delivery system reforms

- **The new waiver proposal covers a 5-year period from July 2017 – June 2022**
  - Authority to restructure toward Accountable Care Organization (ACO) models and strengthen integration with behavioral health and long term services and supports
  - $1.8 billion over 5 years of upfront investment (DSRIP) to support transition toward ACO models
    - Includes direct funding for community-based providers of behavioral health (BH) and long term services and supports (LTSS)
  - ~$6.2 billion over 5 years ($1.2 billion per year) of Safety Net Care Pool funding in addition to DSRIP
  - Expansion of MassHealth-covered services for Substance Use Disorders (SUD)
  - Additional changes to support the overall goals of MassHealth restructuring

1115 waiver demonstration goals

1. **Accountable Care:** enact payment and delivery system reforms that promote **member-driven, integrated, coordinated care** and hold **providers accountable for the quality and total cost of care**

2. **Improve integration among physical health, behavioral health, long-term services and supports, and health-related social services**

3. **Maintain near-universal coverage**

4. **Sustainably support safety net providers to ensure continued access to care** for Medicaid and low-income uninsured individuals

5. **Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services**

1 MassHealth restructuring: moving away from fee-for-service care

- **Restructuring MassHealth for a robust, sustainable program**
  - Fundamental structure of MassHealth program has not changed in 20 years
  - Current fee-for-service payment model for providers results in fragmented care at unsustainable cost

- **Not a one-size-fits-all approach**
  - Different ACO model options that reflect the range of provider capabilities

- **Leverages MCO partnerships**
  - MCOs will work with MassHealth to implement ACO contracts/other value-based payments
  - Will partner directly with ACOs to deliver coordinated care

- **Care integration – with explicit focus and expectations to strengthen BH system and improve integration of BH and LTSS**
  - ACOs will be required to work with Community Partners to provide community-based, expert management of care for members with complex BH and LTSS needs

- **Member-focused care**
  - Eligible members will be able to choose amongst available MCOs and ACOs, based on the primary care provider or other care relationship that matters most to them
  - ACOs and MCOs will be measured and held accountable to member satisfaction and quality scores

1 MassHealth restructuring: overview of accountable care models

- **ACOs are provider-led organizations that are held contractually responsible for the *value* - quality, coordination, integration and total cost of members' care – rather than *volume* of care**
- **3 ACO model designs** reflect a range of provider capabilities
- All models include strong **care delivery and integration standards, member protections** including appeals to ensure access and quality, and expectations for **linguistically and culturally appropriate care**

Model A:
Integrated ACO/MCO

- Fully integrated: ACO joins with MCO to provide full range of services
- Includes admin (e.g., claims payment) and care delivery & coordination
- ACO/MCO receives a prospective capitation payment and is at full risk

Model B :
Direct to ACO

- ACO provider contracts directly with MassHealth
- Full MassHealth/ MBHP provider network, but ACO may have preferred provider relationships
- ACO accountable for total cost/quality and integration of care
- MassHealth/MBHP pay claims up-front, retrospective reconciliation with ACO for total cost of care

Model C :
MCO-administered ACO

- ACOs contract and work with MCOs
- MCOs play larger role to support population health management
- MCO pays claims, contracts provider network
- ACO accountable for total cost/quality and integration of care, with varying levels of risk (all levels include two-sided performance risk)

1 DSRIP investments to support ACO transitions and BH/LTSS Community Partners

- **$1.8B 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

DSRIP investment

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

2 Integrating physical and behavioral health (BH), long-term services and supports (LTSS) and health-related social services

- **Current health care system is siloed, resulting in fragmented care**
  - Physical and BH systems operate largely separately
  - Physical/BH providers have limited experience with LTSS and social services
  - Providers vary widely in competency to support needs of individuals with disabilities
  - Individuals, including those with complex needs, must navigate across systems, sometimes with overlapping care coordinators but no single point of integration

- **A major focus of MassHealth's restructuring approach and an explicit goal of this waiver demonstration is the integration of care** across physical health, BH, LTSS and supports and health-related social services
  - Creating a BH system that improves outcomes, experience and coordination of care, including for members with complex needs (e.g., SMI, dual diagnoses, SUD)
  - Integration of LTSS, including phasing LTSS into ACO and MCO accountability over time, following One Care model
  - Improving accommodations and competency to support individuals with disabilities
  - Strengthening linkages with health related social services

- **Unique program of certified BH and LTSS Community Partners with formal linkages to ACOs to integrate care for members with range of needs**
  - ACOs and Community Partners required to establish formal partnerships
  - MassHealth will specify explicit standards for care integration, including interdisciplinary care team approach for complex members, while encouraging innovation
  - Community Partners receive distinct stream of DSRIP funds

34 Safety Net Care Pool (SNCP) redesign

SNCP Overview

- Established to reduce the percentage of people in Massachusetts who lacked insurance
- Provides funding to deliver residual uncompensated care, infrastructure expenditures and access to state health programs
- Current SNCP structure approved through June 30, 2017 to allow for the development and transition to a new SNCP structure

Goals of SNCP Redesign

- Align framework with proposed delivery system reforms
- Restructured and new payments should be linked to providers' performance on ACO models
- Safety net providers are focused on the same goals as the overall delivery system

SNCP Structure	Annual (avg)	5 yr total	
DSRIP	$360M	$1.8B	
Uncompensated Care/Safety Net Providers	$1.06B	$5.3B	**$1.2B/ yr; $6.2B over 5 years**
Public Hospital (subset of above)	$320M	$1.6B	
ConnectorCare affordability wrap	$170M	$860B	
Total	**$1.59B**	**$8B**	

34 Safety Net Care Pool (SNCP) redesign: additional detail

Delivery System Reform Incentive Pools

- DSRIP ($360M/year; $1.8B over 5 years)
  - Investment for ACO participants to implement delivery system reforms
- PHTII
  - Incentive-based program for Cambridge Health Alliance
  - Focus on DSRIP accountability and strengthening outcomes under current framework

Payments for Uncompensated Care ($1.06B/yr; $5.3B over 5 years)

- Uncompensated care (includes DSH and UCC pools)
  - Proposal to claim expenditures for uncompensated care above and beyond current DSH limits
- Safety Net Provider Payments
  - Restructured supplemental payments to 11 safety net hospitals who qualify based on payer mix and level of uncompensated care provided
  - Payments are not time-limited and tied to DSRIP accountability measures
- Public Hospital Global Budget Initiative for the uninsured
  - Cambridge Health Alliance will manage care for the uninsured within a budget and improve care for this population

ConnectorCare Affordability Wrap ($170M/yr; $860M over 5 years)

- Currently receive federal matching dollars for premium assistance
- Request to include federal match for cost sharing subsidies

5 Expansion of Substance Use Disorder (SUD) treatment

Context

- 1,099 people died from opioid overdoses in Massachusetts in 2014 (65% increase over 2012)
- Current SUD treatment system spans the American Society of Addiction Medicine (ASAM) continuum of services
- Many gaps remain for MassHealth members – results in members cycle repeatedly through detoxification programs

Waiver proposal to expand MassHealth SUD coverage to address the opioid crisis

- Expanded MassHealth benefits to include the full continuum of medically necessary 24-hour community-based rehabilitation services
  - MassHealth currently covers Acute Treatment Services (ATS or detoxification services) Clinical Stabilization Services (CSS), Enhanced Transitional Support Services (ETSS)
  - Expanded benefit will include Transitional Support Services (TSS) and Residential Rehabilitation Services (RRS) (ASAM levels 3.1 and 3.3)
- Capacity will expand by nearly 400 beds in FY17, and over 450 additional beds in FY18
- Members with SUD will receive care management and recovery support services, including support navigators and recovery coaches
- Adopt a standardized ASAM assessment across all providers

Additional Changes

- Support integration of LTSS by **phasing in accountability for long term services and supports** (LTSS) in ACO and MCO programs
  - Follow One Care model (e.g., person-centered, focus on independent living in community settings, culturally competent)
  - Ensure ACOs/MCOs demonstrate competency and strong community partnerships
- **Flexibility to use ICB grant funding** to support pilot ACOs before DSRIP starts, in addition to ICB grants for hospitals and community health centers
- Make certain **changes to encourage enrollment in and support the success of coordinated care models** (ACOs and MCOs)
  - Certain benefits no longer available/more limited in PCC Plan (e.g., chiropractic services, orthotics, eye glasses, and hearing aids)
  - Differential cost sharing between PCC Plan vs ACOs/MCOs
  - 12 month enrollment periods in ACOs/MCOs with appropriate exceptions
  - Members may switch from PCC to ACO or MCO at any time
- **Establish premium assistance program for students to enroll in student health insurance plans (SHIP)** with cost sharing/benefit wrap when cost effective
- **Expand authority for MassHealth CommonHealth eligibility beyond age 65** for working disabled adults who were determined eligible for CommonHealth before turning 65

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Timelines

Public listening sessions

- **Friday, June 24th, 2:30 – 4:00 pm** (1 Ashburton Place, 21st Floor, Boston)
- **Monday, June 27th, 2:00 – 3:30 pm** (Fitchburg Public Library, Fitchburg MA)
- Communication Access Realtime Translation (CART) services and American Sign Language (ASL) interpretation will be available at both meetings

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1115 waiver proposal timelines

- **June 15 – July 17**: 1115 waiver proposal posted for 30 day public comment period
  - Proposal can be found at: http://www.mass.gov/hhs/masshealth-innovations or picked up in person at 1 Ashburton Place, 11th Floor, Boston
  - Written comments may be submitted through July 17 at MassHealth.Innovations@State.MA.US
- **Mid-July**: 1115 waiver proposal submitted to CMS

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)