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**MassHealth 1115 Hearing**

**Executive Office of Health and Human Services**

**June 24, 2016**

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**Agenda**

Presentation on 1115 Waiver Proposal EOHHS/MassHealth

Comments and Discussion

 -Medical Care Advisory Committee

-Payment Policy Advisory Board

Comments

-General Public

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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

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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

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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

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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)

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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 Investments will be used in the following three areas:

1. ACO transition and 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
1. 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
1. 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

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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

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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**

For DSRIP, the annual average spend will be $360M and the 5 year total will be $1.8B

For the Uncompensated Care/Safety Net Providers, the annual average spend will be $1.06B and the 5 year total will be $5.3B.

For Public Hospital (subset of above), the annual average spend will be $320M and the 5 year total will be $1.6B.

For ConnectorCare affordability wrap, the annual average spend will be $170M and the 5 year total will be $860B.

The total annual average will be $1.59B and the 5 year total will be $8B.

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Safety New 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

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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

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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)** withcost 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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**Agenda**

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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

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)