MassHealth 1115 Demonstration: Strategy for 2022 Extension

July 2021

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- This meeting is open to the public
- You are welcome to share comments or questions using the “Chat” feature.
- For the first portion of the Listening Session, your cameras and participation will be disabled. Please hold your questions and comments until the facilitator opens the meeting for participation.
- For the second portion, we will open up for comments and questions. If you would like to speak, **please use the “Raise Hand” feature** to alert the facilitator, who will call on you. Be sure to share your name and organization, if applicable
- Please mute yourself when not speaking, and please be aware that your background is visible when your camera is on
- Please limit your comments to **no more than 2 minutes**.
- We have **CART** and **Spanish interpretation** available
- For IT issues, questions about using CART for today’s session, questions about interpretation, or for feedback on session logistics, please use the chat feature to message us, or email Alysa St. Charles (Alysa.StCharles@umassmed.edu)
- Slides will be posted after the meeting concludes.

Executive Summary

MassHealth's current 1115 demonstration (2017-2022) was designed to **restructure the delivery system toward integrated, value-based and accountable care.**

Key features of MassHealth's current 1115 demonstration include:

- Over 1 million members (>80% of eligible population) are enrolled in accountable care organizations (ACOs) that are paid for **better health outcomes, lower cost, and improved member experience**
- Top 50,000 (~5%) highest-risk members receive **enhanced care coordination** from certified community-based organizations called **Community Partners**
- Supported by **$1.8 billion Delivery System Reform Incentive Program** that expires in 2022
- Authorities, including expanded **eligibility**, **substance use disorder services**, state subsidies for **lower-income Marketplace enrollees**, and funding for **safety net providers**

In its proposal to be submitted to CMS in October/November, MassHealth will seek approval for a renewed 1115 demonstration that:

1) Continues the path of restructuring and reaffirms **accountable, value-based care**
2) Makes reforms and investments in **primary care, behavioral health and pediatric care**
3) **Advances health equity**, with a focus on initiatives addressing health-related social needs and specific disparities, including maternal health and health care for justice-involved individuals
4) **Streamlines the MassHealth delivery system** for members and providers
5) Sustainably supports the Commonwealth's **safety net** and maintains **near-universal coverage**

MassHealth 1115 Demonstration: Strategy for 2022 Extension

0. Overview
1. Continue the path of restructuring and reaffirm accountable, value-based care
2. Make reforms and investments in primary care, behavioral health and pediatric care
3. Advance health equity
4. Streamline the MassHealth delivery system for members and providers
5. Sustainably support the Commonwealth's safety net and maintain near-universal coverage

MassHealth's 1115 Demonstration, 2017-2022: Goals and key reforms

MassHealth's current 1115 demonstration (2017-2022) was designed to **restructure the delivery system toward integrated, value-based and accountable care**.

Goals of current demonstration

- Enact **payment and delivery system reforms** that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care
- **Improve integration** of physical, behavioral health and long-term services
- **Address the opioid addiction crisis** by expanding access to a broad spectrum of recovery-oriented substance use disorder (SUD) services
- Sustainably **support safety net providers** to ensure continued access to care for Medicaid and low-income uninsured individuals

Key reforms

- Significant re-structuring of MassHealth delivery system:
  - Launched **MassHealth ACO program** in 2018 with accountability for cost, quality, and member experience
  - 17 of the state's biggest provider systems became ACOs, enrolled >80% of eligible members
- Unprecedented partnership across delivery system silos:
  - Created **Behavioral Health and Long-Term Services & Supports Community Partners (CP)** program in 2018 to provide enhanced care coordination for highest risk members
  - Launched **Flexible Services** program in 2020 to provide targeted housing- and nutrition-related supports
- **Expanded SUD treatment benefit** and added new beds, recovery coach benefit, other investments
- Established **sustainable safety net hospital funding structure** tied to ACO performance and preserved **near-universal coverage**

MassHealth's 1115 Demonstration, 2017-2022: Progress and opportunities

Key examples of progress *(early indicators)*

- **ACOs are strengthening member connection to primary care**. PCP visits increased 2% from 2018-2019, and were 12% higher for ACOs than non-ACOs
- **ACOs are reducing preventable acute utilization.** Reduced avoidable admissions by 11% from 2018-2019
- **ACOs are improving clinical quality.** Scores were high and increased in 2018-2019 on a significant majority of measures
- **ACO care coordination programs funded by DSRIP are working.** Seventy percent of these programs have improved outcomes in the first two years
- **CPs are succeeding at engaging the hardest-to-reach members.** CPs have actively engaged ~20k members, with promising early impacts
- Implemented risk-adjustment methodology that **accounts for social complexity/risk in ACO rates**
- **Through the Flexible Services program,** ACOs partner with social service organizations to provide housing and nutritional supports aimed at improving health outcomes and/or reducing health care costs

Major opportunities *(only some require new waiver authority)*

- **Delivery system reform** can go further:
  - PCPs within ACOs are mostly still **reimbursed fee-for-service,** not funded for team-based, integrated care
  - Certain **behavioral health services and delivery models** require significant investment and reform
  - Elements of the program need to be **standardized & simplified**
  - The unique needs of **children, youth, and families** require further focused attention
- **Health inequities and disparities** highlight long-standing, systemic racism that further reforms and MassHealth work must address, including:
  - Black MassHealth members' maternal morbidity rate is >1.8x higher than white members
  - Hispanic and non-Hispanic Black MA residents have asthma hospitalization rates 3.5x higher than non-Hispanic White residents

MassHealth's 2022 Demonstration extension: Goals

MassHealth has identified five goals for the next 1115 demonstration:

1. **Continue the path of restructuring and reaffirm accountable, value-based care** – increasing expectations for how ACOs improve care and trend management, and refining the model
2. Make reforms and investments in **primary care, behavioral health, and pediatric care** that expand access and move the delivery system away from siloed, fee-for-service health care
3. **Advance health equity,** with a focus on initiatives **addressing health-related social needs** and specific disparities, including **maternal health** and health care for **justice-involved** individuals
4. **Streamline the MassHealth delivery system for members and providers** by standardizing **behavioral health** networks and **pharmacy** formularies, and by simplifying and streamlining **care coordination**
5. **Sustainably support the Commonwealth's safety net and maintain near-universal coverage** – including level, predictable funding for safety net providers, with a continued linkage to accountable care, and updates to eligibility policies to support coverage and equity

1115 Extension Strategies

MassHealth's 1115 extension is critical to achieving the Commonwealth's goals, through the following strategies:

1

Continue the path of restructuring and reaffirm accountable, value-based care

- Re-procure and refine the ACO program, maintaining the same core pillars and requirements, holding ACOs accountable for high quality care, while implementing improvements based on lessons learned.
- Re-procure the Behavioral Health and Long-Term Services and Supports Community Partners (CP) program, while transitioning the program to sustainable financing and a more accountable structure.
- Scale successful programs by transitioning ~80% of DSRIP funding to ongoing base funding for whole person primary care and care coordination (e.g., supports for members with disabilities, embedded community health workers & peers in primary care practices, CP program).
- Expand the Community Supports Program (CSP, CSP-CHI [formerly known as CSPECH]) benefits to further support members with behavioral health needs who are experiencing or at risk of homelessness.
- Continue and make enhancements to the Flexible Services Program to provide evidence-based supports for members with nutritional and housing supports needs.

1115 Extension Strategies

MassHealth's 1115 extension is critical to achieving the Commonwealth's goals, through the following strategies:

2

Make reforms and investments in primary care, behavioral health and pediatric care

- Invest $115M per year in primary care through a new payment model that supports enhanced care delivery expectations (e.g., behavioral health integration) and more flexibility.
- Invest $200M+ per year in expanding behavioral health access and integration as part of the *Roadmap for Behavioral Health Reform* (e.g., behavioral health urgent care, 24-7 mobile crisis intervention, newly designated Community Behavioral Health Centers).
- Improve behavioral health workforce capacity and diversity by expanding coverage for peers for both mental health and substance use disorder, and offer clinician recruitment & retention opportunities (e.g., loan repayment).
- Expand coverage for diversionary behavioral health services (e.g., Community Support Program, Structured Outpatient Addiction Program) to members in MassHealth fee-for-service (e.g., Duals)
- Implement enhanced clarity, expectations, and investments in care coordination for children. Tailor Flexible Services to better address the unique needs of families.

1115 Extension Strategies

MassHealth's 1115 extension is critical to achieving the Commonwealth's goals, through the following strategies:

3

Advance health equity, with a focus on health-related social needs, maternal health, and justice-involved populations

- Launch $500M initiative over 5 years for ACO-participating hospitals that make demonstrated progress in reducing health care disparities.
- Hold ACOs accountable for health equity measures (e.g., preventative dental care, maternal health), including stratification by race, ethnicity, language, disability status, sexual orientation, and gender identity.
- Provide MassHealth coverage for eligible individuals in jails and prisons and transition supports to improve health outcomes for justice-involved population pre/post release.
- Address racial and ethnic disparities in maternal health: 12-month postpartum eligibility regardless of immigration status, doula coverage, and increased supports for high-risk pregnancies.
- Strengthen coverage and care for members with disabilities: streamline access to CommonHealth, require collection and reporting of quality measures stratified by disability, and improve the LTSS CP program.
- Continue and refine first-of-its kind risk-adjustment approach for ACO rates that accounts for both medical and social needs.

1115 Extension Strategies

MassHealth's 1115 extension is critical to achieving the Commonwealth's goals, through the following strategies:

4

Streamline the MassHealth delivery system for members and providers

- Streamline the administration of the behavioral health benefit in areas such as provider credentialling/enrollment, utilization management, and networks, in order to make it easier for providers to participate in MassHealth and for members to find and keep treatment relationships with behavioral health providers
- Streamline care coordination to ensure members have a single accountable entity, including by:
  - Requiring ACOs to proactively identify and engage members with high/rising risk
  - Requiring ACOs to offer intensive supports when needed to address holistic needs, including behavioral health, long-term services and supports, and health related social needs
  - Strengthening the LTSS CP program for members with disabilities to have a consistent home for care coordination
- Implement a uniform pharmacy formulary and standardize 340B payment methodologies for retail drugs across delivery systems.
- Update CommonHealth eligibility requirements to streamline applicant & member experience and reduce eligibility system workarounds

1115 Extension Strategies

MassHealth's 1115 extension is critical to achieving the Commonwealth's goals, through the following strategies:

5

Sustainably support the Commonwealth's safety net and maintain near-universal coverage

- Extend Safety Net Provider Payments, and tie new funding for safety net hospitals to health equity
- Preserve $153M Safety Net Provider funding for current Group 1 hospitals while expanding Group 2 funding from $20M to $40M, with eligibility for nine additional hospitals.
- Most of the $100M+ annually in health equity incentives targeted toward ACO-participating, safety net hospitals
- Funding supported by extended hospital assessment; MassHealth will continue to work through the details of its safety net financing with stakeholders in advance of formal waiver submission
- Maintain current coverage expansions, including state insurance subsidies for the Health Connector for individuals up to 300% of FPL
- Make targeted updates that expand eligibility to maintain near-universal coverage and advance equity, including:
  - Streamline access to CommonHealth for disabled adults
  - Offer 3-month retroactive eligibility for pregnant individuals and children
  - Provide 12-month postpartum eligibility, regardless of immigration status
  - Implement continuous eligibility to reduce coverage disruptions for members who are homeless or post-release from jail or prison

1115 Extension Strategies: Details, Health Equity

MassHealth will address health disparities at a population-level, while also investing in ACOs and ACO-participating hospitals to report on, and to close, gaps in health disparities

Key health equity objectives for ACOs and ACO-participating hospitals

- **$500M initiative over 5 years for ACO-participating hospitals** that make demonstrated progress in reducing health care disparities
- **ACO quality payments** (% of TCOC) tied to health equity measures
- **Health equity measures** for these programs will include stratification by race, ethnicity, language, disability status, sexual orientation, and gender identity, using standardized data
- ACOs & ACO-participating hospitals accountable for **establishing infrastructure to address health disparities**, e.g., health equity committees, strategic plans, health equity and anti-racism staff trainings, better data collection
- Accountability will start with pay for reporting, and in later years of the demonstration **transition to pay for performance**

MassHealth strategies for addressing disparities in targeted populations

- For **justice-involved individuals**, maintain full coverage during incarceration to improve continuity of care and support transitions post-release
- Reduce racial/ethnic disparities in **maternal health**, including:
  - 12 months postpartum eligibility
  - adding coverage of doula services
  - enhanced care coordination for members with high-risk pregnancies, e.g., SUD, depression, diabetes, heart disease
- Strengthen coverage and care for **members with disabilities**, including:
  - Streamlining access to CommonHealth
  - Incentivizing collection of self-reported disability data for all members, stratifying quality measures by disability status
  - Strengthening LTSS CP program to provide single care coordination home

1115 Extension Strategies: Details, DSRIP Transition

MassHealth will scale successful programs by transitioning ~80% of DSRIP funding to sustainable base funding for whole person primary care and care coordination

Current waiver DSRIP is a one-time investment

- Flexible innovation funding to implement and test different population health initiatives
- DSRIP expires after the current five-year demonstration and cannot be renewed
- $1.8 billion total - average of $360 million per year
- Administratively complex for plans and providers
- Add-on per-member per-month funding

Proposed waiver funding will create sustainability for critical services

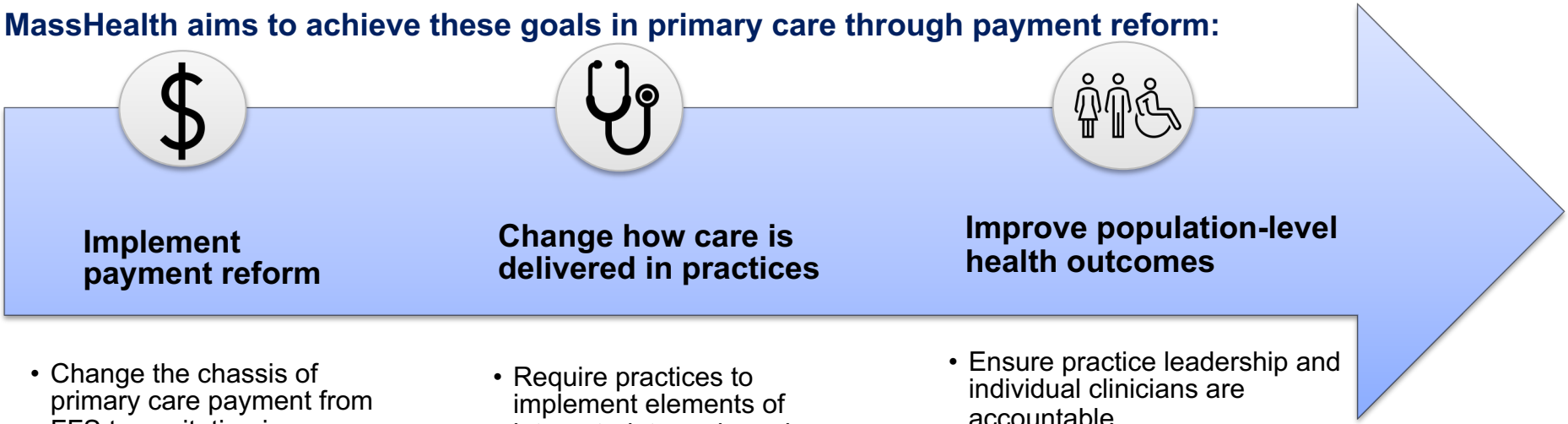
- Structured investments to implement proven programs
- Investments integrated into baseline medical and admin rates for a scalable, sustainable, and more streamlined administration – average of $290M / year, including:
  - Sustainable funding for Community Partners program
  - $115M investment in primary care services
  - Continuation of Flexible Services Program, with greater focus on child/family needs, and ongoing nutrition and tenancy supports

1115 Extension Strategies: Details, Primary Care

MassHealth will increase investment in primary care by $115M+ annually, implementing a sub-capitation payment model to change care delivery and improve population health

- **Increase flexibility for providers** by empowering them to deliver care in ways that most appropriately serve their patients while balancing administrative burden
- **Expand behavioral health integration and care coordination in primary care**, addressing both upstream prevention and facilitating effective, readily-accessible treatment for all members
- **Address the unique needs of children, youth, and families** by optimizing care models for family-centered approaches

MassHealth aims to achieve these goals in primary care through payment reform:



- Change the chassis of primary care payment from FFS to capitation in a way that meaningfully changes service delivery
- Incentivize population health and delivery system improvements

- Require practices to implement elements of integrated, team-based care, focused on outcomes
- Fundamentally change workflows to better serve patients and providers

- Ensure practice leadership and individual clinicians are accountable to and focused on population-level outcomes
- Payment and care delivery system improvements that catalyzes progress towards improved outcomes

1115 Extension Strategies: Details, Health-Related Social Needs (HRSNs)

MassHealth will continue the Flexible Services program, while making enhancements and improvements to its overall HRSN strategy

Flexible Services Program (FSP)	▪ MassHealth will **continue to refine FSP, taking** a data-driven, staged approach towards program evolution (e.g., moving towards more **standardized programs** based on evolving evidence) ▪ **Program Changes:** – Improving accessibility by removing certain in-person requirements – Targeting family-level need for nutritional supports – Providing child care that facilitates access to Flexible Service supports
Enhanced HRSN Care Coordination	▪ Increased ACO expectations to connect members with resources to address HRSNs (e.g., WIC referral; closed-loop referral for higher-risk members to ensure need is met, etc.) ▪ ACO requirements to identify and support children and youth with moderate to significant medical complexity, including addressing HRSNs ▪ New Targeted Case Management benefit for highly-complex kids, including addressing HRSNs
Housing Supports in the MassHealth Benefit	▪ Continue the successful Community Support Program (CSP) targeting chronically homeless members with behavioral health needs [CSP-CHI], and expand the program to serve additional homeless members who are high utilizers of health care services ▪ Add CSP benefit providing tenancy preservation services for members facing eviction due to behavioral health needs and disability

Timeline for MassHealth's 2022 Demonstration Extension

- **July 2021:** MassHealth posts policy overview document publicly, summarizing major anticipated components of 1115 demonstration extension
- **August/September 2021:** MassHealth posts formal 1115 demonstration extension document for public comment
- **October/November 2021:** 1115 demonstration extension formal submission to CMS
- **July 2022:** start of new 1115 demonstration period

All proposals included in this document are subject to CMS approval. However, certain policy initiatives included in this document support the 1115 proposals, but do not necessitate separate authority. Some authorities will be via the State Plan.

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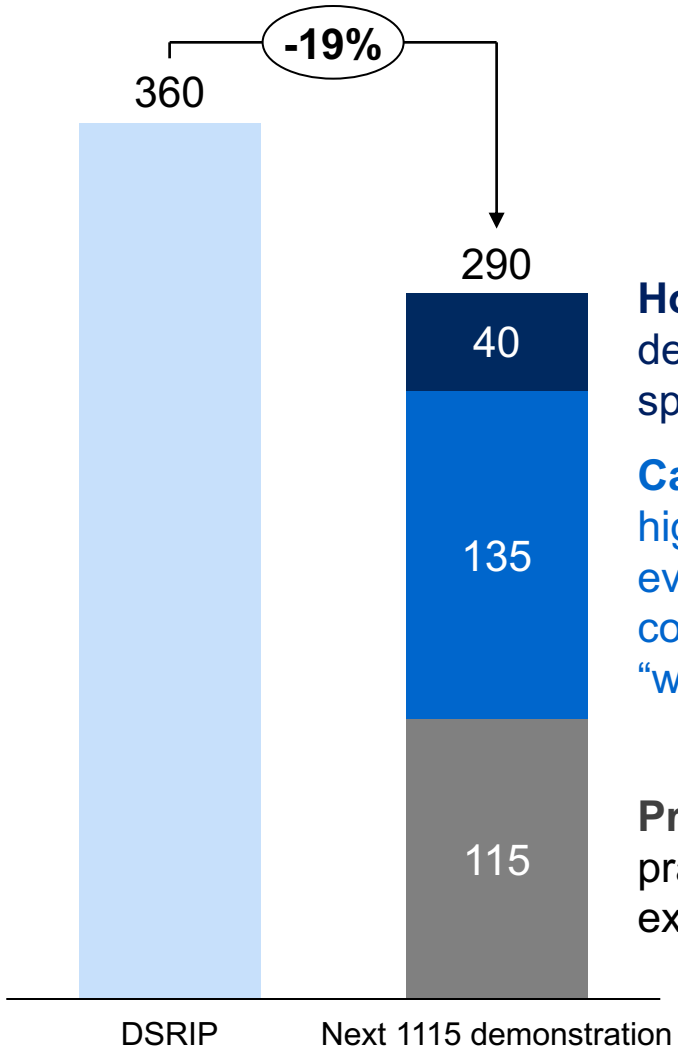
1 Continue the path of restructuring and reaffirm accountable, value-based care

- The current 1115 demonstration authorizes $360M per year in DSRIP funding to launch delivery system transformation efforts in 2017; DSRIP will end in FY22
- In the next 1115 demonstration period, MassHealth will dedicate $290M (~80% of current waiver) in sustainable funding for "what works" to support investments in
  - Advanced primary care
  - Proven care coordination supports for our most complex members
- In addition, EOHHS has committed to Invest $200M+ per year in expanding behavioral health access and integration as part of the *Roadmap for Behavioral Health Reform*

Delivery system investments ($M per yr.)



Housing & nutrition services: demonstrated to offset medical spend

Care management/pop. health: high-touch supports by ACOs and evolved CP program for most complex members based on "what works" in DSRIP

Primary care: sub-cap for PC practices that meet specific expectations and criteria

1 Continue the path of restructuring and reaffirm accountable, value-based care

The next 1115 demonstration sustainably funds DSRIP's demonstrated successes by scaling and strengthening them, by:

1) Investing **$115M per year in primary care**
   - ACOs have empowered primary care providers to coordinate care and manage population health in new ways with data, technology, and significant expansions of critical personnel like community health workers and peers
   - The next 1115 demonstration creates a primary care sub-capitation model, offering additional flexibility for providers and rewards outcomes
   - Investment will be tied to meeting enhanced care delivery expectations and implementing the new payment model

2) Engaging high- and rising-risk members with **enhanced supports that integrate care for the whole person,** supported by **$135M per year**
   - ACOs and CPs have implemented and tested programs providing supports for high-risk members, many of which have proven effective
   - The next 1115 demonstration establishes heightened requirements that ensure ACOs continue to work with CPs, while providing much-needed flexibility

1 Continue the path of restructuring and reaffirm accountable, value-based care

Accountable Care Organizations

- ACOs are health care organizations that are rewarded for **better health outcomes, lower cost, and improved member experience.**
- ACOs are responsible for achieving these results through **team-based care coordination** and integration of behavioral and physical health care.
- MassHealth members enrolled in an ACO select, or are assigned, a **specific primary care provider** and have **access to networks of specialty providers** (e.g., hospitals, specialists, behavioral health providers) that participate in their plan.
- There are **two primary ACO models**, both of which assume **upside and downside risk** and are financially accountable for specific **quality measures**.

Accountable Care Partnership Plan (Model A)

- A group of providers (ACO Partner) working with an MCO
- MCO establishes a network to provide covered services
- Receive a risk-adjusted, prospective capitation rate

Primary Care ACO (Model B)

- Provider-led ACO contracts directly with MassHealth
- Members access the MassHealth FFS provider network
- Providers are paid FFS, with the ACO held to a Total Cost of Care benchmark

1 Continue the path of restructuring and reaffirm accountable, value-based care

Accountable Care Organizations

Accountable care organizations have demonstrated early indicators of success, including improved connection to primary care, reductions of preventable acute utilization, improved clinical quality, and improvements in care coordination

- ACOs are accountable to a quality slate with 20 clinical measures and 2 member experience areas
- **ACO quality performance in 2019 was high,** with ACOs surpassing the attainment threshold on almost all measures (12/13 for finalized measures)[1]
- **Performance on quality measures improved between 2018 and 2019**, with 9/13 clinical quality measures increasing in score
- Member experience scores are determined via a survey of members with a range of ages and care needs. ACOs are accountable for performance on two member experience measures: **Overall care delivery** and **Integration/coordination of care**
- In 2019, ACOs surpassed the attainment threshold in both member experience domains
- In both 2018 and 2019 , members expressed **strong levels of satisfaction with their individual providers**, and the need for increased coordination or help managing behavioral health and other specialists and services

1. Five measures are subject to ongoing technical negotiations between MassHealth and CMS, with the goal ensuring accurate and scientifically sound measure calculation. Two measures still are undergoing data validation

1 Continue the path of restructuring and reaffirm accountable, value-based care

Accountable Care Organizations

- **Both Models A and B** are orienting the system towards value
  - **Model As** have additional tools and flexibility to innovate via payer abilities (e.g., value-based contracting, enhanced data, payer-provider integration)
  - **Model Bs,** without an MCO partner, are lower cost to administer, but have less flexibility to leverage payer abilities
- While both A and B have **similar cost and quality performance,** the total cost to the state is **higher for Model A** due to higher administrative payments
- MassHealth will **re-procure the Model A and B ACO programs**, increasing expectations for Model As on clinical integration with provider partners, and value-based payment, including leveraging their ability for innovation (e.g., required implementation of the primary care sub-capitation model, increased financial expectations for pharmacy efficiency, etc.)
- ACO rate-setting will continue to **adjust and account for both medical and social complexity**, leveraging the innovative Neighborhood Stress Score for risk-adjustment.
- **Model C will sunset**, as this model has been less effective at scaling up and has faced operational challenges

1 Continue the path of restructuring and reaffirm accountable, value-based care

ACOs are financially accountable for specific quality measures. In the next 1115 demonstration, MassHealth will continue to refine its ACO quality strategy

Guiding principles for design of the quality measure slate, as a whole

1) Design a representative measure slate that provides a holistic view of ACO performance
2) Prioritize health outcomes, including measures sourced from clinical and patient-reported data
3) Include topics and measures for which there are opportunities to promote health equity by race, ethnicity, language, disability status, and/or other social risk factors
4) Strive for parsimony; aim to minimize provider and member burden

Guiding principles for individual measure selection

5) Prioritize alignment with the Massachusetts Quality Measure Alignment Taskforce and the CMS Child and Adult Medicaid Core Sets
6) If critical measurement gaps remain, consider other nationally endorsed measures or other measures in use in MassHealth programs

1 Continue the path of restructuring and reaffirm accountable, value-based care

Proposed ACO Quality Slate: draft, and in development

Domain	Measure	Steward	NQF #
Preventive Care	Screening for Depression and Follow Up Plan	CMS	0418
	Health Related Social Needs Screening	EOHHS	N/A
	Immunization for Adolescents	NCQA	1407
	Childhood Immunization Status	NCQA	0038
	Topical Fluoride for Children at Elevated Caries Risk	ADA	2528
	Timeliness of Prenatal Care	NCQA	1517
	Postpartum Depression Screening and Follow-Up	NCQA	N/A
Care Coordination and Integration	Follow-up after Hospitalization for Mental Illness	NCQA	0576
	ED Visits for Individuals with Mental Illness, Addiction or Co-occurring Conditions	EOHHS	N/A
Care for Acute and Chronic Conditions	Controlling High Blood Pressure	NCQA	0018
	Comprehensive Diabetes Care: HBA1c Poor Control	NCQA	0059
	Asthma Medication Ratio	NCQA	1800
	Initiation and Engagement of Alcohol or Other Drug Abuse or Dependence Treatment	NCQA	0004
Health Equity	Health Equity: Race, Ethnicity, and Language Stratification	MA QATF	N/A
Member Experience	Care Coordination	AHRQ	N/A
	Person-Centered Integrated Care	AHRQ	N/A

1 Continue the path of restructuring and reaffirm accountable, value-based care

Care coordination lessons from the Community Partners program (2018-2021):

Behavioral Health and Long-Term Services and Supports CPs are community-based entities focused on members with complex BH and/or LTSS needs, respectively. CPs partner with ACOs/MCOs, providers, and social services/community resources to support improved care delivery and member experience.

- The CP program has shown **promising early results**, although results vary considerably
  - CPs **vary in size, structure, sophistication, and integration with the ACOs**, with apparent implications for performance
  - The current CP **payment model focuses more on processes than outcomes**

- "**Many-to-many**" ACO-CP partnerships create complexity for members and providers, with variability in:
  - **Delineation of roles** between ACO/MCO and CP programs
  - **Communication/interoperability**

- CPs have been quite successful in addressing **health-related social needs,** but have encountered more needs than there are resources to connect members to
  - If first-order health-related social needs of members aren't met, it's difficult to engage members on clinical needs

1 Continue the path of restructuring and reaffirm accountable, value-based care

Evolving the Community Partners Program for MassHealth's next 1115 demonstration

MassHealth will reprocure the BH and LTSS CP programs, incorporating **increased expectations for CPs,** including serving as the lead care coordination home and demonstrating value to ACO's on cost and quality, likely resulting in **fewer entities and a simpler landscape of relationships**

- BH CPs will be **required to be** (or include as part of an integrated partnership) **Community Behavioral Health Centers (CBHCs)**[1], aligning the CP and CBHC programs and ensuring that members' treating provider and care coordination home are aligned where possible
- The LTSS CP program will expand, and will align with the BH CP program in providing whole-person coordination, requiring LTSS CPs to meet **higher standards for clinical staffing and capabilities**
- MassHealth will standardize and clarify the concrete supports CPs are intended to provide, while ensuring a strong role for these community-based entities in ACO/MCO-CP partnerships

1. CBHCs will be procured in 2021 as part of the Commonwealth's BH Roadmap

1 Continue the path of restructuring and reaffirm accountable, value-based care

Evolving the Community Partners Program for MassHealth's next 1115 demonstration

- **CPs will be contracted directly by ACOs/MCOs** (rather than the current structure in which MassHealth directly contracts with CPs), transitioning the CP program from a state-administered demonstration to a core part of the MassHealth program.
  - This new construct will allow MassHealth to make much-needed simplifications to the CP program
  - ACOs/MCOs will pay CPs via a simple, panel-based payment model that holds CPs **accountable for outcomes** while giving them much-needed **flexibility and revenue stability**
  - MassHealth will establish payment parameters that ACOs/MCOs must abide by in contracting with CPs, including a minimum payment rate and quality structure
  - ACOs/MCOs will have strong requirements and guardrails for CP partnership, including maintaining a minimum program enrollment volume, and ACOs/MCOs will be required to pay CPs at or above the default minimum rate set by MassHealth
- MassHealth will continue to play an important role in selecting, managing, and supporting CPs, including, for example, in quality and data reporting

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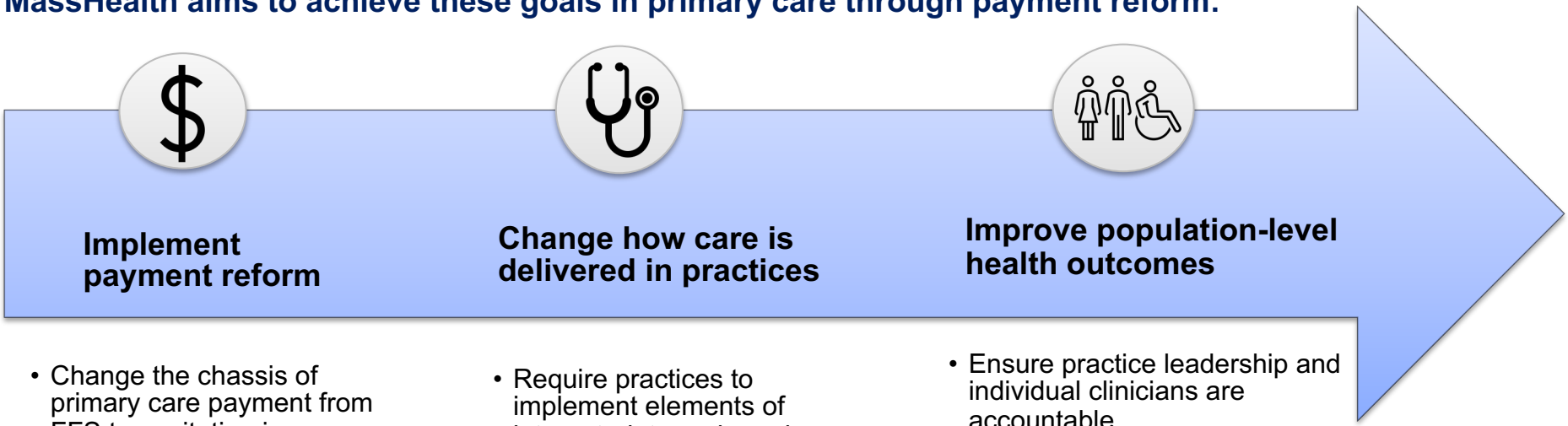
2 Make reforms and investments in primary care, behavioral health and pediatric care

MassHealth will meaningfully invest in and improve primary care

- **Increase flexibility for providers** by empowering them to deliver care in ways that most appropriately serve their patients while balancing administrative burden
- **Expand behavioral health integration and care coordination in primary care**, addressing both upstream prevention and facilitating effective, readily-accessible treatment for all members
- **Address the unique needs of children, youth, and families** by optimizing care models for family-centered approaches

MassHealth aims to achieve these goals in primary care through payment reform:



Implement payment reform

- Change the chassis of primary care payment from FFS to capitation in a way that meaningfully changes service delivery
- Incentivize population health and delivery system improvements

Change how care is delivered in practices

- Require practices to implement elements of integrated, team-based care, focused on outcomes
- Fundamentally change workflows to better serve patients and providers

Improve population-level health outcomes

- Ensure practice leadership and individual clinicians are accountable to and focused on population-level outcomes
- Payment and care delivery system improvements that catalyzes progress towards improved outcomes

2 Make reforms and investments in primary care, behavioral health and pediatric care

MassHealth will meaningfully invest in and improve primary care

MassHealth will implement primary care sub-capitation in the ACO program

- Through a **"tiered" sub-capitation, increased payment will be tied to enhanced care delivery requirements** to catalyze ongoing improvements in primary care
- The sub-capitation program will **move providers away from FFS incentives**, including by not conducting claims-based reconciliation on the sub-capitation
- MassHealth proposes a **three-tiered sub-capitation program**, with increasing care delivery expectations in each tier
- To enable broad program participation, the 'baseline' tier will be achievable for the market on January 1st, 2023, when new ACO contracts are anticipated

MassHealth's primary care sub-capitation program will include:

- ACOs and primary care practices will be held **accountable to the ACO Quality Slate**
- ACOs will pay primary care practices a **prospective, risk-adjusted PMPM**
- **Payments will increase by "tier,"** tied to increased care delivery expectations
- Providers will continue to submit claims, which will be zero-paid
- Sub-capitation payments will **not be reconciled to claims**

2 Make reforms and investments in primary care, behavioral health and pediatric care

MassHealth will meaningfully invest in and improve primary care

Requirements to participate in primary care sub-capitation program – To be eligible, practices must meet baseline expectations

- **Participate in the MassHealth ACO program**, and have meaningful practice-level accountability for quality and total cost of care
- **Shift from a FFS-based practice model to capitation** and a panel-based primary care model
- **Support robust access to high quality care**
- **Robust population health management and member engagement strategies**
- **Employ integrated, team-based care, including addressing HRSN, BH, and oral health, e.g.:**
  - Screening and referral for oral health, BH, and for health-related social needs
  - Fluoride varnish for kids

Expectations as practices advance "tiers" Practices are supported with increased $ for delivering more advanced primary care

- **Meet robust standards for BH integration, ability to manage mild-moderate BH in primary care**
  - Leverage roles such as peers, RN case managers, and BH clinicians
  - On-site access to BH treatment, including MAT, to manage mild-moderate BH conditions
- **Meet increasing standards of care for children, youth, and families, e.g.:**
  - Leverage family partners as part of care team
- **Demonstrated success and improvement on quality metrics**, including member experience

Increasing investment to support enhanced clinical service delivery

2 Make reforms and investments in primary care, behavioral health and pediatric care

Supporting the Commonwealth's Behavioral Health Roadmap

- The Baker-Polito Administration recently released its *Roadmap for Behavioral Health Reform*
  - The Roadmap is a multi-year blueprint, based on listening sessions and feedback from nearly 700 individuals, families, providers and other stakeholders who identified the need for expanded access to treatment, more effective treatment, and improved health equity. Key initiatives of the Roadmap are outlined on slide 33.
- While the Roadmap is a broad multi-year initiative, spanning beyond Medicaid, certain aspects of it will be supported by the 1115 demonstration, including:
  - Enhanced expectations for **integrating behavioral health in primary care**
  - Targeted investments in the **MassHealth behavioral health workforce**
  - **Expanding diversionary services** (e.g., CSP, SOAP) to members not enrolled in managed care, which primarily includes members who are dually eligible for Medicare and Medicaid
  - Extending **investments through existing SUD waiver and pending SMI/ IMD waiver**
- As part of the Roadmap's vision for addressing key **challenges driven by complexities** in the existing behavioral health care system, MassHealth will **streamline how ACOs administer the behavioral health benefit,** resulting in streamlining and improvements for:
  - Provider credentialling, enrollment, and participation
  - Members' experience of their available network
  - Implementation of coverage expansions and delivery system innovations envisioned in the Roadmap

2 Proposed Reforms through the Behavioral Health Roadmap

Structural Support for Access

Centralized Front Door to Treatment	An **easy way for anyone seeking behavioral health treatment to find and access the treatment** they need, through a central phone line
Access to Provider Networks & Services through Insurance	Strengthened **behavioral health provider networks** and **expanded behavioral health service coverage** in both MassHealth and private insurance
Administrative Simplification	**Dramatically simplified and standardized administrative processes** to reduce provider burden and make provider **participation in MassHealth/ insurance** easier
Workforce Competency	Targeted support to increase **competency and diversification** of clinical + non clinical workforce; **increase provider participation in insurance**, including MassHealth

Treatment Services

Integrated Primary Care	New payment models and incentives for **PCPs that integrate behavioral health treatment** to promote early intervention, increase access, and reduce siloes
Outpatient Treatment	**Community Behavioral Health Centers** with access to **real-time urgent care** and **evidence-based, integrated mental health and addiction treatment** for all ages
Urgent/ Crisis Treatment	**24/7 community crisis response to avoid** ED visits and hospitalization through 24/7 on-site and mobile crisis intervention; 24/7 **Crisis Stabilization for youth and adults**
Acute/24-hour Treatment	More inpatient psychiatric beds; **strengthens 24-hour substance use disorder treatment** to address co-occurring needs and better meet patient needs

2 Make reforms and investments in primary care, behavioral health and pediatric care

Enhancing focus and investment on children, youth, and families

Primary Care:

- As a requirement of participation in the sub-capitation model, practices must meet pediatric/adolescent-specific requirements (e.g., offering fluoride varnish, coordination with CBHI and schools, etc.)
- To qualify for higher "tiers" and earn associated investment, practices must meet more advanced requirements for pediatric/adolescent-specific expertise (e.g., staff competencies, BH offerings)

Care Coordination:

- Most youth will have their needs met in primary care, including coordination with CBHI; community-based, family-centered SSOs; education sector; and other state agencies
- For youth with some complexity/ rising risk, ACOs/MCOs will identify children with medical complexity and provide enhanced complex care management
- For youth who are the most complex, MassHealth will introduce **Targeted Case Management**, a new benefit that offers specialized care coordination. Targeted Case Management will be provided by selected academic medical centers and primary care providers, and is available across MassHealth delivery systems.

Health-Related Social Needs:

- ACOs will be required to target a portion of Flexible Services programming to children/youth
- Leveraging Flexible Services nutritional supports at a family, rather than member, level
- Applying Flexible Services to child care that facilitates access to approved nutritional and housing supports

Additional Flexible Services discussion on **slide 38**

MassHealth 1115 demonstration: strategy for 2022 extension

0 Overview

1 Continue the path of restructuring and reaffirm accountable, value-based care

2 Make reforms and investments in primary care, behavioral health and pediatric care

3 Advance health equity

4 Streamline the MassHealth delivery system for members and providers

5 Sustainably support the Commonwealth's safety net and maintain near-universal coverage

3 Advance health equity, with a focus on HRSN, maternal health, and justice-involved populations

MassHealth will offer incentives for ACOs and ACO-participating hospitals addressing health inequities to:

- **Implement activities essential for achieving health equity** including collection of standardized and comprehensive social risk factor data
- **Report on stratified health and health care performance indicators to identify disparities**
- **Meaningfully reduce disparities** during the demonstration period

These investments will enable ACOs and ACO-participating hospitals to work toward health equity by:[1]

- Establishing a **culture of equity** that recognizes and prioritizes the elimination of disparities through respect, fairness, cultural competency, and advocacy
- Maintaining **robust structures** to facilitate identification and understanding of disparities to support implementation of evidence-based interventions
- **Collaborating and partnering** with other sectors that influence the health of individuals
- Ensuring **equitable access** to healthcare
- Delivering **high-quality care** that continuously reduces disparities

[1] National Quality Forum. A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity. 2017.

3 Advance health equity, with a focus on HRSN, maternal health, and justice-involved populations

	Key Objectives for ACOs and ACO-participating Hospitals	Accountability over time
Activities	▪ Strengthen infrastructure to address health inequities and systemic racism, including through collection of member-reported data on race, ethnicity, language, and disability (RELD) and on sexual orientation and gender identity (SOGI)	▪ Majority of incentive in 2023, declining over time
Identification and Reporting	▪ Report on stratified health and health care performance indicators to identify disparities that need to be addressed	▪ Increasing accountability over 2024-2027
Performance	▪ Achieve meaningful reductions in identified and targeted disparities at the provider- and population-levels	

- **Significant ($100M annually) financial incentives** for ACO participating hospitals
- Aligned equity measures as part of **ACO quality slate and payment** (% of TCOC)

3 Advance health equity, with a focus on HRSN, maternal health, and justice-involved populations

MassHealth interventions addressing health-related social needs:

- **Continue the Flexible Services Program (FSP)**
  - FSP launch was delayed by 2 years and therefore does not have conclusive data, but is showing promising early results.
  - As programs demonstrate success, FSP can evolve to more **standardized programs** based on evidence
- As described as part of Specialized Care Coordination supports (slides 47-51), build on success of existing CSP-CHI by expanding the target population and incorporate **a new targeted, evidence-based housing support programs** for housing unstable members
  - **CSP-Homeless Individuals (CSP-HI):** Expand CSP-CHI and CSP-SIF models to include members with BH needs who are homeless and high utilizers of healthcare (new name reflects expanded target population)
  - **CSP-Tenancy Preservation Program:** Work with state housing agencies to expand existing successful homelessness prevention program – Tenancy Preservation Program – for members at risk of losing housing due to their disability/BH condition
  - See slide 39 for additional initiatives focusing on the homeless population
- **Expand on and raise expectations for HRSN Care Coordination**
  - ACOs will continue to be required to **annually screen their members for HRSNs**
  - Establish **greater expectations for HRSN care coordination for high- and rising-risk members**, such as introducing follow-up expectations for certain HRSN referrals, as appropriate

3 Advance health equity, with a focus on HRSN, maternal health, and justice-involved populations

MassHealth interventions addressing the needs of members experiencing homelessness

Challenges	MassHealth Initiatives to Improve Access to Services
People experiencing homelessness have **lapses in MassHealth coverage**	Provide **continuous eligibility** for 24-months to homeless individuals
Large number of homeless members are not enrolled in managed care, and therefore do not have **access to CSP housing supports**	**Expand CSP eligibility to FFS population**, including CSP housing-related services
Many **homeless members do not meet "chronically" homeless criteria**, but would benefit from CSP-CHI like services	**Expand target population for CSP-CHI services** to include additional members experiencing homelessness who are high utilizers of health care services
Medical costs increase dramatically if **members are evicted** and become homeless	**New CSP service** for members in Housing Court facing eviction (i.e., CSP-TPP), based on proven Tenancy Preservation Program
BHCPs have variable familiarity with the **needs of homeless members** and available resources	**Increase expectations** for BHCPs regarding skills, expertise, and data related to homelessness. **Leverage data** to coordinate with homeless providers
Variability among hospitals and BH facilities in **addressing member's housing situation and needs upon discharge**	Provide **Resource Toolkit for shelters, hospitals, and plans** to share best practices for discharging of members who are homeless or housing unstable
CSP-CHI providers encounter **administrative challenges** in working with multiple MCEs	**Administrative streamlining** to reduce complexity for providers

3 Advance health equity, with a focus on HRSN, maternal health, and justice-involved populations

MassHealth interventions addressing justice-involved individuals

Propose offering Medicaid benefits throughout all or portions of members' incarceration, making pre-trial and sentenced individuals at Houses of Correction, Department of Corrections, and Department of Youth Services facilities eligible for MassHealth

- Today, individuals have their Medicaid benefits suspended while incarcerated
- Would expand inmates' access to MassHealth benefits to improve continuity of care before and after involvement with the justice system
- While there is interest in similar policies at state and federal levels, particularly for pre-release services, to date none have been authorized or implemented

Expand existing Behavioral Health Supports for Justice Involved Individuals (BH-JI) program statewide (*already underway)* and extend the community-based services as a **CSP-JI benefit** (see slide 51)

- Trained CSP-JI Navigators will assist justice involved individuals in engaging with health care services. Services include a needs assessment, safety planning, and community supports, and frequently follow In-Reach supports in correctional facilities by BH-JI vendors (often same as CSP-JI provider).

3 Advance health equity, with a focus on HRSN, maternal health, and justice-involved populations

MassHealth interventions addressing maternal health

- **Maternal health will be a key focus of health equity funding and investments**
  - ACO Quality Slate will include HEDIS postpartum depression screening measure

- MassHealth has proposed extending **postpartum eligibility to 12 months,** regardless of immigration status. *Note: proposed for immediate implementation as part of current 1115 amendment, prior to state plan option effective date.*

- MassHealth will add **doula services** as a MassHealth benefit under the state plan
  - There is strong evidence that access to doulas can improve health outcomes for pregnant, birthing, and postpartum members.

- MassHealth will require ACOs provide **enhanced care coordination for high-risk pregnant and postpartum members** (i.e., complex BH or SUD diagnoses, chronic conditions which may complicate pregnancy, a history of adverse outcomes in previous pregnancies, and complex social conditions). In addition:
  - MassHealth will focus on perinatal BH support through strengthening our partnership with **MCPAP for Moms** and tracking perinatal depression screening and referrals.
  - MassHealth will also **increase outreach and targeted technical assistance** in partnership with MCPAP for Moms.

3 Advance health equity, with a focus on HRSN, maternal health, and justice-involved populations

MassHealth interventions addressing members with disabilities

Strengthen access to coverage	▪ **Streamline eligibility processes to strengthen access to CommonHealth coverage for adults with disabilities**, including: – coverage for all adults with disabilities under age 65 with sliding scale premiums, with no required spend-down – coverage for long-time CommonHealth members over age 65 when they retire
Measure disparities to improve outcomes	▪ ACOs will be **accountable for measuring and closing disparities, including for members with disabilities**, through: – establishment of sustainable institutional health equity infrastructure – data collection and stratified reporting on performance indicators, including RELD and SOGI – achievement of significant annual decreases in disparities across the ACO population
Improve service delivery	▪ **Strengthened, more comprehensive LTSS CP model**, providing whole-person care coordination, accountable to increased expectations for clinical staffing and capability, including: – increased scale of LTSS CP program, with improved engagement rate – accountability to provide members a consistent care coordination home – focus more on outcomes than process

3 Advance health equity, with a focus on HRSN, maternal health, and justice-involved populations

MassHealth interventions supporting a diverse workforce

MassHealth will propose increasing the number of diverse and culturally competent behavioral health (BH) clinicians who commit to serving MassHealth members.

1. Funding for bold student loan repayment up to $300,000 to incentivize **psychiatrists** and **nurse practitioners with prescribing privileges** to maintain panels that comprise at least 40% MassHealth members with a 4-year service commitment.
2. Funding for student loan repayment up to $50,000 to improve recruitment and retention of **MassHealth-participating behavioral health clinicians** by focusing on **licensed behavioral health clinicians or masters-prepared social workers intending to obtain licensure within one year of award application**, in exchange for a 4-year service commitment in settings that serve a significant number of MassHealth members.

In addition, MassHealth will support **trainings for Community Health Workers, certified mental health peer specialists, and recovery coaches** (e.g., training needed for certification) employed by ACO-participating primary care providers and behavioral health providers.

Programs will support a workforce that better reflects the backgrounds and cultures of the members it serves.

3 Advance health equity, with a focus on HRSN, maternal health, and justice-involved populations

MassHealth interventions to strengthen health equity data and infrastructure

Data Collection, Identification and Analysis of Disparities

- Standardize and strengthen **social risk factor** (including race, ethnicity, language, disability, sexual orientation, gender identity, and health-related social needs) **data collection**
- **Maintain robust structures** to identify and understand disparities, including through **stratified reporting** on key performance indicators

Equity Culture, Structure, and Partnerships

- **Invest in entities serving MassHealth members through incentives** for activities essential to health equity, stratified reporting by social risk factors, and demonstrable reductions in health disparities
- **Develop clear processes and expectations for key contracted partners** (including ACOs/MCOs) to establish necessary infrastructure for health equity (e.g., health equity committees, strategic plans, health equity and anti-racism staff training, and professional development)
- **Enhance a culture of and infrastructure for equity at MassHealth** to prioritize elimination of disparities and achievement of health equity
- Regularly engage with **partners from other sectors**, **members, and communities** to inform and align efforts

MassHealth 1115 Demonstration: Strategy for 2022 Extension

0. Overview
1. Continue the path of restructuring and reaffirm accountable, value-based care
2. Make reforms and investments in primary care, behavioral health and pediatric care
3. Advance health equity
4. Streamline the MassHealth delivery system for members and providers
5. Sustainably support the Commonwealth's safety net and maintain near-universal coverage

4 Streamline the MassHealth delivery system for members and providers

Pharmacy

Goals

- Simplify experience for members and providers
- Support clinical integration of pharmacy
- Lower net cost of pharmacy and ensure that the state's net cost of Rx for managed care is no more than MassHealth would achieve directly
- Increase efficiency & responsiveness in dynamic pharmacy environment

MassHealth will simplify its pharmacy program

- Pharmacy operations are currently split between an in-house program and multiple MCO programs managed by different pharmacy benefit management companies (PBMs), with different formularies, creating unnecessary complexity
- MassHealth will simplify the pharmacy program by **implementing a uniform formulary**, to simplify member and provider experience
- Changes to managed care contracts will eliminate PBM "spread pricing" and ensure that the Commonwealth captures the full value of rebates/ net price through managed care that it would if MassHealth administrated the Rx benefit directly
- MassHealth will also seek waiver authority to **standardize 340B payment methodologies for "retail" drugs** (i.e. drugs which are not physician administered) across delivery systems (including across Model A and Model B ACOs, as well as MCOs and PCC Plan/fee-for-service) to eliminate payment inconsistencies.

4 Streamline the MassHealth delivery system for members and providers

Care Coordination

MassHealth will **standardize approaches** to care coordination currently paid for by time-limited innovation financing, and incorporate these services into the core ACO program. ACOs are accountable for ensuring members receive appropriate care coordination and care management supports.

Tiered care coordination supports will be provided based on member risk**:**

A **Baseline supports** are provided to all MassHealth members. Members in this category have lower risk that can be appropriately managed by their PCP. These include an assigned PCP; care needs screening; systematic follow-up on tests, treatments, services; and basic support for transitions of care.

B **Enhanced supports** are provided to rising- and high-risk members that need additional support beyond their PCP. These include comprehensive assessment and care planning; broader HRSN support; and intensive support for transitions of care.

C **Specialized supports** are provided to rising- and high-risk members who need them. These supports will be **time-limited, situation-specific, and adjunctive** to enhanced supports. These include assistance with certain housing needs; or, community resources for the justice-involved population.

4 Streamline the MassHealth delivery system for members and providers

A *Baseline care coordination supports include:*

All MassHealth members, regardless of risk, will receive baseline care coordination supports. These supports include:

- Assignment **to a PCP practice** that will serve as the **lead, responsible entity and first point of contact** for the member's baseline care coordination needs
- **Screening for** physical health, behavioral health, LTSS, and HRSN needs and referrals to providers and supports that can assist with identified needs (supported by a dynamic electronic community resource database for HRSN needs maintained by each ACO)
- **Collaboration and communication** among providers involved in the member's care, including **systematic support and timely follow-up** on care and transitions of care

4 Streamline the MassHealth delivery system for members and providers

B *Enhanced care coordination supports provided by ACOs/MCOs include:*

- Each ACO/MCO will **stratify their population to identify high- and rising-risk members** needing additional support from a multi-disciplinary care team that will:
  - Maintain relationships and open communication with PCP/health system/community/specialty care team members to facilitate coordination
  - Serve as the **main point of contact and "first line" coordinator for the member** (and the member's family, where appropriate), ensuring **members and providers have clarity about "who is on first" for care coordination**
  - **Provide outreach** and engagement; comprehensive assessment; **member-centered care planning;** and **intensive support for transitions of care** (e.g., directly participating in discharge planning, on-site presence in acute settings)
  - **Offer broader HRSN coordination** (e.g., active, closed-loop referrals)

- For these identified high- and rising-risk members, each ACO and MCO will:
  - Refer members to MassHealth-defined care coordination programs, as appropriate (e.g., new CP programs, see slide 50), and partner with those programs as part of the care team
  - Refer members not appropriate for MassHealth-defined programs to ACO/MCO-defined complex care management programs that meet standards of MassHealth-defined care coordination programs

- ACOs and MCOs will provide **regular, standardized reporting** to MassHealth on their identified high-and rising-risk members and their care coordination team assignments.

4 Streamline the MassHealth delivery system for members and providers

B *Select MassHealth-defined care coordination programs for high- and rising-risk members include:*

Program	Eligible members	Lead accountable entity
Behavioral Health Community Partner	▪ Adults with serious mental health/ substance use diagnoses and history of high, potentially preventable utilization (e.g., repeated ED visits/ hospitalizations)	▪ BH CP ▪ ~10-15 statewide ▪ Likely the member's OP treatment site
LTSS Community Partner	▪ Adults with significant functional impairments, LTSS utilization, or related diagnoses and history of high, poorly managed utilization	▪ LTSS CP ▪ ~7-10 statewide ▪ Likely includes member's regional ASAP/ RLC
CBHI Intensive Care Coordination	▪ Children with serious emotional disturbance and certain complex BH needs	▪ CSA ▪ 23 statewide
Specialty children's model	▪ Children with medical complexity and history of high, poorly managed utilization	▪ A specialized provider within member's specialty or primary care, acting as medical home ▪ ~5-10 statewide

Additional CP discussion on slides 25-27

4 Streamline the MassHealth delivery system for members and providers

C *Supplemental specialized care coordination supports for a subset of high-and rising risk members include:*

A subset of members **will receive specialized care coordination supports**, which episodically supplement but do not replace a member's care coordination home.

Specialized supports will include:

Program	Anticipated number of members served, based on eligibility criteria	Supports Provided
Community Support Program (CSP)	~50k MassHealth members annually with BH/SUD/co-occurring needs that put them at risk for hospitalization	Supports related to implementation of clinical treatment plan, acute coordination of care, and attaining skills & resources to maintain community tenure
CSP - Homeless Individuals: Expansion of existing CSP-CHI program	~3-5k MassHealth members annually with a BH diagnosis and that are **EITHER**: • Chronically homeless as defined by US Dept of Housing & Urban Development (HUD) **OR** • Non-chronically homeless members who are high utilizers of healthcare	Pre-tenancy (e.g., assisting member in search for appropriate housing), transitional (e.g., assisting with move into housing), and tenancy-sustaining (e.g., helping member remain in housing) supports
CSP - Tenancy Preservation Program	~500-1k MassHealth members annually that are housing unstable members, have a BH diagnosis, & are involved with Housing Courts	Homelessness prevention provided in Housing Court to address evictions related to disability/behavior
CSP - Justice Involvement	~3k MassHealth members annually that are recently released from incarceration or on probation/parole and have a BH diagnosis	Intensive support for re-entry, including connection to SUD treatment

4 Streamline the MassHealth delivery system for members and providers

Streamlining MassHealth's behavioral health services to improve navigation and engagement for members and providers, will require, at minimum, plans delivering BH (ACOs and MCOs directly or BH subcontractors) to achieve:

A **Efficient and effective operations and a broad, consistent BH network**

- **Broad networks** that ensure **consistency and continuity of care** for members across ACOs, MCOs and the PCC Plan
- Efficient and uniform **enrollment and credentialing processes**
- **Utilization management processes** that ensure clinically appropriate BH care delivery, and that are at parity with those used in physical health care
- Coordination with MassHealth on **quality/program integrity**
- Effective collaboration with MassHealth to implement **payment and care delivery policy** (e.g., BH Roadmap initiatives such as Community Behavioral Health Centers)

B **Improved performance on key quality indicators, enhanced integration, and decreased TCOC for members with BH needs**

- **High performance on BH-related quality scores**
- **Innovative payment and delivery models above and beyond those MassHealth prescribes** (e.g., value-based payments, integrated primary care, etc.)
- **Excellent TCOC management for members with BH needs** (e.g., reduce ED visits and readmissions)
- **Integrated delivery of physical and behavioral health care**, supported by close collaboration between ACOs/MCOs and behavioral health vendors (when applicable)
- High levels of **responsiveness** on BH Roadmap implementation (e.g., Community Behavioral Health Center networks), inpatient placement needs of members, and other priorities

MassHealth 1115 demonstration: strategy for 2022 extension

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5. Sustainably support the Commonwealth's safety net and maintain near-universal coverage

5 Sustainably support the Commonwealth's safety net and maintain near-universal coverage

Key elements of next waiver's financing

MassHealth is committed to **sustainable safety net hospital funding** tied to ACO performance and preserving Massachusetts' **near-universal coverage.**

- Direct vast majority of new funding ($500M over five years) to ACO-participating hospitals to measure and close disparities in care
- Transition DSRIP to core, sustainable program payments
- Preserve Safety Net Provider Payments and expand eligibility to additional high Medicaid hospitals
- Preserve other long-time funding for the Commonwealth's safety net (e.g., the Health Safety Net)
- *Funding supported by extended hospital assessment; MassHealth will continue to work through the details of its safety net financing with stakeholders in advance of formal waiver submission*

Over the next five years, MassHealth's renewed waiver will generate **$515M in new funding for safety net hospitals** and preserve programs that support near-universal coverage in the Commonwealth

5 Sustainably support the Commonwealth's safety net and maintain near-universal coverage

Preserve Safety Net Provider Payments and expand eligibility to additional high Medicaid hospitals

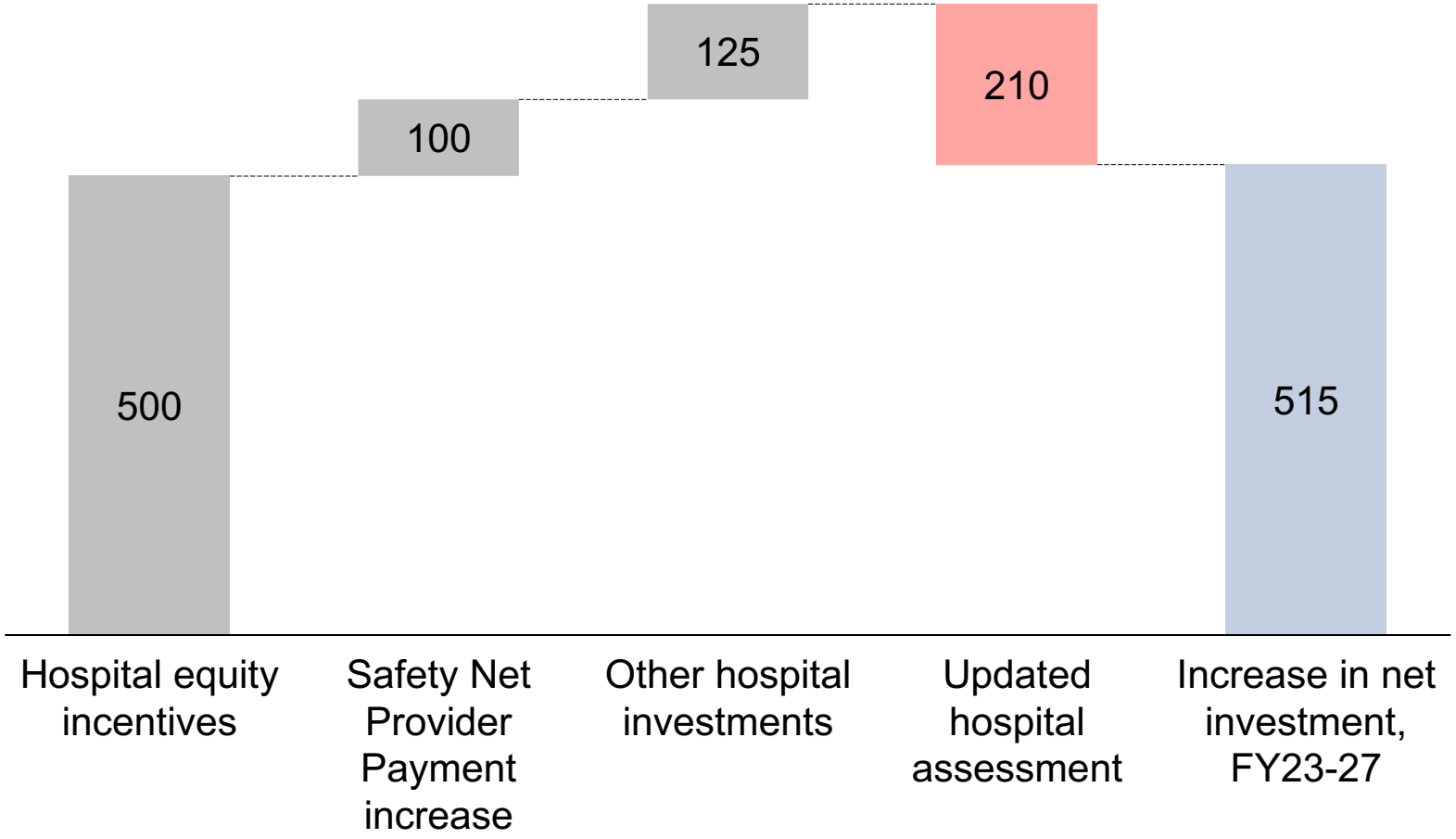
- **$193M per year in Safety Net Provider Payments** to high-Medicaid hospitals:
  - $153M to six "Group 1" hospitals, which have the highest percentage of Medicaid and uninsured volume
  - $40M to seventeen "Group 2" hospitals, with Medicaid/uninsured payer mix above 20% and commercial payer mix below 50%
    - Note: reflects a **$20M increase per year over current waiver**, with expanded eligibility to include nine additional hospitals that met the payer mix thresholds in FY2019
  - *See Appendix for hospital recipients*

- In addition:
  - **$100M per year in health equity incentives**: vast majority directed to ACO-participating safety net hospitals
  - **$125M in additional investments in hospitals tied to clinical quality and service**

MassHealth will continue to work through the details of its safety net financing with stakeholders in advance of formal waiver submission

5 Sustainably support the Commonwealth's safety net and maintain near-universal coverage

Proposal would generate $515M increased investment in hospitals over five years relative to current funding



5 Sustainably support the Commonwealth's safety net and maintain near-universal coverage

Massachusetts' 1115 waiver has been critical to achieving:

- The lowest uninsured rate of any state in the country
- The lowest average premiums of any state's health insurance exchange[1]

The new waiver proposal will continue to support near-universal health coverage in Massachusetts by maintaining and building on coverage expansions. It will:

- **Maintain current coverage expansions through the waiver**, including state subsidies to make insurance through the Health Connector affordable for people with incomes up to 300% of the Federal Policy Level (FPL)
- **Further strengthen coverage** by:
  - **Extending postpartum eligibility to 12 months**, regardless of immigration status, to support improved maternal health (proposed via 1115 amendment in May 2021)
  - **Streamlining access to CommonHealth** to cover all disabled adults under age 65 with sliding scale premiums, without a spend-down, and to cover long-time CommonHealth members over age 65 when they retire
  - **Extending retroactive eligibility from 10 days to 3 months** for pregnant individuals and children, consistent with federal rules without a waiver
  - **Providing continuous eligibility for members who are homeless and for members recently released from jail/prison**

[1] Connector premiums as of 2017-18; since then, premiums have grown <5%

Appendix

Context: What is a Section 1115 demonstration?

States require approval from the Center for Medicaid and Medicare Services (CMS) for Medicaid and Children's Health Insurance Program (CHIP) expenditure. In most cases, this authority is granted through a state's **Medicaid and CHIP State Plans**. Services authorized under Massachusetts' State Plan are generally those that could be delivered fee-for-service for a defined population.

Section 1115 of the Social Security Act gives CMS authority to approve **"non-traditional," experimental, pilot, or demonstration projects** that are likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is **to demonstrate and evaluate** state-specific policy approaches to better serve the Medicaid population. Demonstrations are generally approved on 5-year cycles, and must be renewed or extended to continue.

Massachusetts has operated with an 1115 demonstration since 1997. The most recent demonstration was authorized in 2017, and will expire in 2022. This document will detail context on the current 1115 demonstration and proposed extension strategy MassHealth intends to submit to CMS in 2021, for the period 2022 – 2027. All policy proposed in this document is contingent upon CMS approval.

Context: What are MassHealth Accountable Care Organizations?

- ACOs are health care organizations that are rewarded for **better health outcomes, lower cost, and improved member experience.**

- ACOs are responsible for achieving these results through **team-based care coordination** and integration of behavioral and physical health care. ACOs are also responsible for taking a whole person view of their members, including long term services and supports and health related social needs.

- MassHealth members enrolled in an ACO select, or are assigned, a **specific primary care provider** and have **access to networks of specialty providers** (e.g., hospitals, specialists, behavioral health providers) that participate in their plan.

- ACOs assume **upside and downside risk** and are financially accountable for specific quality measures.
  - **The 1115 waiver does not assume savings in the first 2 years** of the ACO program. Starting in the third year (2020), the state is accountable for savings, ramping up to 2.1% savings (off baseline trend) by Year 5.

- ACOs represent a **diverse range of provider systems:**
  - Hospital-based and community primary care-based ACOs
  - Large, statewide and regional ACOs
  - Provider-led and provider-health plan partnership ACOs

Context: What are MassHealth Community Partners?

- Community Partners (CPs) contract with ACOs to provide **wrap-around expertise and support for behavioral health (BH) services and long-term services and supports (LTSS).**

- CPs serve **the most complex ACO members**, with serious mental illness, substance use disorders, co-occurring disorders, or disabilities that require long-term services and supports.

- CPs are paid to **engage** these members and collaborate with the health care system to **coordinate and improve** their care.

- CPs are **community-based organizations** with expertise in supporting the populations they serve.

Context: What is the DSRIP Program?

- The Delivery System Reform Incentive Payment (DSRIP) program is a five-year program authorizing **$1.8 billion investment through MassHealth's federal 1115 waiver**.

- DSRIP funding **time-limited and decreases over 5 years.**

- ACOs and CPs use DSRIP funds to **design and test innovative programs**, with the expectation that they measure those programs' outcomes, **and to stand up infrastructure required for population health management.**

- In CY2019, **ACOs and CPs spent $244.1M** in DSRIP funding:
    - **$173.7M** by ACOs*
    - **$70.4M** by CPs

- ACOs and CPs had to receive MassHealth approval for **investment plans** by demonstrating that their investments would support **population health management**, not duplicate other available funds, and be measurable.

- Additionally, **$25.5M of DSRIP funding was used for Statewide Investments in 2019** to support workforce development (training, hiring, retention), technical assistance for ACOs and CPs, and related initiatives. This was an increase of ~18% over the $21.6M spent on Statewide Investments programs in 2018.

* Certain ACOs also received an additional **$76.3M** for safety net hospital (DSTI) glide-path funding

Safety Net Provider Funding: Hospitals

Group 1 - Current	Group 2 - Current Hospitals	Group 2 - New Hospitals
Boston Medical Center	Baystate Medical Center	Baystate Noble Hospital
Holyoke Medical Center	Baystate Franklin	Baystate Wing Hospital
Lawrence General Hospital	Berkshire Medical Center	Heywood Hospital
Mercy Medical Center	North Shore Medical Center	Martha's Vineyard Hospital
Signature Healthcare Brockton Hospital	Southcoast Hospitals Group	Shriners Hospitals for Children Boston
Steward Carney Hospital	Morton Hospital (Steward)	Shriners Hospitals for Children Springfield
	Good Samaritan Medical Center (Steward)	Holy Family Hospital (Steward)
	Tufts Medical Center	MetroWest Medical Center
		Lowell General Hospital