

# 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

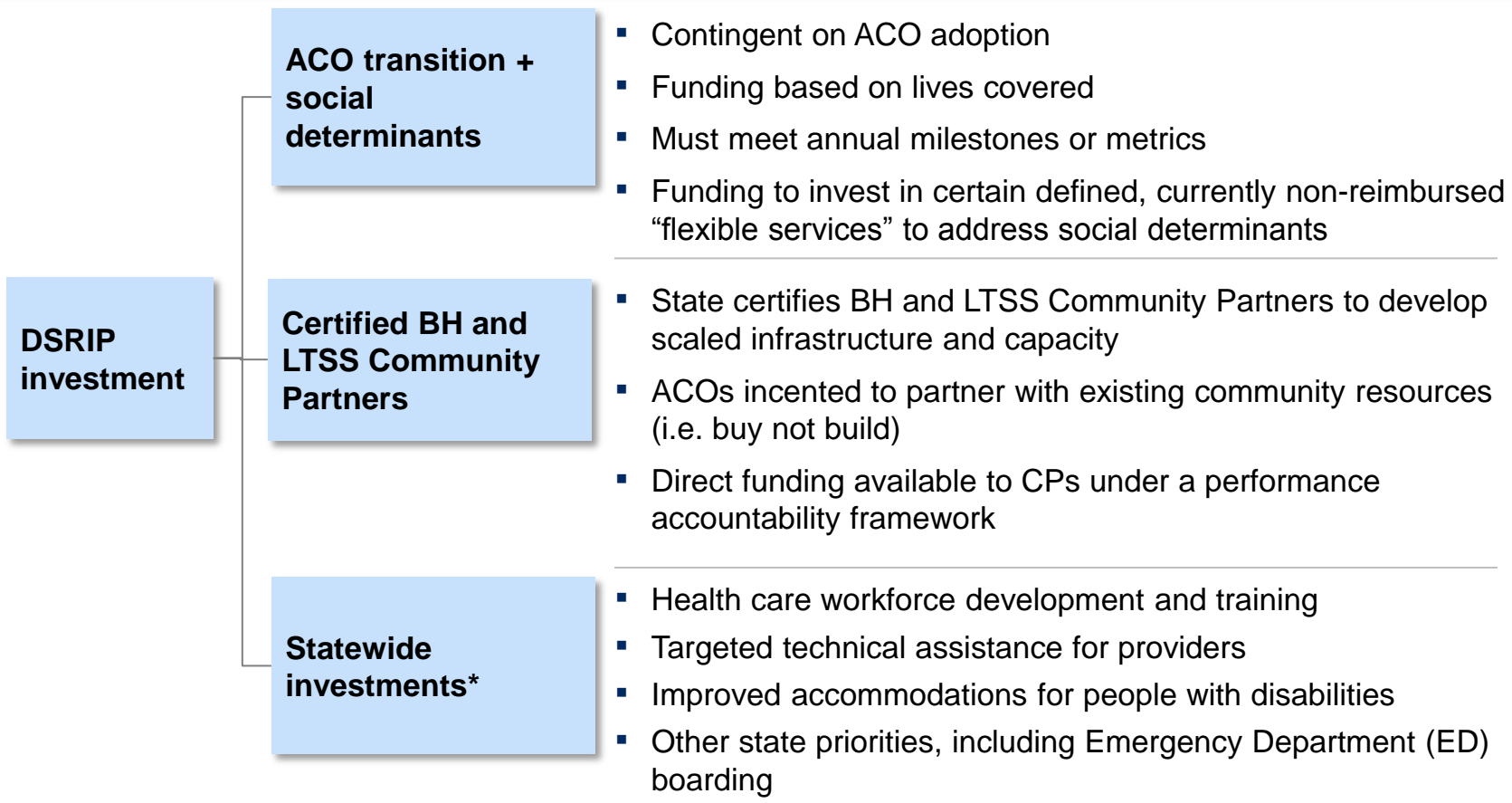
- ACO provider contracts directly with MassHealth
- Full MassHealth/ MBHP provider network, but ACO may have preferred provider relationships
- ACO accountable for total cost/quality and integration of care
- MassHealth/MBHP pay claims up-front, retrospective reconciliation with ACO for total cost of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



## 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



## 3 4 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	
<b>Total</b>	<b>\$1.59B</b>	<b>\$8B</b>	

## 3 4 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

# Agenda

- Presentation on 1115 Waiver Proposal      EOHHS/MassHealth

<ul style="list-style-type: none"><li>▪ <b>Comments and Discussion</b></li></ul>	<b>Medical Care Advisory Committee Payment Policy Advisory Board</b>
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# Timelines

## Public listening sessions

- **Friday, June 24<sup>th</sup>, 2:30 – 4:00 pm** (1 Ashburton Place, 21<sup>st</sup> Floor, Boston)
  - **Monday, June 27<sup>th</sup>, 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, 11<sup>th</sup> Floor, Boston
    - Written comments may be submitted through July 17 at [MassHealth.Innovations@State.MA.US](mailto:MassHealth.Innovations@State.MA.US)
  - **Mid-July:** 1115 waiver proposal submitted to CMS
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## 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 procurement effective October 2017 (sequenced after ACO procurement)