

**September 30, 2016**

**MassHealth Accountable Care Organization (ACO) Models: Questions and Answers**

MassHealth recently released its Request for Responses (RFR) for Accountable Care Organizations (ACOs). In order to provide the public with an overview of the ACO program, this document contains information on some of the key aspects of the program, including the structure of ACOs and their provider networks, member experience and rights in ACOs, and payment and quality accountability of ACOs. This document is for public information purposes only. Potential bidders should refer to COMMBuys for all applicable procurement information.

This document describes the three ACO models that are part of MassHealth's ACO program: (1) Accountable Care Partnership Plans; (2) Primary Care ACOs; and (3) MCO-Administered ACOs. MassHealth is releasing a Request for Responses for ACOs in September 2016, and will be selecting ACOs to participate in each of the three ACO models.

**SECTION 1: Background**

**1. How will MassHealth ensure public transparency and stakeholder/advocate involvement in the reform effort?**

- MassHealth is committed to continued public transparency and a collaborative process with stakeholders and advocates. MassHealth will:
  - Hold two public meetings (one in Boston, and one in the west) in October to provide public information about MassHealth's delivery system reform
  - Procure for and convene a Delivery System Reform Implementation Advisory Council in November/December; this Council will meet at least every other month on an ongoing basis, will receive regular operational updates on the progress of the reform, and will provide input and recommendations for MassHealth's implementation of the reform, any technical guidance MassHealth develops, and any future refinements to the reform implementation based on initial learnings
  - Provide ongoing updates at a monthly forum convened by advocates, starting in September
  - Provide regular, ongoing communication to MassHealth's providers, MCOs, and other delivery system partners to provide clarity on the reform design and transparency to the implementation process
  - Reconvene 3 of the previously-assembled Technical Advisory Groups (TAGs): BH, LTSS and Quality. These workgroups will inform the development of the Community Partners certification application and additional programmatic details on DSRIP, as well as quality and member experience measurement approach for ACOs and Community Partners. These TAGs will hold several meetings, starting in September and running through January
  - Release a public Request for Information in September to solicit comments (due October) on CP design

- Continue to accept and review comments and input received at the [MassHealth.Innovations@state.ma.us](mailto:MassHealth.Innovations@state.ma.us) email address across a broad range of MassHealth restructuring topics, including input on CPs, DSRIP, and the implementation of the ACO models described in the ACO procurement
- Release additional detail on the DSRIP payment amounts after finalizing additional details with CMS

## 2. How will MassHealth ensure the ACO reform is member-centered?

MassHealth is committed to delivery system reform that is member-centered and improves member's care experience and outcomes. As detailed further in this document, MassHealth aims to ensure this focus on members through:

- **Structural and care delivery requirements for ACOs:** MassHealth ACOs must include consumers or consumer advocates as voting members of their governing boards and incorporate Patient and Family Advisory Councils as part of their broader governance structures. Additionally, ACOs' responsibilities for care delivery include requirements to provide member-centered care plans for appropriate members, similar to those present in the One Care program. As part of the ACO procurement process, bidding ACOs will be asked to demonstrate their knowledge of the MassHealth member population and its care needs, to describe their cultural competencies and plans to improve these competencies, and to propose strategies for community engagement
- **Member protections across all models:** All ACOs are required to inform members of their enumerated member rights and to ensure that such rights are protected. Additionally, Accountable Care Partnership Plans and Primary Care ACOs must establish their own grievance processes and communicate them to members; members in MCO-Administered ACOs are enrolled in MCOs and will have access to their MCOs' grievance proceedings. Accountable Care Partnership Plans must also maintain their own appeals processes, like MCOs, for any appealable actions they take (e.g., prior authorization decisions); other ACOs do not have the authority to take such actions (e.g., Primary Care ACOs and MCO-Administered ACOs do not directly authorize services). All members in ACOs (and MCOs) will have access to MassHealth/Board of Hearings appeals processes and to an Ombudsman resource
- **Staged, thoughtful introduction of long term services and supports (LTSS) into the MCO and ACO programs:** MassHealth intends to transition LTSS into the scope of MCO covered services and include it in ACO cost of care accountability in Year 3 (FY20) or Year 4 (FY21). Prior to this transition, MassHealth will conduct significant stakeholder engagement and readiness testing with MCOs and ACOs. As part of the ACO and MCO procurement processes, bidding MCOs and ACOs will be evaluated considering their experience and capabilities around LTSS, including their knowledge of the population and their competencies with disability culture

## 3. What is an Accountable Care Organization (ACO)?

- An ACO is a group of Primary Care Providers (PCPs) that have partnered with each other and with other providers to deliver care that is integrated, wellness-focused, culturally and linguistically accessible, and member-centered
- ACOs will provide the structure for primary care providers to integrate members' care by requiring and facilitating providers' communications with each other and investing in necessary primary care infrastructure
- ACOs will establish new affiliations to expand beyond a purely medical model of care, including working with Community Partners and navigating members to community resources to address health-related social needs
- MassHealth will establish, with further stakeholder input, clear requirements governing ACOs' affiliations with Community Partners; these requirements will ensure that ACOs are building linkages to the community, "buying" existing expertise rather than "building" redundant capacity, and not over-medicalizing care
- ACOs will provide care coordination and care management activities to certain members; for example, following up with a member after discharge from the hospital

#### **4. What are the ACO models?**

MassHealth's ACO program includes three ACO models. An ACO will only be able to participate in one model at a time. Members' benefits and covered services will not differ between models.

- **Accountable Care Partnership Plan** ("Model A ACO" or "Partnership Plan") – An Accountable Care Partnership Plan is an ACO that is partnered with a single managed care organization (MCO). Each Partnership Plan has an exclusive group of PCPs, and all members enrolled in a Partnership Plan receive primary care from these PCPs. Like a MassHealth MCO, the Partnership Plan is paid a capitated rate for attributed members, and is at risk for losses and savings beyond the capitation rate. The Partnership Plan must meet all of MassHealth's requirements for MCOs, including capital reserves and other financial considerations. Unlike MassHealth MCOs, Partnership Plans must meet the requirements for ACOs, including provider-led governance and HPC certification. Because the Partnership Plan is an MCO, it will perform many of the administrative functions of that MassHealth MCOs perform (e.g., paying claims, maintaining the provider network, prior authorization, etc.). The Partnership Plan will communicate directly with enrollees what it offers and how to access services. Unlike a MassHealth MCO, Partnership Plans do not have to cover an entire specified geographic region. Partnership Plans will define their service areas, with MassHealth approval, and will need to have network adequacy in those service areas.
- **Primary Care ACO** ("Model B ACO") – A Primary Care ACO is an ACO that contracts directly with MassHealth. Each Primary Care ACO will have an exclusive group of participating Primary Care Clinicians (PCCs), and all members enrolled in a Primary Care ACO receive primary care from these PCCs. Unlike MassHealth MCOs and Accountable Care Partnership Plans, Primary Care ACOs are not paid a capitation to provide services. Instead, their attributed members receive non-behavioral health care from MassHealth's fee-for-service network, which is paid for directly through the MassHealth claims system. Members attributed to Primary Care ACOs are also

automatically enrolled in MassHealth’s behavioral health plan (the existing contract is with Massachusetts Behavioral Health plan-MBHP). The Primary Care ACO is accountable through shared savings and losses payments based on Total Cost of Care (TCOC) and quality performance for the Primary Care ACO’s population of Attributed Members.

- **MCO-Administered ACO** (“Model C ACO”) – An MCO-Administered ACO is an ACO that is part of the primary care provider network(s) for one or more MassHealth MCO(s). An MCO-Administered ACO may contract with multiple MCOs; an MCO may also contract with multiple MCO-Administered ACOs as part of its network. Each MCO-Administered ACO has an exclusive group of Participating PCPs. Members who enroll in an MCO may be attributed to an MCO-Administered ACO. Members attributed to an MCO-Administered ACO receive care from their MCO’s network, which is paid for directly by the MCO. MCO-Administered ACOs are accountable to their MCOs through shared savings and losses payments. MassHealth must approve these financial arrangements and the associated requirements in the contracts between an MCO-Administered ACO and its MCOs in order for the MCO-Administered ACO to be eligible for DSRIP.

#### **5. How do Behavioral Health Community Partners and LTSS Community Partners fit into the ACO reform?**

MassHealth will require ACOs to establish agreements with Community Partners; MassHealth believes this requirement will improve care for members in ACOs and will encourage ACOs to be more effective in expanding beyond a medical model of care and in integrating across the physical health, BH, and LTSS delivery systems. As described elsewhere in this document, MassHealth is committed to significant stakeholder involvement, and will issue a public Request for Information seeking input on Community Partners.

- Community Partners will provide ACOs with ready linkages to the communities they serve
- Community Partners will bring expertise in BH clinical management (for BH CPs) and coordinating between the physical health and LTSS systems (for LTSS CPs), providing the integration of care necessary to serve these populations more effectively
- Community Partners will receive infrastructure funding directly through DSRIP, providing ACOs an opportunity to expand their own capabilities more efficiently than building new capabilities in-house

### **SECTION 2: Requirements for participation in ACO models**

#### **6. What are the governance requirements for ACOs?**

All ACOs will need to have provider-led and member-focused governance, including:

- At least one consumer or consumer advocate with a voting seat on the governing board, ensuring an empowered and valuable consumer perspective in ACO decision-making
- Most of the remaining governing board seats also must be held by providers or their representatives, and the governance structure must include representation from diverse

provider types. These requirements help to ensure expertise that is appropriate to members' needs is represented in an ACO's decision-making process, and help to keep an ACO's focus on front-line care

- A Patient and Family Advisory Committee, and
- A Quality Committee.

All ACOs will be required to work with Community Partners (CPs) to coordinate and integrate member care.

All ACOs will also be required to maintain Health Policy Commission (HPC) ACO certification, and appropriate Division of Insurance (DOI) Risk-Bearing Provider Organization (RBPO) certification.

Partnership Plans will also be required to meet MassHealth's MCO requirements, including maintaining HMO licensure. Partnership Plans may take several forms, and a Partnership Plan may meet its governing board requirements through its ACO, its MCO, or a joint arrangement.

#### **7. What are the solvency and financial protection requirements for ACOs?**

All ACOs will be required to obtain either a Risk Bearing Provider Organization (RBPO) certificate or waiver from the Division of Insurance. In addition, MassHealth will require the following financial protections from ACOs:

- Partnership Plans will be required to meet the same financial requirement as MCOs, including operating reserves.
- Primary Care ACOs will be required to maintain a repayment mechanism, in the form of a performance bond, line of credit or escrow account, to guarantee a portion of potential shared losses payments to EOHHS.
- MCO-Administered ACO's repayment arrangements with their MCOs will be negotiated between the MCO and MCO-Administered ACO and are not specified by EOHHS.

#### **8. Does the ACO program allow for pediatric-only ACOs?**

Pediatric-only ACOs are welcome to participate in the MassHealth ACO program. Pediatric-only ACOs are ACOs in which all of the participating primary care providers are pediatric providers, and therefore all attributed members are children. Pediatric-only ACOs must meet the same requirements as other ACOs. If any pediatric-only ACOs become part of the MassHealth ACO program, the pediatric-only ACOs will be accountable for a smaller subset of the full ACO quality measure slate, as some ACO quality measures do not apply to children.

All ACOs, whether or not they are pediatric-only ACOs, must ensure and are financially accountable for ensuring high quality care for any children they serve, including but not limited to well-child visits, prevention focused care, and integration of children's mental health.

#### **9. What experience with MassHealth populations do ACOs need to demonstrate?**

ACOs must serve a minimum number of members (20,000 for Partnership Plans; 10,000 for Primary Care ACOs; and 5,000 for MCO-Administered ACOs).

ACO must also ensure their members receive culturally competent care. As part of the ACO procurement process, bidding ACOs will be asked to demonstrate their knowledge of the MassHealth member population and its care needs, to describe their cultural competencies and plans to improve these competencies, and to propose strategies for community engagement.

### **SECTION 3: ACO provider affiliations and networks**

#### **10. What providers will members in ACOs have access to?**

- In a Partnership Plan, members will have access to all providers in the Partnership Plan's network, similar to members enrolled with MassHealth MCOs.
- In a Primary Care ACO, members will have access to all providers in MassHealth's fee-for-service network and providers in the MassHealth-contracted behavioral health plan network (the existing contract is with Massachusetts Behavioral Health plan-MBHP), similar to members enrolled with the MassHealth PCC Plan.
- In an MCO-Administered ACO, each member's network will be determined by the MCO the member is enrolled with. Each member will have access to the MCO's network.

#### **11. What continuity of care requirements will ACOs have?**

Accountable Care Partnership Plans and MCOs will be required to provide continuity of care for new enrollees for at least thirty days, or as long as medically necessary or required to ensure a coordinated transition to an in-network provider, including:

- Ensuring any enrollees who are receiving inpatient care (physical or BH) can continue to do so at the hospital currently providing that care, so long as is medically necessary
- Honoring existing prior authorizations made by enrollees' previous Partnership Plans or MCOs, or by MassHealth directly
- Ensuring any enrollees with durable medical equipment (DME), prosthetics, orthotics, and supplies (POS), physical therapy (PT), occupational therapy (OT), or speech therapy (ST) that was authorized by the enrollees' previous Partnership Plans or MCOs or by MassHealth directly can continue to receive those services for at least thirty days after enrollment
- Ensuring that any enrollees receiving an ongoing course of treatment, including outpatient care (e.g., chemotherapy, behavioral health services), can continue to receive care from existing providers for at least thirty days after enrollment

Members may be allowed to receive care from providers outside of their ACO's or MCO's network under certain circumstances. ACO and MCOs will have processes to identify and assist members in such circumstances, and may develop single case agreements with these providers.

As with MassHealth MCOs today, ACOs and MCOs will not be accountable for the costs of most LTSS for the initial years of their contracts; members in ACOs and MCOs will continue to receive these services from MassHealth, through MassHealth's LTSS network.

**12. Question: What providers will be affiliated with ACOs?**

A MassHealth ACO must have exclusive participation from a group of primary care providers. ACOs must also have affiliations with hospitals in order to meet ACOs' responsibilities to manage members' discharges and transitions of care. ACOs must partner with BH and LTSS CPs. Partnership Plans, like MCOs, must also contract with and manage a full, adequate network of providers for all covered services. Primary Care ACOs may have a designated circle of providers for which MassHealth will not require the referrals that would be required in the PCC plan.

**13. Question: What is the role of a primary care provider in an ACO?**

Primary care providers are the foundation of an ACO. Each ACO's primary care providers participate exclusively with that ACO, meaning that a member must join the ACO to receive primary care services from that provider. This also means that a member that chooses a primary care provider who is in an ACO will be assigned to that ACO. Primary care providers can still provide specialty services to eligible members outside of their ACO, but cannot have these members assigned to their primary care panels.

Each ACO will be required to invest a minimum portion of its DSRIP dollars in primary care-related investments, like training PCPs to use electronic health record systems, or hiring community health workers to allow a primary care practice to perform follow-ups in a member's home or community. ACOs will also be required to develop a performance management strategy for their primary care providers, including incentive payments that move primary care away from fee-for-service medicine.

**14. Question: What are the requirements for ACOs to partner with CPs?**

MassHealth ACOs must contract with enough MassHealth-certified CPs to ensure their members with BH or LTSS needs have appropriate access to CPs that the ACO is partnered with. MassHealth will issue further guidance on the appropriate access standard. MassHealth will continue to engage with stakeholders between September-December 2016, including issuing an RFI, prior to the launch in January 2017 of the CP application process.

**SECTION 4: ACO responsibilities and the member experience**

**15. Question: What services are included in ACO accountability?**

Primary Care ACOs and MCO-Administered ACOs will not be responsible for directly providing services. Members in Primary Care ACOs will have their covered services provided directly by MassHealth, through MassHealth's network, and members in MCO-Administered ACOs will have their covered services provided by the MCOs they are enrolled in. Primary Care ACOs and MCO-Administered ACOs will be financially accountable for TCOC performance on the same set of services as those covered by the MassHealth MCOs; non-MCO covered services (e.g., most LTSS) will not be initially included in ACO financial accountability, although LTSS services will be phased in as described elsewhere in this document.

Accountable Care Partnership Plans, like MassHealth MCOs, will be directly responsible for providing a set of covered services. Members enrolled in Partnership Plans or MassHealth MCOs will receive these services through their Partnership Plan or MCO.

**16. Question: What requirements will ACOs have for care delivery and management? What will member care look like under ACOs?**

MassHealth's ACO program prioritizes integrated and member-centered care. All ACOs will be responsible for ensuring their members receive medically necessary care that is appropriate, evidence-based, accessible, and coordinated. ACOs will also be required to incorporate the expertise of their CPs to ensure thoughtful care planning that is responsive to member needs. MassHealth ACOs will be required to:

- Support culturally and linguistically appropriate services
- Ensure access to primary or urgent care during extended hours
- Provide a clinician hotline for members. MCO-Administered ACOs will instead be required to coordinate with their MCOs to provide a clinician hotline
- Screen all their members to identify their care needs, including unmet needs, such as BH-related needs, functional or LTSS needs, and health-related social needs
- Assist members with accessing appropriate care based on identified needs, including information and navigation support, referrals, working with CPs to ensure eligible members receive decision support
- Facilitate access to social services to address health-related social needs, including using flexible services DSRIP funding
- Coordinate care, including establishing discharge protocols to manage transitions of care, and coordinating with agencies or providers involved in members' care
- Establish wellness initiatives and education programs for members
- Establish disease management programs for prevalent conditions
- Proactively identify members who might benefit from care management (e.g., through primary care referral, or predictive risk stratification), including members who are medically complex, have multiple comorbidities, are at risk for readmission, are episodically or chronically homeless, have significant BH care needs, have LTSS needs, or are receiving services from state agencies
- Provide member-centered comprehensive assessment and care planning for certain members, including for members with LTSS or significant behavioral health needs, and including using LTSS CPs to ensure appropriate independence for the functional component of such assessments.
- Provide appropriate care management activities for certain members as appropriate, which may include convening integrated care teams (including working with CPs to ensure BH and/or LTSS representation) and assigning care coordinators or clinical care managers to oversee member's care.



ACOs will report to MassHealth on their care delivery and management strategies, and in some cases will be required to receive approval. Additionally, all ACOs will be accountable for a range of quality and member experience measures, including process and outcome measures related to care management, care integration, and member satisfaction.

**17. Question: What rights and protections will members in ACOs have?**

All ACOs will be required to ensure members' rights and inform members of these rights, including the rights to:

- Receive written information in an easily understood and readily accessible form.
- Be treated with respect and with due consideration for the member's dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Participate in decisions regarding his or her health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with applicable federal law.
- Request and receive any of the member's medical records in the ACO's possession, and be notified of the process for requesting amendments or corrections to such records.
- Freely exercise his or her rights and not have the exercise of those rights adversely affect the manner in which the ACO or any provider treats the member.
- Choose which providers they want to see from among available providers.
- Have immediate and unrestricted access Emergency Services Program and Mobile Crisis Intervention services at hospital emergency departments and in the community, 24 hours a day, seven days a week.
- Not be discriminated against on the basis of health status or need for health care services, race, color, national origin, sex, sexual orientation, gender identity, or disability.

All ACOs will be required to have member grievance policies, or coordinate with their MCOs' grievance policies, that provide for acknowledgement of receipt of member grievances, timely resolution of such grievances, and inclusion of member rights and grievance policy information as part of a welcome packet that is delivered to members upon their attribution to the ACO.

Like MCOs, Partnership Plans will be required to also have an appeals process in place. All members in all ACOs will continue to have access to MassHealth's appeals and grievance processes as well, and ACOs will not be allowed to discourage or impede access to their own or MassHealth's member protection processes.

Members who enroll in MCOs or Partnership Plans will also have provisions for continuity of care, as described above.

**SECTION 5: ACO payments and quality accountability**

**18. Question: How will ACOs get paid?**

ACOs are financially accountable for both the cost and quality of member care. ACOs' financial incentives are designed to take the focus off providing high-volume, siloed care, and ensure that each member has an accountable entity focused on integrating and coordinating their care. The ACO payment models will allow ACOs to succeed financially by shifting member care to appropriate sites (e.g., from facilities to community-based care, as appropriate), investing in primary and preventative care, integrating behavioral health, and ensuring appropriate access to services.

- Partnership Plans will receive a prospective, monthly capitation payment, subject to a risk corridor, like MCOs.
- Primary Care ACOs will receive a TCOC target, calculated based on the ACO's population and anticipated costs. After each year, MassHealth will assess the performance of each Primary Care ACO against its TCOC target, and will make a shared savings payment if the ACO has achieved savings, or require the ACO to pay a shared losses payment if the ACO has losses against the target.
- MCO-Administered ACOs will receive a TCOC target, calculated based on the ACO's population and anticipated costs. MCOs will perform the assessment on TCOC performance and make or receive payments for their MCO-Administered ACOs.

Shared savings and shared losses for Primary Care and MCO-Administered ACOs will be based on each ACO's chosen risk track. Each risk track gives ACOs a different share of savings and losses, allowing ACOs to choose their level of accountability. Primary Care ACOs will choose between two risk tracks, and MCO-Administered ACOs will have a choice of three.

Each ACO's rates and TCOC targets will be based on a blend of that ACO's historic TCOC experience and the average TCOC for eligible members; MassHealth intends to increase the amount of the blend that is based on average TCOC for eligible members over time.

**19. Question: How will ACOs' quality performance be measured?**

ACOs will be scored on 38 claims, clinical, and member experience measures broken into six quality domains:

- Prevention and Wellness
- Chronic Disease Management
- Behavioral Health/Substance Abuse
- Long Term Services and Supports
- Integration
- Avoidable Utilization

An ACO's performance on each individual measure will be scored against a national or statewide benchmark. Each measure will have a minimum threshold (e.g. 30<sup>th</sup> percentile of benchmark performance) and an excellence benchmark (e.g. 90<sup>th</sup> percentile of benchmark performance). Scores will vary continuously between one and two points from the minimum threshold to the

excellence benchmark. Performance below the minimum threshold will receive zero points. The percentage of points achieved out of points available will be calculated for each domain to produce a domain score.

Starting in performance year two, for each domain, additional points will be available as improvement points. Improvement points will be earned by obtaining a quality score on a measure that is significantly different from the previous performance period. Domain scores are capped at 100% of available points, but may be reached by a combination of achieved and improvement points.

Finally, domain scores will be averaged together at varying weights to produce an overall quality score.

**20. Question: How will quality scores impact shared savings and losses?**

Primary Care ACOs' and MCO-Administered ACO's shared savings or losses are also impacted by the ACO's quality performance. These ACOs can only receive shared savings if they reach minimum performance standards on quality, and can reduce the amount of any shared losses they must pay by up to 20% through strong quality performance. MassHealth will also incorporate quality scores in a similar way for the risk corridor arrangements with Partnership Plans, providing accountability for quality performance.

**21. Question: What can DSRIP payments be used for?**

MassHealth ACOs may use DSRIP funding for the following purposes:

- **ACO startup/ongoing support:** Funding to build up and maintain the infrastructure, workforce capacity, new care delivery models, and new workflows that will be necessary to deliver member-centered, coordinated care to their members, including through investment in and performance management of participating primary care providers
- **Support for flexible services:** Services designed to address health-related social needs that are currently not reimbursed
- **Transitional funding for certain safety net hospitals:** Funds will be directed to hospitals currently receiving funding through the Delivery System Transformation Initiatives (DSTI) program to establish a "glide path" for reduction in supplemental funding
- **Initiatives to improve the availability and use of accessible medical and diagnostic equipment for people with disabilities.**

An ACO's DSRIP funding allocation for startup/ongoing and for flexible services will be determined by multiplying the number of lives attributed to the ACO by a per member per month (PMPM) amount. DSTI Glide Path funding will be based on a schedule determined by EOHHS for each specific DSTI hospital.

EOHHS will set the initial base PMPM rates for startup/ongoing funds, based on factors including the number of ACOs that sign contracts with EOHHS.

The PMPM rates for *startup/ongoing support* will be adjusted on an ACO-by-ACO basis, depending on:

- ACO's safety net category (based on the percentage of ACO revenue that is generated from care provided to Medicaid/uninsured individuals)
- ACO's chosen model and risk track

The base PMPMs used to calculate payment amounts for *startup/ongoing support* will decrease over the five years to sustainably transition ACOs to self-funding their operating costs under a long-term TCOC pricing model (e.g. funded through shared savings, reductions in FFS-specific activities, increased efficiency and use of technology).

The PMPM rate used to determine the size of *support for flexible services* will be held constant throughout the DSRIP period, and will not be modified by the PMPM increases that apply to the startup/ongoing base PMPMs.

Funds for DSTI glide path funding will be allocated according to an EOHHS-determined schedule, which is being developed based on negotiations with CMS regarding the overall funding glide path for DSTI hospitals, inclusive of other funding streams.

## **SECTION 6: MEMBER ENROLLMENTS**

### **22. What are the enrollment options for members after the MassHealth restructuring is implemented? How do members select an ACO?**

MassHealth will re-procure its MCOs in 2016, and the new MCO contracts will be effective as of October 1, 2017. Due to MassHealth's re-procurement of the MCO program, some existing MCOs may no longer be available and there may be some new MCO options. In addition, due to the launch of the ACO reform, new ACO options will be offered to members, also starting as of October 1, 2017.

Starting October 1, 2017, eligible members will be able to enroll in Partnership Plans or Primary Care ACOs alongside their present-day options of the PCC Plan or available MCOs. All eligible members will have the right and opportunity to enroll in a managed care option and select a primary care provider, as they do today. Eligible members will often have more choices than today, choosing among the following managed care options (as available):

- Available Partnership Plans in their area (new choice)
- Available Primary Care ACOs in their area (new choice)
- Available MCOs in their region, including the option (new choice) to receive care from available MCO-Administered ACOs contracted with these MCOs, based on the member's choice of PCP
- The PCC Plan

As ACOs may have smaller, more closely coordinated primary care networks than MassHealth MCOs, ACOs may not be available everywhere.

Members will have access to information they need to choose their MassHealth coverage from multiple sources, including which providers (PCPs and specialists) are available in each MCO and ACO.

Members will be able to make enrollment decisions based on what is most important to them, and will have the information needed to make those decisions. For example, if a member's PCP is their most important care relationship, they will be able to identify the options (e.g., ACOs, MCOs, and/or the PCC Plan) where that PCP is available. Members will also be able to identify options based on the availability of key specialists or facilities.

### **23. How do members join MCO-Administered ACOs?**

If a member is enrolled in a MassHealth MCO, the member's MCO will still be that member's primary enrollment, determining the member's network. If the member is enrolled in a MassHealth MCO and the member's PCP participates in an MCO-Administered ACO, the member is considered "attributed" to that MCO-Administered ACO for the purposes of the ACO's cost and quality accountability.

Participation in a MCO-Administered ACO happens through enrollment in an MCO that contracts with that ACO. For example, if an MCO-Administered ACO contracts with two MCOs, eligible members who wish to be assigned to that ACO's PCPs will need to enroll with one of those two MCOs.

### **24. What will happen to members' existing enrollments when the enrollment options change on October 1, 2017?**

All eligible members will receive notice and enrollment guides from MassHealth in advance of October 1, 2017 explaining their options. MassHealth's Customer Service Center will be staffed up to handle high-volume calls to explain options and do enrollments. All eligible members will have an opportunity to choose among the options presented above. If they do not choose within a defined period, MassHealth will assign them. MassHealth will seek to keep members aligned with primary care providers in the assignment process. Members who choose or who are assigned will have further opportunity to change their selection without cause within the first ninety days and for a limited number of reasons after those first 90 days. Every year, members will have a new enrollment period, including a new opportunity to change plans without cause for ninety days.