

MassHealth Restructuring Frequently Asked Questions (FAQ)

August 15, 2016

Key Goals and Outline of this Document

This document provides clarification to some of the most frequently asked questions regarding MassHealth's restructuring effort, as detailed in the documents released on the MassHealth Innovations website on April 14, 2016 (<http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/masshealth-innovations/masshealth-restructuring-updates.html>). Please note, these FAQs and related MassHealth issuances are for informational purposes. They represent MassHealth's current anticipated policy but are subject to further review and all necessary state and federal approvals.

- Questions about ACO programmatic design details
- Questions about DSRIP and Certified Community Partners

Questions about ACO programmatic design details

1. What populations are eligible for ACO enrollment, and how will Medicare-eligible members be impacted?

MassHealth anticipates that members who are currently eligible to enroll in the Primary Care Clinician (PCC) Plan or the Managed Care Organization (MCO) program, including members eligible for CarePlus plans, will be eligible for enrollment in or assignment to ACOs.

Options for members with Medicare will not change as part of the initial ACO reform. Over the coming years, MassHealth may consider expanding and better aligning existing programs for dual eligibles, such as One Care and Senior Care Options, with the ACO models and other value-based reforms.

2. Can a primary care provider participate in more than one ACO?

Each ACO will be required to ensure that its participating PCPs align with only one ACO at a time. All eligible MassHealth members on a participating PCP's panel will be included in the population for which the PCP's ACO is held accountable for cost and quality. This alignment between PCPs and ACOs will help ensure that ACOs are held accountable for all of the eligible members they serve, and will strengthen incentives for ACOs to invest in primary care and population health management. Members who prefer to maintain their PCP relationships will be able to choose their ACO or MCO enrollment based on the ACO or MCO in which their PCP participates.

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

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MassHealth will re-procure its MCOs in Fall 2016, and the new MCO contract 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 Model A or Model B 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 Model A ACO/MCOs in their region (new choice)
- Available Model B ACOs in their region (new choice)
- Available MCOs in their region, including the option (new choice) to receive care from available Model C 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 standard/CarePlus 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 PCCP) where that PCP is available. Members will also be able to identify options based on the availability of key specialists or facilities.

4. How do members join Model C ACOs?

If a member is enrolled in a Standard/CarePlus 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 Standard/CarePlus MCO and the member's PCP participates in a Model C ACO, the member is considered "attributed" to that Model C ACO for the purposes of the ACO's cost and quality accountability.

The PCPs that participate in a Model C ACO will only be available for member assignment or selection in the MCOs with which the Model C ACO is contracted. For example, if a Model C 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.

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

All eligible members will receive notice from MassHealth in advance of October 1, 2017 explaining their options, and will be able to call or email MassHealth's Customer Service Center to better understand their options. 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. 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 within the first ninety days.

6. How are current or new members assigned if they do not select an enrollment option?

Consistent with current practice, managed care eligible members who do not choose a managed care option will be assigned to one. MassHealth is considering assigning members who do not choose an option by prioritizing that member's existing primary care relationship:

- If a member's primary care provider has joined a Model A ACO or a Model B ACO and the member does not choose a managed care option, the member would be assigned to that ACO.
- Otherwise, the member would be auto-assigned to an available ACO or MCO based on MassHealth's auto-assignment rules (based on factors such as quality scores, access and availability, and cost performance).

Therefore, if a primary care provider today has a patient panel which includes some PCC plan participants and some MCO participants, and that PCP joins a Model A or B ACO, eligible members who do not choose a managed care option on their own will be assigned to that ACO. Each of these members will then have the opportunity to switch to another ACO or MCO or enroll with the PCC plan within the first ninety days of enrollment.

7. To which providers will members in ACOs have access?

All members enrolled in ACOs, MCOs, or the PCC Plan (PCCP) will have access to an appropriate and adequate network, and the ability to choose a PCP from among the available options in that network. PCPs who choose to participate in an ACO will be aligned with a single ACO. PCPs who do not participate in an ACO may be available as PCPs in the PCCP, or in any of the available standard/CarePlus MCOs, but will not be available in Model A or B ACOs. Specialists, hospitals, and other providers may be available across multiple networks just as they are today.

Initially, as today, all managed care eligible members will have access to MassHealth's network for LTSS, regardless of enrollment. In future years, subject to further stakeholder engagement, quality measurement, and design, MassHealth aims to fully integrate LTSS into the scope of accountability for MCOs and Model A ACOs, including requiring these MCOs and ACOs to contract for LTSS provider networks, similar to Integrated Care Organizations in the One Care program.

- Model A: the Model A integrated ACO/MCO will contract for and define a network of providers. Members enrolled in a Model A ACO/MCO will have access to all these providers. Members enrolled in a Model A ACO/MCO can select any of the available PCPs who participate in that

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Model A ACO/MCO. Model A ACO/MCOs are required to ensure that their affiliated PCPs participate as PCPs only in that ACO/MCO. These PCPs are not available for selection in any other ACO or MCO, or in the PCCP.

- Model B: the Model B ACO will contract directly with MassHealth, Model B ACO members will have access to all of the providers in the MassHealth network (including MassHealth's behavioral health vendor's network for behavioral health providers, similar to members enrolled in the PCCP today). Members enrolled in a Model B ACO can select any of the PCPs who participate in that Model B ACO. Model B ACOs are required to ensure that their affiliated PCPs participate as PCPs only in that ACO. These PCPs are not available for selection in any other ACO or MCO.
- Model C: the MCO will contract for and define a network of providers which include Model C ACOs. Members enrolled in an MCO will have access to all the MCO's participating providers, including all of the MCO's in-network PCPs, regardless of whether or not they are attributed to an ACO. Some of these available PCPs will be participating PCPs in Model C ACOs; these PCPs may only participate with one ACO at a time, and are therefore not available in any Model A or B ACOs. Each PCP that participates in a Model C ACO is only available in MCOs that have contracted with that ACO; these participating PCPs are therefore not available in any other MCOs or in the PCCP. Model C ACOs can contract with any available regional MCOs (they must contract with at least one).

8. Will primary care providers (PCPs) have the option to join ACOs without exclusively aligning with a single managed care plan option?

Yes. If a PCP does not want to exclusively align with a Model A or Model B ACO, the PCP can join a Model C ACO. Model C ACOs can contract with any available regional MCOs (they must contract with at least one) and can have attributed members who are enrolled with any of the regional MCOs with which they contract. Although a Model C ACO is not required to exclusively partner with a single regional MCO, a Model C ACO may still choose to have a closer affiliation with one of its contracted MCOs or even to partner exclusively.

9. We understand that MassHealth plans to offer fewer optional benefits in the Primary Care Clinician (PCC) plan beginning in October 2017, considering elimination of certain benefits (eyeglasses, hearing aids, orthotics, and chiropractor) in the PCC plan. Given that Model B ACOs are contracting directly with MassHealth, will members enrolled in Model B ACOs be subject to the proposed benefit changes for the PCC Plan?

Members enrolled in Model B ACOs will not be subject to the proposed benefit changes for the PCC Plan. Only members of the PCC plan (i.e., members who are not enrolled in a Model B ACO, or any other ACO or MCO option) will be subject to the proposed benefit changes for 2017.

10. What is the financial risk that ACOs will take on?

Model A ACO/MCOs will include a health plan, and therefore will take on financial risk that is comparable to the current MCOs. Like MCOs, Model A ACO/MCOs will be paid a prospective comprehensive per member per month capitation rate, will manage provider networks, and will enroll members. All ACOs will be accountable for a defined set of services, while certain other services will be paid for separately by MassHealth; for example, certain LTSS services, as happens in the MCO program today. Please see question 13 below for additional detail.

Model B and Model C ACOs will be accountable through shared savings/shared losses arrangements (i.e., retrospectively). Model B and C ACOs will each be able to select from risk track options; some risk tracks will have more limited potential for losses and gains, while others will have more. Each risk track lays out the upside and downside savings/risk share for the ACO, and in most cases these will increase over the course of the five years. ACOs may be able to switch risk tracks between performance years.

Model A ACO/MCOs and standard/CarePlus MCOs will bear greater total risk than Model B and Model C ACOs, and will have additional administrative responsibilities (e.g., network management, claims payment). The different responsibilities that Model A ACO/MCOs (and MCOs) bear (*versus* Model B and C ACOs) will be reflected in the payment structure, e.g., through administrative payments.

11. What are the financial requirements to ensure that ACOs can take on this risk?

As a managed care plan, each Model A ACO/MCO will need to hold insurance licensure and meet all additional solvency and financial requirements required of MassHealth contracted MCOs including requirements for risk-based capital reserves.

Model B and C ACOs must possess sufficient resources to repay downside risk, such as cash reserves or lines of credit, consistent with CMS ACO models. Model B and C ACOs must demonstrate that they have submitted application to the Commonwealth of Massachusetts Division of Insurance (DOI) pertaining to the Risk Certificate for Risk-Bearing Provider Organizations (RBPO) and must maintain appropriate DOI-issued RBPO certification or waivers. If a Model A ACO/MCO is structured as a partnership between an ACO and an MCO that are separate legal entities, the ACO partner may also need to submit an RBPO application to DOI and maintain appropriate certification or waiver.

MassHealth will monitor the performance of all ACOs on an ongoing basis, and may make adjustments to the program, including to an ACO's risk track to meet program goals, such as ensuring the financial stability of the delivery system and productive incentive structures for ACOs and MCOs. MassHealth will reserve the right to engage ACOs that are failing to meet contract requirements or performing poorly under their applicable risk model in order to improve their performance.

12. What responsibilities will ACOs have with respect to care delivery and care management?

All ACOs will be responsible for ensuring their members receive care that is appropriate, evidence-based, accessible, and coordinated. For example, ACOs will be required to:

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- Screen members to *identify care needs*, such as chronic disease, behavioral health (BH) conditions including substance use disorders, functional impairments, and health related social needs
- Provide assistance to members with *accessing appropriate care* based on identified needs which may include information and navigation support, referrals, working with Community Partners to ensure eligible members receive decision support with appropriate conflict mitigation
- *Proactively evaluate* their populations to determine which members might benefit from care management, including analyzing data on member utilization and care needs to identify members with long-term services and supports (LTSS) and/or BH needs, members with Special Health Care Needs, and members at-risk for adverse events (“risk stratification”)
- Provide *appropriate care management activities* for members which may include person-centered care plans, integrated care teams (including working with CPs/CSAs to ensure BH and/or LTSS representation, as specified by EOHHS), designated care coordinators or clinical care managers, disease-specific management programs, care transitions management, and/or working with BH CPs to provide intensive BH clinical management
- Ensure that all members have access to emergency behavioral health services, including immediate and unrestricted access to Emergency Services Program and Mobile Crisis Intervention services at hospital emergency departments and in the community, 24 hours a day, seven days a week
- Coordinate with staff in other state agencies (e.g., DMH, DDS, DCF and DYS), or community service organizations, if the agency/organization is already involved in meeting the member’s needs, or providing information and referral if the agency/organization could be helpful in meeting such needs

These requirements particularly prioritize integrated and member-centered care. ACOs will report on their care delivery and management strategies to MassHealth, and in some cases will be required to receive approval; ACOs will also be required to incorporate the expertise and counsel of their CPs to ensure thoughtful design that is responsive to member needs. 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.

13. What requirements will ACOs have to partner with Community Partners?

ACOs are going to be required to partner with sufficient number of Certified Community Partners (CPs) to adequately serve the CP-eligible member population, as further specified by MassHealth.

ACOs are going to be required to delegate certain responsibilities to BH and LTSS CPs (e.g., LTSS assessments and counseling and navigation on available LTSS options, care coordination activities amongst BH and LTSS providers). In addition, ACOs will be required to have BH and LTSS CP expertise on integrated care teams for initial development of member-centered care plans as well as their ongoing

maintenance. MassHealth will define different levels of requirements based on the complexity and needs of a given individual.

MassHealth will release further information on the specific requirements for ACOs to partner with CPs in the coming months. All final contracts between ACOs and MassHealth will incorporate these requirements.

14. Will MassHealth release more detail on the ACO models?

Yes. MassHealth will release a full ACO procurement, including model contracts and any additional supplemental materials, later this summer.

15. Will providers be able to receive data from MassHealth?

Providers who apply to participate in the ACO procurements (including the pilot) will receive databooks, providing information on the MassHealth population and cost and quality performance, during the procurement process.

Participating Pilot ACOs (pilot participants) will receive regular performance reporting from MassHealth (e.g., regular member rosters, claims extracts, summary reports). Pilot ACOs will receive these reports during the Pilot performance period (December 2016 through September 2017). ACOs that join the full ACO reform launching in late 2017 will receive these reports during a “reporting period” that will start by early 2017 (to allow ACO contracting to complete) and run until the full ACO launch. After the full ACO launch, participating ACOs will continue to receive reporting and other supports.

Providers who submitted notices under the Notice of Opportunity for provider reports earlier this year will begin receiving those reports in July 2016.

16. What costs are included in ACO accountability?

ACOs are financially accountable for the costs of MassHealth services in the broad categories of physical health, behavioral health, and pharmacy, to align with the scope of accountability for MassHealth’s MCO program. Physical health services will include preventive, primary, acute and post- acute care through the first 100 days after hospitalization. Other services, including long-term services and supports (LTSS), will continue to be paid for by MassHealth (“wrapped”) for Model B ACOs, and for other models until LTSS is phased into MCOs. The total cost of care (TCOC) calculation applied to Models B and C ACOs will incorporate various adjustments to reduce the impact of outlier spending on services such as pharmacy.

Accountability for state plan LTSS costs (i.e., not including Home and Community Based Waiver services) will be phased in over the course of the demonstration period. Appropriate measures will be taken to ensure that ACOs demonstrate the necessary capacity to manage LTSS prior to the inclusion of LTSS costs in the ACOs TCOC. Including LTSS in the ACO total cost of care will align financial incentives for the ACOs to leverage community-based, and ensure a preventative and wellness-based approach for members with LTSS needs in order to re-balance spending of LTSS away from more intensive settings of

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care to the least restrictive setting of a beneficiary’s choice. In Model B, MassHealth will continue to be responsible for contracting the LTSS network, establishing fee schedules and paying claims for LTSS services. In Models A and C, MCOs will ultimately contract the LTSS network, establishing fee schedules and paying claims for LTSS services.

As MassHealth transitions to ACO models, MassHealth members will continue to receive dental care benefits as they do today, through a contracted Third Party Administrator (currently DentaQuest) as described in the MassHealth dental program regulations at 130 CMR 420.000 and 450.105. MassHealth will promote the integration of oral health and quality of oral health care through a range of methods (e.g., inclusion of oral health metrics in the ACO quality measure slate, contractual expectations for ACOs). In addition, for members who will be enrolled in ACOs, dental services will continue to be paid FFS and associated dental costs will not be counted against the ACO total cost of care budget.

In addition to financial accountability, ACOs will have broad accountability to integrate care across service categories, including for services that are not part of their financial accountability, and will be measured on several domains of care integration and member satisfaction.

Below are two tables that summarize the benefits for MassHealth managed care eligible members, and categorize them based on whether they are currently covered by MCOs (i.e., the services that would be part of the cost accountability for ACOs) or “wrapped” by MassHealth (i.e., the services that would continue to be paid for directly by MassHealth and not included in ACO or MCO accountability).

MCO covered services/services included in ACO cost accountability

Medical Services	Medical Services (cont.)	Medical Services (cont.)
Abortion Services	Hearing Aid Services	Vision Care (including comprehensive eye exams and vision training)
Acute Inpatient Hospital Services	Home Health Services	Transportation Services (emergency; nonemergency transportation 50 miles outside the MA border)
Ambulatory Surgery Services	Hospice Services	Wigs
Audiologist Services	Laboratory Services	
Chiropractor Services	Medical/Surgical Supplies	Behavioral Health (Mental Health and Substance Abuse) Services
Chronic Disease and Rehabilitation Inpatient Hospital Services	Nursing Facility Services	Diversionsary Services
Community Health Center Services	Orthotic Services	Emergency Services Program (ESP) Services, including Youth Mobile Crisis Intervention for Members under 21
Dental Services (emergency)	Outpatient Hospital Services	Inpatient Services
Dialysis Services	Oxygen and Respiratory Therapy Equipment	Outpatient Services, including Intensive Home- or Community-Based Services for Youth
Durable Medical Equipment	Pharmacy Services	
Early Intervention Services	Physician, Nurse	

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	Practitioner, and Nurse Midwife Services	
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services	Podiatrist Services	
Emergency Transportation Services	Prosthetic Services	
Emergency Inpatient and Outpatient Hospital Services	Radiology and Diagnostic Services	
Family Planning Services	Therapy Services (physical therapy, occupational therapy, and speech/language therapy)	

MassHealth “wrapped” services/services not included in ACO cost accountability

Adult Day Health Services	Eyeglasses, Contact Lenses, and Other Visual Aids	Transportation Services (nonemergency transportation within MA and up to 50 miles beyond the border)
Adult Foster Care Services	Family-Planning Services	
Continuous Skilled Nursing Services	Group Adult Foster Care Services	
Day Habilitation Services	Hospice Services	
Dental Services	Personal Care Services	

17. What will happen to providers in the Primary Care Payment Reform program?

The Primary Care Payment Reform (PCPR) program will end on December 31, 2016. We expect that many PCPR providers will join ACOs, and be leaders in the formation and participation of the new ACO models. PCPR providers should plan to transition to supporting their care model investments under ACO frameworks, including using ACO DSRIP funding.

MassHealth may make additional infrastructure funding available to PCPR providers through the Infrastructure and Capacity Building grant, to further support the maintenance of investments and progress made by these providers during the program. The Governor’s House 2 budget proposal includes funding for this grant program, subject to final appropriation in the state budget cycle.

18. What is the ACO Pilot?

MassHealth has released a procurement for an ACO Pilot. This pilot will allow MassHealth to begin the transition towards accountable care and population-based payments (and away from fragmented, fee-

for-service care) with selected, experienced ACOs under a limited risk model. Further information about the Pilot can be found on COMMBUYS. The deadline for applications was July 8, 2016.

Questions about DSRIP and Community Partners

19. When will MassHealth release additional information about DSRIP details?

- MassHealth will release additional information about DSRIP funding for ACOs alongside ACO procurement release, targeted for early September
- MassHealth will release additional information about DSRIP funding for CPs alongside CP certification requirements, targeted for late November/early December
- MassHealth will release additional information about DSRIP supporting statewide investments in October of 2016

20. When will MassHealth release additional information about Certified CPs?

MassHealth will release additional information about Certified CPs in October/November 2016.