# MassHealth Delivery System Restructuring Open Meeting

Executive Office of Health & Human Services

October 2016

Boston, MA and Springfield, MA

# Agenda

I. **The Case For Change – *Goals of MassHealth Restructuring***

II. Current State – *MassHealth's Delivery System Today*

III. Mechanics of Change – *Transition to Future State*

IV. Future State – *MassHealth's Delivery System After Reform*

V. Support Through Change – *MassHealth Support for Members and Providers throughout Transition*

VI. Timeline

# Current vs. Sustainable System

## Current system

- Rewards volume
- Built to address emergency or short-term medical events; difficult for members to navigate the system
- Multiple doctors treating the same patient for the same condition without talking to each other
- Limited transparency into quality and efficiency of care
- Patient information often stored in silos or paper medical records

## Sustainable system

- Rewards outcomes and value
- Member's health managed seamlessly across providers and over time (not visit by visit)
- Providers act as a team to ensure coordination of right services
- Easy to understand quality and cost data made available to consumers and providers
- Appropriate electronic health information readily available across care teams and with consumers

# Goals of MassHealth Restructuring

- Improve population health and care coordination through payment reform and value-based payment models
- Improve integration of physical and behavioral health care
- Scale innovative approaches for populations receiving long-term services and supports
- Ensure financial sustainability of MassHealth

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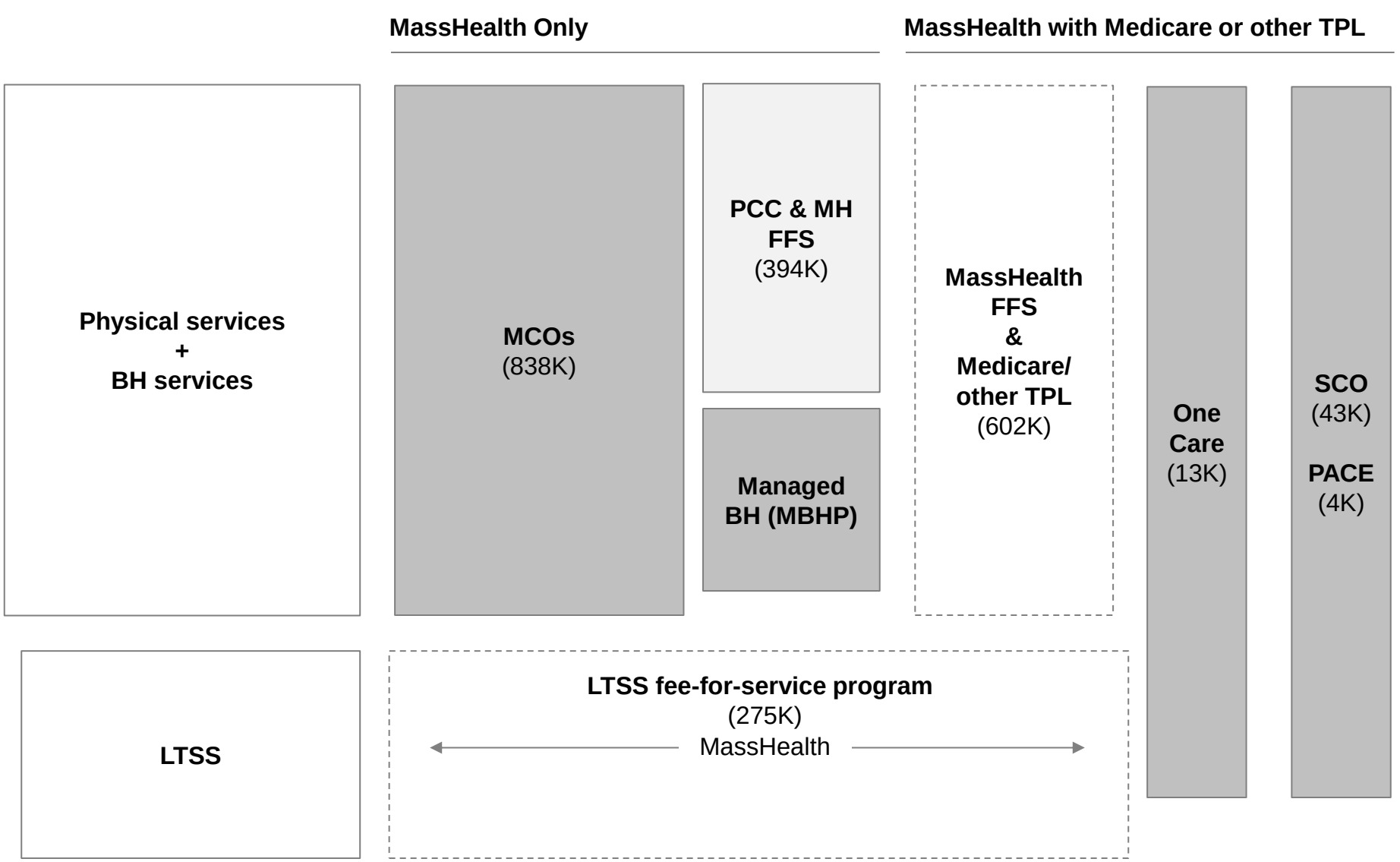
# MassHealth Managed Care Populations

- Today, MassHealth's managed care populations are generally:
  - Under 65, no third-party liability (TPL) (including Medicare)
  - Living in the community
  - In MassHealth Standard, CommonHealth, CarePlus, and Family Assistance
- Currently, managed care members can choose:
  - **Primary Care Clinician Plan (PCC Plan):**
    - Behavioral health (BH) is managed by a vendor; capitated payment
    - All other services (medical and long-term services and supports) are provided directly by MassHealth, paid fee-for-service (FFS)
  - **A Managed Care Organization (MCO)** in their region:
    - Manages medical and BH services; capitated payment
    - Long-term services and supports (LTSS) is provided directly by MassHealth, paid FFS

# Current MassHealth Delivery System



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# Plan Selection and PCC Plan Changes

**Effective October 1, 2016:**

1. **Plan Selection and Fixed Enrollment Period**
   - Members enrolled in a MassHealth MCO will have a 90-day **Plan Selection Period** every year
     - During this time, members can change their health plans for any reason
     - After the 90-day Plan Selection Period has ended, members will enter a **Fixed Enrollment Period** where they will remain in their MCO
     - During the Fixed Enrollment Period members can change plans only for certain reasons – generally if a member's care and access needs are not being met
   - The same rules will apply for members in ACOs when they launch in 2017

2. **Additional Referrals for Primary Care Clinician Plan (PCC):**
   Members enrolled in the PCC Plan will now need to get referrals from their primary care provider for certain additional health care services

For more information, visit:
http://www.mass.gov/eohhs/consumer/insurance/masshealth-member-info/

# ACO Pilot

**One Year ACO Pilot:** Primary care provider-based entities that will coordinate care and be accountable for total cost of care for their attributed members, starting **December 2016**

**Pilot Goals are to:**

- Build and test key systems needed to support the full ACO launch
- Provide an opportunity for experienced ACOs to start adapting their programs for the MassHealth population
- Begin MassHealth's shift to value-based, accountable care

**Pilot will allow MassHealth to evaluate and monitor:**

- How effectively care is being coordinated and integrated
- Impact on members and their care relationships
- Impact on provider organizations
- Total Cost of Care (TCOC) measurement
- MassHealth's ability to share data with ACOs
- Impact on MassHealth Operations

**Pilot Membership:**

- Based on member's relationship with a Primary Care Provider (PCP) who is in a Pilot ACO
- Will only affect members currently in the PCC Plan
- Members will continue to receive behavioral health (BH) services through the Massachusetts Behavioral Health Partnership (MBHP)
- Members will continue to have access to the full MassHealth network of providers for non-BH services
- Attributed members who do not wish to participate in the Pilot may change their PCP

# ACO Pilot (cont.)

**ACO Pilot Features:**

- Primary care provider-based entities that will coordinate care and be accountable for total cost of care for their attributed members
- Pilot governance is provider-led (75% of board) and will include a voting consumer board member as well as a Patient and Family Advisory committee
- Pilot ACOs will not authorize or pay for MassHealth services
- ACO providers will continue to bill MassHealth directly for services
- Pilot ACOs will be not be accountable for LTSS

**ACO Pilot Payment and Quality:**

- Eligible for shared savings payments and at risk for shared losses based on Total Cost Of Care (TCOC)
- Must meet quality measure targets in order to receive shared savings; including:
  - claims-based
  - clinical (records-based)
  - member experience (survey-based)

# ACO Pilot (cont.)

- MassHealth has selected the following to enter into Pilot ACO contract negotiations:
  - Boston Accountable Care Organization
  - Community Care Cooperative
  - UMass Memorial Healthcare, Inc.
  - Partners Healthcare Accountable Care Organization
  - Children's Hospital Integrated Care Organization
  - Steward Medicaid Care Network
- Contracted Pilot ACOs will identify all PCPs in their organization, as well as any providers in their "referral circle." Members will not need a PCC referral to see providers in the Pilot ACO's referral circle.

# Full ACO Procurement

On September 29, 2016, MassHealth released a single, joint procurement for three different Accountable Care Organization models which will begin serving members in **December 2017**.

**A. Accountable Care Partnership Plan** (“Model A”)

A single ACO that is partnered with a single managed care organization (MCO)

**B. Primary Care ACO** (“Model B”)

An ACO that contracts directly with MassHealth

**C. MCO-Administered ACO** (“Model C”)

An ACO that contracts with one or more MCOs

**Key dates:**

- September 2016: MassHealth released ACO RFR and Model Contracts for all three models
- January 2017: Bidder responses due
- May 2017: Selections announced (expected)
- Summer 2017: MassHealth ACO Readiness Review
- Fall  2017: Member notices
- December 2017: Enrollment begins
- December 2017 - December 2022: Initial 5-year contract period

# Full ACO Procurement (cont.)

- **ACO is Responsible for:**
  - **Direct investment** in their PCPs and requirements for **performance management and incentives**
  - Surveying members to **identify care needs**
  - **Coordinating care**, managing discharges and transitions, and operating a clinician call line
  - Performing **comprehensive assessments** and developing **person-centered care plans**, as appropriate
  - **Team-based care management**, including a care coordinator or clinical care manager as appropriate
  - Governance that is provider-led (75% of board) and includes a voting consumer board member as well as a Patient and Family Advisory committee
  - Processes to accept member grievances and requirements to protect member rights (e.g., governance, access to medical records, choice of providers, non-discrimination)

- **MassHealth will evaluate RFR proposals from potential ACOs for:**
  - Ability and willingness to perform contract requirements
  - Experience such as **population health management, care integration, quality improvement, cost control**
  - Knowledge of our **member population** and their **care needs**
  - Strength of proposed member **engagement** strategies and **protections**
  - Strength of proposed plan for integrating, coordinating, and/or managing care across the range of services and providers for MassHealth's diverse populations (disability, children, etc.) and relationships with community-based organizations

# ACO Models

**A. Accountable Care Partnership Plan** (Model A)

- Single ACO partnered with a single MCO
- All enrolled members receive primary care from that ACO's PCPs
- Each ACO's PCPs can only provide primary care services for members who are in their ACO
- Members can see any providers in the Partnership Plan's network
- Must meet all MassHealth requirements for MCOs and ACOs, including provider-led governance and Health Policy Commission (HPC) certification
- Must provide the same administrative functions as MCOs, such as:
  - paying claims
  - maintaining provider network
  - prior authorization, etc.
- Communicate directly with enrollees about benefits of participating, provider network, and how to access services
- Must define their service areas, subject to MassHealth approval, and will need to meet network adequacy standards in those service areas
- May serve areas different than a full MCO region

# ACO Models (cont.)

**B. Primary Care ACO** (Model B)

- An ACO that contracts directly with MassHealth
- All enrolled members receive primary care from the Primary Care ACO's PCPs
- Each ACO's PCPs can only provide primary care services for members who are in their ACO
- Aside from their PCP, members can see any provider in the MassHealth network
- Members enrolled in Primary Care ACOs are also automatically enrolled with MassHealth's behavioral health contractor (currently MBHP)

**C. MCO-Administered ACO** (Model C)

- An ACO that contracts directly with one or more MassHealth MCOs
- An MCO may contract with more than one MCO-Administered ACO
- MCO enrollees may choose, or be assigned to, an MCO-Administered ACO by their MCO
- Members can see any provider in their MCO's network
- MCO enrollees may be attributed to an MCO-Administered ACO based on their PCP relationship

# ACO Payment

## A. Accountable Care Partnership Plan (Model A)

- Paid a prospective capitated rate for attributed members
- At risk for losses and savings beyond the capitation rate
- Authorizes medical and BH services in Y1 and Y2, adds LTSS in Y3 or Y4
- Pays for the same services that MCOs pay for

## B. Primary Care ACO (Model B)

- Accountable through shared savings and loss payments based on TCOC and quality performance for attributed members
- Attributed members receive non-behavioral health care from MassHealth's fee-for-service network, paid for directly through the MassHealth claims system (capitated, managed BH vendor pays for BH services)
- MassHealth authorizes non-BH services; managed BH vendor authorizes BH services
- MassHealth pays for services

## C. MCO-Administered ACO (Model C)

- Accountable to their MCOs through shared savings and losses payments
- MassHealth approves these financial arrangements and the associated requirements
- MCO authorizes medical and BH services in Y1 and Y2, adds LTSS in Y3 or Y4
- MCO pays for medical and BH services in Y1 and Y2, adds LTSS in Y3 or Y4

# ACO Quality Measure Goals and Objectives

ACOs will be accountable for providing high-value, cross-continuum care, across a range of measures that improves member experience, quality, and outcomes

- Quality metrics will ensure savings are not at the expense of quality care
- ACOs cannot earn savings unless they meet minimum quality thresholds
- Higher quality scores may:
  - Raise an ACO's shared savings payment
  - Reduce the amount the ACO needs to pay back in shared losses

- MassHealth will regularly evaluate measures and determine whether measures should be added, modified, removed, or transitioned from pay-for-reporting to pay-for-performance, and **will engage stakeholders as appropriate**

- **ACO measure slate will cover seven domains:**
  1. Prevention and Wellness
  2. Chronic Disease Management
  3. Behavioral Health / Substance Use Disorder
  4. Long-Term Services and Supports
  5. Avoidable Utilization
  6. Progress Towards Integration Across Physical Health, Behavioral Health, LTSS, and Health-Related Social Services
  7. Member Care Experience

# Review of ACO Exclusivity Rules

- An ACO can only participate in one model at a time
- An Accountable Care Partnership Plan (Model A) can only partner with a single MCO, but an MCO can partner with multiple Accountable Care Partnership Plans
- An MCO-Administered ACO (Model C) can partner with multiple MCOs
- Specialists can work with multiple ACOs and contract with multiple networks
- Primary Care Providers can only participate in one ACO as a primary care provider – as a specialist, that same person could work with multiple ACOs
- Hospitals and other providers can work with multiple MCOs and ACOs

**Example:**

Dr. Smith is both a Primary Care Provider **and** an Infectious Disease Specialist

- As a PCP, if Dr. Smith is part of an ACO, s/he can only provide primary care to patients of that ACO
- At the same time, as an ID specialist, Dr. Smith may see patients across different MCOs and ACOs and PCCP

# Community Partners

- In order to better support members with high BH or complex LTSS needs and their families, MassHealth will also procure Community Partners (CPs). These community-based entities will **help members navigate the complex system of care**.
- MCOs and ACOs will be required to partner with MassHealth identified **CPs with experience in behavioral health and LTSS**

**Objectives:**

- I**mprove member experience and quality of care** for members with BH and LTSS needs who are enrolled in MCOs and ACOs.
- Improve continuity of care for members with BH needs and ensure appropriate setting and level of care for members with LTSS needs
- Create opportunity for ACOs and MCOs to **leverage the expertise and capabilities of existing community-based organizations** servicing populations with BH and LTSS needs
- **Invest in the continued development of BH and LTSS infrastructure** (e.g., technology, information systems) that is sustainable over time
- **Improve collaboration** across MCOs and ACOs, CPs, community organizations addressing the social determinants of health, and the BH, LTSS, and physical health delivery systems in order to break down existing silos and **deliver integrated care**
- **Avoid duplication** of care coordination and care management resources
- **Support values** of community-first and cultural competence, SAMHSA recovery principles and independent living

# BH and LTSS Community Partner Selection

- **CPs selected through a MassHealth-led procurement process** to ensure:
  - Selection of CPs most capable of serving the population with high/complex needs, as demonstrated by strong existing member relationships and high quality care
  - Investment in and leveraging community resources (buy, not build)
  - Infrastructure funding will be effectively leveraged to support scalable models
- **Minimum criteria to apply for procurement, such as**
  - Community-based entity
  - Capacity to serve minimum panel size
  - Existing infrastructure (e.g., personnel, facilities / equipment, IT / systems)
  - Collaborative working relationships with other entities in the surrounding area (e.g., local providers, community organizations)
  - Cultural and linguistic competence
- **The procurement will include geographic region definitions** (e.g., 5 regions that coincide with current MCO regions) **that will inform the number of BH and LTSS CPs per region**
- **CPs should be prepared to contract with multiple MCOs and ACOs**. MCOs and ACOs will need CP contracts to qualify for full DSRIP funding.
- **MassHealth is looking for significant input from stakeholders**
  - RFI posted September 16, 2016 – responses due by October 7, 2016
  - Resumed BH and LTSS technical advisory groups in September 2016

# Managed Care Organization Procurement

- **MCO program is integral to MassHealth's long-term quality and sustainability**
  - MCOs currently cover ~840K lives in the traditional MCO and CarePlus programs; represents ~75% of all eligible non-elderly MassHealth members. MCO reprocurement will seek value through increased focus on quality, monitoring and oversite

- **MCO Procurement is a critical element of MassHealth payment reform efforts**
  - MassHealth looking to select MCOs with clear track record of delivering high-quality member experience and strong financial performance
  - Emphasis on selecting plans that will be strong partners in the exchange of high-quality and timely encounter and performance data
  - Successful bidders must demonstrate capacity to manage MCO-Administered ACOs (Model C)
  - Bidders will need to commit to accept responsibility and meet requirements for LTSS in Y3 or Y4 of a 5-year initial contract period

- **Key dates:**
  - November 2016: MassHealth releases RFR and Model Contract (expected)
  - February 2017: Bidder responses due
  - May 2017: Selections announced (expected)
  - Summer 2017: MassHealth MCO Readiness review
  - Fall 2017: Member notices
  - December 2017: Contracts effective

# Discussion

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# Current and Future Choices for Managed Care Members

- Today, MassHealth's managed care populations are generally:
  - Under 65, no TPL (including Medicare)
  - Living in the community
  - In MassHealth Standard, CommonHealth, CarePlus, and Family Assistance

- Currently, managed care members can choose:
  - **PCC Plan:**
    - BH is managed by a vendor; capitated payment
    - All other services (medical and LTSS) are provided directly by MassHealth, paid FFS
  - **An MCO** in their region:
    - Manages medical and BH services; capitated payment
    - LTSS is provided directly by MassHealth, paid FFS

- When new ACO and MCO contracts begin in December 2017, these members will have the following choices:
  - **Accountable Care Partnership Plans** (Model A) in their region *(new choices)*
  - **MCOs** in their region; may also choose primary care through an **MCO-Administered ACO** (Model C – *new choices*)
  - **Primary Care ACOs** (Model B) *(new choices)*
  - **PCC Plan**

# Introducing LTSS into MCOs and ACOs

- **MCO and ACO procurements will include required responses in order to determine capabilities around taking on LTSS accountability – in Year 3 or 4**
  - MCOs and Partnership Plan (Model A) contracts will be amended to include LTSS in capitation
  - Primary Care (Model B) and MCO-Administered (Model C) ACO contracts will be amended to include LTSS in Total Cost of Care – Incrementally, no capitation, no network responsibility; shared savings model
- **MassHealth will define contractual requirements (building off the One Care Model) including cultural competence and other elements in the One Care model**
  - MassHealth will define a Readiness Review process in collaboration with stakeholders
  - No plan or ACO will go live with LTSS until they are fully ready and qualified
- **MassHealth is committed to ensuring significant advocate/member engagement at each step in the process (similar to the One Care stakeholder engagement process)**

# MassHealth's Long-Term Services and Supports

**Goals for LTSS:** In addition to significant transformation in medical and behavioral health services, MassHealth also seeks to improve administration and delivery of LTSS:

- **Integrated:** MCOs and ACOs will begin taking responsibility for coordinating – and in some models, paying for – LTSS
- Increase SCO and One Care enrollment
- **Community-Based:**
  - Invest in community expertise through LTSS CPs
  - Target care coordination and CP resources to support care transitions
- **Sustainable:** Update LTSS policies and delivery systems to ensure services are matched to need
- **Integrity:** Improve LTSS administration and oversight to direct scarce resources to members who need them most

# MassHealth's Long-Term Services and Supports Roadmap

- LTSS is currently provided FFS for most members; integrated in One Care, SCO, and PACE
- Goal is to integrate LTSS into MCOs and ACOs in Year 3 or 4 of their five year contracts;
- MCOs and ACOs must undergo a thorough readiness review and demonstrate network adequacy prior to taking responsibility for LTSS
- MassHealth also plans measured expansion of One Care and SCO through outreach, marketing, and passive enrollment over the next few years; reprocure One Care for 2019
- FFS LTSS will be administered by a Third Party Administrator (TPA)

# Third Party Administrator for LTSS

**Even as we prepare for LTSS integration with managed care, we need to take immediate steps to improve and support the way LTSS is provided through the FFS system today**

Third Party Administrator (TPA) will provide clinical, administrative/operations, and systems support to MassHealth:

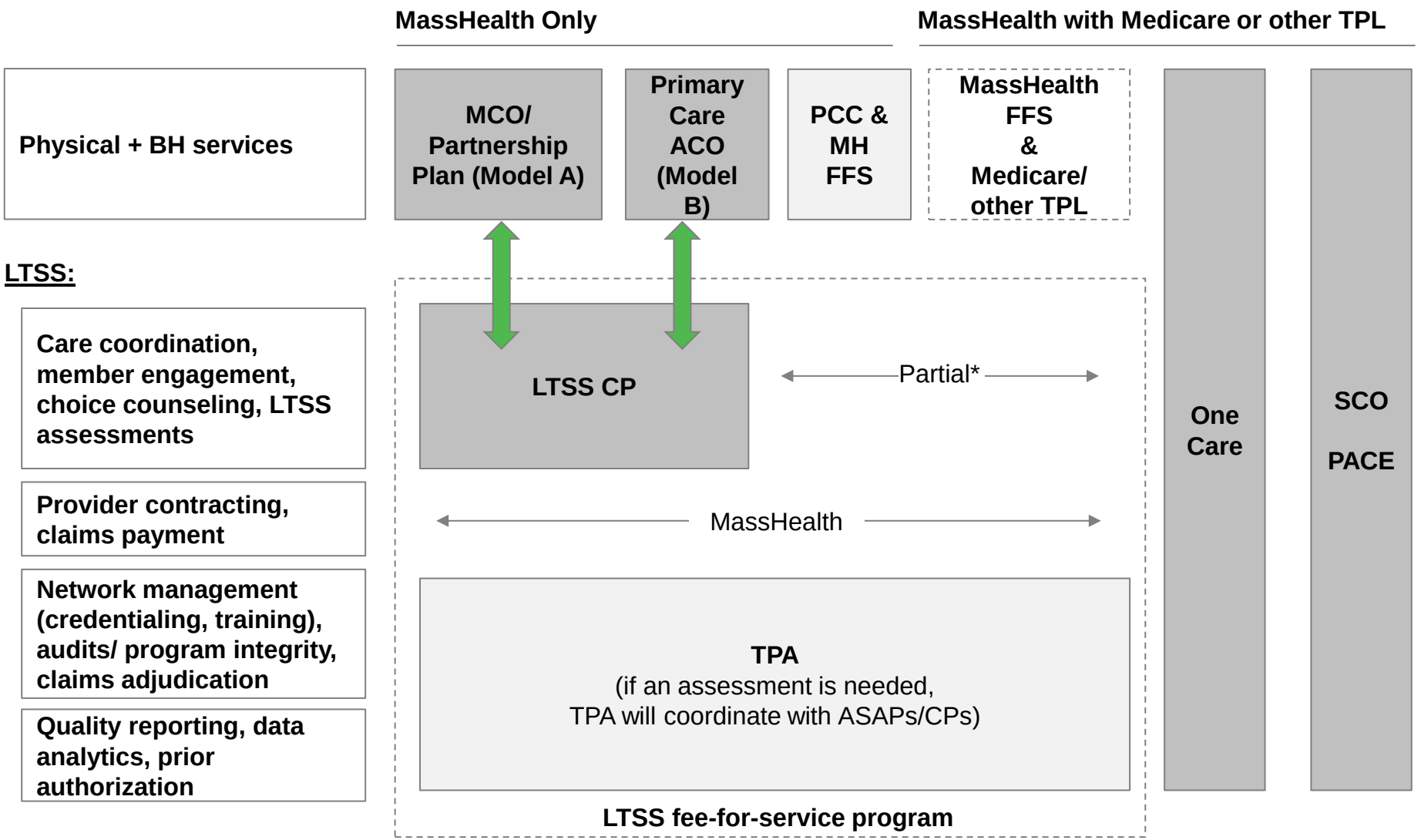
- Strengthen **program integrity analyses and audits**
- Conducts **analyses on utilization and quality patterns**
- **Implements regulations and prior authorizations** as defined and directed by MassHealth
- **Credentials providers and maintains a provider directory**
- **Primarily provider facing** (MassHealth customer service team may transfer member calls to the TPA re: specific prior authorizations)

- **Scope**:
  - LTSS State Plan FFS services (not under the responsibility of a managed care entity) provided to members over and under 65
  - Home and Community-Based Waiver Services are not presently in scope for the TPA

- **TPA is <u>NOT</u> at risk for overall LTSS total cost of care**

# TPA: How does it fit in with CPs, ACOs, and the delivery system?

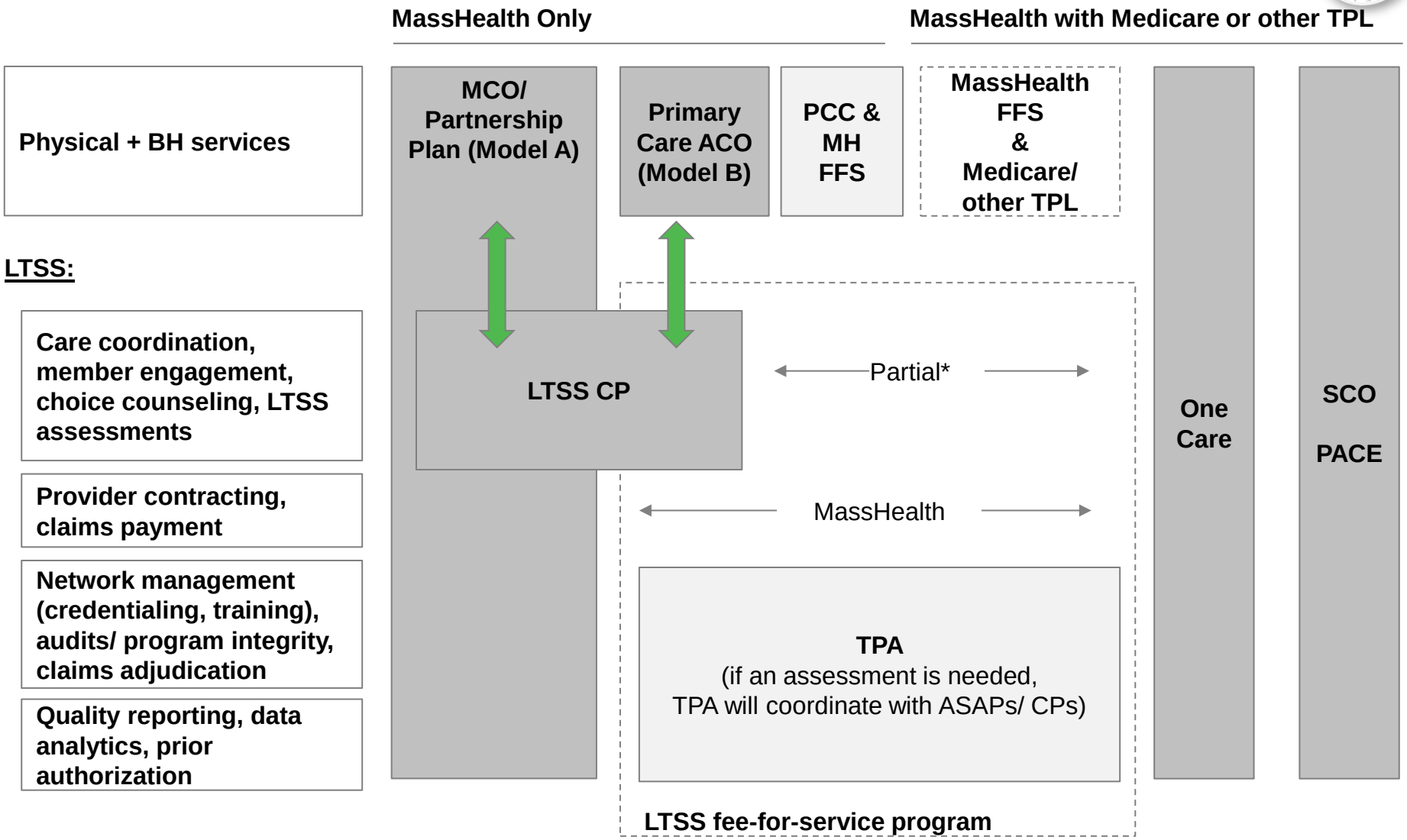
## NEW MODEL (Y1 – Y2 or Y3):




*ASAPs conduct assessments for NF & ADH, ADRCs conduct options counseling, ASAPs and sister agencies do these functions for waiver recipients for services funded under the waiver only, who will conduct assessments for other state plan LTSS services TBD

# TPA: How does it fit in with CPs, ACOs, and the delivery system?

## STARTING IN Y3 or Y4:




*ASAPs conduct assessments for NF & ADH, ADRCs conduct options counseling, ASAPs and sister agencies do all of these functions for waiver recipients for services funded under the waiver only, who will conduct assessments for other state plan LTSS services TBD

# TPA: LTSS the TPA will be administratively supporting

TPA will assist MassHealth in administering the State Plan LTSS listed below, when delivered Fee-for-Service.*

- MassHealth LTSS State Plan that are not covered by MCOs
- LTSS not covered by Medicare for dual eligibles
- LTSS for FFS members (elders not in SCO/PACE, dual eligibles not in One Care, members in PCCP, Primary Care ACO, or with TPL)

- Adult Day Health
- Adult Foster Care
- Chronic Inpatient Hospitals
- Chronic Outpatient Hospitals
- Day Habilitation
- Durable Medical Equipment
- Early Intervention
- Group Adult Foster Care
- Home Health Agency services
- Hospice
- Independent Nurse (Private Duty Nursing)
- Independent Therapist
- Nursing Facilities
- Orthotics
- Oxygen and Respiratory Therapy
- Personal Care
- Prosthetics
- Speech and Hearing Centers

***The TPA will be responsible for conducting prior authorization for all LTSS subject to PA, except for Nursing Facility (NF) services, Chronic Disease and Rehabilitation (CDR) hospital services, and for members in Community Case Management (CCM).**

# 1115 Waiver Updates

- **Statewide Investments – Delivery System Reform Investment Program (DSRIP): high-priority investments** that will play a key role in efficiently scaling up statewide infrastructure and workforce capacity; examples of investments include:

  - **Technical Assistance (TA):** For ACOs and CPs to identify and implement **evidence-based and high ROI interventions,** establish **new workflows and processes** to improve care coordination and integration

  - **Workforce development** -- Funding to support a wide spectrum of health care workforce development and training **to allow for individuals to more effectively operate** in a new health care system

  - **Student loan repayment program** – Repay a portion of a student's loan in exchange for a two year commitment as a:
    - primary care provider at a community health center (CHC)
    - behavioral health professional or licensed clinical social worker at a CHC, community mental health center, or an Emergency Service Program

  - **Initiatives to improve the availability and use of accessible medical and diagnostic equipment for people with disabilities**:
    - Funding to help with the **purchase of items** such as: adjustable examination tables, chairs, accessible weight scales, lift equipment, gurneys, and digital mammography machines.
    - Funding to **support an online provider directory** whereby MassHealth members with disabilities can search for **providers by preferred accessibility preferences**

# 1115 Waiver Updates (cont.)

- **Student Health Insurance Program (SHIP):** MassHealth is seeking to expand Premium Assistance to allow for and require the purchase of SHIP plans available on the individual market for eligible students, beginning for the fall 2016 college semester.

- **CommonHealth:** MassHealth is seeking federal financial participation (FFP) for the current state-funded CommonHealth program for working adults 65+ years old (no changes to the CommonHealth program)

- **Long-Term Services and Supports (LTSS):** Adding LTSS to MCO and ACO scope of responsibility, with phase in beginning in Y3 or Y4 of those contracts

- **Substance Use Disorder (SUD)** policy innovations to:
  - move currently funded Bureau of Substance Abuse Services (BSAS) residential rehab services to the MassHealth covered benefit on or around January 1, 2017
  - improve health outcomes through increased access to treatment and ongoing recovery support
  - reduce costs through reduction of Emergency Department use and avoidable hospitalization
  - maximize federal financial participation

- **PCC Plan Benefits:** MassHealth will **not** implement proposed changes to reduce PCC Plan benefits compared to other plan options

# Cost-Sharing Policy Changes

1. MassHealth is not seeking to exceed federal cost-sharing limits
2. MassHealth is seeking authority for higher copayment amounts (within federal nominal cost sharing limits) in PCC Plan relative to other delivery system options

Today, MassHealth charges members >150% FPL sliding scale premiums, and charges copays for adults on pharmacy and inpatient hospital services:

- Pharmacy copays ($1 and $3.65)
- Inpatient hospital copays ($3)

Under the proposed new cost-sharing schedule:

- Copays are eliminated for members at or under 50% FPL (~60% of membership)
- For members >50% FPL, adds differential copay amounts to encourage members to enroll in ACOs and MCOs to access lower copays compared to the PCC Plan
- Copays will be charged on additional service categories
- Max copays for most services would be $4 in the PCC Plan and $2 in an ACO, MCO, or FFS; $5 for non-emergency ED use and inpatient acute hospital services for all members
- All copays will be subject to a cap of 2% of family income each quarter
- Premiums for members with income >150% FPL will be 3% of family income

# Cost-Sharing Exemptions

Populations exempt from copays today will continue to be exempt from copays:

- Children under 21
- Pregnant Women
- Individuals living in an institution
- Individuals receiving hospice
- American Indian/American Native
- Have reached a copayment cap

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# Enhanced Support for Members and Providers

MassHealth understands that members and providers will need additional support in navigating new enrollment options, new networks, and evolving options for LTSS, and will build up resources for these transitions.

- Member communications:
  - Multiple methods to explain changes and new options
  - Tools and customer service support to help members identify where in the system their most important providers are
- Provider communications:
  - Information about new delivery system structure (webinars, provider forums, etc.)
  - Bulletins explaining changing rules
  - New requirements for LTSS providers working with the TPA
- MassHealth will spend the next year developing:
  - Enhanced provider directories
  - Web-based decision tools
  - Noticing, developed in collaboration with stakeholders
  - Enhanced enrollment guides
  - Enhanced customer service center capability
  - Community-based outreach

# Stakeholder Engagement

MassHealth will work with stakeholders over the next several months through:

- **Open Meetings** – throughout restructuring, starting October 2016
  - Oct. 7, 2016 2pm – 4pm - UMass Center, 1500 Main St., Springfield
  - Oct. 13, 2016 3pm – 5pm – 1 Ashburton Place, 21st flr., Boston
- **Technical Advisory Groups** – reconvened groups procured in 2015
- **Bidders Conferences**
  - ACO procurement: Oct. 5, 2016 9am – 12pm - 1 Ashburton Place, 21st flr., Boston
- **MassHealth Risk Adjustment Open Public Meeting**
  - Oct. 14, 2016 2pm -3pm - CHIA, 501 Boylston St., Boston

In addition, MassHealth plans to:

- Procure a **Delivery System Implementation Advisory Council** – expected to convene in December 2016
- Procure **Ombudsman** supports for members in accountable and managed care products (MCOs, ACOs, SCO, PACE, and One Care plans)

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**VI. Timeline**

# Timeline

**September 2016:**
- Reconvene TAGs
- Release ACO procurement

**October 2016:**
- Responses due for Community Partner RFI
- Plan Selection and Fixed Enrollment Periods begin
- PCC Plan referral changes begin

**November 2016:**
- Release MCO procurement

**December 2016:**
- Pilot ACOs go live

**January 2017:**
- ACO procurement responses due
- TPA begins

**February 2017:**
- MCO procurement responses due

**Spring 2017:**
- ACO selections announced
- MCO selections announced
- Release One Care procurement

**Summer 2017:**
- MCO and ACO Readiness Reviews

**Fall 2017:**
- Member notices
- One Care plan selections announced; Medicare contracting begins

**December 2017:**
- New MCO and ACO enrollments begin

**Spring 2018:**
- New cost-sharing changes begin

**January 2019:**
- New One Care plans begin

**December 2019 or 2020:**
- MCOs and ACOs accountable for LTSS

# Discussion

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