MassHealth Delivery System Restructuring: Overview

Executive Office of Health & Human Services

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FOR POLICY DEVELOPMENT PURPOSES ONLY

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MassHealth restructuring update

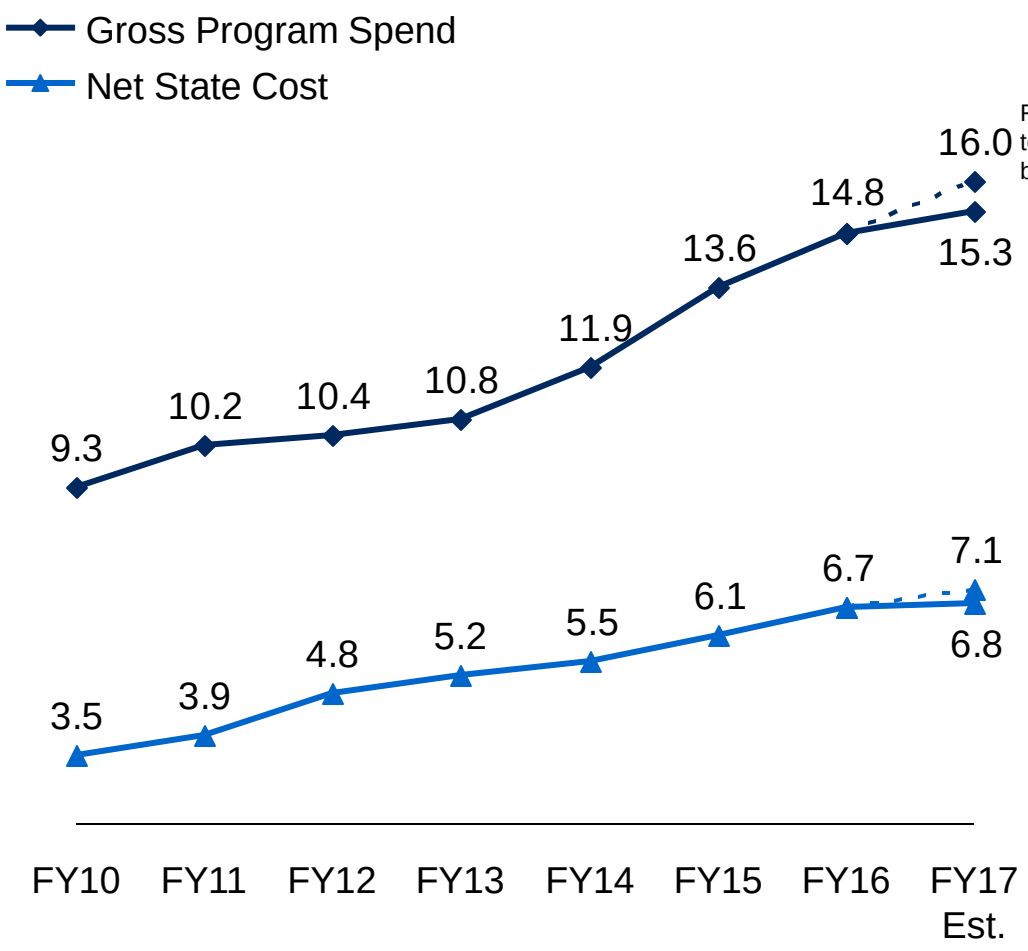
- **We are committed to a sustainable, robust MassHealth program for our 1.8M members**
  - Unsustainable growth, now almost 40% ($15B+) of the Commonwealth's budget
  - The current fee-for-service model for providers results in fragmented, siloed care
  - The fundamental structure of the MassHealth program has not changed in 20 years

- **We are transitioning from fee-for-service, siloed care and into integrated, accountable care models**
  - Accountable Care Organizations (ACOs) are provider-led organizations that coordinate care, have an enhanced role for primary care, and are rewarded for *value* – better cost and outcomes – not volume
  - Managed Care Organizations (MCOs) remain the insurer, pay claims and work with ACO providers to improve care delivery
  - We have a major and unique focus on better integrating our members' physical, behavioral health (BH) and long term services and supports (LTSS) needs, as well as building linkages to social services

- **We are negotiating a new 5-year 1115 waiver with the federal government that includes ~$1.5Bn of upfront investment over 5 years to support this effort**
  - Financing for current waiver expires June 30, 2017 with $1Bn/ year at risk
  - Proposing 5-year Delivery System Reform Investment Program (DSRIP) investment
  - Unique investment approach, including:
    - Support for providers who sign on for ACO models
    - Funding for BH and LTSS community organizations
    - Services not traditionally reimbursed as medical care to address health-related social needs
    - Statewide investments in health care workforce development, improved accommodations for people with disabilities, other state priorities
  - Also proposing expansion of treatment continuum for Substance Use Disorder/ Opioids

MassHealth growth trajectory

MassHealth Program Spending*
$ billions



- **MassHealth has significantly outpaced revenue growth for the Commonwealth**
- **We have brought down growth** for FY16 and FY17 through **near-term** program integrity, operational and other efforts
- We must ensure **long-term sustainability** of the program

* Includes Hutchinson settlement; excludes MATF (supplemental payments)

Accountable care and delivery system reform: four strategies

A **Bring Accountable Care Organizations (ACOs) to MassHealth**

- ACOs are **provider-led organizations that coordinate care, have an enhanced role for primary care, and are rewarded for *value*** – improving total cost of care and outcomes – not volume

B **Integrate community-based partners and linkages to social services**

- ACOs incented to partner with **community-based expertise for behavioral health BH, LTSS** and **build linkages to social services**
- ACOs will have access to DSRIP **funding designated explicitly for addressing social determinants**
  - "Flexible services" not traditionally reimbursed but likely to improve health outcomes (e.g., air conditioner for kids with asthma, housing supports)

C **Partner with MCOs to support ACOs**

- The state expects **Managed Care Organizations (MCOs) to work with ACO providers** to improve care delivery and population health management

D **Invest to help transition the system into integrated, ACO models**

- DSRIP funding **encourages providers to enter into ACO models**
- It **serves as a bridge** – supports a transition into a sustainable model; it is not a rate increase
- DSRIP investments are used to support development of scalable new capabilities and capacity

MassHealth ACO models: goals and principles

- **Materially improve member experience**– ACOs expected to innovate and engage members differently (e.g., better transitions of care, improved coordination between a member's various providers)
- **Strengthen the relationship between members and Primary Care Providers (PCPs)** by attributing members to an ACO through their selection of a PCP
- **Encourage ACOs to develop high value, clinically integrated provider partnerships** by expecting and allowing ACOs to define coordinated care teams and, for some ACOs, to establish preferred networks
- **Partner with MCOs**, with expectations for MCOs to help administer the ACO program and work with providers in strengthening provider-based care management
- **Increase BH/ LTSS integration and linkages to social services in ACO models** through explicit requirements for partnering with BH and LTSS Community Partners

MassHealth ACO models: what is an ACO and what does it provide?

- **What is an ACO and what does it provide**
  - An ACO is a provider-led entity (e.g., a group of providers or a health system)
  - ACOs are expected to build explicit coordinated care teams with providers across the care continuum
  - ACOs are expected to deliver a coordinated and improved member experience and have flexibility to engage members differently (e.g., enhanced services, care coordination)
  - Unless it is integrated with a health plan, an ACO does not set fee schedules or process claims from other providers – that remains the responsibility of MassHealth and our MCOs

- **Which providers can be an ACO**
  - At minimum, an ACO must include primary care providers (PCPs)
  - Hospitals, specialists, BH, LTSS and social service providers may join or partner with ACOs
  - ACOs must have partnerships with certified community based BH and LTSS providers
  - ACOs must meet other criteria (e.g., minimum number of members, risk bearing capability)

- **How do ACOs and Managed Care Organizations (MCOs) fit together**
  - MCOs have an important role in implementing ACO models
  - MCOs remain the insurer, pay claims, and work with ACOs to improve care delivery and support integration of care
  - MCOs also support providers to build provider capacity, including providing analytics for population health management

A MassHealth ACO models: who is eligible and how do members enroll?

- **Who is eligible**
  - Members for whom MassHealth is the primary payer
  - Does not include members where Medicare or a private insurer is the primary payer
  - At this time, non-dual HCBS[1] waiver populations are eligible to enroll in an ACO, but HCBS waiver services will continue to be provided outside of ACO scope and budgets
  - Includes adults, youth/ children, members with BH and/ or LTSS needs

- **There are three ACO models (not a one size fits all model)**
  - Model A: Integrated entity that includes both the ACO provider and health plan (MCO)
  - Model B: ACO providers who contract directly with MassHealth, which remains the insurer
  - Model C: ACO providers who contract directly with health plans (MCOs)

- **Members choose an ACO based on PCP selection**
  - Members directly enroll in Model A and Model B ACOs based on their selection of PCP
  - For Model C, members enroll in an MCO and choose an ACO based on their selection of PCP
  - For members whose PCP is not in an ACO, members will still have MCO and PCCP options

- **ACO models have the same set of benefits as the broader MCO program;** ACOs and MCOs may invest in additional care coordination or services to engage members

- **In addition, we want to ensure quality access to care for individuals with disabilities**
  - ACO and MCO contracts will focus more directly on accommodations for MassHealth members with disabilities, including provision of accessible medical and diagnostic equipment
  - DSRIP funding may be available to support related enhancements

1 Home and Community Based Services

A MassHealth ACO models: how does the payment model work?

- **ACOs have total cost of care accountability for the following areas:**
  - All managed care eligible spend (physical health + behavioral health)
  - LTSS: Year 1 reporting only; Year 2 and on some accountability phases in
  - At this time, HCBS waiver services continue to be provided outside of ACO scope and budgets
  - Total cost of care is risk-adjusted (UMass Medical School is developing a risk adjustment model that incorporates some of the social determinants of health)
  - Separate “rating category” or adjustor for Serious Mental Illness (SMI)

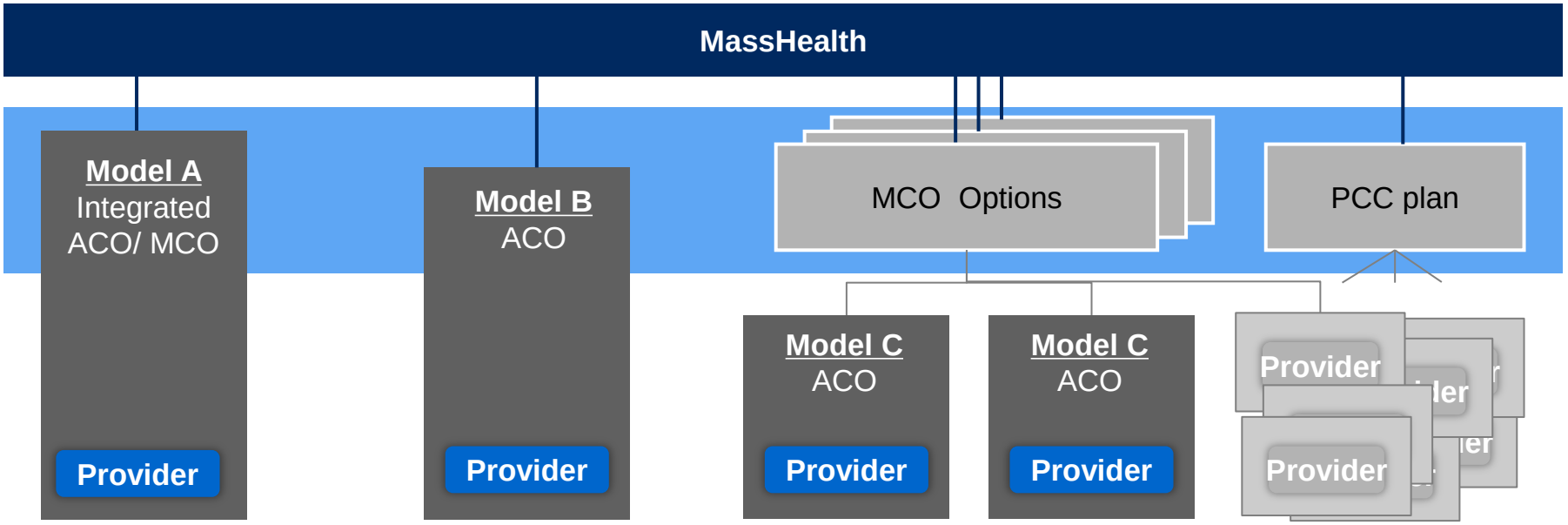
- **Who is paying claims**
  - Model A: the MCO that is part of the integrated ACO/MCO entity
  - Model B: MassHealth and MBHP pay claims to providers in the MassHealth and MBHP network
  - Model C: MCOs pay claims to providers in their networks
  - ACOs are not responsible for paying claims and authorizing LTSS services (exceptions in future years, if the ACO is integrated with an MCO qualified to cover LTSS)

- **Payments for ACOs are linked to performance on quality metrics across multiple domains**
  - We will also measure quality and access of care specifically for members with disabilities (e.g., for ID/DD members, individuals with physical disabilities)

- **In addition, we will increase member protections to ensure right care from the right providers**
  - Members in ACO models will have access to an ombudsman and advocacy resource
  - Members with LTSS needs in ACO models will be able to access an LTSS Community Partner (CP – see later in document for detail) as an independent advocate and resource counselor

A MassHealth ACO models: 3 types of ACO models

Member enrollment



Model A: Integrated ACO/MCO model

- Fully integrated: an ACO joins with an MCO to provide full range of services
- Risk-adjusted, prospective capitation rate
- ACO/MCO entity takes on full insurance risk

Model B: Direct to ACO model

- ACO provider contracts directly with MassHealth for overall cost/ quality
- Based on MassHealth/ MBHP provider network
- ACO may have provider partnerships for referrals and care coordination
- Advanced model with two-sided performance (not insurance) risk

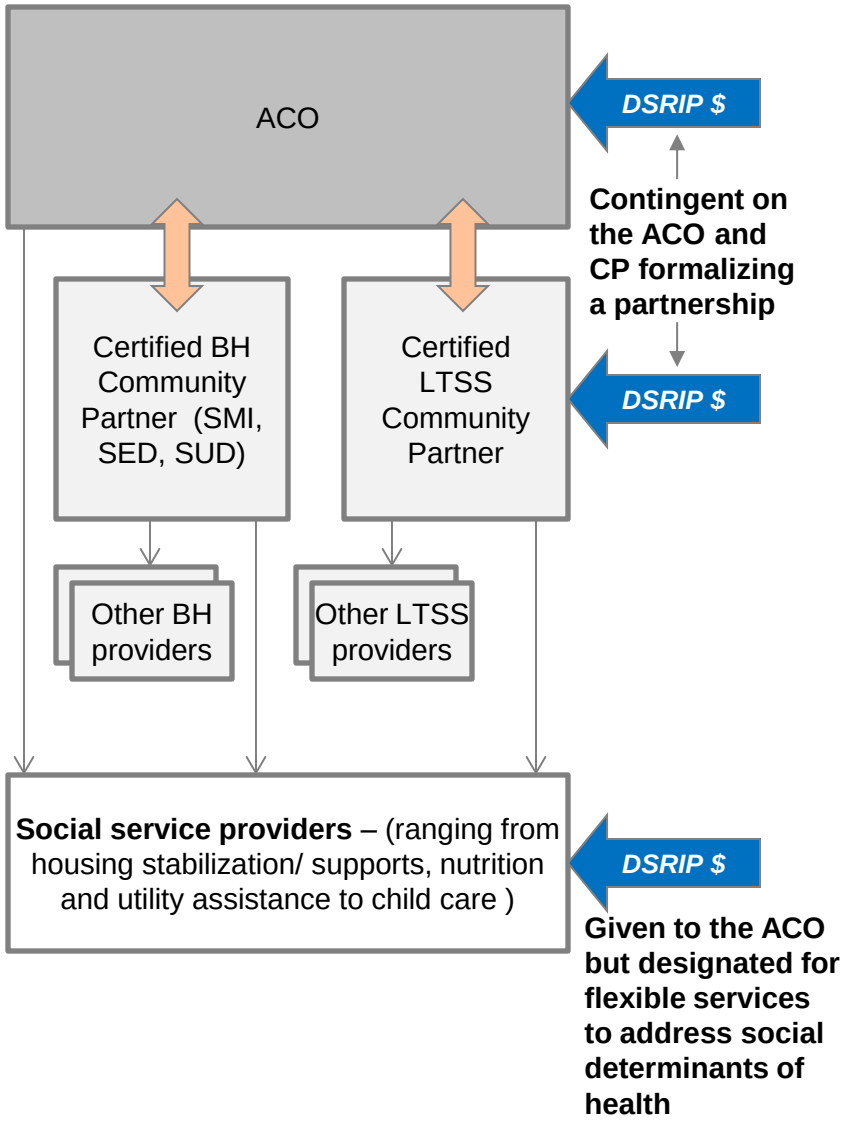
Model C: MCO-administered ACO model

- ACOs contract and work with MCOs
- MCOs play larger role to support population health management
- Various levels of risk; all include two-sided performance (not insurance) risk

Increasing levels of sophistication, care coordination, and DSRIP $s

B Community Partners (CPs) and linkages to social services

→ Indicate referrals and relationships



Goals:

- Encourage ACOs to "buy" BH/ LTSS care management expertise from existing community-based organizations vs. "build"
- Invest in infrastructure and capacity to overcome fragmentation amongst community-based organizations

Who can be a BH or LTSS Community Partners

- The State certifies BH and LTSS CPs
- Criteria include expertise in care coordination and assessments and infrastructure/ capacity
- CPs can be providers but self-referrals monitored
- LTSS CPs must demonstrate expertise across multiple populations with disabilities

How it works

- Certified CPs and ACOs both get direct DSRIP funding
  - Funding for both is contingent on ACOs and CPs formalizing arrangements for how they work together
- Portion of ACO funding designated for "flexible services" to address social determinants
- MCOs may provide support to Model A and Model C ACOs for integrating with BH and LTSS CPs

SMI = Serious Mental Illness, SED= Serious Emotional Disturbance, SUD = Substance Use Disorder

C Partnering with Managed Care Organizations (MCOs) for delivery system reform

- **MCOs have a significant role in administering the ACO program**
  - In most cases when a member enrolls in an ACO, MCOs remain the insurer
  - MCOs may integrate with ACOs for Model A (may also support ACOs in Model B)

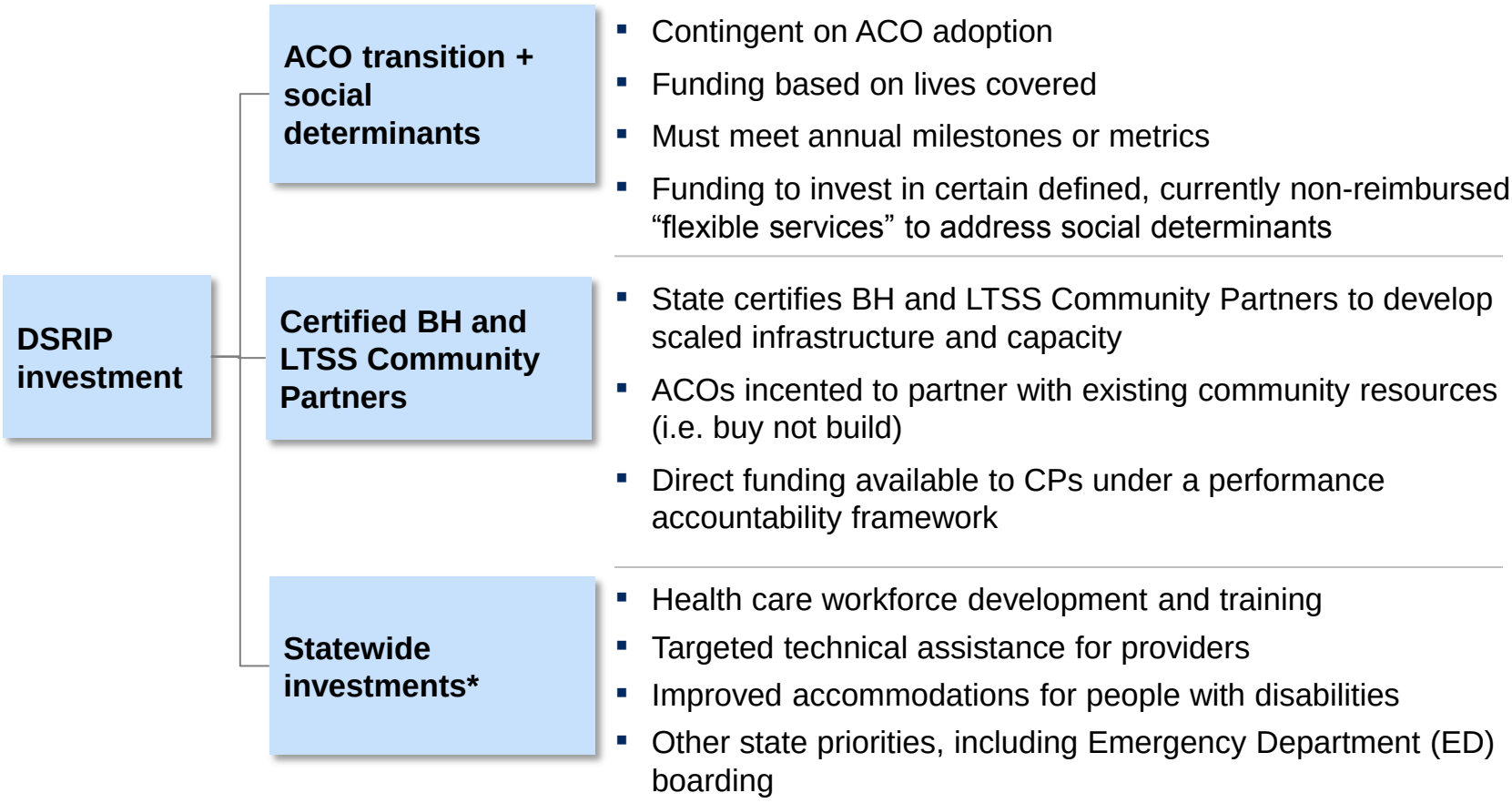
- For Models A and C, **MCOs will be explicitly responsible for working with ACO providers (or integrating as an entity) to improve care delivery**

- **We are partnering with MCOs to support ACO providers in improving care**
  - Upcoming reprocurement will include expectations for MCOs to contract with ACOs
  - MCOs help determine which care management functions best done at the provider vs. at the MCO level
  - MCOs also support providers in making the shift to accountable care (including analytics for population management)
  - MCOs may also help ACOs determine how best to integrate BH and LTSS CPs into care teams

- In addition, we will expand a **One Care-like model** into the non-Duals MCO program in future years (One Care is an integrated care demonstration for Duals)
  - Improves **integration of LTSS and other services, like DME and transportation,** into the physical and BH managed care benefit

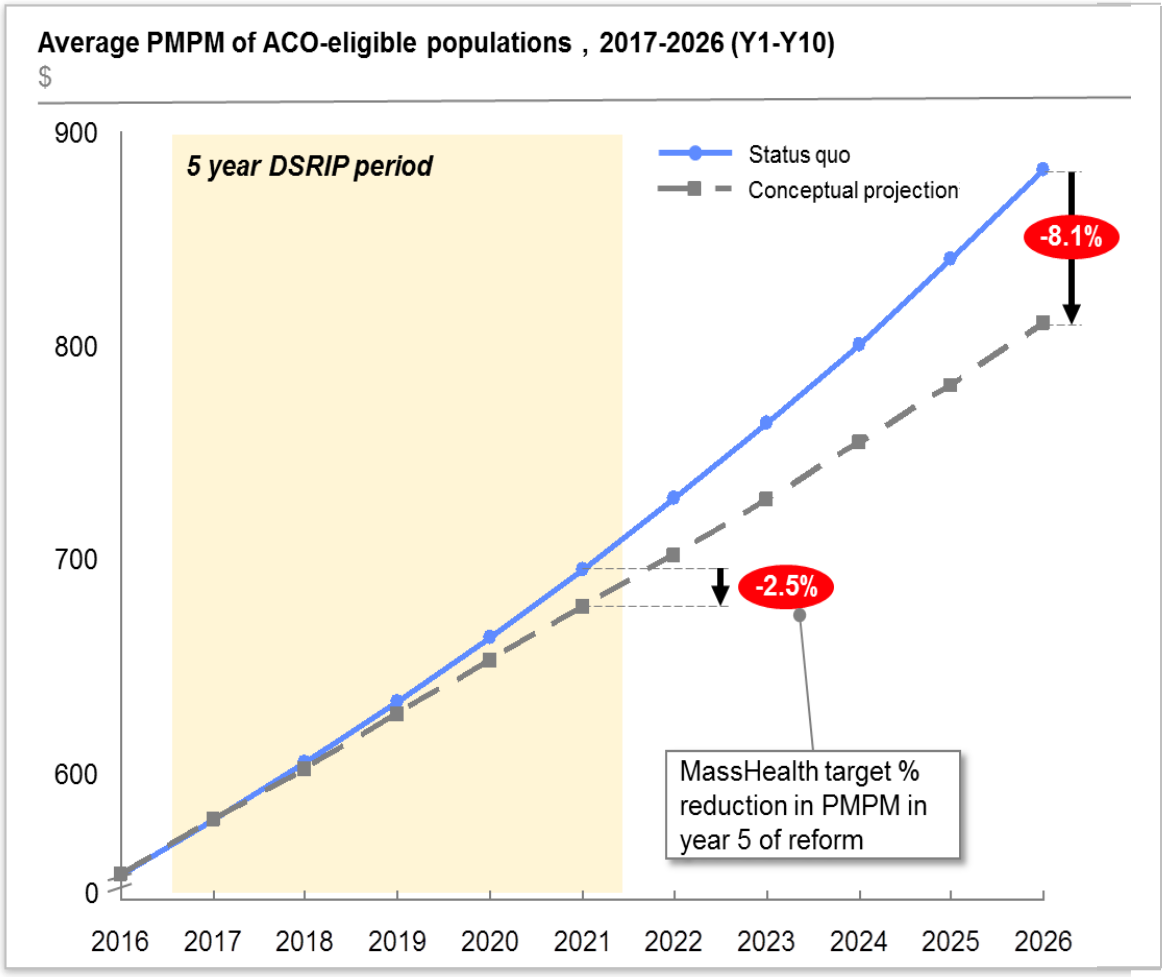
DSRIP: summary of investments

- **$1.5B of upfront investments** (as part of the 1115 waiver renewal) to support delivery system restructuring
  - **State commits to annual targets** for performance improvement over 5 years (reduction in total cost of care trend, reduction in avoidable utilization, improvement in quality metrics)
  - **Access to new funding** contingent on providers partnering to better integrate care



*Subject to final 1115 waiver approval

DSRIP: in order to receive DSRIP from CMS, MA must commit to targets for quality and bending the cost curve



- State accountability to CMS for DSRIP funds also dependent on **reduction in avoidable utilization** and **quality**
- Quality domains include **chronic disease management**, **BH/LTSS**, and **patient experience**

We are also working to expand Substance Use Disorder (SUD) treatment

Context

- 1,099 people died from opioid overdoses in Massachusetts in 2014 (65% increase over 2012)
- ~75% were enrolled in MassHealth at the time of death
- Our current SUD treatment system spans the American Society of Addiction Medicine (ASAM) continuum of services
- However, many gaps remain for MassHealth members, especially for step-down and residential – results in members cycle repeatedly through detoxification programs.

1115 waiver: what we have proposed to CMS

- **Proposal: expand access to SUD treatment, particularly for members who require residential treatment services, recovery coaching and care coordination**
  - Federal Financial Participation generated on current Bureau of Substance Abuse Services (BSAS) services for MassHealth members funds a significant expansion for SUD treatment across the continuum of care
- For all Medicaid eligible members:
  - **Expand SUD benefit to include Transitional Support Services (TSS) and Residential Rehabilitation Services (RRS)**
  - Cover up to 90 days of medically necessary residential treatment (based on ASAM assessment)
- For Members with FFS coverage:
  - **Expand SUD benefit to include enhanced acute treatment services for dually-diagnosed members and Structured Outpatient Addiction Programs**
  - These services are currently available only to members enrolled in managed care plans
- **Expand access to care coordination, supportive case management and recovery support services** throughout the system, and extend availability of services into recovery
- Negotiations with CMS are ongoing and positive

In addition, we have a number of other important initiatives underway

Strengthen program integrity in LTSS

- **We have strengthened LTSS program integrity – home health example:**
  - Home health spending grew last year by $170M, or 41%
  - Over 80% of growth driven by providers new to the Commonwealth since 2013
  - We have referred 12 providers to the Attorney General's office for fraud
  - Actions: moratorium on new home health providers; clinical prior authorizations in place for home health services
- **We will be implementing independent, conflict-free clinical assessments**
  - Ensure members receive a conflict-free assessment of their full set of needs and that individuals have access to a full range of services, not just a service from the agency that assessed the individual

Encourage enrollment in managed and accountable care

- **We will present members with options and incentives to choose to enroll in high quality, integrated MCO and ACO programs** *(effective October 2017)*
  - All benefits available to all members under MCO and ACO programs
  - PCC plan will have fewer optional benefits (e.g., physical therapy, chiropractor)
- **We will be encouraging enrollment in Senior Care Options, One Care and PACE programs to better integrate care**
  - Active member outreach and engagement efforts about the benefits of these plans
  - Passive enrollment for SCO (late FY2017) and One Care with opt-out
- **We will move to annual open enrollment windows for the MCO program** *(Oct. 2016)*
  - Similar to commercial/ Connector plans (90 day opt-out, provisions to switch plans)

Improve customer service and operations

- **Made significant improvements to the eligibility system and completed 1.2 million outstanding eligibility redeterminations** as required by the federal government
- **Improved website/ consumer functionality and** member satisfaction (+8%)
- **Reduced call center wait times** and improved support for health centers and providers
- **Developing comprehensive enrollment materials/ trainings** to support choice

Timelines

Public listening session

- April 20th, 9-11a (1 Ashburton Place, 21st Floor, Boston)
- Written comments may be submitted through the end of April at MassHealth.Innovations@State.MA.US
- Comments beyond the end of April can be provided through the formal public comment process (see below)

1115 waiver proposal timelines

- May: **1115 waiver proposal posted** for 30 day public comment period, including 2 public hearings (dates and locations TBD)
- June: **1115 waiver proposal submitted** to CMS
- The waiver proposal for CMS will focus on:
  - Authorities required for ACO models
  - DSRIP uses and financing
  - Safety Net Care Pool structure and financing
  - Expansion of treatment continuum for Substance Use Disorder
- The waiver proposal does not include operational details for ACO and Community Partner models

Implementation timelines

- Advanced ACO pilot: solicitation spring 2016, launch December 2016
- DSRIP funding begins FY18
- Community Partners launch early FY18
- Full ACO models: solicitation summer 2016, roll-out October 2017
- MCO reprocurement effective October 2017 (sequenced after ACO procurement)