Slide footer on all slides unless otherwise noted

F**or policy development purposes only**

Slide 1:

**MassHealth Delivery System Restructuring: Overview**

**Executive Office of Health and Human Services**

**April 14, 2016**

Slide 2:

**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 and 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 ~$1.5+Bn 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 accomodations for people with disabilities, other state priorities
* Also proposing expansion of treatment continuum for Substance Use Disorder/ Opioids

Slide 3:

**MassHealth growth trajectory**

**MassHealth growth has been unsustainable**

* In FY10, $9.3 billion was spent on MassHealth, $3.5 billion of which was state dollars. Over the past 7 fiscal years, MassHealth spending has grown 65% to $15.3 billion for FY17 (Includes Hutchinson settlement, excludes MATF supplemental payments), $6.8 billion of which is state funding, which has grown 94% in the same time.
* The Compound Annual Growth Rate (CAGR) for total spending has ranged from 6.4% in FYs 10-14, to 14.7% in FYs 14 and 15, and 8.7% in FYs 15 and 16. State spending on MassHealth has had a Compound Annual Growth Rate of 12.2% in FY 10-14, 9.9% in FY 14-15 and 10.6% in FYs 15-16.
* MassHealth has significantly outpaced revenue growth for the Commonwealth.

In FY 16-17, MassHealth brought down near term growth to 3.3% for total spending and 1.2% for state spending through **near-term** program integrity and operational efforts, among others. We must ensure **long-term sustainability of the program.**

Slide 4:

**Accountable care and delivery system reform: four strategies**

* 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
* Integrate community-based partners and linkages to social services
* ACOs incented to partner with community-based expertise for behavioral health BH, LTSS and build linksages 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)
* 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
* 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

Slide 5:

**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

Slide 6:

**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

Slide 7:

**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 HCBS1 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

Slide 8:

**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

Slide 9:

**MassHealth ACO models: 3 types of ACO Models**

MassHealth’s current thinking is that we will develop four accountable care models. Members will choose which option best suits their needs. Members will also select a primary care provider once they have selected an option.

The options include Model A Integrated ACO/MCO, Model B ACO, MCO options, which include Model C and Non ACO Plans, and the PCC plan which includes Non ACO plans.

**Model A integrated ACO/MCO, Provider**

**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 ACO, Provider**

**Model B: Direct to ACO model**

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

**MCO Options, Model C ACO, Provider**

**Model C: MCO administered ACO model**

* ACO 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

Model A is expected to be most sophisticated providers, followed by Model B, then Model C ACOs and then Non-ACO. Care coordination and DSRIP funding are also expected to be at the highest level in Model A, then Model B, then Model C.

Slide 10:

**Community Partners (CPs) and linkages to social services**

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
* Refer to BH, LTSS and social service providers
	+ Social service providers range from housing stabilization/supports, nutrition and utility assistance to child care)
* 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

CPs and ACOs will be eligible for direct DSRIP funding, but that funding will be contingent on the ACO and CP formalizing a partnership.

Social service providers will receive DSRIP funding from funds given to ACO designated for flex services to address social determinants of health.

Slide 11:

**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

Slide 12:

**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, e.g., 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

DSRIP investments will be split into 3 categories:

1. ACO transition and social determinants
	* Contingent on ACO adoption
	* Funding based on lives covered
	* Must meet annual milestones or metrics
	* Funding to invest in certain defined, currently non-reimbursed “flexible services” to address social determinants
2. Certified BH and LTSS Community Partners
	* State certifies BH and LTSS Community Partners to develop scaled infrastructure and capacity
	* ACOs incented to partner with existing community resources (i.e. buy not build)
	* Direct funding available to CPs under a performance accountability framework
3. Statewide investments (subject to final 1115 waiver approval)
	* Health care workforce development and training
	* Targeted technical assistance for providers
	* Improvement of disability access
	* Other state priorities, including Emergency Department (ED) boarding

Slide 13:

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

**Average PMPM of ACO-eligible populations, 2017-2026 (Y1-Y10)**

Starting at approximately $570 PMPM in 2016, MassHealth is projecting PMPMs to grow to $700 PMPM by 2021, and $900 PMPM by 2026. After 5 years of payment reform and the end of the 5 year DSRIP funding agreement, MassHealth is targeting a 2.5% reduction in PMPM below status quo projections, and an 8.1% reduction below status quo by 2026.

* 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**

Slide 14:

**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

Slide 15:

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

Slide 16:

**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)

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