WORKING DRAFT
FOR POLICY DEVELOPMENT PURPOSES ONLY

MassHealth Payment and Care Delivery Reform: Public Meeting

Executive Office of Health & Human Services

November 6, 2015

- Content of this presentation represents a potential framework for payment and care delivery reform presented for group discussion as part of an iterative process for policy development.
- The information presented is initial view intended for working discussion session and does not represent or predict EOHHS final decisions.

What we will cover today

Process update

Recap overall direction for care delivery/ payment reform

Themes we have heard in stakeholder workgroup meetings

Review specific approach for transition to accountable care system

Recap: MassHealth received extensive feedback during the stakeholder listening process April-July

- MassHealth held **8 stakeholder listening sessions and numerous individual stakeholder meetings** across the state and created a **dedicated email address** for stakeholders to submit feedback

- Turnout was very strong, and **MassHealth received extensive input** from a broad array of stakeholders

- MassHealth sought feedback on six key priorities:
  - Improve **customer service and member experience**
  - Fix **eligibility systems and operational processes**
  - Improve **population health and care coordination through payment reform** and value-based payment models
  - Improve **integration of physical, behavioral health and LTSS care** across the Commonwealth
  - Scale **innovative approaches for populations receiving long term services and supports**
  - Improve **management of our existing programs** and spend

Feedback from listening sessions – Payment and Care Delivery Reform

- Consider **flexible and broadly applicable** approaches, not “one size fits all” solutions
- **Address fragmentation of care**; improve integration between physical, oral, behavioral health, pharmacy, and long term services and supports (LTSS)
- Move towards a **provider based care management approach** and resource it appropriately
- Address **concerns of small providers** in new payment models
- **Reduce avoidable ED, hospital and institutional utilization**, and build in protections to ensure cost savings are not at expense of primary care, behavioral health, or community-based LTSS
- Incorporate **social determinants of health** (e.g., support access to housing, tenancy preservation programs, nutritional access and support)
- Develop a **robust risk adjustment methodology**, ideally including social determinants
- Facilitate access to **peer services and community resources**
- Ensure new models value **member choice** and support providers’ ability to **manage member populations**
- Include incentives for **member engagement** and satisfaction, protections for **quality and access**
- Improve the quality, transparency, availability, and usability of **MassHealth data**

Feedback from listening sessions – BH/LTSS (1 of 2)

- Ensure focus on **care coordination and management** for frail elders, members with disabilities and/or significant behavioral health needs under accountable care models
- Ensure such standards prevent "**over-medicalization**" of care
- Evaluate ACOs on **LTSS outcomes**
- Ensure **consumer direction** for the Personal Care Attendant (PCA) program
- Draw on the **expertise of community mental health centers and community addiction treatment providers** to coordinate care of their clients, including seniors
- Examine the behavioral health "**carve out"** relationship; improve the integration of behavioral and physical health services
- Consider broadening access for the Community Support Program for People Experiencing Chronic Homelessness (CSPECH) and CommonHealth services
- Examine **Prior Authorization** processes for services for specific conditions; improve access for members who need these services

Feedback from listening sessions – BH/LTSS (2 of 2)

- Improve the **financial sustainability of the One Care program** and consider expanding it
- **Expand Senior Care Options (SCO) and PACE programs** for dual eligible seniors
- Consider **quality-of-life and recovery goals** in the development of quality measures for members with behavioral health needs
- Explore **expanding access to peer services and Recovery Learning Communities** for behavioral health;
- Improve treatment and access for members with **opioid addictions**;
- Evaluate LTSS and BH **reimbursement rates** including parity considerations
- Infuse the **recovery model** throughout the infrastructure of behavioral health services; and
- Identify ways to **address concerns related to privacy and consent** regarding sharing of data

Recap: Stakeholder engagement process for payment and care delivery reform

- **Workgroups on payment and care delivery transformation**
  - Strategic Design
  - Payment Model Design
  - Attribution (co-led by the Health Policy Commission)
  - Quality
  - Health Homes
  - Certification and Criteria (co-led by the Health Policy Commission)
  - BH
  - LTSS

- **Public meetings** between August 2015 and March 2016 to solicit broad public input and provide transparent updates on progress

Workgroups will not be responsible for making policy decisions, such decisions will be made by the Executive Office of Health and Human Services (EOHHS) using inputs from the workgroups. Findings, products, and issues raised in the workgroups will be brought to the regular open, public meetings

Recap: Goals for workgroups and timeline

Goals	Timeline Subject to refinement based on progress of Work Groups, discussions with CMS, etc.
1 Inform the design of new payment and care delivery models 2 Foster dialogue across different parts of the delivery system	Aug 2015 – Jan/Feb 2016 •Conceptual discussion •Identify options and set direction •Targeted testing of major policy options for feedback Detailed technical design starting in Jan/Feb 2016
3 Inform MassHealth's discussion with CMS re: 1115 waiver	▪ Draft and refine proposal over the next 3-4 months

Where we are:

- ***Productive discussions on several topics (key themes synthesized on pg 20-21)***
- ***Further discussion upcoming on several topics (see page 37)***

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Restructuring MassHealth: principles of our approach

Person-centered	Concentrate on improving quality and member experience
Clinically appropriate	Ensure clinically sound design through direct input from Massachusetts members and providers
Appropriate for all	Account for varied member populations and providers (i.e., not a one-size-fits-all model)
Pragmatic	Identify realistic solutions that can be implemented in a practical and timely manner
Fact-based	Make design decisions based on facts and data
Financially Sustainable	Ensure improvements lead to a more cost effective and sustainable system

In response to your identified priorities for payment reform . . .

What we heard from you

- Members are often **not in charge of or engaged in their care**
- Providers are often working in silos and lacking incentives to **create integrated care experience** for members
- **Payment model** is not aligned for improving quality/cost, and investing in integration of care

… we identified key principles and goals for our accountable care strategy

What we plan to do

- Move to a **sensible care delivery and payment structure** where:
  - We pay for **value, not volume**
  - Members drive their **care plan**
  - Providers are encouraged to **partner in new ways** across the care continuum to **break down existing siloes** across physical, BH and LTSS care
  - **Community expertise** is respected and leveraged
  - Cost growth and avoidable utilization are **reduced**

Payment and delivery reform will impact members, providers and payers in the Commonwealth

	From…	…To
Members	▪ Interacting with many providers, with **no single point of contact coordinating care**	▪ Receiving **member-driven integrated care** where all providers are acting as a coordinated team to best meet the individual's needs
Providers	▪ Working in silos and lacking incentives to **create integrated care experience** for members (e.g., between acute care and primary care, and across physical, BH and LTSS care)	▪ Partnering in new ways **across the care continuum to improve care experience**

Recap: Payment and Care Delivery Reform – starting point for workgroups

- **Overall goal:** Developing a model that promotes **integration and coordination of care** to reduce siloes**,** enhance **population health,** and allow providers to take on **financial accountability** for the **total cost and quality of care**

- MassHealth is exploring linking payment and care delivery reform strategies with Massachusetts' conversations with CMS about the **1115 waiver**

- **State commits to annual targets for performance improvement over 5 years, e.g.,**
  - Reduction in total cost of care trend
  - Reduction in avoidable utilization (e.g., avoidable admissions)
  - Improvement in quality metrics

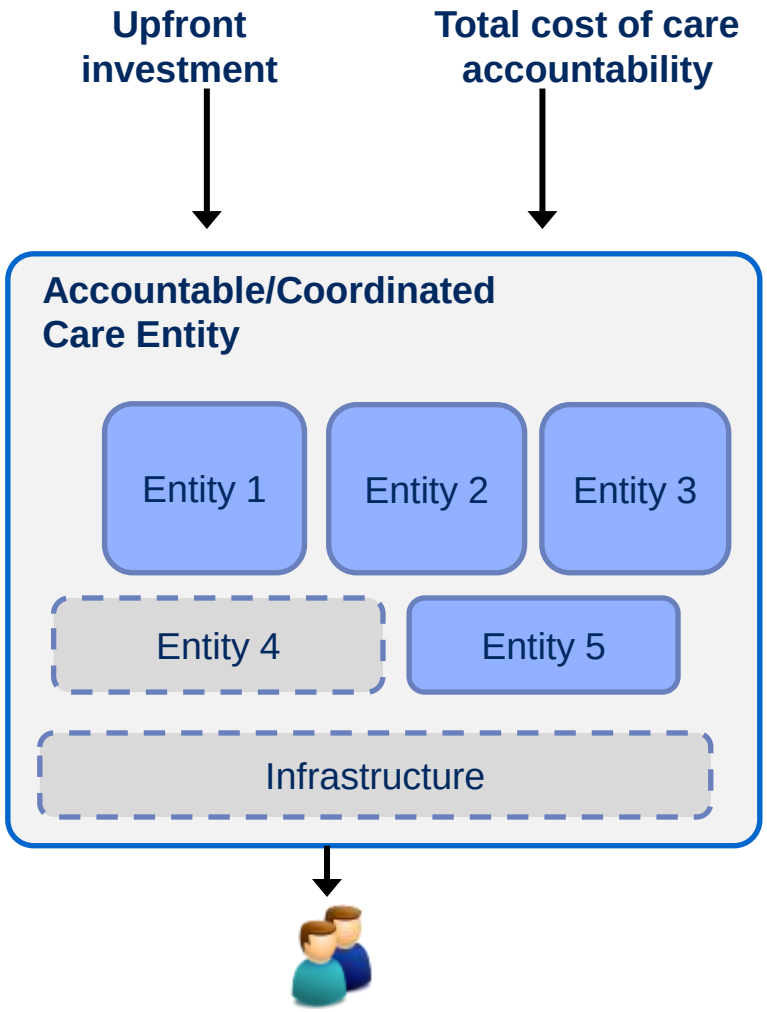
- **Make case to receive federal investment upfront through waiver**
  - Seek upfront CMS investment in new care delivery models
  - Upfront funding at risk for meeting performance targets
  - Creates access to new funding to support transition and system restructuring

- **Access to new funding contingent on providers partnering to better integrate care**
  - ACO-like model with greater focus on delivery system integration
  - Total cost of care accountability

- Commitment to **significantly improving the quality, transparency, availability, and usability of MassHealth data**

- **Partnering with other payers to** improve **alignment and consistency**

Recap: Payment and Care Delivery Reform – starting point for workgroups



- **Partnerships** across the care continuum
- **Explicit goals** on reducing avoidable utilization (e.g., avoidable ED visits) and increasing primary, BH, and community-based care;
- A feasible and **financially sustainable transition** for provider partnerships that commit to accountable care
- An appropriate focus on **complex care management**, e.g. through a Health Homes model
- **Explicit incorporation of social determinants of health**, through the technical details of the payment model and in care delivery requirements;
- Valuing and explicitly incorporating the **member experience and outcomes**

Optional entity

Key design questions (discussed across all workgroups)

1. **Goals and outcomes** the Commonwealth aspire to achieve in the next 5 years through payment and care delivery reform efforts
2. **Member populations** to be included in ACO models; **timing/sequencing** of implementation
3. **Number and types of ACO models** MassHealth should launch
   - Minimum requirements and requirements for Behavioral Health and LTSS populations
   - Payment model requirements
4. **Configurations for partnerships across the care continuum**
   - "Buy *vs.* build" incentives
   - Support for BH/LTSS and CBO infrastructure
   - Management Services Organization (MSO) services
5. **How ACO model interacts and interrelates with other programs**
   - ACO and MCO
   - ACO and SCO, One Care, PACE
   - ACO and LTSS
6. **Member engagement goals, member protections and member choice**
   - Ability to select into ACO
   - Ability to opt-out
   - Network requirements
7. **Strategies to incorporate social determinants of health into the models**
8. **Care coordination expectations and models**
9. **Timing and sequencing of various procurements**

Creating a strawman framework that answers these questions will then inform further on technical details of payment model

10. ***CMS waiver discussions, statewide targets on cost, quality, access and member experience***

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Themes we have heard in stakeholder workgroup meetings (1/2)

Goals and outcomes	▪ MassHealth should consider sustainable cost growth and utilization targets that **result in shifting existing utilization patterns** in the system ▪ MassHealth should consider robust quality measures that focus on **member experience/outcomes** and include BH, LTSS, and social measures where possible ▪ MassHealth should think about a clear linkage between **quality and outcomes measurement and certification requirements**; the clearer our **outcomes measures** and accountability, the less prescriptive we need to be about **the certification requirements and care delivery model**
Member pop.s	▪ MassHealth should **empower member choice** in ACOs ▪ As a **starting point**, MassHealth's ACO should include populations where MassHealth has responsibility for the **total cost of care**, e.g. the non-Duals population, and focus on financial accountability for **MassHealth services**, not those managed by other agencies (e.g. HCBS waiver services). For Duals, MassHealth should focus on **thoughtful improvement and expansion** of existing programs (e.g. SCO, One Care) ▪ MassHealth should determine how to ensure **appropriate capabilities** are in place as part of a transition to ACO accountability for LTSS
ACO models	▪ MassHealth should consider launching a **simple set** of ACO models that get to scale
Member experience	▪ Members should have choice and the ability to **opt out** of models (for models where ACO is part of a managed care product) ▪ ACOs should provide all their members with **integrated, member-driven** care coordination
Require-ments	▪ There is benefit to being **less prescriptive** to ensure ACOs have the flexibility to partner in various configurations to best meet member needs. At the same time, ACOs should **meaningfully demonstrate** community partnerships, care coordination expertise, access to BH resources and expertise, shared governance, and capabilities across the care continuum

Themes we have heard in stakeholder workgroup meetings (2/2)

Provider Partnerships

- MassHealth should consider creating incentives to leverage **existing infrastructure** and community resources as much as possible (“buy” vs “build”)
- MassHealth should consider mechanisms to ensure the ACO model has appropriate **balances for smaller and larger providers**
- MassHealth should consider setting minimum **functional/service requirements** for ACOs rather than minimum provider memberships
- MassHealth should consider a model where as many entities as possible **share in cost of care risk** under an ACO construct, to **align incentives** and give all members of the care team an **equal voice**

Social determinants

- MassHealth should consider mechanisms to encourage ACOs to work towards addressing **social determinants of health** in the design of new payment models
- MassHealth should consider mechanisms to incentivize ACOs to integrate social and health care services, including through **partnership with community organizations**

Health Homes/ Care Coordination

- Certain members may require **specialized expertise** to ensure proper coordination
- Many **community providers** have important experience that ACOs should leverage through **collaborative partnerships**
- MassHealth should consider **potential need for additional infrastructure** and resources for BH, LTSS and CBOs to actively participate in care coordination/management
- MassHealth should consider a **streamlined approach** to think about health home services in the context of existing care coordination/management activities

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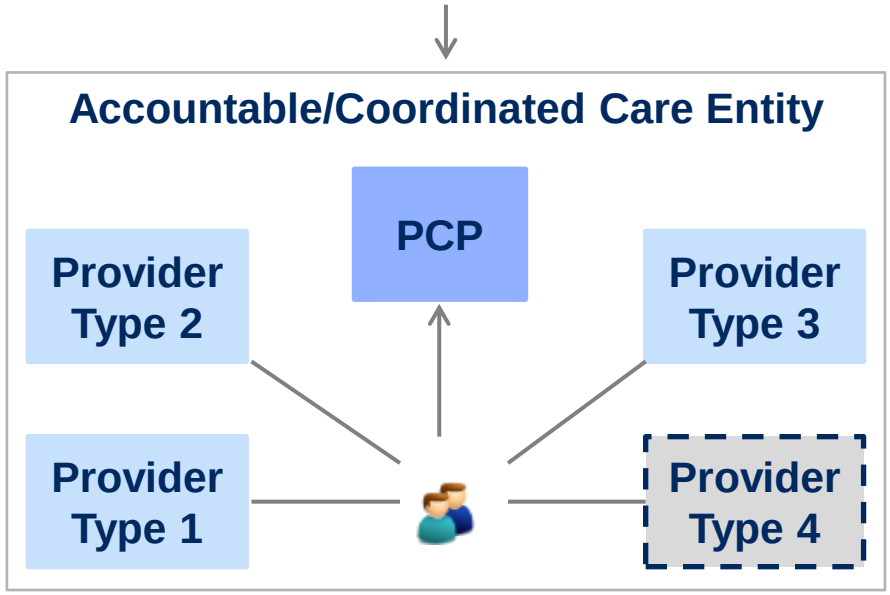
Accountable Care: How it will work

- **A** Member experience and care model
- **B** ACO Payment Models
- **C** Populations and sequencing
- **D** CMS Waiver and Federal Investment
- **E** Outcomes and goals for cost and quality
- **F** Social determinants of health
- **G** Care coordination and health homes

A ACOs can achieve member-driven, integrated care

Integrated, accountable care

Payment and accountability



- ACOs are **responsible for members, not individual services**
- ACOs will have **accountability for total costs and an incentive to avoid unnecessary utilization**
- To become MassHealth ACOs, providers will have to **demonstrate partnerships across the care continuum** – e.g. with community BH and LTSS providers
- These partnerships must be meaningfully leveraged to provide members with an **integrated, member-driven experience** – member satisfaction will be measured

These partnerships could represent a major improvement in care delivery experience for our members

A Member engagement / empowerment and enhanced benefits for members are key principles for MassHealth accountable care models

- **Active member choice** should be primary determinant of member relationship to ACO (i.e., attribution), if applicable and feasible
- Members will have the **ability to opt out** within defined limits (for models where ACO is part of a managed care product – *see next page)*
- Members may benefit from **innovative management techniques under ACO model that are not currently reimbursable** (e.g. home visits, use of community health workers)

B ACO Payment Models: Three Models under Consideration

- **Model 1: Retrospective ACO model**
  - Individual providers paid fee-for-service throughout the year
  - ACO has total cost of care/ quality accountability and periodically receives a retrospective reconciliation compared to a risk-adjusted budget
  - Various options for member attribution (based on claims, or through PCP selection)
  - Insurance risk bounded through various arrangements

- **Model 2: Prospective ACO/MCO model**:
  - Integrated ACO/MCO model
  - Attributes members through active selection/enrollment into the ACO
  - ACOs receive up-front, prospective payments, manage a provider network and pay claims for their attributed members (like MCOs)

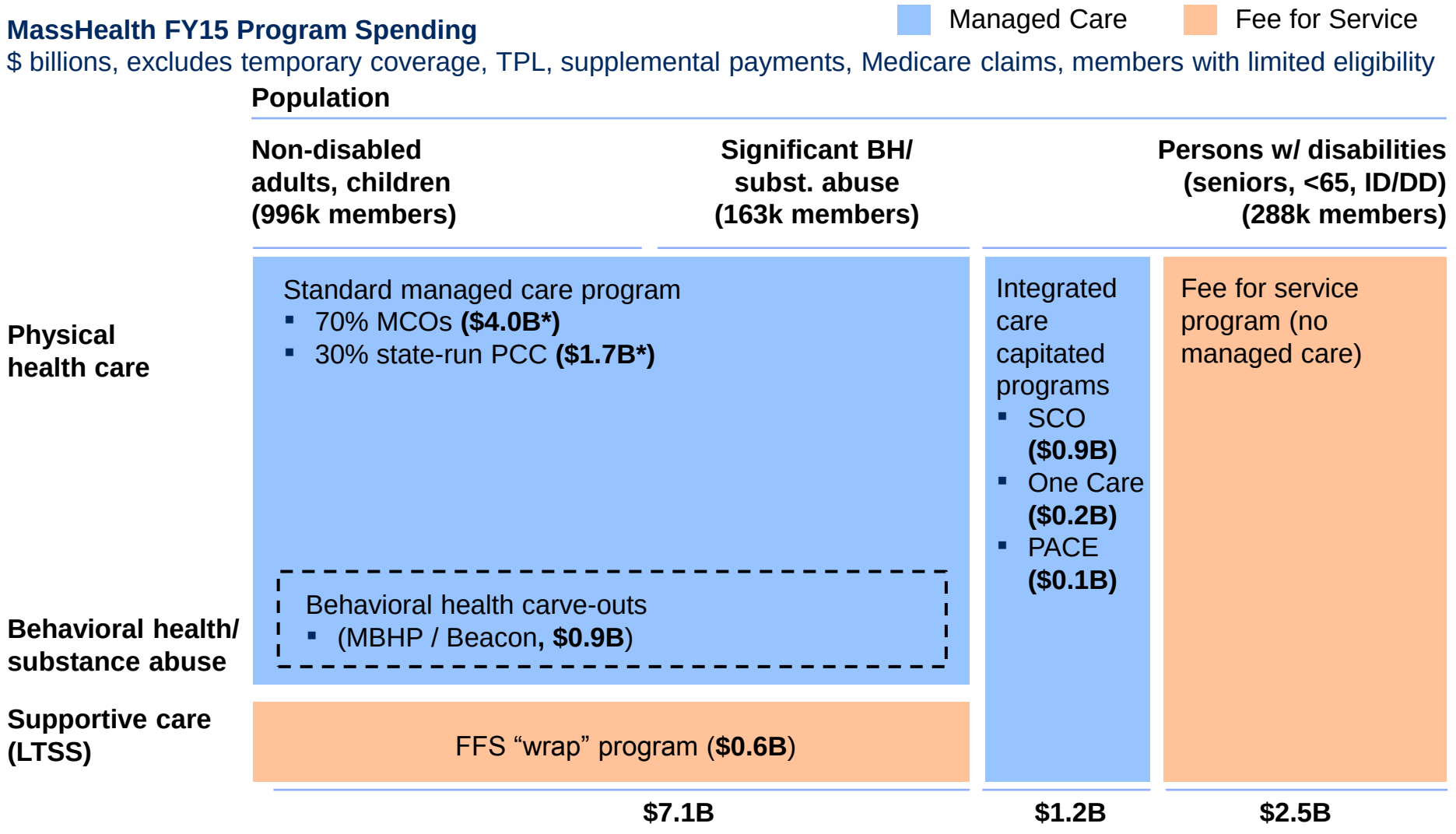
- **Model 3: Prospective ACO model**:
  - Pricing model focused on performance vs. insurance risk
  - Member attributed through active selection/enrollment into the ACO
  - Need to further explore feasibility

- Minimum case volume applies across aggregate MassHealth volume (PCC/MCOs)

Additional Considerations
- All models subject to feasibility and CMS approval
- ACO and MCO procurement will be aligned to ensure operational simplicity across models

C Current state: Certain populations are eligible for integrated models, but most care is un-integrated FFS

MassHealth FY15 Program Spending
$ billions, excludes temporary coverage, TPL, supplemental payments, Medicare claims, members with limited eligibility



Note: member and spending figures may include estimates; chart is a simplification to illustrate scope and does not show all circumstances (e.g. HCBS populations, MassHealth Limited, Premium Assistance)

* Excludes behavioral health spending

C Reform under consideration: Current thinking for eligible populations

- **Starting point: Medicaid-only population**, including those with LTSS needs, **included in MassHealth ACO models**
  - MassHealth spend only
  - Non-dual HCBS Waiver populations eligible, ACO budgets will not include waiver services
  - Future discussions on how to bring value-based contracting expectations to SCO/One Care models

- ACOs will be **financially accountable** for physical health, BH, and pharmacy (with adjustments for price inflation) starting in year 1

- We will transition financial accountability for **MassHealth state plan LTSS costs over time**, starting year 2 to allow for:
  - Establishing strong partnerships between ACOs and LTSS providers
  - Developing solid measurement strategy for quality and member experience
  - Discussions with CMS and approvals

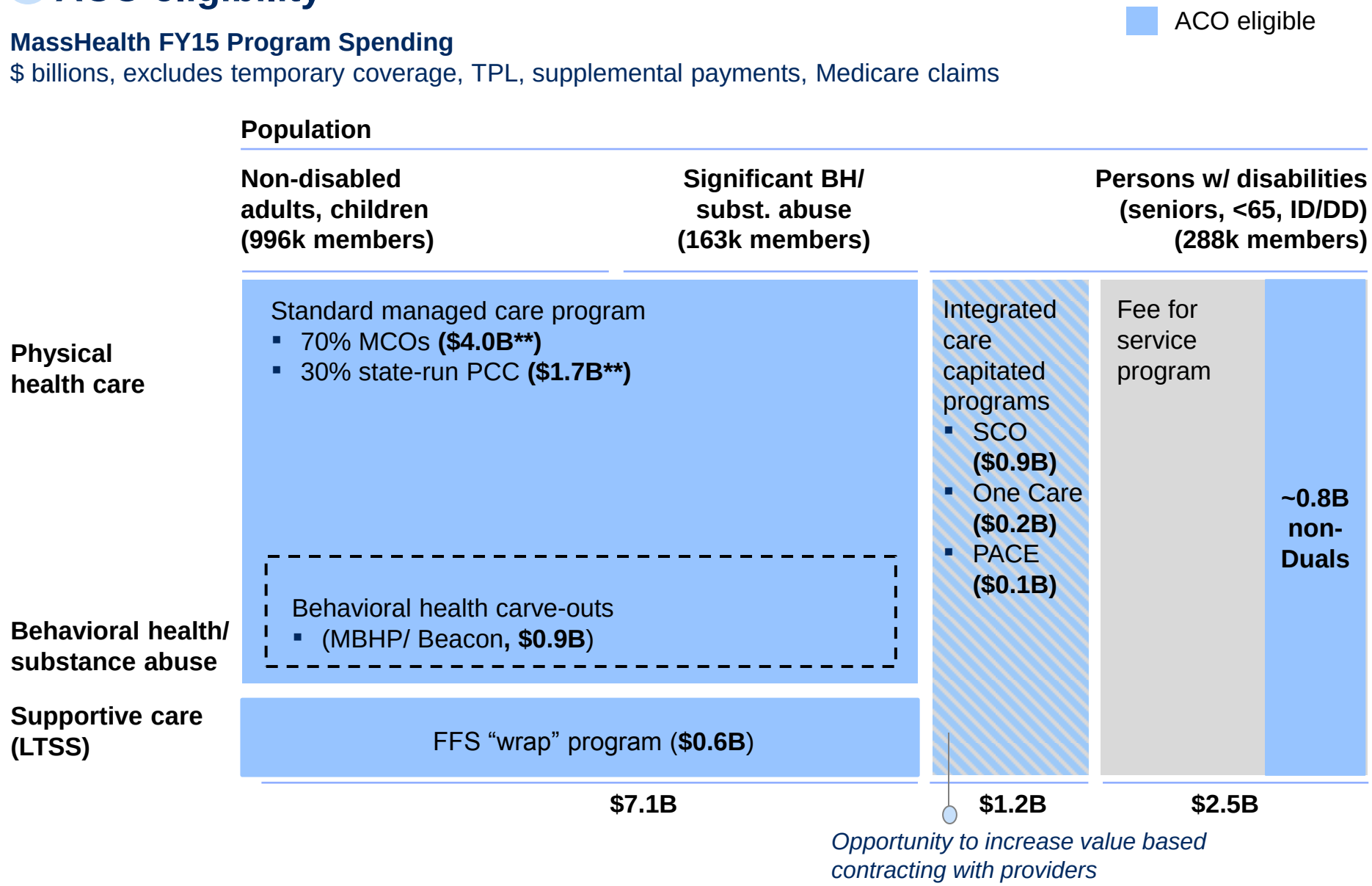
- ACOs will have broad responsibility to integrate care across all these disciplines and to integrate **social services and community supports**

- Quality/ member experience metrics core part of **ACO and state accountability**

- This is a **starting point** and we will explore ways to further increase coordination and expand integrated and accountable care to other populations over time, including duals

C ACO eligibility*

MassHealth FY15 Program Spending
$ billions, excludes temporary coverage, TPL, supplemental payments, Medicare claims



*Note that member and spending figures may include estimates
Chart is a simplification to illustrate scope and does not show all circumstances (e.g. HCBS populations)

** Excludes behavioral health spending

C There are important strategic questions to resolve to ensure ACOs are incorporating LTSS thoughtfully, and aligning with our Duals strategy

Strategic Questions on ACOs

- How should ACOs be held accountable for LTSS costs?
- What core capabilities or partners does an ACO need to have to provide competent care management for members with significant LTSS needs?
- What barriers do LTSS providers need to overcome to become effective and empowered ACO partners, and how can MassHealth help them do so?
- What LTSS quality measures can MassHealth employ?

Strategic Questions on Duals

- How should MassHealth expand and improve One Care?
- How should MassHealth expand and improve SCO?
- How should MassHealth expand and improve PACE?
- How should MassHealth increase integration among these programs and ACOs?

D Context on DSRIP Investment Model and CMS Expectations

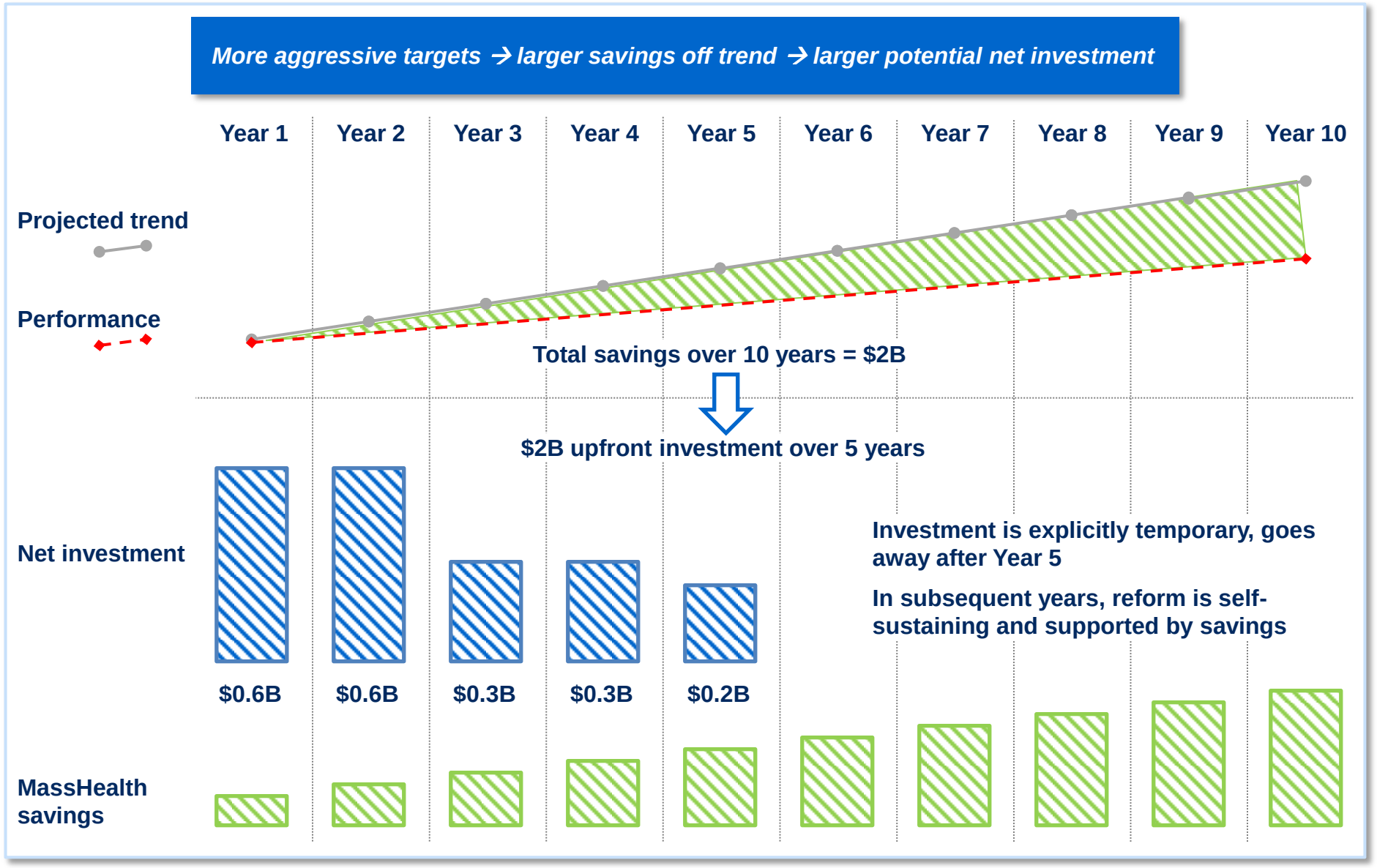
What is Delivery System Reform Incentive Program (DSRIP)?

- Waiver program in which providers can receive time-limited federal investment to catalyze delivery system improvement
- Funding at risk and tied to performance metrics
- Several states have received significant new federal funding under DSRIP waivers, to catalyze/accelerate care delivery reform or implement new payment models
- Going forward, significant number of other states “competing” for funding; process will be more structured than states receiving earlier investments (OR, NY)

Expectations from CMS

- State commitment to concrete and measurable improvement targets on cost, quality, and member experience
- Implementation of and broad participation in alternative payment models (APMs)
- Meaningful delivery system reform, including provider partnerships across the care continuum
- Confidence in state ability to execute successfully

D CMS Investment and Targets: Concept Overview



E Accountability for quality and access measures

Current thinking

- 2 different uses for measures :
  - **CMS Waiver agreement:** The state will be accountable to CMS
  - **ACO Payment model:** ACOs will be accountable to the state
- **Vetted, national measures** with stable baselines for payment / CMS accountability
- Additional measures for **reporting only:** Reporting-only measures can transition to accountability after baselining period
- Potential to include few **additional custom measures key priority domains (e.g., LTSS)**
- Need to balance measurement transparency with parsimony/alignment to avoid administrative burden

Current domains under consideration by the Quality workgroup

- Member/caregiver experience
- Access
- Care coordination / patient safety
- Preventive health and Wellness
- Efficiency of care
- At risk or special populations, as applicable
  - Behavioral Health
  - Chronic conditions
  - LTSS (e.g., frail elders, disabled)
  - Pediatrics
  - Maternity care
  - Opioid users
  - End of Life

Key area of emphasis for quality workgroup

ACOs will be accountable for established quality and utilization measures from Day 1

E Examples of quality and access measures from other states

Clinical/ Medical	▪ Well-child visits in the first 15 months of life ▪ Developmental screening in the first 36 months of life ▪ Colorectal cancer screening ▪ Congestive heart failure admission rate ▪ Chronic obstructive pulmonary disease rate ▪ Adult asthma admission rate
BH	▪ Alcohol or other substance misuse (SBIRT) ▪ Screening for clinical depression and follow-up plan ▪ Depression Remission at 6-Months ▪ Follow-up for Hospitalization for Mental Illness ▪ Adherence to Antipsychotic Medications for People with Schizophrenia
LTSS	▪ Percent of Long Stay Residents who have Depressive Symptoms
Cross cutting	▪ All-cause readmission rate ▪ Potentially Preventable Emergency Department Visits
Member Experience/ Access	▪ CAHPS Composite: Access to Care ▪ CAHPS Composite: Satisfaction with Care ▪ Percent of Primary Care practices accepting new Medicaid members (Physician survey)
Health Disparities	▪ Age-adjusted preventable hospitalizations rate per 10,000 – Aged 18+ – Ratio of Black non-Hispanics to White non-Hispanics – Ratio of Hispanics to White non-Hispanics *Reporting only*

F Social determinants of health

For social determinants of health, we strive to:

- Incorporate socioeconomic variables **into risk adjustment**
- **Measure and report** social needs and complexity
- Create the right program structure, requirements and incentives to leverage community-based organizations with **expertise in managing socially complex populations** as partners in the ACO care model

G Care coordination and health homes

For care coordination and health homes, ACO models will:

- Incorporate an approach to care management for members with complex needs, e.g. through an **integrated "health homes"** model
- Emphasize appropriate partnership with certain community organizations with **existing expertise**
- Be encouraged to "buy" and **form partnerships** rather than "build" new capacity

Upcoming discussion topics at workgroups

- Specific targets for cost, quality/outcomes and access
- How ACOs and MCOs fit together
- Requirements for:
  - ACO governance
  - Configurations of provider partnerships
  - Expertise for care coordination/management, particularly for specialized populations
- How ACOs and health homes fit together
- Specific strategies to encourage ACOs to “buy” and form partnerships rather than “build” new capacity

Thank you!

Do you have any questions?