

**WORKING DRAFT  
FOR POLICY DEVELOPMENT PURPOSES ONLY**



# MassHealth Payment and Care Delivery Reform: Public Meeting

Executive Office of Health & Human Services

December 15, 2015

WORKING DRAFT – FOR POLICY DEVELOPMENT PURPOSES ONLY

- 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

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**

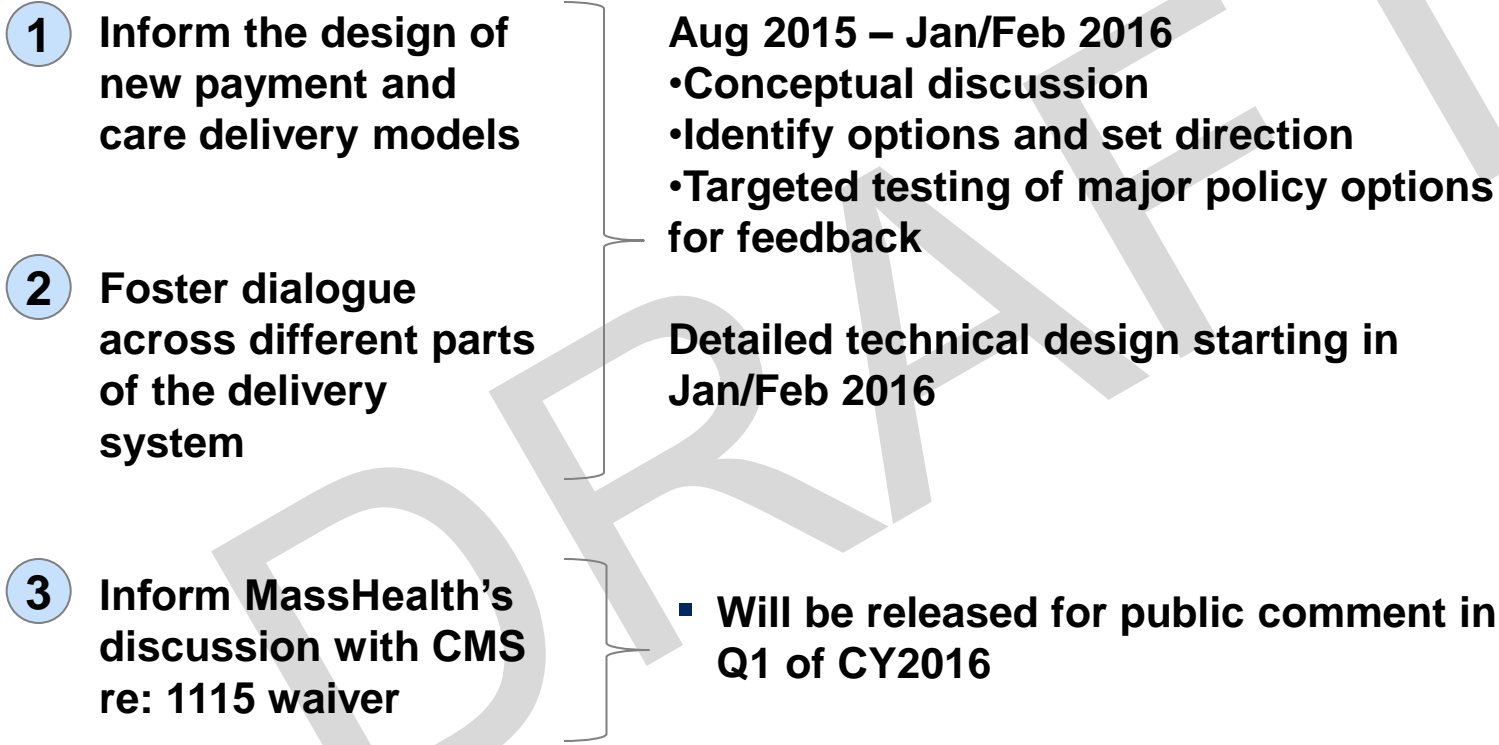


# Recap: Goals for workgroups and timeline

## Goals

## Timeline

Subject to refinement based on progress of Work Groups, discussions with CMS, etc.



**Where we are:**

- *Productive discussions on several topics (key themes synthesized in the appendix)*
- *Further discussion upcoming on several topics (see page 32)*

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# Restructuring MassHealth: principles of our approach

**Person-centered**

Concentrate on improving quality and member experience

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**Clinically appropriate**

Ensure clinically sound design through direct input from Massachusetts members and providers

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**Appropriate for all**

Account for varied member populations and providers (i.e., not a one-size-fits-all model)

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**Pragmatic**

Identify realistic solutions that can be implemented in a practical and timely manner

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**Fact-based**

Make design decisions based on facts and data

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**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

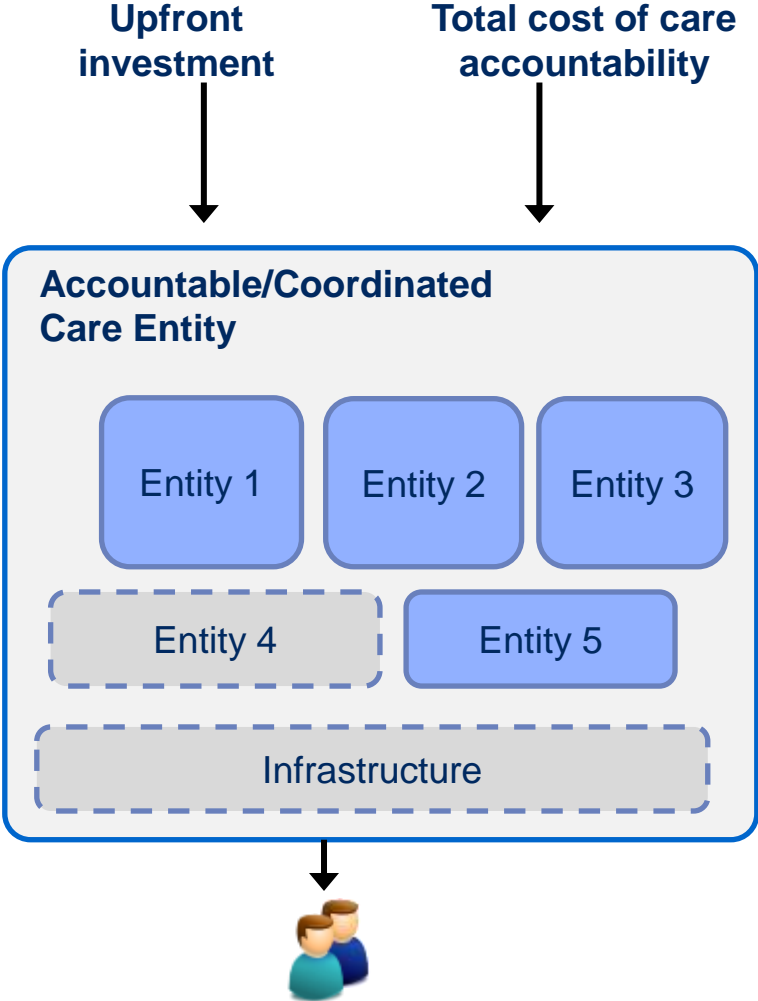
### What we plan to do

- 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**

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

- 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*

## Recap: 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**
- 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



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## Accountable Care: Topics for discussion today

### **CMS Waiver and Federal Investment:**

- Goals for cost and quality
- A** - Goals / framework for distribution and use of funds
- B** ACO care and payment model, member experience
- C** Social determinants of health
- D** Care coordination and health homes

## A Context on DSRIP Investment Model and CMS Expectations

### What is Delivery System Reform Incentive Program (DSRIP)?

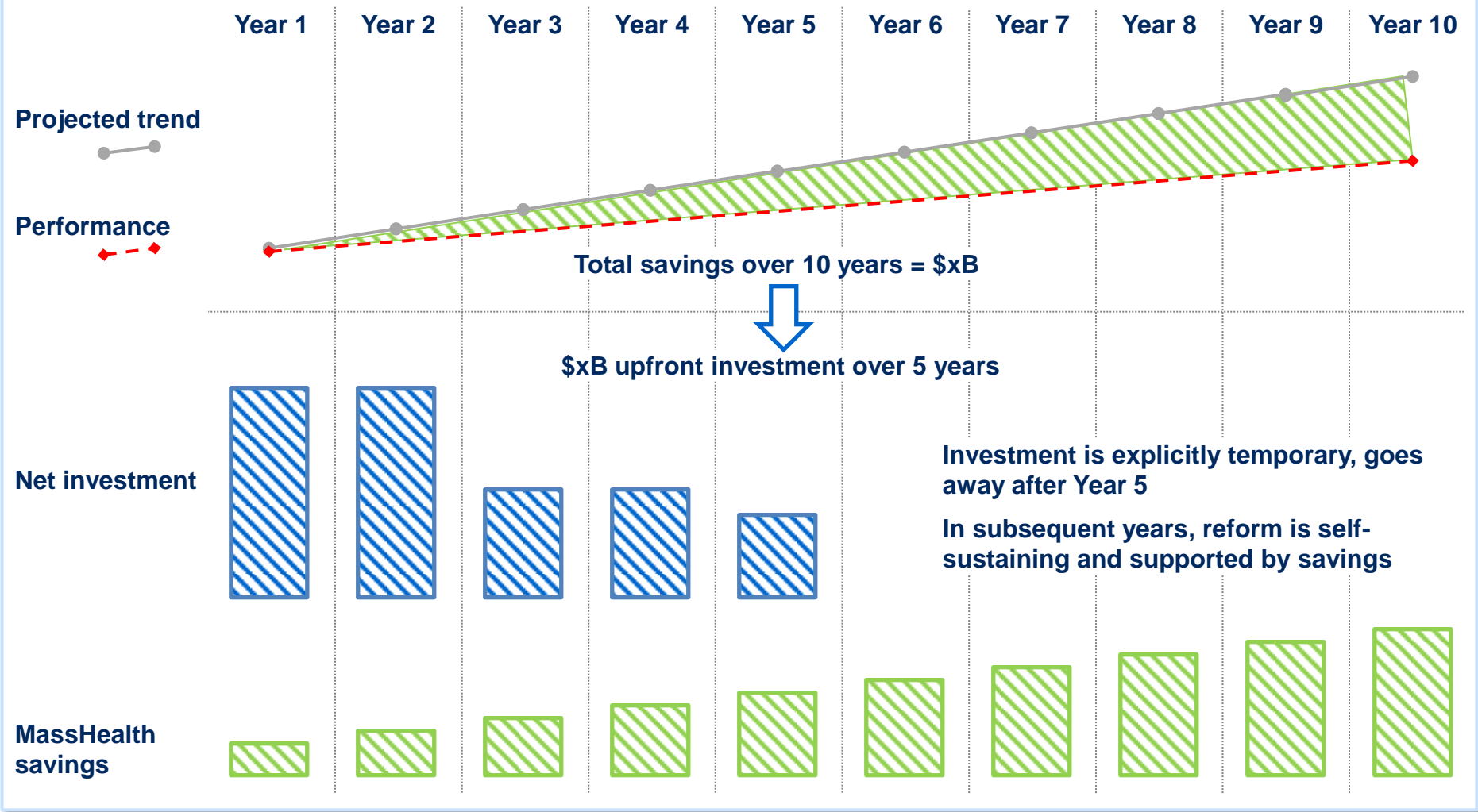
- Waiver program in which providers can receive time-limited federal investment to catalyze delivery system improvement
- Funding at risk and tied to performance metrics
- Several states have received significant new federal funding under DSRIP waivers, to catalyze/accelerate care delivery reform or 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

# A CMS Investment and Targets: Concept Overview

*More aggressive targets → larger savings off trend → larger potential net investment*



## A Accountability for quality and access measures: Principles

- Reliability, validity, stability, and drawn from nationally accepted standards of measures (wherever possible) and with broad impact
- Alignment with other payers and CMS
- Cross-cutting measures that fall into multiple domains
- Patient-centered, patient-reported, quality of life/functionality
- Variation and opportunity for improvement (e.g. provider level variation, disparities)
- Promotion of co-management/coordination across spectrum of care
- Feasibility of data collection and measurement and minimization of administrative burden as much as possible

# A Accountability for quality and access measures: Use of measures and domains

## Use of measures

- 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** complete system-level measurement with parsimony/alignment to avoid administrative burden
- Strategy to **risk-adjust** for patient mix
- **Evolution** of measure slate as we gain more experience with ACOs and as measurement science advances

## Measurement Domains

- 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
  - 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**

## A Where we are

- Obtained input from multiple workgroups (Quality, BH, LTSS, Strategic Design, Payment) to iterate on a straw slate of measures
- LTSS / end of life measures are particularly preliminary / work-in-progress – further discussions and stakeholder engagement needed to refine thinking
- Will obtain further input from BH and LTSS workgroups on straw slate

# A Straw Slate for CMS Reporting – FOR DISCUSSION

Will obtain further input on these measures from BH and LTSS workgroups

## Patient Experience/Access

- CAHPS Clinician & Group Survey (CG) or CMS CAHPS ACO Survey with \*Health Status/ Functional Status measure AND select patient reported outcome measures
- HCAHPS: A 32 item survey instrument that produces 11 measures including the CTM-3

## Care coordination / Patient safety

- Medication Reconciliation Post-Discharge (MRP)
- Timely transmission of transition record
- Care for Older Adult (COA) - Advanced care plan

## Prevention and Wellness

- Childhood immunization status (CIS)
- Developmental screening in the first 36 months of life
- Dental Services—Fluoride or sealants (NQF)
- Immunization for Adolescents (IMA)
- Tobacco use assess and cessation intervention
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Adult BMI Assessment (ABA)
- Prenatal & Postpartum Care (PPC)

## Efficiency of care

- Use of imaging studies for Low Back Pain (LBP)
- \*Hospital All-Cause Readmissions
- \*Pediatric All-Condition Readmission Measure
- \*Potentially preventable ED visits
- \*PC-01 Elective Delivery
- \*PC-02: Cesarean Section

## At Risk Populations

- \*Controlling high blood pressure (CBP)
- \*PQI-5: COPD
- \*PQI-8: Congestive Heart Failure Admission Rate
- Medication Management for People with Asthma (MMA)
- \*Comprehensive diabetes care: A1c poor control (CDC)
- \*Comprehensive diabetes care: High blood pressure control (CDC)

## Behavioral Health / Substance Abuse

- Screening for clinical depression and follow-up plan: Ages 12-17
- Screening for clinical depression and follow-up plan: Age 18+
- Initiation and Engagement of AOD Treatment (IET)
- Follow-Up After Hospitalization for Mental Illness (FUH)
- Appropriate prescribing of antipsychotic medications (use in elderly with dementia) (NQF)
- \*Depression remission at 12 months
- Follow-up care for children prescribed ADHD medication

## End of Life Care

- Proportion admitted to hospice for less than 3 days
- Hospice and Palliative Care -- Pain Screening and treatment
- Hospice and Palliative Care -- Dyspnea Screening and treatment

## Long Term Services and Supports

- People make choices about lives, including: housing, roommates, jobs and daily activities
- People who have adequate transportation
- People who need additional services and supports
- People whose support workers come and leave when they are supposed to



## A Preliminary view on MassHealth goals for DSRIP

- Drive uptake of Total cost of care (TCOC) accountability under a spectrum of ACO options
- Provide transitional support to build capabilities and infrastructure
- Incentivize ACOs to hit milestones/see results in early years
- Support integration of BH, LTSS, social and human service providers into ACO models

## A Preliminary view on uses of DSRIP funds

- ACO start-up costs, subject to accepting minimum level of lives, to implement population health management capabilities
- Subsidized support for population health management operating costs for a limited transitional period
- Investment in integration for BH, LTSS, social and human service providers into new payment models

## A Outstanding design elements on DSRIP funding

- Distribution of DSRIP funds over time
- Estimated allocation of DSRIP funds across the uses
- Approach to setting milestones and metrics to receive DSRIP over time, including portion that is at risk for not meeting requirements
- Approach to distributing funding to achieve integration of BH, LTSS, social and human services into new payment models

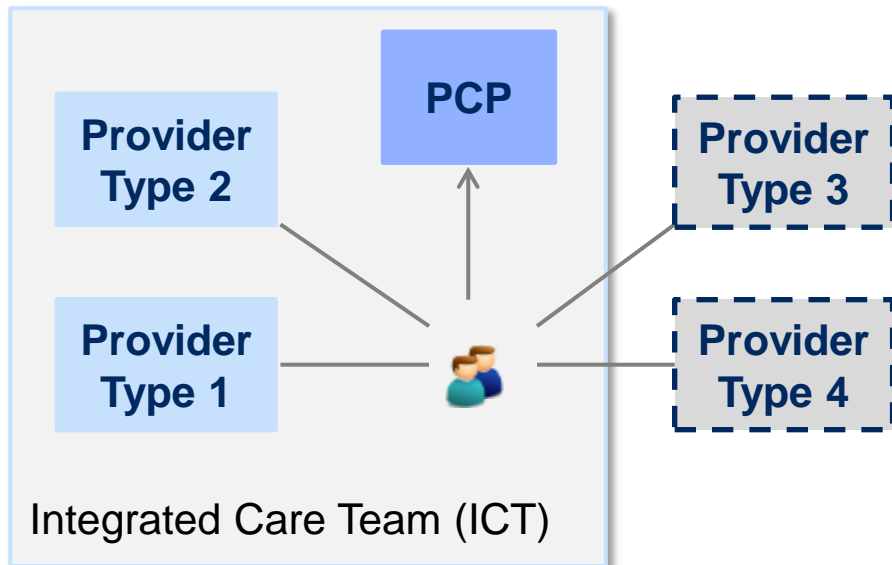
## B ACOs can achieve member-driven, integrated care

### Integrated, accountable care

Payment and accountability



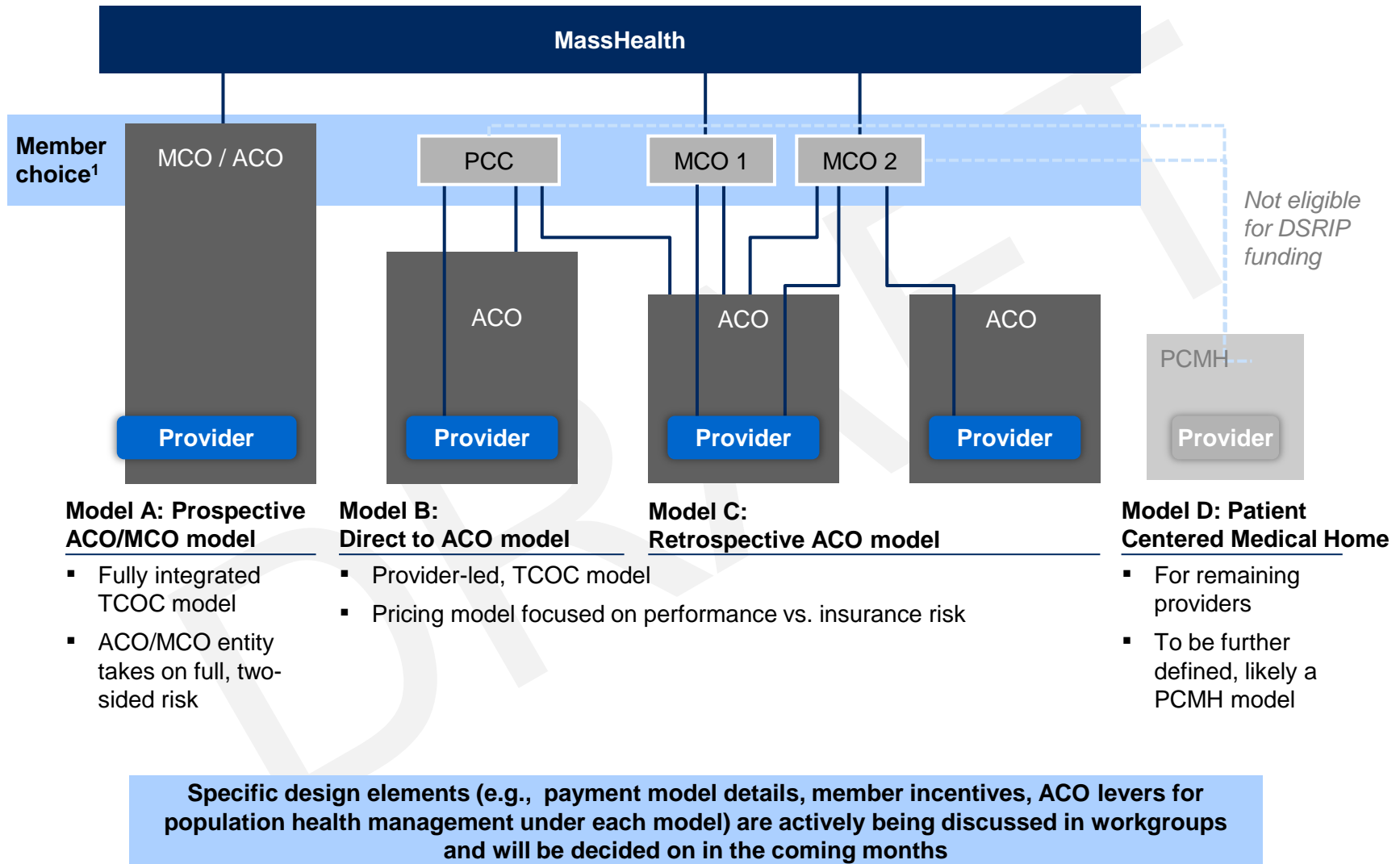
#### Accountable/Coordinated Care Entity



### Elements required for ACOs to have meaningful impact

- A network of providers who serve as an integrated care team (ICT) for the member
- Increased member engagement in care
- Integration and investments into LTSS, BH and social determinants
- Aligned payment model (global payments)
- Panel stability to support continuity of care and investments in population health

# B DRAFT – MassHealth Accountable Care Models - *Framework for discussion*



<sup>1</sup> Members will also select a primary care provider once they have selected an option

## C 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

## D Care coordination and health homes

### Approaches under consideration

- 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**
- Encourage to “buy” and **form partnerships** rather than “build” new capacity
- **Use DSRIP funds** to invest in infrastructure for BH, LTSS, social and human service providers

## Upcoming discussion topics at workgroups

- Specific targets for cost, quality/outcomes and access
- Specific design elements for accountable care models; 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 methodology for distribution of DSRIP funds
- Specific strategies to encourage ACOs to “buy” and form partnerships rather than “build” new capacity



**Thank you!**

**Do you have any questions?**

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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

## Requirements

- 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**
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### Health Homes/ Care Coordination

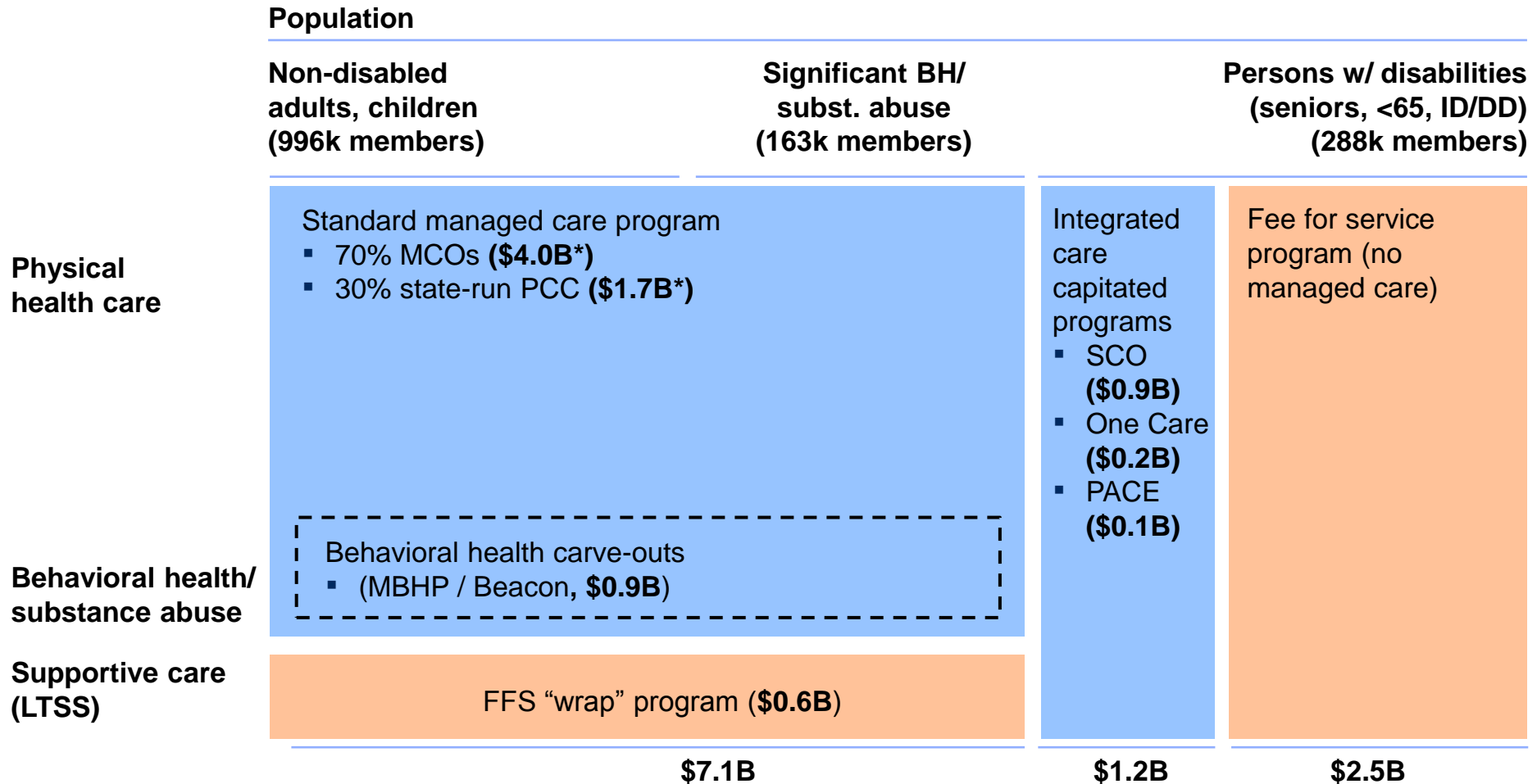
- Certain members may require **specialized expertise** to ensure proper coordination
- Many **community providers** have important experience that ACOs should leverage through **collaborative partnerships**
- MassHealth should consider **potential need for additional infrastructure** and resources for 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

# 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

Managed Care      Fee for Service



*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)*

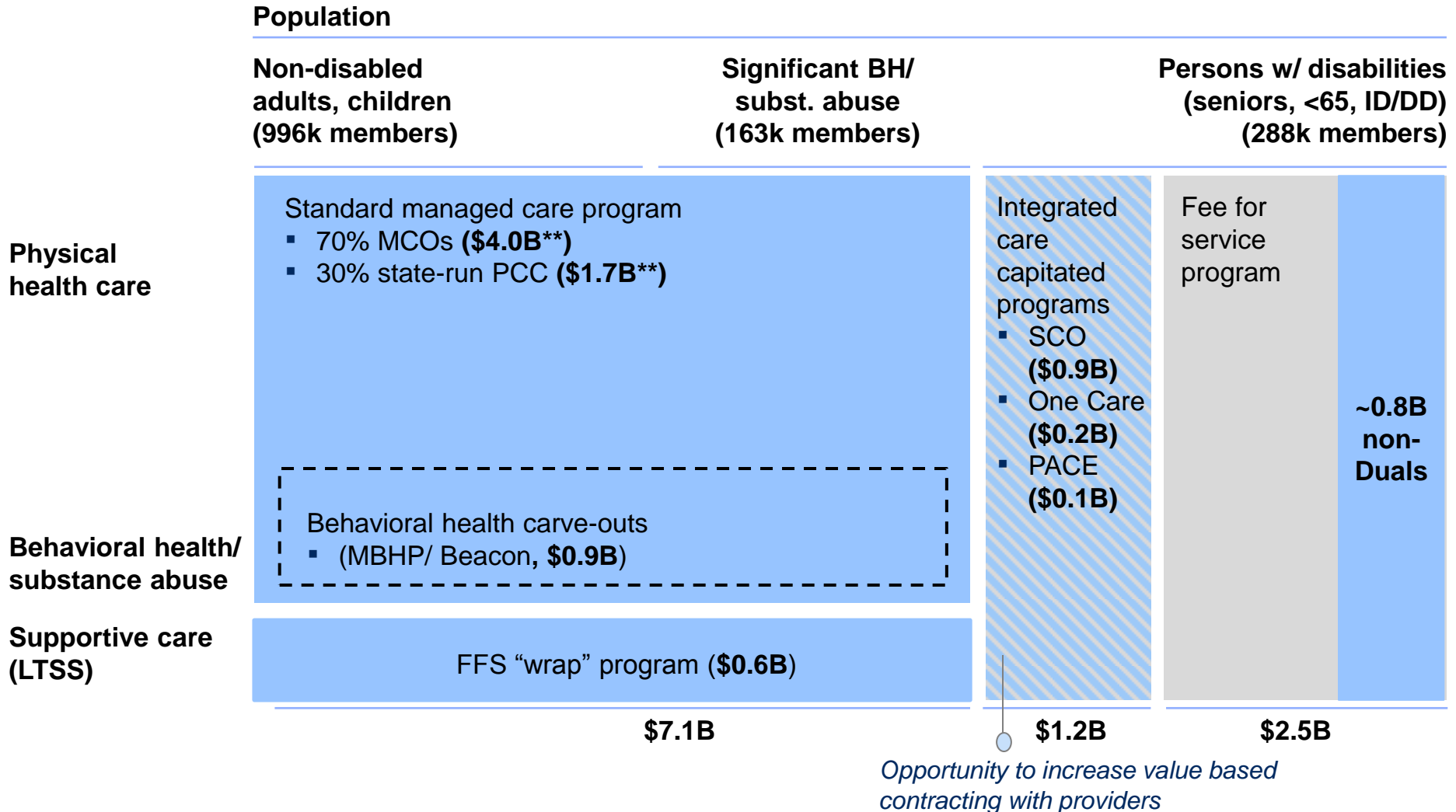
\* Excludes behavioral health spending

# ACO eligibility\*

■ ACO eligible

## MassHealth FY15 Program Spending

\$ billions, excludes temporary coverage, TPL, supplemental payments, Medicare claims



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Chart is a simplification to illustrate scope and does not show all circumstances (e.g. HCBS populations)

\*\* Excludes behavioral health spending

## A Key aspects of measurement

- Measure Types
  - **Structure** – characteristics of the delivery system
  - **Process** what is done to, for, or by the patient
  - **Outcome** – patient health state (classic meaning of outcome) or delivery system result (e.g. hospitalization)
  - **Patient Experience** – obtained through surveys or interviews
  - **Balancing** – intended to track unintended consequences
- Essential Components of Measure “Specifications”
  - Numerator (top number)
  - Denominator (bottom number)
  - Case finding period (time window for denominator)
  - Anchor date
  - Criteria (e.g. clinical situations, age group)

## B 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 A: Prospective ACO/MCO mode:**
  - 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 B: Direct to ACO model**
  - Pricing model focused on performance vs. insurance risk
  - Member attributed through active selection/enrollment into the ACO
  - Need to further explore feasibility
- **Model C: 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
- 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

## **B 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?