**DRAFT**

Slide footer on all slides unless otherwise noted

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Slide 1

**MassHealth Payment and Care Delivery Reform: Public Meeting**

Executive Office of Health & Human Services

March 10, 2016

***WORKING DRAFT - FOR POLICY DEVELOPMENT PURPOSES ONLY***

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**Agenda**

* **Recap of overall direction and timeline updates for care delivery & payment reform**
* Update on latest thinking:
* Population health focus
* Community Partners connections
* DSRIP payments and accountability
* Additional program updates (budget, program integrity, other)

Slide 3

**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**

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**Recap: Payment and Care Delivery Reform – overall construct**

* 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
* 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
* Key principles

**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**

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**Timeline Update: 1115 Waiver**

* EOHHS has been in active discussions with CMS and has received positive feedback so far
* We plan to continue dialogue with CMS and with stakeholders during March-April before finalizing details of a waiver proposal
* Anticipated state public comment period – begins late April
* Formal submission to CMS – May

*Timelines may be updated based on CMS and other discussions*

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**Time Update: ACO and MCO Procurements (draft, calendar year quarters)**

* The next phase of ACO and delivery system design work and implementation planning will take place between January 2016 - July 2016.
* The detailed technical design implementation work will take place between July 2016 - July 2017.
* The pilot procurement will take place between April 2016 – July 2016.
* The pilot performance period will be October 2016 – July 2017.
* The ACO procurement will take place between July 2016 – October 2016.
* The virtual launch of ACOs (contracting, reporting, capacity building, readiness) will take place between October 2016 – July 2017.
* The launch of ACO models will take place between July 2017 – October 2017.
* MCO re-procurement, selection, and preparation will take place between July 2016 – July 2017.

Notes:

* CY 2016 – Working through details, procurements, preparing for implementation
* End of 2016 – Beginning transition
* Pilot opportunity
* Virtual launch (reporting, readiness, capacity building) for all other ACOs
* MCO re-procurement on parallel, aligned timeline
* Significant work still to be done in coming months to define and prepare for the full launch in 2017

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**Pop. Health: ACOs will be held to a high standard of care, and will have tools to manage population health**

**ACO Expectations and Responsibilities**

* Performing on quality measures that span several domains including population health and member satisfaction
* Increased access to high-value care and easier referrals within a coordinated network
* Tighter integration across physical health, BH, and LTSS
* Faster follow-up after key care events
* More care in home and community settings
* Care coordination services
* Comprehensive care planning for high-risk members that leverages appropriate expertise for members with SMI or LTSS needs
* Real investment in and connection to social services

**ACO Population Health Management Tools *(based on existing Medicare models)***

* Total Cost of Care payment model
* Continuous member enrollment (with member opt-out)
* The ability to define a Coordinated Care Team of providers who can work closely together
* Increased member engagement in care, including through primary care referrals

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**Community Partners: Framework for partnership *(example)***

This framework involves the creation of ACOs which will work in close collaboration with 3 types of Community Partners (CPs) to coordinate and manage care. These CPs will be Behavioral Health (BH) CPs, Long-term Supports and Services (LTSS) CPs, and Social Services CPs.

**ACO Responsibilities**

* Primary accountable entity for member’s total cost of care
* Provide team-based care coordination for appropriate members
* ACO’s PCP responsible for primary care referrals in all cases
* Refer and provide access to CPs for delegated services and integrate CPs where appropriate into care planning/coordination

**Community Partner Responsibilities**

 **BH CPs**

* Primarily accountable to provide 6 Health Home (Section 2703 of ACA) services to SMI members
* Coordinate with ACO (i.e., ACO PCP must sign off on care plan, notification must go both ways, huddles should include both. ACO PCP still owns referral)
* May be direct service provider as well

**LTSS CPs**

* Provide expertise on community-based LTSS services
* Assess member’s LTSS service needs
* Provide options counseling and member advocacy
* Participate on member’s care team and inform care planning
* Provide navigational assistance for certain LTSS services

**Social Service CPs**

* Assist members with applications and navigation for certain health-related social services

***Detail still to be discussed: ACOs and CPs will have significant flexibility to define their relationship.***

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**Delivery System Reform Incentive Payment (DSRIP) Program**

**Overview**

* Proposed DSRIP program is a 5yr investment authorized by CMS through the 1115 waiver to catalyze delivery system reform in the State

**DSRIP Funding Uses**

* Eligibility for receiving DSRIP funding linked explicitly to participation in MassHealth payment reform
* Three main funding streams:
	+ **Development of Medicaid ACOs:** Funding used to build up ACO’s capabilities and infrastructure necessary to operate under total cost of care umbrella, as well as to pay for flexible services (i.e. currently non-reimbursed services that address social determinants of health)
	+ **Community Partners:** Funding used to help community based BH, LTSS and social service providers build up care coordination capabilities, infrastructure, and workforce capacity to better serve MassHealth members
	+ **Statewide infrastructure:** Funding stream will help state more efficiently scale up statewide infrastructure and workforce capacity
		- Dedicated stream of funding for primary care workforce development and training (e.g. CHCs and others), statewide technical assistance, community resource database, etc.
* To receive funding, ACOs and CPs need to demonstrate partnerships with each other (e.g. MoUs)

**DSRIP Accountability**

* Depending on the recipient type, accountability will be based on some combination of process measures, quality measures, spending targets, and avoidable utilization targets
* Massachusetts will be accountable to CMS for the same categories of measures

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**Additional Program Updates**

* FY17 budget priorities
* LTSS program integrity updates
* Home Health
* Overall program integrity
* SCO/PACE/integrated care
* Independent, conflict-free assessments

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**Home Health Overview**

* MassHealth spending on Home Health services is growing unsustainably:
* $585 million spending in FY15
* 41% increase (+$170m) in FY15 alone
* 86% of FY15 spending growth driven by providers new to the Commonwealth since 2013
* MassHealth has implemented programmatic changes to ensure members are receiving appropriate levels of care, including:
* Moratorium on new providers effective 2/5
* Referral required from physician not affiliated w/ home health agencies
* Prior authorization required for all home health services beyond specified thresholds (e.g., 30 home health visits in 90 days)
* Enhanced provider audit activity
* 12 providers referred to Medicaid Fraud Division of Attorney General’s office

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**Spending on Home Health services increased $170M (41%) in FY15. Spending will approach $1.0b in FY17 with no action**

The below information charts Home Health Program Annual Spending increases in $M.

FY 2014 - $415M

FY 2015 - $585M

FY 2016 - $760 Forecast\*

FY 2017 - $953M Forecast \*

*\* Projection before impact of 3/1 program reforms*

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**86% of FY15 spending increase driven by new providers**

The below information charts Home Health Program Annual Spending increases in $M.

FY 2013 - 317 Providers (4 new providers, 313 existing providers – pre-2013)

FY 2014 - 415 Providers (73 new providers, 342 existing providers)

FY 2015 - 585 Providers (219 new providers, 366 existing providers)

In terms of FY 14-15 growth:

* 41% increase in total number of providers
* 200% increase in new providers
* 7% increase in existing providers