MassHealth Payment and Care Delivery Reform: Public Meeting

Executive Office of Health & Human Services

March 10, 2016

WORKING DRAFT – FOR POLICY DEVELOPMENT PURPOSES ONLY

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)

Recap: 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 – overall construct

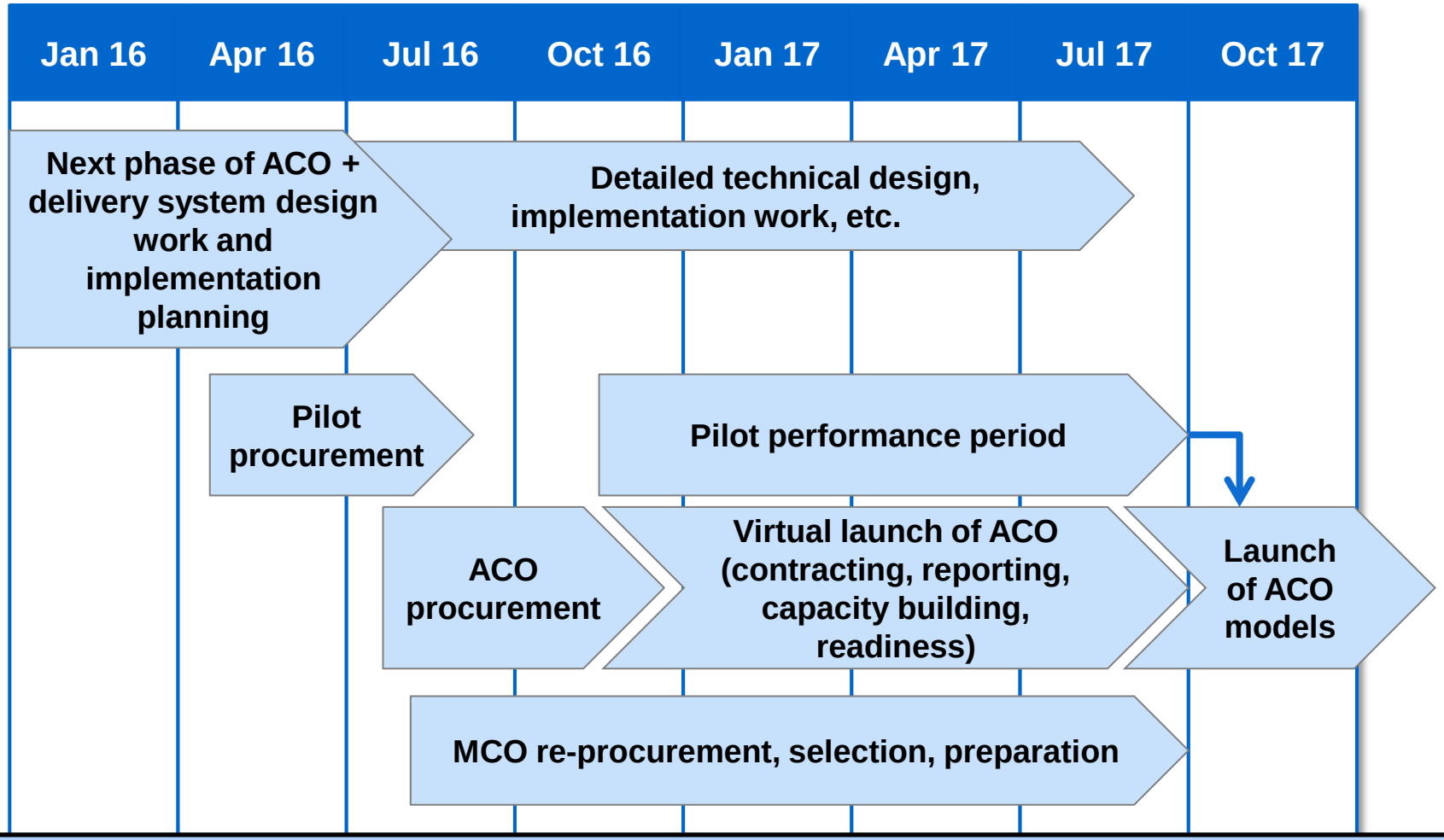
- MassHealth is exploring linking payment and care delivery reform strategies with Massachusetts' conversations with CMS about the **1115 waiver**
- **State commits to annual targets for performance improvement over 5 years**
- **Make case to receive federal investment upfront through waiver**
  - Seek 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**

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

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



- 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

Community Partners: Framework for partnership *(example)*

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 Partners (CP) Responsibilities

BH CP

- 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 CP

- 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 Services CP

- 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 relationships**

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 Account-ability

- 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

Home Health - Overview

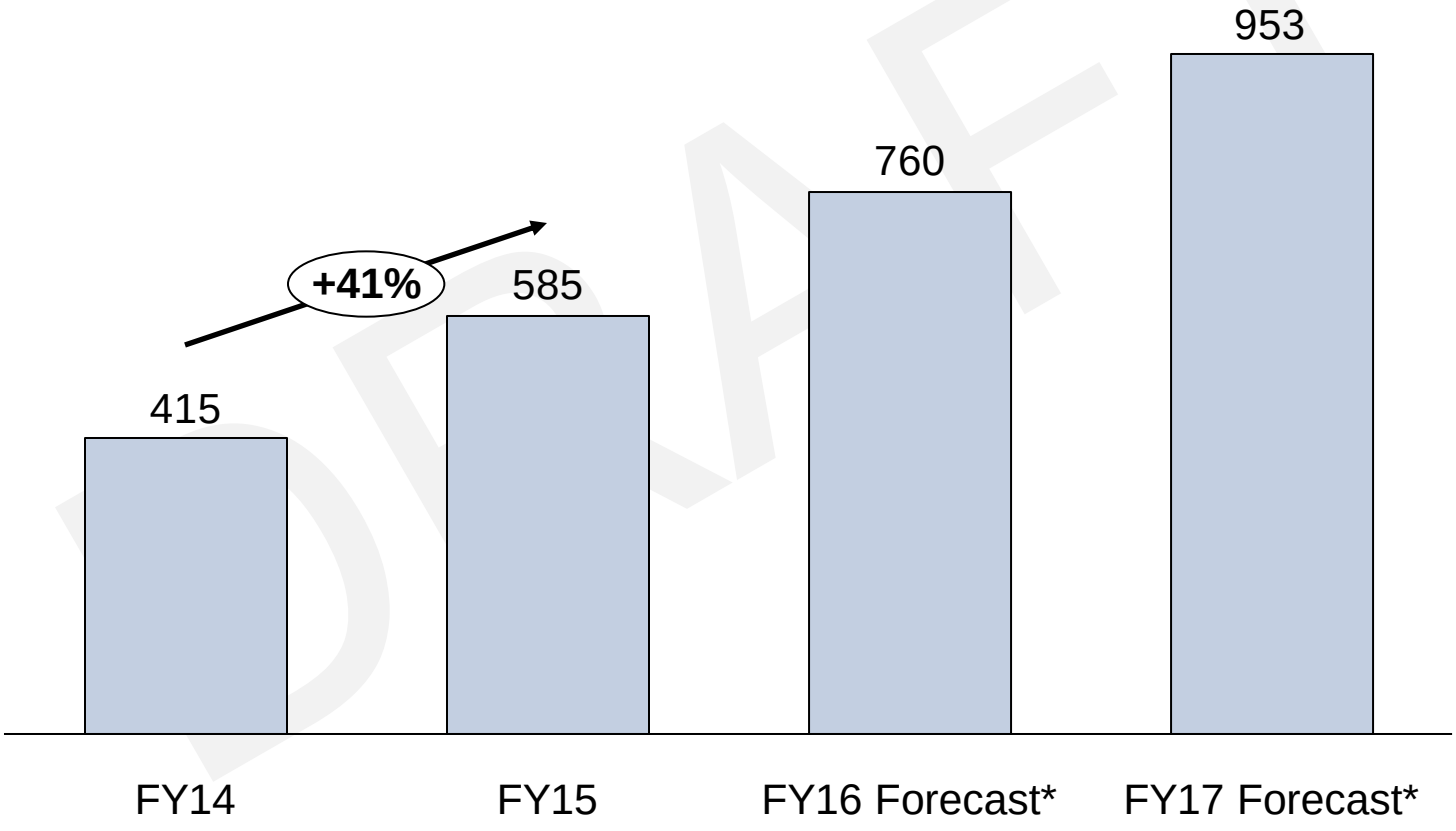
- MassHealth spending on Home Health services is growing unsustainably:
  - $585 million spending in FY15
  - 41% increase (+$170m) in FY15 alone

- 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

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

Home Health Program Spending
Annual spend, $M



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

86% of FY15 spending increase driven by new providers

Home Health Program Spending
Annual spend, $M