Summary of Stakeholder Listening on MassHealth Restructuring

August 2015

Beginning in April and continuing through July, MassHealth conducted a statewide, transparent, public listening initiative to discuss restructuring of the MassHealth program to improve the quality and efficacy of its services and its financial sustainability. MassHealth articulated and sought input on the following six priorities:

1. Improve customer service and member experience;
2. Fix eligibility systems and operational processes;
3. Improve population health (including health promotion and disease prevention) and care coordination through payment reform and value-based payment models;
4. Improve integration of physical, oral, behavioral health (BH) and long term services and supports (LTSS) care across the Commonwealth;
5. Improve integration and experience of care for individuals with disabilities (over and under 65 receiving LTSS care); and
6. Improve management of our existing programs and spend

Several consistent messages emerged from this effort, and in response to that feedback, MassHealth is preparing to implement several concrete changes. In addition, however, the complex issues discussed revealed divergent opinions among stakeholders, some of which is summarized in this document; these topics will require in-depth discussion. MassHealth has therefore identified the need for a second phase of stakeholder engagement, separated into multiple tracks. These are described briefly below, and further details are in Section C of this document:

- Public meetings (every 4-6 weeks) between now and March 2016 to solicit broad public input and provide transparent updates on progress;
- A standing forum for members and/or their families and caregivers to provide ongoing guidance and feedback on the development, implementation, and performance of its programs and reforms;
- A series of focused workgroups around payment and care delivery transformation (priorities 3 through 5 above); and
- A separate, additional workgroup specifically on customer service (priorities 1 and 2 above), in light of the feedback received during these initial sessions.

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.

A. Summary of Feedback To-Date

Customer Service

Suggestions centered on enhancing MassHealth and Connector eligibility systems and operational processes and on improving the consistency, speed, and unity of the MassHealth and Connector customer service experience. Some specific suggestions included:

- Reduce customer service phone wait times, improve the clarity of communications, and improve accessibility and usability for persons with disabilities;
- Give partners that are supporting MassHealth applications (e.g., providers, certified application counselors) access to a separate, efficient line. Give providers their own line for billing issues;
- Streamline the application process and make it easier for all involved to see the status of applications;
- Simplify the identity proofing process in particular;
- Improve clarity of MassHealth notices, including using language at an appropriate grade level for written notices, and reduce notice frequency;
- Improve website functionality and accessibility and make the website more useful for members and providers by increasing the amount of information available online;
- Move towards a "no wrong door approach," where MassHealth and the Connector can conduct efficient transfers of customers from one line to the other. Cross-train customer service staff between MassHealth and the Connector to improve each side's knowledge of the whole system;
- Improve the knowledge of call center staff and the consistency and accuracy of responses; and
- Build allowances into the system for warm hand-offs and escalation that go beyond a simple phone number referral

Payment and Care Delivery Reform

MassHealth was encouraged to consider flexible and broadly applicable approaches to payment and care delivery reform rather than more rigid, "one size fits all" solutions. Stakeholders emphasized the need to make the patient experience of care more integrated and coordinated, and to expand the traditional focus of healthcare providers to include social determinants and community resources. Specific suggestions included:

- Develop strategies to address the fragmentation of care directly, and to improve integration between physical, oral, behavioral health, pharmacy, and long term services and supports;
- Consider the financial and human resources necessary to support cross-continuum coordination of care, particularly for high-risk patients, and build in necessary transition mechanisms;
- Consider ways to shift utilization and resources from acute and institutional settings of care to primary care, behavioral health, and other community based supports; at the same time, some providers noted existing resource challenges for acute and institutional facilities;

- Consider models that explicitly address concerns of small providers in new payment models;
- Empower small and community-based providers to reduce avoidable hospital and ED utilization, and build in protections to ensure that provider systems' cost savings do not come at the expense of high-value care like primary care, behavioral health, or community-based LTSS;
- Significantly improve the quality, transparency, availability, and usability of MassHealth data;
- Consider creative but impactful ways to support social determinants of health, with specific emphasis on housing, tenancy preservation programs, fuel assistance programs, and nutritional access and support;
- Develop a robust risk adjustment methodology, which ideally addresses social determinants of health (including socioeconomic status) explicitly
- Facilitate access to peer services and community resources;
- Move towards a provider based care management and care coordination approach; and
- Ensure that accountable payment models consider and value the role of member choice as well as how member choice affects risk that is placed on providers in managing patient populations. Create incentives to ensure that new accountable payment models increase member engagement and satisfaction while also including explicit protections around quality and access.

Behavioral Health, and Long Term Services and Supports

Suggestions for MassHealth's approach to behavioral health and long term services and supports (LTSS) were varied and specific, and emphasized the importance of continued member involvement. Stakeholders emphasized the unique needs of the behavioral health and LTSS populations, and the important role behavioral health and LTSS services play in members' lives. The need for more integrated care was a common theme. Specific suggestions included:

- Design, in concert with members and advocates, explicit expectations for coordination and delivery of care for frail seniors, or members with disabilities or with significant behavioral health needs in new payment models;
- Ensure provider systems (e.g., Accountable Care Organizations) are evaluated on outcomes related to long term services and supports, and build in explicit expectations to ensure members' LTSS care is not "over-medicalized";
- Ensure consumer direction for the Personal Care Attendant (PCA) program;
- Move towards a provider based care management and care coordination approach;
- Consider the role and expertise of community mental health centers and community addiction treatment providers in coordinating care and managing the complex needs of their populations, including seniors;
- Examine the behavioral health "carve out" relationship, and 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 Authorizations for services related to specific conditions, and improve access to these services for members who need them;
- Ensure sufficient focus on care coordination and management for long term services and supports under accountable payment models;
- Improve the financial sustainability of the One Care program and consider avenues for its expansion;
- Expand Senior Care Options (SCO) program for dual eligible seniors;
- Consider members with behavioral health needs in the development of quality measures that are inclusive of quality-of-life and recovery goals;
- Explore expanding access to peer services for behavioral health and to Recovery Learning Communities;
- Specifically improve treatment and access for members with opioid addictions;
- Evaluate and address issues about reimbursement rate adequacy and parity for behavioral health and LTSS;
- 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.

Managed Care Organizations (MCOs)

Specific points regarding the MCO program included:

- Recognizing and examining the financial situation of current MCOs;
- The need for an improved and more transparent rate setting process for the MCOs;
- Longer term improvements to the MCO program that drive quality and efficiency;
- Improvements to the stability of member enrollment that protect member choice; and
- The need for an approach to deal with new high cost specialty drugs in MCO rate setting.
- Improvements in integration of behavioral and physical health services

B. Identified Next Steps

Based on the feedback received through its listening initiative, MassHealth has identified several concrete follow-up items, and has begun to refine an initial point of view to guide the development of new payment models. Above all, MassHealth has identified the need for more stakeholder engagement, including detailed discussion in focused work groups. MassHealth is committing to further public meetings and continued transparency throughout its design work over the next several months.

Customer Service

MassHealth is targeting tangible improvements for the next Open Enrollment, including:

- More **online self-service options**: members will be able to select health plans via the MassHealth website starting this month; also, the application website (HIX) will allow members to update certain information online without having to call or submit paper;
- **Customer satisfaction surveys:** a baseline survey will be administered in October/November 2015; results will be published and findings will inform focus of effort. Survey will be repeated at 6-month intervals to measure progress;
- **Application assister direct access phone line**: Navigators and Certified Application Counselors (CAC) will be provided with expedited phone access to MassHealth to assist applicants and members at point and time of service. This is expected to lead to increased online vs paper applications and increased first- point- of- contact resolutions;
- **Improved identity proofing (IDP) process**: MassHealth has joined with the Connector to significantly increase the number of agents/staff across our programs that are trained and authorized to do identity proofing for online applications and have streamlined the process flow. This will increase the success rate and improve user experience for on-line applicantions and MH redeterminations;
- MassHealth and the Connector are engaging in **cross-training** of a subset of customer service representatives **to increase knowledge across programs** to increase competencies on both sides in serving **mixed households**;
- **Streamlined Provider Revalidation process**: MassHealth has eliminated the requirement for original wet signatures on certain forms, allowing electronic interface: also, document requirements have been significantly reduced; and
- **Website redesign**: this fall we will start shifting content to audience-specific tabs that will be added to its home page. Information about coverage types, covered services, copayments, and premium payments will become easier to find. Over time, material will be rewritten and simplified so that it is more readable and more accessible to members and applicants, including those with disabilities.

<u>Payment and Care Delivery Reform</u>

MassHealth will move forward with the development and launch of an accountable payment model. MassHealth's approach will not be "one size fits all," and will account for the unique needs of member populations including members with significant behavioral health needs, elders and members with disabilities.

MassHealth is currently considering:

- **A model that promotes integration and coordination of care to reduce siloes, improve care coordination, enhance population health, and take on financial accountability for total cost of care;**
- **Explicit goals on reducing avoidable utilization** (e.g., avoidable ED visits, admissions, re-admissions) and **increasing primary, behavioral health and community-based care**, and **incentivizing providers to collaborate** on driving these changes over time;

- **A feasible and financially sustainable transition** for provider partnerships that commit to integrated, person-centered, and accountable care. MassHealth is considering **a range of possible supports** (e.g. financial investment, technical assistance, timing) to ensure the success of its payment models;
- A **statewide Health Homes program** that would provide targeted funding to qualified, identified specialty providers to deliver care management and coordination services to appropriate populations of members with eligible chronic conditions. Health Homes criteria would be specific and sensitive to those conditions and their corresponding needs, and could potentially encompass community health centers, community mental health centers, and other qualifying Community Based Organizations;
- **Explicit incorporation of social determinants of health**, through the technical details of the payment model and in care delivery requirements;
- **Consistent, MassHealth-wide implementation** across MassHealth- and MCO-managed lives, to create a unified set of goals;
- **Valuing and explicitly incorporating the member experience** and outcomes into the continued development of new payment models; and
- **Linking** MassHealth's payment and care delivery reform strategies with Massachusetts' conversations with the Center for Medicare and Medicaid Services (CMS) about the **1115 waiver**
- **Commitment to** significantly improving the quality, transparency, availability, and usability of MassHealth data

MassHealth is committed to significant engagement and discussion with stakeholders as it refines this initial point of view over the next several months. MassHealth intends to engage in a public dialogue on more concrete models and design options in the stakeholder process outlined later in this document. MassHealth recognizes the importance of multi-payer consistency for new care delivery and payment models, and is involving the Health Policy Commission and other payers (including the Group Insurance Commission and Medicare and commercial health plans) in upcoming discussions to improve alignment and consistency across value-based payments in the Commonwealth.

<u>Behavioral Health and Long Term Services and Supports</u>

In addition to the emphasis on integration of behavioral and physical healthcare in its payment and care delivery reform strategy, MassHealth is also:

- Reviewing its policies and regulations and coordinating a policy and regulation review with other state agencies with the goal of **removing concrete barriers to integration**, including some mentioned during the stakeholder process:
    - For example, MassHealth has identified allowing same-day billing of consults for primary and behavioral health care as a specific goal of this effort;
    - Some providers (e.g., BH, LTSS) have identified lack of eligibility for federal IT infrastructure investments as a barrier to care integration;

- **Reviewing its contracts** with the Managed Care Organizations and the Massachusetts Behavioral Health Partnership (MBHP) **to support more integrated care models**;
- Beginning an examination of rates paid for behavioral health services and providers, with the goal of **reducing disparities and improving member access**;
- Continuing to improve patient flow and access to the **right services at the right time**, and working to **reduce ED boarding/backlogs and DMH wait lists** of members awaiting placement;
- Committing to improve **coordination with other agencies**, including the Department of Mental Health (DMH) and the Department of Children and Families (DCF);
- Continuing to focus on **improving the financial stability of the One Care program**;
- Initiating a structured, fact-based **review of rates paid to LTSS providers**, and working on a pay-for-quality program for nursing facilities; and
- Exploring the **expansion of integrated care models for persons with disabilities** (including dual-eligible members), in partnership with the disability community.

MCOs

MassHealth has supplemented the stakeholder listening sessions with data-driven internal review, active engagement with the MCOs, and discussions with colleagues in other states to understand Medicaid best practices. Based on these inputs, MassHealth will be extending the current MCO contracts for one year (through September 2016), with new MCO rates effective October 2015. This contract extension will also implement several short term reforms to enhance fairness and transparency of the MCO rate setting process, including:

- Updated assumptions about the **risk pool** and changes in **member mix** due to redeterminations;
- Updated forecasts in **pharmacy growth** that account for high cost specialty drugs;
- Improvements to make quarterly **risk adjustment process** more accurate and transparent;
- Introduction of PCC option for CarePlus members for **consistency across MCO programs**;
- Incentives for compliance with current data submission requirements to ensure **accurate and timely data**; and
- Requirements and funding for **rate increases for behavioral health**, to address the disparity in current rates.

MassHealth is also considering longer term improvements to the MCO program that respond to stakeholder feedback and align the program with MassHealth's broader priorities. The longer term MCO reforms that MassHealth is considering include:

- A more **competitive bidding process** that rewards plans with higher quality, higher customer satisfaction, and better cost effectiveness;
- **Member enrollment options** that improve plan stability while protecting member choice;
- Further improvements to **risk adjustment**;

- Increased **data quality and transparency**, including new standards and requirements for timely and accurate MCO data submission to address claims lag and other data quality issues; and
- Approaches for new **high cost specialty drugs**.

C. Continuing Stakeholder Engagement Proposal

Over the next 6-9 months, MassHealth will conduct a second phase of stakeholder engagement to gather input on various ideas and initiatives outlined above. MassHealth is committed to a fully transparent process that includes:

- Public meetings (every 4-6 weeks) between now and March 2016 to solicit broad public input;
- A standing member forum for members and/or their families and caregivers to provide ongoing guidance and feedback to EOHHS on the development, implementation, and performance of its MassHealth reforms;
- Continued use of the MassHealth.Innovations@state.ma.us email address to accept written testimony;
- Eight workgroups to solicit focused input on payment and care delivery transformation, summarized below in Table 1
- A separate, additional stakeholder process focused on customer service

Table 1: Summary of Work Groups

Work Group	Scope of Work & Schedule of meetings
Strategic Design	Discussing the overall approach to delivery system and payment reform for MassHealth members, with specific consideration for accountable and integrated care and payment models across the care continuum. Each meeting will be focused on a key strategic question. *Every 2 weeks for 16 weeks, anticipated start the 2nd week of August*
Attribution *(co-led by the HPC)*	Discussing approaches for determining the appropriate accountable provider for each member *Every 2 weeks for 8 weeks, anticipated start the 4th week of August*
Payment Model Design	Discussing payment approaches to drive better care and lower cost for its members without significant behavioral health or LTSS needs (e.g., ACOs and PCMH-based models), including the many technical details of how financial accountability for providers might work (e.g., risk adjustment, scope of services, relative vs absolute performance measurement). *Every 2 weeks for 16 weeks, anticipated start the 1st week of September*
Certification Criteria *(co-led by the HPC)*	Key capabilities for provider systems to take financial and clinical accountability for population health, proposed approach for coordinating MassHealth certification with Division of Insurance and Health Policy Commission *Every 2 weeks for 16 weeks, anticipated start the 1st week of September*
Health Homes	Discussing the Health Home and Patient-Centered Medical Home models of care, with particular focus on primary care and behavioral health. This group will make recommendations about care management and coordination staffing models, enabling practitioners to practice at the top of their license, and the infrastructure needs and investment strategies for community health centers and mental health centers. *Every 2 weeks for 16 weeks, anticipated start the 1st week of September*
Quality Improvement	Performance measurement approach for quality of care, multi-payer coordination around metrics, improved standardization of reporting *Every 2 weeks for 16 weeks, anticipated start the 1st week of September*
LTSS Payment and Care Delivery Models	Discussing integrated and patient-centered care for members with disabilities or significant LTSS use and payment models that support such integrated and patient centered care models. *Every 2 weeks until TBD, anticipated start the 1st week of September*
BH Payment and Care Delivery Models	Discussing integrated and patient-centered care for members with severe and persistent mental illness or substance abuse needs and payment models that support such integrated and patient centered care models. *Every 2 weeks for 16 weeks, anticipated start the 1st week of September*

Work groups will have roughly 20-35 members and will meet weekly to monthly, depending on topic and scheduling.

EOHHS anticipates most Work Group meetings being approximately two hours long, and held in the MassHealth offices at 1 Ashburton Place, Boston, MA 02108, or a nearby location.