MassHealth Payment and Care Delivery Reform: Public Meeting

Executive Office of Health & Human Services

January 13, 2016

WORKING DRAFT – FOR POLICY DEVELOPMENT PURPOSES ONLY

Agenda

- **Recap of overall direction for care delivery & payment reform and timelines**
- Review specific approach for transition to accountable care system
- Next steps
- Additional program updates

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 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**

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

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	Aug 2015 – Jan/Feb 2016 •Conceptual discussion •Identify options and set direction •Targeted testing of major policy options for feedback
2 Foster dialogue across different parts of the delivery system	Detailed technical design starting in Jan/Feb 2016
3 Inform MassHealth's discussion with CMS re: 1115 waiver	▪ Will be released for public comment in Q1 of CY2016

Where we are:

- ***Productive discussions on several topics***
- ***Further discussion upcoming on several topics***

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Accountable Care: Topics for discussion today

A. CMS Waiver and Federal Investment:
- Goals for cost and quality
- Goals / framework for distribution and use of funds

B. ACO care and payment model, member experience

C. Care coordination, community partnership, health homes

D. Social determinants of health

A Context on DSRIP Investment Model and CMS Expectations

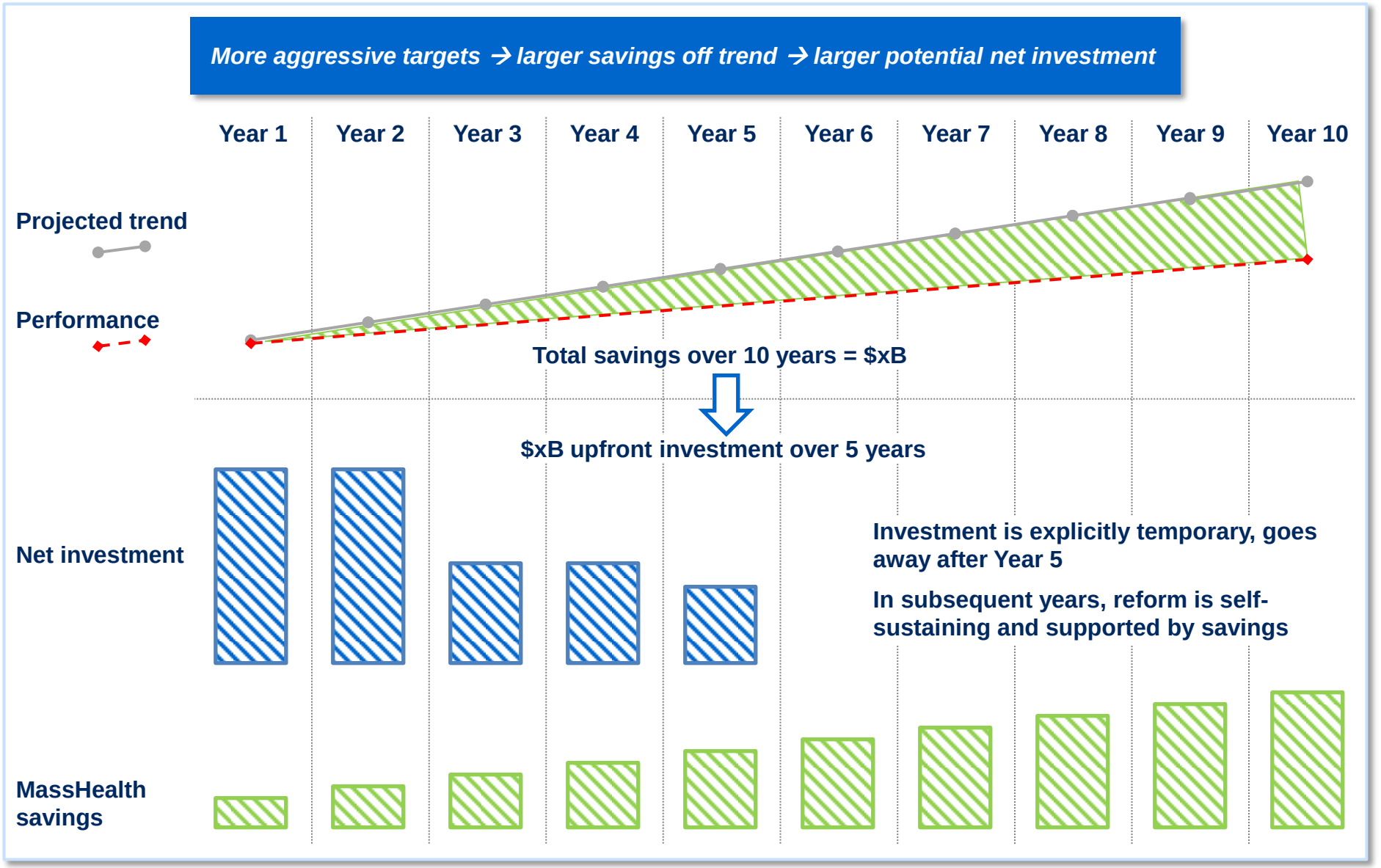
What is Delivery System Reform Incentive Program (DSRIP)?

- 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



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 transitionary period
- Investment in integration for BH, LTSS, social and human service providers into new payment models *[further discussion in section C]*

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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 Draft Measure Slate for CMS accountability

Obtaining further input on these measures from workgroups and stakeholders

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
- Well child visits in first 15 months of life (W15)
- Well child visits 3-6 yrs (W34)
- Developmental screening in the first 36 months of life
- Oral Evaluation, Dental Services
- Adolescent well-care visit (AWC)
- Prenatal & postpartum Care (PPC)
- Tobacco use assess and cessation intervention
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- Adult BMI Assessment (ABA)
- Chlamydia Screening in Women (CHL)

Efficiency of care
- Use of imaging studies for Low Back Pain (LBP)
- Hospital All-Cause Readmissions
- Potentially preventable ED visits (NYU ED)
- PC-01 Elective Delivery

End of Life Care
- Proportion admitted to Hospice for less than 3 days
- Hospice and Palliative Care – Pain Assessment

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)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
- Depression remission at 12 months
- Follow-up care for children prescribed ADHD medication

Long Term Services and Supports
- Patients 18 and older with documentation of a functional outcome assessment and a care plan
- Service/care plans address participants' assessed needs (including health and safety risk factors) either by the provision of waiver services or through other means
- *People who make choices about the people who support them (PES)*
- *People who feel their staff have adequate training (PES)*

For measures that do not have an existing baseline, accountability will start in outer years

* Outcome measures

A Patient experience measures for CMS accountability

Who

- Patient experience data will be collected based on a joint procurement by MassHealth, HPC, and CHIA
- This is expected to:
  - **Include** members MassHealth and Commercial plans
  - **Include** members with LTSS needs
  - **Include** pediatric age groups

What

- Patient experience measures used in commercial/Medicare APM models, e.g.,
  - Getting timely appointments (access)
  - Provider communication with patients (care coordination, patient centeredness)
- Customization / additional questions to reflect unique needs of the MassHealth population and priorities for MassHealth ACO models, e.g.,
  - health literacy
  - health & functional status, resource stewardship

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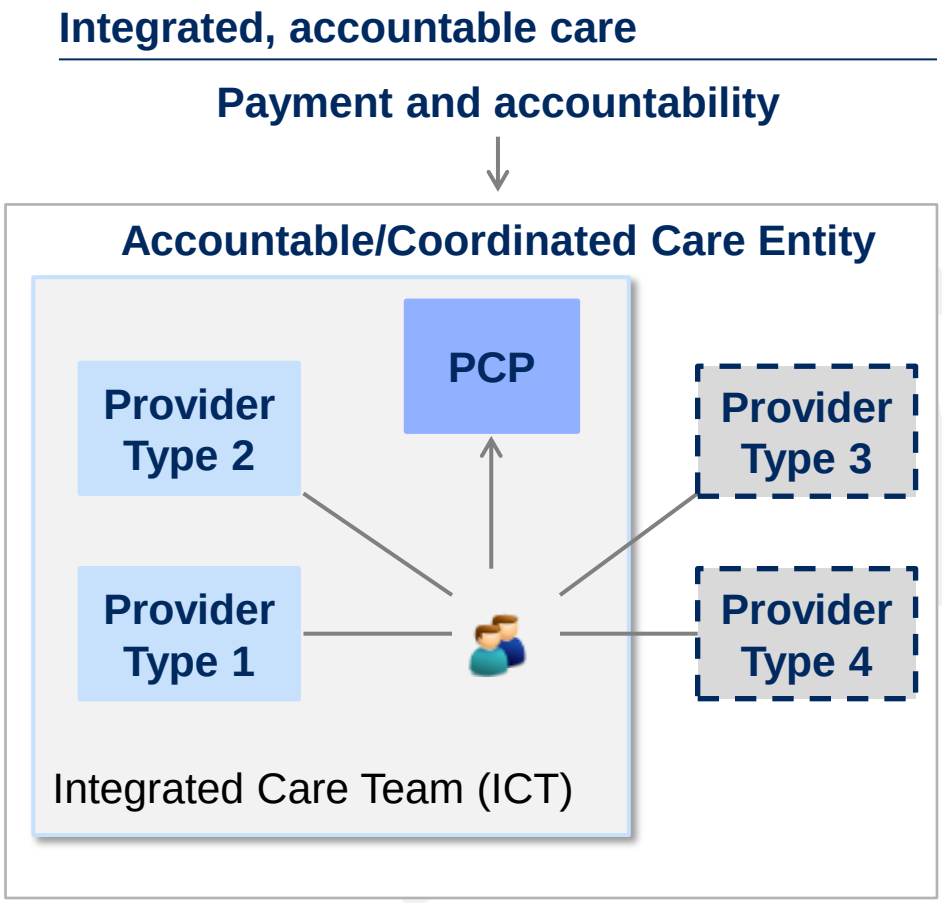
B ACOs can achieve member-driven, integrated care



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 Network of providers who serve as a coordinated care team (CCT) for members

Expectations and Capabilities

Coordinated care team (CCT)

- *Well defined* set of providers – can vary, but in all cases must represent PCPs, BH, and expertise in social determinants and LTSS
- Should be able to *direct* the majority of care
- Can represent multiple organizations, but must have *clear delineation of roles*
- PCPs (and in some cases BH providers) are the *quarterback of care*
- Greatest impact and member benefit if care (handoffs) remain within the CCT where possible – promotes coordination, accountability and efficiency

Policy Implications under Consideration

- ACOs should have some reasonable ability (varying levers) for keeping care within the CCT
- Members likewise should be able to opt-in and opt-out of ACOs (and their CCTs)
- ACOs must clearly communicate CCT providers upfront

B Coordinated Care team: Example Design Levers for discussion (based on Medicare Next Gen ACO model)

Population-Based Payments

- Allow ACOs designate a **Preferred Provider Network (PPN)**, a subset of the broader provider network a member has access to (analogous to the CCT concept)
- ACO gets **paid a prospective PMPM** and, in return, is paid a **reduced FFS rate** for care provided **by PPN providers to attributed members**
- This gives ACOs **up-front access to funds** and some **flexibility to manage their provider network**

Prospective Global Capitation

- Providers in the PPN **do not get paid FFS** for caring for members of their ACO
- Instead, the ACO receives prospective PMPM capitation to cover these costs
- This gives ACOs even greater up-front access to funds and flexibility to negotiate terms within their care team
- Requires ACOs to have the infrastructure to **manage these contracts, pay claims, and submit encounter data to MassHealth**

B Increased member engagement in care

Principles

- For an ACO to be successful, members must experience care differently and be more actively engaged in their care
- Joining an ACO should be a two-way commitment
  - Member understands and agrees to care by the CCT
  - The ACO commits to a more coordinated experience of care through the CCT and clear communications/handoffs across providers and with members

Policy Implications under Consideration

- Member opt-in or selection of an ACO should occur through a variety of mechanisms, e.g.,:
  - Selection of integrated ACO/MCO product, or
  - Selection of PCP that is part of an ACO, with a clear recognition of ACO responsibilities
- Member incentives (financial and network-related) to keep care within a CCT, as appropriate

B Member engagement: Example Design Levers for discussion

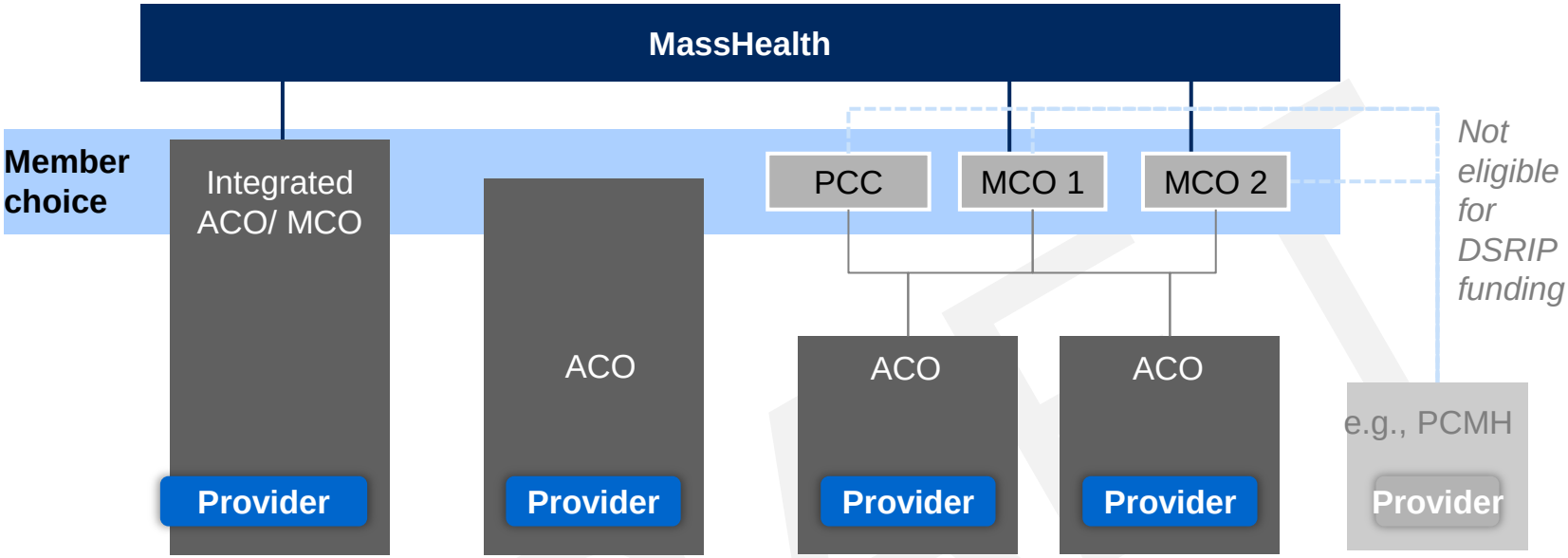
Voluntary Alignment, Enhanced Benefits, and Coordinated Care Payments

- Features of Medicare Next Gen ACO model
- Members in the ACO may **"voluntarily align"** with the ACO, engaging more actively with their care team.
  - ACOs have the ability to offer **enhanced benefits** (e.g., telehealth services) that are paid for by Medicare to these members
- Medicare to authorize direct **"Coordinated Care Payments"** (~$50/year) to **reward members** who receive most of their care from the PPN care team

Primary Care Referral Authorizations

- Feature of many managed care constructs, **including the PCC Plan** (for some services), which empowers the primary care providers to authorize certain services
- We could expand primary care authorization to include more services, when a provider is **outside of the PPN**
- This could **increase coordinated care within the PPN** while allowing for a "release valve" controlled by the member's primary care provider

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



Model A: Prospective ACO/MCO model

- Fully integrated TCOC model
- ACO/MCO entity takes on full, two-sided risk

Model B: Direct to ACO model

- Provider-led, TCOC model
- Performance (not insurance) risk
- Preferred networks (PCP/ACO referrals)
- Flexibility over provider contracts

Model C: Retrospective ACO model

- Provider-led, TCOC model
- Performance (not insurance) risk
- MCOs play larger role to support population health management

Model D: Additional value-based reforms

- For remaining providers
- To be further defined, e.g. an MCO-led PCMH model

Increasing levels of sophistication

1 Members will also select a primary care provider once they have selected an option

C Care coordination, community partnership and health homes – approaches under consideration

- Incorporate an approach to care management for members with complex needs, e.g. through an **integrated "health homes" / "community partner"** 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
- 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

C Background: Health Home Services in the Affordable Care Act (ACA)

- ACA §2703 requires health home programs to include the following six service types:

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care
5. Individual and family support
6. Referrals to social and community support

- States have flexibility to define these services
- Services **do not** include treatment
- Services should include use of **health information technology**, as feasible and appropriate

C Example funding model

MassHealth DSRIP Program (DSRIP funds + potentially § 2703 Health Homes funds)

- ACO required to partner with appropriate expertise for **management of high-risk member populations**
- This is a pre-requisite to receive DSRIP funds

- **MOUs** must delineate division of r**esponsibilities** and **performance** expectations
- ACO and partner **share information**

- MassHealth procurement of a state-defined model and expectations
- Regional **procurement** (#TBD) of select number of **certified CPs** (#TBD)
- CPs must have signed **MOUs** with ACOs to receive DSRIP funds
- **Dedicated** DSRIP **start-up funding**
- LTSS and BH providers and other CBOs with **appropriate capabilities** (see next slide)

Goal is to address **infrastructure gap** faced by community entities through a feasible strategy of **scalable investments**, tied to **partnership and performance**

C Example entities with specialized expertise *(illustrative, not comprehensive)*

BH expertise

- CMHCs
- RLCs
- Other BH providers
- Other CBOs who have core capabilities

LTSS expertise

- ASAPs
- ILCs, RLCs, ADRCs
- Other LTSS providers
- Other CBOs who have core capabilities

SDH expertise

- Housing support
- Shelters
- WIC centers
- YMCAs, other social service organizations

D Social determinants of health

For social determinants of health, we strive to:

- Incorporate socioeconomic variables **into risk adjustment**
- Prioritize including **measures in CMS/ACO accountability slate** where there are known disparities by race/ethnicity in performance
- **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
- Promote **cross-linkages** between agencies caring for socially vulnerable.

Agenda

- Recap of overall direction for care delivery & payment reform and timelines
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Topics for further stakeholder input / discussion

- 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

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Thank you!

Do you have any questions?

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Appendix

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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

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

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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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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

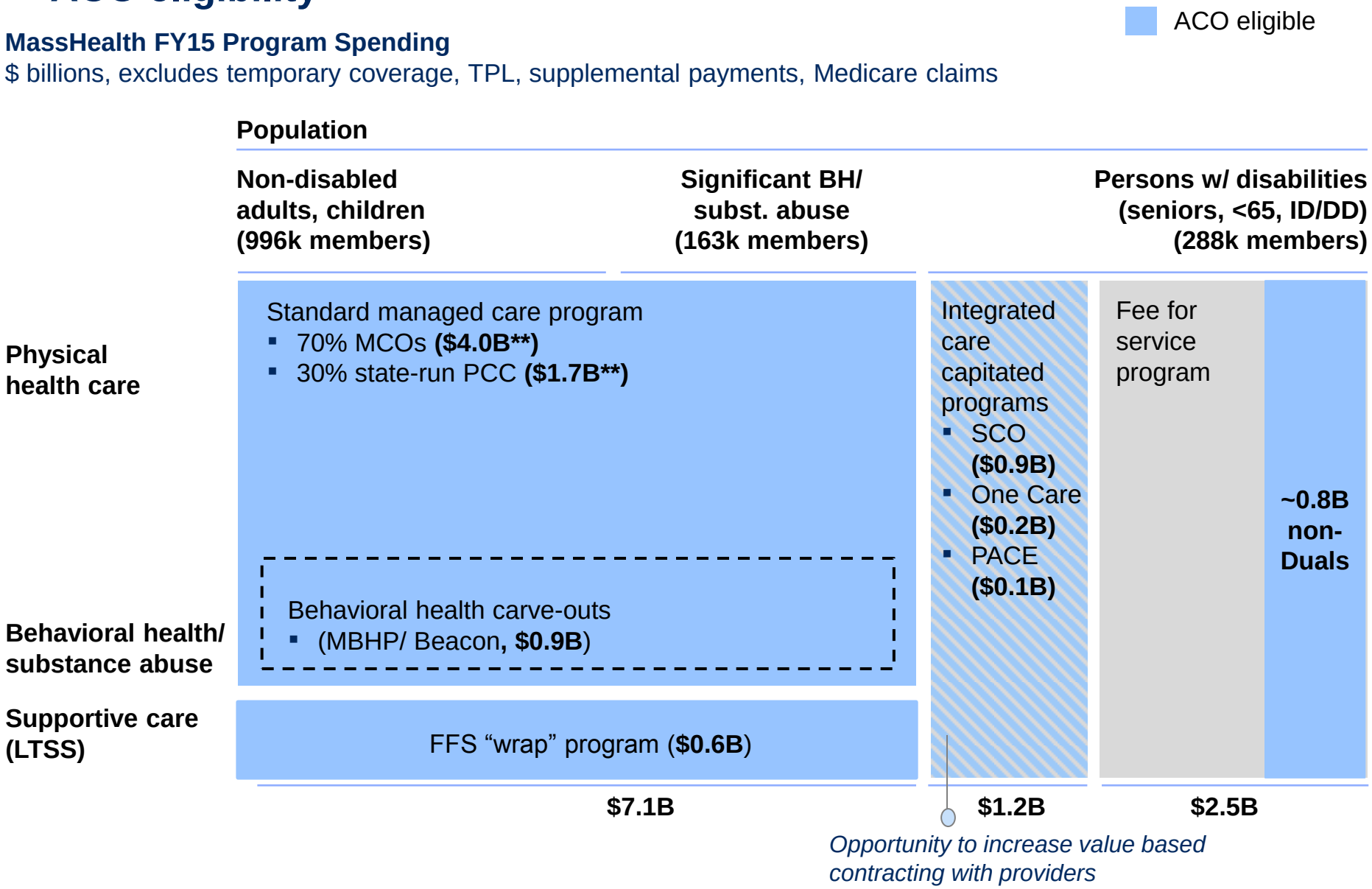
	Population			
	Non-disabled adults, children (996k members)	**Significant BH/ subst. abuse (163k members)**		**Persons w/ disabilities (seniors, <65, ID/DD) (288k members)**
Physical health care	Standard managed care program ▪ 70% MCOs **($4.0B*)** ▪ 30% state-run PCC **($1.7B*)**		Integrated care capitated programs ▪ SCO **($0.9B)** ▪ One Care **($0.2B)** ▪ PACE **($0.1B)**	Fee for service program (no managed care)
Behavioral health/ substance abuse	Behavioral health carve-outs ▪ (MBHP / Beacon**, $0.9B**)			
Supportive care (LTSS)	FFS "wrap" program (**$0.6B**)			
	$7.1B		**$1.2B**	**$2.5B**

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*

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



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** Excludes behavioral health spending