Delivery System Reform Implementation Advisory Council

Meeting #2

June 22, 2017

Meeting Agenda

Agenda Item	Description	Time
1 DSRIC Updates	• Council Chair & Vice Chair Announcement • Council Chair Opening Statement • DSRIC Work Plan and Processes	10 mins
2 MassHealth Updates		10 mins

3 ACO/CP Contractual Requirements	• Recap of CP Models
	• Framework for ACO/CP Relationships
	  • Level 1 Requirements
	  • Level 2 Requirements
	  • Level 3 Partnerships
		90 mins

4 Next Steps	• Next Meeting Logistics • Meeting Locations	5 mins
5 Closing	• Vice-Chair Closing Statement	5 mins

1 DSRIC Updates

DSRIC Chair and Vice Chair Announcement

After reviewing the nominations, we are pleased to formally announce the DSRIC Chair and Vice-Chair:

Barry Bock – DSRIC Chair

Dennis Heaphy – DSRIC Vice-Chair

EOHHS is very grateful for their time, leadership, and willingness to fill these important roles. Congratulations!

DSRIC Annual Work Plan

- Prior to the start of each calendar year, EOHHS will review the MassHealth workplan for that calendar year and bring milestones/dates for the upcoming year to the Council Chair and Vice-Chair.

- Based on these milestones, EOHHS and the Chair/Vice-Chair will align on a concrete purpose for DSRIC for that year and compile a list of potential topics that DSRIC might advise on. This will serve as the Council's **annual work plan**.

- EOHHS will present the DSRIC annual work plan to the Council prior to the start of each year. The work plan will be flexible and topics may change to better accommodate the policy priorities of EOHHS and the Council. EOHHS hopes that this process will ensure that DSRIC can weigh in on substantial delivery system reform issues in a timely manner.

Potential DSRIC Topics for CY17
1 ACO/MCO and CP relationships
2 Statewide Investments design and implementation
3 Other topics TBD

DSRIC Processes: Submitting Feedback

To submit feedback on general Council processes:

- Council members may email DSRICinfo@massmail.state.ma.us with comments on DSRIC procedures, logistics, etc.
- Chair, Vice-Chair, and EOHHS will review comments on a rolling basis and discuss them at agenda-setting meetings.

To respond to an EOHHS request for input on a document or policy question:

- EOHHS anticipates sending out reading materials to Council members two weeks prior to the next meeting.
- Council members are expected to read over the materials and provide their feedback during the DSRIC meeting.

To submit suggestions for agenda topics:

- *See next slide.*

DSRIC Processes: Agenda Setting

Agenda Setting Steps	Anticipated Timing
1 EOHHS will send an email requesting suggestions for agenda topics to discuss at the next meeting.	*6 weeks prior to meeting*
2 Following the request, Council members have 1 week to submit agenda topic suggestions to DSRICinfo@massmail.state.ma.us.	*5 weeks prior to meeting*
3 EOHHS and Council Chair/Vice-Chair meet to discuss MassHealth's policy priorities as well as feedback and topic suggestions from Council members, and align on agenda.	*4 weeks prior to meeting*
4 EOHHS will send Council members any reading materials (when relevant) via email.	*2 weeks prior to meeting*
5 EOHHS will send Council members the agenda and presentation via email.	*1 week prior to meeting*

2 MassHealth Updates

1115 Waiver Updates

- **DSRIP Protocol:** Approved (5/15/17)
- **ACO:** Announcement of ACOs selected to enter into contract negotiations with MassHealth (6/8/17)
- **CP:** Receipt of bids for BH and LTSS Community Partner procurements (6/2/17)
- **MCO:** MCO bids currently under review by procurement committee
- **Statewide Investments:** Held two public meetings (Boston and Worcester) around three SWIs related to workforce development
- **EOHHS Quality Taskforce & DSRIP Quality Subcommittee**: First meetings held (May 30 and June 6, respectively)

3 ACO/CP Contractual Requirements

Agenda

- **Recap BH and LTSS CP models**
- Introduce framework for evolution of ACO-CP relationships
  - Level 1: ACO/MCO-MH contract requirements, CP-MH contract requirements
  - Level 2: ACO/MCO-CP Agreements (previously called “MOU”) -- needs to be operational as of Day 1 of the CP program
  - Level 3: Advanced business partnerships between ACOs and CPs
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Principles and goals of the Community Partner program

Principles

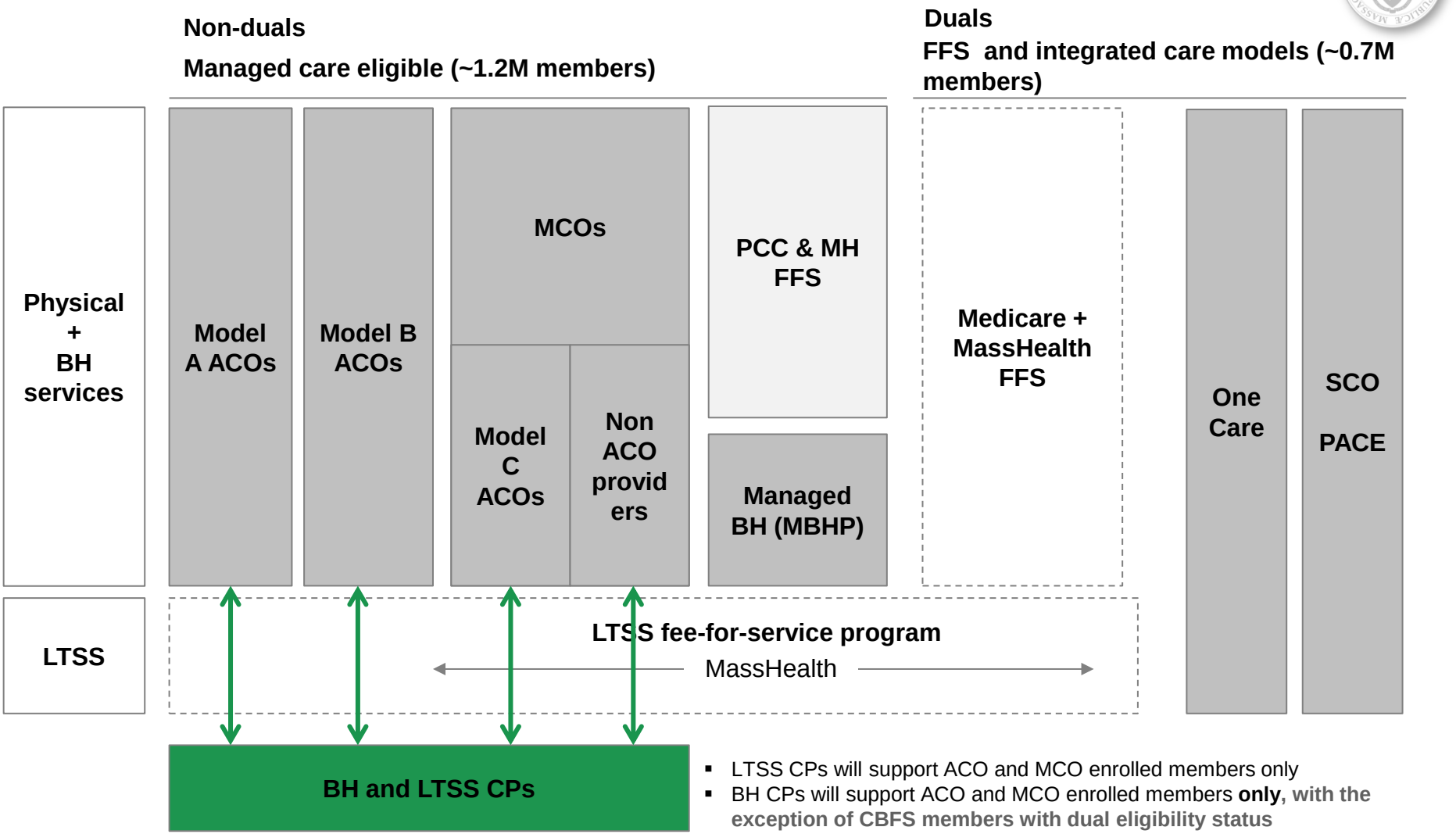
- Encourage ACOs to **"buy" BH/LTSS care management expertise** from existing community-based organizations vs. build
- Invest in infrastructure and capacity to **overcome fragmentation** amongst community-based organizations

Goals

- Support members with high BH needs, complex LTSS needs and their families to help them **navigate the complex system of BH and LTSS care** in Massachusetts
- **Improve member experience, continuity and quality of care** by holistically engaging members with high BH needs (SMI, SED and SUD[1]) and LTSS needs
- Create opportunity for ACOs and MCOs[2] to **leverage the expertise and capabilities of existing community-based organizations** serving populations with BH and LTSS needs
- **Invest in the continued development of BH and LTSS infrastructure** (e.g. technology, information systems) that is sustainable over time
- **Improve collaboration** across ACOs / MCOs, CPs, community organizations addressing the social determinants of health, and BH, LTSS, and health care delivery systems in order to break down existing silos and **deliver integrated care**
- **Support values** of Community First, SAMHSA recovery principles, independent living, and cultural competence

1 SMI = Serious Mental Illness; SED = Serious Emotional Disturbance; SUD = Substance Use Disorder
2 ACO = Accountable Care Organization; MCO = Managed Care Organization
3 EOHHS = Executive Office of Health and Human Services

BH and LTSS CPs will support ACO and MCO-enrolled members



- LTSS CPs will support ACO and MCO enrolled members only
- BH CPs will support ACO and MCO enrolled members **only**, **with the exception of CBFS members with dual eligibility status**
- PCC plan: Not eligible for CP. No accountable entity with TCOC responsibility
- FFS and TPL populations: MassHealth is NOT the primary payer of services except for LTSS
- One Care/SCO/PACE: specific care models for target populations already exist

BH CP model: who will they serve? How will members be identified?

BH CPs will serve a population with high BH needs and include:

- ACO and MCO-enrolled members age 21 and older with SMI and/or SUD and high service utilization
- For members < 21 years of age with SED, existing CSAs under CBHI[1] will continue to provide ICC services for such members.
  - Members 18-20 with SUD diagnosis and high utilization will be eligible for BH CP supports if requested
- Members with co-occurring BH and LTSS needs will be offered BH CP supports. Only assignment to a single CP is permitted

Member Identification and Assignment for BH CPs

- **There are two pathways by which members will be identified and assigned for CP supports:**
  1. **Analytical process** (i.e., claims and service-based analysis) by MassHealth
     - MassHealth intends, where possible, to maintain existing member-provider relationships by assigning members to the CP that provides other services to that member
     - ACO or MCO will also assign a portion of members to a CP, as defined by MassHealth
  2. **Qualitative process** (i.e., provider referral or member self-identification)
     - All referrals would go directly to the member's MCO or ACO for approval
- **Members retain existing choice** of services and providers for which they are eligible based on their health plan
- **Members will have choice.** Members my decline assignment to a particular CP or to any CP at all

1 CSA = Community Service Agency; CBHI = Children's Behavioral Health Initiative; ICC = Intensive Care Coordination

BH CP model: example definition for the BH CP focus population

PRELIMINARY – SUBJECT TO CHANGE

Example definition of BH CP focus population:
Members with a relevant diagnosis AND some relevant utilization / co-morbidities in the last 12 months

Members must have a diagnosis from the below list, e.g., …

- Any SUD diagnosis excluding caffeine and nicotine
- Schizophrenia
- Bipolar disorder
- Personality / other mood disorders
- Psychosis
- Trauma
- Attempted suicide or self-injury
- Homicidal ideation
- Major depression
- Other depression
- Adjustment reaction
- Anxiety
- Psychosomatic disorders
- Conduct disorder
- PTSD

…AND meet at least one of the following criteria, e.g.,

- ESP interaction
- Detoxification
- Methadone treatment
- IP visits (e.g., 3+)
- ED visits (e.g., 5+)
- Select medical comorbidities (e.g., 3+)
- High LTSS utilization
- Current DMH enrollment

- It is estimated that **~60K members meet the eligibility criteria for the BH CP program** based on 2015 data. These members had an average ~$30,000 per member per year (PMPY) spend in 2015 (about half of which is BH-related spend).
- MassHealth will fund BH CP supports **for up to 35,000 members** at any given time

BH CP model: what will they do for members?

BH CP Functions – Comprehensive Care Management

1. **Outreach** and **active engagement** of assigned members;
2. Identify, engage, and **facilitate member's care team**, including PCP, BH provider, and other providers and individuals identified by the member, on an ongoing basis and as necessary;
3. Conduct **comprehensive assessment** and **person-centered treatment planning** across BH, LTSS, physical health, and social factors that leverages existing member relationships and community BH expertise;
4. **Coordinate services across continuum of care** across to ensure that the member is in the right place for the right services at the right time;
5. Support **transitions of care** between settings;
6. Provide **health and wellness coaching**; and
7. Facilitate access and referrals to social services, including identifying social service needs, providing navigation assistance, and follow-up on social service referrals, including flex services

LTSS CP model: who will they serve? How will members be identified?

LTSS CPs will serve a population with complex LTSS needs and include:

- ACO and MCO-enrolled members age 3 and older
- Members with complex LTSS and behavioral health needs; members with brain injury or cognitive impairments; members with physical disabilities; members with intellectual or developmental disabilities, including Autism; older adults eligible for managed care (up to age 64); and children and youth with LTSS needs.

Member Identification and Assignment for LTSS CPs

- **There are two pathways by which members will be identified and assigned for CP supports:**
  1. **Analytical process** (i.e., claims and service-based analysis) by MassHealth
     - MassHealth intends to identify members with high LTSS utilization using a claims-based analysis. ACO and MCOs will be notified of identified members who may benefit from LTSS CP supports.
     - ACO or MCO will assign members to a CP, as defined by MassHealth
  2. **Qualitative process** (i.e., provider referral or member self-identification)
     - All referrals would go directly to the member's MCO or ACO, as appropriate
- **Members retain existing choice** of services and providers for which they are eligible based on their health plan
- **Members will have choice.** Members may decline assignment to a particular CP or to any CP at all

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LTSS CP model: example definition for the LTSS CP focus population

Example LTSS CP Focus population of individuals with complex LTSS needs:
Members with $300 plus spend on LTSS over 3 consecutive months.

Example LTSS spend includes the following services:

- PCA Services
- Home Health
- Independent Nurse
- Adult Foster Care
- Group Adult Foster Care
- Adult Day Health
- Day Habilitation

- ACOs and MCOs will also identify members with complex LTSS needs through other mechanisms including:
  - Care Needs Screening
  - Enrollee self-referrals
  - Referrals from CPs, providers, or other individuals familiar with the enrollee

- MassHealth funding may support approximately **20,000-25,000 members** at a time.

LTSS CP model: what will they do for members?

LTSS CPs Supports – LTSS Subject Matter Expert for ACO/MCO

1. Outreach and orientation;
2. LTSS Care Planning, including Choice Counseling;
3. Care Team Participation;
4. LTSS Care Coordination;
5. Support During Transitions of Care;
6. Health and Wellness Coaching; and
7. Connection to Social Services and Community Resources

LTSS CP Enhanced Supports – Comprehensive Care Management

1. ACOs or MCOs and LTSS CPs may collaboratively elect to identify members with complex LTSS needs who would benefit from comprehensive care management provided by the LTSS CP
2. Comprehensive care management, or LTSS CP Enhanced Supports, will be provided by LTSS CPs that are selected to provide this additional support through a competitive procurement
3. EOHHS released a Notice of Intent to Procure LTSS CP Enhanced Supports on May 15, 2017

Agenda

- Recap BH and LTSS CP models
- **Introduce framework for evolution of ACO-CP relationships**
  - **Level 1: ACO/MCO-MH contract requirements, CP-MH contract requirements**
  - **Level 2: ACO/MCO-CP Agreements (previously called "MOU") -- needs to be operational as of Day 1 of the CP program**
  - **Level 3: Advanced business partnerships between ACOs and CPs**
- Recap Level 1 requirements, including ACO and CP decision rights
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Evolution of the ACO and MCO – CP relationship over time

Level 1:
ACO/MCO-MH contract requirements
CP-MH contract requirements

ACO or MCO contract main domains:
- Care coordination and management
- Comprehensive assessment and care planning
- CP partnership requirement

CP Contract main domains:
- Outreach
- Comprehensive assessment (BH CP)
- Care planning and care coordination

Examples:
- ACOs must complete Care Needs Screening to identify enrollee needs
- ACOs must complete Comprehensive assessment for LTSS CP eligible enrollees

Level 2:
ACO/MCO-CP Agreements (minimum requirements for business partnerships)

Domains:
- Program management as a joint effort
- Enrollee identification, referral, assignment, and disengagement
- Care coordination and management
- Transitions of care
- Authorization of services
- Data sharing and IT systems
- Conflict resolution
- Flexible services
- Incidence reporting

Examples:
- Designation of key contact for communication at ACO, MCO and CP
- Quarterly discussions focused on cost, utilization, enrollee engagement, and quality/performance
- Joint protocols and procedures for data exchange, event notifications
- Collaborative case conferences/clinical rounds between ACO/PCP and CP team

Level 3:
Blueprint for advanced business partnerships

Examples of potential domains:
- Shared savings
- Bundled payments
- Joint ACO/MCO-CP interventions to improve care delivery and quality of care for defined population
- IT/EHR integration

Timeline	ACO and MCO contracts effective Aug 2017 CP contracts effective Nov 2017	Template to be released July 2017 ACO, MCO - CP MOUs to be executed Feb 2018	Policy development to be complete Dec 2018 EOHHS guidance to ACOs, MCOs and CPs by Q1 2019

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Contractual requirements embedded in MH-ACO/MCO and MH-CP contracts

- **ACOs and MCOs will be expected to contract with all BH CPs** in the service areas in which the ACO or MCO operates and vice-versa.
- **ACOs and MCOs will be expected to contract with at least two LTSS CPs** in the service areas in which the ACO or MCO operates.
- MassHealth provides set of **minimum requirements** to be included in ACO/MCO contracts with CPs. ACOs/MCOs and CPs may choose to go beyond the minimum requirements.

ACO and CP Decision Rights

1 ACO Decision Rights

1. **What services an enrollee receives**
   - Authorizing covered services (Model A)
   - Provider networks (Model A)
   - Approving care plans

2. **Where enrollees receive CP supports**
   - Choice of LTSS CPs (assuming >2 in service area)
   - Assignment of enrollees identified by MassHealth to CPs
     - All LTSS CP enrollees, and
     - BH CP enrollees with no identified pre-existing relationships (~80%)
   - Retaining care management for BH CP enrollees with complex medical conditions

3. **Which *referred* enrollees receive CP supports**
   - Determination of appropriateness for CP supports for all referred enrollees

4. **Other levers**
   - Approval of flexible services
   - At least quarterly meetings with CPs to discuss enrollee engagement, cost, utilization, quality and performance measures, communication, grievances and appeals

2 ACO-CP Join Decision Management

1. **Service level agreements and/or policies and procedures in the areas of:**
   - Assignment
   - Disengagement
   - Outreach
   - Care coordination and management
   - Transitions of care
   - Comprehensive assessment and care planning
   - Authorization of services
   - Data sharing and information technology systems
   - Conflict resolution between parties
   - Flexible services
   - Incidence reporting
   - Payment
   - Termination of contract
   - Sustainability

Examples:

1. Assignment: process, form, format and frequency for exchange of assignment data
2. Disengagement: policies and procedures for changes to assignment for voluntary or automatic reasons

3 CP Decision Rights

1. How to spend DSRIP Infrastructure funding
2. Reject assignments and referrals if at capacity (as agreed upon by EOHHS)
3. Strategies for day-to-day engagement and management of members

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Relationships between ACOS/MCOs and CPs

- **ACO/MCO-CP Agreements (Level 2) are anticipated to include**:
    1. Program Management
    2. Member Identification, Referral and Assignment
    3. Outreach and Care Delivery Coordination
    4. IT systems and Information Sharing
    5. Conflict Resolution
    6. Performance Measures and Sustainability
    7. Termination of Contract

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- **Discuss Level 3 partnerships**

Level 3: Blueprint for advanced business partnerships

Discussion questions

- How are ACOs and CPs thinking about their relationship for Year 1? For outer years of the demonstration?
  - Clinical integration
  - Performance management & financial arrangements (e.g., shared savings, bundled payments)
  - Governance
  - IT/EHR integration
  - Other domains?

- What are the best mechanisms for the state to facilitate learning and collaboration across ACOs and CPs to create a “blueprint” for ACO/CP partnerships?

Anticipated stakeholder engagement on ACO/CP partnerships
Draft – Subject to change

Level 1:
ACO-MH contract requirements
CP-MH contract requirements

- Already in draft ACO/MCO contracts; very limited / no room for any changes at this point
- Recap for the ACOs/MCOs in late June meeting

Level 2:
ACO/MCO-CP Agreements (minimum requirements for business partnerships)

- MassHealth releases ACO-CP Contractual requirements in
- Discuss expectations with ACO/MCOs late July
- Discuss expectations with CPs once selected (late August/early September)
- Bring ACO/MCO and CPs together in early September

Level 3:
Blueprint for advanced business partnerships

- Starting in summer 2018, bring together ACOs, MCOs, and CPs for focused discussion on tactical challenges + best practices

4 Next Steps

Next Meeting

- **Date:** Thursday, August 17

- **Location:** Boston, exact location TBD

For future meetings:

- Does the Council agree to try to alternate 50/50 between Boston and other MA locations?

- Any suggestions or offers for future meeting spaces?

5 Closing