MassHealth Payment and Care Delivery Reform: MHSA Symposium

Executive Office of Health & Human Services

January 8, 2016

WORKING DRAFT – FOR POLICY DEVELOPMENT PURPOSES ONLY

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

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

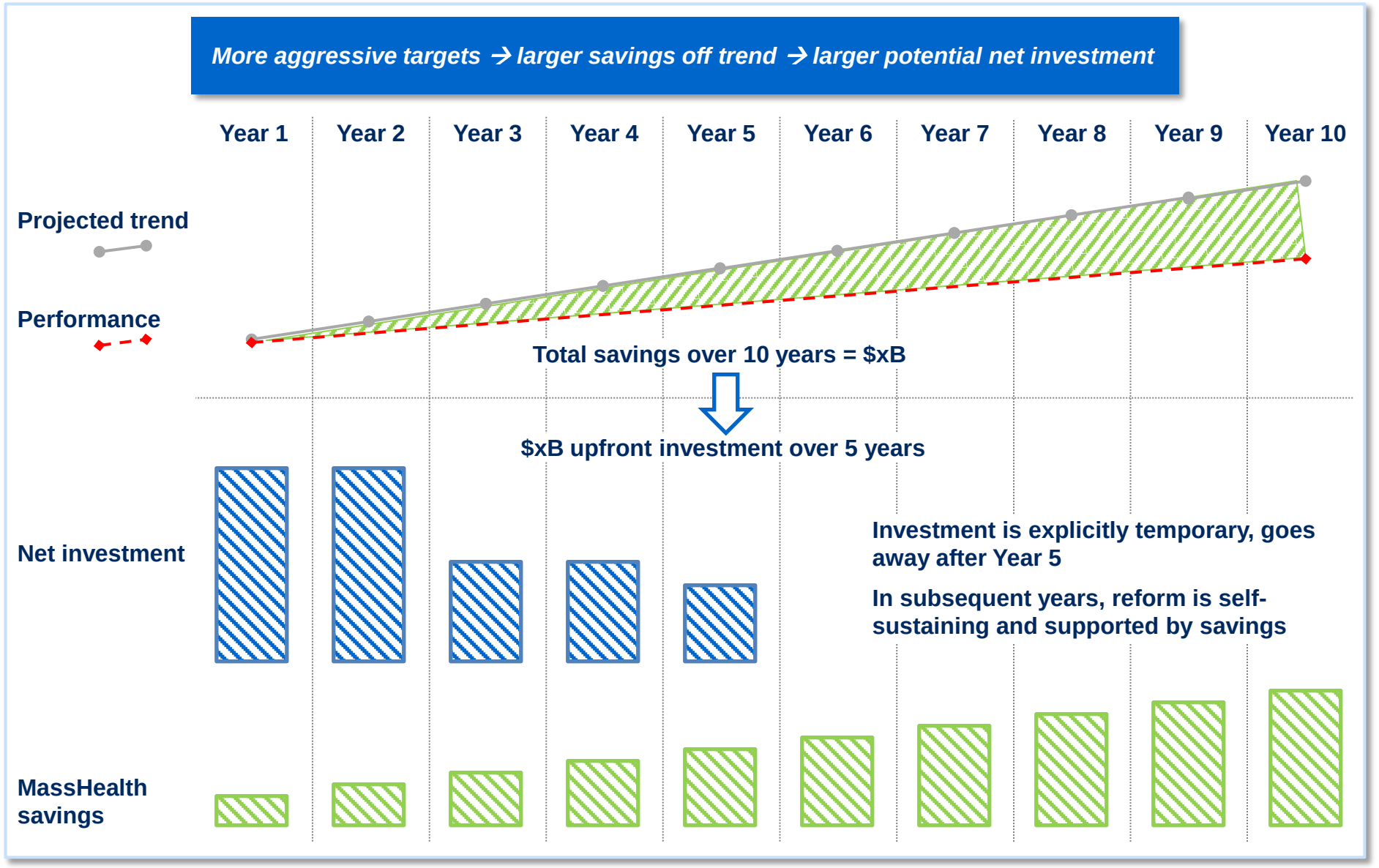
What is Delivery System Reform Incentive Program (DSRIP)?

- 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

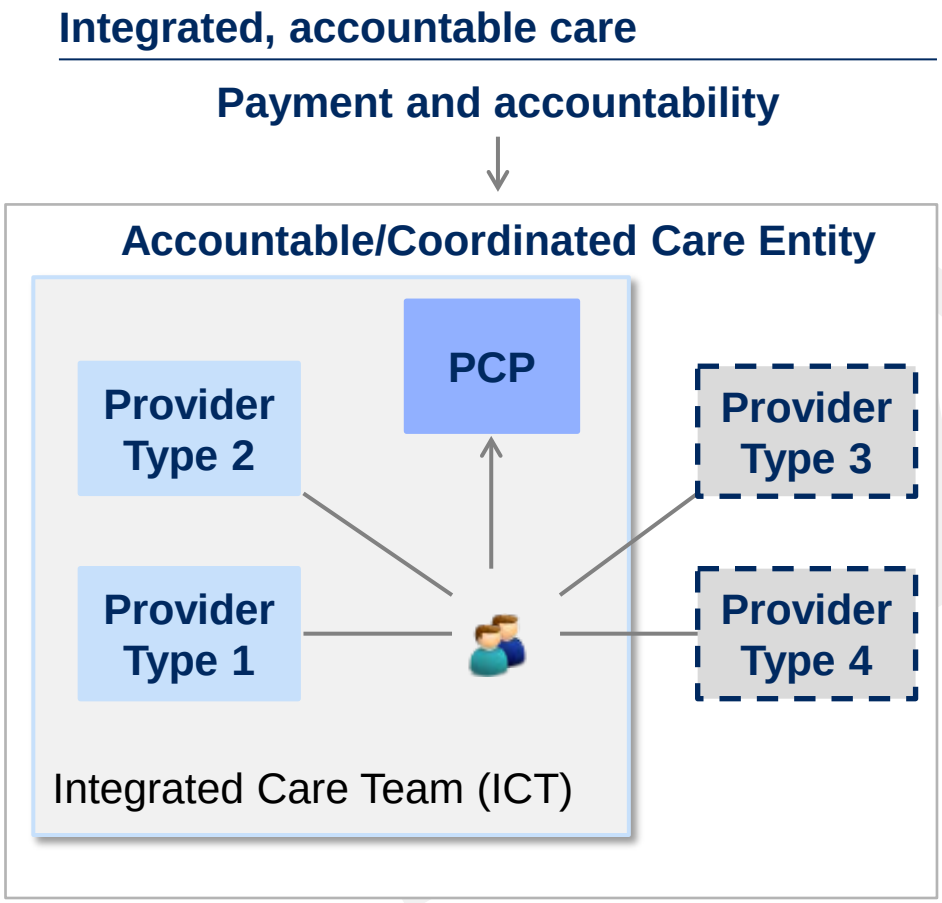
A CMS Investment and Targets: Concept Overview



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]*

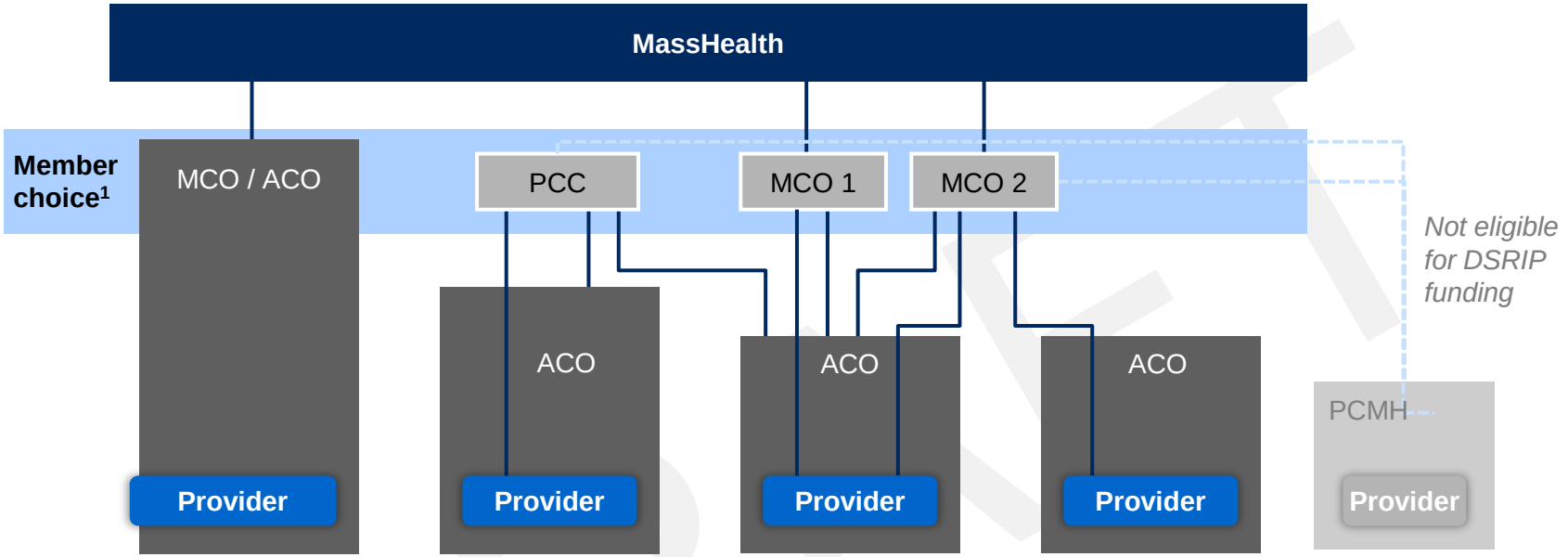
B ACOs can achieve member-driven, integrated care



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 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
- Pricing model focused on performance vs. insurance risk

Model C: Retrospective ACO model

Model D: Patient Centered Medical Home

- For remaining providers
- To be further defined, likely a PCMH model

Specific design elements (e.g., payment model details, member incentives, ACO levers for population health management under each model) are actively being discussed in workgroups and will be decided on in the coming months

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"** 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**
- **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

Upcoming discussion topics at workgroups

- 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

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***

Thank you!

Do you have any questions?

Appendix

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

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

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

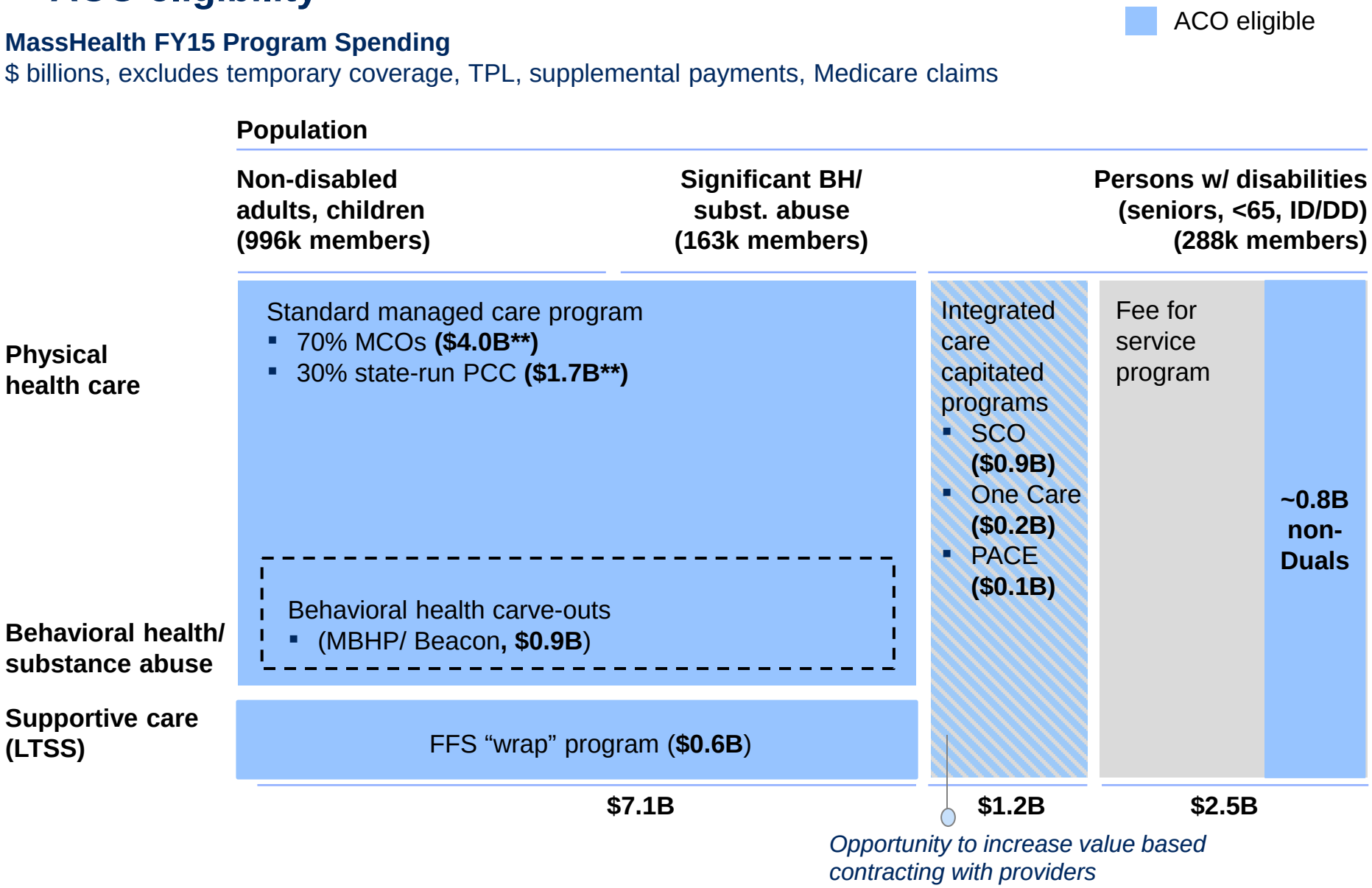
	Population		
	Non-disabled adults, children (996k members)	**Significant BH/ subst. abuse (163k members)**	**Persons w/ disabilities (seniors, <65, ID/DD) (288k members)**
Physical health care	Standard managed care program ▪ 70% MCOs **($4.0B*)** ▪ 30% state-run PCC **($1.7B*)**	Integrated care capitated 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



*Note that member and spending figures may include estimates
Chart is a simplification to illustrate scope and does not show all circumstances (e.g. HCBS populations)

** Excludes behavioral health spending

A Key aspects of measurement

- Measure Types
  - **Structure** – characteristics of the delivery system
  - **Process** what is done to, for, or by the patient
  - **Outcome** – patient health state (classic meaning of outcome) or delivery system result (e.g. hospitalization)
  - **Patient Experience** – obtained through surveys or interviews
  - **Balancing** – intended to track unintended consequences

- Essential Components of Measure "Specifications"
  - Numerator (top number)
  - Denominator (bottom number)
  - Case finding period (time window for denominator)
  - Anchor date
  - Criteria (e.g. clinical situations, age group)

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 Straw Slate for CMS Reporting – FOR DISCUSSION

Will obtain further input on these measures from BH and LTSS workgroups

Patient Experience/Access
- CAHPS Clinician & Group Survey (CG) or CMS CAHPS ACO Survey with *Health Status/ Functional Status measure AND select patient reported outcome measures
- HCAHPS: A 32 item survey instrument that produces 11 measures including the CTM-3

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
- Childhood immunization status (CIS)
- Developmental screening in the first 36 months of life
- Dental Services—Fluoride or sealants (NQF)
- Immunization for Adolescents (IMA)
- Tobacco use assess and cessation intervention
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Adult BMI Assessment (ABA)
- Prenatal & Postpartum Care (PPC)

Efficiency of care
- Use of imaging studies for Low Back Pain (LBP)
- *Hospital All-Cause Readmissions
- *Pediatric All-Condition Readmission Measure
- *Potentially preventable ED visits
- *PC-01 Elective Delivery
- *PC-02: Cesarean Section

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)
- Appropriate prescribing of antipsychotic medications (use in elderly with dementia) (NQF)
- *Depression remission at 12 months
- Follow-up care for children prescribed ADHD medication

End of Life Care
- Proportion admitted to hospice for less than 3 days
- Hospice and Palliative Care -- Pain Screening and treatment
- Hospice and Palliative Care -- Dyspnea Screening and treatment

Long Term Services and Supports
- People make choices about lives, including: housing, roommates, jobs and daily activities
- People who have adequate transportation
- People who need additional services and supports
- People whose support workers come and leave when they are supposed to

*= Outcome Measure