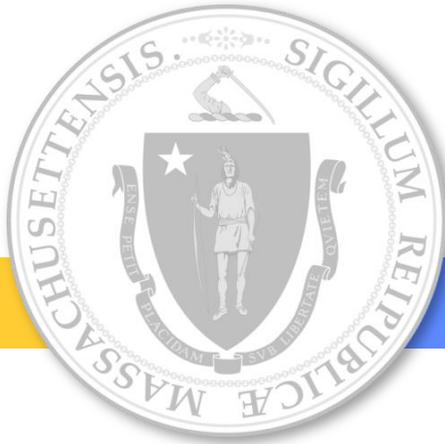


MassHealth Delivery System Restructuring



ACOs and Community Partners

Executive Office of Health & Human Services

September 18, 2017

Agenda



- I. Background
- II. Introduction to ACO Models
- III. Introduction to Community Partners
- IV. Quality Measurement



I. Background



1115 Demonstration Waiver Approvals

- On November 4, 2016, Massachusetts received federal approval of its request for an amendment and extension of the 1115 Demonstration Waiver, providing MassHealth additional flexibility to design and improve programs.
- The Waiver authorizes \$52.4B in spending over five years, including \$1.8B in Delivery System Reform Incentive Payments (DSRIP) to fund MassHealth's restructuring and transition to accountable care.
- In addition to MassHealth's existing Managed Care Organization (MCO) program and the Primary Care Clinician Plan (PCC Plan), the Waiver also recognizes two new types of entities, **Accountable Care Organizations (ACOs) and Community Partners (CPs)**.
- ACOs are:
 - Groups of Primary Care Providers, and other providers with whom they work to better coordinate care
 - Responsible for coordinating care
 - Incentivized to invest in primary care
 - Rewarded for value – managing total cost of care and improving patient outcomes and member experience– not the volume of services provided
- CPs are:
 - Community based organizations, collaborating with ACOs to provide care coordination and care management supports to individuals with significant behavioral health issues and/or complex long term services and supports needs

Implementation of Payment and Care Delivery Reform



- Payment reform elements include:
 - ACO Pilot
 - MCO Reprourement
 - ACO Full Rollout
 - Community Partners
 - DSRIP
- Full payment reform implementation will provide MassHealth managed care eligible members with new enrollment options, including the ACO Program. Specifically, these members will be able to choose among:
 - Accountable Care Partnership Plans in their service area
 - Primary Care ACOs
 - MCOs in their region; MCO enrollees may also choose primary care through an MCO-Administered ACO in their MCO's network
 - PCC Plan

ACO Pilot



- ACO pilot began December 2016 and will run for 1 year (through November 30, 2017) with the following six organizations:
 - Boston Accountable Care Organization
 - Community Care Cooperative
 - UMass Memorial Healthcare, Inc.
 - Partners Healthcare Accountable Care Organization
 - Children’s Hospital Integrated Care Organization
 - Steward Medicaid Care Network
- Contracted Pilot ACOs identified all Primary Care Clinician Plan PCCs in their organization, as well as any providers in their “referral circle,” improving access to coordinated care. Members do not need a PCC referral to see providers in the Pilot ACO’s referral circle.
- Pilot ACOs are eligible to receive shared saving (and are at risk for shared losses) based on the total cost of care for their PCC Plan members. Pilot ACOs are also required to report on quality performance for these members to receive shared savings. Currently, approximately 150,000 PCC Plan members receive care with Pilot ACOs and are considered part of the Pilot ACO program.

Full Accountable Care Organization (ACO) Procurement



Under the 1115 Demonstration Waiver, MassHealth is authorized to move forward with development of three ACO models anticipated to start serving members in **March 2018**:

A. Accountable Care Partnership Plans

- Managed care organizations (MCOs) with a closely partnered ACO, or integrated entities meeting the requirements of both, that provide vertically integrated, coordinated care under a capitated rate

B. Primary Care ACOs

- ACOs that contract directly with MassHealth to take financial accountability for a defined population of enrolled members through retrospective shared savings and risk

C. MCO-Administered ACO

- An ACO that contracts directly with MassHealth MCOs to take financial accountability for the MCO enrollees they serve through retrospective shared savings and risk



MassHealth Entered into Contracts with 17 ACOs

These ACOs are expected to cover over **850,000** MassHealth members total:

- Atrius Health with Tufts Health Public Plans
- Baystate Health Care Alliance with Health New England
- Beth Israel Deaconess Care Organization with Tufts Health Public Plans
- Boston Accountable Care Organization with Boston Medical Center HealthNet Plan
- Cambridge Health Alliance with Tufts Health Public Plans
- Children's Hospital Integrated Care Organization with Tufts Health Public Plans
- Community Care Cooperative
- Health Collaborative of the Berkshires with Fallon Community Health Plan

- Lahey Health
- Mercy Health Accountable Care Organization with Boston Medical Center HealthNet Plan
- Merrimack Valley ACO with Neighborhood Health Plan
- Partners HealthCare ACO
- Reliant Medical Group with Fallon Community Health Plan
- Signature Healthcare Corporation with Boston Medical Center HealthNet Plan
- Southcoast Health Network with Boston Medical Center HealthNet Plan
- Steward Medicaid Care Network
- Wellforce with Fallon Community Health Plan



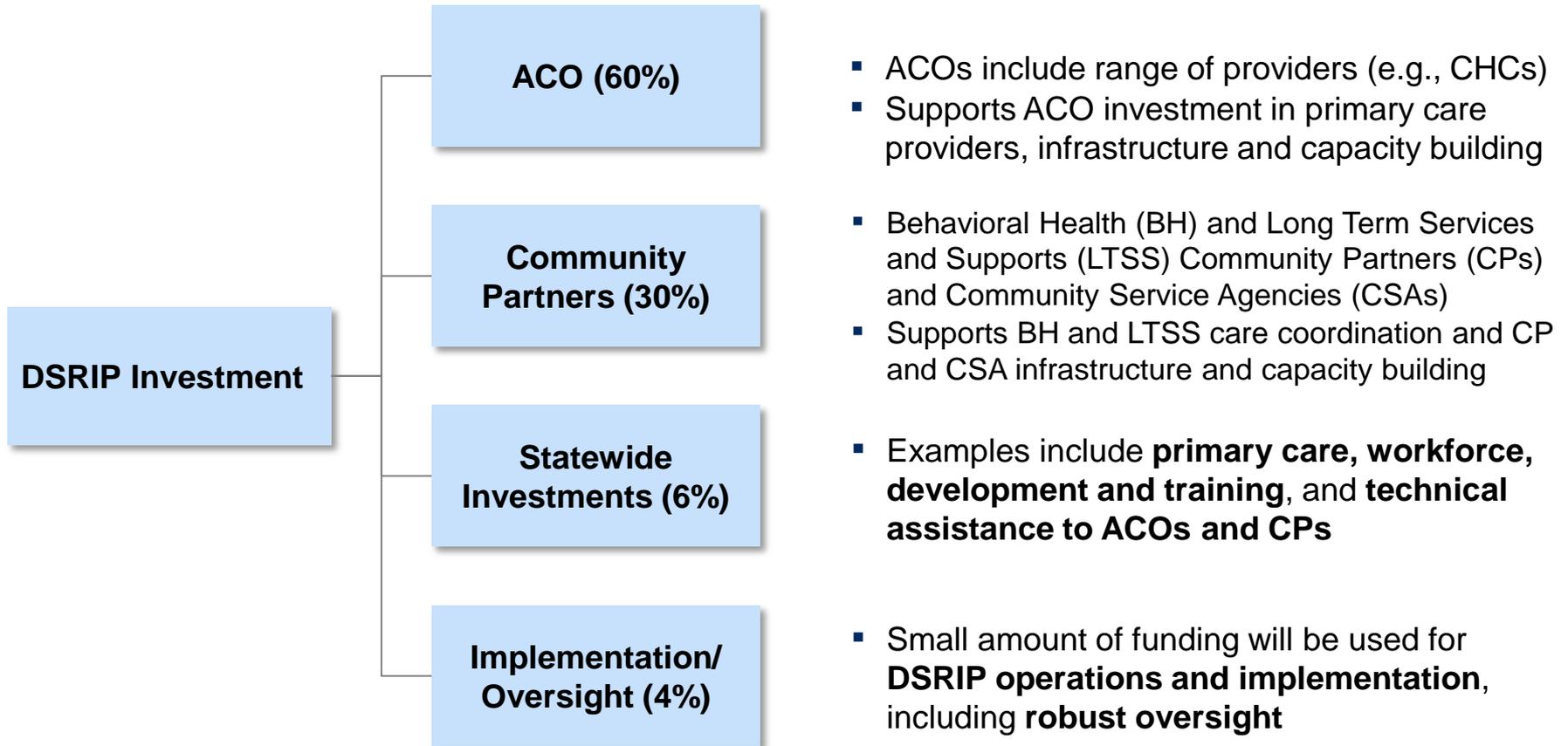
Community Partners (CPs)

- MassHealth has procured **Community Partners**—entities experienced with Behavioral Health and Long Term Services and Supports to support ACOs and MCOs in providing quality care to certain members.
- **CPs will:**
 - Support members with high BH needs and complex LTSS needs to help them navigate the complex systems of BH services and LTSS in Massachusetts
 - Improve member experience, continuity and quality of care by holistically engaging members
 - Create opportunity for ACOs and MCOs to leverage the expertise and capabilities of existing community-based organizations serving populations with BH and LTSS needs
 - 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.



Delivery System Reform Incentive Payment

- DSRIP totals \$1.8B over five years and supports four main funding streams
- **Eligibility for receiving DSRIP funding will be linked explicitly to participation in MassHealth payment reform efforts**





II. Introduction to ACO Models

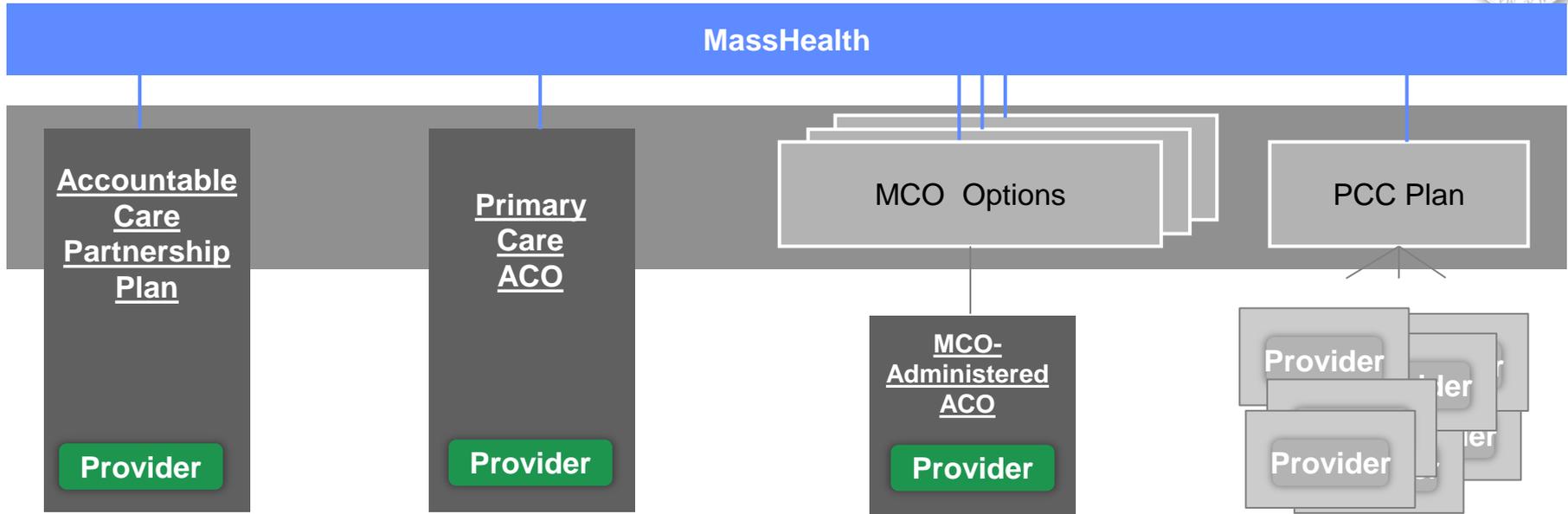


MassHealth ACO Goals and Principles

- **Materially improve member experience**—ACOs are expected to innovate and engage members differently (e.g., better transitions of care, improved coordination between a member’s various providers)
- **Strengthen the relationship between members and Primary Care Providers** by attributing members to an ACO through their selection of a primary care provider
- **Encourage ACOs to develop high value, clinically integrated provider partnerships** by expecting and allowing ACOs to define coordinated care teams and, for some ACOs, to establish preferred networks
- **Increase Behavioral Health / Long Term Service and Support integration and linkages to social services** in ACO models through explicit requirements for partnering with BH and LTSS Community Partners

MassHealth Restructuring

Member enrollment



Accountable Care Partnership Plan

- MCO and ACO have significant integration and provide covered services through a provider network
- Risk-adjusted, prospective capitation rate
- Takes on full insurance risk

Primary Care ACO

- ACO contracts directly with MassHealth for overall cost/ quality
- Based on MassHealth provider network/MBHP
- ACO may have referral circles
- Choice of level of risk; both include two-sided performance (not insurance) risk

MCO & MCO-Administered ACO

- MCO contracts with “MCO-Administered” ACO as a part of their network
- MCO plays a larger role to support population health management
- Various levels of ACO risk; all include two-sided performance (not insurance) risk

PCC Plan

- Primary care Providers based on the PCC Plan network
- Specialists based on MassHealth network
- Behavior Health administered by Massachusetts Behavioral Health Partnership (MBHP)



Flexible Services Program

- Under the 1115 Demonstration Waiver, MassHealth received federal approval to provide DSRIP funds to ACOs for the purpose of funding flexible services.
- Flexible services funding will be used to address health-related social needs by providing supports that are not currently reimbursed by MassHealth or other publicly-funded programs
- The proposed MassHealth Flexible Services Program will allow ACOs to utilize a portion of their Delivery System Reform Incentive Plan (DSRIP) funds to pilot innovative approaches to social service integration within MassHealth ACOs
- Flexible Services will only be available for MassHealth members enrolled in an ACO



Flexible Services Domains

- Not all social service needs of every member will be addressed by the Flexible Services Program -- ACOs will need to prioritize what to address
- This “flexible use” of MassHealth dollars will allow ACOs to apply innovative approaches to providing goods and services that address social determinants of health (SDH) that fall within the following domains:

Flexible Services Domains – Buckets of allowable goods and services

- 1. Transition services for individuals transitioning from institutional settings into community settings** – reduce health risks and costs while transitioning
- 2. Home and community-based services to assist individuals to remain in community dwellings** – assist in maintaining housing in community setting
- 3. Maintain a safe and healthy living environment** – increase member’s functioning and independence related to a medical condition and promote home safety
- 4. Physical activity and nutrition** – promote health by increasing activity and access to affordable healthy food
- 5. Experience of violence support** – facilitate connections to services of a DPH-funded provider or EOHHS-funded agency
- 6. Other individual goods and services** -- not previously covered and provides benefit and support related to SDH, upon approval of MassHealth



III. Introduction to Community Partners



Objectives for Community Partners (CP) Program

- Support members with high BH needs, complex LTSS needs and their families to help them **navigate the complex systems of BH and LTSS** in Massachusetts.
- **Improve member experience, continuity and quality of care** by holistically engaging members with high BH needs (SMI, SED, and SUD¹) and complex LTSS needs.
- Create opportunity for ACOs and MCOs 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 promote cultural competence.

¹ SMI = Serious Mental Illness; SED = Serious Emotional Disturbance; SUD = Substance Use Disorder

BH CP Model: What will the BH CP do for Members?



BH CP Functions

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** 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 flexible services where applicable.

Anticipated LTSS CP Model: What will the LTSS CP do for Members?



LTSS CPs Supports

1. Perform **outreach** and **orientation** to assigned members.
2. Conduct **LTSS care planning** and **choice counseling** to develop a LTSS Care Plan using person-centered processes.
3. **Participate on the member's care team**, to provide LTSS expertise and support integration of LTSS into the member's care, as directed by the member.
4. Facilitate member access to LTSS through **care coordination and navigation**.
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 flexible services, where applicable.

Enhanced Supports

1. ACOs and/or MCOs and LTSS CPs may collaboratively identify members with complex LTSS needs who would benefit from comprehensive care management provided by the LTSS CP.
2. Enhanced Supports arrangements may be made available through a competitive grant arrangement
3. MassHealth anticipates releasing additional information on the Enhanced Supports model in Spring 2017.



IV. Quality Measurement



ACO Quality Measures Goals and Objectives

- ACOs will be accountable for providing high-value, cross-continuum care, across a range of measures that improves member experience, quality, and outcomes.
- Quality metrics will ensure savings are not at the expense of quality care.
- ACOs cannot earn savings unless they meet minimum quality thresholds.
- Higher quality scores may:
 - Raise an ACO's shared savings payment
 - Reduce the amount the ACO needs to pay back in shared losses.
- MassHealth will regularly evaluate measures and determine whether measures should be added, modified, removed, or transitioned from pay-for-reporting to pay-for-performance, and will engage stakeholders as appropriate.



Principles

- Reliability, validity, stability, and drawn from nationally accepted standards of measures (wherever possible) and with broad impact
- Alignment with other payers and CMS
- Cross-cutting measures that fall into multiple domains
- Patient-centered, patient-reported, quality of life/functionality
- Variation and opportunity for improvement (e.g. provider level variation, disparities)
- Promotion of co-management/coordination across spectrum of care
- Feasibility of data collection and measurement, and minimization of administrative burden as much as possible

These principles were derived from several existing approaches in Massachusetts (AQC and SQAC), CMS guiding principles, and from a multi-stakeholder discussion in the Quality workgroup.



ACO Quality Measure Domains

ACO quality measures will cover seven domains:

1. Prevention and Wellness
2. Chronic Disease Management
3. Mental Health / Substance Use Disorder
4. Long-Term Services and Supports
5. Avoidable Utilization
6. Progress Towards Integration
7. Member Care Experience

Proposed ACO Quality Measure Slate



#	Domain	Measure
1	Prevention & Wellness	Well child visits in first 15 months of life
2	Prevention & Wellness	Well child visits 3-6 yrs
3	Prevention & Wellness	Adolescent well-care visit
4	Prevention & Wellness	Weight Assessment / Nutrition Counseling and Physical Activity for Children/Adolescents
5	Prevention & Wellness	Prenatal Care
6	Prevention & Wellness	Postpartum Care
7	Prevention & Wellness	Oral Evaluation, Dental Services
8	Prevention & Wellness	Tobacco Use: Screening and Cessation Intervention
9	Prevention & Wellness	Adult BMI Assessment
10	Prevention & Wellness	Immunization for Adolescents
11	Chronic Disease Management	Controlling High Blood Pressure
12	Chronic Disease Management	COPD or Asthma Admission Rate in Older Adults
13	Chronic Disease Management	Asthma Medication Ratio
14	Chronic Disease Management	Comprehensive Diabetes Care: A1c Poor Control
15	Chronic Disease Management	Diabetes Short-Term Complications Admission Rate
16	Behavioral Health/ Substance Abuse	Developmental Screening for behavioral health needs: Under Age 21
17	Behavioral Health/ Substance Abuse	Screening for clinical depression and documentation of follow-up plan: Age 12+
18	Behavioral Health/ Substance Abuse	Depression Remission at 12 months
19	Behavioral Health/ Substance Abuse	Initiation and Engagement of AOD Treatment (Initiation)
20	Behavioral Health/ Substance Abuse	Initiation and Engagement of AOD Treatment (Engagement)
21	Behavioral Health/ Substance Abuse	Follow-Up After Hospitalization for Mental Illness (7-day)

Proposed ACO Quality Measure Slate (cont.)



#	Domain	Measure
22	Behavioral Health/ Substance Abuse	Follow-up care for children prescribed ADHD medication - Initiation Phase
22	Behavioral Health/ Substance Abuse	Follow-up care for children prescribed ADHD medication - Continuation Phase
24	Behavioral Health/ Substance Abuse	Opioid Addiction Counseling
25	LTSS	Assessment for LTSS
26	Integration	Utilization of Behavioral Health Community Partner Care Coordination Services
27	Integration	Utilization of Outpatient BH Services
28	Integration	Hospital Admissions for SMI/SED/SUD Population
29	Integration	Emergency Department Utilization for SMI/SED/SUD Population
30	Integration	Emergency Department Boarding of SMI/SED/SUD Population
31	Integration	Utilization of LTSS Community Partners
32	Integration	All Cause Readmission among LTSS CP eligible
33	Integration	Social Service Screening
34	Integration	Utilization of Flexible Services
35	Integration	Care Plan Collaboration
36	Integration	Community Tenure
37	Avoidable Utilization	Potentially Preventable Admissions
38	Avoidable Utilization	All Condition Readmission
39	Avoidable Utilization	Potentially Preventable Emergency Department Visits

Community Partner Quality Measures Considerations



Goals for measures:

- Integration of community partner into ACOs
- Pull measures as much as possible directly from ACO slate for maximal alignment
- CP should be accountable for traditionally medical measures
- CP should impact avoidable utilization including ED and readmissions
- Engagement- CPs should ensure members have comprehensive assessments completed and care plans developed with the member and shared with the PCP



Community Partner Quality Measures Considerations (cont.)

There are a number of operational challenges to establishing quality measures for CPs and CSAs:

- Lack of national benchmark specific to CP population
- Lack of robust adjustment for socioeconomic and functional status
- Challenge of sample size – for random sampling and for sufficient power

Mitigating strategies:

- Years 1 and 2 will be used to calculate benchmarks for years 3 and beyond.
- Claims based measures versus record review measures- rely on claims or CP records
- Benchmarks based on our CP population for each measure



CP Quality Measure Domains

CP quality measures will cover five domains:

1. Quality
2. Member Experience
3. Integration
4. Avoidable Utilization
5. Engagement



Questions?



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