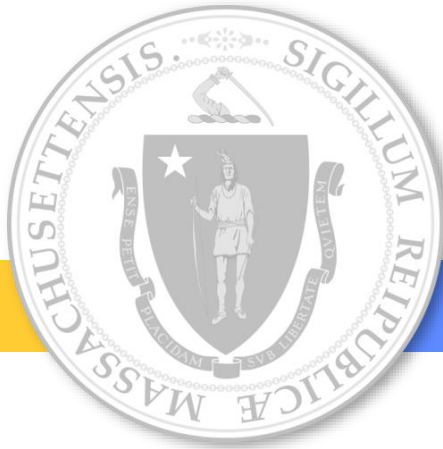


# MassHealth Delivery System Restructuring – Provider Overview



Executive Office of Health & Human Services

Spring 2017

# Agenda



- I. Background and Timeline
- II. Strategy for Reform
- III. Introduction to ACO Models
- IV. Introduction to Community Partners
- V. Member Communication and Enrollment
- VI. Discussion



# I. Background and Timeline

# Current vs. Sustainable System



## Current system

- Rewards volume
- Built to address emergency or short-term medical events; difficult for members to navigate the system
- Multiple doctors treating the same patient for the same condition without talking to each other
- Limited transparency into quality and efficiency of care
- Patient information often stored in silos or paper medical records

## Sustainable system

- Rewards outcomes and value
- Member's health managed seamlessly across providers and over time (not visit by visit)
- Providers act as a team to ensure coordination of right services
- Easy-to-understand quality and cost data made available
- Appropriate electronic health information readily available across care teams



# 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



## II. Strategy for Reform

# 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 **December 2017**:

## **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 ACOs**

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

# MCO Procurement



- Concurrent to ACO selection, MassHealth is re-procuring MCOs. Details can be found on [COMMBUYS](#).
- The MCO re-procurement is an important element of MassHealth payment reform efforts.
- MassHealth is looking to select MCOs that can demonstrate a high-quality member experience and strong financial performance which will include
  - Exchange of high-quality and timely encounter and performance data
  - Implementation of any mandates based on regulation changes and the managed care final rule
  - Reporting requirements and more defined performance measures.



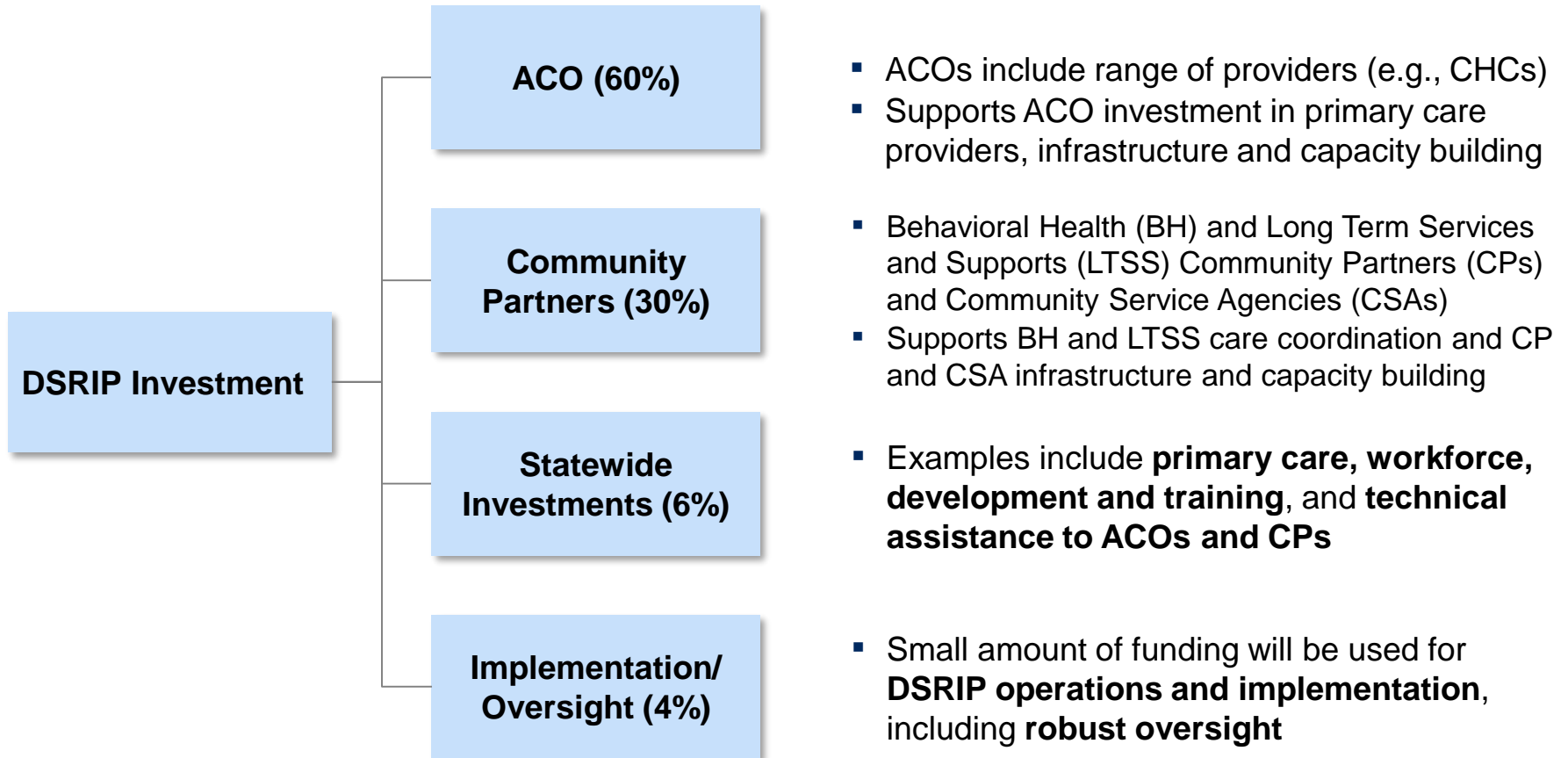
# Community Partners (CPs)

- MassHealth will procure **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**



# Anticipated Key Payment Reform Dates



## **September 2016**

- ✓ *Reconvene Technical Advisory Groups (TAGs)*
- ✓ *ACO procurement released*

## **October 2016**

- ✓ *Responses due for Community Partner (CP) RFI*
- ✓ *MCO Plan Selection and Fixed Enrollment Periods begin*
- ✓ *PCC Plan referral changes begin*

## **December 2016**

- ✓ *Pilot ACOs go live*
- ✓ *MCO Procurement released*

## **February 2017**

- ✓ *ACO procurement responses due*

## **March 2017**

- ✓ *CP procurement released*

## **Spring 2017**

- Release procurement for Technical Assistance to ACOs and CPs
- MCO procurement responses due
- ACO selections announced
- CP procurement responses due

## **Summer 2017**

- MCO selections announced
- MCO and ACO Readiness Reviews begin
- CP selections announced (August)

## **Fall 2017**

- Member enrollment guides distributed
- Members select or are assigned to new ACOs/MCOs for January 2018

## **Winter 2017**

- New MCO and ACO enrollments begin
- MH IT infrastructure to support CPs

## **January 2018**

- CP Contracts finalized with ACOs, MCOs

## **April 2018**

- CP requirements go into effect between CPs and MCOs, ACOs
- CP enrollment begins

## **2020/2021**

- MCOs and ACOs accountable for LTSS on or around Year 3



# III. 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



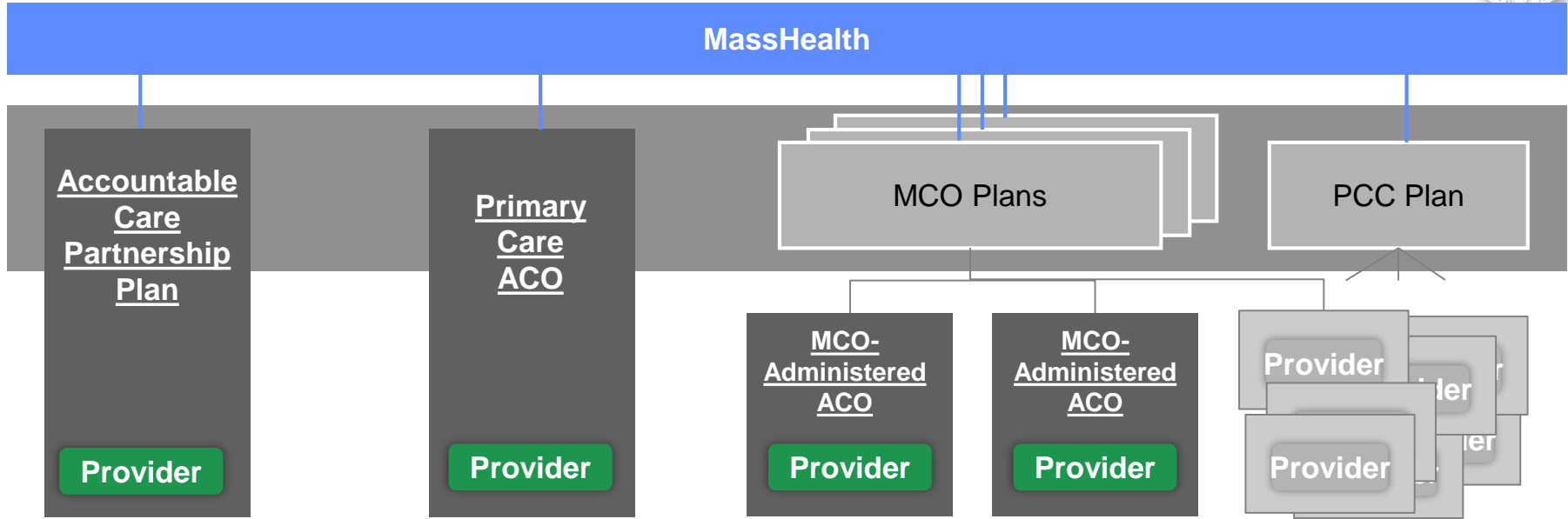
## ACO Responsibilities include:

- Direct investment in their PCPs and requirements for performance management and value-based payment arrangements
- Screening members to identify care needs
- Coordinating care, managing discharges and transitions, and operating a clinician advice and support line for members
- Performing comprehensive assessments and developing person-centered care plans, as appropriate
- Team-based care management, including a care coordinator or clinical care manager as appropriate
- Governance that is provider-led (75% of board) and includes a voting consumer board member as well as a Patient and Family Advisory Committee
- Processes to accept member grievances and requirements to protect member rights (e.g., access to medical records, choice of providers, non-discrimination)



# 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(s) 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)



# Accountable Care Partnership Plan

- Either an MCO with a separate, designated ACO partner, or a single, integrated entity that meets the requirements of both.
- A single MCO may participate in more than one ACO, each with a different ACO Partner.
- All enrolled members receive primary care from PCPs in the ACO.
- Each ACO's PCPs can only serve MassHealth managed care eligible members on their panel if those members are enrolled in their ACO.
- Members can see any providers in the Partnership Plan's network.
- Must meet all MassHealth requirements for MCOs and ACOs, including provider-led governance and Health Policy Commission (HPC) certification.
- Must provide the same administrative functions as MCOs do today, such as:
  - paying claims
  - maintaining an adequate provider network within service area
  - prior authorization, etc.
- Communicate directly with enrollees about benefits of participating, provider network, and how to access services.
- Will be selected for defined service area.
- May serve areas different than the geographical area under the MCO contract (i.e., a "Region").

# Primary Care ACO



- Contracts directly with MassHealth.
- All enrolled members receive primary care from the Primary Care ACO's PCPs.
- Each ACO's PCPs can only serve MassHealth managed care eligible members on their panel if those members are enrolled in their ACO.
- Aside from their PCP, members can see any provider in the MassHealth network.
- Primary Care ACOs may establish "Referral Circles"—a list of specialists who members can access without needing a referral.
- Members enrolled in Primary Care ACOs are also automatically enrolled with MassHealth's behavioral health contractor (currently MBHP).

# MCO-Administered ACO



- For members who choose an MCO.
- MCO enrollees may choose or may be attributed to an MCO-Administered ACO, based on their PCP choice or assignment.
- Contracts directly with one or more MassHealth MCOs. In the first year MCOs must contract with each MCO-Administered ACO operating within their region. In Years 2 - 5, MCOs must contract with at least one MCO- Administered ACO per region.
- Each MCO-Administered ACO's PCPs can only serve MassHealth managed care eligible member on their panel if those members are enrolled in an MCO with which the ACO has a contract.
- MCO enrollees may see any providers in their MCO's network (subject to their MCO's rules) regardless of their attribution to an MCO-Administered ACO.



# 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.

# 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





## 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



# IV. Introduction to Community Partners



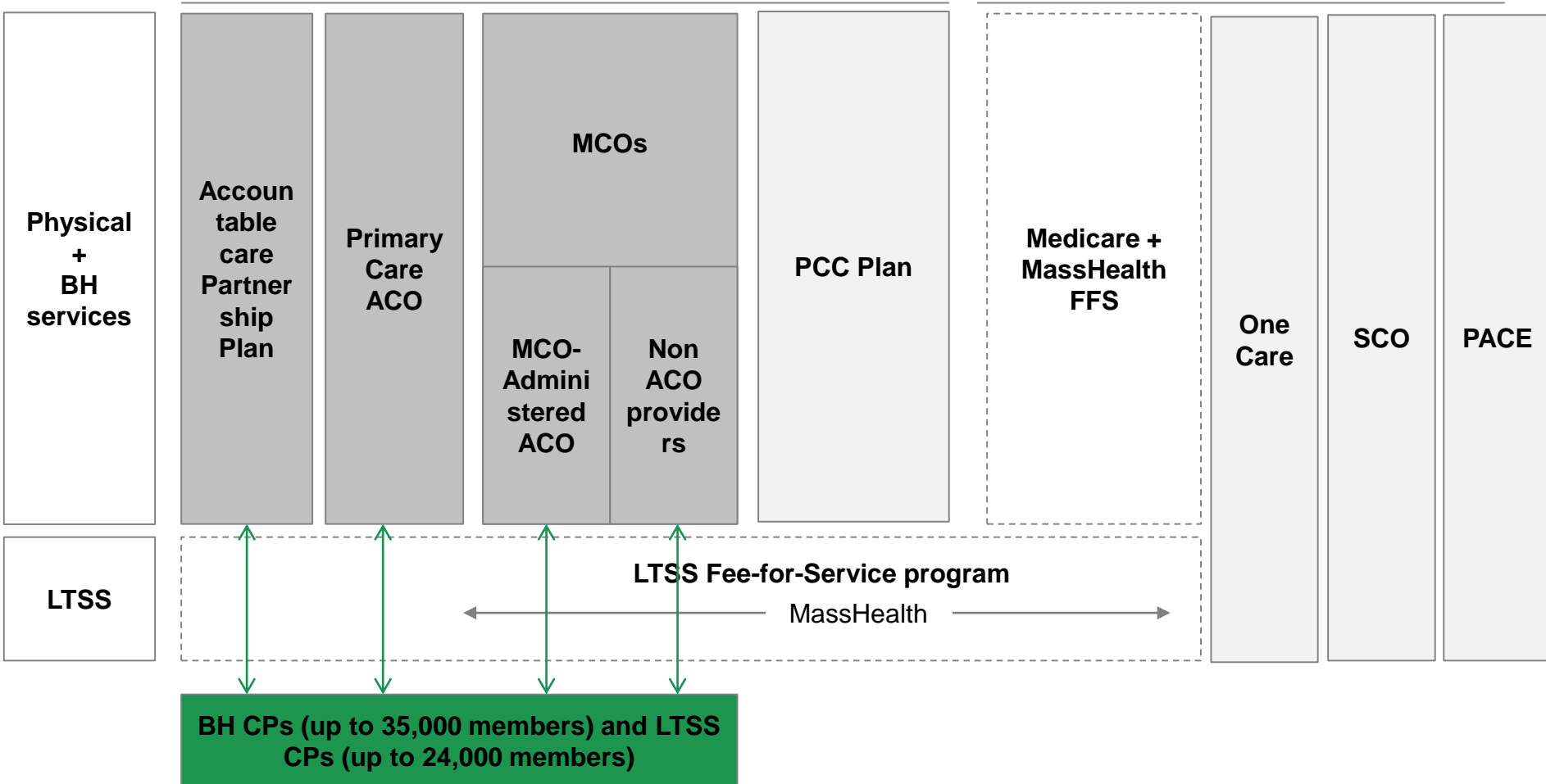
# BH and LTSS CPs will Support ACO and MCO-Enrolled Members

Non-duals

Managed care eligible (~1.2M members)

Duals

FFS and integrated care models (~0.7M members)



MH – MassHealth  
FFS – Fee-for-Service  
SCO – Senior Care Options

PACE - Program of All-Inclusive Care for the Elderly



# 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 SUD<sup>1</sup>) 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.

<sup>1</sup> 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.



## BH CP Model:

### How will Members be Identified and Assigned to a BH CP?

MassHealth members will be identified and assigned for BH CP supports by:

1. Analytical Process (i.e. claims and services-based analysis) by MassHealth
  - MassHealth intends, where possible, to maintain existing member-provider relationships by assigning member to the CP that provides services to that member.
  - ACOs and MCOs will also assign a portion of members to a CP.

OR

2. Qualitative process (e.g. provider referral or member self-identification)
  - Referrals from members, providers and others familiar with member are made to ACO or MCO for approval.
  - ACOs and MCOs may assign members to a CP.

**Members have choice.** Members may decline assignment to a particular CP or to any CP at all.

# Community Service Agency (CSA) Intersection with the BH CP Program



- CSAs will continue to deliver the services as they do today; medical necessity criteria and service specification will remain unchanged; CSAs will be paid for services as they are today
- CSAs will be eligible for DSRIP funding for **infrastructure and capacity development**
- A CSA must partner with all ACOs and MCOs in the service areas it serves to be eligible for DSRIP funding, and will be subject to contract requirements with MassHealth.



# 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.



## LTSS CP Model:

### How will Members be Identified and Assigned to LTSS CPs?

MassHealth members will be identified and assigned for LTSS CP Supports by

1. Analytical Process (i.e. claims and services based analysis) by MassHealth
  - MassHealth intends to identify members with high LTSS utilization using a claims and services based analysis.
  - ACOs and MCOs will assign identified members to a LTSS CP.

OR

2. Qualitative process (i.e., provider referral or member self-identification)
  - Referrals from members, providers and others familiar with the member are made to ACO or MCO for approval.
  - ACOs and MCOs may assign members to a CP.

**Members have choice.** Members may decline assignment to a particular CP or to any CP at all



# CP Quality Measures Considerations

Goals for measures:

- Integration of CPs with ACOs and MCOs.
- Align with ACO quality measure slate.
- CP, along with ACO, should be accountable for traditionally medical measures in order to promote integration of care.
- CP supports should impact avoidable utilization including ED and readmissions.
- Measures for engagement - CPs should ensure:
  - For BH CPs - members have comprehensive assessments completed and shared with the PCP
  - For LTSS CPs – person-centered LTSS care plan is developed under the direction of the member and shared with the PCP and integrated into the overall care plan



# CP Quality Measure Domains

## CP quality measures will cover five domains:

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



# 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.

# 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

# BH CP Measure Slate (1 of 3)



#	Measure	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #
<b>I. Quality</b>					
<b>A. Prevention &amp; Wellness</b>					
1	Prenatal Care	Timeliness of Prenatal Care: The percentage of deliveries of live births to ACO/MCO/health plan enrollees (any age) between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of assignment to the BH CP.	C	NCQA	1517
15	Annual primary care visit	Percent of CP-engaged members who had an annual primary care visit in the last 15 months	C	EOHHS	N/A
<b>B. Chronic Disease Management</b>					
3	COPD or Asthma Admission Rate in Older Adults	All discharges with a principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO/MCO/health plan enrollees with COPD or asthma, with risk-adjusted comparison of observed discharges to expected discharges for each ACO.	C	CMS	N/A
4	Asthma Medication Ratio	The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	C	NCQA	1800
5	Diabetes Short-Term Complications Admission Rate	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 ACO/MCO/health plan member months ages 18 to 64. Excludes obstetric admissions and transfers from other institutions.	C	CMS	272



# BH CP Measure Slate (2 of 3)



#	Measure	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #
<b>C. Behavioral Health / Substance Use Disorder</b>					
6	Initiation and Engagement of AOD Treatment (Initiation)	The percentage of ACO/MCO/health plan adolescent and adult members with a new episode of AOD who received the following: Initiation of AOD Treatment	C	NCQA	4
7	Initiation and Engagement of AOD Treatment (Engagement)	The percentage of ACO/MCO/health plan attributed adolescent and adult members with a new episode of AOD who received the following: Engagement of AOD Treatment	C	NCQA	4
8	Follow-Up After Hospitalization for Mental Illness (7-day)	Percentage of discharges for ACO/MCO/health plan enrollees ages 6 to 64 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge.	C	NCQA	576
9	Follow-up After Hospitalization for Mental Illness (3-day) by BH CP	Percentage of discharges for BH CP-enrolled members ages 21 to 64 who were hospitalized for treatment of selected mental illness diagnoses and who had a face-to-face encounter with a BH CP within 3 days of discharge	H	EOHHS	N/A
<b>II. Member Experience</b>					
<b>A. Access</b>			Survey	TBD	N/A
<b>B. Care Planning</b>			Survey	TBD	N/A
<b>C. Participation in Care Planning</b>			Survey	TBD	N/A
<b>D. Quality and Appropriateness</b>			Survey	TBD	N/A
<b>E. Health and Wellness</b>			Survey	TBD	N/A
<b>F. Social Connectedness</b>			Survey	TBD	N/A
<b>G. Self Determination</b>			Survey	TBD	N/A
<b>H. Functioning</b>			Survey	TBD	N/A
<b>I. Self Reported Outcomes</b>			Survey	TBD	N/A
<b>J. General Satisfaction</b>			Survey	TBD	N/A

# BH CP Measure Slate (3 of 3)



#	Measure	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #
<b>III. Integration</b>					
11	Utilization of Behavioral Health Community Partner Care Coordination Services	Percentage of ACO/MCO/health plan-enrolled, BH CP assigned members who received at least one BH CP support during the measurement period	H	EOHHS	N/A
12	Social Service Screening	Percentage of CP-engaged members who were screened for social service needs	H	EOHHS	N/A
13	Utilization of Flexible Services	Percentage of ACO-enrolled, CP-engaged members (up to age 64) recommended by their care team to receive flexible services support that received flexible services support	H	EOHHS	N/A
14	Utilization of Outpatient BH Services	Percentage of ACO/MCO/health plan enrollees that have utilized outpatient BH services during the measurement period	C	EOHHS	N/A
<b>IV. Avoidable Utilization</b>					
16	All Condition Readmission	Risk-adjusted ratio of observed to expected ACO/MCO/health plan enrollees CP CP-engaged (up to age 64) who were hospitalized and who were subsequently hospitalized and readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	NQF	1789
17	Potentially Preventable ED Visits	Risk-adjusted ratio of observed to expected emergency department visits for ACO/MCO/health plan enrollees CP-engaged ages 18 to 64 per 1,000 member months.	C	3M	N/A
<b>V. Engagement</b>					
1	BH Comprehensive Assessment /Care Plan in 90 Days	Percentage of ACO/MCO/health plan-enrolled, BH CP-engaged members with documentation of a comprehensive assessment and approval of a care plan by primary care clinician or designee and member (or legal authorized representative, as appropriate) within 90 days of assignment to BH CP. Expected attainment = 70% or above	H	EOHHS	N/A



# CSA Measure Slate

#	Measures	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #
<b>I. Quality</b>					
<b>A. Prevention &amp; Wellness</b>					
1	Well child visits in first 15 months of life	Percentage of CSA members who turned 15 months old during the measurement period and who had the following number of well-child visits with a primary care practitioner (PCP) during their first 15 months of life: zero, one, two, three, four, five, six or more.	C	NCQA	1392
2	Adolescent well-care visit	Percentage of CSA members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrics and gynecology (OB/GYN) practitioner during the measurement period.	C	NCQA	N/A
3	Oral Evaluation, Dental Services	Percentage of CSA members under age 21 years who received a comprehensive or periodic oral evaluation as a dental service within the measurement period.	C	Dental Quality Alliance	2517
<b>B. Behavioral Health</b>					
4	Follow-Up After Hospitalization for Mental Illness (7-day)	Percentage of discharges for CSA members ages 6 to 64 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge.	C	NCQA	576
<b>II. Member Experience: Wraparound Fidelity Index Short Form (WFI-EZ) - Caregiver Form</b>					
<b>A. Your Experiences around Wraparound</b>			Form	TBD	N/A
<b>B. Satisfaction</b>			Form	TBD	N/A
<b>C. Outcomes</b>			Form	TBD	N/A
<b>III. Avoidable Utilization</b>					
6	Hospital Admissions for SMI/SED/SUD Population	Risk-adjusted percentage of CSA members with a diagnosis of SMI, SED, and/or SUD who were hospitalized for treatment of selected mental illness diagnoses or substance use disorder (regardless of primary or secondary diagnosis)	C	EOHHS	N/A
7	Emergency Department Utilization for SMI/SED/SUD Population	Risk-adjusted percentage of CSA members with a diagnosis of SMI, SED, and/or SUD who utilized the emergency department for a selected mental illness or substance use disorder that is either the primary or secondary diagnosis	C	EOHHS	N/A
<b>V. Engagement</b>					
9	CSA Comprehensive Care Plan in 90 Days	Percentage of CSA members with documentation of a care plan and approval of care plan by primary care clinician or designee and member or legal authorized representative as appropriate . Expected attainment = 70% or above	H	EOHHS	N/A

# CP Accountability Framework



- There are three funding streams for CPs:
  1. Care Coordination funds (at-risk)
  2. Infrastructure and capacity building funds (at-risk)
  3. Outcome based payments
- There is one funding stream for CSAs:
  1. Infrastructure and capacity building (at-risk)
- Funds begin to be at risk in year 2 for reporting only and in year 3 for performance



# CP Accountability Framework

## CP/CSA funding streams

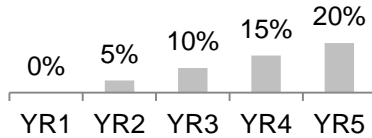
Care Coordination Supports (CPs only)

Infrastructure (CPs and CSAs)

Outcome Based Payments (CPs only)

## Performance Accountability

- Funding at risk with increasing pct over time, based on **DSRIP Accountability Score**



**DSRIP Accountability Score**

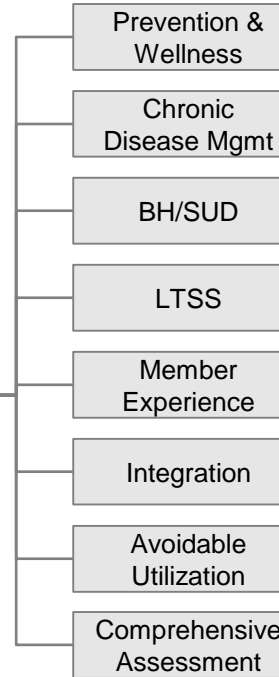
*50% of improvement over self added to Quality Score*

## CP/CSA Quality Score

**CP/CSA Quality Score**

*Weighted average based on domain weights*

## Domains



## Individual Measures

- For all measures, state sets an attainment and excellence benchmark
- Targets will be set after 2 years of baseline data

- Incentive pool based on avoidable utilization excellence (preventable ED visits + all cause readmissions)
- CPs meeting or exceeding the Excellence Benchmark for avoidable utilization will be eligible for outcomes based payments

### Available funding for outcome based payments

	YR3	YR4	YR5
BH CPs	\$1m	\$1m	\$1m
LTSS CPs	\$500k	\$500k	\$500k



# V. Member Communication and Enrollment



# Managed Care Eligible Coverage Types

Members < age 65 without TPL in the following MassHealth coverage types can join an ACO, MCO, or PCC Plan:

- **Standard**
- **CommonHealth**
- **CarePlus**
- **Family Assistance**

Members enrolled in an ACO or MCO will also have access to CPs as necessary.

Providers are encourage to check the Eligibility Verification System (EVS) to confirm the MassHealth enrollment status of their patients:

<https://newmmis-portal.ehs.state.ma.us/EHSProviderPortal/providerLanding/providerLanding.jsf>

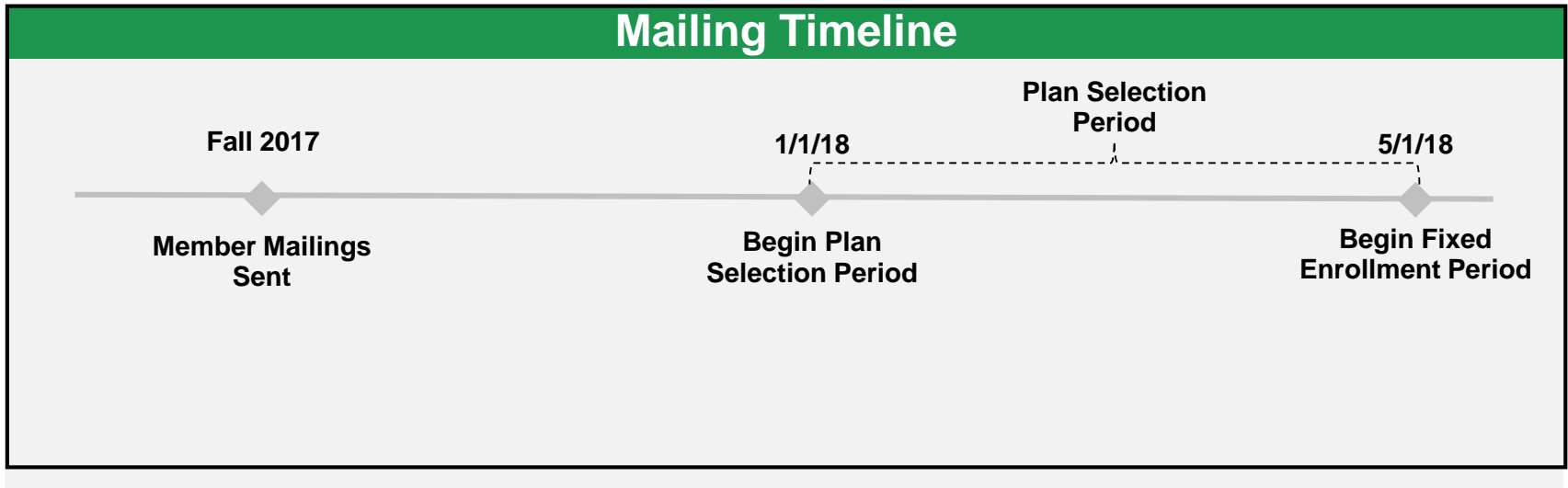
# Member Enrollment in New MCOs and ACOs



- To ensure that all managed care eligible members are enrolled in MCOs and ACOs (or PCC Plan) by January 1, 2018, certain members will have a “**Special Assignment**” to plans.
- Special Assignment will be based on keeping members with their PCP to the extent possible.
  - Members who will be Specially Assigned will receive a notice and an enrollment guide from MassHealth in late 2017.
  - All MCO and ACO options will be presented in the Enrollment Guide.
  - Members who are Specially Assigned will have the option to change plans.
- MCO and ACO enrolled members will have a Plan Selection Period beginning January 1, 2018



# Member Noticing for Managed Care Eligible Population





# Member Perspective

*“If I am enrolled in \_\_\_\_, which providers can I see for \_\_\_\_?”*

	Primary Care	Hospital/ Specialists	Behavioral Health (BH)	Long-Term Services and Supports (LTSS)	Pharmacy
<b>PCC Plan</b>	MassHealth PCPs	MassHealth Hospital/ Specialists	MBHP providers	MassHealth LTSS providers	MassHealth network Pharmacies
<b>Primary Care ACO</b>	Primary Care ACO's PCPs	MassHealth Hospital/ Specialists	MBHP providers	MassHealth LTSS providers	MassHealth network Pharmacies
<b>MCO</b>	PCPs in the MCO's network	Hospitals/ specialists in the MCO's network	BH Providers in the MCO's network or the network of its BH vendor	Year 1 & 2 – MassHealth LTSS providers	Pharmacies in the MCO's network
<b>MCO-Administered ACO</b>	MCO- Administered ACO's PCPs			Year 3 or 4 – LTSS Providers in the MCO's network	
<b>Partnership Plan</b>	PCPs in the Partnership Plan's network	Hospitals/ specialists in the Partnership Plan's network	BH Providers in the Partnership Plan's network or the network of its BH vendor	Year 1 & 2 – MassHealth LTSS providers	Pharmacies in the Partnership Plan's network
				Year 3 or 4 – LTSS Providers in the Partnership Plan's network	



# Member Support Materials & Events

In anticipation of new enrollment options, MassHealth is actively seeking avenues to educate and engage members.

## Global Awareness & Education

- Staff Training: MassHealth Enrollment Center (MEC)
- MassHealth Training Forum (MTF) Presentations
- EOHHS Website Updates
- Sister Agency & Advocacy Training
- Certified Application Counselor (CAC) & Navigator training
- Navigator Feedback Sessions
- Advertising

## Support Material

- Enrollment Guide presenting all available MCO, ACO, and PCC Plan options
- Member-specific letters with information about Special Assignment, Plan Selection Period, and Fixed Enrollment Period
- Choice Counseling Tool
- Member Booklet
- Video/Animation “How to Enroll”

## Member Engagement

- Community Health Worker (CHW) Training
- Ombudsman
- Community Enrollment Events throughout the Commonwealth

## Customer Service Center

- Searchable Provider Directory
- Enhanced Call Center Staff



# Provider Communication and Education

- To support the goals of MassHealth Restructuring, MassHealth is focused on strategies that bring awareness of payment reform activity and delivery system change to the provider community.
- Providers will need information about how and when MassHealth restructuring will impact them, including network contracting choices, payments and accountability, and administrative changes, as well as changes for members
- MassHealth will develop messaging tailored for specific provider groups, including:
  - Primary Care Providers
  - Hospitals
  - Community Health Centers
  - Specialists
  - Behavioral Health Providers
  - Long-Term Services and Supports Providers
- MassHealth will use a variety of communication strategies and methods to share information with providers, including:

## Resources and Information:

- Webinars
- Provider bulletins
- MassHealth website
- MassHealth regulations
- Message text (POSC)

## Collaboration Strategies:

- Work with ACOs/MCOs to provide consistent messaging
- Work closely with Provider Associations
- Proactive outbound calls from MassHealth
- Knowledgeable MassHealth Provider Services staff, available to answer providers' questions as needed



# Provider Perspective (1 of 2): PCPs

“What are my ACO participation options and their implications?”

My options for ACO participation are . . .	And what it means for the MassHealth managed care-eligible members I can serve is . . .
Do not participate in an ACO	I need to <b>contract with the PCC Plan and/or MassHealth MCOs</b> in order to have any of their enrollees on my primary care panel*
Join a Partnership Plan as a Network PCP	I serve a panel of members who are <b>all enrolled in my ACO</b> . I cannot simultaneously have a PCP panel in any other products (i.e., the PCC Plan, an MCO, another ACO)
Join a Primary Care ACO as a Participating PCP	
Join an MCO-Administered ACO as a Participating PCP	My ACO will partner with one or more MCOs (in year 1, my ACO will partner with all the MCOs operating in its geography). I will be required to contract with those MCOs as a Network PCP for their enrollees, and all of their enrollees who are assigned to my panel will be considered part of my ACO’s attributed population

- *Primary care exclusivity is only with respect MassHealth managed care-eligible members. PCPs may provide primary care services to MassHealth Fee-For-Service members, including Dually Eligible MassHealth members, and they may also provide specialty services to MassHealth members in any delivery system.*
- *Primary care exclusivity is **site- /practice-level**, similar to PCC Plan enrollments or participating in the ACO Pilot.*
- *MassHealth will provide additional operational details of primary care provider enrollment/ACO affiliation to those providers participating with ACOs over the coming months.*

# Provider Perspective (2 of 2): non-PCP providers

*“What does ACO reform mean for my contracts and who I can see?”*



		<i>I want to see members enrolled in . . .</i>			
		<b>The PCC Plan</b>	<b>A Primary Care ACO</b>	<b>An MCO</b> <i>(regardless of whether or not they are attributed to an MCO-Administered ACO)</i>	<b>A Partnership Plan</b>
<i>I am a...</i>	<b>Hospital</b>	Be in MassHealth's hospital network <i>(via the MassHealth hospital RFA)</i>		Contract with each MCO whose enrollees I want to see <i>(negotiated rate)</i>	Contract with each Partnership Plan whose enrollees I want to see <i>(negotiated rate)</i>
	<b>Professional (e.g., specialist)</b>	Be a MassHealth-participating provider <i>(via MH professional reg/fee schedule)</i>			
	<b>Behavioral Health (BH) Provider</b>	Be an in-network provider for MassHealth's BH Vendor <i>(via contract with the BH Vendor)</i>		Contract with each MCO (or that MCO's BH Vendor if they have one) whose enrollees I want to see <i>(negotiated rate)</i>	Contract with each Partnership Plan (or that Plan's BH Vendor if they have one) whose enrollees I want to see <i>(negotiated rate)</i>
	<b>Long-Term Services and Supports (LTSS) Provider</b>	Contract with MassHealth as an LTSS provider at the MassHealth fee schedule; LTSS is "wrapped" coverage directly by MassHealth	For years 1 and 2, contract with MassHealth as an LTSS provider at the MassHealth fee schedule; LTSS is "wrapped" coverage directly by MassHealth for all members, regardless of model		
			Starting on or about year 3, contract with each MCO whose enrollees I want to see <i>(negotiated rate)</i>	Starting on or about year 3, contract with each Partnership Plan whose enrollees I want to see <i>(negotiated rate)</i>	
	<b>Pharmacy</b>	Contract with MassHealth as an in-network pharmacy provider		Contract with each MCO (or that MCO's pharmacy benefit manager as applicable) whose enrollees I want to see	Contract with each Partnership Plan (or that Plan's pharmacy benefit manager as applicable) whose enrollees I want to see



# VI. Discussion



**Visit us at:**

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