

MassHealth Delivery System Restructuring: Additional Details

Executive Office of Health & Human
Services

April 14, 2016

Agenda

- **Overview**

- Accountable Care Organization (ACO) model overview
- Delivery System Reform Incentive Payment (DSRIP)
- Implementation timelines
- 1115 waiver updates

MassHealth restructuring update

- **We are committed to a sustainable, robust MassHealth program for our 1.8M members**
 - Unsustainable growth, now almost 40% (\$15B+) of the Commonwealth's budget
 - The current fee-for-service model for providers results in fragmented, siloed care
 - The fundamental structure of the MassHealth program has not changed in 20 years

- **We are transitioning from fee-for-service, siloed care and into integrated, accountable care models**
 - Accountable Care Organizations (ACOs) are provider-led organizations that coordinate care, have an enhanced role for primary care, and are rewarded for *value* – better cost and outcomes – not volume
 - Managed Care Organizations (MCOs) remain the insurer, pay claims and work with ACO providers to improve care delivery
 - We have a major and unique focus on better integrating our members' physical, behavioral health (BH) and long term services and supports (LTSS) needs, as well as building linkages to social services

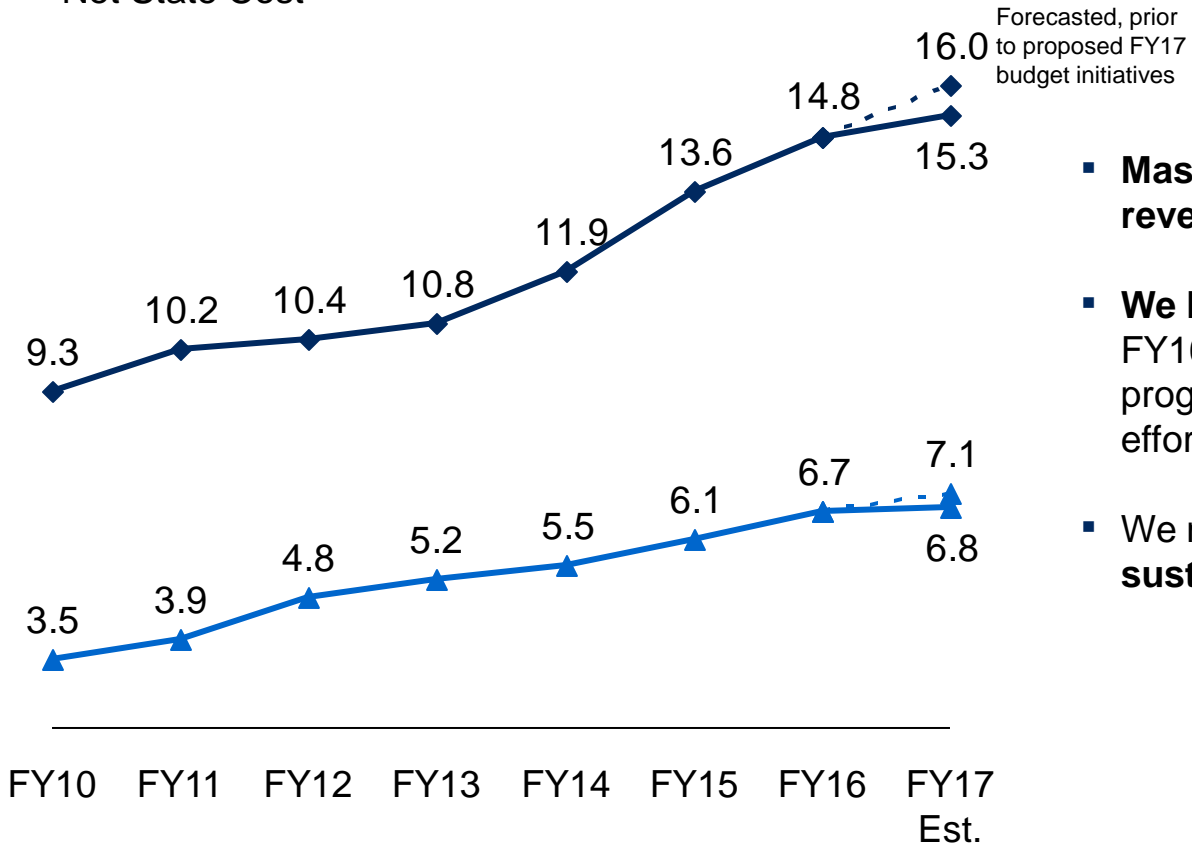
- **We are negotiating a new 5-year 1115 waiver with the federal government that includes ~\$1.5Bn of upfront investment over 5 years to support this effort**
 - Financing for current waiver expires June 30, 2017 with \$1Bn/ year at risk
 - Proposing 5-year Delivery System Reform Investment Program (DSRIP) investment
 - Unique investment approach, including:
 - Support for providers who sign on for ACO models
 - Funding for BH and LTSS community organizations
 - Services not traditionally reimbursed as medical care to address health-related social needs
 - Statewide investments in health care workforce development, improved accommodations for people with disabilities, other state priorities
 - Also proposing expansion of treatment continuum for Substance Use Disorder/ Opioids

MassHealth growth trajectory

MassHealth Program Spending*

\$ billions

- ◆ Gross Program Spend
- ▲ Net State Cost



- **MassHealth has significantly outpaced revenue growth for the Commonwealth**
- **We have brought down growth for FY16 and FY17 through near-term program integrity, operational and other efforts**
- **We must ensure long-term sustainability of the program**

* Includes Hutchinson settlement; excludes MATF (supplemental payments)

Accountable care and delivery system reform: four strategies

A Bring Accountable Care Organizations (ACOs) to MassHealth

- ACOs are **provider-led organizations that coordinate care, have an enhanced role for primary care, and are rewarded for *value*** – improving total cost of care and outcomes – not volume

B Integrate community-based partners and linkages to social services

- ACOs incented to partner with **community-based expertise for behavioral health BH, LTSS and build linkages to social services**
- ACOs will have access to DSRIP **funding designated explicitly for addressing social determinants**
 - “Flexible services” not traditionally reimbursed but likely to improve health outcomes (e.g., air conditioner for kids with asthma, housing supports)

C Partner with MCOs to support ACOs

- The state expects **Managed Care Organizations (MCOs) to work with ACO providers** to improve care delivery and population health management

D Invest to help transition the system into integrated, ACO models

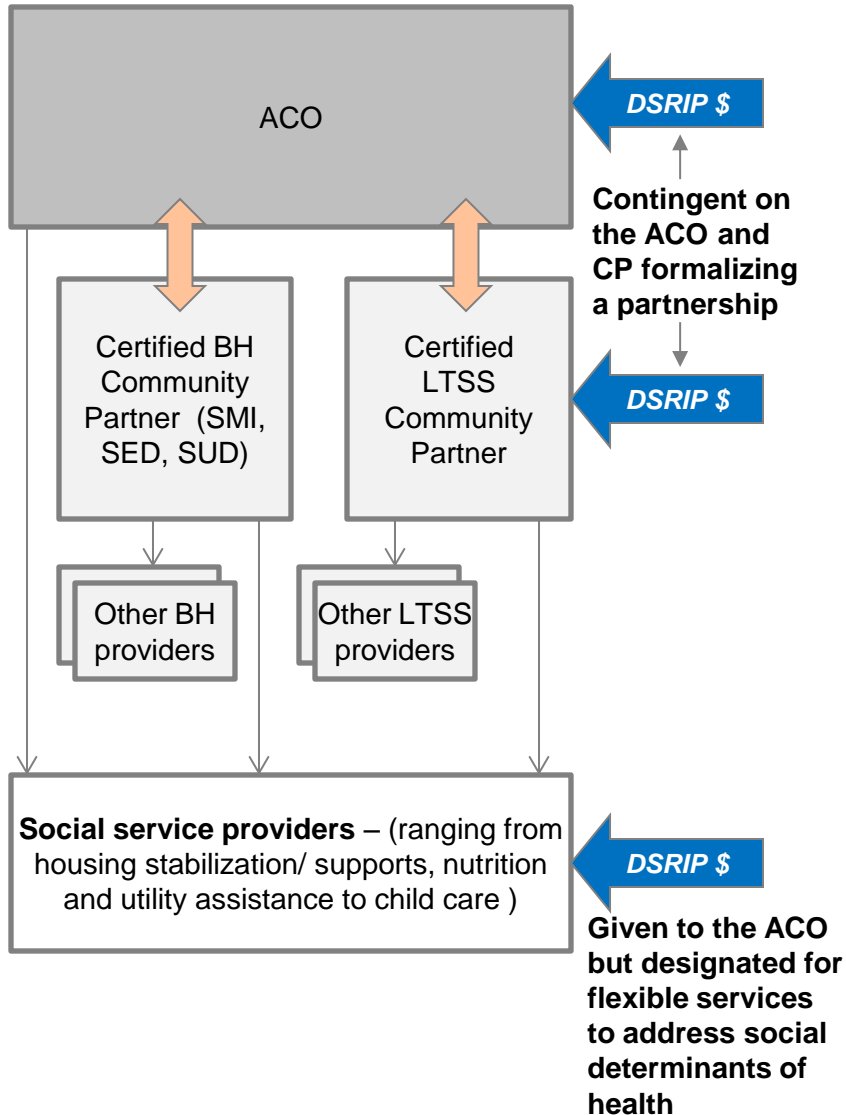
- DSRIP funding **encourages providers to enter into ACO models**
- It **serves as a bridge** – supports a transition into a sustainable model; it is not a rate increase
- DSRIP investments are used to support development of scalable new capabilities and capacity

A MassHealth ACO models: goals and principles

- **Materially improve member experience**– ACOs 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 (PCPs)** by attributing members to an ACO through their selection of a PCP
- **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
- **Partner with MCOs**, with expectations for MCOs to help administer the ACO program and work with providers in strengthening provider-based care management
- **Increase BH/ LTSS integration and linkages to social services in ACO models** through explicit requirements for partnering with BH and LTSS Community Partners

Please see next section of the document for more detail on our ACO strategy

B Community Partners (CPs) and linkages to social services → Indicate referrals and relationships



Goals:

- 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

Who can be a BH or LTSS Community Partners

- The State certifies BH and LTSS CPs
- Criteria include expertise in care coordination and assessments and infrastructure/ capacity
- CPs can be providers but self-referrals monitored
- LTSS CPs must demonstrate expertise across multiple populations with disabilities

How it works

- Certified CPs and ACOs both get direct DSRIP funding
 - Funding for both is contingent on ACOs and CPs formalizing arrangements for how they work together
- Portion of ACO funding designated for “flexible services” to address social determinants
- MCOs may provide support to Model A and Model C ACOs for integrating with BH and LTSS CPs

Please see later section of the document for more detail on Community Partners

C Partnering with Managed Care Organizations (MCOs) for delivery system reform

- **MCOs have a significant role in administering the ACO program**
 - In most cases when a member enrolls in an ACO, MCOs remain the insurer
 - MCOs may integrate with ACOs for Model A (may also support ACOs in Model B)

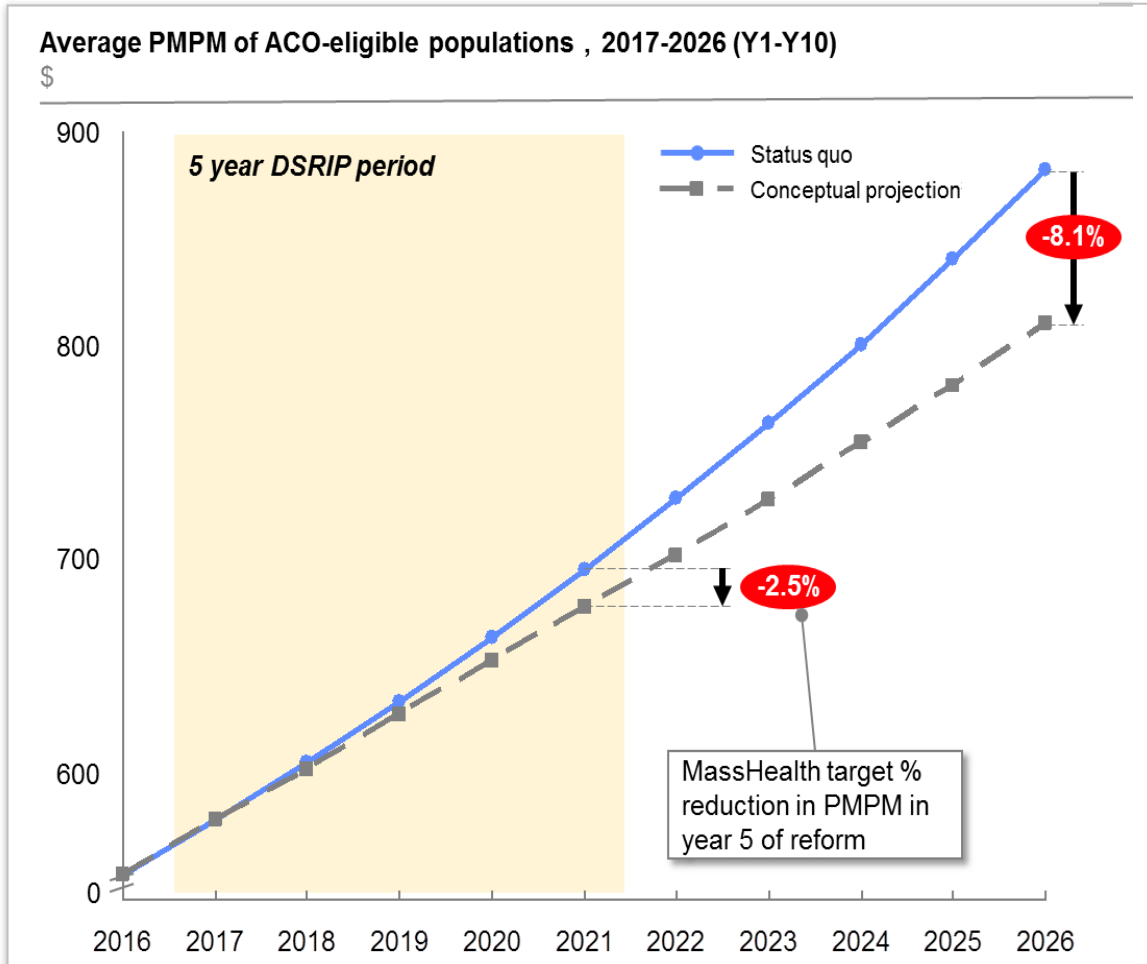
- **For Models A and C, MCOs will be explicitly responsible for working with ACO providers (or integrating as an entity) to improve care delivery**

- **We are partnering with MCOs to support ACO providers in improving care**
 - Upcoming reprocurement will include expectations for MCOs to contract with ACOs
 - MCOs help determine which care management functions best done at the provider vs. at the MCO level
 - MCOs also support providers in making the shift to accountable care (including analytics for population management)
 - MCOs may also help ACOs determine how best to integrate BH and LTSS CPs into care teams

- In addition, we will expand a **One Care-like model** into the non-Duals MCO program in future years (One Care is an integrated care demonstration for Duals)
 - Improves **integration of LTSS and other services, like DME and transportation,** into the physical and BH managed care benefit

Please see later section of the document for more detail on MCO role in delivery system reform

D DSRIP: in order to receive DSRIP from CMS, MA must commit to targets for quality and bending the cost curve



- State accountability to CMS for DSRIP funds also dependent on **reduction in avoidable utilization and quality**
- Quality domains include **chronic disease management, BH/LTSS, and patient experience**

We are also working to expand Substance Use Disorder (SUD) treatment

Context

- 1,099 people died from opioid overdoses in Massachusetts in 2014 (65% increase over 2012)
- ~75% were enrolled in MassHealth at the time of death
- Our current SUD treatment system spans the American Society of Addiction Medicine (ASAM) continuum of services
- However, many gaps remain for MassHealth members, especially for step-down and residential – results in members cycle repeatedly through detoxification programs.

1115 waiver: what we have proposed to CMS

- **Proposal: expand access to SUD treatment, particularly for members who require residential treatment services, recovery coaching and care coordination**
 - Federal Financial Participation generated on current Bureau of Substance Abuse Services (BSAS) services for MassHealth members funds a significant expansion for SUD treatment across the continuum of care
- For all Medicaid eligible members:
 - **Expand SUD benefit to include Transitional Support Services (TSS) and Residential Rehabilitation Services (RRS)**
 - Cover up to 90 days of medically necessary residential treatment (based on ASAM assessment)
- For Members with FFS coverage:
 - **Expand SUD benefit to include enhanced acute treatment services for dually-diagnosed members and Structured Outpatient Addiction Programs**
 - These services are currently available only to members enrolled in managed care plans
- **Expand access to care coordination, supportive case management and recovery support services** throughout the system, and extend availability of services into recovery
- Negotiations with CMS are ongoing and positive

In addition, we have a number of other important initiatives underway

Strengthen program integrity in LTSS

- **We have strengthened LTSS program integrity – home health example:**
 - Home health spending grew last year by \$170M, or 41%
 - Over 80% of growth driven by providers new to the Commonwealth since 2013
 - We have referred 12 providers to the Attorney General's office for fraud
 - Actions: moratorium on new home health providers; clinical prior authorizations in place for home health services
- **We will be implementing independent, conflict-free clinical assessments**
 - Ensure members receive a conflict-free assessment of their full set of needs and that individuals have access to a full range of services, not just a service from the agency that assessed the individual

Encourage enrollment in managed and accountable care

- **We will present members with options and incentives to choose to enroll in high quality, integrated MCO and ACO programs** (*effective October 2017*)
 - All benefits available to all members under MCO and ACO programs
 - PCC plan will have fewer optional benefits (e.g., physical therapy, chiropractor)
- **We will be encouraging enrollment in Senior Care Options, One Care and PACE programs to better integrate care**
 - Active member outreach and engagement efforts about the benefits of these plans
 - Passive enrollment for SCO (late FY2017) and One Care with opt-out
- **We will move to annual open enrollment windows for the MCO program** (*Oct. 2016*)
 - Similar to commercial/ Connector plans (90 day opt-out, provisions to switch plans)

Improve customer service and operations

- **Made significant improvements to the eligibility system and completed 1.2 million outstanding eligibility redeterminations** as required by the federal government
- **Improved website/ consumer functionality and member satisfaction (+8%)**
- **Reduced call center wait times** and improved support for health centers and providers
- **Developing comprehensive enrollment materials/ trainings** to support choice

Timelines

Public listening session

- April 20th, 9-11a (1 Ashburton Place, 21st Floor, Boston)
 - Written comments may be submitted through the end of April at MassHealth.Innovations@State.MA.US
 - Comments beyond the end of April can be provided through the formal public comment process (see below)
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1115 waiver proposal timelines

- May: **1115 waiver proposal posted** for 30 day public comment period, including 2 public hearings (dates and locations TBD)
 - June: **1115 waiver proposal submitted** to CMS
 - The waiver proposal for CMS will focus on:
 - Authorities required for ACO models
 - DSRIP uses and financing
 - Safety Net Care Pool structure and financing
 - Expansion of treatment continuum for Substance Use Disorder
 - The waiver proposal does not include operational details for ACO and Community Partner models
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Implementation timelines

- Advanced ACO pilot: solicitation spring 2016, launch December 2016
- DSRIP funding begins FY18
- Community Partners launch early FY18
- Full ACO models: solicitation summer 2016, roll-out October 2017
- MCO reprocurement effective October 2017 (sequenced after ACO procurement)

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MassHealth ACO models: what is an ACO and what does it provide?

- **What is an ACO and what does it provide**

- An ACO is a provider-led entity (e.g., a group of providers or a health system)
- ACOs are expected to build explicit coordinated care teams with providers across the care continuum
- ACOs are expected to deliver a coordinated and improved member experience and have flexibility to engage members differently (e.g., enhanced services, care coordination)
- Unless it is integrated with a health plan, an ACO does not set fee schedules or process claims from other providers – that remains the responsibility of MassHealth and our MCOs

- **Which providers can be an ACO**

- At minimum, an ACO must include primary care providers (PCPs)
- Hospitals, specialists, BH, LTSS and social service providers may join or partner with ACOs
- ACOs must have partnerships with certified community based BH and LTSS providers
- ACOs must meet other criteria (e.g., minimum number of members, risk bearing capability)

- **How do ACOs and Managed Care Organizations (MCOs) fit together**

- MCOs have an important role in implementing ACO models
- MCOs remain the insurer, pay claims, and work with ACOs to improve care delivery and support integration of care
- MCOs also support providers to build provider capacity, including providing analytics for population health management

MassHealth ACO models: who is eligible and how do members enroll?

- **Who is eligible**
 - Members for whom MassHealth is the primary payer
 - Does not include members where Medicare or a private insurer is the primary payer
 - At this time, non-dual HCBS¹ waiver populations are eligible to enroll in an ACO, but HCBS waiver services will continue to be provided outside of ACO scope and budgets
 - Includes adults, youth/ children, members with BH and/ or LTSS needs

- **There are three ACO models (not a one size fits all model)**
 - Model A: Integrated entity that includes both the ACO provider and health plan (MCO)
 - Model B: ACO providers who contract directly with MassHealth, which remains the insurer
 - Model C: ACO providers who contract directly with health plans (MCOs)

- **Members choose an ACO based on PCP selection**
 - Members directly enroll in Model A and Model B ACOs based on their selection of PCP
 - For Model C, members enroll in an MCO and choose an ACO based on their selection of PCP
 - For members whose PCP is not in an ACO, members will still have MCO and PCCP options

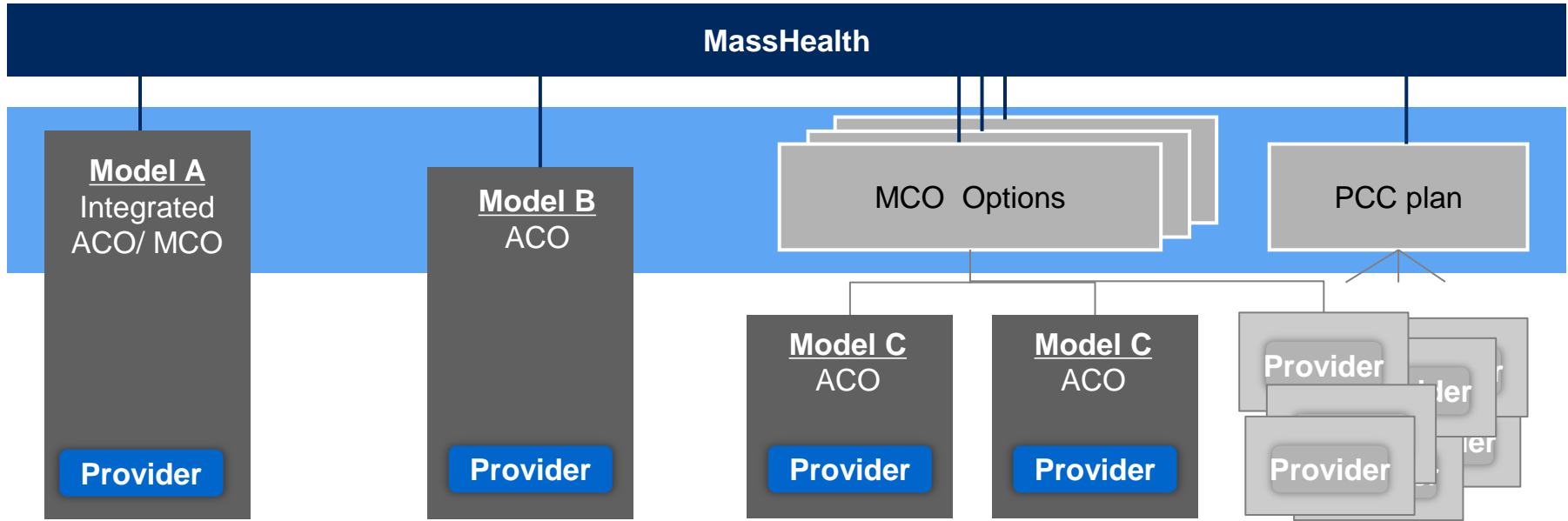
- **ACO models have the same set of benefits as the broader MCO program;** ACOs and MCOs may invest in additional care coordination or services to engage members

- **In addition, we want to ensure quality access to care for individuals with disabilities**
 - ACO and MCO contracts will focus more directly on accommodations for MassHealth members with disabilities, including provision of accessible medical and diagnostic equipment
 - DSRIP funding may be available to support related enhancements

MassHealth ACO models: how does the payment model work?

- **ACOs have total cost of care accountability for the following areas:**
 - All managed care eligible spend (physical health + behavioral health)
 - LTSS: Year 1 reporting only; Year 2 and on some accountability phases in
 - At this time, HCBS waiver services continue to be provided outside of ACO scope and budgets
 - Total cost of care is risk-adjusted (UMass Medical School is developing a risk adjustment model that incorporates some of the social determinants of health)
 - Separate “rating category” or adjustor for Serious Mental Illness (SMI)
- **Who is paying claims**
 - Model A: the MCO that is part of the integrated ACO/MCO entity
 - Model B: MassHealth and MBHP pay claims to providers in the MassHealth and MBHP network
 - Model C: MCOs pay claims to providers in their networks
 - ACOs are not responsible for paying claims and authorizing LTSS services (exceptions in future years, if the ACO is integrated with an MCO qualified to cover LTSS)
- **Payments for ACOs are linked to performance on quality metrics across multiple domains**
 - We will also measure quality and access of care specifically for members with disabilities (e.g., for ID/DD members, individuals with physical disabilities)
- **In addition, we will increase member protections to ensure right care from the right providers**
 - Members in ACO models will have access to an ombudsman and advocacy resource
 - Members with LTSS needs in ACO models will be able to access an LTSS Community Partner (CP – see later in document for detail) as an independent advocate and resource counselor

MassHealth ACO models: 3 types of ACO models (1 of 2)



Model A: Integrated ACO/MCO model

- Fully integrated: an ACO joins with an MCO to provide full range of services
- Risk-adjusted, prospective capitation rate
- ACO/MCO entity takes on full insurance risk

Model B: Direct to ACO model

- ACO provider contracts directly with MassHealth for overall cost/ quality
- Based on MassHealth/ MBHP provider network
- ACO may have provider partnerships for referrals and care coordination
- Advanced model with two-sided performance (not insurance) risk

Model C: MCO-administered ACO model

- ACOs contract and work with MCOs
- MCOs play larger role to support population health management
- Various levels of risk; all include two-sided performance (not insurance) risk

Increasing levels of sophistication, care coordination, and DSRIP \$\$



MassHealth ACO models: 3 types of ACO models (2 of 2)

Three ACO models with different features (Models A, B, C)
ACOs can choose based on experience, capabilities, appetite for risk

Model A: integrated ACO/ MCO entity

- Regulated and paid like a health plan (e.g., prospective capitation, licensure requirements)
- Members can actively choose and enroll in a Model A ACO/MCO, like an MCO
- Must be integrated (ownership or joint venture) with ACO provider
- 100%, two-sided, insurance risk
- Must meet MassHealth network adequacy rules
- May have preferred providers for referrals

Model B: Direct to ACO (MassHealth remains the insurer)

- Operates under PCC plan authority with additional CMS authority/waivers as necessary
- Members can actively choose and enroll in a Model B ACO, like an MCO
- Network / authorizations:
 - MassHealth maintains PCC network, fee schedule, and role in authorizing services
 - ACO may define a preferred provider network, within which they can establish funds flows for provider performance management and/or waive PCC referral requirements to enhance access and coordination
- Payment mechanics – similar to CMS NextGen¹ ACO model
 - MassHealth contracts with ACO for total cost of care accountability with two-sided risk
 - ACO expected to have strong integration and advanced capabilities; option to take capitation
 - No insurance risk for ACO (only performance risk), with risk corridors
 - ACO must have RBPO certification, with a mechanism to assure the ability to manage risk (e.g., restricted cash reserves, line of credit or performance bond, consistent with CMS Next Gen¹ ACO model)

Model C: MCO- supported ACOs

- Three tracks (less advanced, moderately advanced, most advanced)
- Retrospectively adjudicated with two-sided risk, with flexibility for more advanced arrangements
- Expectation for MCOs to administer Model C ACOs, support care management
- Members select an MCO and have choice of PCP within MCO network

Performance on quality and member experience metrics will impact an ACO's ability to earn rewards under all models

¹ National model approved by Center for Medicare and Medicaid Innovation (CMMI)

Overview of ACO Model A: ACO/MCO model

Will operate within existing CMS/MassHealth managed care authority

Network	<ul style="list-style-type: none">Members access providers in the integrated ACO/MCO networkMembers will be able to access out-of-network providers in certain circumstances
Contractual relationships	<ul style="list-style-type: none">MassHealth contracts with selected entities that meet requirements (e.g., health plan functionality, shared ownership/ joint venture between a health plan and health system)ACO/MCO is required to establish formal relationships with BH and LTSS community partners¹ to receive DSRIP fundingACO/MCO contracts directly with providers to build a network for covered services. Initially, LTSS continues to be covered directly by MassHealth (see below)
Payment model	<ul style="list-style-type: none">The payment model is a prospective insurance model with the ACO/MCO responsible for all covered costs, like current MCOs
Scope of services	<ul style="list-style-type: none">ACO/MCO is responsible for covering medical, behavioral health and pharmacy spend as of Year 1, as in the MCO programCertain services (e.g., most LTSS, transportation, DME, and dental) will be wrapped initially by MassHealth as in the MCO program, and phased into responsibility over time
Minimum requirements	<ul style="list-style-type: none">ACO/MCO is selected by MassHealth based on criteria such as size, experience, governance, HPC certification, and approach to care coordinationAs a health plan, the ACO/MCO must comply with applicable DOI requirements (including those related to capital reserves and health plan licensure)
Quality requirements	<ul style="list-style-type: none">ACO/MCO is accountable for achieving quality targets to realize full shared savings
Population health mgmt. tools	<ul style="list-style-type: none">ACO/MCO defines and contracts for its own network, allowing it to guide member care to a set of more coordinated or higher value providers

¹ Please see later section for more details

Overview of ACO Model B: direct to ACO model

Will operate under PCC plan authority, with waivers

<p>Network</p>	<ul style="list-style-type: none"> Members access providers in the PCC plan and MBHP networks, subject to MassHealth’s PCC authorization processes and referral rules The ACO may offer enhanced access to a sub-set of affiliated providers (“Coordinated Care Team (CCT)”) by asking MassHealth to waive otherwise-applicable PCC referral rules for these providers for members in the ACO
<p>Contractual relationships</p>	<ul style="list-style-type: none"> MassHealth enters into a risk-sharing arrangement with the ACO ACO is required to establish formal relationships with BH and LTSS community partners¹ In addition, the ACO can develop preferred relationships or contracts with a Coordinated Care Team (CCT)
<p>Payment model</p>	<ul style="list-style-type: none"> Initially, providers are paid FFS with a retrospective reconciliation to the ACO assessed based on risk-adjusted total cost of care performance May advance to Population-Based Payments (PBP)² (CMMI Next Gen feature)³ <ul style="list-style-type: none"> ACO’s providers/CCT are paid on a reduced fee schedule, and the difference is instead paid directly to the ACO up front each month, allowing the ACO flexibility to distribute and invest funds internally May advance to in-network capitation for medical and BH providers⁴ (CMMI Next Gen feature)³ <ul style="list-style-type: none"> ACO receives payment for all services its providers/CCT provide to the ACO’s members up front each month, and is responsible for paying those provider claims; authorization and claims processing is done by MassHealth
<p>Scope of services</p>	<ul style="list-style-type: none"> ACO is accountable for costs associated with medical, behavioral health and pharmacy spend (with adjustments) as of Y1 under their TCOC model Certain services (e.g. most LTSS, transportation, DME, and dental) will be phased into accountability over time
<p>Minimum requirements</p>	<ul style="list-style-type: none"> ACOs will be selected by MassHealth based on criteria such as size, experience, governance and HPC certification Must have RBPO certification, with a mechanism to assure the ability to manage risk (e.g., restricted cash reserves, line of credit or performance bond, consistent with CMMI Next Gen ACO model)³
<p>Quality requirements</p>	<ul style="list-style-type: none"> The ACO is accountable for achieving quality targets to realize full shared savings
<p>Population health mgmt. tools</p>	<p>The ACO has tools to guide member care, including:</p> <ul style="list-style-type: none"> Ability to define a CCT; flexibility to distribute and invest funds within that team (under PBP or capitation) Data & reporting from MassHealth Modified referral requirements for sub set of providers

¹ Please see later section for more details ² ACOs will have this option starting in Year 1 ³ National model approved by Center for Medicare and Medicaid Innovation (CMMI)
⁴ ACOs will have this option starting in Year 2

Overview of ACO Model C: MCO-administered model

Will operate within existing CMS/MassHealth managed care authority

Network	<ul style="list-style-type: none">Members access providers in their health plan's network, including providers in and out of their ACO, subject to their plan's authorization processes and referral rulesThere may be ACO-affiliated providers that the member can access with enhanced ease
Contractual relationships	<ul style="list-style-type: none">MassHealth contracts with MCOs to enroll members, manage networks, and administer benefits (as today)MCOs contract directly with providers to build a networkEach MCO enters into risk-sharing agreements with ACOs in their network. These ACOs may be in-network for and may contract with multiple MCOsEach ACO is required to establish formal relationships with BH and LTSS community partners^{1,2} to receive DSRIP fundingThe ACO can develop preferred relationships or contracts with providers
Payment model (MCO administered)	<ul style="list-style-type: none">Providers are paid FFS by the MCO with a retrospective reconciliation from the MCO to the ACO assessed based on risk-adjusted total cost of care performanceThe payment model includes less advanced, moderately advanced, and most advanced risk sharing tracks, each of which will have a different amount of two-sided risk, offering a range of options for providers
Scope of services	<ul style="list-style-type: none">ACO is accountable for costs associated with medical, behavioral health and pharmacy spend (with adjustments) as of Y1 under their TCOC modelCertain services (e.g. most LTSS, transportation, DME, and dental) will be wrapped initially by MassHealth as in the MCO program, and phased into MCO and ACO responsibility over time
Minimum requirements	<ul style="list-style-type: none">ACOs selected by MassHealth based on criteria such as size, experience, governance and HPC certification
Quality requirements	<ul style="list-style-type: none">The ACO is accountable for achieving quality targets to realize full shared savingsMCOs are also accountable for quality, as today
Population health mgmt. tools	<p>The ACO will have tools to guide member care, including:</p> <ul style="list-style-type: none">Utilization management and population health management assistance from MCOsData & reporting from MH and the MCOs

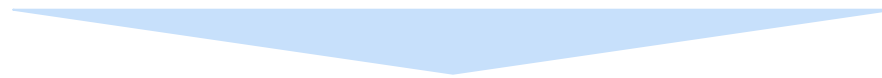
¹ BH = Behavioral Health; LTSS = Long Term Services and Supports; ² Please see later section for more details

Attribution: ACOs strengthen the role of members' primary care provider

- **Member enrollment and attributed to an ACO based on choice of PCP:** a PCP can only participate in one ACO at a time, and all eligible members who receive care from that PCP are considered part of the ACO
- **Coordinated care team relationships:** ACOs invest in relationships and linkages across the continuum, improving connections between primary care and hospitals, specialists, BH and LTSS providers, community agencies, etc. Every eligible member who receives care from a PCP that joins an ACO will be able to benefit from these relationships
- **Member-centered ACO model:** currently, members may experience poor communication among their providers and lack a single, accountable provider who they look to for coordinating their care. Every member in an ACO will have a PCP with accountability for their total care
- **Specialty and tertiary care access:** specialists, hospitals, and other providers may be available across multiple ACO and MCO networks, just as they often are today

Referral circles: ACOs may make care easier for members to access from affiliated providers to improve coordination

- **MassHealth will work with ACOs to allow them to waive MassHealth's primary care referral requirements for certain providers in the coordinated care team ("referral circle").** ACOs may offer other enhancements to encourage members to receive coordinated care



- **More value for members:** ACOs can offer improved service and coordination when members visit providers that are part of the ACO's preferred provider network
- **Better access to appropriate care:** currently, members may experience delays in scheduling appointments due to poor coordination, or have difficulty getting the right primary care referrals. This experience may be improved within ACOs
- **Transparency and collaboration:** in defining a preferred network, ACOs will have an opportunity to communicate with their members about which providers are part of its coordinated team, and about the benefits of more coordinated care
- **Members retain choice and access:** members can access a provider outside of their ACO's preferred network, as long as the provider is in the network for the payer (no change from today). MassHealth or the MCO's referral and authorization rules will continue to apply

ACO quality and member experience metrics: summary

Quality Measures

- All ACOs will be evaluated on the following quality domains:
 - Prevention and wellness
 - Avoidable utilization (preventable admissions and all-cause readmissions)
 - Chronic disease management
 - Behavioral health/substance abuse
 - Long-term services and supports
 - Member experience (see below)
- **Some measures will be phased in**, e.g., measures without existing baselines

Member Experience Survey

- Base survey will be **primary-care focused**, based on the Consumer Assessment of Healthcare Providers and Systems, or CAHPS, a nationally validates and used survey instrument
 - Oversampling of MassHealth members to ensure adequate sample sizes
- **MassHealth will field survey supplements to capture:**
 - Aspects of member experience more pronounced in the MassHealth population in the primary care setting (e.g., management of functional impairments)
 - Member experience In the non-primary care setting (e.g., BH, LTSS providers affiliated with the ACO)

Payment Model Integration

- ACOs will be **financially accountable for quality performance**,
- Quality performance will influence ACO shared savings, as in CMMI ACO¹ models

DSRIP

- The ACO quality measure slate will **also be used for DSRIP accountability**

¹ National model approved by Center for Medicare and Medicaid Innovation (CMMI)

Pilot ACO: Provider-led ACO to contract directly with MassHealth and operate within the PCC

MassHealth will launch a small number of pilot ACOs in December 2016. This will allow interested and capable providers to begin working within a TCOC model and preparing for full roll out in 2017. The pilot will be similar to Model B, with ACOs contracting with the PCC with a FFS retrospective payment model

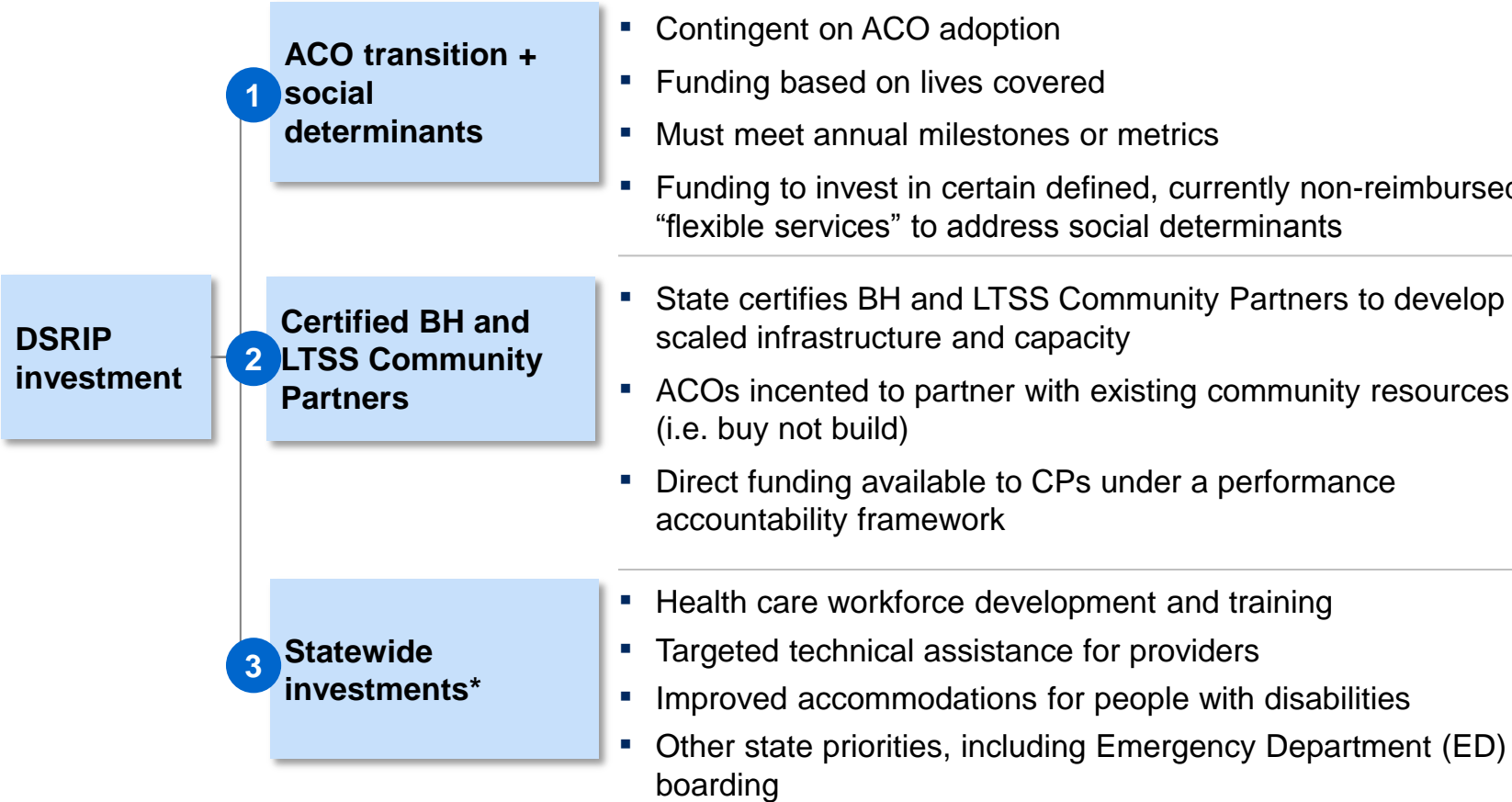
Eligible members	<ul style="list-style-type: none"> MassHealth members in a PCC plan and affiliated with a pilot PCP are eligible 	Quality	<ul style="list-style-type: none"> Shared savings/losses paid out proportionally to quality score (as in Medicare models) Subset of broader ACO quality metrics slate due to shorter performance period
Spend	<ul style="list-style-type: none"> Includes medical and pharmacy spend BH spend included via MBHP arrangement LTSS is reporting only (spend excluded) 	Panel size	<ul style="list-style-type: none"> Minimum panel size to be defined e.g., 10,000 in the PCC with pilot PCPs PCPs may have a maximum panel size
Network	<ul style="list-style-type: none"> ACO will use full PCC network with MBHP as the BH network ACO required to include PCPs (and meet other MassHealth requirements) ACO may create preferred provider network No provider panel exclusivity -- PCPs / affiliates can still see MCO and non-ACO eligible PCC members. 	Member attribution	<ul style="list-style-type: none"> PCC plan members who are attributed to a participating PCP will be in the pilot, and can opt-out by switching PCPs or plans Other members can join if PCP maximum panel size not reached
Period	<ul style="list-style-type: none"> 10 mo. performance period (Dec '16 – Sep '17) to sync with full rollout 	Member communication	<ul style="list-style-type: none"> MassHealth will notify members in the pilot before pilot launch and of their opportunity to opt-out throughout MassHealth call center insurance brokers will be trained to discuss ACO as option ACO may market subject to relevant laws and regulations
Payment model overview	<ul style="list-style-type: none"> FFS with retrospective reconciliation ACOs will receive shared savings if they manage TCOC to below the savings target Target will be set prospectively and will be relative to historical performance 		

Agenda

- Overview
- Accountable Care Organization (ACO) model overview
- **Delivery System Reform Incentive Payment (DSRIP)**
- Implementation timelines
- 1115 waiver updates

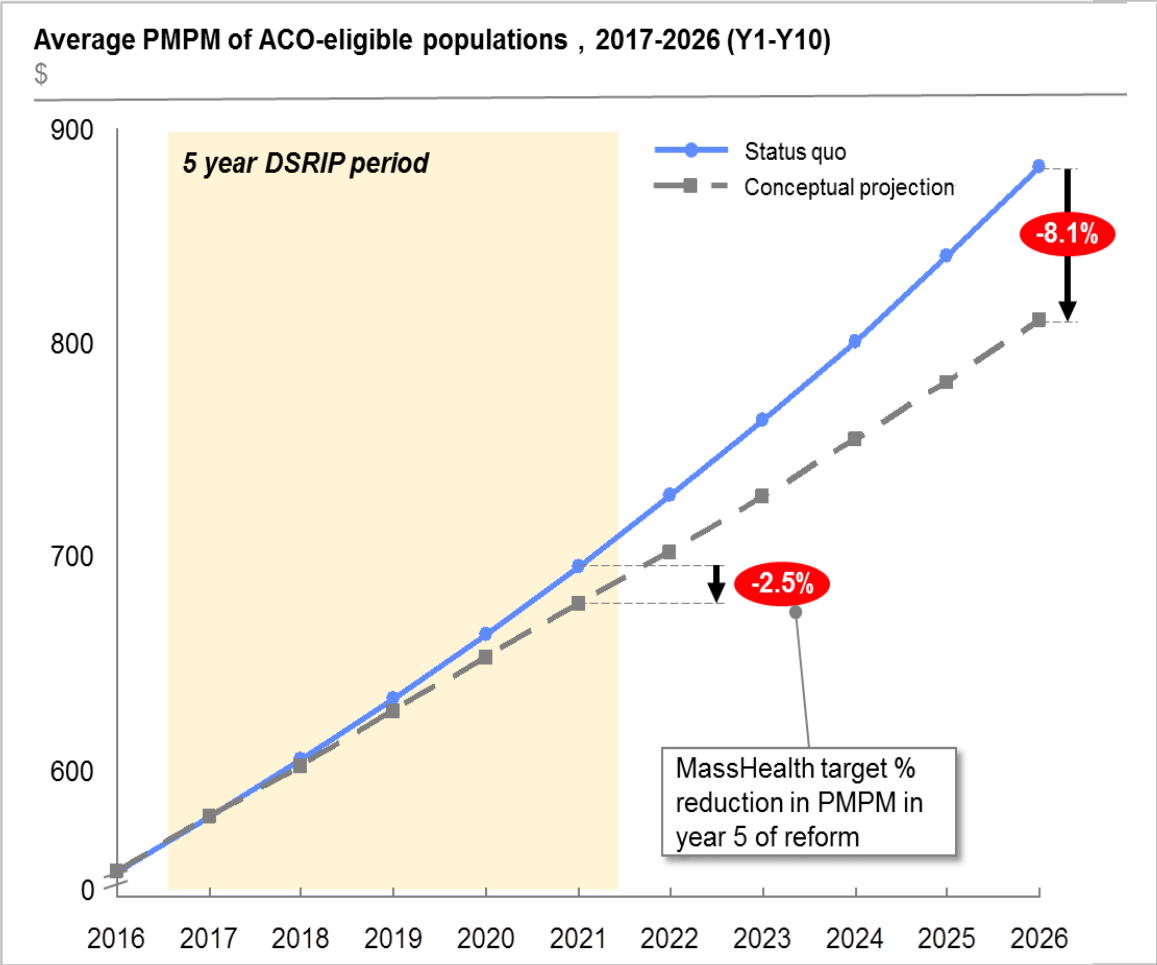
Delivery System Reform Incentive Program (DSRIP): summary of investments

- **~\$1.5B of upfront investments** (as part of the 1115 waiver renewal) to support delivery system restructuring
 - **State commits to annual targets** for performance improvement over 5 years (reduction in total cost of care trend, reduction in avoidable utilization, improvement in quality metrics)
 - **Access to new funding** contingent on providers partnering to better integrate care



*Subject to final 1115 waiver approval

DSRIP: in order to receive DSRIP from CMS, MA must commit to targets for quality and bending the cost curve



- State accountability to CMS for DSRIP funds also dependent on **reduction in avoidable utilization and quality**
- Quality domains include **chronic disease management, BH/LTSS, and patient experience**

1 DSRIP funding: ACO transition + social determinants

Overview

- **DSRIP funding to ACOs** distributed on a PMPY basis based on attributed lives
 - PMPY for ACOs linked to the proportion of lives serving Medicaid/ uninsured populations
-

Funding uses

- **Initial and ongoing funds**
 - ACO development and infrastructure (e.g., performance management infrastructure, workforce capacity, HIT investments, contracting/network development)
 - Investment in new care delivery models (e.g., expanded primary care hours, patient navigation services, telemedicine, ED diversion)
 - **Flexible services:** a portion of ACO funds explicitly designated to pay for currently non-reimbursed services that address social determinants of health (e.g., housing supports, nutrition, etc.)
-

Accountability

- All ACOs will have TCOC accountability, beginning in their first Performance Year
- Up to 20% of DSRIP funds will be at-risk by Year 5, and will depend on meeting process/quality metrics and milestones

2 Certified Community Partners: goals

- **Create explicit opportunity for ACOs and MCOs to leverage existing community-based expertise and capabilities** to best serve consumers with LTSS and BH
- **Break down existing silos** in the care delivery system across BH, LTSS and physical health
- **Ensure care is person-centered, and avoid over-medicalization of care** for LTSS
- **Preserve conflict-free principles** including consideration of care options for consumers and limitations on self-referrals
- **Make explicit and scalable investments in community-based infrastructure** within an overall framework of **performance accountability**
- Create a **certification process** for BH and LTSS Community Partners
- **Encourage ACOs/MCOs and Community Partners to formalize how they work together**, especially for care coordination and performance management

2 Certified Community Partners: overview (1 of 3)

- **What BH and LTSS Community Partners (BH CP and LTSS CP) provide:**
 - Care management, care coordination and member outreach for individuals with significant BH and LTSS needs
 - Expertise in community-based options and person-centered planning for BH and LTSS needs
 - Member referrals to BH/ LTSS direct service providers and social service agencies
 - LTSS CP: clinical and functional assessments for LTSS services
- **Certification of BH and LTSS CPs**
 - A CP must be a community-based organization with extensive and broad expertise in BH and/or LTSS in a geographic region
 - A CP can be a direct service provider but will have a limit on self-referrals
 - BH CP must be able to provide the 6 Health Homes services outlined in § 2703 of the ACA
 - LTSS CP must have competencies to work with multiple subpopulations with disabilities
 - Other criteria (e.g., strong relationships with social service organizations, IT infrastructure for data capture and maintenance, quality measurement/reporting, electronic encounter/billing capacity)
- **Encouraging formation of new entities and partnerships to be CPs**
 - Explicit goal of overcoming fragmentation and siloes that hinder care integration
 - Promotes entities to come together to serve the continuum of members (e.g. elders, adults and children with physical disabilities, and members with brain injury, ID/DD, mental illness, and SUD)

2 Certified Community Partners: overview (2 of 3)

- **Expectations for how ACOs work with Community Partners**
 - ACOs and CPs will each receive separate streams of DSRIP funding
 - Funding is contingent on ACOs and CPs formalizing arrangements for how they work together
 - The State will set minimum criteria for how ACOs should partner with CPs
 - A CP may also be a part of an ACO (separate DSRIP streams still apply)

- **At a minimum, ACOs expected to partner with CPs for the following members:**
 - BH CP: Individuals enrolled in ACOs with SMI, SED, SUD¹
 - LTSS CP: May include a combination of disability eligibility and/or LTSS utilization

- **BH and LTSS CPs and non-ACO members**
 - BH CPs will be required to provide Health Home services to populations not eligible for managed care
 - LTSS CP certification process will favor demonstrated expertise with populations not eligible for MCOs/ACOs
 - MCOs and CPs also encouraged to formalize partnerships (see next page)

- **Linkages to social services**
 - ACOs expected to work with social services providers to address social determinants of health
 - ACOs will receive DSRIP funding designated for “flexible services” to address social determinants (must meet certain criteria)
 - ACOs expected to work with CPs for BH and LTSS populations to screen for and incorporate social determinants into care planning
 - ACOs have flexibility in how to structure care teams (including Community Health Workers) and partner with social service organizations

2 Certified Community Partners: overview (3 of 3)

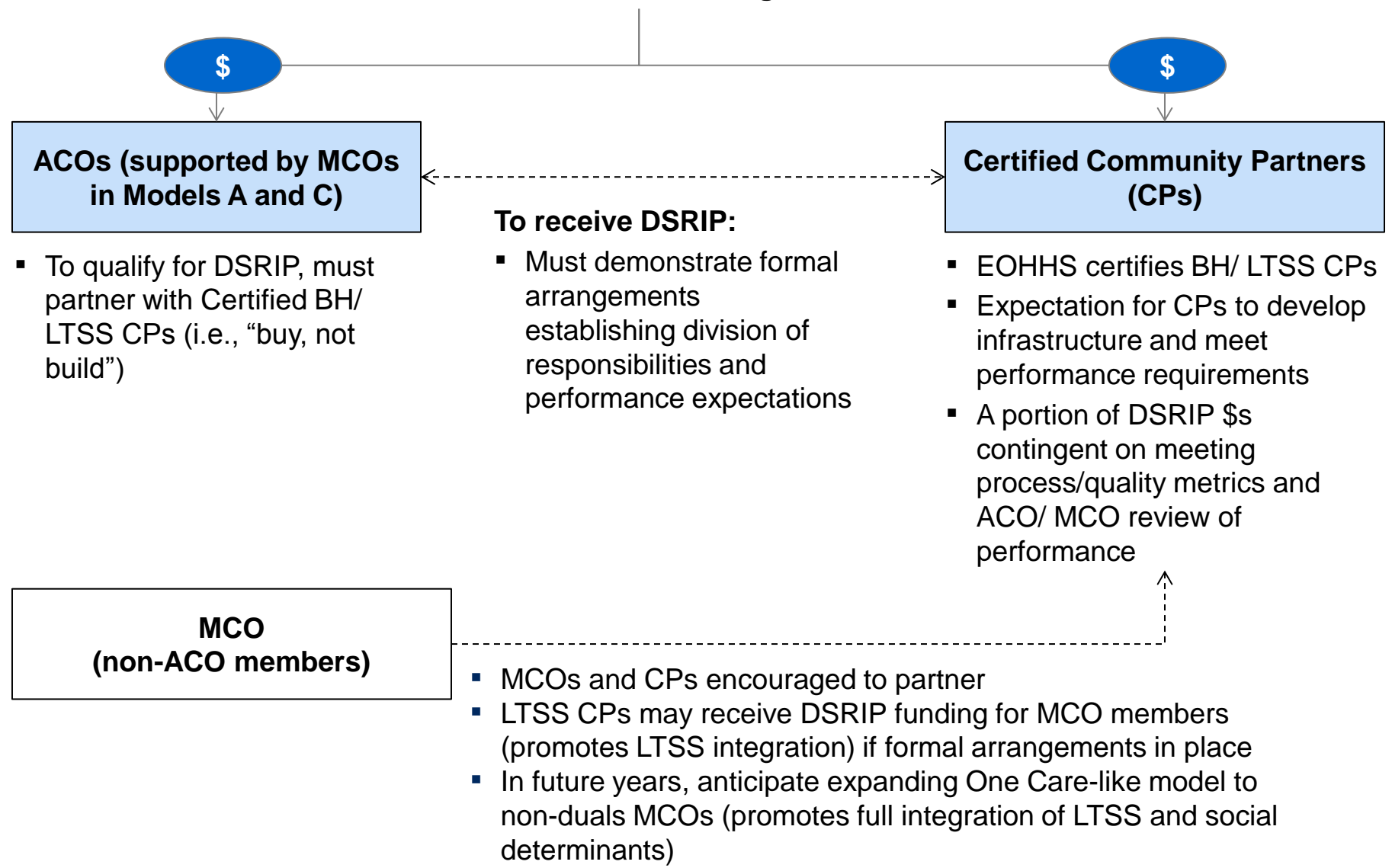
- **Three streams of funding supporting CP activities**
 - DSRIP directly to CPs for infrastructure and care coordination
 - Programmatic funding to BH CPs through § 2703 of the ACA (Health Homes program) – 90% federal match for 2 years, DSRIP funding for Years 3-5
 - DSRIP to ACOs explicitly designated for flexible services to fund social service needs

- **Performance accountability and incentives built into funding streams**
 - Process and quality metrics defined by the state
 - ACO/ MCO evaluation of CP performance

- **Note on how CPs interact with MCOs**
 - MCOs and CPs encouraged to partner to promote integration across all managed care eligible lives
 - LTSS CPs may receive DSRIP funding for MCO members if formal arrangements in place
 - No separate funding for BH CPs and flexible services for MCO lives that are not in an ACO (existing expectation that MCOs are addressing these needs)

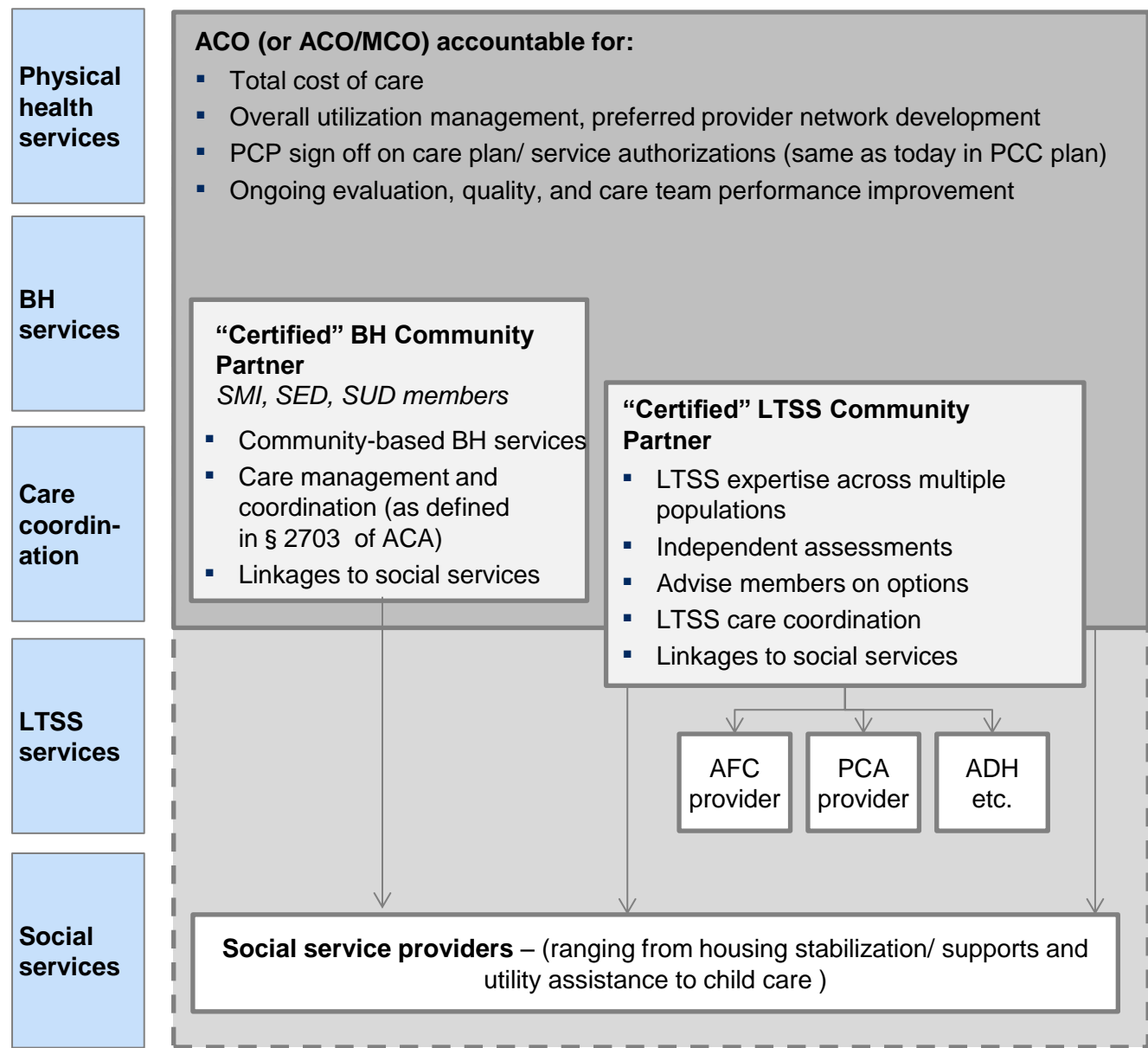
2 Certified Community Partners: promoting integration across a siloed system

MassHealth DSRIP Program



2 Certified Community Partners: graphical overview

→ Indicate referrals and relationships



- Physical and BH (and some other) services are currently part of MCO capitation
- **These services are included in ACO’s Year 1 total cost of care budget** (or capitation payment for Model A ACOs)
- **Expectation that ACOs integrate BH, LTSS, and social services into whole-person care, with Community Partners**
- LTSS accountability gradually transitioned in for ACOs (and MCOs)
- MassHealth continues to directly pay and authorize LTSS services (with PCP referral authorization where required)

2 Certification of BH and LTSS CPs

- Community-based providers will need to meet **robust set of requirements** to qualify as CPs
- **State will establish set of certification domains** across BH and LTSS CPs. Examples domains include:
 - Infrastructure and systems (e.g., ability to share information electronically)
 - Care management and coordination capabilities
 - Relationships with social service providers and local and public agencies
 - Quality measurement and reporting
 - Governance
 - Relationships with social service providers and local and public agencies
- **BH CPs must:**
 - Demonstrate capacity to deliver outpatient MH & SUD, including outreach & home-based, services
 - Demonstrate Ability to provide six Health Home (§ 2703) services.
 - Be CSA¹ or have agreements with local CSAs for serving children
- **LTSS CPs must:**
 - Demonstrate expertise in serving multiple of the following populations with disabilities: elders, adults with physical disabilities, children with physical disabilities, members with acquired or traumatic brain injury, ID/DD², and individuals w/ co-occurring BH & LTSS needs
 - Demonstrate ability to conduct independent assessments, person-centered counseling on LTSS options, and navigation to quality LTSS providers
- **State to establish checks and balances to limit inappropriate self-referrals for services**

¹ CSA: a Community Service Agency for the Children's Behavioral Health Initiative (CBHI)

² Intellectual disability/developmental disability

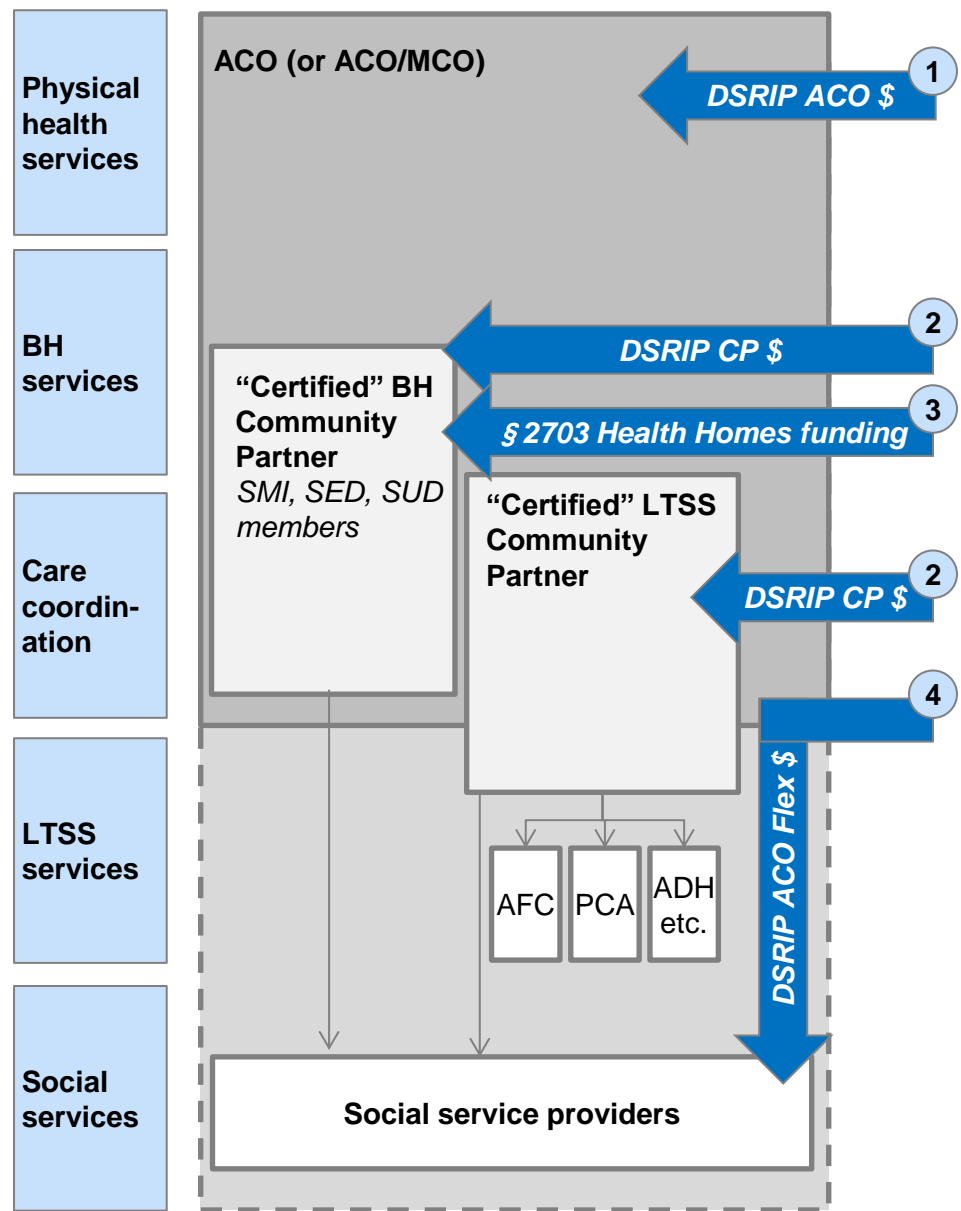
2 Incorporating “flexible services” to address social determinants of health

- **Clear expectations for ACOs and CPs to address social determinants of health (SDH)**
 - Assessment of social service needs
 - Linkages with social service organizations
 - For members engaged with CPs, CPs to recommend services to be included in the care plan, make referrals and provide navigational assistance for accessing social services

- **ACOs expected to be innovative in partnering with social service organizations**
 - ACOs can establish linkages with a select set of social service organizations who provide the best value to serve its members
 - ACOs will be able to direct flexible services spending \$s from DSRIP to provide funding for social services as needed (see below for criteria)

- **DSRIP spending for non-reimbursed flexible services must satisfy the following criteria:**
 - Must be health related
 - Not covered benefits under the MassHealth State Plan
 - Must be consistent with and documented in member’s care plan
 - Determined to be cost-effective alternatives to covered benefits, likely to generate savings
 - Likely to improve health outcomes, prevent or delay health deterioration
 - Funding is not available from other publicly-funded programs
 - Other criteria established by MassHealth

2 Community Partner funding sources: overview



Summary of funding streams:

- 1 **DSRIP directly to ACOs**
 - For infrastructure, startup, ongoing costs
 - Contingent on formalizing relationships with Community Partners

- 2 **DSRIP directly to CPs**
 - PMPY for infrastructure and startup costs
 - PMPY based on population served (for ACOs and existing MCOs)
 - Years 3-5 for § 2703 BH Health Homes program
 - A portion (growing to 20% by Year 5) contingent on meeting process & quality metrics, and on ACO/MCO evaluation of CP performance

- 3 **§ 2703 Health Homes funding**
 - Federal program (part of ACA), 90% federal match
 - 2 years of funding for care coordination/management (Years 3-5 transition to DSRIP)

- 4 **DSRIP to ACOs: explicitly designated for flexible services**
 - PMPY to ACOs based on attributed population
 - Can only be used for flexible services that address social determinants of health

Funding tapers over time; must be built into total cost of care budget by Y6

3 DSRIP funding: statewide investments

Overview

- Statewide investments DSRIP funding stream will **help the state more efficiently scale up statewide infrastructure and workforce capacity** than when compared to provider-specific investments

Funding Use Cases*

- **Healthcare/ PCP Workforce Development and Training** (e.g., primary care retention, workforce development)
- **Technical Assistance (TA)**
 - External support for care delivery, quality, and program improvements, administered via a grant program, with ACOs/CPs paying for part of TA costs
 - Targeted TA specifically for CHCs to help prepare for ACO participation and execution
- **Alternative Payment Methodology (APM) Preparation Fund**
 - Grant program targeted at helping less-sophisticated providers join ACO models to maximize ACO participation
- **Establishing Clinical/Community Linkages**
 - Expand **DPH's e-Referral program**, which allows providers to refer patients through their EHRs to community-based organizations
 - Establish **community resource database** that is complementary to Mass Options, with a focus on social services addressing social determinants of health
- **Behavioral Health and Substance Use**
 - Expand **MCPAP for Moms** to equip perinatal providers to identify/prevent alcohol and other drug use during pregnancy
 - Reduce number of **BH/SU members experiencing long stays in EDs**
- **Improved accommodations for people with disabilities**

Agenda

- Overview
- Accountable Care Organization (ACO) model overview
- Delivery System Reform Incentive Payment (DSRIP)

- **Implementation timelines**

- 1115 waiver updates

Implementation timelines



ACO Pilot

- Applications open (May 2016)
- Selection (Sep 2016)
- **Launch (Dec 2016)**



Health Policy Commission's ACO Certification Process
September 2016 onwards

Full ACO Roll-out

- Applications open (Jul/Aug 2016)
- Selection (Dec 2016)
- DSRIP starts (Jul 2017)
- **Launch (Oct 2017)**



MCO reprourement

- Applications open (Oct 2016)
- Responses due (Jan/Feb 2017)
- Selection (May 2017) *
- **Launch (Oct 2017)**



Community Partners

- Applications open (Sep 2016)
- Responses due (Dec 2016)
- Certification (Feb 2017) *
- **DSRIP starts + Launch (Jul 2017)**



DSRIP statewide investments

- Phased application and selection (Sep 2016 – Mar 2017)
- **DSRIP starts + Launch (July 2017 onwards)**



* Correction April 15, 2016:
Now reads 2017 instead of 2016

Agenda

- Overview
- Accountable Care Organization (ACO) model overview
- Delivery System Reform Incentive Payment (DSRIP)
- Implementation timelines

- **1115 waiver updates**

1115 waiver update

- Negotiating a new 5-year 1115 waiver with CMS
 - Authorization for current waiver expires June 30, 2017, putting \$1Bn/ year of funding at risk
 - CMS is not amenable to continuing current waiver structure and funding without significant changes/innovations
 - New waiver proposal centers on ACOs and integrating BH, LTSS and social determinants, pushing for system reform/integration beyond other states' waivers
 - Proposing ~\$1.5Bn of upfront funding (DSRIP) to support delivery system reforms

- Safety Net Care Pool: sustainable support for safety net hospitals
 - Current waiver provides significant funding for 7 safety net providers (primarily DSTI)
 - CMS unwilling to extend funding for DSTI (FY17 will be year 6), intended as transitional funding for transformation
 - However, safety net providers need ongoing support for operations
 - New waiver will restructure payments to be more sustainable, fact based
 - MA is committed to a sustainable glide path over 5 years to the new funding level

- MA is also working with CMS on various other 1115 waiver authorities
 - 1115 waiver includes authority for federal matching for state programs (e.g., HSN, ConnectorCare, certain expanded MassHealth populations and services)
 - MA proposes to expand substance use disorder treatment through the 1115 waiver (likely submitted as one waiver proposal, may be processed with CMS on separate track)
 - Also working with CMS on technical updates to Safety Net Care Pool financing structure

- Discussions with CMS to date are positive, collaborative, and ongoing

Waiver financing

- Massachusetts must identify a source of state share for DSRIP as part of its proposal to CMS to continue waiver funding beyond June 30, 2017
- **Hospital assessment satisfies the state share requirement and brings in revenue through DSRIP without financial impact on hospitals as a class**
 - Current assessment (HSN) is 0.8% of hospital revenue, low relative to other states and 6% federal limit
 - New \$250M/yr hospital assessment results in total assessments ~2% of hospital revenues
 - State increases MassHealth hospital payments by \$250M per year
 - Assessment supports state share for DSRIP funding, available to providers participating in ACO models (hospitals + other providers and partners)
 - Generates federal matching funds through DSRIP and hospital payment enhancement, enabling \$500M in total spending annually (\$250M hospital payments, \$250M toward DSRIP)
- **In FY17 alone, accelerating assessment addresses budget gap**
 - \$73.5M one-time transfer from Delivery System Reform trust fund to General Fund
 - Hospitals still receive \$250M payment annually starting 10/1/16
- **Starting in FY18, 100% of the assessment used for hospital payment increases + DSRIP**

Sustainable hospital safety net funding: overview

Current 1115 waiver safety net support

- 7 hospitals eligible for Delivery System Transformation Initiatives
- Payments not tied to a value based payment model for services (most service payments remain FFS)
- Serves as both transformation funding and ongoing operational support for safety net providers
- As part of current 1115 waiver agreement, MA is required to restructure these payments

Principles for Redesign

- **Sustainable** payment levels for the Commonwealth and for an efficient safety net provider
- **Aligned with value based payment models**
- **Glide path** to provide reasonable transition for hospitals to new supplemental payment structure/level

Proposed Approach for Redesign

- Expand pool of eligible providers (from 7 to 11)
- Funding distributed using fact based rather than historic methodology
- Payments fixed over time (predictable, not tied to FFS volume) and aligned with value based payments
- Reduce funding level to encourage efficiency and sustainability while ensuring necessary ongoing support
- DSRIP serves as transition funding + ACO incentive

Accountability

- Hospital safety net supplemental payments accountability tied to DSRIP performance (same measures, risk)
- Payments will have gradual increased risk over the five year waiver term, consistent with DSRIP

Appendix

Certified BH Community Partner (BH CP) responsibilities

- BH CP must be a MassHealth provider of outpatient BH services
- Focus: SMI, SED, SUD members (ACO and CP may work together to serve other populations)

Minimum for ACO and CPs to receive DSRIP:

1 **Manage overall performance and composition of the care team**

- Primary accountable entity for total cost of care
- Responsible for all referrals
- Decision-maker on utilization management
- Ongoing evaluation, quality improvement, and care team performance management

2 **Provide person-centered care management and coordination** (consistent with CMS/ federal definitions to receive funding for BH and behavioral health change interventions)

- Comprehensive care management
- Care coordination
- Care transitions
- Health promotion
- Member engagement/ outreach
- Linkages to social supports
 - Assess social service needs/ social determinants of health
 - Identify social service needs to support care plan
 - Provide expertise on high-quality, community-based social service organizations
 - Refer and help members navigate amongst range of social services

3 **Budget for Flexible Spending services**

4 **Provide community-based BH services to a segment of their care managed members**

BH CP	ACO
Some ACOs may look to BH CP for support	✓
✓ At minimum: Must perform all activities	✓ At minimum: PCP signs off on care plan
✓ Care plan/ budget	✓ Approve budget
✓	

Certified LTSS Community Partner (LTSS CP) responsibilities

- LTSS CP can be a convening entity for LTSS services
- LTSS CP can be a direct service provider but will have a limit on self-referrals

Minimum for ACO and CPs to receive DSRIP:

1 **Manage overall performance and composition of the care team**

- Primary accountable entity for total cost of care
- Responsible for ALL referrals
- Decision-maker on utilization management
- Ongoing evaluation, quality improvement, and care team performance management

2 **Provide independent assessments and person-centered counseling on service options**

- Conduct independent assessment for LTSS functional and clinical needs
- Counseling on LTSS options available to members
- Make recommendations for care plan

3 **Refer members to quality LTSS providers**

- LTSS CP makes referral; ACO signs off as part of care plan; MassHealth authorizes

4 **Provide care management and coordination**

- Person-centered planning
- Care coordination for the member and member engagement/ outreach
- Care transition assistance
- Connections to public agencies (state and municipal agencies)
- Linkages to social supports
 - Assess social service needs/ social determinants of health
 - Identify social service needs to support care plan and refer to social service orgs.

5 **Budget for Flexible Spending services**

6 **May provide some MassHealth State Plan LTSS services**

LTSS CP	ACO
Some ACOs may look to LTSS CP for additional assistance	✓
✓	
✓	✓
	<ul style="list-style-type: none"> Minimum: LTSS CP should be incorporated into care teams ACOs may look to LTSS CPs for additional support
Care plan/ budget ✓	Approve budget ✓
✓	

Glossary of Acronyms and Terms (1 of 4)

Acronyms
<i>ACA (Affordable Care Act)</i>
<i>ACO (Accountable Care Organization)</i>
<i>ADA (American Disabilities Act)</i>
<i>ADH (Adult Day Health)</i>
<i>AFC (Adult Foster Care)</i>
<i>ASAM (American Society of Addiction Medicine)</i>
<i>BH (Behavioral Health)</i>
<i>BH CP (Behavioral Health Community Partner)</i>
<i>BSAS (Bureau of Substance Abuse Services, Department of Public Health)</i>
<i>CAHPS Survey (Consumer Assessment of Healthcare Providers and Systems Survey)</i>
<i>CBHI (Children's Behavioral Health Initiative)</i>
<i>CCT (Coordinated Care Team)</i>
<i>CMMI (Centers for Medicare and Medicaid Innovation)</i>
<i>CMS (Centers for Medicare and Medicaid Services)</i>
<i>CP (Community Partner)</i>
<i>DCF (Department of Children and Families)</i>
<i>CSA (Community Service Agency)</i>
<i>DDS (Department of Developmental Services)</i>
<i>DME (Durable Medical Equipment)</i>

Glossary of Acronyms and Terms (2 of 4)

Acronyms

DMH (Department of Mental Health)

DPH (Department of Public Health)

DOI (Division of Insurance)

DSRIP (Delivery System Reform Incentive Payment program)

DSTI (Delivery System Transformation Initiatives)

ED (Emergency Department)

EHR (Electronic Health Record)

EOEA (Executive Office of Elder Affairs)

EOHHS (Executive Office of Health and Human Services)

FFS (Fee-for-Service)

HCBS Waiver (Home- and Community-Based Services Waiver)

HH (Home Health)

HIT (Health Information Technology)

HSN (Health Safety Net)

ID/DD (Intellectual Disabilities/Development Disabilities)

LTSS (Long-term Services and Supports)

LTSS CP (Long-term Services and Supports Community Partner)

MCB (Massachusetts Commission for the Blind)

MH (Mental Health)

MCDHH (Massachusetts Commission for the Deaf & Hard of Hearing)

MBHP (Massachusetts Behavioral Health Partnership)

MCO (Managed Care Organization)

Glossary of Acronyms and Terms (3 of 4)

Acronyms

MCPAP (Massachusetts Child Psychiatry Access Project)

MRC (Massachusetts Rehabilitation Commission)

PBP (Population-Based Payment)

PCA (Personal Care Attendant)

PCC Plan (Primary Care Clinician Plan)

PCP (Primary Care Physician)

PMPM Payment (Per-Member Per-Month Payment)

PMPY Payment (Per-Member Per-Year Payment)

RBC (Risk-Based Capital)

RBPO (Risk Bearing Provider Organizations)

RC2/RC10 (Rate Categories 2 and 10)

SCO Plans (Senior Care Option Plans)

SDH (Social Determinants of Health)

SED (Serious Emotional Disturbance)

SMI (Severe Mental Illness)

SUD (Substance Use Disorder)

TA (Technical Assistance)

TCOC (Total Cost of Care)

Glossary of Acronyms and Terms (4 of 4)

Terms
Conflict-Free Assessment – An assessment performed by an independent healthcare provider
Downside Risk – Risk associated with financial losses
Duals – Medicare/Medicaid eligible populations
Health Homes – A federally-funded program to coordinate care for people with Medicaid who have chronic conditions by adding Section 1945 to the Social Security Act.
Insurance Risk - Insurance risk entails the financial costs of diseases, accidents, or injury spread out over a covered population (i.e., insured members)
Interoperability - Ability of health information systems to work together within and across organizational boundaries in order to advance the effective delivery of healthcare for individuals and communities.
Next Generation Models – National ACO model approved and launched by Center for Medicare and Medicaid Innovation (CMMI)
One Care - One Care, the Massachusetts Duals Demonstration, was implemented as a Financial Alignment Demonstration through an opportunity in the Affordable Care Act (ACA) allowing states to develop and test integrated care models for people who are dually eligible for Medicaid and Medicare.
Performance Risk - Performance or utilization risk involves managing the rates of utilization of medical services by a defined population
Prospective Payment Models - Payment models in which payers pay a global payment before the care is delivered.
Retrospective Payment Models - Payment models in which payers pay providers after the care is delivered.
Retrospective Reconciliation - Financial reconciliation at the end of a period of time during which the total cost of services is reconciled against a clinically fair target price.
SCO Plans - Comprehensive health plan that covers all of the services reimbursable under Medicare and MassHealth through a senior care organization and its network of providers. The SCO program offers MassHealth Standard members aged 65 or older quality health care that combines health services with social support services.
Social Determinants of Health - Conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life
Upside Risk – shared savings from improving total cost of care (subject to quality metric achievement)

Quality metrics: MassHealth ACO quality measure slate

Measure
Prevention & Wellness (9 measures)
<i>Pediatrics</i>
Well child visits in first 15 months of life (W15)
Well child visits 3-6 yrs (W34)
<i>Adolescent</i>
Adolescent well-care visit (AWC)
Weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)
<i>Maternity</i>
Prenatal and postpartum care
PC-01 elective delivery
<i>Oral</i>
Oral evaluation, dental services
<i>Adult (emphasis on SDH)</i>
Tobacco use assess and cessation intervention
Adult BMI assessment (ABA)
Avoidable Utilization (2 measures)
% reduction in potentially preventable admissions
% reduction in hospital all-cause readmissions
Patient Experience Survey (in development)
Will evaluate patient experience in primary care, BH, and LTSS settings, with one area of focus being cross-spectrum care coordination in primary care setting

Measure
Chronic Disease Management (6 measures)
Controlling high blood pressure (CBP)
COPD or asthma admission rate in older adults
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 Use (8 measures)
Developmental screening for behavioral health needs and documentation of follow-up plan: Ages <21
Screening for clinical depression and follow-up plan: Age 12+
Depression remission at 12 months
Initiation and engagement of alcohol and other drugs (AOD) treatment (IET)
Members with current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options: 18+
Follow-up after hospitalization for mental illness (FUH)
Use of multiple concurrent antipsychotics in children and adolescents (APC)
Follow-up care for children prescribed ADHD medication
Long Term Services and Supports (2 measures)
Patients received age-appropriate LTSS assessment
Documentation and member agreement with member care plan

Measure slate will be evaluated and potentially updated on an annual basis